CHILDREN IN STATE CARE
COMMISSION OF INQUIRY

ALLEGATIONS OF SEXUAL ABUSE AND DEATH FROM CRIMINAL CONDUCT

Presented to the South Australian Parliament
by the Hon. E.P. Mullighan QC
Commissioner
Children in State Care and Children on APY Lands

Commission of Inquiry
South Australia

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Commissioner

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31 March 2008

His Excellency Rear Admiral Kevin Scarce AC CSC RANR
Governor of South Australia
Government House
Adelaide

Your Excellency

In accordance with section 11 of the Commission of Inquiry (Children in State Care and Children on APY Lands) Act 2004, I present my final report of the Children in State Care Commission of Inquiry.

Yours sincerely

[Signature]

The Hon. E.P. Mullighan QC
Commissioner
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Nothing prepared me for the foul undercurrent of society revealed in the evidence to the Inquiry; not my life in the community or my work in the law as a practitioner and a judge. I had no understanding of the widespread prevalence of the sexual abuse of children in South Australia and its frequent devastating and often lifelong consequences for many of them.

Some witnesses previously had not been able to say what had happened to them. An elderly woman, who had been in State care as a child, said early in her evidence: “Who is ever there for frightened little girls in cupboards? Now you are there because you give me a voice and I wanted to say that.”

Witnesses gave various reasons for not disclosing; and talked of the benefit of at last being able to do so. According to one witness: ‘You get told so many times not to say anything and someone suddenly says, “I want to hear what you have to say”’.

Some of the witnesses had always wanted to tell. One said: ‘I never forgot nothing because I knew one day, through all I went through, that one day I would get a voice out there, out in the world, because virtually, when I got brought up in the homes and taken away at six, it was virtually, I didn’t know, the world was shut out to me’.

Before the Inquiry I had no understanding that people who had been abused felt fear, guilt, shame and responsibility, which contributed to their silence. One woman said: ‘I felt ashamed and believed it was my fault’. A man whose life collapsed in his middle years gave up a comfortable existence and went to live in a cave. When he heard of the Inquiry he made the approach: ‘I thought that perhaps for the first time in my life somebody would be willing to hear my pain’. A young woman expressed the view: ‘I feel very empowered by coming here and doing this’.

I was not prepared for the horror of the sexual cruelty and exploitation of little children and vulnerable young people in State care by people in positions of trust and responsibility, or the use of them at paedophile parties for sexual gratification, facilitated by the supply of drugs and alcohol.

I had no understanding that, for many people, a consequence of having been sexually abused as a child was the loss of a childhood and an education.

The hearings were of considerable benefit to the people making disclosures, who expressed the importance of having been believed by someone ‘in authority’. One elderly woman gave evidence in the presence of one of her six children. That night the children discussed at length what had happened and a daughter later told me: ‘We had always felt sorry for our mother; now we feel proud of her’.

A considerable body of evidence was received about runaway children and their sexual exploitation over many years. Some were children in State care. Many were sexually exploited and prostituted themselves in public and private places. I had no knowledge of the fear, isolation and loneliness of the children living on the streets and the means by which they survived.

Some witnesses expressed their reasons for giving evidence to the Inquiry.

One man told me: ‘I’ve had days where I just wanted to give it all away and I just hope that this [coming to the Inquiry] will end it’. A young woman said she hoped that her evidence would help police apprehend current abusers ‘… before they do it to another person’.

Undoubtedly, in disclosing what had happened to them, people were affected in various ways. Some felt relief, gratitude, a sense of closure, respected, believed or being included.

It must be acknowledged that because of the nature of the Inquiry, most witnesses gave evidence about sexual abuse and deaths of children in State care. However, many people also gave evidence about positive aspects of out-of-home care of children. There was also a considerable body of evidence about the dedication of foster and other carers and the quality of upbringing they provided to children in State care.

While the full extent of the sexual abuse of children in State care can never be known, it is possible that the people who gave evidence to the Inquiry are the tip of the iceberg.

As the Inquiry progressed I soon felt a deep sense of privilege and responsibility at having been entrusted with the disclosures of people’s most painful memories. I observed their selflessness and courage in sharing their stories as part of their process of healing, but also their desire to assist in some way to prevent future sexual abuse of children in State care.

The Hon. E.P. Mullighan QC
Commissioner
The extensive work undertaken by the Inquiry has been possible only because of the efforts of the Counsel Assisting, the Project Manager and the staff.

Ms Angel Williams was the Project Manager throughout the Inquiry and effectively managed its establishment, staff, budget and facilities. She also contributed to the completion of the report, particularly relating to the statistics of the Inquiry and the chapter relating to records.

Ms Liesl Chapman of counsel worked extensively as the senior investigator of the section of the Inquiry investigating deaths of children in State care, and in other roles, until she was appointed Counsel Assisting the Inquiry in June 2007. She remained in that role until the completion of the Inquiry and of this report, to which she made an invaluable contribution. Ms Chapman organised and managed the substantial work of all the investigators.

In all there were 57 members of staff, although not all at the same time, and some worked on a part-time basis. There were substantial difficulties for many of the staff due to the nature of the work. At all times they supported people approaching the Inquiry and treated them with respect, courtesy and understanding, which assisted them to disclose sexual abuse. The task of handling, storing and maintaining the integrity of the many thousands of files and other records was undertaken efficiently and effectively.

Most of the people approaching the Inquiry were assisted in practical ways by the witness support staff and, where necessary, put in contact with appropriate services and assistance.

Two psychologists at different times provided valuable assistance to staff as needed. Judith Cross, the Chief Executive of Relationships Australia (SA), was appointed by the Minister to assist the Inquiry as a person with appropriate qualifications and experience in social work and social administration. She met periodically and extensively with me and provided valuable assistance to the Inquiry.

It is appropriate to acknowledge the contribution of the media. Wide publicity was given to the Inquiry at various times, which informed the community about its work. Many people were encouraged to approach the Inquiry as a consequence of this publicity.

At all times the Inquiry received the support of the Government and the Opposition in the Parliament and of other Members—in particular the Minister for Families and Communities, the Hon. Jay Weatherill MP, and, at the outset of the Inquiry, the then Leader of the Opposition, the Hon. Rob Kerin MP, the Speaker of the House of Assembly, the Hon. Peter Lewis MP, and the Shadow Minister for Families and Communities, Isobel Redmond. All supported and provided assistance to the Inquiry during its establishment. As Shadow Attorney-General, Ms Redmond has continued her support of the Inquiry on behalf of the Opposition.

The Hon. E.P. Mullighan QC
Commissioner
Schedule 1

1 Interpretation

In this Schedule –

*child in State care* means a child who was, at the relevant time, a child who had been placed under the guardianship, custody, care or control of a designated Minister or another public official, or the former body corporate known as the *Children’s Welfare and Public Relief Board*, under a relevant Act;

*designated Minister* means a Minister responsible for the administration of a relevant Act;

*relevant Act* means the *Children’s Protection Act 1993* or a corresponding previous enactment dealing with the protection of children;

*sexual abuse* means conduct which would, if proven, constitute a sexual offence.

2 Terms of reference

(1) The terms of reference are to inquire into any allegations of–

(a) sexual abuse of a person who, at the time that the alleged abuse occurred, was a child in State care; or

(b) criminal conduct which resulted in the death of a person who, at the time that the alleged conduct occurred, was a child in State care,

(whether or not any such allegation was previously made or reported).

(2) The purposes of the inquiry are –

(a) to examine the allegations referred to in subclause (1); and

(b) to report on whether there was a failure on the part of the State to deal appropriately or adequately with matters that gave rise to the allegations referred to in subclause (1); and

(c) to determine and report on whether appropriate and adequate records were kept in relation to allegations of the kind referred to in subclause (1) and, if relevant, on whether any records relating to such allegations have been destroyed or otherwise disposed of; and

(d) to report on any measures that should be implemented to provide assistance and support for the victims of sexual abuse (to the extent that these matters are not being addressed through existing programs or initiatives).

(3) The inquiry is to relate (and only to relate) to any conduct or omission occurring before the commencement of this Act.

(4) The inquiry need not (but may, if relevant) relate to a matter that has been the subject of the Review within the meaning of the *Child Protection Review (Powers and Immunities) Act 2002*.

(4a) The inquiry may relate to a matter that has been the subject of the commission of inquiry under section 4A.

(5) The person conducting the inquiry must not purport to make a finding of criminal or civil liability.
Explanatory note

Reference is made to ‘the department’ throughout this report. At March 2008, Families SA is the name of the division of the Department for Families and Communities that is responsible for the care and protection of children in State care. The term ‘the department’ is used to include the present department and its predecessors, which have undergone several name changes during the period covered by the Inquiry. See Appendix G for a list of the changes.
During the Children in State Care Commission of Inquiry, which started in November 2004, 792 people told the Inquiry that they were victims of child sexual abuse while living in South Australia. The 406 males and 386 females made 1592 allegations dating from the 1930s to the present against 1733 alleged perpetrators. Many told the Inquiry it was the first time they had disclosed the sexual abuse, and many said it still affected them as adults. Their evidence reflects surveys and studies conducted around the world in the past 30 years, which show that child sexual abuse is widespread, the reporting rate is low and the effects can be devastating and lifelong.

The alleged victims believed they were, or could have been, in State care at the time. There are valid reasons for the uncertainty: they were generally babies or children when placed to live in institutions, with foster families or in other care arrangements; they were often not told why; they were not aware of the legalities concerning the placement; and they did not have records of their childhood.

The Inquiry had to determine how many of the 792 people were children in State care when the alleged abuse occurred. It was not an easy task. It required interpreting the terms of reference (see page IX), researching the legislative history of the Children’s Protection Act 1993, and requesting and reading thousands of government and non-government records relating to the alleged victims and their places of care.

The Inquiry interpreted its terms of reference to mean that a child in State care was a child who had been placed under the guardianship, custody, care or control of the Minister, a public official or the Children’s Welfare and Public Relief Board (1927–66) as a result of a court order; an order by the Minister, CWPRB or Aborigines Protection Board (1934–63); or a written agreement between the child’s parent/guardian and the Minister.

After researching relevant records, the Inquiry found that 533 people did not come within the terms of reference. Some had been placed in State care at periods in their childhood, but the alleged sexual abuse occurred outside this time. Many had lived in care, including foster care, with some involvement from the Department of Families and Communities or its predecessors (see explanatory note, opposite), but there was no court order or written agreement as per the Inquiry’s interpretation of State care. Records obtained by the Inquiry revealed that parents had also privately placed their children in institutions or foster care, often with the involvement of non-government organisations. Although the allegations of these witnesses have not been published, their evidence has not been ignored. It has added significantly to the Inquiry’s knowledge about the prevalence, seriousness and long-term effects of child sexual abuse, different places of care, and the workings of the child protection system during the past 65 years.

Using available records, the Inquiry found that 242 people—124 males and 118 females—were children in State care at the time of the alleged abuse. They made a total of 826 allegations against 922 alleged perpetrators. Their allegations are individually summarised in chapter 3. Most of these people, 124, were aged 41–60; 25 were older than 60; and 16 were younger than 18. Forty-four were of Aboriginal or Torres Strait Islander descent. Twenty-two had a disability.

The Inquiry could not determine if a further 17 witnesses were in State care at the time of their alleged abuse. This was due to either a lack of records or uncertainty about the legality of placements due to the historical actions of the Aborigines Protection Board in placing children contrary to legislation, as found by the Supreme Court in Trevorrow v. State of South Australia (No 5) (2007). Their allegations are also individually summarised in chapter 3.

The allegations of 20 people who were not in State care, but who had been placed in non-government institutions with people who were in State care and came forward to the Inquiry, are also included in chapter 3. Their evidence of
child sexual abuse in those places of care tends to confirm
the evidence of people who were in the terms of reference.
The Inquiry considers that the publication of each person’s
allegations is important for several reasons. It is an
acknowledgment of the personal courage required to
speak about their experiences; it is a significant
contribution to the history of South Australia; and it is a
forceful and compelling message about the vulnerability of
children in State care and the need for reforms to ensure
they are protected from sexual abuse and, if that fails, that
their allegations receive an appropriate response.

The Inquiry believes that many adults who were sexually
abused as children in State care have not come forward.
Evidence received referred to other children in State care,
particularly in large congregate care, who were also
sexually abused. Research of records revealed names of
other people who allegedly were sexually abused as
children in State care, but did not come forward.
The Inquiry also received 924 names of children to
investigate in order to determine whether any had died
from criminal conduct while in State care (see chapter 5).

**The Inquiry’s approach and conduct**

In its early stage, the Inquiry developed an awareness
campaign, which included outreach programs for groups
that could be disadvantaged in gaining access, or coming
forward, to the Inquiry, namely Aboriginal, elderly, young
and disabled people and prisoners.

The Commissioner conducted the hearings of 496 alleged
victims of sexual abuse and 266 general or expert
witnesses. Some people had more than one hearing. There
were 809 hearings, which resulted in 46,500 pages of
transcript. In addition, 448 individuals and organisations
 corresponded with the Inquiry or made a written
submission in regard to child sexual abuse and/or the child
protection system, but did not have a hearing.

In order to investigate the allegations of sexual abuse and
deaths of children in State care, the Inquiry requested 5880
records, which resulted in the receipt of 33,300 files.
Despite this large volume, sometimes very few or no
records in relation to alleged victims were available.

The Inquiry employed a total of 57 staff, who worked at
various times during its three-year life.

**Sexual abuse of children in State care**

Evidence to the Inquiry established how vulnerable these
children were when placed in State care. Many said they
had already experienced sexual, physical or emotional
abuse in the family home; witnessed violence and
alcoholism among adults; suffered the effects of poverty,
including transience; or been neglected by parents for
various reasons, including mental illness. Some said they
developed behavioural issues as children, including being
difficult to control, absconding or committing minor crime.
Their vulnerability arising from the effects of such abuse
made them prime targets for perpetrators when placed in a
care and protection system that was deficient in its
knowledge, understanding and recognition of child sexual
abuse. Of the transition from an abusive family home to
State care, one witness told the Inquiry that he could
‘understand the State stepping in, but in that sense
I was basically taken out of the frying pan and thrown into
the fire’.

The Inquiry heard that, having been placed in State care,
often by a court order that would expire at the age of 18,
many children were moved between different types of care.
For example, until the 1970s the main forms of care were
institutional (large congregate care in children’s homes) and
foster care. Some witnesses were placed in different
institutions, had more than one foster placement and, if
they absconded or committed a crime, also spent time in a
secure care facility. This movement, combined with their
dislocation from the family home and, often, separation
from siblings, only served to increase their sense of
isolation and vulnerability. Witnesses said:

> We might not have had the ideal family, but we had
> my family.

> I just wanted my mum. I wanted mum. I didn’t want
to live with somebody else.

> To put a child in State welfare, in a home—make
sure they have more contact with other siblings as
much as possible because the heartache, the
heartbreak and to wait so long [to be reunited with
siblings] is devastating.
Evidence given to the Inquiry demonstrates that the alleged sexual abuse occurred in every type of care from the 1940s onwards, including institutional care (large congregate care in government and non-government homes up to the 1970s), smaller group care (cottages, hostels and youth shelters from the 1960s to early 1980s), residential care units (admission, assessment and community units from the 1970s to the present), foster care (placements with other families from the 1940s to the present), family care (placement on probation to live at the family home from the 1940s to the present) and in secure care facilities (from the 1950s to the present).

There were 133 people who said they were sexually abused in more than one placement.

In regard to institutional care, the Inquiry heard allegations from 114 people who said sexual abuse was perpetrated by staff members; older children living at the institution; visitors, including family members; professionals, such as doctors; and outsiders, including strangers, school bus drivers, a hospital employee, carers at holiday placements and carers’ family members, friends and neighbours. Some witnesses spoke about a pervasive culture of child sexual abuse in the large congregate care environment:

You got to the stage where you thought [sexual abuse] was just part of the norm; keep your mouth shut, otherwise you were worse off than everybody else.

Sixty-two people placed in insecure care, 49 placed in smaller group care and 18 placed in residential care units said they were victims of child sexual abuse perpetrated by staff; older male residents; volunteers; visitors to the cottages and units; fathers; family friends; acquaintances including male relatives of friends and friends of friends; and male strangers including men in a police cell.

The Inquiry heard from 103 people who alleged they were sexually abused in foster care by foster parents, their sons, other fostered children living in the home, boarders, relatives and friends of foster parents, and outsiders including a teacher, taxi driver, camp worker, student social worker, priest, neighbours and strangers.

Thirty-four people who were children in State care but on probation and living in the family home told the Inquiry their alleged abusers included birth parents, step-parents, partners of parents, other relatives, family friends and outsiders, including a doctor, local community group leader, community centre worker, regular driver, acquaintances and strangers.

‘Outsiders’ included paedophiles who targeted and exploited the children in State care when they absconded from their placements. The reasons given for absconding varied, and included escaping from sexual abuse at their placement and being lured by the promise of money, cigarettes, drugs, alcohol, food, shelter or clothes in return for sex. A witness said:

This social group absorbed people like myself, and you would be passed around between them, and paid … they were wanting sex, I was paid for it, and everyone went their own ways.

Many former children in State care told the Inquiry they did not disclose the sexual abuse when they were children for various reasons, including being told by the perpetrator not to, a fear of repercussions, a sense they would not be believed, not having anyone to confide in, dependency on the perpetrator, and feelings of shame and self-blame. Witnesses said:

I’m five and a half years old. I’m terrified—you know, scared shitless—and there’s this bloke [the perpetrator] threatening to bloody kill me.

They had a thing in there if you were a telltale, you suffered for it. You’d really get bashed up and everything else to go with it.

I didn’t feel that I could actually go to somebody and say because then I’d just be classed as a liar, troublemaker, something. I’m just a welfare child.

You couldn’t complain. Who do you complain to? I didn’t have anyone else to rely upon. It’s the hand that feeds you and puts a roof over your head, so you have these conflicting thoughts even as a youngster.
I was ashamed to tell anyone what happened.

You feel as though it’s your fault it’s happening. You can’t understand why it’s happening. You don’t sort of blame the people that’s doing it to you. You seem to blame yourself.

Most of the people who said they disclosed the sexual abuse as children were not believed. One witness said a staff member responded to his allegation of sexual abuse with ‘Oh, bullshit, you little liar’. Other witnesses said:

Oh, I was the worst in the world. I was a liar. I was a lazy gin. I was only saying these things because I didn’t want to work.

I don’t know at what point I started telling my welfare officer, and she basically said I was a liar.

Some witnesses had never spoken about their allegations until their hearing at the Inquiry.

I’ve wanted to, all my life. I’ve wanted to tell.

I thought perhaps for the first time in my life somebody would be willing to hear my pain.

Thank you for listening to my story … I’ve never really told anybody about it.

Thank Christ I’ve got that out of my system, you know. I’ve had good friends over the years, I’ve had good wives and good partners, and I told them nothing.

Many witnesses told the Inquiry about the effects of child sexual abuse on them as adults:

I was always angry [about] what happened to me … It ruined my life, as far as I’m concerned.

But it was still in my head, and so I still had the nightmares, I still had the horror.

I just wish it had never happened, that’s all. That’s all I’ve got to say. I don’t think people realise how much it really plays on your mind. It’s not so bad when you’re in your 20s but, you know, you get older and it plays on your mind a lot. It still does … I reckon it’s a lot worse.

Response of the State and recommendations

Based on the evidence of the alleged victims who came forward to the Inquiry, it is apparent that in the past 65 years the State has failed to protect some of the children in its care from sexual abuse. Lessons must be learnt from this. The former children in State care have demonstrated their commitment to reform by giving evidence to the Inquiry about their own traumas—a process they hope will ensure that children are better protected in the future.

Some witnesses said:

I’ve got no axe to grind. I’m not here to grind axes.

I’m here to make sure it doesn’t happen again to any kid.

This is why I am sitting here today, so it doesn’t happen [to children in the current system].

I think it’s good that it’s told so that it doesn’t happen to other people.

I’d like that nothing like this happens to any other kids, for a start, because I’ve got grandchildren.

It’s got to stop so it doesn’t happen to other kids like me.

The evidence shows a need for the government to implement strategies to prevent the sexual abuse of children in State care, to provide an environment to encourage those children to disclose, and to respond appropriately when a disclosure is made.

Six months before the Inquiry began, and in response to the Layton review, the South Australian Government released its Keeping them safe reform agenda for the State’s child protection system. During the life of the Inquiry, the government released parts of the reform agenda relating only to children in State care—Rapid response – whole of government services for children and young people under the guardianship of the Minister (October 2005) and Keeping them safe – in our care (September 2006). The reform agenda is a significant development in child protection policy and a sign of positive change and goodwill. However, considerable
resources are required to achieve the reforms necessary to protect children in State care from sexual abuse.

The Inquiry heard evidence to suggest that the State’s child protection system, like its counterparts elsewhere in Australia, is in crisis, largely because of poor past practices. The number of children being placed in care has increased; there is a shortage of foster carers and social workers; children tend to be placed according to the availability of placements rather than the suitability; and serviced apartments, motels and B&Bs are used for accommodation because there is no alternative. Such a system cannot properly care for an already vulnerable group of children, let alone protect them from perpetrators of sexual abuse. More resources must be made available to deal with the crisis, as well as to implement necessary reforms for the present and future.

The Inquiry endorses the government’s establishment in 2004 of the Guardian for Children and Young People (GCYP), whose statutory role is to promote the best interests of, act as an advocate for and monitor the circumstances of children under the guardianship or in the custody of the Minister, as well as provide advice to the Minister on the quality of their care and any systemic reforms. During the past four years, the GCYP has introduced some important practical methods of communicating with children in State care, which are crucial to the prevention and detection of sexual abuse. Several of the Inquiry’s recommendations build on measures that have been established by the GCYP in the protection of children in State care from sexual abuse.

**Prevention**

There is a need to implement strategies aimed at preventing the sexual abuse of children in State care.

Early intervention is one form of prevention. It focuses on recognising warning signs that families may be at risk and, if possible, taking action to keep them together. Many witnesses at the Inquiry endorsed this approach. Indeed, the government, in *Keeping them safe – in our care*, states its policy to support early intervention strategies. The Inquiry endorses the government’s establishment of five children’s centres for this purpose at Enfield, Elizabeth Grove, Hackham West, Wynn Vale and Angle Park, and its commitment to build a further 15 across South Australia.

The education sector also plays an important role in the early detection and prevention of child sexual abuse. The government has updated its mandatory notification training, and a refresher course is required every three years for teacher registration. It also funded the development by the Australian Childhood Foundation in partnership with the National Research Centre for the Prevention of Child Abuse and the Indigenous Health Unit at Monash University of a targeted training program, SMART (strategies for managing abuse-related trauma), which has been attended by hundreds of education workers. Evidence received by the Inquiry referred to the challenge of developing refresher courses. The Inquiry recommends that SMART training be ongoing and include updated refresher courses.

A crucial part of prevention is to educate children in State care about protective behaviours. In 2007, the Department of Education and Children’s Services announced that it had been updating its child protection curriculum as part of the broader *Keeping them safe* agenda. Called *Keeping safe*, it is due to be implemented in schools in 2008. However, evidence to the Inquiry demonstrated that children in State care often have disrupted schooling and miss out on learning these skills. The Inquiry recommends that the protective training currently being taught by the Second Story Youth Health Service to some children in State care be reviewed and delivered to all children in State care at their residential or secure care facility.

Providing child-safe environments is also an important element of prevention. There is now a national register of sexual offenders, the Australian National Child Offenders Register (ANCOR), operated by the CrimTrac Agency. All states and territories have enacted legislation to ensure that the register receives and provides up-to-date information, nationwide. The aim of the South Australian legislation is to ‘protect children from sexual predators by preventing such people from engaging in child-related work’. This includes work that involves contact with
child care or residential services wholly or partly for children are merely required to establish policies and procedures to maintain child-safe environments. The Inquiry recommends amendments to legislation to require all non-government organisations involved in child-related work to do criminal history checks before engaging anyone to do child-related work.

Evidence to the Inquiry shows that the empowerment of children is essential for the prevention of child sexual abuse. In her submission, the Guardian for Children and Young People (GCYP) said that ‘arguably the most fundamental and significant change we can make is to listen to and act on what children and young people have to say about their lives in care’. Part of this involves encouraging meaningful participation by children in decision-making and changing community attitudes.

The GCYP told the Inquiry that the Youth Parliament in 2006 resulted in the passing of a Bill for a charter of rights for children in State care and the Inquiry recommends that the South Australian Parliament endorse the charter. The Inquiry also recommends the establishment of a Youth Advisory Committee, which would be appointed by the GCYP and consist of children and young people currently and formerly in State care to advise and assist her; and the establishment of a Minister’s Youth Council consisting of children and young people currently and formerly in State care, to directly consult with and advise the Minister for Families and Communities. The Inquiry established its own Young People Advisory Group to ensure that a strong voice for children and young people in care was heard and reflected in this report.

The Inquiry recognises that the empowerment of children in State care with disabilities is more complex and for this reason recommends that a specialist position be created in the GCYP office to address individual and systemic advocacy for such children.

Children can be empowered only if the community is educated about, and accepts responsibility for, child sexual abuse. The Inquiry recommends the development of a public awareness campaign on child sexual abuse—its prevalence, existing misconceptions, perpetrators’ tactics, services for victims, and treatment for offenders.

Stopping offenders is also a major part of prevention. The Inquiry heard evidence about the important role of treatment programs for young sexual offenders and also adult offenders, both in custody and living in the community. The Rehabilitations Programs Branch, Department for Correctional Services, is responsible for providing treatment to sex offenders in custody. Although the treatment program has permanent funding, evidence to the Inquiry raised concerns that it is available only at Yatala and Port Augusta prisons and only has resources to treat offenders in the last two years of their sentences. The Inquiry recommends the expansion of the program so all child sex offenders may participate at any stage of their sentences.

**Someone to tell**

In light of the evidence to the Inquiry that many adults did not disclose sexual abuse when they were children in State care, it is important that strategies are in place to promote such disclosures. In particular, evidence to the Inquiry from former and current children in State care emphasised the need for a trusted case worker in their lives.

*Keeping them safe – in our care* sets out a policy of ‘connected care’, which involves building a ‘care team’. Such a policy must not, however, negate the need for every child in State care to have an allocated case worker. In May 2004, the government acknowledged that not every child in State care has been allocated a case worker and the GCYP told the Inquiry this is still true in 2007. Evidence to
the Inquiry indicates that the government finds it difficult to recruit and retain social workers, some of the reasons being heavy workloads, insufficient professional support and supervision, and an increase of inexperienced workers. This issue has been a concern since the 1960s, and was most recently addressed in the Layton report in 2003. Since then, the Inquiry has heard consistent evidence from former and current children and young people in State care about the importance to their protection of having regular contact with a case worker. The Inquiry recommends that the requirement for every child in State care to have an allocated case worker and regular face-to-face contact with that worker be formalised in Keeping them safe – in our care. Also, sufficient resources should be allocated to recruit and retain qualified case workers and ensure there is appropriate professional development and training on child sexual abuse issues.

The provision of suitable and stable placements and appropriately trained residential and foster carers is also important to promoting the disclosure of sexual abuse by children in State care. Many foster carers showed their commitment to the care of children by giving the Inquiry a significant amount of evidence about deficiencies in the current system. The increased number of children being placed in State care and the continuing shortage of foster carers show that significant resources need to be allocated to provide placements that will protect children.

Carers are among the most important people in the lives of children in State care; for many, taking on the role of immediate parent. As part of the need to promote the disclosure of sexual abuse, the Inquiry recommends that residential and foster carers receive training that addresses child sexual abuse. Because of the increased vulnerability of children in State care with disabilities, which may be the result of reduced cognitive and emotional judgment and communications skills, lack of education about appropriate sexual behaviour and a reliance on others for intensive personal care, the Inquiry recommends a special training program for all carers of these children.

There are now real challenges about ‘getting it right’ for Aboriginal children in State care because of the mistakes of past governments in removing these children from their families. Aboriginal children are over-represented in the child protection system: in Keeping them safe – in our care, the government reported that Aboriginal children make up 23.9 per cent of children in care but only 3.2 per cent of the population. Evidence to the Inquiry also included differing views about the Aboriginal child placement principle and/or its implementation. To focus on ‘getting it right’ for Aboriginal children in State care—and protecting them from sexual abuse while in that care—the Inquiry recommends the creation of a specialist position in the GCYP office to ensure focused systemic advocacy for these children.

Responding to disclosures

The Inquiry heard consistent evidence from alleged victims of child sexual abuse that when they did disclose as children they were generally not believed.

The Department for Families and Communities’ Special Investigations Unit (SIU) currently handles allegations of sexual abuse of a child in State care against a carer, staff member or volunteer. Under its guidelines, the SIU must refer an allegation of sexual abuse to police within 24 hours and to conduct its own investigation in direct consultation with the police. The Inquiry considers that the Guardian for Children and Young People should have a role in this process as an independent advocate for the child: to monitor the State’s response to the allegation, the progress of the complaint in the criminal justice system and the appropriateness of the child’s placement and therapeutic care. (In some cases, the GCYP may be satisfied that the child has his or her own advocate of choice.) This would require legislative amendment to the role of the GCYP. The Inquiry believes it should also be mandatory for the Department for Families and Communities chief executive or the Commissioner of Police to notify the GCYP when a child in State care makes an allegation of sexual abuse. The Inquiry also recommends various legislative amendments to entrench the independence of the GCYP.
Evidence to the Inquiry from former and current children in State care establishes the need for an independent body to investigate any complaints from a child about the response to his or her allegation of sexual abuse. As one alleged victim told the Inquiry, there was no organisation ‘to investigate my complaint properly that operated separate and independent and run away from under the direction and control of the Minister’. The Health and Community Services Complaints Commissioner (HCSC Commissioner) was established in 2005, with a child protection jurisdiction coming into effect in July 2006. The HCSC Commissioner has jurisdiction to receive, assess and resolve complaints about child protection services, and legislation enables that to be done independently. The Inquiry considers that the HCSC Commissioner holds an important statutory office that provides an independent complaints investigation and reparations process, which was not available to former children in State care. However, the current legislation does not permit a child under 16 to complain directly to the HCSC Commissioner. The Inquiry recommends legislative amendment to enable all children in State care to make a direct complaint, the implementation of a public awareness campaign about the role of the HCSC Commissioner in child protection, and that the role include the title of ‘Child Protection Complaints Commissioner’ when performing this function.

Many of the witnesses who told the Inquiry they did disclose sexual abuse when they were children in State care said the response was not only dismissive, but also punitive. All the evidence was in favour of an appropriate therapeutic response when a child in State care alleges sexual abuse. The Inquiry heard evidence from Child Protection Services (CPS) that despite additional funding from the Keeping them safe reform agenda, the majority of child victims are not receiving treatment. CPS submitted: ‘We haven’t even reached 30 per cent treatment levels across the State for children who have been abused’. The Inquiry heard that CPS has focused on treatment of children in State care during the past few years, but its program is full. Evidence to the Inquiry established that the existing provision of therapeutic services to children by the CPS, Child and Adolescent Mental Health Services (CAMHS) and Yarrow Place— the lead public health agency responding to adult (16 years and above) rape and sexual assault in South Australia—is both highly professional and well regarded. However, those services need to be reviewed so counselling and therapy are provided to more children and young people in care, in both metropolitan and regional areas, as well as to estimate the resources required to achieve an appropriate level of response.

The Inquiry also heard evidence that the role of a carer when a child in State care has alleged sexual abuse is crucial, but can also be challenging. A witness said: ‘Trying to get some resources to provide not just support, but actual therapy, for the foster parents has been a big challenge’. The Inquiry recommends the provision of therapeutic support for relevant carers when a child in State care makes a disclosure of sexual abuse.

Evidence was also given about the response of the criminal justice system to allegations of child sexual abuse in general and the positive changes during the past four years to the structure of South Australia Police, as well as increased training for police officers, aimed at providing an appropriate response to victims. The Inquiry was made aware of the long and increasing delays in getting cases to trial because of a backlog in the criminal courts. Such delays have a particularly significant impact on the ability of children to give their best evidence, and the Inquiry recommends that the Criminal Justice Ministerial Task Force, established by the Attorney-General to try to address the backlog, gives special consideration to cases of child sexual abuse and develops measures to prioritise those trials.

Submissions and evidence were received about the use of restorative justice as an alternative to the criminal justice system in cases of child sexual abuse. Some submissions expressed significant reservations about this concept and some were in favour of having available an alternative approach. The Inquiry recommends that a panel of appropriately qualified people be formed to consider and establish a model for restorative justice in regard to complaints of child sexual abuse.
Children in State care who run away

Evidence was given to the Inquiry by former children in State care, departmental employees and police about the sexual exploitation of children by paedophiles who operate in Adelaide. The State Government has been aware of this practice since the 1980s. In particular, the department has been grappling with how best to protect children in State care who abscond from their placements and tend to run to these abusers. A former staff member of a residential care unit told the Inquiry:

They would disappear for two or three days at a time. They would come back looking like a lost, bedraggled dog, dirty, filthy, hungry … sometimes with cigarettes, sometimes with new shoes.

Former children in State care told the Inquiry about the ‘very close-knit community’ at known haunts around Adelaide and that it was ‘very easy to make money’. They were taken to parties attended by men and children at private houses that involved sex, drugs and alcohol. A professional endeavouring to provide therapeutic care for these children in State care today said:

You can do all the talking, protective behaviours, interventions, and all of those things fail. They’re too superficial. Because every time they run and there’s reinforcement, be it a dollar or a new pair of sneakers or a skateboard, you have lost whatever therapy you have done leading up to that.

The problem still exists. In July 2007, the department identified 16 children living in residential units as frequent absconders, who are considered to be at high risk from sexual exploitation.

The Inquiry heard evidence about intensive therapeutic care programs in Victoria and the United Kingdom, which include therapeutic secure care as a last option for children in serious danger. As a result, the Inquiry recommends that a secure care therapeutic care facility be established as part of Keeping them safe – in our care.

Supporting adults who make disclosures of child sexual abuse

Many of the people who told the Inquiry they were sexually abused while children in State care said they still suffer the long-term effects, including difficulty to disclose the abuse even as adults. Despite this, they wanted the State (as their childhood parent) to know what had happened, listen and take action to protect all children in State care.

Some people said the State Government should acknowledge and apologise for the pain and hurt suffered by children in State care in the past because of sexual abuse.

It’s really up to, I guess, whoever is in power today … but a sense of recognition of what happened would be helpful.

I’ve been hurt and that apology, a genuine apology, is extremely important to me, because it would help relieve some of the grief that sits there to this day.

I would just like someone to say, ‘Sorry’.

The Inquiry recommends that the government acknowledge and apologise for the pain and hurt caused in the past as a result of the sexual abuse of children while they were in the care of the State.

During the past eight years, Tasmania, Queensland and Western Australia have established mechanisms for ex gratia payments and/or the provision of services for adults who suffered abuse while in State care. The Inquiry recommends that a task force be established in South Australia to closely examine the interstate redress schemes, to receive submissions from individuals and relevant organisations on the issue of redress for adults who were sexually abused in State care, and to investigate the possibilities of a national approach to the provision of services.

The Inquiry also recommends that the government continue to provide free counselling for former children in State care who were victims of sexual abuse. The
department’s Post Care Services does not provide therapeutic counselling and refers people to non-government services that are already overstretched. During the course of the Inquiry, the government established Respond SA, which was run by Relationships Australia (SA) for all adult victims of child sexual abuse. It operated a telephone helpline, face-to-face counselling, workforce development, research and advocacy. The Inquiry recommends the continuation of a specialist service such as Respond SA provided by an organisation independent of government or church affiliation that has never provided institutional or foster care.

The allegations of 170 people were referred to the Paedophile Task Force (PTF) for investigation, at their request. Many people made allegations against more than one offender. It is important that these allegations are not seen as a lesser priority in the criminal justice system because they are ‘historical’. The PTF, the Office of the Director of Public Prosecutions, the Legal Services Commission and the courts need to receive sufficient resources to investigate, prosecute, defend and conduct trials concerning the allegations of child sexual abuse arising from this Inquiry in a timely manner.

Deaths of children in State care

The Inquiry received 924 names of children alleged to have died while in State care, including 831 from different sources in the department, 76 from witnesses to the Inquiry, 16 from the Inquiry’s research of records on other matters and one from State Records South Australia. The Inquiry had to investigate—by requesting, retrieving and reading all relevant records—whether those children were in State care at the time of their death and whether any of the deaths were the result of criminal conduct. The Inquiry found that 391 children had died while in State care, the earliest in 1908.

The Inquiry identified three main areas of concern. The first was that the department was unable to provide a single list of children who had died while in State care. It provided the Inquiry with eight lists from different sources, giving a total of 831 names. There was considerable overlap in names and errors in recording basic information, such as double recording of one death under slightly different names. One person recorded as dead was alive.

The Inquiry also found that many children listed were never in State care (for example, had only received financial assistance from the department) and some had died after being released from State care. After accounting for those matters, the Inquiry identified from available records that of the names on the departmental lists, 421 children had been in State care and 377 had died while in State care.

The second concern was that the department had no records of the deaths of 16 children who had died in State care. Thirteen of those deaths came to the Inquiry’s attention only because of evidence given by witnesses, and three were revealed by the Inquiry’s research of unrelated records on other matters.

The third concern was that when the department did record the death of a child in State care, a common notation on the child’s State ward index card was simply ‘released – died’. Among departmental client files it was rare to find a record of the cause of death, let alone the circumstances. If the cause or circumstances were recorded, there were no details about the source of that information. To find out, the Inquiry researched records from the State Coroner and the Office of Births, Deaths and Marriages (BDM). For some deaths, the Inquiry was left simply with a stated cause on a BDM certificate, which supplied no information about the circumstances of the death.

The Inquiry recommends that the department creates an electronic database to centrally record information concerning children who die while in State care. It must also maintain paper files that record the date of death, the official cause, the circumstances (including the source of that information), whether the State Coroner held an inquest and, if so, a copy of the finding.
The Inquiry investigated 15 allegations of criminal conduct linked to the deaths of children in State care.

One of those allegations, referred to police in 2003 and raised in State Parliament, was that a child had been murdered at St Stanislaus House at Royal Park in the 1960s. The Inquiry received a report from police on its investigation, which concluded that the allegation was not substantiated. The Inquiry considered that the police investigation was thorough.

The Inquiry found that there was nothing to substantiate allegations of criminal conduct in relation to a further four deaths—those of three teenagers in State care from drug overdoses and of a fourth teenager who set fire to herself. Another death had a link to alleged criminal conduct in that it involved the suicide by a girl in State care after she made allegations of sexual abuse against her foster father. In relation to the death of a baby girl, the Inquiry considers it inappropriate to make a determination, given the currency of the matter.

The Inquiry found that eight deaths of children in State care were caused by criminal conduct. One boy was murdered at Kaniva in 1990 but no-one has been arrested. Two girls were killed in the 1970s when as pedestrians they were hit by a car driven by a man who was convicted of causing their deaths by dangerous driving. A boy died in a fight in the 1960s, and the offender was convicted of manslaughter. A three-year-old girl in State care was killed in the 1960s by a youth in State care who pleaded guilty to manslaughter. A baby boy who was placed in State care and on probation to live with his mother, was killed by her in the 1960s in a murder-suicide. In the 1950s, a boy was killed when hit by a car; the driver, a youth, was convicted and sent to secure care until the age of 18.

The Inquiry was unable to determine the cause or circumstances of 20 deaths of children in State care. In 15 cases this was because available records in South Australia from the department, the State Coroner and BDM lacked sufficient information; in four cases because the State Coroner had not been able to determine the cause; and, in one case, because a police investigation is continuing to verify evidence that a girl was found hanging at Vaughan House in the 1970s.
List of recommendations

For a discussion of recommendations 1–41, see Chapter 4.1, ‘State response to sexual abuse of children in State care’.

RECOMMENDATION 1
The SMART (strategies for managing abuse-related trauma) program should be ongoing, with the development of updated, refresher professional development seminars and collaborative practice forums.

RECOMMENDATION 2
That the self-protective training being taught by Second Story be reviewed to ensure that it covers the Keeping safe: child protection curriculum developed for teaching all children in schools and is adapted to target the specific needs and circumstances of:

- children and young people in care generally
- Aboriginal children and young people in care
- children and young people in care with disabilities.

That such self-protective training is then delivered to children and young people in State care at their residential or secure care facility.

RECOMMENDATION 3
That the application of section 8B of the Children’s Protection Act 1993 be broadened to include organisations as defined in section 8C.

That consideration is given to reducing or waiving the fee for an organisation applying for a criminal history report in order to comply with section 8B.

That a criminal history report be defined as a report that includes information as to whether a person is on the Australian National Child Offender Register (ANCOR).

RECOMMENDATION 4
That the Children’s Protection Act 1993 be amended to require organisations to lodge a copy of their policies and procedures established pursuant to section 8C(1) with the chief executive and that the chief executive be required to keep a register of those policies and procedures.

RECOMMENDATION 5
That Families SA, as part of the screening process of employees, carers and volunteers, obtains information as to whether or not that person is on the Australian National Child Offender Register (ANCOR).

RECOMMENDATION 6
That Families SA extends its screening processes to cover known regular service providers to children and young people in care with disabilities, such as regular bus or taxi drivers.

RECOMMENDATION 7
That the Charter of rights for children and young people in care be the subject of legislation in South Australia.

RECOMMENDATION 8
That the Children’s Protection Act 1993 be amended to provide for a Youth Advisory Committee, established and appointed by the Guardian for Children and Young People. The committee would consist of children and young people currently or formerly under the guardianship or in the custody of the Minister. Membership should include an Aboriginal person/s and a person/s with a disability.
List of recommendations

RECOMMENDATION 9
That a Minister’s Youth Council be established to directly advise the Minister for Families and Communities. Council members must be children or young people aged 12–25 years currently or previously under the guardianship or in the custody of the Minister. The membership must include an Aboriginal child or young person; a child or young person/s with a disability; and a youth adviser to the Guardian for Children and Young People.

RECOMMENDATION 10
That resources be allocated to ensure that the participation of children and young people on the Youth Advisory Committee appointed by the Guardian of Children and Young People (see recommendation 8) and on the Minister’s Youth Council (see recommendation 9) is not limited by financial barriers.

RECOMMENDATION 11
That there be a special position created in the office of the Guardian for Children and Young People to assist the GCYP in addressing s52C(2)(b) of the Children’s Protection Act 1993 and ensuring that both individual and systemic advocacy is provided for children with disabilities in care.

RECOMMENDATION 12
That an extensive media campaign be implemented to educate the community about child sexual abuse—its prevalence, existing misconceptions, perpetrators’ tactics, services for victims, and treatment for offenders—and highlight that child protection is a community responsibility.

RECOMMENDATION 13
That the Sexual Behaviour Clinic of the Rehabilitation Programs Branch, Department for Correctional Services, be expanded so that all child sex offenders may attend the program while in custody and at any stage of their sentence.

RECOMMENDATION 14
That the following be formalised in, and implemented as part of, the Keeping them safe reform agenda:

- Every child and young person in care has an allocated social worker
- Every child and young person in care has regular face-to-face contact with their allocated social worker, the minimum being once a month, regardless of the stability or nature of the placement
- The primary guiding principle in determining the workload of each social worker is quality contact between each child and young person in care and their social worker, which includes face-to-face contact at least once a month and the ability to respond within 24 hours if contact is initiated by the child or young person.

As part of implementing the above, it is recommended that:

- Sufficient resources are allocated to recruit and retain qualified social workers
- Emphasis is placed on the professional development and support of social workers including –
  - The reduction of team sizes to a maximum of seven or eight, to increase the capacity for better supervision of social workers and their own professional development
  - Mandatory training in supervision for all social workers employed in supervisory roles
  - The introduction of a system of registration or accreditation for social workers, which requires ongoing professional development and training.
List of recommendations

RECOMMENDATION 15
That the training of social workers by Families SA in regard to child sexual abuse be reviewed to include:

- what constitutes child sexual abuse
- that it is a crime and a breach of human rights
- its prevalence in family and other contexts
- statistics on different perpetrator groups
- the tactics that perpetrators use to secure silence
- the abuse of power inherent in child sexual abuse
- that perpetrators are solely responsible for the abuse
- that children, by definition, are incapable of giving informed consent to sexual abuse
- that children should be able to tell trusted adults about any abuse to which they are subjected
- what others can do if they suspect that a child is at risk (for example, reporting to police or Families SA)
- that child sexual abuse is a community issue requiring vigilance and appropriate responses
- how to respond to a disclosure
- understanding the dynamics involved in disclosure (for example, a child disclosing has usually identified some quality in the confidant that they can trust—people who have been abused are often very attuned to ‘reading’ people’s likely responses)
- understanding needs beyond mandatory reporting protocols and requirements (that is, the needs of the person or child who has been subjected to child sexual abuse)
- listening to children and young people
- empowering children and young people
- caring for a child or young person who has been sexually abused
- the role of the Guardian for Children and Young People generally and specifically as an advocate for a child in care who has been sexually abused
- the role of the Health and Community Services Complaints Commissioner as an independent investigator.

Input in regard to the content of the program and its delivery should be received from current and former children and young people in care and professionals working in the area of child sexual abuse.

The training program should be mandatory for all social workers.

RECOMMENDATION 16
That adequate resources are directed towards:

- ensuring that no child or young person ever needs to be placed in emergency accommodation such as serviced apartments, bed and breakfast accommodation, hotels and motels
- placing children and young people according to suitability of placement rather than availability
- the recruitment and retention of foster carers including providing adequate support (such as respite care) and ongoing consultation
- accommodating a maximum of three children in residential care facilities.

RECOMMENDATION 17
That Families SA and relevant stakeholders develop relevant training programs about child sexual abuse for all carers of children and young people in care (foster, relative/kin and residential carers).

That the programs be developed in consultation with current and former children and young people in care, and professionals working in the area of child sexual abuse.

The particular training programs must address aspects of child sexual abuse, including:

- what constitutes child sexual abuse
- that it is a crime and a breach of human rights
- its prevalence in family and other contexts
- statistics on different perpetrator groups
- the tactics that perpetrators use to secure silence
- the abuse of power inherent in child sexual abuse
List of recommendations

- that perpetrators are solely responsible for the abuse
- that children, by definition, are incapable of giving informed consent to sexual abuse
- that children should be able to tell trusted adults about any abuse to which they are subjected
- what others can do if they suspect that a child is at risk (for example, reporting to police or Families SA)
- that child sexual abuse is a community issue requiring vigilance and appropriate responses
- understanding the dynamics involved in disclosure (for example, a child disclosing has usually identified some quality in the confidant that they can trust—people who have been abused are often very attuned to ‘reading’ people’s likely responses)
- understanding sexual abuse of children and young people in care with disabilities and the difficulties of disclosure
- identifying and understanding cultural issues relating to supporting disclosures by Aboriginal children and young people in care
- listening to children and young people
- empowering children and young people
- understanding needs beyond mandatory reporting protocols and requirements (that is, the needs of the person or child who has been subjected to child sexual abuse)
- caring for a child or young person who has been sexually abused, taking into account the need for a therapeutic response and understanding their vulnerabilities
- protective behaviours for carers
- the role of the Guardian for Children and Young People generally and specifically as an advocate for a child in care who has been sexually abused
- the role of the Health and Community Services Complaints Commissioner as an independent investigator.

The training program should be mandatory and accredited.
There should be a system of registration/accreditation of carers with registration being contingent on completion of this training; and the completion of updated training programs on this topic every three years.

RECOMMENDATION 18
That there be mandatory specialist training for all carers and potential carers of children and young people with disabilities in State care, which includes the topics referred to in Recommendation 17 as well as particular issues concerning the prevalence of sexual abuse of children and young people with disabilities; prevention of sexual abuse of children and young people with disabilities; assessing behaviours as indicators of sexual abuse; supporting disclosure and responding to disclosure.

RECOMMENDATION 19
That there be a specialist position created in the Office of the Guardian for Children and Young People to assist in carrying out the guardian’s functions pursuant to section 52C Children’s Protection Act 1993 in relation to Aboriginal children and young people under the guardianship or in the custody of the Minister.
List of recommendations

RECOMMENDATION 20
That the practice guidelines of the Special Investigations Unit (SIU) be amended to include specific guidelines concerning notifications and investigations of alleged sexual abuse of children and young people in care.

In regard to notifications, it is recommended that the guidelines include requirements for mandatory notification of sexual abuse allegations by SIU to South Australia Police and the Guardian for Children and Young People immediately or within 24 hours, depending on the urgency of the circumstances.

In regard to SIU investigations, it is recommended that the guidelines include requirements for:

- a strategy discussion between SIU and SA Police before the start of any SIU investigation, with the GCYP given prior notification of the discussion and invited to attend
- a written record signed by SIU and SA Police of the strategy discussion, outlining any actions to be taken by each, with a copy provided to the GCYP within 24 hours
- SIU to only take action in accordance with what was agreed in writing at the strategy discussion
- SIU to take no action that would prejudice a police investigation or potential prosecution. In particular, the SIU must not speak to the child, alleged perpetrator, potential witnesses or other potential complainants without seeking, and then gaining, approval in writing from SA Police
- the GCYP to be kept informed by SIU and SA Police of the progress and outcome of the investigation. Both SIU and SA Police to provide the GCYP with information concerning the investigation on request and to respond within 24 hours to any request by the GCYP for information regarding the investigation.

RECOMMENDATION 21
That there be a review of therapeutic services to children and young people provided by Child Protection Services, Child and Adolescent Mental Health Services (CAMHS) and Yarrow Place Rape and Sexual Assault Service.

The review should include the:

- services’ ability to provide counselling and therapeutic services to children and young people in care
- structures required to increase the number of children and young people to whom counselling and therapeutic services can be provided, in both metropolitan and regional areas
- resources required to achieve an appropriate level of response, that is, the provision of counselling and therapeutic services to at least 60 per cent of children and young people who have been abused. Child Protection Services and CAMHS should receive a significant allocation of resources to increase their ability to provide such a level of response.

RECOMMENDATION 22
That therapeutic support is made available for the relevant carers when a child or young person in care makes a disclosure of sexual abuse.

RECOMMENDATION 23
That the Children’s Protection Act 1993 be amended to add a function to the Guardian for Children and Young People, namely to act as an advocate for a child or young person in State care who has made a disclosure of sexual abuse.

That in accordance with section 52B of the Act, the GCYP is provided with sufficient staff and resources to accomplish this function.
List of recommendations

RECOMMENDATION 24
That it be mandatory for the chief executive of the Department for Families and Communities or Commissioner of Police to notify the Guardian for Children and Young People when a child or young person under the guardianship or in the custody of the Minister makes an allegation of sexual abuse. (Also refer Recommendation 20.)

RECOMMENDATION 25
That Families SA’s new C3MS (Connection client and case management system) include a separate menu for allegations of sexual abuse of a child in State care, which would collate the names of all such children.

That the system include a separate field in relation to each child in State care, which is dedicated to recording any information about allegations of sexual abuse, including when that information had been forwarded to the Guardian for Children and Young People.

RECOMMENDATION 26
That consideration is given to changing the name of the Guardian for Children and Young People to avoid confusion with the role of the Minister as legal guardian of children and young people placed in State care.

RECOMMENDATION 27
That section 52A of the Children’s Protection Act 1993 is amended to delete section 52A(5)(f), powers of removal of the Guardian for Children and Young People, and replace it with provisions similar to the powers of removal relating to the Health and Community Services Complaints Commissioner and Employee Ombudsman.

RECOMMENDATION 28
That the Children’s Protection Act 1993 be amended to expressly refer to the independence of the Guardian of Children and Young People; that the GCYP must represent the interests of children and young people under the guardianship or in the custody of the Minister; and that the Minister cannot control how the GCYP is to exercise the GCYP’s statutory functions and powers—subject to section 52C(1)(f).

RECOMMENDATION 29
That the Children’s Protection Act 1993 is amended to allow the Guardian for Children and Young People to prepare a special report to the Minister on any matter arising from the exercise of the GCYP’s functions under the Act. The amendment should require the Minister to table the special report in parliament within six sitting days of receipt.

It should be expressly stated in the Act that the Minister may not direct the Guardian to change the contents of the report.

RECOMMENDATION 30
That the Children’s Protection Act 1993 is amended to provide the Guardian for Children and Young People with powers to obtain information from any person in connection with the GCYP’s functions under the Act. This power should be coupled with a penalty for failure to comply. It should also be an offence for a person to persuade or attempt to persuade another by threat or intimidation not to provide information.

There should be general provision making it an offence to obstruct the GCYP.

It is recommended that the amendment be modelled on similar provisions to those of section 47(2)–(6) and sections 78–81 of the Health and Community Services Complaints Act 2004.
List of recommendations

RECOMMENDATION 31
That the Health and Community Services Complaints Act 2004 be amended to allow all children and young people to make a complaint directly to the Health and Community Services Complaints Commissioner.

RECOMMENDATION 32
That the child protection function of the Health and Community Services Complaints Commissioner be promoted by permitting the Commissioner to adopt an additional title as ‘Child Protection Complaints Commissioner’. This should be enacted in the Health and Community Services Complaints Act 2004.

That within a reasonable time after the delivery of the Inquiry’s report to the Governor, there be a public awareness campaign concerning the role of the HCSC Commissioner to receive complaints from people (including current and former children and young people in State care) about child protection service providers.

RECOMMENDATION 33
That an amendment to the Health and Community Services Complaints Act 2004 provides that a relevant consideration for extending the two-year limit in the child protection jurisdiction is that the complaint arises from circumstances since the launch of the Keeping them safe reform agenda in May 2004.

RECOMMENDATION 34
That the Criminal Justice Ministerial Task Force gives special consideration to the backlog of cases of sexual abuse involving child complainants and developing measures to prioritise the listing of those trials.

RECOMMENDATION 35
That the Criminal Justice Ministerial Task Force, or another committee specially established for the purpose, develop appropriate guidelines to ensure that trials involving child complainants of sexual abuse are fast-tracked.

RECOMMENDATION 36
That specialist training is undertaken by police, prosecutors, defence counsel and the judiciary in regard to working in the criminal justice system with (child) victims of sexual abuse who have a disability.

RECOMMENDATION 37
That a panel of appropriately qualified people be formed to consider and establish a model for restorative justice in regard to complaints of child sexual abuse made by victims.

RECOMMENDATION 38
That the South Australian Government makes a formal acknowledgment and apology to those people who were sexually abused as children in State care.

RECOMMENDATION 39
That the South Australian Government fund a free specialist service to adult victims of child sexual abuse (while in State care) as was provided by Respond SA.

That the service is provided by an organisation that is independent of government and church affiliation, and has never provided institutional or foster care. That the organisation employs practitioners specially trained in the therapeutic response to adult victims of child sexual abuse.
List of recommendations

RECOMMENDATION 40
That a task force be established in South Australia to closely examine the redress schemes established in Tasmania, Queensland and Western Australia for victims of child sexual abuse; to receive submissions from individuals and relevant organisations on the issue of redress for adults who were sexually abused as children in State care; and to investigate the possibilities of a national approach to the provision of services.

RECOMMENDATION 41
That the Paedophile Task Force, the Office of the Director of Public Prosecutions, the Legal Services Commission and the courts be allocated sufficient resources to investigate, prosecute, defend and conduct trials concerning the allegations of child sexual abuse arising from this Inquiry.

For a discussion of recommendations 42–48, see Chapter 4.2, ‘Children in State care who run away’.

RECOMMENDATION 42
That the provision of therapeutic and other intensive services for children in State care who abscond as envisaged in Keeping them safe – in our care, action six: ‘Children with complex care needs’, be implemented and developed as a matter of urgency and be adequately resourced.

That a group of care workers with suitable training and experience for such intensive therapeutic services be established and assigned to work on a one-on-one basis with children in State care who have complex needs and frequently abscond from placements.

That a specialist team be engaged to examine the benefits of establishing a specific therapeutic intervention program in South Australia that identifies, assesses, assists and treats children at high risk, similar to those in place in Victoria and the United Kingdom.

RECOMMENDATION 43
That a secure care therapeutic facility to care for children exhibiting behaviour placing them at high risk be established as a last-resort placement.

That the Minister appoints a panel of suitably qualified persons to select and design the secure care therapeutic facility and determine the therapeutic services to be provided.

RECOMMENDATION 44
That a missing persons protocol between the South Australia Police local service areas and the Department for Families and Communities be implemented in all regions where residential care facilities are located (including transitional accommodation houses).

That a contact officer be established in each SA Police local service area where residential care facilities are located (including transitional accommodation houses) to facilitate the development and implementation of the missing persons protocol and to facilitate the flow of information concerning children and young people who frequently abscond and are ‘at risk’ of sexual exploitation.

RECOMMENDATION 45
That the South Australia Police computer system (PIMS) create separate fields to record if a child is in State care, and if a child is ‘at risk’ due to frequent absconding, to enable that information to be readily available.

That the SA Police local service areas and Missing Persons Unit maintain specific files about children in State care who are considered to be ‘at risk’ due to frequent absconding. The files should contain information about each time a child absconds, including where he or she has been located.
List of recommendations

RECOMMENDATION 46
That section 16 of the Children’s Protection Act 1993 be amended to provide for a more general power to recover children in State care by deleting the requirement of a reasonable belief as to ‘serious danger’ and inserting a lesser standard such as ‘a risk to the wellbeing of the child’.

RECOMMENDATION 47
That the following offences be created:
(1) Harbouring a child in State care contrary to written direction.
(2) Communicating with a child in State care contrary to written direction.

The legislation should provide for a written notice to be served on a person with a presumption that, upon proof of prior service, the offence is committed if the child is found with that person.

RECOMMENDATION 48
That the South Australia Police undertake an operation in relation to Veale Gardens and other known beats to detect sexual crimes against children and young persons in State care, apprehend perpetrators and develop further police intelligence.

For a discussion of recommendations 48–51, see Chapter 5, ‘Deaths of Children in State care’.

RECOMMENDATION 49
That the Department for Families and Communities creates a central database of children who die while in State care as part of C3MS.

The database should contain:
- the child’s last place of care
- the name of the child’s last carers
- the date of death
- the cause of death (as initially advised to the department)
- the circumstances of the death (as initially advised to the department)
- the source of initial advice about the cause and circumstances of death
- confirmation that the death was reported to the State Coroner and when
- if an inquest was not held, the cause of death as found by the coroner and when that finding was made
- if an inquest was held, the cause of death as found by the Coroner’s Court and when that finding was made
- if an inquest was not held because of a criminal prosecution, the name of the investigating police officer and the outcome of the criminal prosecution.

RECOMMENDATION 50
That where a child dies in State care, the Department for Families and Communities maintains a physical file, which contains:
- information about when the child died and in what circumstances, including reference in the file to where the information has come from
- information from the State Coroner as to whether an inquest is to be held
- the coroner’s finding as to cause of death
- a copy of the coroner’s reasons in the event that a coronial inquest is held.
List of recommendations

RECOMMENDATION 51
That the South Australian Government provides financial assistance to a family member of any child who dies in State care to enable that family member to be legally represented at a coronial inquest into that child’s death.

For a discussion of recommendations 52–54, see Chapter 6, ‘Keeping adequate records’.

RECOMMENDATION 52
That departmental client subfiles have a 105-year retention period.

RECOMMENDATION 53
That the Department for Families and Communities implements an appropriate electronic document and records management system (EDRMS), including file tracking, to appropriately manage paper and electronic records, including client and administration files. The EDRMS should interface with C3MS.

RECOMMENDATION 54
That the Department for Families and Communities continues with the discovery and consignment listing of any records relating to children in State care held permanently at State Records of South Australia or at other temporary storage providers where the department is the agency responsible.
Chapter 1 Approach and conduct of the Inquiry
# 1 Approach and conduct of the Inquiry

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Establishment

On 1 July 2004, the South Australian Minister for Families and Communities, the Hon. Jay Weatherill MP, introduced a Bill into Parliament to set up a Commission of Inquiry into the handling of complaints of sexual abuse from people who were, at the time of abuse, children in State care. The Inquiry was intended to inform the State Government’s child protection policy. On 19 July, the Hon. Rob Kerin, then Leader of the Opposition, presented Parliament with a petition signed by 219 South Australians, requesting the establishment of an independent inquiry to investigate and report allegations of sexual abuse of wards of the State and others in institutional care. On the same day, the Minister announced the appointment of Justice E P Mullighan as Commissioner of the Children in State Care Commission of Inquiry, and the Bill was passed on 4 August. On 28 October the Minister told Parliament:

... the essence of this inquiry is a healing process and crucial to that is to give people a forum at which they can tell their story. The telling of the story in a way which is respected and honoured is itself part of the healing process.

The Commission of Inquiry (Children in State Care) Act 20041 (Commission of Inquiry Act) was proclaimed on 18 November and E P Mullighan QC (former Supreme Court judge) started his role as Commissioner on 6 December.

Raising awareness


The Inquiry developed a campaign to raise awareness of its terms of reference and encourage people to come forward. It included distributing posters, pamphlets and information to relevant organisations throughout the State and promoting the Inquiry on radio and television news and current affairs programs. National, metropolitan and regional newspapers also provided extensive coverage about the Inquiry and its terms of reference. A website for the Inquiry was established in January 2005 and had a total of 20,540 visits—50 per cent were from Australia, 20 per cent from the United States, 20 per cent from the United Kingdom and 10 per cent from other countries.

The Inquiry also advertised in publications with a target audience, such as The Big Issue, Koori Mail, Blaze and Link and in street press, and had information broadcast on community radio stations such as Three D in Adelaide and CAAMA in Alice Springs.

The Inquiry also developed an extensive outreach program for groups that could potentially be disadvantaged in getting access or coming forward to the Inquiry, namely prisoners and Aboriginal, elderly, young and disabled people.

Aboriginal people

The Inquiry immediately recognised that it needed a special focus to reach Aboriginal people. It expected that Aboriginal children, who were and remain over-represented in the child protection system, would be among those who had been sexually abused while in State care.2 The Inquiry also anticipated that Aboriginal people would understandably lack confidence in a process established by the government, such as the Inquiry. This is given the historical removal of Aboriginal children to be ‘brought up in a Christian atmosphere’, which was intensified by the State’s assimilation policies of the 1950s and 1960s and caused Aboriginal children to be placed in dormitories on mission stations, homes run by missionary and other church organisations, and other government and non-government institutions.

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1 Amended on 28 June 2007 to the Commission of Inquiry (Children in State Care and Children on APY Lands) Act 2004 (Commission of Inquiry Act).
2 In Keeping them safe – in our care: draft for consultation (Department for Families and Communities, 2006) the State Government reported that 23.9 per cent of children in care were Aboriginal children, whereas only 3.2 per cent of the general population in that age group were Aboriginal. See Chapter 4.1.
The Inquiry received information indicating that impediments existed in Aboriginal communities about discussing sexual abuse, such as acute shame for both the victim and the community, the absence of traditional language to name it, fear of recriminations and the effects of substance abuse. Given the small populations in remote communities, it may have been difficult for someone wanting to approach the Inquiry to do so unnoticed. Other more practical concerns included the need for interpreters and counselling. If these matters were not considered, disclosures could be limited and evidence misunderstood.

To enable Aboriginal people to participate equitably, the Inquiry:

- established an Aboriginal Advisory Committee within three months
- travelled to Aboriginal communities to provide information and take evidence
- engaged facilitators to assist communications with Aboriginal people in Adelaide
- took evidence from health and welfare professionals who were likely to have an awareness of sexual abuse of Aboriginal children.

The Aboriginal Advisory Committee’s membership and objectives are set out in Appendix A. It assisted the Inquiry to develop and deliver outreach activities to Aboriginal people throughout the State by advising on the communities to visit, the people to meet, and traditional laws and customs that might influence Inquiry processes.

The Inquiry greatly benefited from the wise counsel of Kaurna elder Lewis O’Brien, who has a vast knowledge and experience of the law, customs and traditions of not only his people but also most Aboriginal communities.

Two Aboriginal women assisted the Inquiry by making it easier for individuals who had been sexually abused as children to give evidence. Amelia Campbell, who has worked extensively as a volunteer with the homeless in Adelaide and is well known in Aboriginal communities in Adelaide and Raukkan, referred numerous people who gave evidence in a variety of places, including the Inquiry’s office, their homes, the premises of community and welfare organisations, and even the Adelaide Park Lands. Coral Wilson, who retired in 2006 as a Department for Correctional Services Aboriginal liaison officer at the Adelaide Remand Centre, helped the Inquiry in obtaining evidence from Aboriginal prisoners. She also travelled to Aboriginal communities with the Inquiry to help with the outreach program.

From March 2005 to late 2006, the Inquiry visited 10 Aboriginal communities, including regional centres such as Port Augusta, Murray Bridge and Mount Gambier, and smaller communities as far west as Ceduna and north to Iron Knob, Oodnadatta and Coober Pedy.

The outreach program involved meetings with Aboriginal communities and relevant professionals in the areas of health, family, youth, welfare, law, police and correctional services; promoting the Inquiry on Aboriginal radio and in regional print media; distributing posters and pamphlets; visiting prisons; and attending community social and sporting events. Meetings with Aboriginal women and elders were held in several locations.

During the outreach visits, a pattern emerged of Aboriginal people talking generally about the existence of child sexual abuse in their communities or alluding to knowing people who had been sexually abused as children. On occasions, people would name others they believed to have been abused as children in State care. Sometimes people would approach Inquiry staff at meetings and show an interest in giving evidence concerning their own abuse, but then would not proceed. Attempts to engage Aboriginal leaders to facilitate disclosure were largely unsuccessful.

One person in a regional centre said the Inquiry was ‘a bit remote’ from the community. Others said Aboriginal people in remote communities were used to white people

...flying in for five minutes, then they never see them again. If you want their trust you need to keep going back, spend time with them, get to know them and earn their trust.
An Aboriginal worker in a remote community said:

The best way to earn the trust of Aboriginal people and get them to open up is to spend time with them doing fun and everyday things. In such an environment there is no pressure and when they see you are genuine they will start to open up.

The Inquiry identified that other communities required outreach, for example, the Anangu Pitjanjatjara Yankunytjatjara (APY) Lands, Yalata on the west coast of the Yorke Peninsula and Gerard in the Riverland. However, the dilemma was that although communities such as Koonibba, Raukan and the APY Lands were established by or with the consent of the State Government or at various times managed by the State, investigations of available historical records gave no indication that the alleged victims of child sexual abuse in those communities came within the Inquiry’s terms of reference. Despite this, the information was too important to ignore and the Commissioner became involved in discussions with the Minister about the issue. In June 2006, the Minister and the Federal Minister for Indigenous Affairs, and others, discussed the issue of violence and child abuse in Aboriginal communities. Following a request by the Federal Minister, the Minister and the Commissioner prepared a proposal to expand the Inquiry to permit the investigation of sexual abuse of children in all Aboriginal communities in South Australia. Pending the outcome of the proposal, the Inquiry postponed its outreach to the outstanding regional and remote communities. Eventually the two governments agreed to the Commonwealth Government funding a more limited inquiry confined to some communities only on the APY Lands. The Commission of Inquiry Act was amended in June 2007 to establish the Children on APY Lands Inquiry, which is the subject of a separate report.

While waiting for the outcome of the proposal, the Inquiry and Aboriginal services Nunkuwarrin Yunti of SA Inc. and SA Link-Up held a public hearing on 6 December 2006 in Adelaide. The hearing was to enable Aboriginal people to provide information that could assist in the making of the Inquiry’s recommendations. It was attended by 56 Aboriginal people, members of the Aboriginal Advisory Committee and Inquiry staff.

A woman who works extensively with Aboriginal people in prisons told the hearing she had spoken to many Aboriginal people affected by abuse and encouraged them to give evidence to the Inquiry ‘because I feel they need to have some closure on these incidents that have affected their lives’. An Aboriginal woman who has worked with government for more than 22 years said: ‘Sometimes I think the only way to change the system is to get into the system’. One man said that more than 45 years ago he lived in a boys home at Semaphore where the children were sexually abused. He said he felt safe only when the home was closed down:

I’ve never lost the feeling of being institutionalised. It stays with you forever and then you’ve got to force other institutions to put our cases. What a bloody joke in the 21st century. This country doesn’t protect us. Until they acknowledge what they did …

A woman told the hearing that while policy recommendation is good, ‘talk is cheap, you know. But if it is not translated into anything to be done, without resources allocated to it, it’s no good.’ A Ngarrindjeri woman asked that the Inquiry discover the truth of what was happening because there is ‘a lot of terrible things going on with those children that have been sexually abused’. She said governments did not want to deal with it because ‘it is too political’.

Other people at the hearing said that children were masking the effects of sexual abuse by taking substances and sniffing petrol—a boy was offering sex for petrol or drugs in one community. One Aboriginal woman said:

We have to have enough guts to stand up and say ‘leave our children alone’. All of us as adults have problems because of what happened. We are trying to fix what has happened and to take care of our children. I mean stop sexually abusing them. Everybody stop it and that’s the only message. You know we are all supposed to be so-called bloody civilised people. It breaks my heart. Past generations were sexually abused.

The hearing demonstrated the importance of the government consulting with and taking action in all Aboriginal communities.
There were 152 people of Aboriginal or Torres Strait Islander descent who told the Inquiry they were victims of child sexual abuse; the Inquiry was able to confirm from available records that 44 were in State care at the time of the alleged abuse.

**Elderly people**

The Inquiry was aware that publicity might have an adverse effect on elderly people (aged 70 and above), particularly those who were frail or had no family support, by activating dormant memories.

Various organisations, including the Council on the Ageing (COTA), Aged and Community Services SA & NT, Aged Care and Housing Group (ACH Group), Masonic Homes Inc., Helping Hand Aged Care and UnitingCare Wesley Port Adelaide Inc., advised and assisted the Inquiry in informing elderly people and ensuring they had access to the Inquiry.

The Commissioner attended or addressed meetings of COTA’s Policy Council, the Association of Independent Retirees, the Seniors Education Association Inc. and a Seniors Organisation Forum on 20 July 2006 organised by COTA for advice on the best way for the Inquiry to reach elderly people. The meetings were well attended, with contributions from many people on a wide range of issues concerning the Inquiry, such as the motivation and punishment of paedophiles including elderly offenders, services for victims, the difficulty of disclosing to family members and the training of foster carers and workers.

An Inquiry staff member participated in the World Elder Abuse Awareness Day Conference held in Adelaide on 15 June 2006, which provided the Inquiry with extensive material about abuse, as well as its application to childhood sexual abuse.

Information about the Inquiry was also sent to a range of organisations and specialist publications.

Twenty-two people aged 70 or older came forward to the Inquiry; six were in State care at the time of the alleged child sexual abuse.

**People with disabilities**

The Inquiry was aware that people with disabilities would generally have difficulty in approaching, and disclosing allegations of sexual abuse to, the Inquiry. On 2 December 2005 about 80 people attended a forum held by the Inquiry in Adelaide to raise awareness of its role among the State’s disability sector and better understand how to communicate effectively with people with disabilities.

Presenters included the South Australian Guardian for Children and Young People, Pam Simmons, who outlined her office’s role in the protection of children and young people in State care with disabilities from abuse; the director of the Office for Disability and Client Services, Department for Families and Communities, Dr David Caudrey, who spoke about government policy for the protection of vulnerable people in the disability services sector; and the acting director Central Coordination, Department of Education and Children’s Services, Trish Winter, who discussed the challenges across schools in responding to allegations of child sexual abuse.

The Inquiry further publicised its work through articles distributed to disability service providers via peak organisations such as National Disability Services (NDS) and the Association of Non-Government Organisations of SA (ANGOSA).

Inquiry staff also met non-government agencies including Anglicare SA, Novita Children’s Services, CARA (Community Accommodation & Respite Association), Life Without Barriers, CanDo4Kids, Down Syndrome Society of South Australia, the Salvation Army, UnitingCare Wesley, Citizen Advocacy, Independent Advocacy, Disability Complaints & Advocacy Service, and Disability Action Inc. Other non-government agencies provided extensive written information and support.

The Inquiry received considerable help from State Government departments and agencies, including presentations and submissions from the Department for Families and Communities’ Exceptional Needs Unit and Specialist Intervention & Support Service, as well as individuals with particular interests and expertise in disability.
Disability SA, the peak South Australian Government service provider for people with disabilities, brought 202 cases relating to alleged sexual abuse to the Inquiry’s attention. Most of the cases are current, although a small number relate to abuse 30–50 years ago. As Disability SA and its predecessors have not kept a register of abuse cases, the identification of potentially relevant cases relied on the recall of staff. Thus there may be other cases not known to the Inquiry.

The Inquiry inspected the 202 client files, along with department and police records in most of the cases, to gain an understanding of the difficulties associated with disclosures of sexual abuse by children with disabilities, as well as the response to disclosures. However, only about 10 per cent came within the Inquiry’s terms of reference.

Forty-four people who had a disability came to the Inquiry. Of those, it was established that 22 were in State care at the time of the alleged abuse.

Youth

The Inquiry understood that it would need a special effort to let young people (under the age of 18) know that it was safe and important to make disclosures. Adults who had been in State care told the Inquiry that as children they had no respect for institutions such as courts, police, welfare, education and health, and did not trust most of the people working in them. As self-described ‘welfare children’ they felt stigmatised and of lesser value and importance than other children.

The Inquiry appointed a member of staff as youth liaison officer, who worked with one of the Inquiry’s investigators to contact organisations that provide assistance and services to youth, such as Side Street Youth Service (counselling, support and information for youth aged between 12 and 25 who are homeless or at risk of homelessness or who have experienced physical or sexual abuse), Second Story Youth Health Centres (provides health services to young people aged 12–25 years) and StreetLink Youth Health Service (provides a health service and outreach to homeless and at-risk young people).

The Inquiry received invaluable assistance in encouraging children in State care to come forward from organisations including the Commonwealth/State Youth Supported Accommodation Assistance Program, UnitingCare Wesley, the Youth Affairs Council of South Australia, Inner City Youth Services, the Port Youth Accommodation Program and the Second Story Youth Health Centres.

In mid 2006 the Inquiry established the Young People Advisory Group, which consisted of 10–13 members aged 16 to 26. The group’s objectives are set out in Appendix A. The group met nine times, identified relevant issues for young people in State care today and expressed views which contributed to the recommendations in this report.

Fifty-one young people (under 18) came to the Inquiry and said they were victims of child sexual abuse; the Inquiry determined that 16 had been in State care at the time.

Prisoners

The Inquiry knew that prisoners wanting to give evidence or provide information may face special problems, such as feelings of isolation, lack of appropriate support and personal safety if other prisoners became aware of their actions.

The Commissioner addressed staff and prisoners at Yatala Labour Prison, Adelaide Women’s Prison, Mobiling Prison, Adelaide Pre-Release Centre, and the Mount Gambier and Port Augusta prisons. To make it easier for prisoners to come forward, the Inquiry developed processes with the advice and support of the chief executive officer of the Department for Correctional Services, Peter Severin, and prison managers and staff.

The Inquiry heard evidence from 76 prisoners who alleged they were victims of child sexual abuse; the Inquiry determined that 20 were in State care at the time of the alleged abuse.

Reference to whether someone was a prisoner at the time of giving evidence has not been included in this report for privacy and safety reasons.
Determining who was a child in State care

In regard to allegations of sexual abuse, Schedule 1 of the Commission of Inquiry Act states:

1. The terms of reference are to inquire into any allegations of:
   (a) sexual abuse of a person who, at the time that the alleged abuse occurred, was a child in State care; (whether or not any such allegation was previously made or reported).

‘Child’ is defined in section 3 to mean a person under 18 years of age.

‘Sexual abuse’ is defined in Schedule 1 of the Commission of Inquiry Act as meaning conduct that would, if proven, constitute a sexual offence. ‘Sexual offence’ is defined in section 3 of the Act to mean a sexual offence within the meaning of section 4 of the Evidence Act 1929—in that Act the term ‘sexual offence’ is defined to mean rape, indecent assault, any offence involving unlawful sexual intercourse or an act of gross indecency, incest, any offence involving sexual exploitation or abuse of a child, or exploitation of a child as an object of prurient interest; or any attempt to commit, or assault with intent to commit, any of those offences. Some of the sexual offences as defined by the Evidence Act as at 18 November 2004 have changed in name, description or penalty over time in accordance with various amendments to the Criminal Law Consolidation Act 1935. (See Appendix B for a legal analysis of the changes.)

A ‘child in State care’ is defined in the Commission of Inquiry Act to mean a child who was, at the relevant time, placed under the guardianship, custody, care or control of a designated Minister (namely, a Minister responsible for the administration of the Children’s Protection Act 1993 or a corresponding previous enactment dealing with the protection of children) or another public official, or the former body corporate known as the Children’s Welfare and Public Relief Board (CWPRB), under a relevant Act (namely, the Children’s Protection Act or a corresponding previous enactment dealing with the protection of children).

The word ‘placed’ has a dual role in the definition. It requires the child to have been placed under the guardianship, custody, care or control of the Minister, a public official or the CWPRB; and second, it requires the placement to have occurred under the Children’s Protection Act or corresponding previous enactment.

Therefore the Inquiry has had to consider the legislative history of how a child was placed under the guardianship, custody, care or control of the Minister, a public official or the CWPRB.

The Children’s Protection Act deals with placing children into the custody of the Minister by virtue of a voluntary custody agreement, into the temporary custody of the Minister by virtue of a child being removed from a dangerous situation by a police officer or departmental employee or by court order where the child is reasonably suspected of being at risk or having been found to be at risk. The focus is on the protection of children who, because of circumstances such as neglect, abandonment or unfit guardianship, are found to be ‘in need of care’.

The placement of children who have been charged with criminal offences and are brought before a court within the juvenile criminal justice system is dealt with by the Young Offenders Act 1993, not the Children’s Protection Act. For that reason, it could be said that the Inquiry’s terms of reference do not include children placed in State care in the juvenile criminal justice system.

The Inquiry, however, has included those children for several reasons. From the State Children Act 1895 until 1971, both the ‘in need of care’ and ‘criminal justice’ placements of children were dealt with in the same legislation. In 1971 the two types of placements were split into separate pieces of legislation (the Community Welfare Act 1972 for in need of care placements and the Juvenile Courts Act 1971 for criminal justice placements). Eight years later, in 1979, the placements were again combined into a single piece of legislation (the Children’s Protection and Young Offenders Act 1979) before being split in 1993.

3 Children’s Protection Act 1993, Part 3.
4 ibid., Part 4, Division 2.
5 ibid., Division 4.
6 ibid., Part 5.
7 State Children Act 1895; Maintenance Act 1926; Social Welfare Act 1926–1965.
Second, the types of orders that could be made for children in need of care and those in the criminal justice system were almost identical. The only difference was the type of institution to which the child was sent, although that was not necessarily the case.² Even when the two types of placements were split into separate pieces of legislation from 1971–78, the Juvenile Courts Act provided for a complaint to be laid alleging that the child was in need of care and control (a complaint used for children ‘in need of care’) alongside the complaint setting out the criminal offences.

Finally, the legislative definition of ‘State child’ has included children who were placed in the juvenile criminal justice system (‘convicted child’) as well as those children being placed in the ‘in need of care’ system³ (‘neglected’, ‘destitute’, ‘uncontrollable’, ‘incorrigible’ children).

The following legislation dealt with the placement of children in State care before the Children’s Protection Act 1993 and is considered to be a list of all ‘corresponding previous enactments dealing with the protection of children’ for the purposes of the Inquiry’s terms of reference:

- **Children’s Protection and Young Offenders Act 1979**
- **Community Welfare Act 1972**
- **Juvenile Courts Act 1971**
- **Social Welfare Act 1965**
- **Immigration (Guardianship of Children) Act 1946 (Cwlth)**
- **Aborigines Act 1934–1939**
- **The Aborigines Act 1923**
- **Maintenance Act 1926–1937**
- **Education Act 1926–1972**
- **State Children Act 1895**

The Education Act contained a provision under which a child found to be a ‘habitual truant’ from school could be placed under the care and control of the State Children’s Council (SCC), its successor the CWPRB or the Minister.¹⁰ The relevant provision was repealed in 1993 but was then taken up by the Children’s Protection Act in the definition of ‘child at risk’¹¹ where it continues to be a basis for placing a child in State care.

The Immigration (Guardianship of Children) Act placed every evacuee child¹² and immigrant child¹³ who arrived in Australia after 30 December 1946 under the guardianship of the Commonwealth Minister.¹⁴ However, the Minister could place the child in the custody of a person representing any approved authority or organisation¹⁵, which of course included the States. The Minister could delegate his powers and functions to any officer or authority of the Commonwealth or of any State or Territory of the Commonwealth.¹⁶ If the Minister delegated his powers under section 6 of the Act, then regulation 4 under the Act applied. The regulation preserved guardianship of the child in the Commonwealth by not permitting the child to be committed under State laws, but allowed the State to exercise rights and powers over the child as if the child was formally placed under the relevant State legislation.

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² For example, under s. 111, Maintenance Act 1926–1937, only convicted children were to be sent to reformatory schools, unless the court believed that a neglected, destitute or uncontrollable child ought to be sent there. By s. 112, destitute, neglected and uncontrollable children only were to be sent to institutions other than reformatory schools but could be transferred to a reformatory school for misconduct with the approval of the Governor of South Australia or chief secretary. Similarly, a child in a reformatory school could be transferred to any other institution for good conduct.

³ Under the State Children Act 1895, s. 4, a ‘State child’ was convicted, destitute or neglected; under the Maintenance Act 1926–37, s. 5, a State child was ‘any child who has been committed to an institution’; under the Social Welfare Act 1926–1965, s. 5, a State child was ‘any person, whether under or over 18 years of age who … is being detained in an institution …’.

¹⁰ Children’s Protection Act 1993, s. 6(2).

¹² Immigration (Guardianship of Children) Act 1946 (Cwlth), s. 4, ‘Evacuee child’ means a person under the age of 21 years who has, in pursuance of the arrangement made for that purpose during the year 1940 between the Government of the UK and the Government of the Commonwealth, been received into Australia for custody and care by the Government of the Commonwealth.

¹³ ibid., ‘Immigrant child’ means (a) an evacuee child, or (b) a person under the age of 21 years who comes to Australia as an immigrant otherwise than in the charge of, or for the purpose of living in Australia under the care of any parent or relative of that person.

¹⁴ ibid., s. 6. Until the child reaches the age of 21 or the child leaves Australia permanently or until the provisions cease to apply to the child.

¹⁵ ibid., s. 7.

¹⁶ ibid., s. 5.
The Senate report on child migration in 2001\(^\text{17}\) stated:

The Minister delegated his powers as Guardian of the child migrants to State Welfare Authorities shortly after the legislation was enacted. The Department stated that it was ‘Not intended that he exercise direct control over migrant children, but that State authorities should assume that role’. Indentures were made between the delegated State government, Welfare officials and voluntary organisations in which the organisations agreed to bear the responsibility for the care and welfare of the children placed under their care. The statutory scheme established by the IGOC [Immigration (Guardianship of Children)] regulations ‘… envisaged that the State authority would be primarily responsible for the supervision of the welfare and care of child migrants. The local State authority was likely to have better knowledge of the rights, powers and responsibilities of guardians and custodians under Child Welfare legislation and better understanding of local conditions. In addition to this, offices of the State authority dealing with the Child Welfare matters on a regular basis were better equipped to deal with these matters than the staff of the Immigration Department.’ (Department of Immigration and Multicultural Affairs submission.)

The CWPRB annual report in 1948 described the child migrants’ status:

… under the provision of the Federal Immigration (Guardianship of Children) Act 1946, all immigrant children arriving in this State automatically come under the Guardianship of the Chairman of the [CWPRB] Board thus they will be, in the interests of their welfare, under the supervision of officers of the Department.

In practice, therefore, it appeared to be the view of both the Commonwealth and the State that the children had been ‘placed in State care’ by virtue of the delegated legislation.

**How a child was placed in State care**

A child could be placed in State care if ordered by the court, CWPRB or Minister, or by written agreements under the relevant legislation as follows:

1. A court order that the child be sent to an institution upon the court finding that a child was destitute, neglected, uncontrollable or incorrigible.\(^\text{18}\) The child could then be apprenticed or fostered\(^\text{19}\) to foster parents.

2. A court order that the child be placed in the custody and under the control of the SCC\(^\text{20}\), CWPRB\(^\text{21}\) or under the guardianship, care and control of the Minister\(^\text{22}\) or under the control of the director-general\(^\text{23}\) upon the court finding that a child was destitute, neglected, uncontrollable or incorrigible. The child could then be placed by the SCC, CWPRB or the Minister in an institution or home, apprenticed or fostered with foster parents, placed with any guardian or relative or any other suitable person, or placed in a hospital.\(^\text{24}\)

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\(^{17}\) Senate Community Affairs References Committee 2001, Lost innocents: righting the record – report on child migration, SCARC, Canberra.


\(^{20}\) State Children Amendment Act 1909, s. 21, for convicted, destitute, neglected, uncontrollable or incorrigible children, to 6 Apr. 1927.

\(^{21}\) Maintenance Act 1926, ss. 102–3 and 113, for destitute, neglected, uncontrollable or incorrigible children or children found guilty of any crime or offence (other than homicide) punishable by imprisonment, 7 Apr. 1927 – 26 Jan. 1966.


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(3) A court order that the child be remanded to an institution or any other suitable place pending a final court order in proceedings in which the child was charged with being destitute, neglected, uncontrollable or incorrigible.\(^{25}\)

(4) A written order by the CWPRB\(^{26}\) for children under eight years considered to be destitute or neglected, placing them in the custody and under the control of the CWPRB or in an institution until the age of 18 years. Consent was required from both parents if the child was ‘legitimate’ and only from the mother if the child was ‘illegitimate’. If the parents were deceased or could not be found, no consent was required.

(5) A written order by the Minister\(^{27}\) for children considered to be uncontrollable or neglected placing them under the control of the Minister or an institution until the age of 18 years. Consent was required from both parents if the child was legitimate and only from the mother if the child was illegitimate. If the parents were deceased or could not be found, no consent was required.

(6) A written order by the Minister\(^{28}\) that the child be placed under the guardianship of the Minister for such period as the Minister thinks fit, but not extending beyond the age of 18, if satisfied that the guardian has maltreated or neglected the child, or the guardians are unable or unwilling to maintain the child.

(7) A written agreement between a parent/guardian and the Minister for the child to be under the Minister’s custody or care and control for three months\(^{29}\) if the Minister considered it to be in the interest of the child.\(^{30}\)

(8) A voluntary custody agreement between the guardians of a child (or a child above the age of 16) and the Minister for the child to be in the custody of the Minister.\(^{31}\)

(9) The child was removed from any place by a police officer or officer of the department upon suspicion by that person on reasonable grounds that the child was in need of care or in immediate danger of suffering physical or mental injury or the child’s safety was in serious danger or the child was at risk and then placed for a short period pending court proceedings.\(^{32}\)

(10) The child was convicted of a criminal offence (found guilty of any crime or offence other than homicide punishable by imprisonment) and the court ordered that the child be sent to a reformatory school\(^{33}\) or reformatory institution\(^{34}\) or training centre.\(^{35}\)

(11) The child was charged with, or convicted of, a criminal offence and the court ordered that the child be placed in the custody and under the control of the SCC\(^{36}\), CWPRB\(^{37}\) or under the guardianship, care and control

\(^{25}\) State Children Act 1895, s. 117, to 6 Apr. 1927; Children’s Protection Act 1993, ss. 23 and 39, from 1 Jan. 1994.

\(^{26}\) Maintenance Act 1926–1937, s. 102a, from 30 Nov. 1950 to 26 Jan. 1966.

\(^{27}\) Social Welfare Act 1926–1965, s. 102a, for children under 12 years, from 27 Jan. 1966 – 30 June 1972; Community Welfare Act 1972, s. 39, for any child on application by a parent, guardian or custodian but consent of child required if the child was over 15 years, from 1 July 1972 – 4 July 1979.

\(^{28}\) Community Welfare Act 1972, s. 39, for any child on application by the guardian or, from 1981, by a child of or above the age of 15 but in that case the order could not exceed one year and the Minister had to consult with the guardian if the guardian could be found, and s.27, from 5 July 1979 – 31 Dec. 1993.

\(^{29}\) Changed to four weeks in 1981, Community Welfare Act Amendment Act No 67 of 1981.

\(^{30}\) Community Welfare Act 1972, s. 40, upon request from a parent, guardian or a child where the child is 15 years or over; the child’s consent was required if the child was 15 years or over, from 1 July 1972 – 31 Dec. 1993.

\(^{31}\) Children’s Protection Act 1993, s. 9, if the child was 16 years or over, the child must consent; if the child was under 15, the child had to be consulted if it appeared that he or she had a sufficient understanding of the consequences of a custody agreement, from 1 Jan. 1994.


\(^{33}\) State Children Act 1895, s. 36, to 6 Apr. 1927; Maintenance Act 1926–1937, s. 113, from 7 Apr. 1927 – 26 Jan. 1966.


\(^{35}\) Children’s Protection and Young Offenders Act 1979, ss. 51 and 100, from 1 July 1979 – 31 Dec. 1993; Young Offenders Act 1993, ss. 23 and 36, from 1 Jan. 1994.

\(^{36}\) State Children Amendment Act 1909, s. 21, for convicted, destitute, neglected, uncontrollable or incorrigible children, to 6 Apr. 1927.

\(^{37}\) Maintenance Act 1926, ss. 102–3 and 113, for destitute, neglected, uncontrollable or incorrigible children or children found guilty of any crime or offence (other than homicide) punishable by imprisonment, from 7 Apr. 1927 – 26 Jan. 1966.
of the Minister or under the control of the director-general. The child could then be placed by the SCC, CWPRB or the Minister in an institution, home or hospital; with any guardian or relative or any other suitable person; or apprenticed or fostered with foster parents.

(12) The child was charged with a criminal offence and was remanded in detention or in custody to an institution or home or any other suitable place during those proceedings.

(13) The child was apprehended by a police officer with or without warrant and then detained overnight pending court proceedings.

(14) The child was a habitual truant from school and was ordered by a court to be sent to an institution or placed under the care and control of the Minister.

(15) The child was Aboriginal and, with approval from the SCC or CWPRB, there was an order by the chief protector committing the child to an institution by way of a written transfer of control (the child could then be apprenticed or fostered). Unless the Minister otherwise directed, this applied to legitimate Aboriginal children who had obtained a qualifying certificate within the meaning of the Education Act 1915 or reached 14 years; and illegitimate Aboriginal children who, irrespective of age, in the opinion of the chief protector and the SCC/CWPRB, were neglected or otherwise proper people to be dealt with under the Act.

(16) The child was Aboriginal and, with CWPRB approval, there was an order by the Aborigines Protection Board (APB) that the child be committed to an institution. This applied to any Aboriginal child. The APB was responsible for determining, with the CWPRB, which children were neglected or otherwise proper people to be dealt with under the Act.

(17) The child was an evacuee child or immigrant child placed in South Australia.

Assessing whether a witness was a child in State care

Many people who came forward to allege sexual abuse did not know whether any of the provisions outlined above applied to them. They were often very young at the time they were placed in a care arrangement or were simply not told the legal circumstances under which they came to be living, say, in an institution or with a foster family. The Inquiry determined whether these witnesses were in State care under the relevant legislative provisions at the time of the alleged abuse by requesting records from the department or other relevant organisations such as the Anglican Church, Catholic Church and Salvation Army. Departmental records generally included:


43 Education Act 1915–1972, s. 48. From 1972, the Education Act provided that the truanting child shall be dealt with in accordance with the Juvenile Courts Act. Under that Act, s. 42, the court could order that the child be placed under the care and control of the Minister. The provision was repealed in 1993. The habitual truant provisions are currently dealt with in the Children’s Protection Act 1993.

44 Aborigines (Training of Children) Act 1923, s. 6.

45 Aborigines Act 1934, s. 38, from 18 Oct. 1934 – 21 Nov. 1939.

46 Aborigines (Training of Children) Act 1923, s. 8; Aborigines Act 1934, s. 40.


48 Immigration (Guardianship of Children) Act 1946 (Cwlth), ss. 4–7, regulation 4 of regulations made under the Act, notified in the Government Gazette on 19 Dec. 1946.
The Inquiry found that a SWIC may be anything from one to eight pages. There were comprehensive details on some cards and others with no information other than the child's name and the date he or she was placed in State care.

Client Information System (CIS) computer records. CIS developed out of the department's investigation into its information needs in the early 1980s. The department began information systems planning in conjunction with the Justice Information System (JIS) that was under consideration by the State Government in 1982. JIS was an independent unit established to collect, store and sort information for government agencies including the departments of Community Welfare (DCW), Police, Correctional Services and the Attorney-General. Planning for various DCW information systems to be integrated into the JIS computer network began in 1983, starting with foster care, child protection and the central file index. A project team was established to develop the department's involvement in JIS and further data systems. CIS was introduced in 1991 as an application of JIS. It included juvenile justice, child protection, financial services, foster care and file movement information. The JIS suite of applications was completed in 1992–93.

Client file. The department created paper client files relating to children for different reasons, one being that the child was in State care. Generally, the client files contain correspondence, reports and notes relating to the department's care of the child.

On the basis of records, the Inquiry's investigations revealed that:

- Some people who came forward to the Inquiry had been children in State care. They had a SWIC, JIS computer record or departmental client file that contained or referred to a legislative order or agreement.

- In some cases it was not possible to determine whether or not the person was in State care due to the lack of available records. This may be because the department or other relevant organisations were unable to locate any or sufficient records (even though the person placed at the institution or in foster care remembered the involvement of the department) or because records had been destroyed. There were insufficient records to clarify the nature of the department's involvement and whether there were any orders or written agreements.

- The Aborigines Protection Board (APB) had placed some Aboriginal people when they were children during the 1940s to 1960s. Under the legislation the Aboriginal children could be placed in State care if the APB, with the agreement of the CWPRB, issued a transfer of control. The Supreme Court in Trevorrow v. the State of South Australia (No 5) [2007] SASC 285 considered the reality of what occurred to Aboriginal children under the legislative scheme. The court found that 'insurmountable difficulties arose because of the ongoing and consistent refusal' of the CWPRB to take part. As a result, the Supreme Court found that:
it was the practice of the APB and the Aborigines Department to act to remove children thought to be neglected, and to do so with the state of mind that they lacked the legal authority or power to so act.\textsuperscript{55}

In other words, Aboriginal children were placed in care (for example, in institutions or homes or foster care) by the APB but not in accordance with the existing legislation. Because of this historical finding by the Supreme Court, the Inquiry has included Aboriginal children placed by the APB as coming within its terms of reference.

- Some people were not the subject of legislative orders or agreements at the time of the alleged sexual abuse. However, records showed that the department was involved in placing the child with registered foster parents (who received guardianship payments), visited the child regularly, arranged counselling and support for the child, moved the child if the child was unhappy and kept a file on the child. Similarly, the department placed some children in homes and a departmental social worker would regularly attend their review meetings. There were also records of placements being arranged by the Child Guidance Clinic, which appears to have operated as part of the Health Department of South Australia and had responsibility for children generally, including indigenous children.\textsuperscript{56} In all these cases, the records indicated there was a relationship between the child and the department although, because there was no legislative order or formal written agreement, the people were not ‘in State care’ as defined by the Commission of Inquiry Act at the time of the alleged abuse.

- There was no involvement by the department in relation to some people. Available records showed that they were living in institutions or foster care because of private arrangements between their parents/an organisation and an institution. These people were not ‘in State care’ as defined by the Commission of Inquiry Act at the time of the alleged abuse.

\textbf{The process of examining allegations}

The terms of reference in Schedule 1(2)(a) state that one of the purposes of the Inquiry is to examine the allegations.

Each allegation was initially examined by an ‘investigator’, who was a legal practitioner. The Commissioner appointed seven investigators over the period of the Inquiry. Each person who approached the Inquiry was allocated an investigator who prepared a brief summary of the proposed evidence and obtained relevant files from government and other agencies. Witness assistance was arranged at this time if required.

It was obvious that some people would have difficulty disclosing childhood sexual abuse and, to do so, they would need to have confidence in the Inquiry. The hearings were conducted without undue formality but in a manner to protect the importance and seriousness of the occasion. They were attended by the Commissioner, who heard all the evidence, the assigned investigator and any companion nominated by the witness. The evidence was elicited by the Commissioner, who attempted to develop the sense of confidence essential for disclosure, and at times by the investigator. Most hearings took between two and four hours.

The Commissioner did not adopt the technique of many inquiries of accessing evidence by written statement with occasional brief supplementation by oral evidence. Instead, the Commissioner considered that it was important that each person be given the opportunity to be fully heard in person, unless they wanted to only give a written statement.

Most evidence was taken at the Inquiry’s office, however hearings were also held in locations to suit witnesses, such as people’s homes, regional centres, interstate and sometimes over the telephone. One witness would only give evidence in a public park so that he could run away if necessary, and another on the premises of the former Glandore Boys Home, where he alleged he was sexually abused as a child.

\textsuperscript{55} ibid., s. 90.

\textsuperscript{56} The Child Guidance Clinic is discussed in Trevorrow v. State of South Australia [2007] SASC 285, summarised at (27).
In setting up the hearings process, the Inquiry hoped that it might assist healing as far as possible. It was soon established that most people giving evidence about what had happened to them had suffered, and continue to suffer, greatly. Many had not been able to disclose the sexual abuse when it occurred due to guilt, shame or fear of a sense of powerlessness. If they had attempted to disclose they were disbelieved and usually punished.

At the end of the hearings, the investigator, under the Commissioner's supervision, further examined the allegations. This involved reading the evidence, obtaining and reading relevant files, comparing other available evidence and seeking additional materials where appropriate.

**Provision of support**

The Commission of Inquiry Act requires the Minister, after consultation with the Commissioner, to appoint a person with appropriate qualifications and experience in social work or social administration to assist in the conduct of the Inquiry. The consultation occurred and the Minister appointed the chief executive officer of Relationships Australia (SA), Judith Cross. Under an agreement between Relationships Australia (SA) and the Department for Families and Communities, Respond SA was established to provide assistance and counselling services to survivors of child sexual abuse, including those attending the Inquiry. The manager of Respond SA was Jodie Sloan.

During the course of the Inquiry Ms Cross and the Commissioner met periodically and sometimes with Ms Sloan and the Inquiry’s witness support manager. Ms Cross provided advice about many matters, including the problems facing people making disclosures to the Inquiry, the services and facilities that should be provided to them, and the development of a witness support program for the Inquiry. Relationships Australia (SA) presented a substantial submission to the Inquiry and Ms Cross gave extensive evidence.

**Witness support**

The Inquiry appointed a witness support manager in June 2005. If a person who contacted the Inquiry requested support or was identified as possibly needing assistance by the investigator, the manager contacted them to discuss their participation. This service was provided to people in Adelaide, regional South Australia, prison or interstate.

The manager was available for hearings if requested and contacted witnesses after the hearing to provide counselling and/or support. The support included making referrals for counselling or providing other assistance. For example, people were helped to obtain copies of historical records through the Freedom of Information Act and to understand some of the outdated terminology. Also, some people who gave evidence did not have a permanent residence, for example, some were sleeping in motels on a nightly basis, in cars or in overcrowded hostels. The manager provided advocacy to assist these people with an emergency transition into safe, affordable housing, which included letters of support.

Over the period of the Inquiry, the witness support manager provided support, counselling or referrals for 448 people.

The experience of the witness support manager was part of the basis for the Inquiry’s recommendation for an advocate for children in State care who have been sexually abused and the continuation of a service such as Respond SA.

**Reporting on the failure of the State**

Under the terms of reference, Schedule 2(2)(b), the Inquiry is to report on whether there was a failure on the part of the State to deal appropriately or adequately with matters that gave rise to the allegations.

The examination of allegations, as referred to in Schedule 2(2)(a), necessitates reaching some conclusions. But the extent of the examination and nature of any conclusions must be determined in the context of the Commission of Inquiry Act.
The Act states that the Commissioner must seek to adopt procedures that will facilitate a prompt, cost-effective and thorough investigation of any matter relevant to the Inquiry. Yet it also contains significant confidentiality provisions that had an impact on the extent of the investigation, the examination of allegations and the nature of any conclusions.

The Commission of Inquiry Act creates an environment of confidentiality in regard to the disclosure of allegations of sexual abuse. It states that the Commissioner must take evidence in private unless he considers it in the public interest to conduct proceedings in public. All the hearings with people who alleged they were sexually abused as children were held in private, as it was not considered in the public interest to do otherwise. The Inquiry believes the confidentiality provisions contributed to the overwhelming response from people who came forward to disclose their experiences of sexual abuse while in care. Many said they saw the Inquiry as an opportunity to disclose to someone ‘in authority’ and, as one person expressed it, felt ‘validated’ on doing so.

The Act also states that confidentiality is to be maintained once the allegations have been made. The Commissioner must take all reasonable steps to avoid the disclosure of information that may identify, or lead to the identification of, an alleged victim of a sexual offence, an alleged perpetrator if the interests of justice so require, and a witness who has provided information about a sexual offence (or suspected offence) against a child, if the public interest so requires. This provision is absolute in relation to the alleged victims. The Act does not permit waiving confidentiality of the alleged victim’s identity by anyone in the conduct of the Inquiry, including the alleged victim. This has affected the Inquiry’s ability to investigate allegations of sexual abuse, for example by restricting the dissemination of information to potential witnesses to the issue of departmental responses to particular allegations.

The Commission of Inquiry Act also states that the Commissioner must take all reasonable steps to avoid prejudicing any criminal investigation or prosecution. Dissemination of allegations by the Inquiry had the potential to prejudice past, present or future police investigations, for example, by alerting an alleged perpetrator who may then destroy or contaminate evidence, or warning of possible surveillance.

Finally, in regard to conclusions that may be reached following the Inquiry’s investigation and examination of allegations, the Commission of Inquiry Act provides that the Commissioner must not make a finding of criminal or civil liability.

These provisions of the Act are important. The appropriate tribunal to make findings about criminal conduct is the criminal court and the people involved in that process (the complainant, witnesses and the accused) must have the protections and safeguards of the criminal justice system. People involved in civil proceedings must also have the protection and rights available in that part of the justice system.

Also, a finding by the Inquiry that a particular perpetrator has sexually abused a child in State care (whether that be a finding made beyond reasonable doubt or on the balance of probabilities) may well prejudice a police investigation, a criminal prosecution or a civil court, particularly if the perpetrator can be identified in the Inquiry’s report.

It is evident from the Commission of Inquiry Act that the Inquiry was never intended to take the place of the South Australia Police or a court. The Act specifically provides for the dissemination of information by the Commissioner of the Inquiry to the Commissioner of Police or the Director of Public Prosecutions under certain circumstances. The Commissioner, under an arrangement with the Commissioner of Police, provided him with information concerning the commission, or alleged commission, of sexual offences against children that arose during the course of the Inquiry as required by s10(2) of the Commission of Inquiry Act.

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57 Commission of Inquiry Act, s. 5(1)(b).
58 ibid., ss. 5(2) and 5(3).
59 ibid., s. 9(5).
60 ibid., s. 5(1)(f).
61 ibid., Schedule 1, clause 2(5).
62 ibid., s. 10(2).
If the Inquiry had been intended to receive allegations and then conduct hearings by calling all relevant witnesses as if it were a tribunal or court, the enacting legislation would have been quite different and there is no doubt that the Inquiry’s work would not have been completed for more than a decade.

Consequently, the Inquiry has not conducted hearings to seek a response from alleged perpetrators or other witnesses on individual allegations. If the alleged victim of sexual abuse told the Inquiry that he or she reported the matter to the State Government (the department or the police), the Inquiry obtained all relevant records to determine whether that disclosure was recorded and the nature of the State response. Similarly, if it was apparent from other information that the State was aware, or should have been aware, of the matters giving rise to the allegations of sexual abuse, then the Inquiry has obtained all relevant records to determine the State’s level of awareness and any recorded response.

Chapter 3 contains accounts from people who said they told members of staff at homes, their foster carers or departmental workers that they were being sexually abused as children. Sometimes a note was found in a person’s departmental client file recording a disclosure of child sexual abuse; but many times not. If a note was not found, it does not mean that the disclosure was not made and the witness at the Inquiry should not be believed. Rather, it could mean that a disclosure was made, and as many witnesses at the Inquiry said, their disclosure as a child was rejected, discounted or ignored by the adult. If this was the case, then clearly the State’s response, through its staff, was inappropriate and inadequate. There was such a significant number of witnesses who reported this experience of being disbelieved to the Inquiry that, put together, the evidence demonstrates a culture during the last century of not properly listening to, or acting on, disclosures by children of sexual abuse.

Where a record was made of a disclosure, the nature of the disclosure as recorded is set out in the summary of the particular person as well as the response of the State to that disclosure, as shown in the files. There are examples where the files do not show what, if any, response was given to the recorded disclosure. There is no doubt that such situations demonstrate a failure to keep appropriate and adequate records. There are some instances where the response was contained in the files, however, on the basis of the files, it could be said that the response was inadequate. There are other more recent instances where the response on the file shows that the department took appropriate action in, for example, reporting the allegation to the police and moving the child to another placement. However, there are some instances where the police appear to have discounted the allegations on the basis that there was no independent support for them. Such a response from the police could not be considered to be appropriate or adequate.

The Inquiry has also taken evidence from witnesses about the State’s response to the sexual abuse of children in State care generally, including its Keeping them safe reform agenda (see Chapter 4.1) and its awareness of, and response to, children in State care who are sexually abused when they run away from placements (see Chapter 4.2).

A significant number of people came forward to give general evidence about the department’s actions in individual cases or the foster care system generally or the child protection system overall. The fact that they did so is testament to their commitment for reform. However, it is not possible for this Inquiry to meet some of their expectations as it is not an inquiry into the department, the foster care system or the overall child protection system and is limited by its terms of reference. Nevertheless, much of their evidence has informed the recommendations made in Chapter 4.

The method of State record keeping

The terms of reference, Schedule 2(2)(c) state that another purpose of the Inquiry is to determine and report on whether appropriate and adequate records were kept in relation to allegations of the kind referred to in subclause (1) and, if relevant, on whether any records relating to such allegations have been disposed of or destroyed. (See chapter 6.)
The Inquiry requested all relevant records on alleged victims of sexual abuse who gave evidence to determine whether they were in State care and, if they disclosed the allegations as children, that disclosure was recorded. The Inquiry could then determine whether appropriate and adequate records were kept of the allegation.

The Inquiry also obtained evidence from general witnesses and information from other general records on the issue of record keeping where a child in State care may have made an allegation of sexual abuse.

**Reporting on measures to assist and support victims**

The terms of reference, Schedule 2(2)(d) state that another purpose of the Inquiry is to ‘report on any measures that should be implemented to provide assistance and support for the victims of sexual abuse (to the extent that these matters are not being addressed through existing programs or initiatives)’. The Inquiry has taken evidence from many general witnesses on this topic and in February 2007 released its Issues paper, which sought submissions on 43 separate matters that had been raised by witnesses at the Inquiry, some of which related to the provision of assistance and support for victims of sexual abuse. The Inquiry received 36 submissions from organisations and individuals (see Appendix D). The Inquiry reports on the measures that should be implemented in Chapter 4.

**How allegations are presented**

Chapter 3 summarises the allegations of child sexual abuse while in State care made by people who came forward to the Inquiry. The summary is considered to be important for several reasons. It acknowledges each person who gave evidence that he or she was sexually abused as a child in State care and the impact that child sexual abuse has had on their lives. It is also an important contribution to the history of South Australia. Finally, putting the summaries together makes for a forceful and compelling message about the vulnerability of children in State care and the need to continue to make reforms to ensure their protection.

The allegations of the following people who came forward to the Inquiry are included in Chapter 3:

- People who were children in State care at the time of their allegation of sexual abuse.
- People in relation to whom the Inquiry could not properly determine whether they were in State care at the time of the allegation due to a lack of records or due to the historical actions of the APB, discussed earlier in this chapter.
- People who had been placed privately in non-government homes alongside people who came forward to the Inquiry were in State care and were living in those non-government homes. The evidence of these privately placed people is not only important in itself, but also, for the purposes of the terms of reference, is important because it supports the evidence of the people who were children in State care at those non-government homes.

There are many people who came forward to the Inquiry and made allegations of child sexual abuse but a summary of their allegations is not included in this report because they did not come within the terms of reference. They may have been sexually abused before they were placed in State care, after their term expired or their allegations occurred after 18 November 2004. Or they may not have been placed in State care as defined by the Commission of Inquiry Act (discussed earlier in this chapter). For example, there were people who gave evidence about child sexual abuse who were in a foster care arrangement, but they had not been formally placed in State care within the Inquiry’s terms of reference as there was no court order or written agreement. Their evidence has not been ignored by the Inquiry. It was important for each person that they came to the Inquiry and made their disclosures; they did not know the technicalities of how they came to be in a placement, as they were only children at the time. It was also important to the Inquiry that they did so—their evidence has added to the Inquiry’s knowledge about child sexual abuse, its long-term effects and the child protection system.

The allegations are presented according to where the person was placed at the time the sexual abuse is alleged to have occurred (for example, at a government home, cottage home, hostel or residential unit; in secure care, foster care or the family home). The various places referred
to in this report do not represent all the places that have existed during the past century for the care of children—this report only includes those where people said they were placed at the time of alleged child sexual abuse while in State care.

Also, children in State care were regularly moved from one placement to another, and the Inquiry heard evidence from 133 people who alleged they were sexually abused in more than one placement. This means that one person may have a summary written under more than one place. Each person’s summary will note whether the person has made other allegations while living in another place.

The summaries are written to preserve anonymity of the complainant, as required under the Commission of Inquiry Act. Rather than use people’s names, the Inquiry has adopted the general term ‘person in care’, abbreviated to PIC/s. Also, despite the fact that most people shared important personal information in giving evidence, much of this has not been included to maintain anonymity. In each summary, the Inquiry has endeavoured to include some brief information about:

• When, how and why the person was placed in State care. This report identifies the relevant legislative order/agreement placing the child in State care, or whether insufficient records were available to make a finding about whether the person was in State care at the time.

• Some brief information from the person’s evidence about their circumstances before being placed in State care.

• Their allegations of sexual abuse while in the particular placement.

• Whether they disclosed the sexual abuse when they were a child and, if so, the response they say they received.

• If a disclosure was made, whether that disclosure was recorded in the child’s records and, if so, the recorded response of the State to the allegations.

The summaries in Chapter 3 vary in length for several reasons. Each person recalled or was able or wanted to disclose different levels of detail about the sexual abuse. Also, some personal details were omitted to preserve anonymity. Further, there were more records available for some people than others.

To comply with the Commission of Inquiry Act the names of alleged perpetrators of sexual abuse do not appear in this report and all reasonable steps have been taken to avoid providing details that could identify them. The Inquiry has referred, with the consent of the complainants, the names of many alleged perpetrators to the police for investigation under section 10(2) of the Act. The Inquiry considered that preserving the anonymity of the alleged perpetrators was reasonable to avoid prejudicing current and future police investigations and prosecutions. Because the Inquiry was not set up to replace the police or criminal courts, it was not its role to notify alleged perpetrators or require them to respond, cross-examine witnesses or present a defence.

The Inquiry has continued the approach outlined in its Interim report, and the allegations are set out on the basis that it is reasonably possible that they are true, which is a different and lesser standard than that applied in the criminal or civil courts where witnesses would be cross-examined. There is no doubt that a complainant of child sexual abuse can be believed on his or her word alone and such was the case for some of the witnesses who came forward to the Inquiry. For other complainants who appeared before the Inquiry, their evidence was supported by available records and/or the evidence of other alleged victim/s who independently came forward. Using this standard, the Commissioner rejected the evidence of only two complainants who were children in State care on the basis of clear exaggeration indicating unreliability.

Further, although the rules and practices of evidence do not apply, the Inquiry has not set out allegations that are based only on rumour, speculation or mere repetition of hearsay information.

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63 ibid., s. 9(5)(a).
64 ibid., s. 9(5)(b).
## 2 Statistics

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<th>Topic</th>
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<td>Staff</td>
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</tbody>
</table>
Evidence and information to the Inquiry

There were 1920 people who provided evidence or information to the Inquiry about child sexual abuse and the child protection system. These people included alleged child sexual abuse victims, people who spoke about the sexual abuse of other children, expert witnesses, carers, government and non-government organisations, the police, the department and its current and former employees and other interested individuals.

Allegations of child sexual abuse

A total of 792 people told the Inquiry they were victims of child sexual abuse. Some people made allegations against more than one perpetrator, and one allegation of an act of child sexual abuse could involve more than one perpetrator. In total, 1592 allegations of child sexual abuse were made to the Inquiry against 1733 alleged perpetrators. Some of the alleged victims did not know the identity of the alleged perpetrators.

Of the 792 people who made allegations of child sexual abuse:

- 406 were male
- 386 were female
- the age distribution was:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–18 years</td>
<td>51</td>
</tr>
<tr>
<td>19–30</td>
<td>119</td>
</tr>
<tr>
<td>31–40</td>
<td>167</td>
</tr>
<tr>
<td>41–50</td>
<td>206</td>
</tr>
<tr>
<td>51–60</td>
<td>165</td>
</tr>
<tr>
<td>61 or over</td>
<td>84</td>
</tr>
</tbody>
</table>
- 152 were of Aboriginal or Torres Strait Islander descent
- 22 were elderly (aged 70 or over)
- 44 were people with a disability
- 78 were prisoners when giving evidence.

A further 460 people who were allegedly sexually abused as children did not come forward but came to the Inquiry's attention via other sources:

- Some of the people who were alleged victims of child sexual abuse and came forward identified 82 other children they said were victims of child sexual abuse.
- Disability SA identified 199 people who were alleged child sexual abuse victims.
- Other sources such as police operations records, general records researched by the Inquiry and expert or general witnesses identified 179 other alleged child sexual abuse victims.

Allegations of child sexual abuse made by children in State care

Following investigations by the Inquiry, available records confirmed that 242 people were children in State care at the time of the sexual abuse. Of those people:

- 124 were male
- 118 were female
- the age distribution was:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–18 years</td>
<td>16</td>
</tr>
<tr>
<td>19–30</td>
<td>35</td>
</tr>
<tr>
<td>31–40</td>
<td>42</td>
</tr>
<tr>
<td>41–50</td>
<td>62</td>
</tr>
<tr>
<td>51–60</td>
<td>62</td>
</tr>
<tr>
<td>61 or over</td>
<td>25</td>
</tr>
</tbody>
</table>
- 44 were of Aboriginal or Torres Strait Islander descent
- 6 were elderly (aged 70 or over)
- 22 were people with a disability
- 20 were prisoners when giving evidence.

The allegations of child sexual abuse of children in State care cover the period from the 1940s to 2004.

From the 242 people who were children in State care at the time of the alleged sexual abuse, there were 826 allegations of child sexual abuse and 922 alleged perpetrators. One allegation of an act of child sexual abuse could involve more than one perpetrator.
Evidence

The Commissioner conducted hearings with 496 people who alleged they were victims of child sexual abuse.

The Inquiry also heard evidence from 224 general or expert witnesses (see Appendix C). Some of these witnesses gave evidence on more than one occasion.

More than 40 people had two or more hearings.

In total, the Commissioner conducted 809 hearings, which resulted in 46,500 pages of transcript.

In addition, 448 individuals and organisations corresponded with the Inquiry or made a written submission, but did not have a hearing.

The 714 individuals and organisations who gave general or expert evidence, corresponded with the Inquiry or made a submission, included:

- current and former public servants
- Department for Families and Communities and Department of Health members of staff
- current and former police officers
- members of the Aboriginal community
- members of support groups for victims and survivors of sexual abuse
- members of alcohol and drug agencies
- expert witnesses including psychiatrists, psychologists, doctors, community health nurses and counsellors
- current and former child advocates
- administrators of non-government organisations including church organisations involved in the care of children
- academics in Australia and overseas
- current and former public servants
- foster carers and other residential carers of children
- directors of child protection facilities
- sexual offenders
- people involved in an inquiry about sexual abuse of children in children's homes in Nova Scotia, Canada
- people involved in the provision or management of child protection services in Queensland, New South Wales, Victoria, Western Australia and Tasmania
- people involved in Queensland inquiries into abuse of children in institutions and foster care.

The Inquiry has also received 35 written submissions from various organisations and individuals, in response to the issues upon which the Commission seeks submissions paper issued by the Inquiry in February 2007 (issues paper). As part of the formal submission received by the department, more than 90 department staff members gave oral evidence in support of the written submission (see Appendix D for a list of submissions).

Referrals to the police

The Inquiry referred allegations from 170 people to the police. Some of those people made multiple allegations against single perpetrators or multiple perpetrators.

Referrals for counselling

There were 448 people who came forward to the Inquiry and said they were victims of child sexual abuse who received counselling. There were 172 referrals to Respond SA, 39 to private psychologists or psychiatrists, 41 to other counselling service providers and 196 were provided with in-house counselling and support (see Appendix E for a list of witness support services).

Deaths of children in State care

From different sources, the Inquiry received a list of 924 names of children who may have died in State care. After requesting and reading available records, the Inquiry determined that there were 479 children who had been in State care. Of those, 421 came from departmental lists and an additional 58 from witnesses who came forward. The Inquiry determined that 86 of the 479 deaths occurred after the child was released from State care. Of the remaining 393 deaths of children in State care, the Inquiry confirmed 391 and was unable to verify two alleged deaths.
There were 171 deaths of children while placed in institutions; 124 while in foster care or similar placements; 21 when the children had absconded from their placement and 77 when the children were on probation to their parents.

There were 15 allegations of criminal conduct as the substantial cause of death, which were investigated by the Inquiry.

**Records**

The Inquiry made 5880 records requests to more than 38 government agencies (including the department, South Australia Police, the Courts Administration Authority, the Coroner and other government agencies); eight private and religious organisations; and 130 individuals. The Inquiry received 33,300 files and other records for inspection and the investigation of allegations. Internally, the Inquiry created about 4000 files to manage this information.

**Staff**

The Inquiry employed 57 staff over the three-year period (see Appendix F for a list of staff categories and numbers).
Chapter 3 Allegations of sexual abuse
This chapter presents the allegations of child sexual abuse made by people who came forward to the Inquiry and were children in State care at the time of their allegations. The allegations date from the 1940s to 2004 and are presented according to where the person was placed at the time of the alleged abuse. The placements included institutional care (large congregate care), smaller group care (cottages, hostels and shelters), residential units (admission, assessment and community units), foster care, the family home (on probation to parents) and secure care.

Of these people, 114 said they were sexually abused while placed in institutional care, 49 in smaller group care, 18 in residential care units, 103 in foster care, 34 on probation in the family home and 62 in secure care facilities. There were 133 people who alleged they were sexually abused in more than one placement.

Each person’s allegations are summarised under the placement in which they alleged sexual abuse. The summaries are written to preserve the complainants’ anonymity—instead of names, the Inquiry has adopted the general term ‘person in care’, abbreviated to PIC/s.

Each summary sets out brief information about when, how and why the person was placed in State care; their circumstances before being placed in State care; in what placements they alleged sexual abuse; the allegation/s of sexual abuse while in a particular placement; whether they told anyone about the sexual abuse when they were a child and, if so, what response was received; and whether the disclosure was recorded in relevant files and, if so, the recorded State response.

A history of types of care for children in State care

Before 1860, children in need of care were placed in the Destitute Asylum alongside adults. However, public concern about worsening physical and moral conditions in the asylum and the need to segregate children from adults led to the passing of an Act that gave the government power to establish industrial schools and reformatories specifically for children. The Magill Industrial School and reformatories for boys and girls were opened soon after.

However, large congregate care of children in institutions (institutional care) was not regarded as the only, or the best, form of care for children. Children were also boarded out in private homes in the mid 19th century. This practice later became known as foster care and, although it was founded on the idea that children in need would be better cared for in a family home, many children were sent out to service as labourers and domestic servants.

The use of children as labourers was one of the catalysts for the first South Australian inquiry into the care of State children, known as the Way Commission (1883–85). Its findings led to the establishment of the State Children’s Council (SCC), a government body charged specifically with overseeing the care of children. New legislation introduced the term ‘State child’. The SCC and its successor in 1927, the Children’s Welfare and Public Relief Board (CWPRB), continued to place children in need of care in institutions and into foster care. The government increasingly used the services of non-government agencies, particularly religious bodies, to provide institutional care. Conditional subsidies were provided and the institutions were supervised by the State.
In 1938–39, another inquiry was appointed to investigate the care of State children, with particular focus on those who had committed offences and were placed in secure care facilities. The inquiry into ‘Delinquent and other children in the care of the State’ found that conditions in many institutions were highly inadequate. Instead of providing training and nurturing care, many were characterised by their reliance on punitive discipline.

Many of the problems highlighted in the Delinquent Inquiry’s report were ongoing. Institutions were supposed to provide temporary accommodation for children before placement in foster care. However, due to an ongoing shortage of foster carers, children were remaining in these institutions longer, which led to overcrowding. Children of different ages and backgrounds were accommodated together—a situation which, when combined with the lack of supervision by trained staff, increased the likelihood of abuse.

After World War II, the government responded to these problems by establishing different forms of residential care such as hostels for boys and girls of school leaving age, farm schools and a remand home. Before the Social Welfare Act was passed in 1965, introducing compulsory licensing of residential care facilities, the government also began to consider the advantages of smaller group care. In line with changing philosophies of child care that recognised the need to provide children with more individual attention, the government established its first cottage homes in the 1960s.

The passing of the Community Welfare Act in 1972 brought important reforms in the history of State care. It consolidated many ideas and practices that had been developing through the 1960s. Early intervention to avoid removing children from their families became central to departmental policy. Children were increasingly regarded as individuals with differing needs and, if alternative care was necessary, assessment before placement became an integral part of the care process. Individualised programs were developed for each child and their progress and suitability were regularly reviewed. Discipline and punishment were gradually replaced by education and therapeutic care.

From the late 1970s, the government operated assessment, admission and community units. It tightened its control of non-government agencies, which increasingly provided other forms of residential care. The government successfully encouraged these agencies to close down large congregate institutions in favour of smaller group care, and ultimately to provide foster care services. During this period, foster care again became the preferred option for the care of State children.

Today, however, because of the increasing number of children placed in State care over the past decade and the decreasing number of foster carers, there is a shortage of accommodation for children, resulting in placements in serviced apartments, B & B accommodation and motels.
### 3.1 Institutional care

#### History

#### Summary of institutional care allegations

#### Government institutions
- Seaforth Home, 1921–75
- Glandore Industrial School / Glandore Children's Home, 1950–73
- Struan Farm School, Naracoorte, 1947–69

#### Non-government institutions
- Farr House, Anglican Church, 1860–1982
- Kennion House, Anglican Church, 1886–1984
- St Vincent de Paul Orphanage (Goodwood Orphanage), Catholic Church, 1866–1975
- Convent of the Good Shepherd (The Pines), Catholic Church, 1941–74
- Salvation Army Boys Home, Eden Park, 1900–82
- Salvation Army Girls Home / Fullarton Children's Home, 1900–86
- Salvation Army Boys Home, Kent Town, 1929–72

#### Homes for Aboriginal children
- Koonibba Children's Home, 1913–63
- Gerard Mission Children's Dormitory, 1946–61
- Colebrook Home, 1927–81
- Campbell House Farm School, Meningie, 1959–63
- Kurbingai Hostel, 1958–62
- Oodnadatta Children's Home, 1924–27, 1946–74
- Otherway House, 1983–84

#### Homes for children with disabilities
- Lochiel Park Boys Training Centre / Community Unit, 1958–present
- Minda, 1898–present
- Hospitals
Chapter 3 Allegations of sexual abuse

History

The accommodation of South Australian children in purpose-built institutions emerged in the late 19th century, when authorities stopped placing children alongside adults in the Destitute Asylum, and did not fall out of favour until the 1970s. The rationale behind large congregate care was to segregate State children from the broader community for training and education to make them ‘useful’ citizens. The children were dealt with as ‘types’ and ‘groups’ rather than as individuals. They could be placed in government or private institutions; the latter generally operated by religious organisations to provide a Christian environment and spiritual training believed to be beneficial for ‘neglected’ and ‘delinquent’ children. Once ready to be released into society, a child in State care who had been living in an institution could be placed in foster care, apprenticed for service or returned to their families on probation.

The first official State institution for children in South Australia, the Magill Industrial School, was completed in 1869. It was a receiving home for children who had been placed in State care, but had not yet been placed out to ‘boarding-out’ homes (foster homes) or placed ‘in service’ (employment), which were the predominant forms of care at the time. The industrial school was later moved to Edwardstown and was renamed the Glandore Industrial School in 1949, the Glandore Children’s Home in 1958 and, finally, the Glandore Boys Home in 1966. The Magill Industrial School site became the Boys Reformatory, Magill, known simply as ‘the Reformatory’.1

Another early government facility for children placed in State care was the Central Depot in Adelaide’s central business district, which operated for 65 years from 1900. It provided temporary accommodation for children waiting on a court appearance before being committed into State care and children being transferred between care placements.2

The other principal government institution in this early era was Seaforth Home at Somerton. Seaforth opened in 1921 as a beachside home for convalescing children and a holiday residence for those who had been placed out in service.3 After concerns about ‘mingling’ of the sexes at the industrial school, from 1928 boys under the age of six and all girls were moved to Seaforth and it became the principal government institution receiving children placed in State care.

Religious organisations also operated institutions providing large congregate care. The Anglican Church had Farr House (opened in 1860) and Kennion House (1886); the Catholic Church operated institutions such as the St Vincent de Paul Orphanage (1866), known as Goodwood orphanage, and St Joseph’s Orphanage (1903).

The private schools and institutions operated by religious organisations could be proclaimed by the Governor as reformatory schools or institutions for the ‘reception, detention, maintenance, education, employment, and training of State children’ and would be subject to government supervision and control.4 They accepted children in State care in return for subsidies5, but also accepted children placed privately by parents, or referred by welfare officers working for private organisations.

The relationship of the government with non-government institutions strengthened in the mid 1950s to the early 1970s with legislative and departmental changes. From 1950 the Children’s Welfare and Public Relief Board (CWPRB) inspected institutions for the placement of children under the age of seven years. The Social Welfare Act in 1965 required all non-government children’s homes to be licensed, which meant that homes had to be inspected and recommended.6 After the passing of the Community Welfare Act 1972 and the establishment of the Residential Child Care Advisory Committee (RCCAC) in

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1 Under the State Children Act 1895, ss. 40–1, and Maintenance Act 1926, ss. 111–2, only ‘convicted’ children were to be sent to reformatory schools, although a child who had not been ‘convicted’ could be sent there if ‘in the opinion of the court and under the special circumstances of the case’ the child ‘ought’ to be sent to a reformatory school; alternatively, a child who was not ‘convicted’ could be transferred to a reformatory school with the approval of the Governor for ‘misconduct’.
3 State Children’s Council (SCC) annual reports 1922, p. 3, and 1921, p. 3.
4 State Children Act 1895, ss. 16, 21–2; Maintenance Act 1926, ss. 16, 153–4.
5 State Children Act 1895, s. 79; Maintenance Act 1926, s. 151.
6 State Records of South Australia (SRSA) GRG 29/6/1866/186, see documents in Licensing of children’s homes under the Social Welfare Act; Social Welfare Act 1926–1965, s. 106.
1974, non-government homes were subject to further licensing and funding agreements, and certain standards of care and uniform procedures were expected.

Institutional care was criticised from the start. The 1883–85 Way Commission outlined shortcomings such as institutions’ poor quality of staff, children’s frustrations (seen in absconding and violent behaviour) and medical crises due to unsanitary practices. The commission’s report quoted a regular volunteer at Magill, who said, ‘Everyone must be against the system of a large institution for children. It seems to repress every kindly, childish feeling.’ The 1938–39 inquiry into delinquent children stated that institutions operated under ‘regimes of discipline, impressed by force and inflicting mental and physical distress’ rather than fostering ‘trustworthiness, self-responsibility, and self-respect’. It noted:

The life which most of them [residents] are leading would produce mutinous feelings in a normal or even unusually quiet boy. The result on one who has shown himself to be adventurous and high-spirited (as well as wayward) can easily be imagined.

The CWPRB ‘future policy’ of 1941 established several new institutions, many of which reflected the 1939 inquiry’s recommendations to improve the physical appearance and atmosphere of government institutions. These included the establishment in January 1947 of a residential farm school near Naracoorte, Struan Farm, to provide a home for ‘the better class of delinquent boy[es]’ from the reformatory as well as children committed as neglected or destitute. In June 1944 the CWPRB became concerned at the lack of accommodation for State children who were making the transition to working in the community, and as a result it established Kumanka Boys Hostel in North Adelaide in 1946 and Allambi Girls Hostel in Norwood the following year.

Historical records reveal that sexual abuse in institutions was an issue. During 1948 and into the first half of the 1950s the CWPRB faced reports of frequent incidents of sexual ‘misconduct’ at the Edwardstown Industrial School (later to become Glandore). During 1950 the CWPRB provided evidence, drawn from ‘actual cases known to the department’, to a Commission of Inquiry Relative to Sexual Offenders. In 1951 the Glandore Industrial School superintendent wrote to the CWPRB to report that after hearing ‘a chance remark’, he had questioned a boy who had recently been at Struan Farm School. He discovered information ‘regarding abnormal sex conduct’ at the farm school. The boy named seven boys who had been involved and who ‘used to talk about it quite freely, saying what good fun it was and telling the others that they ought to try it some time’. One of these boys had ‘got into bed with him one night’ but had ‘jumped out again quick when he called for help’. The boy also said that it was ‘common talk among the boys from Magill that anybody could have a go at’ two particular Struan boys. The CWPRB conducted enquiries and resolved that ‘greater supervision of the boys was necessary’. It generally dealt with institutional sexual ‘misconduct’ by sanctioning discretionary corporal punishment by superintendents and transferring boys to the Magill Reformatory.

During the 1950s and into the 1960s, overcrowding and understaffing of institutions became major issues as an increasing number of children were placed in State care.

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7 Community Welfare Act 1972, s. 61.
9 CWPRB annual report 1941, p. 3.
10 SRSA GRG 29/123 [unit no and name removed], superintendent Glandore Industrial School to CWPRB secretary, 17 Oct. 1951.
11 SRSA GRG 29/124 [unit no and name removed], superintendent Glandore Industrial School to CWPRB secretary, 17 Oct. 1951.
12 For example, see CWPRB minutes in SRSA GRG 29/124, vol. 16, (minute 1121) 19 May 1949, and (minute 1145) 10 Nov. 1949; vol. 17, (minute 1279) 12 June 1952, (minute 1285) 24 July 1952, and (minute 1395) 30 Sep. 1954; CWPRB annual report 1950, p. 3.
13 SRSA GRG 29/123 [unit no and name removed], superintendent Glandore Industrial School to CWPRB secretary, 17 Oct. 1951.
14 SRSA GRG 29/124 [unit no and name removed], superintendent Glandore Industrial School to CWPRB secretary, 17 Oct. 1951.
By 1960, the lack of space in institutions such as Glandore resulted in older boys being housed with younger, more vulnerable boys. In October 1964 the CWPRB stated that in the previous five years "the number of children placed annually under official control increased by 49 per cent." The CWPRB also reported that it lacked sufficient institutional staff. A Glandore file from 1966–67 regarding the behaviour of various boys includes staff references to 'sex relations' between boys, 'sadistical' bullying and 'standing over' of smaller or more vulnerable boys by older boys and descriptions of children as 'backward', 'frightened' and 'starved for affection'.

The Community Welfare Act 1972 represented the demise of large congregate care and a new philosophy relating to the care of children. The department prioritised differential treatment, which emphasised children as individuals with specific needs. It embraced unit living and smaller group care as ways of integrating children in State care into the community. In 1979 the Minister for Community Welfare stated:

The thrust of the department over the past decade has been to make every effort to ensure that children remain in the community wherever this is possible and appropriate. This direction arose from an identification through local and overseas observations that institutional care was no more effective than other programmes, and was often associated with long term negative consequences. Although a secondary factor, it became increasingly apparent that the cost effectiveness of institutional intervention strategies was becoming questionable.

The overall philosophy of the department was to support and enhance the ‘preservation, strengthening or restoration of the family unit’.

By the end of the 1970s, most large institutions had closed.

Summary of institutional care allegations

The Inquiry heard allegations from 114 people that they were sexually abused as children living in large congregate care. Of these, nine told the Inquiry that they were victims of sexual abuse in more than one institution.

The Inquiry was able to determine from available records that 69 of the 114 people were children in State care at the time of the alleged sexual abuse, which occurred in government and non-government institutions, homes for Aboriginal children and homes for disabled children. Due to the lack of available records and/or the Aborigines Protection Board (1934–63) (see page 14) in acting contrary to the existing legislative scheme, the Inquiry was unable to determine whether 11 of the people were children in State care at the time of the alleged sexual abuse.

In regard to the remaining 34 people, existing records indicated that they were not children in State care at the relevant time. However, 20 of these alleged cases of sexual abuse took place in the same homes where the 69 people who had been in State care were living. Accordingly, their allegations are set out in this report as they support the allegations made by those people who do come within the terms of reference. Fourteen of the 34 people who were not in State care alleged sexual abuse in non-government homes from where no people in State care came forward. Their allegations are not published as they do not come within the terms of reference. However, their evidence made an important contribution to the knowledge of the Inquiry concerning large congregate care and the long-term effects of child sexual abuse.

The allegations of sexual abuse, which span the 1940s to 1970s, include acts of gross indecency, indecent assault, and oral, vaginal and anal intercourse/rape. The alleged perpetrators include staff, other residents (children), visitors to the institutions, adults in the outside community and adults whose identities remain unknown.

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17 See correspondence on SRSA GRG 29/6/1960/509, Glandore Children’s Home additional temporary accommodation.
18 CWPRB annual report 1964, p. 3.
19 ibid.
20 See SRSA GRS 4164/5/6, file 20/001/65, Glandore Boys Home supervisor’s notes.
21 Department for Community Welfare (DCW), Children and youth under institution care, submission to the Senate Standing Committee on Social Welfare, South Australia, Sep. 1982, p. 7.
22 ibid.
3.1 Institutional care

Government institutions

Thirty-nine PICs (persons in care) gave evidence to the Inquiry that they were sexually abused while placed in government institutions. The Inquiry was able to confirm from records that all of those people were in State care at the time of the sexual abuse. Three of the 39 PICs said they were sexually abused at two government institutions—Glandore Children’s Home and Struan Farm School. The PICs alleged their abusers were members of staff, older residents, people visiting the institutions and people they had contact with outside the institutions. The alleged abuse included anal penetration, fellatio, digital penetration, indecent assault and gross indecency.

Seaforth Home, 1921–75

History

Seaforth Home was established in 1921 as a beachside convalescent home for children. After 1928, all girls and boys under six remanded in State care by a court were sent directly to Seaforth. During the 1930s, between 30 and 50 children—mostly girls—lived there at one time. School-age girls were taught dressmaking and other domestic duties, while those over 14 spent much of their time working in the laundry. The 1938–39 Inquiry into the treatment of ‘delinquent’ children found that Seaforth Home was ‘used partly as a dumping ground for adolescent girls who, by reason of their subnormality or instability, cannot retain a situation found for them’. The report said these girls required ‘a separate home or institution where they would receive proper training’. The report concluded that the home was ‘attractive, well run, and well organised and therefore ideal for babies and younger children’.

Another report in 1940 by the secretary of the Children’s Welfare and Public Relief Board (CWPRB) suggested the girls needed to be taught ‘vocational and technical subjects’, instead of being purely focused on domestic duties. By subjecting girls to laundry work day after day there was ‘a danger that the inmates may be exploited in the interests of the successful running of the institution’. In the early 1940s improvements were made at Seaforth, including a separate sleep-out for small boys and a playroom filled with new toys. By 1950, however, the kindergarten was ‘overcrowded’. The CWPRB transferred boys under six to the Glandore Industrial School if they were suitable for primary school. In 1968 the average number of children at Seaforth was about 79, with a maximum at any one time of 101. The staff to children ratio was about one to 12.

A 1971 department annual report stated:

The wide age range of the girls at Seaforth has been a problem for some years. Because of special problems with some disturbed and retarded older girls, alternative arrangements for this group of girls are being considered.

The following year the report said:

Seaforth Home provides open residential care for children placed under care as neglected or uncontrolled and for some children on remand, or safekeeping or for truants. Infants, toddlers and children to age six and girls up to age 18 were accommodated and a social worker was attached to the home on a part-time basis.
In 1973 the department noted that numbers at Seaforth had ‘steadily declined’ during the previous few years. Two years later it was closed and replaced by five independent cottages (including two located previously at Glandore).

Allegations of sexual abuse

Nine women told the Inquiry they were sexually abused while in State care and placed at Seaforth Home. Records confirm that they were in State care and that they lived at Seaforth for varying amounts of time between the late 1940s and early 1970s. Each PIC was placed in State care by a court for being either neglected, destitute, illegitimate, under unfit guardianship or, in one case, charged with a criminal offence.

The allegations of sexual abuse made by the nine PICs include indecent assault, digital penetration and vaginal sexual intercourse. The alleged perpetrators were staff members, including a visiting health professional sanctioned by the home, other residents and visiting family members.

Abuse by multiple perpetrators

The Inquiry took evidence from a woman who was placed in State care in the mid 1960s when she was 13, after a court found she was neglected. She said she experienced sustained sexual abuse in her family before being placed in State care. According to her State ward index card (SWIC), the PIC spent eight months at Seaforth before she absconded. She alleged sexual abuse at Seaforth and later at the Convent of the Good Shepherd, known as The Pines.

The PIC told the Inquiry that within about one month of her arrival at Seaforth, a man she believed was a maintenance worker touched her breasts and digitally penetrated her on the home’s grounds. She said this occurred on about six occasions. She also said a female staff member washed her breasts and vagina numerous times under the guise of instructing her: ‘She showed me how to wash properly, and I said I could do it, but she—again I thought she was giving me love and I accepted again.’

The PIC said a man she met while walking from Seaforth to primary school also sexually abused her. She said:

*The rest of the group had gone, and he was just going around, and he’d gone past me, and then I saw him turn and come back, and he asked where I was going, and I said I was going to school, and he asked if he could take me down to the beach and get an ice-cream, so I should really go, you know—supposed to be going to school, and he said, ‘Go later. Just say that you didn’t feel well’, and that’s what I did. I went with him and we had sex. He got me an ice-cream.*

She said she had sexual intercourse with this man on about six occasions. To her recollection, Seaforth residents were not escorted to and from school; on the occasions when she met this man, she often did not attend school or arrived late. She said that at one stage she absconded from Seaforth and stayed with the man for a short time: ‘I got this man to pick me up and I stayed with him a couple of days’.

Departmental records for this PIC show that she absconded from Seaforth for almost two months. No details are evident about her location or return. She was then transferred to another government home.

She told the Inquiry that because of the sustained family abuse she experienced at home, she became highly sexualised and had begun to self-harm by the time she was placed in care. As a result, she said she felt that the sexual abuse while in State care ‘was my fault. It was me, not them, to blame’.

Abuse by staff

A PIC lived at Seaforth for two years in the mid 1960s after a court determined she was neglected and illegitimate and placed her in State care when she was five. After Seaforth, the girl was placed with relatives.

The PIC said she ‘hated’ Seaforth and recalled being struck with a wet belt as punishment because ‘I didn’t make my bed properly’. She told the Inquiry that on several occasions over a ‘reasonably long period of time’ a
member of the home’s general staff took her into a building, pulled down her underwear, opened his pants and lay on her. She could not recall being penetrated but remembered a residual ‘wet spot’ near her vagina. ‘He told me if I told anyone he’d kill me.’ She did not tell anyone until she was an adult, when she confided in a parent.

In the late 1960s a seven-year-old Aboriginal girl was placed in State care until she turned 18, a court finding she was neglected and under unfit guardianship. The PIC told the Inquiry she did not know why she was removed from her family. She recalled being told by a relative to run ‘and then I came to a great big fence and it was too big of a fence for me to jump’. She said she was sexually abused at Seaforth Home, Clark Cottage, the family home and in foster care.

Records indicate she spent about 12 months at Seaforth, after two months on remand at another government institution. She recalled she was unhappy and frightened at Seaforth, ‘being in this great big place and so lost … my hell started then’. She said Seaforth staff told her that ‘nobody wanted us, and my family didn’t want me and my mum didn’t want me’. The PIC said female staff members took children to a separate building on Seaforth grounds to see a doctor who visited the home. On the PIC’s several visits, which she recalled as occurring weekly, she was always left alone with the doctor. She said he touched her in a sexual manner, but she did not want to elaborate, saying, ‘I’ve reached a stage where I’m comfortable talking about that he did something to me, but …’

Abuse by other residents

In the late 1940s, when she was seven, an Aboriginal girl was placed in State care until the age of 18, a court finding she was destitute. The PIC told the Inquiry that when she was living on the mission there was constant fear that children would be taken away from their families. She recalled occasions when police, accompanied by a ‘welfare worker’, looked for ‘half-caste’ children, who hid in bushes around the church at the mission. She spoke of the day when the … welfare worker caught up with us … This white lady … grabbed me and looked at me and asked me who my father was and all that. She had a look at my hands—turned my hands over—and said, ‘Oh, yeah, she’s teachable because her father’s white’.

She remembers being taken away with her siblings. She spent the next 11 years living at Seaforth, interspersed with foster placements.

She told the Inquiry she was sexually abused at Seaforth and later at one of her foster placements. She said the department’s workers had told her and her sibling that their parents did not want them any more. As an adult, when she obtained her departmental records under freedom of information legislation, she realised her mother had written to the department numerous times asking to have them returned to her.

The PIC said she was ‘petrified’ at Seaforth:

> When they first took us in there, they showered us, and shaved our hair … and bathed us, and checked our ears and checked our chests and things like that. We wouldn’t eat because we didn’t like the food; we didn’t like the smell of it. We didn’t know what we were eating because it was different. We didn’t want to eat it either because we weren’t sure if it was going to be poisonous.

She gave evidence that when she was about 10 she was sexually abused at Seaforth by an older girl who slept in the same dormitory. This girl came to her bed on two or three occasions at night after the lights went out and kissed and fondled her. The PIC said the incidents ended because the PIC was removed from the dormitory due to illness. She said, ‘I never told anyone because it’s something you don’t like to talk about’ but she ‘knew it wasn’t right’.

A nine-year-old girl was placed in State care by a court in the early 1950s for unlawfully damaging public property. She was placed in the family home for about nine months and then spent about three years at Seaforth, which included several holiday placements. She absconded from Seaforth numerous times, after which the
department transferred her to another government institution. She told the Inquiry she was sexually abused while placed in the family home and at Seaforth. She said an older girl sexually assaulted her at Seaforth. She ‘was a service girl … We had to respect the service girls because they were the working girls. We had to do what they told us.’ Throughout her time at Seaforth, the older girl climbed into her bed and touched her breasts and genitals. The PIC described the abuse as ‘horrible’. She said she reported the behaviour to a staff member, who was dismissive; the PIC cannot recall her words, but ‘can just remember a feeling of feeling put down’. Records received by the Inquiry do not record this disclosure to staff.

Abuse by visitors

A PIC told the Inquiry her father and a relative’s partner sexually abused her while she was placed at Seaforth in the early 1970s. Departmental records show she spent a total of eight months at the home on two occasions when aged 10 and 11. She was initially there on remand and returned after a court found her to be neglected and placed her in State care until she turned 18. The PIC said there was violence at home and her mother ‘would be drinking and taking drugs and having other men at the house’ and her father would often be away truck driving.

The PIC alleged her father sexually abused her from the time she was five, and departmental records show the department was on notice about allegations of sexual abuse against the father concerning two of the PIC’s siblings during her first stay at Seaforth, and allegations against the father concerning the PIC and two different siblings during her second stay.

While she was at Seaforth, the PIC alleged the abuse would occur when her father took her and her siblings out. The PIC alleged that at Seaforth:

> The home was allowing my father to continue to have access to us. We would spend weekends with him. He would send a couple of us to the shop and keep one at home. The one who remained at home would be sexually abused. This happened to me on many occasions.

A departmental report shows the father visited Seaforth regularly and had ‘a good deal of affection for his children which, despite what has happened, is in some measure reciprocated by all the children except [the PIC]’.

The PIC told the Inquiry a family member and her partner visited her at Seaforth on several occasions. She alleged the partner forced her to perform oral sex and had sex with her in his car during these visits, which took place on the Seaforth grounds. She said she believed that staff knew about these incidents:

> I know that on some occasions staff would come past the car and see what was happening. They would look the other way and walk off. It was mostly one particular female staff member who did this.

Departmental records received by the Inquiry show staff had concerns during the PIC’s second placement at Seaforth. One report noted that the PIC and the family member’s partner were in a car and that the partner was ‘kissing and cuddling’ the PIC. On another visit, it was reported that staff noticed the partner was again alone with the PIC in a car, ‘lying on back seat of car with [the PIC] on top of him’. It is recorded that the PIC was spoken to but she claimed ‘the entire incident was innocent’. It was reportedly decided that the PIC would not be allowed to be alone in the car with the man, and that other staff would be made aware of this. It was reported that the PIC’s departmental worker said he had spoken to the family member and the partner together and the partner ‘denied he was making any sexual advances and was very upset over the situation’. The worker reportedly told them

> They were not to take children out for the day from Seaforth but may visit them as usual but to stay within the grounds. [The partner] not to stay in car to talk with children but get out away from the car.

The problem of supervising visitors to Seaforth was not new. About 14 years earlier, in February 1962, the matron wrote in a letter to the department:
The visitors' room here will not accommodate more than two families at a time. Frequently it is necessary for the children to see their parents in the grounds. They are asked to occupy one of the garden seats. On more than one occasion, when doing a round of the visitors, I have found the children in their parents' car, with other people besides their parents, and whose names are not on the permits. It is also difficult to keep the other children away from these cars, especially subnormal girls. It would be a great assistance in the supervision of visitors here, if cars were not permitted in the Grounds.

A handwritten note on the bottom of the matron's letter said, 'Visitors to be informed when permits are issued that cars will not be permitted in the Grounds'.

There is no evidence that staff reported the incidents of the PIC and her visitor in the car to the police.

The PIC told the Inquiry:

I have been affected sexually by the abuse because I don't want anyone to touch me in a sexual way. I even find it hard to let people give me a hug. It has affected my confidence and self-esteem.

The department instituted court proceedings for neglect in relation to a PIC when she was aged about seven in the early 1970s. Her SWIC shows she was remanded to Seaforth for about two months during adjournments of the court proceedings before the final order placing her in State care until she turned 18 was made 11 months later. The PIC said her mother 'was constantly entertaining male guests and the house was filthy' and her father was often away for work. The PIC alleged she was sexually abused at Seaforth and also in the family home, before and after being placed in State care. She alleged her father sexually abused her from the age of three until her teenage years. She also said that before being placed in State care, she and her siblings were 'dragged into performing sexual acts' on her mother's men friends.

The PIC described Seaforth as a 'cruel and uncaring place'. She said that during one court hearing related to the neglect charges she was asked whether she liked the home. 'I thought that must have been a trick question, so I said, "It's marvellous," and then they said, "Good. You can stay," and I thought, "Oh, no".'

She said her father took the siblings out of Seaforth during the day more than once, ‘… where he sexually abused us while we were there—out with him. He sent one of us off to the shop and abused the other one.’ She alleged he put his fingers in her vagina.

The PIC said that during the same period at Seaforth, a partner of a family member visited her several times and had sex with her in the grounds of the home. She said her relative facilitated the abuse by keeping watch for staff in the car park area. The PIC alleged that Seaforth staff ‘knew what was going on’. Records obtained by the Inquiry indicate staff at Seaforth were aware of possible misconduct by the partner in regard to the PIC's sibling, at a later date.

After two months at Seaforth, the PIC was placed in foster care and then in the family home, where, she said, her father's sexual abuse continued.

Abuse by outsiders

A woman told the Inquiry about sexual abuse she alleged occurred during holiday placements from Seaforth in the early 1960s. The PIC was placed in State care by court order in the late 1950s when she was six, charged with being neglected and under unfit guardianship. The departmental files recorded allegations of sexual abuse at her family home. She was initially placed at Seaforth for a few months and was then transferred to several foster placements over the next two years, returning to Seaforth briefly between each placement. The PIC returned to Seaforth in the 1960s when she was nine and stayed there for three years. She also alleged she was sexually abused in one of her later foster placements.

The PIC's records show her holiday placements from Seaforth occurred over a two-year period. She alleged abuse during several holidays with one couple, and said the husband would force her to have vaginal intercourse with him and, while digitally penetrating her, would masturbate and ejaculate into a handkerchief. Departmental records show four visits to the couple's home during one six-month period.

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The PIC also alleged she was sexually abused by male foster carers at other holiday placements while at Seaforth, but could not specify which placements. She alleged she was indecently assaulted while showering and that she was forced to have sexual intercourse in her bed.

The PIC said that on her return to Seaforth an older resident advised her not to report the sexual abuse. She said she told a senior staff member but no action was taken. As the department was unable to locate the PIC’s file relating to her time at Seaforth, the Inquiry could not ascertain whether staff at Seaforth noted or responded to her allegations.

The PIC told the Inquiry she later reported the abuse to two departmental workers while living in another government institution. She said one worker did not offer any advice and changed the subject. The PIC’s client file did not record a disclosure of sexual abuse. A report on the file written by the second worker makes no reference to the PIC disclosing sexual abuse but does note that she ‘will not accept another foster home placement and that there is no point in looking for a foster home’. A later note on the file indicates concern at the PIC’s sexualised behaviour but there is no information indicating whether anything was done about it.

A female PIC was 13 when she was placed in State care by a court in the early 1960s for being neglected and under unfit guardianship. She told the Inquiry she had suffered several years of physical and sexual abuse by a man who lived with her family; departmental workers had visited but ‘did nothing’. The PIC said she ran away and was then placed in State care. The PIC told the Inquiry she was sexually abused while placed at Seaforth and Vaughan House and in foster care.

The PIC’s initial placement was Seaforth, where she stayed for six months. She said that while at Seaforth, she and 15 to 20 other residents were taken to a hotel for a dinner. An older friend of hers was not invited: ‘Anyone over 16 didn’t go’. She recalled that ‘Matron lined us up before we went and said we were all to behave and do as we were told … we would get lollies if we were good’. At the hotel, a number of men in suits were sitting at a table and ‘every girl sat next to a man’.

She said that after the dinner the man next to her said, ‘We’re going upstairs for a while’. He led her from the dining room, ‘took me upstairs and had sex with me’. The PIC did not understand what was happening:

> He just said, ‘We’re going to get undressed and go to bed for a while, and it was sort of made clear that you didn’t repeat to anyone else what had happened. We were only there for maybe 10 minutes at the most.

The PIC said she was bleeding afterwards: ‘I felt sick. It hurt. You didn’t say anything.’ She said other girls, each with a different man, went upstairs, one at a time. ‘When I came back down, we had ice-cream.’ The children were taken back to Seaforth on a bus. The PIC remembered that she was given lollies.

Records obtained by the Inquiry show outings from the home were common. As early as 1946, the department’s annual report noted the practice of allowing some girls out on visits was established for some who were treated as ‘trust girls’. Such girls were, ‘when possible, taken to the pictures and to other places occasionally, and allowed more privileges’.

Glandore Industrial School / Glandore Children’s Home, 1950–73

History

The Glandore Industrial School had its origins in the Industrial School, Magill, which was moved to Edwardstown in 1898 and used as a receiving house for children in State care. During the late 1920s the CWPRB became concerned about the ‘mingling of the sexes’ at the Edwardstown Industrial School and it was resolved that all girls and boys under the age of six would be moved to Seaforth. The school then became a home for boys aged six to 18. In 1949 it was renamed Glandore Industrial

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36 CWPRB annual report 1946, p. 10.
A newspaper report about a boy being flogged at the Industrial School hastened the government’s existing plans for an Inquiry into the treatment of ‘delinquent’ children in June 1938. The Inquiry found that young offenders were placed at the school, although it was supposed to receive only neglected or destitute boys. It also found that there was no supervision of the older boys at night. The only trained staff were the matron and Education Department teachers. The Inquiry’s report recommended adequate staff training and the construction of new institutions to separate young offenders from children in need.

Despite such recommendations, the school remained understaffed after the outbreak of World War II. In 1944, the CWPRB found it to have ‘an appearance of general neglect’. A visit the following year found some improvements but that there was still a great need for ‘more home-like conditions’. The CWPRB observed that poor conditions combined with the shortage of staff may have contributed to the increased number of incidents of absconding.

The CWPRB expressed concern at the ongoing sexual misconduct, primarily between boys, at the school. In 1947, the CWPRB discussed the use of corporal punishment for sexual offences. The department’s medical officer was consulted; he inferred ‘that the question is really one relating to cases of so-called sexual perversions’. The medical officer stated his belief that masturbation was ‘normal experimental action’ however, ‘the act of sodomy’ and other ‘perversions’ required ‘segregation of the originator’, psychiatric care and possibly corporal punishment. He believed the decision to use corporal punishment should be at the ‘discretion’ of the superintendent, a sentiment endorsed by the CWPRB.

In 1948 the CWPRB reported on sexual misconduct involving an attendant at the school. The male attendant was charged with indecent assault of two teenage boys. He claimed it was ‘a framed-up job’ based on ‘pure malice’. However, he was suspended from duty and the decision was made that

Even if he is found to be ‘not guilty’ of the charges brought against him, there is enough information in the evidence to indicate quite clearly that he is an undesirable [sic] type to have on the staff.

The CWPRB was concerned that the attendant had ‘unearthed unnatural sex activity’ and ‘listened to dirty sex talk among the boys’ and had failed to report this to the superintendent. The charges were dropped but the officer was not reinstated.

Other reports of ‘subnormal sexual misconduct’ among boys at the school in the late 1940s appear in historical records. The boys involved were transferred to the Boys Reformatory, Magill. The CWPRB noted its concern about ‘the obvious lack of supervision over the boys … consideration should be given to introducing proper night lighting, supervision through doors, and better records from staff on evening and night duty’.

Records show that problems with sexual misconduct continued into the 1950s. In October 1951 four boys were transferred to the reformatory for sexual misconduct.

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37 CWPRB annual report 1949, p. 6.
38 Maintenance Act 1926–1958, s. 152(a), which states that the Industrial School, Glandore, ‘will bear the name of Glandore Children’s Home’. This new section is inserted in s. 7 of the Maintenance Act Amendment Act 1958.
39 So-called ‘delinquent’ boys were ‘placed under the Board’s custody and control,’ in order to avoid their being sent to a reformatory; this classification enabled the Board to place them into institutional care. ‘Delinquent’ report 1939, p. 15.
42 ibid., (minute 942), 26 Apr. 1945.
43 ibid., (minute 881), 3 Feb. 1944.
45 Ibid.
47 Ibid.
49 ibid., (minute 1096), 7 Oct. 1948.
Chapter 3 Allegations of sexual abuse

Another was moved out in July 1952, prompting the CWPRB to request ‘detailed particulars and numbers of all boys who had been involved in unusual sexual behaviour’ and to discuss the issue with the school’s superintendent.51 The CWPRB resolved that in regard to sexual offenders at the school, ‘every case [was] to be fully reported, setting out the punishment inflicted, together with any recommendation that he [the superintendent] cared to make’.52 The CWPRB also requested a report from the medical officer on the best treatment for sexual offenders in institutions.53

By the late 1950s almost 100 boys were in residence, including some young offenders. Dormitories were overcrowded and, as the CWPRB secretary reported, it was ‘more difficult to control a large number of boys’. He suggested to the chairman that ‘the worst boys’ at the school should ‘be placed in another institution where the discipline and training would be more rigid and in keeping with this type of boy’.54 By 1960, the shortage of accommodation was regarded as ‘acute’, with some older boys having to remain in the younger boys’ dormitory due to the lack of alternative beds.55

By the mid 1960s, between 85 and 130 boys were accommodated at Glandore at one time.56 In 1964 the University of Adelaide Psychology Department conducted a research project on absconding at Glandore.57 The report described a regimented program beginning with ‘ reveille’ at 6.30am. Boys slept in one of 10 small dormitories, according to age. A dormitory ‘mother’ and female staff supervised the younger boys at night, while male attendants supervised older boys.58 Boys were placed away from the home with holiday hosts during school holidays.59 Boys interviewed about absconding said that the most common motivation behind the decision to abscond was fear of being reprimanded, caned or otherwise physically assaulted. Another prevalent reason was general dislike of the institution.60

Department of Social Welfare annual reports for 1968–70 emphasise the purpose of Glandore as a temporary home for neglected or uncontrolled boys: The department ‘tries actively to place as many boys as possible back with their own parents or with relatives or suitable foster parents’. This policy was partly influenced by ‘problems of overcrowding’.61 During 1971, 47 boys were permanently transferred from the home into departmental cottages, hostels and the Lochiel Park Boys Training Centre.62

The passing of the Community Welfare Act 1972 signalled the end of Glandore Boys Home as a large congregate care institution. According to the department’s annual report in that year: ‘The accepted principle that children in residential care benefit from being in small groups is to be put into practice’.63 The home was closed in 1973 and some buildings on the site were converted into cottage homes.

52 ibid., (minute 1288), 14 Aug. 1952. Unfortunately the correspondence docket related to the board’s discussions of this issue (483/1948) is missing/destroyed. Although a punishment book for the Boys Reformatory has survived, no punishment records for the Industrial School have been located.
53 ibid., (minute 1285), 24 July 1952.
55 SRSA GRG 29/6/1960/509, see correspondence on Glandore Children’s Home additional temporary accommodation.
58 CWPRB annual report 1961, p. 11.
59 ibid., 1964, p. 12.
60 Psychological tutorials, p. 29, and DCW annual report 1963, p. 11.
63 DCW annual report 1972, p. 22.
Allegations of sexual abuse

Twenty-seven PICs gave evidence to the Inquiry of the sexual abuse they allegedly experienced while placed at the Glandore home. Records show they lived at the home for varying amounts of time; between them they span the years from the 1940s to the early 1970s. The Inquiry was able to confirm from records that they were all in State care at the time of the alleged sexual abuse. They had all been placed in State care by a court—24 were committed after being found to be under unfit guardianship, destitute, neglected, and/or uncontrolled and three had been convicted of criminal offences. Their allegations of sexual abuse included indecent assault, digital penetration, anal rape, oral rape and prurient interest, perpetrated by staff members, other residents and outsiders.

Some PICs said they complained to either the matron, nursing staff or other workers at Glandore about the sexual abuse. They recalled that the responses to such complaints ranged from, ‘You must have been sitting on cold concrete or have piles’, ‘Stop telling tales’, ‘Hush up about it’, ‘Do you want to go on holidays, will that make it better?’ to being given a hug by a kind nursing sister and told ‘Not to worry about it, just keep away from him’.

The PICs also gave evidence about a regime of physical punishment at the home. Reference was made to a guard:

Everyone was so scared of that man. He used to walk around with a big stick in his pants all the time. If he thought that you were doing something wrong, by gee, you would cop it.

One PIC also told of a senior officer who would always walk around with his cane down his trousers:

He used to sneak around the back of the dormitories of a night-time to look through the windows to see if anyone was out pillow-fighting or anything like that, and then he’d come in and the cane would start … of course you’d cop it in front of everybody, no matter what …

A teacher with almost 40 years’ experience told the Inquiry he taught at Glandore in the late 1960s. From what the children would say, he believed there was a very strong punishment regime at the home.

… one thing which I think gives an indication of the feeling in the place was every day when the kids rocked up to school, as they came into the classroom we virtually had to frisk them because of weapons being carried …

Abuse by multiple perpetrators

One PIC was placed in State care in the late 1950s when he was 10, a court finding him in need of discipline. He was initially placed with his parents but after three months was transferred to Glandore. He lived there for a few years and was placed out for holidays during that time. He was charged with unlawfully absconding in the early 1960s and transferred to the Boys Reformatory, Magill, where he alleged he also was sexually abused.

The PIC told the Inquiry he was sexually abused within a week of his arrival at Glandore. He said a residential worker took him to a shower block and directed him to undress and have a shower. While he was drying himself, the worker told him to bend over, then anally raped him. The worker allegedly told the PIC he would be in Glandore for a while and if he opened his mouth he would be in trouble. The PIC did not tell anyone about this abuse: ‘No, I was bloody scared, absolutely’. The PIC’s SWIC shows he was absent without leave one week after being transferred to Glandore. He recalled running away: “It scared the living hell out of me and I thought, “If this is all I’ve got here, I might as well not stay’.” A few months later the police questioned him about sexual assaults but he denied ever being assaulted because he was frightened.

The PIC also said during his time in Glandore he was placed out for a weekend holiday with a couple. During the weekend, the husband left the home and was absent overnight. The PIC woke the next morning with the wife in his bed, masturbating him. He said he “bolted”, absconded.
Chapter 3 Allegations of sexual abuse

A man who gave evidence about alleged abuse at Glandore was placed in State care in the early 1960s by a court order after he was found to be neglected and under unfit guardianship at the age of four. He recalled violence and alcohol abuse in his family home and told the Inquiry he was sexually abused in foster care, at Glandore and at Kumanka Boys Hostel.

The PIC’s SWIC records that he was at Glandore in the late 1960s when he was aged 11 to 13. The PIC said rape and sexual abuse were common knowledge at the home. He recalled that:

'It was sort of like an ongoing thing type … there’s a sort of code you learn when you’re in places like that, you know. You don’t see things [and] you don’t hear things [and] you don’t— you know.

He said he got raped by ‘most of north wing … sometimes it was pack rape, sometimes it was one … it was sort of like an ongoing thing’.

He told the Inquiry that visitors to the home often took the residents on outings. He remembered a well-dressed man who took him out of Glandore several times and sexually abused him in various locations. He allegedly forced the PIC to perform oral sex at a beach and in a park. On one occasion the PIC performed a sex act while the man drove his car. The PIC said that individual men often took him—and many of the other boys—out of Glandore.

He also told the Inquiry that other men came to collect him to take him out of the home, apparently with the sanction of staff. He was always taken out on his own, sometimes staying overnight. He recalled one man taking him to a place in the city where there were other older men with boys; men and boys went into rooms that were sectioned off. The PIC recalled that boys were fondled under the tables; on reflection, he believed ‘us kids were nothing but a meat market’.

While at Glandore, the PIC went on holiday placements to a family when he was 11. The PIC told the Inquiry that only a couple of weeks after he had gone to this family, the foster father sexually abused him in the bath and anally penetrated him in a bed: ‘I was scared to be alone with him …’ The man had warned him: ‘You open your mouth, you’re dead’.

The PIC said:

‘I’m pretty sure [my foster mother] … was away for the weekend or something and he must have, I don’t know, drugged me or something, but I woke up in bed, in their double bed. I didn’t feel too good, blood everywhere. I don’t know how long I was there, He wasn’t around.

He said the foster mother came in and he told her:

‘I’m hurting, I don’t know what’s wrong’, and she came over and said ‘Well, let me have a look,’ and she pulled back the covers … I think she went to the phone or something … I was taken away … back to Glandore, stayed there a while and started living at Kumanka.

He remembers some people speaking to him, but does not recall whether they were police. He does not remember going to court. The department could not locate any records about this foster family.

Abuse by staff

One PIC lived at the Glandore Industrial School for almost three years in the early 1940s. He was seven when he was placed in State care after a court found he was destitute. He was released from Glandore when he was nine and placed on probation to his family. He told the Inquiry he was sexually abused at both placements.

The PIC remembered being taken into the Industrial School:
I know I was only young but we were living out on the footpath. We were evicted from the house … the second night … my mum yelled out a piercing scream. I can hear her to this day, screaming. She says, ‘Hide, hide, the welfare are coming’.

The PIC said he was taken straight to Glandore that night. He was left alone in a dark quadrangle and told to wait until a staff member came to collect him. He remembered being so ‘absolutely mystified and terrified’ that he soiled himself.

Then … a nurse came out [and] took me into this little ward called ‘little boys ward’ … noticed that I’d wet myself and other things, promptly told me to take my clothes off, rubbed my face in them, told me to go into the little ward.

The PIC said he was sexually assaulted during more than two years of his placement at Glandore. He described being hit by a senior staff member with a leather strap ‘half a metre long, two inches wide, with a handle on the end of it with little tails on the other end of the strap’. The PIC said the staff member … hit you so hard you really never felt anything. You sort of went numb. Then whatever he did after that, you could feel him doing things or something like that but you weren’t quite sure what was happening but it was hurting.

The PIC said he was later … bleeding from my behind. I would be numb and when the numbness worn off, the pain would hit and I would eventually turn up into what they called the infirmary … I didn’t know what was going on. I didn’t realise at the time.

This happened on two occasions. He said the nature of the abuse then changed. The next time, he went to the senior staff member’s office and remembered seeing … a bottle of Coke, there was chocolates, there was a sponge cake … of course they all tasted brilliant to me and I was told that I could have these things and so I got into them but as I was doing it he was taking my pants down. I let this go on because I thought, ‘Well, you know, what can I do anyway,’ but I was more interested in eating these Coca-Colas and all that sort of thing. He was plying into me and things hurt. I knew he was doing things but not as great as being strapped.

He told the Inquiry the rapes continued for about two years.

At the end I was that used to it, it was — there was no really big drama in it and I thought this is the way life was. I didn’t know anything else.

The abuse stopped without explanation. The PIC recalled ‘missing the Coca-Colas actually, because I’d gotten used to this interference’.

He also told the Inquiry he was once called to the room of a female staff member at night. The PIC thought he was to be punished and went to the staff quarters. The female staff member ‘plied me with Cokes again, chocolates and sponge cakes and taught me all you want to know about sex’. He had regular sexual intercourse with this person and with a second female who alternated shifts with the first. He remembered having sexual intercourse with both together.

He told the Inquiry that over the past year he had started having flashbacks for the ‘first time … I wake up at night in a sweat. I can feel that bloody strap.’

A PIC was hospitalised as a result of family violence before being placed in State care for a criminal offence in the 1950s when he was nine. He recalled that ‘I was a little bit happier being away from home, away from the violence, but violence eventually followed me there anyhow’. According to his SWIC, he spent eight years at Glandore and also spent time at the Boys Reformatory, Magill, and in foster care. He said he was sexually abused in all those placements.

The PIC told the Inquiry he absconded from Glandore because he experienced repeated sexual abuse. His SWIC notes that he absconded twice during the period he described and that his behaviour was ‘rather mixed’.
PIC believed the abuse started about a week after he arrived at the home, when a staff member took him into a small storage room and anally raped him: ‘I was in extreme pain’. He said he remembered the staff member, who sometimes took the boys to sporting events, ‘extremely well’. He said the worker sexually abused him monthly over about two years, always taking him to the same storage room, raping him and forcing him to perform oral sex.

The PIC said he complained to two senior staff members soon after the sexual abuse began. He said both caned him; one intimated he was lying while the other implied that the abuse was part of the process of growing up. He spoke of the caning: ‘I used to cry all the time. It wasn’t something that you—you could not possibly stand there. The pain was too bad.’ He said he was sent to hospital for surgery to repair damage to his hands. The Inquiry received one departmental record noting three visits to hospital, two of them for attention after ‘accidents’. The reason for the third visit is not noted and the department could not locate any other records.

The PIC also spoke of being anally raped by a man he believed lived and worked at the home. He recalled the bed in the man’s small room: ‘That’s where he used to sodomise me’. The PIC believed he was not the only victim, saying the man ‘had a lot of boys there … a lot of boys’.

One of the staff members to whom the PIC said he disclosed the sexual abuse appears to have used the disclosure to initiate his own abuse of the boy. The PIC said this staff member took him to the home’s shower block, anally raped him and forced him to perform oral sex. The PIC recalled, ‘I was told that to get things that I wanted’ such as tuck shop allowance or to buy lollies, he would have to submit to the staff member. He also said he enjoyed board games and the man would spend time playing games with him—‘It was a part of a privilege for me’—but he would use the occasion to touch the PIC’s anus and then ‘lead me off’. The PIC said the sexual abuse occurred in various locations around the home, including the staff member’s office and the shower block. He said the man did not warn him to keep quiet, but rather reiterated that the sexual interaction between them was appropriate. The fact that ‘I should never complain because it was a normal thing, was drummed into me’.

The PIC said that after the abuse he became a ‘loner … I was always angry [about] what happened to me … It ruined my life, as far as I’m concerned’.

Another PIC was placed in State care by a court in the mid 1950s when he was 10, having been found to be neglected and under unfit guardianship. He said his father was an alcoholic and when drunk was violent toward family members, including him. He said it was a ‘sad story’. The time had come for his mother to move on and ‘I think that’s what she did, but I don’t blame her for that’. He was then placed in State care, spending almost three years at Glandore and often being placed out for short holidays.

He told the Inquiry that one night, not long after his arrival at Glandore, he woke up vomiting in bed. He got up and turned on the dormitory light, attracting the attention of the worker on duty. The PIC said the worker led him out of the dormitory to the shower block. After he had showered, the worker offered to dry him: ‘I thought he was helping me and I felt good about that because no-one had dried me before except my mother or father’. While drying him, the worker told him to bend over and hold on to the bench, then anally raped him; he said he yelled out, cried and was ordered to have another shower. He was told, ‘Only sooks cry—stop crying, you bloody sook’. The PIC said the man washed his penis in a sink and told him, ‘You’re not to tell anybody about the shower or your punishment’.

About a week after the incident,

I explained it all to the nurse and she was very kind. She give me a hug and told me not to worry about it, just keep away from him and she’d take care of it for me. I can still remember her saying them words. To me she was like a second mother, if you could understand.
He said he did not hear any more about it, ‘nothing whatsoever, not a word. So I just let it go and got on with my life in the home’.

The PIC’s departmental records do not mention his disclosure of the abuse.

The PIC told the Inquiry, ‘The actual abuse has always been there in my mind’. He said that ‘although relieved and happy’ about talking to the Inquiry, he felt ‘traumatised and sickened’, and in particular

I had a lot of difficulty explaining myself, the problem being the little boy in me and his memories kind of clashing with me, a grown-up 60-year-old talking and interpreting to a man my age or thereabouts, about my abuse, and a young boy inside me trying to get in on the discussions.

Another PIC said that after his father left home the family was living in poverty. He said he would run away and the police would bring him back home until finally the ‘welfare’ took him. His SWIC records that he was placed in State care in the mid 1950s when he was nine and spent the next 7½ years at Glandore.

The PIC told the Inquiry that soon after arriving at Glandore, a worker forced him to perform oral sex and then anally raped him. He said the sexual abuse continued every two to three weeks, sometimes in the coal shed or in the early hours of the morning in his dormitory bed. He said the worker told him not to tell anyone. On one occasion, he said, the abuse caused him to bleed and, feeling unable to go to the nurse, he went to the toilet and stopped the bleeding with toilet paper.

The PIC recalled that he was terrified of the worker and ‘my whole body would go rigid and just wait for it to be over’. After each act of abuse he felt dirty and ashamed. He had nightmares about it and started to get sores on his body; he went to the matron but was not asked what was wrong. The PIC said he did not tell anyone about the abuse because of his fear and shame, until the police came to Glandore. When police first spoke to him he denied he had been abused, then ‘broke down’ and told them the truth.

In March 1958, the worker, a 32-year-old from Glandore, was arrested and charged with committing acts of gross indecency with three different boys from the home, including this PIC, over a period of about six months. The department also suspended him at that time. The court record reveals that the worker’s offending came to light when another boy who previously lived at Glandore complained to his parents that he had been indecently interfered with over some months by the same man. A letter from a police officer to the Crown Prosecutor’s office stated:

A statement was obtained from the youth, and as a result of information given by this youth, I went to the Industrial School the same evening and obtained further statements of a similar nature from two other inmates [names]. It was the information supplied by the youth [name] that led to the subsequent arrest of [the worker] on charges of gross indecency. Mr James Francis Slade, the superintendent of Glandore Industrial School, remarked to police on being interviewed, that he was very shocked at what had happened. He and the Welfare Department had no idea whatever that such behaviour was going on between inmates at the school and [the worker].

The PIC said he gave evidence in court. He recalled the experience of appearing in the witness box and of ‘going to pieces inside’. At the time, he was offered no counselling. The worker later pleaded guilty to three charges relating to three different boys, including the PIC. He was sentenced in the Supreme Court in the late 1950s. Justice Mayo, the sentencing judge, said:

You have been in respectable employment and I have a report about you which—apart from the present matters—is all in your favour. It is very difficult indeed to know what to do in a case like yours, because there is some feeling abroad now that these cases should not be treated so seriously as is comprehended by the section of the Statute under which you are charged (Section 71 of the
Criminal Law Consolidation Act 1935–1956), and whenever I have to sentence in a case of this sort I always feel a difficulty as to what is the proper way to treat the offender personally and to deal with him with regard to discouraging others who may be likely to act in the same way. The maximum term is three years. Here there are three separate offences, so that if I dealt with them separately and gave you the maximum sentence it would be a matter of nine years, which I certainly do not intend to do. But as the law stands I have to impose a sentence, although you have no other convictions against you, and it is with a certain amount of regret that I feel compelled to impose a sentence, because, as I say, the attitude towards this type of offence appears to be changing, but it must still be regarded as a very serious one. The sentence of the court is that on each count you be imprisoned and kept to hard labour for the term of six calendar months. They will be served concurrently.

A PIC alleging sexual abuse at Glandore was placed in State care in the late 1950s when he was eight, on a charge of being neglected and illegitimate. He told the Inquiry that after his mother died ‘the police came and the ambulance came and they took us all away’. He spent a few years at Glandore before being placed in foster care, where he alleged he was also sexually abused.

This PIC told the Inquiry he was anally raped by a worker at Glandore about three months after being admitted:

I was just in total shock, you know? I was too frightened to say or do anything because of all the teasing and that sort of thing that used to go on around the place, you know? You couldn’t let anybody know what was happening.

He said the abuse, usually anal penetration, continued over two to three years in a garden shed on the property and sometimes in the dormitory. He said he would often try to resist his assailant and the abuse reached a stage where ‘I threatened to dob on him, you know, to give him up, you know, make sure the police got involved’. The man punched him on the nose, breaking it, then took him to the sick room, where he was only given a cloth to stop the bleeding.

He said he was then briefly fostered out but returned to Glandore when he was about 10. He alleged that on his return he

… was approached by the same person and forced to have anal sex again. I really wanted to commit suicide but I didn’t. I just decided that I was going to toughen up and just allow it not to happen again, but it continued to happen.

The PIC said he threatened the worker again with going to the police and soon after that he was sent out to another family.

A PIC whose first memory is of Glandore was placed in State care in the late 1940s, when he was two, after a court found him destitute. According to his SWIC, he was placed in a foster home briefly, then returned to his parents’ care, but was sent to an institution soon after, the reason recorded as ‘no home’. He said he was sexually abused at Glandore and later at Struan Farm School, Naracoorte.

His SWIC shows he was transferred to Glandore in the mid 1950s when he was eight. He lived there for about six years, and was also placed out to foster care during this period. He described his stay in Glandore as ‘quite traumatic at times. Yes, when I think about it, it was. And other times were very, very good.’ The PIC told the Inquiry he was anally raped by a man he did not know but who ‘had the keys to our hall, to our little room’. He said the sexual abuse happened once or twice a month over ‘too many years’. He sought medical help at one stage:

I was bleeding, right, and I went and told the lady. But, like I said, I think I thought it was just part of the system … I’ve never forgotten it. I know that I was bleeding. [She said] ‘Oh, we’ll fix this up. Yes, not a problem.’ I know that she went into another room and discussed it with somebody else.

No record was made of this treatment in the PIC’s departmental files.

He told the Inquiry the abuse had ruined his life: ‘I’ve never forgotten the first time; it was terrible’.
A PIC placed in State care in the early 1960s at the age of 12 after being charged with a criminal offence spent about one month on remand at Glandore. He was then released on probation to a family member for the remainder of his term.

The PIC recalled that the boys at Glandore showered in a communal area under staff supervision. He had not been at Glandore long when another boy warned him in the showers to ‘be careful’, but he did not understand what the boy meant. He said that one evening while he was trying to sleep, a staff member took him out of the dormitory to a nearby area and told him to touch his [the man’s] penis, but he refused. The staff member then said he knew the PIC’s genitals were not developed and, ‘if I stick this into you, it will make yours come out’. The PIC said he realised the man had seen him showering and that he suddenly understood the other boy’s warning. He said the staff member then anally raped him. In pain, he resisted and was told, ‘if you don’t like that, you can always suck mine’. The PIC said his underwear was bloodied as a result of the anal rape and the stained underwear was replaced: ‘One pair disappeared and the new pair just arrived’.

He said that after he left Glandore he disclosed the abuse to a family member but recalled not being believed.

In the early 1960s, at 13, one PIC was brought before the court on larceny charges. He lived at home with his family and did not mind going to school. He said that one day he was with an older boy who stole some pens, so he took some too. As a result, he was placed in State care until he turned 18, and was sent to Glandore. His SWIC indicates he spent one year there before being charged with other offences and transferred to Brookway Park, where he alleged he was also sexually abused.

The PIC told the Inquiry that on his first day at Glandore he was taken to a room to be issued with his outfit. He said he stripped and the worker issuing the clothing exposed himself then forced the PIC to perform oral sex. He said the worker also masturbated him and forced him to reciprocate. The abuse was interrupted when a person approached the room. The PIC absconded from Glandore that night and went to his family home. He did not tell his parent what had happened to him and the parent returned him to Glandore. The punishment for absconding was the cane, but because the PIC’s parent had returned him, senior staff promised he would not be caned. However, the PIC recalled, ‘as soon as [the parent] left it was on’.

He said the same worker attempted to sexually assault him on a second occasion, approaching his bed with another staff member, waking him and taking him to the shower block. The PIC said he resisted the worker and the assault was unsuccessful. Soon after this attempt, he absconded from Glandore for the second time. The PIC’s departmental files do not record his absconding.

The PIC told the Inquiry he disclosed this abuse to his parent and to his departmental probation officer. As a consequence, he became a target of ‘every screw in the joint’ at Glandore. He said the worker who had sexually abused him took him from his bed to an isolated area and threatened him if he continued to speak out. He said staff physically abused him for any minor infraction, using their hands or a set of keys on a large metal ring. He told the Inquiry: “You don’t know at 12 … [later] I thought, “What an idiot,” you know? No wonder man was brought up to keep his mouth shut.”

He said his departmental worker never spoke with him alone. The senior staff at Glandore allegedly sanctioned this physical intimidation; the PIC reported one as saying, “You will learn, mate, to keep your fucking mouth shut while you’re here. You will learn.” The PIC said he also disclosed his situation to a teacher of the school at Glandore, ‘which I’m pretty sure didn’t help me’.

The PIC told the Inquiry he wanted

... someone to sit down and listen to what’s going on and do something about it, or at least try. But, you know, nobody back in my day wanted to know about it, let alone try anything.

He said of his experience at Glandore that, ‘when I gave [the perpetrator] up you get bashed’ and ‘in the end you just—you more or less just give up, you know’.

3.1 Institutional care
None of the PIC’s departmental files provided to the Inquiry records information on the abuse, or his disclosure, interaction with staff or absconding. One notation records that he ‘needs … discipline’.

One PIC was five when placed in State care in the mid 1960s when a court found him neglected and under unfit guardianship; he remembered that there were many arguments in the family home. The PIC was placed in Glandore for five months. Later, in the early 1970s, he was placed in Windana for two weeks. He alleged he was sexually abused in both institutions.

The PIC did not recall details of his time at Glandore: ‘It couldn’t have been good, because I never remember anything from it’. He said he did remember being forced to perform oral sex on a staff member who took him to a toilet cubicle. The PIC said the staff member warned him not to say anything about the incident. He believed another staff member must have discovered them because he was taken to an office by this second person and asked about what had occurred. The PIC recalled being questioned and seeing the alleged perpetrator in an adjacent area behind what appeared to be a glass partition. He said this was ‘intimidating’. He said that when questioned in the office he ‘denied anything ever happened … I was just so scared’.

A PIC was placed in State care in the mid 1960s when he was five, after a court found him neglected and under unfit guardianship. He told the Inquiry that he remembered being raped when he was about three and running home afterwards. He said he also remembered the police taking him and his siblings away from his parents. Departmental client files reveal the department had been involved with the family due to allegations of unsatisfactory housing and domestic complaints.

The PIC told the Inquiry he was sexually abused at Glandore, in foster care and at Stuart House. He started living at Glandore soon after being placed in State care and stayed four years. Records received from the department show he was ‘unsettled’ at the home, absconded and was a frequent bed-wetter.

The PIC told the Inquiry he had unpleasant memories of the home:

*First I went to small boys, because I was only six. The ladies were awful … I remember the day I first went in there when they, what you call, de-louse you, right? They spray this powder on you, right, like under your arms and between your legs, and on your head.*

He said that on about three occasions he woke up naked in the morning outside the locked dormitory after having gone to bed with his pyjamas on. He had a feeling of having been drugged and cannot recall what happened to him: ‘My rectum was sore at that time …’

The PIC said that he did not tell anyone: ‘That’s how things work. You don’t say anything about anything.’

### Abuse by staff and other residents

In the late 1950s, when he was nine, a PIC was placed in State care until 18 after a court found he was neglected and under unfit guardianship. He was first placed at Glandore, where he spent five years before being transferred to foster care. The PIC told the Inquiry he was sexually abused at Glandore and later at one foster placement.

He said he had no sense of being neglected at home and was unsure why he was placed at Glandore when he was nine: ‘All of a sudden I’ve got … no family, none of my stuff, none of my clothes, nothing’.

He recalled that during his first few days at Glandore, older boys administered ‘a belting’ to the new residents to establish the pecking order. On his second night he saw two people get into bed with a boy in his dormitory; the boy cried out and the PIC raised the alarm, prompting the two people to hide. The PIC told the Inquiry there were usually between one and two staff on duty at night and that the older boys knew staff routines,
including when a staff member was due to visit the dormitory. The next day, he said, he reported the rape to the staff member on duty; he thought he would be called to the superintendent but ‘I never heard no more about it’.

On another occasion, the PIC said he resisted two older boys who tried to rape him in the dormitory, then fled again through a window. He told the Inquiry that such attacks were known as being ‘raided’. The PIC remembered disclosing the abuse to two visitors who took residents on outings—they told him they would follow up his allegations. He said he never went out with them again, nor was the matter discussed with him at the home. The PIC recalled also attempting to tell a female staff member about the attacks but ‘she didn’t want to know about it’. The departmental records supplied for this PIC do not note any abuse or disclosure.

The PIC said that during his time at Glandore two staff members approached him for oral sex. He told one of them ‘to get away’ but the other persisted: ‘He would catch you doing something and then force you to do the other things or you would get in more trouble’. Staff, he said, acted ‘like it was their right’ to abuse the residents. He remembered that the boys discussed the abuse but ‘You got to the stage where you thought it was just part of the norm; keep your mouth shut, otherwise you were worse off than everybody else’. He recalled that older residents sexually abused younger boys ‘all the time—all the time’.

One PIC who spent five years at Glandore was placed in State care by court order in the mid 1950s at the age of six; records show the court found he was neglected and under unfit guardianship. He told the Inquiry that he was anally penetrated four times at Glandore; three times by older boys and once by a man.

He said the first assault happened not long after he arrived at Glandore, when he was in the little boys ward. He recalls walking between this ward and a dormitory ‘when I was knocked to the ground, my pants pulled down, and they were into my bum’. He was anally penetrated by unknown older boys and was injured. He told the officer of the ward what had happened and was taken to the first aid room, where a nurse and matron said, ‘We’ll have to tell [the superintendent] about this’. His anal injuries were treated for the next three to four evenings, but he heard nothing more from anyone about the incident.

The PIC said the next incident occurred one night while he was asleep in the little boys ward and woke up to find a man on top of him, penetrating him digitally and with his penis. He said that when he resisted, the man whispered to him, ‘Shut up or I’ll fuckin’ kill ya’. The other boys in the dormitory had by this time woken up. Attendants arrived and removed the man from the dormitory, and a woman he did not know consoled him before he was put back to bed. The next day the superintendent told staff that no-one else was to go near the PIC and he was left in bed until lunchtime. During the next few days, the PIC said, a Glandore officer frequently approached him and upset him by asking, ‘Do you remember what happened in your bed the other night?’ Another officer told him that if he said he didn’t remember, ‘they’ll leave you alone’. The officer told him:

The bloke that did it, the man that did it, was a policeman, and the police have the right to come on to Glandore and have a boy any fuckin’ time they want one, so you all better keep your bums clean in case—for when they come back.

He told the Inquiry that for several days after that he and the other boys did not wash or wipe their anuses in the hope of avoiding assault.

Another time, he was invited by one of the older boys to learn how to wrestle. He said he had seen older boys going into the grass forts they had built in the vegetable patch to ‘wrestle’, a euphemism for anal sex. He recalled a woman, possibly the superintendent’s wife, who would shout:

I can see you two boys. I can see you’. She said, ‘You get out of there or I’ll tell [the superintendent] what youse are doin’;’ and you could see the kids pulling their pants up and running at the same time out of the veggie patch. That happened quite a few times.
Chapter 3 Allegations of sexual abuse

He told the Inquiry he ‘wrestled’ with an older boy: ‘It just seemed to be the way to go in those days. You know, that was the thing’. Another time, he agreed to ‘wrestle’ with an older boy because he wanted some special toys the boy had stolen from the schoolroom.

The PIC told the Inquiry he also witnessed several instances of abuse while at Glandore. He said he saw the superintendent cane a 9½-year-old boy, beating him so severely on many parts of his body that he had to go to hospital. The beating stopped only when officers came into the superintendent’s office and took the cane amid a ‘yelling match’. Records show the boy referred to by this PIC spent three days in the Adelaide Children’s Hospital in the mid-to-late 1950s. The PIC also said he saw a young boy being sexually abused by an older boy in the shower block.

He told the Inquiry he has

… never ever forgotten the main parts of what happened to me at Glandore, like the four sexual things, the canings and that, and what happened to one or two of the other boys. Never forgotten.

Another PIC was found by a court to be destitute and placed in State care in the mid 1960s, when he was almost nine. He said his family

… had no money. We had no clothes. We had nothing. I did what I had to do to survive for my family’s sake and I pinched things—food, nothing else.

He was sent to Glandore for 10 months and, according to his SWIC, he was then released from State care.

He told the Inquiry that one night at Glandore he was dragged by the neck out of his bed by a male staff member; the man shone a light in his face and smelt of cigarettes but he never saw his face. He said he was taken to the shower block, where he was held down and repeatedly sexually assaulted by three older Aboriginal boys. They penetrated him and made him perform oral sex while the staff member watched from the doorway. He recalled that these assaults occurred on several occasions, about once a week, although they stopped quite some time before his release from Glandore. The PIC told the Inquiry that after each time, he complained to a worker that he had ‘been hurt’, to which the response was, ‘Do you want to go on holidays; will that make you happy?’ The PIC recalled a direct correlation between the abuse and being sent for holidays. His SWIC reveals that during the 10 months he lived at Glandore he averaged one holiday a month, except for one month, when he is recorded going on four holiday breaks.

Another man who gave evidence to the Inquiry was placed in State care in the early 1960s when he was nine, a court finding he was neglected and under unfit guardianship. He said that previously he had witnessed alcohol abuse and violence between his parents and he was himself physically and sexually abused. He told the Inquiry about repeated sexual abuse over his four years at Glandore in the early 1960s, after which he was transferred to another institution.

The PIC said other boys at Glandore anally raped him; he recalled six alleged perpetrators and named three. The PIC said other boys warned that if he reported the abuse he would ‘cop it’. He recalled: ‘When you’re young you’re terrified. You don’t know what’s going to happen.’ The PIC alleges he was assaulted several times as a warning and that his jaw was broken on one occasion, resulting in surgery. His SWIC shows he was in hospital for almost two months at this time.

As a result of the rapes, his anus bled and he sought medical attention from staff. He did not disclose the cause of his injuries and the female staff member treating him told him he must have been sitting on cold concrete, or have haemorrhoids, for his anus to be in such a condition.

Two years later, the PIC said, a staff member took him to the toilet in the evening, undid his pyjama pants and anally raped him. After that the man tried to orally rape him but ‘I kept my mouth shut tightly’, as a result of which the man caned him. The PIC said this man anally raped him on a second occasion.

He said he told a family member about the abuse by the boys and the staff member, and that the family member referred the allegations to senior staff at the home. He cannot recall any investigation, nor staff speaking to him about his allegations. The staff member did not approach him again.
Another PIC was seven when a court found him to be neglected and under unfit guardianship and placed him in State care in the early 1960s. The PIC told the Inquiry that previously he had experienced physical violence in his family, and while in State care he was sexually abused at Glandore and Windana Remand Home.

The PIC said that soon after his arrival at Glandore a staff member took him to a shed on the property and sexually abused him. The PIC did not want ‘to go into detail’ but said the abuse occurred frequently: ‘If I refused to get involved then I was belted, punched, hit, slapped—you know, when you get in the shower—slapped on the arse’. He said he was forced to perform sexual acts on the worker and the worker indecently assaulted him. This progressed to anal penetration.

The PIC recalled that on one occasion, when he was seven, two men in suits photographed boys in the shower block.

He also said older boys at Glandore sexually abused younger boys at night in the boys dormitory. Asked whether this happened to him, he said, ‘It always did, always’. He did not report the abuse at the time and had not done so since because of ‘the pain of getting back to it all’.

In the mid 1960s, a PIC was placed in State care when he was almost 13 after committing larceny—he told the Inquiry he had been physically abused at home and stole to get food.

He was placed at Glandore for three weeks after the court order and, later, for two years. He also lived at Struan Farm School before returning to Glandore for one year before his release from State care at 18. The PIC told the Inquiry he was sexually abused at Glandore and Struan.

He told the Inquiry he was raped by an older resident on four occasions at Glandore. He could not remember how old he was when the rapes started or how long he had lived at the home. He recalled that the older boy was ‘built like a man’. ‘I knew that he was doing it to other boys … and he had threatened me a number of times that he was trying to get me.’ The PIC recounted one incident when this boy

... had jumped on me, put his hands straight over my mouth so I couldn’t scream, and two other guys were holding my legs down, and I know what he was doing.

The PIC also said he was raped by two other residents at Glandore but ‘their faces I’d never seen because it was always in the dark and they always followed this guy called [name]’. In addition to the rapes, the PIC alleged he was

... tied up by the penis, dragged down the corridor of one of the dormitories, then attacked and smothered in toothpaste, then I was held— toothpaste burns. I don’t know if you know. It burns.

The abuse usually occurred at night. The PIC said:

They only had one person in charge of all the boys, and that person maybe would come down every once—every half to an hour, and [the other residents] always kept somebody out on guard.

The PIC said he absconded from Glandore regularly, ‘because of the abuse, the way—and also the way that the authorities were treating that abuse’. He said, ‘What hurt was, I had a strong feeling they knew what was going on but they weren’t doing anything’. He told the Inquiry he reported the older boy who raped him after the first assault but said a senior staff member ‘didn’t believe me, told me to go away’. Later, he said, this staff member ‘said he would do something about it because he’d had other complaints’. However, the older boy would stay on at Glandore, be removed for several months then return to the home. The PIC said:

Everybody’s fear would just come back again because they knew what was going to happen. We could never understand why they kept bringing him back.

The department informed the Inquiry that not all records relating to this PIC could be located. The records provided do not record the PIC’s disclosure of abuse to staff.
Chapter 3 Allegations of sexual abuse

A PIC who alleged his father physically and sexually abused him was placed in State care in the mid 1960s at the age of 11, after a court found him to be destitute. He told the Inquiry he was sexually abused while placed at Windana Remand Home, Glandore, in the family home, at Kumanka Boys Hostel and McNally Training Centre.

Records received from the department show the PIC was placed at Glandore when he was 12 and was in and out of the home over two years—also spending time at foster and holiday placements.

The PIC alleged he was forced to have oral sex with several different Glandore staff members. Of one staff member he said:

*Whenever he felt like oral sex he would take me off to a dormitory or to the ablutions block on the western side of the central dormitory. When he wanted to have oral sex he was aggressive and intimidating to frighten me.*

He also alleged he was sexually abused by a number of boys at the home and that the abuse was often forced oral sex. He alleged that one boy anally raped him and threatened him with violence: ‘He pushed my face into the pillow and said, “Shut up, cunt, or I’ll smash your face”’. On another occasion, after being sexually abused by a boy, he had reported the abuse to a staff member, who replied, ‘Oh, bullshit, you little liar’.

The records show after that after more than a year at Glandore the PIC spent several months living with his parents. He alleged his father sexually and physically abused him and that he reported this to a worker with the department and begged to be returned to Glandore. He said the worker called him a liar and a troublemaker. A note on the department’s file states that the PIC came into the office saying that he wanted to return to Glandore, that he had been a slave to his mother and accused of being a thief. The author of the note did not record an allegation of physical or sexual abuse of the PIC by his father.

The PIC was returned to Glandore and alleged that the sexual abuse by staff and boys resumed.

Abuse by other residents

A PIC who alleged he was sexually abused at Glandore and later in foster care had been placed in State care in the early 1950s when he was two, after a court found him neglected and under unfit guardianship. He said he came from a large family and some of his siblings were victims of familial sexual abuse.

His SWIC records that after several placements over four years, he was transferred to Glandore, having been found ‘difficult to manage’ in foster care. The PIC spent several periods at Glandore over the next six years, during which time he also went into numerous foster care and holiday placements. He told the Inquiry that each time it was ‘heartbreaking to come back to Glandore and I remember most times coming back and the first night just sobbing my heart out in bed’.

The PIC told the Inquiry about his impressions of Glandore, particularly its regime of physical punishment for minor incidents. As a six-year old, he was often scared and later absconded several times, ‘mainly because I couldn’t stand the brutality of the place. You can only take so much.’ He said he avoided contact with other residents and staff where possible. He told the Inquiry that during the night there was limited staff supervision of the children’s dormitories, apart from the regularly scheduled rounds performed by a single officer. This schedule was known to residents, which facilitated the ‘raids’ on children in the unlocked dormitories.

The PIC said that in the late 1950s he was playing in the grounds when an older boy approached him in a threatening manner. He tried to run away but the older boy dragged him to a secluded area, took down his pants and sexually assaulted him. He had never disclosed the abuse at the home: ‘I was hurting, ashamed and fearful of what would happen to me if I reported it … I just buried it’.

In the early 1960s, a nine-year-old boy who had been living with a grandparent was placed at Glandore after a court found him to be destitute. The PIC recalled being collected from school by a departmental worker and police, without knowing why or where he was going. Before being admitted to Glandore, he was taken home, bathed, had his...
head shaved and was given new clothes: ‘To me it was just a big game, you know, when you’re growing up, and didn’t know what sort of impact [such an event will have]’. He said the departmental worker who took him to Glandore did not explain what was happening. It was not until he was an adult that he learned of his family’s attempts to have him returned. He spent between one and three years at Glandore before being placed into long-term foster care, a placement he described as generally positive.

At Glandore, the PIC said, he was ill for a short time and placed in the infirmary, where three older boys unknown to him forced him into a toilet and anally penetrated him. He told the Inquiry this happened on three occasions during the day over several days when the area leading into the infirmary was unattended. He said the boys covered his mouth and warned him to keep quiet. He said he was ‘too scared’ to disclose the abuse. The PIC told the Inquiry he was aware of sexual activity among the boys and remained frightened for much of his time at the home: ‘You stick with the fellows that are in your dormitory that you know and you just stay with them and steer clear of everybody else’.

In the late 1940s, a PIC who was less than one year old was placed in State care until 18 after a court found him to be destitute. The PIC told the Inquiry he was sexually abused in foster care, at Glandore and at Struan Farm School.

The PIC told the Inquiry that he spent about two or three weeks in Glandore when he was about eight, during which time a boy sexually abused him.

I had just moved in there, and I was there by myself when an older boy … came in, pushed me down, face on the bed, and pulled my pants down and said to me he was going to … fuck me between the legs, whether I liked it or not … He entered my backside instead. He said after it he would bash me if I reported it. I spoke to a screw later, a guy called [name] at that time, and he said, ‘Oh, don’t be a telltale. Get out before I put you on yard duty’.

The PIC said the same boy later abused him at Struan Farm.

The records indicate that the PIC had another placement at Glandore after he left Struan Farm just before his 16th birthday. The PIC said two Glandore residents—brothers—sexually assaulted him in tall marshes.

*Rumours had been spread that I was an easy target. One of the two stuck his cock up my arse and I remember getting up, pulling up my pants, and I was walking back and I felt just—the bell had rang. What annoyed me, I thought was he was one of my friends, but they told me that if I said anything I was due for the same thing—a bashing again. So I just kept quiet. Now, this same person before tried it again, but I was lucky because an officer walked in at the same time … [The boy] did catch up with me at a later date and locked me in a laundry basket.*

Another PIC told the Inquiry he was abused at Glandore over a two-week period. Departmental records show that in the mid 1960s, when he was six, the PIC was placed in State care until 18 for being destitute; he said his parents had separated and his mother became ill. Records indicate that, as a six-year-old, the PIC stayed at Glandore for about six months and later returned briefly on two occasions. The PIC alleged he was sexually abused at Glandore and also at a foster placement.

He remembered being taken to Glandore in a car with a departmental worker. On arrival he was issued with a set of clothes, and shown his bed in the small boys dormitory and the classrooms. He recalled ‘a very strange feeling, in that I was in an environment that I had absolutely no idea where I was, what I was doing, or anything’.

The PIC told the Inquiry that on his first day at Glandore he was approached by two teenage boys who asked him if he wanted an ‘open’. He did not know what the term meant but ‘I said yes because I didn’t want to upset anybody’. After school that day, the two boys dragged him under a building and anally raped him: ‘To provide lubricant they spat at my anus’. The PIC recalled thinking, ‘I don’t understand why this is happening’ and said he began crying. Later he discovered that ‘open’ referred to anal
intercourse. He said the two older boys also forced him to perform oral sex and that they threatened him, so he did not tell anyone. The message was clear, he said: ‘Don’t talk about this, otherwise you are in trouble’. He recalled crying that evening while the small boys were escorted to the shower block.

The PIC said there was another instance of sexual abuse at the home but he could not recall details. He said he witnessed sexual activity among other boys:

A staff member and myself walked in on two boys having sex—sexual intercourse on the bed. Then there were other occasions where boys were down in the toilet block, down the back of Glandore Boys Home, and basically, you know, you were told to nick off.

He said a staff member ‘stated to me that what they were doing was wrong and that I really got a clear message that this was a wrong practice’.

The PIC told the Inquiry:

Being mixed with other boys who were known perpetrators of abuse and… sticking boys in there where there was nothing like that, I think it was a bloody mixture for disaster. It left vulnerable children to be preyed upon by older, more streetwise children.

In the early 1960s, when he was 11, another PIC was placed in State care by court order until 18 because he was found to be neglected and under unfit guardianship. He told the Inquiry he was from a large family and, after his parents separated, it had been difficult for his father to work and care for the children, some of whom began stealing food to help out. The PIC recalled the police taking him from his home to Glandore and his father’s distress. He alleged he was sexually abused at Glandore and then at Stuart House Boys Hostel.

According to his SWIC, the PIC stayed at Glandore for three months after being placed in State care. The PIC told the Inquiry that one night an older boy came to his bed after lights-out, exposed his penis and attempted to climb into bed. He said the boy told him to masturbate him; he refused but the boy persisted ‘night after night’ despite the refusals. Eventually he masturbated the boy to ‘appease him’. On another occasion the same boy climbed into his bed and attempted to anally penetrate him. He resisted and ‘made so much noise’ that a worker came into the dormitory and turned on the lights, which caused the other boy to flee. The officer asked what was happening, but the PIC said he told him nothing had occurred, as he felt ‘guilty by association’. He said the boy never approached him again.

The PIC told the Inquiry he felt he could not disclose the abuse to anyone at the home: ‘If you told them, you’d get the cane. If you said anything, you’d either get a slap in the mouth or you’d get the cane’. He recalled that the boy who assaulted him had implied that if the PIC did speak out, then he would be attacked: ‘He was a big kid, and the big kids punched you out. So there was always that inference of threatening.’ The PIC said he became aware of other boys being raped by older residents; he described hearing screaming in the dormitory and in the toilet block. He had approached staff to tell them ‘what was happening. They just said, “Don’t be stupid. Get back to what you’re doing,” and then “if you keep it up, you’ll get the cane”’.

The PIC said he, along with other boys, were transferred from Glandore to Stuart House, but his brother had not been transferred. The PIC said he had been extremely upset at being separated from his sibling: ‘I remember it like it was yesterday; I was crying and crying.’

In the late 1960s, an Aboriginal PIC was placed in State care by a court for being neglected and having unfit guardianship. He was four years old when he was taken away from his family in regional South Australia; he believes he was at a mission station but has limited memories of his time there. He told the Inquiry that while in State care he was sexually abused at Glandore and later at Slade Cottage.

The PIC was sent to Glandore within a month of being placed in State care and remained there until he was nine. He said the little boys at Glandore had ‘to sit down on our knees and pray before we’d go to bed’. He told the Inquiry he was sexually abused by another boy at Glandore; he did
One man who contacted the Inquiry spent almost a month at Glandore in early 1970 when he was 12, after a court placed him in State care for larceny. According to his SWIC, he spent the first day on remand at Windana Remand Home and, because of overcrowding, was then transferred to Glandore.

He remembered being ‘very scared’ at Glandore, particularly of older boys whom he saw sexually abusing younger boys. He described to the Inquiry the grounds, highlighting the places boys would go ‘if we were trying to get away from the older boys’. The PIC recalled fighting constantly with older boys who attempted to climb into his bed naked, and said this occurred from the first few days he arrived at Glandore. He also recalled older Aboriginal boys jumping on his friend in the dormitory and that he got into a fight with them when he tried to help his friend.

Abuse by outsiders

Another PIC was placed in State care in the early 1970s when he was six, a court finding him to be neglected. He told the Inquiry he was sexually abused at Glandore and later at Stirling Cottage.

He was initially placed at Windana Remand Home but was moved to Glandore after two weeks because, his SWIC records, Windana was overcrowded. He is recorded as being at Glandore for five weeks. He told the Inquiry he was frequently taken from the home in the evening by a man he did not know and driven in a black car to a large house past Montefiore Hill in North Adelaide. He said he was given a drink and lollies during the drive. There was usually another man in the house. The next morning, the PIC said, he would be back at Glandore; sometimes his anus would be bleeding. He said the same man was on duty at night when he left and returned to Glandore. He guessed he was a staff member and so he approached him about what had happened, but was told to ‘hush up about it’.

Struan Farm School, Naracoorte, 1947–69

History

In 1946, the State Government purchased Struan Estate and 469 hectares of adjoining land near Naracoorte, taking control in January 1947. Struan Farm School was developed as a rural farm colony—the CWPRB believed that it was a place where reformatory boys could ‘mix satisfactorily with the neglected and destitute type of boy’. The school was not proclaimed under the Maintenance Act as an institution to which the court could commit boys. Instead, the CWPRB took responsibility for the transfer of selected boys from other institutions.

Although the home had the capacity to take in 30 boys, during the 1950s only 18 to 20 lived there at any one time. They worked the gardens on school land, were trained in various farming tasks and were taught how to use farming equipment and machinery. They were paid ‘small remuneration for services rendered’. Often the boys trained on the properties of local landowners who required them to care for stock. After completing their training, some boys were placed out to live and work on nearby properties.

Boys were permitted approved visitors and were sometimes allowed to visit their own homes. Residents’ interaction with the local community was encouraged through camps and participation in sporting clubs. The institution also organised outings for the boys to points of interest in the district.

In 1951 an issue ‘regarding abnormal sex conduct’ at Struan Farm emerged. Information from a former resident suggested that sexual activity among residents was common, including the targeting of specific children. The CWPRB consulted a former member of staff and then...
decided that ‘greater supervision of the boys was necessary, and all boys should be made to work longer hours’. It called for ‘careful consideration of the future of Struan’.\(^70\) The CWPRB raised concerns about the placement of Magill Reformatory boys at Struan Farm. The CWPRB noted in 1954 that ‘the first responsibility of the Board in regard to this institution [Struan Farm] was the care and training of State boys’ and registered its preference that Struan Farm be used for non-delinquent boys in State care.\(^71\)

In 1960, the superintendent who had been in charge of Struan Farm from its inception retired and was replaced by a former deputy superintendent of the school.\(^72\) During the 1960s up to 30 boys were accommodated at the institution.

In June 1969 the acting director of Social Welfare wrote to the Minister proposing that Struan Farm be discontinued. He said that because the farm was a completely open institution, only selected boys who wanted to receive instruction in farm work were sent there for training.\(^73\) Although there was accommodation available for 30 boys, ‘in recent years relatively few boys committed to our institutions have genuinely wished to transfer to Struan Farm’.\(^74\) He also raised the issue of the ‘consistently high cost per child [per] day’ to run the institution and the difficulty of securing ‘satisfactory staff’.\(^75\)

Struan Farm School was closed on 31 October 1969 and the institution was taken over by the Department of Agriculture as a research station.\(^76\)

### Allegations of sexual abuse

Six men alleged they were sexually abused at Struan Farm School during the 1960s. The Inquiry was able to confirm from records that they were all in State care at the time of the alleged abuse, which included anal rape and indecent assault perpetrated by staff and other residents. The reasons for their placement in State care by court order were: committing a criminal offence (three men), being destitute (two), and no reason recorded (one).

#### Abuse by staff

One PIC was 12 in the mid 1960s when a court placed him in State care to the age of 18 for committing a criminal offence. His family background included physical violence and alcohol abuse. He told the Inquiry he was sexually abused in a foster placement and later at Struan Farm.

The PIC was sent to Struan Farm in the late 1960s, when he was 14, and spent about nine months there. He told the Inquiry he was sexually abused at Struan Farm within weeks of his arrival. While working in the paddocks, he found a small animal and took it back with him at the end of the day’s work. He said a staff member took him into a small room and ‘dead set laid into me with a cane as punishment’. After later rescuing the animal, the PIC was again punished and ‘that’s when things started to happen in there as well’. The PIC said that after caning him, the staff member pulled the PIC’s trousers down, put him over his knee and began touching his bottom, while masturbating himself. The PIC said this abuse occurred again between four and six times in the same room, and was generally preceded by a punishment: ‘That’s where he’d take me in there and do it … If he could find an excuse to cane me, that’s when it would happen’. He said the staff member never spoke to him during the abuse. When asked by the Inquiry whether there had been anyone he felt he could talk to about what was happening, the PIC said ‘no’.

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\(^{71}\) ibid., vol. 17, (minute 1276), 28 May 1952.


\(^{74}\) ibid.

\(^{75}\) ibid.

\(^{76}\) ibid., memo to heads of branches and institutions from a/secretary SW, 24 Oct. 1969.
The PIC said when the staff member’s room was broken into,

I got the blame … I denied it. He didn’t ever used to say much. He used to hit you with a cane. ‘I’ll get the truth out of you sooner or later,’ he’d say … You’d be there bawling your eyes out, ‘No, it wasn’t me, wasn’t me’.

The PIC remembered that after he had been caned ‘you could damn feel it. It used to burn … I remember some marks that used to bleed’.

The PIC said he did not tell anyone about the staff member’s abuse but he ran away with another boy, whom he named. Their records show that both were reported as absconding for four days. The PIC told the Inquiry they were on the run for a few days, were without food and became hungry. They broke into a building and were apprehended by police and charged with larceny. Both were remanded to secure care facilities.

He said he suffers from anxiety and depression, and ‘I now wonder if the illness came about because of what happened to me as a young child, being sexually abused and physically as well as mentally’.

When asked what he would have liked during his childhood, he said, ‘What I would have liked was a good normal straight life, you know?’

Abuse by staff and other residents

A PIC was placed in State care until aged 18 in the late 1940s when he was two years old after a court found him destitute. According to his SWIC, he was briefly placed in a foster home, then returned to his parents’ care, but was sent to an institution soon after; the reason recorded as ‘no home’. He told the Inquiry he was sexually abused at the Glandore Industrial School and later at Struan Farm.

According to records, the PIC went to live at Struan Farm when he was 15 in the early 1960s and lived there for almost 18 months. He said: ‘sexual behaviour down there was quite frequent, and if you didn’t comply you’d know about it’. The PIC told the Inquiry he witnessed sexual activity among residents and between staff and residents, and named several locations in the school building and on the grounds where this occurred. He also described systematic physical abuse, saying he was once beaten unconscious by three male staff members. He did not know why this had occurred, but was warned, ‘There’s more to come’.

The PIC told the Inquiry he was anally raped by a staff member soon after his arrival: ‘He had a go at me in the cow shed’. He described the man but did not remember his name. He said he saw the same man abuse other residents in the same location.

He said a group of five or six older boys raped him, usually in a storage room, two to three times a week for over a year.

Some of the bigger boys had a go at me, and if you didn’t comply, what they would try and do is nearly drown me in [a creek] down there.

The PIC told the Inquiry he felt as though ‘I had no choice in the matter’:

You said nothing to nobody. Right? If you said something to somebody you either got a good smack in the mouth or they would have gotten a big stick and they would have all laid into you.

The PIC was transferred from Struan Farm into foster care and told the Inquiry that had he not been transferred, ‘I don’t know if I would have survived it or what, at Struan. It was bad, real bad.’

Abuse by other residents

O ne PIC told the Inquiry he was anally raped at Struan Farm by a resident in the early 1960s. He had been placed in State care until the age of 18 in the late 1940s when he was less than one year old, when a court found him destitute. He said his first memory was ‘Seaforth, when I was locked in a baby’s cot’. The PIC told the Inquiry he was sexually abused in foster care, at Glandore Children’s Home and at Struan Farm.
According to his SWIC, the PIC was placed at Struan Farm for about one year when he was 14. He said another boy anally raped him in the laundry: ‘I wasn’t a person who was a strong build. I was a weakling. At Struan he just pushed me down and that was it.’

He remembered being in ‘agony’ after the incident. He said he told a worker at Struan Farm, who said:

Well, there’s not much you can do about it. What can we do? He said, ‘I’ll get you transferred well away from him,’ and I said, ‘Yes. Where?’ He said, ‘The dairy,’ so I went down the dairy. There I was safe. I thought I was safe and I remained safe until I left Struan.

The PIC said the same boy had previously sexually abused him during his first placement at Glandore.

Records provided to the Inquiry concerning the alleged perpetrator indicate that by the mid 1960s the department was aware this person was initiating ‘homosexual activities’ on other boys.

A PIC who was at Struan Farm in the mid 1960s alleged he was raped by a group of boys there. The only record received by the Inquiry is a SWIC that shows the PIC was placed in State care at 15 and sent to Bedford Park Boys Training Centre and then Struan Farm. It does not record the reason or who made the order. The PIC alleged he was sexually abused at both placements and, before he was placed in State care, at two non-government homes—of the latter, he said he was indecently assaulted by a nun at the first home when aged between seven and 10 and anally raped by other residents ‘a few times’ at the second home when he was 10.

The PIC told the Inquiry that as a teenager he started spending time on the streets. According to his SWIC, at 15 he was placed at Bedford Park for two months and then transferred to Struan Farm for one year.

He said he was placed on a train to Struan Farm without being told where he was going or what was happening to him. He felt his transfer to Struan Farm was ‘the only time that I could actually see something happening’ in terms of a departmental effort to respond to a report of previous sexual abuse at Bedford Park. ‘And yet, when I got to Struan’, it became clear the response did not extend beyond transferring him to another institution. He believed the staff at Struan Farm knew of his previous abuse: ‘They knew when I’d come down … the paperwork would have gone down with me.’ When the PIC arrived at Struan Farm a senior staff member allegedly told him: ‘Bad luck. These things happen in institutions’.

The PIC said he was physically assaulted at Struan Farm in retaliation for his disclosure of abuse at Bedford Park. One day, recently arrived residents told the PIC he was to be assaulted:

A message come down with the last lot of blokes … I was going to be set up and belted. Every time … there were scores settled so, you know, you’d come with a message from a mate that one of the blokes down there had done something.

The PIC said a resident who was a friend of the boy who sexually assaulted him at Bedford Park said, ‘Just passing on a compliment from up town’—and a fight broke out between them. The PIC said staff dealt with the fight in the following way:

We were ordered into the boxing ring, gloves on … I gave him a bit of a touch-up and I had a split lip myself, and people left me alone. I was going to fight back.

Not long after the boxing match, the PIC alleged, three residents physically assaulted and anally penetrated him while he was working in the farm’s grounds. ‘I was left up there just distraught.’

The PIC said he absconded from Struan Farm once. When the school bus dropped the children off for church he had said to a fellow resident, ‘I’ve had enough of this. I’ve never been charged with anything. I shouldn’t be here, and I just can’t handle it any more.’ Then, with the other resident, he fled from the church.

We were waving at cars, and nobody would stop, and if we thought it was a cop car or some other car, we’d dive in the bushes and hide. Anyway, we saw this car coming, so we jumped out and waved
it down. A worker from Struan Farm was driving the vehicle. You’d have to be dead unlucky. [He] sat us down for a while and told us how disappointed he was, told us that he understood what we did and took us back to Struan.

The PIC said staff ‘caned us bloody chronic’ when they were returned. They were caned again the next morning in front of the other residents and were threatened with transfer to a secure care institution. The PIC said the approach was:

‘Boys had run away, great expense’, lined us up and got another six, and we were under threat of going to Magill. It worried the shit out of me. I’d never been there. I’d heard all the stories.

The PIC was released from State care at 18. He told the inquiry the effects of the alleged sexual abuse on him included not knowing how to love, trusting very few people, being over-cautious with his own children, not giving freely of himself, having never had a childhood, and having learnt nothing but hatred. He told the Inquiry he wanted to give evidence because

There are so many kids whose lives have been utterly screwed up, and if I can add a little to that and something is eventually done to stop it, so be it.

A man gave evidence about being raped at Struan Farm in the late 1960s, when he was 16. The PIC was placed in State care by a court in the mid 1960s when he was almost 13 after a minor offence. He told the Inquiry he was sexually abused at both Glendore Children’s Home and Struan Farm.

He said the Struan Farm staff recognised his talent for farm work and that he worked on various jobs around the school without supervision. He said he was working alone in one of the fields when the first incident of abuse was perpetrated by ‘one of the bigger boys, the older ones’. This boy had been sent to help the PIC finish his work. To the PIC’s recollection,

I stopped for a rest or had some lunch or something, and he had come along and threatened me. Wanted me to do some acts and then I ran off.

Later that night, the same older boy and another boy confronted the PIC. The accomplice ‘held me by the head with a knife to my throat and the first boy penetrated me while the other guy was holding me down’. The PIC recalled this as ‘the worst one I can remember’ of all the abuse he experienced in State care.

The PIC did not tell anyone at Struan Farm about what had happened: ‘I was too distraught and too upset, and going from experience, no-one would listen. They didn’t want to know.’

When asked whether a departmental worker visited the farm and monitored his progress, the PIC said, ‘If there was, I certainly can’t remember that—never.’

After the abuse, the PIC ‘just wanted to get away and I couldn’t get away quick enough’. He said that in the years that followed,

… it never left. So I basically, for the rest of my life, which I have done, I literally buried myself in work, working 18, 16, sometimes 20 hours a day.

In the late 1960s, when he was 14, a PIC was placed in State care until 18 years for offending. He told the Inquiry he had been sexually abused by a family member and by a schoolteacher before being placed in State care. He said he was sexually abused at Windana Remand Home, McNally Training Centre and Struan Farm, and later in foster care.

The PIC lived at Struan Farm for three months in the late 1960s, and told the Inquiry there were about 15 boys there when he arrived. As the ‘new kid on the block’ among a small group, the PIC said he was physically abused. He recognised some residents from McNally and believed they may have known he was sexually abused while at that institution. He said he and another boy were at some caves near Struan Farm when the other boy physically assaulted and anally raped him. Records obtained by the Inquiry confirm that this boy was at Struan Farm at the same time as the PIC. Records show the alleged perpetrator absconded from Struan Farm soon after.
Non-government institutions

Fifty-three people gave evidence to the Inquiry that they were sexually abused while placed in non-government institutions. Of these, the Inquiry was able to confirm from available records that 17 people were in State care at the time of the alleged sexual abuse. The Inquiry was unable to determine whether five of the people were in State care because of the lack of existing records and/or the actions of the Aborigines Protection Board (see page 14). Available records indicated the remaining 31 people were not in State care at the time of their alleged sexual abuse, however the Inquiry has reported their allegations because their experience at the same institutions supports the evidence of the people who were in State care and reported sexual abuse.

The abuse, which included gross indecency, indecent assault and anal and vaginal penetration, was allegedly perpetrated by staff, other residents, people outside the institution with whom a child would have contact, and people who remain unknown to the PICs.

The Inquiry also heard allegations of sexual abuse from an additional 14 people who were placed in other non-government homes, but has not reported them. After investigating their allegations by requesting and obtaining records, the Inquiry determined they were not in State care as defined by the terms of reference. No people in State care who were placed at these homes came forward.

Farr House, Anglican Church, 1860–1982

History

The Church of England set up Farr House in 1860 as a small institution to house neglected children in a home environment. Originally known as the Orphan Home, Adelaide, it operated in Stepney, then moved to Carrington St in the city and finally to Upper Mitcham in the early 1900s until its closure in 1982. In 1935, when the home was incorporated, it was renamed Farr House after charity worker Julia Farr, who had been the driving force behind its establishment and operations.

Farr House was primarily a girls home, while Kennion House was the Church of England’s equivalent for boys. However, as early as 1935, the home’s treasurer contacted the Children’s Welfare and Public Relief Board (CWPRB) to say it had space to take in additional children of either sex under the age of eight.

After the Residential Child Care Advisory Committee (RCCAC) was established in 1974, Farr House entered a contractual agreement with the department and in 1976 received funding to assist with operating costs and appoint a social worker. In 1980 Farr House provided a home for up to 20 girls aged between eight and 18. The institution gave ‘preference’ to girls who need residential care because parents and relatives are unable to cope, and the child is unsuitable for fostering. Farr House is set up to function as closely as possible to a small family unit, in order to provide care, consistency and individual attention.

By this time Farr House, Kennion House and St Mary’s Mission of Hope in Prospect were managed by Anglican Child Care Services (ACCS), rather than by in-house committees. In applying in August 1980 for a renewal of its licence under section 61 of the Community Welfare Act 1972, the ACCS administrator emphasised that although Farr House ‘was available to all children between the ages of eight and 18’, it still catered primarily for adolescent girls. He qualified this further by stating that the home was ‘not able to cater for children with gross physical, emotional or psychological disabilities’ but that it ‘can cope with behaviour problems’.

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1. The suburb was also known as Springfield.
2. FYOW, s. 1.5.
3. SRSA GRG 29/6/1935/272, ‘Notifying additional room for children (under eight years) in the home’.
5. SRSA GRS 714/1/P Correspondence of the Residential Child Care Advisory Committee (RCCAC), Sep.-Dec. 1980, Anglican Child Care Services to RCCAC secretary, 15 Dec. 1980.
A departmental visitor to Farr House in the late 1970s gave evidence to this Inquiry that suggested the home retained an old-fashioned attitude towards caring for ‘the needy’, saying, ‘At Farr House it was very much … a closed environment’.

During the early 1980s the Anglican Church began to move away from providing congregate institutional care, and Farr House was redeveloped to provide smaller group care in 1981. In March 1982 the superintendent and his wife resigned, reportedly because ‘they were out of sympathy with the new attitudes towards child care being developed by the ACCS Committee’. The home closed soon after and the department transferred the resident girls to other forms of care.

### Allegations of sexual abuse

Two PICs gave evidence of sexual abuse while they were in State care and placed at Farr House—one in the mid 1960s to 1970s, and the other in the early 1980s. Both had been placed in State care by court order until they were 18. The alleged abuse was perpetrated by temporary carers, including a staff member on one occasion.

#### Abuse by multiple perpetrators

In the early 1970s, one month before her third birthday, a PIC was placed in State care with siblings until she turned 18, a court finding they were neglected. The PIC told the Inquiry her mother was unable to care for her and her stepfather was violent and abused her both physically and sexually. Initially placed in Seaforth Home with her older sibling, she ‘cried my eyes out on my first night there’. After a short, unsuccessful fostering arrangement, she was placed in Merlimama Cottage, where she alleged she was sexually abused, and then moved into a longer-term foster placement with a family for six years:

> I was well fed and I had very good manners but I thought I was a horrible child, because that’s the way they made me feel. I used to wet the bed constantly up until I was about 10 … I could never do anything right, and they used to hit me with a belt.

According to her SWIC, in 1980 the department placed the then 12-year-old PIC in Farr House for about two years. The PIC told the Inquiry that she ‘just didn’t fit in’ at the home. One of the staff

... would play emotional games with the girls … made sure that we were too scared to ring our social worker … (a) I didn’t know the number and I didn’t know which office [she] worked out of and (b) it was made very clear to us that we weren’t allowed to call.

The PIC told the Inquiry a male worker at Farr House sexually abused her by hugging her and the other girls inappropriately, and touching her on the bottom. She said she told a staff member about this, but she believes nothing was done.

The PIC also said that one Christmas holiday period while at Farr House, it was arranged for her to stay outside the metropolitan area with a family that had its own children and foster children. She recalled getting ‘lots of nice presents’ from the family. However, she alleged that about New Year’s Eve the foster father woke her, gave her a hug, and kissed her:

> But it wasn’t the kiss I was expecting … and his hands ended up on my bum … I don’t think I did anything because to me it was affection. I just thought that was how it was.

She alleged the abuse later continued when he kissed her again, ‘sticking his tongue down my throat’, then penetrated her with his fingers and got her to masturbate him. She recalled another incident when he penetrated her, and said she believes she started to bleed as a result. At that stage she did not tell anyone and she was...

... pretty numb about the whole thing. I withdrew and I thought that there was something wrong with me because it wasn’t the first time somebody had abused me.

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6 Children in State Care Commission (CISC) of Inquiry general witness [name not for publication], 6 March 2007.

Chapter 3 Allegations of sexual abuse

The PIC said she attempted to tell a Farr House staff member in private about the foster father’s abuse, but her concerns were effectively dismissed and she did not raise the issue again until soon after leaving State care. She said that, at this time, she disclosed the foster father’s abuse to her former departmental worker at Farr House. She understands the worker then went to a member of the Anglican Church and asked that she receive counselling—but ‘they point blank refused’. She believes that this worker ‘genuinely cared about me’.

The PIC also told the Inquiry that some years later she called a branch of the department and voiced her concerns about her foster father, but she was told she had ‘no proof’. She said she also told one of her carers after she left Farr House that she was going to take legal action: ‘I was trying to get help. I was a mess and I didn’t want to continue being a mess.’

The Anglican Archives provided only minimal documentation regarding the PIC to the Inquiry; there is no record of disclosure of the abuse. Her departmental records also do not reveal any information relating to her allegations. Records from the department show it had approved the foster father and his wife as foster parents and were paying them guardianship payments for the care of another child at the time.

On the basis of the PIC’s evidence, she disclosed the alleged abuse by the foster father on at least three occasions. She also gave evidence about her abuse to the Anglican Diocese of Adelaide’s Board of Inquiry into sexual abuse and misconduct\(^8\) and was offered counselling. But she said:

\[\text{I don’t want the counselling now. I wanted it when I was 19 to save myself years and aggro and picking men that really weren’t good enough for me; you know, men that beat the crap out of me or men that put me down or any of the above.}\]

Abuse by outsider

One PIC told the Inquiry she was 10 when her mother died in the mid 1960s and, as a result, she and her sibling were placed in care. This is confirmed by the PIC’s SWIC, which shows the siblings were placed in State care by court order until they turned 18 because they were neglected. They were placed in the care of ‘The Matron, Orphan Home Inc Farr House’. The PIC remained at Farr House for 7½ years until just before she was released from State care. She recalled Farr House as:

\[\text{Scary, huge. I don’t know if it was the house so much that daunted me, or actually moving to the city. Lots of people, loss of friends, all that sort of thing. I’m not a great stickler for rules and I’m still not and I used to continually be in trouble for doing things wrong.}\]

She did not recall physical abuse at the home, but has a strong recollection of being punished:

\[\text{Having to sit at the dinner table for up to an hour after dinner until you had cleared your plate and if you didn’t eat it you got it for breakfast the next morning, cold. I was continually having to polish 32 pairs of school shoes, scrubbing floors.}\]

Playing school netball, being in the church choir and, on Sundays, going to church three times and teaching Sunday school were all opportunities for her ‘to get out and not be stuck at [the] home’.

The PIC did not remember seeing her social worker at Farr House: ‘I don’t recall ever seeing them there. I had to go to them …’

She visited the welfare office in the city from when she was about 13, and recalled the old building where she went to collect clothes. In particular, she remembered a raincoat she was given by the department: ‘I associate this ghastly raincoat with that building’. She had different welfare officers and encountered one who was ‘absolutely wonderful’ and who later helped her find her siblings.

\(^8\) Synod of the Diocese of Adelaide, Report of the Board of Inquiry into the handling of claims of sexual abuse and misconduct within the Anglican Diocese of Adelaide (The Hon Trevor Olsson and Dr Donna Chung), May 2004, Anglican Diocese of Adelaide, viewed 8 March 2008,

3.1 Institutional care

Going out for weekends with different families was common at Farr House. The PIC told the Inquiry that when she was in her early teens, her friend at the home asked her whether she would accompany her on a visit with a young couple. The PIC recalled being driven to an old building on a main road in the eastern suburbs, sitting in the back of the car with her friend, who was clearly upset. The PIC sensed her friend knew what was about to happen. Once they arrived at the building, a woman explained that they were going to have a massage or were going to practise massage. She led them down a dark hallway into a room, where they found a man surrounded by lights mounted on tripods. After the lights were turned on, the PIC said, the woman told her to take all her clothes off and lie down very quietly, ‘virtually just not to move at all’, on the table. The PIC did not say anything in response: ‘I don’t know why, but I think I just did it’. The PIC alleged the man proceeded to rub oil on her body, and massage her completely from top to bottom, including her genital area:

I know he touched my genitals. I don’t know if he penetrated me with his fingers or anything, but I know it took quite a long time and then he got me to roll on my back.

The PIC said she was uncertain where her friend was at this time, but remembered that they both had a bath later. The PIC believes the woman said something to the effect of it all being

... a treat that we had when we went to her place ... and we didn’t have to talk—she said we didn’t have to talk to anyone else about it.

On reflection, however, the PIC says:

I think she probably said, ‘We won’t talk to anyone about this’, not ‘You don’t have to’. But the way we were, and I think in our innocence, it was the sort of thing we didn’t discuss between us anyway, let alone discuss with someone older because—I guess with the matron we had at the orphanage, number one, we probably didn’t believe we’d be believed … So I think it was just a very private thing.

The PIC believes she probably swore her friend to secrecy:

The threat of death or something horrid, being a 13-year-old, whatever I was. Yes. I think we just sort of came to some sort of pact that we weren’t going to talk about it.

The PIC said she was unsure whether she returned to the house. She told the Inquiry that after this, she started wagging school, climbing out of the windows of the home and going to the Pancake Kitchen with boys: ‘I just became a real ratbag’. On a couple of occasions the police had to take her back to the home.

The PIC also told the Inquiry that in her later teen years, while on a high school camp, the two bus drivers would sleep at night next to different girls, including her, and fondle them. She believed a couple of girls may have mentioned the abuse to a prefect, but did not know the outcome of this:

I know myself and several other girls on that trip—I didn’t tell anyone else. I don’t know if anyone else reported it to their parents when they got home. I know it wasn’t reported to the teachers on the trip.

After pressuring her social worker, the PIC said she moved out of Farr House and was placed with a foster couple. She said they were ‘a really weird couple. I look back on that now and how they ever got into a foster situation is beyond me’. She alleged ‘it was nothing for them to be walking around the house naked’ and that they would have sex in her presence: ‘I was always really embarrassed so I’d just go and hide in my room or I’d go out’.

FYOW, s. 1, p. 7. Documentary evidence of weekend placements for girls survives in journals and day books from the 1970s–80s held at the Anglican Archives.
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Reflecting on the abuse she experienced, the PIC told the Inquiry:

_There’s many times my mind has touched on this and I’ve thought, ‘No, don’t go there’. But I think, if I really thought it through, it would be one of the reasons for a lot of my actions later in life. I went totally off the rails for quite a long time. I thought sex was love, so if I had sex with someone they loved me._

She said she would have liked ready access to an advocate while in care:

_I’d say to matron, ‘I want to ring my welfare officer to make an appointment to go and see her’, or ‘I want to ring her to talk to her’, or what have you and she’d say, ‘Well, no, you can’t ring now because you’re grounded’, or ‘You haven’t got any pocket money left’, or what have you … I had to wait until I did have pocket money so that I had the money to ring her to make an appointment to go and see her. Because there was no way in the world I could go from school down to the welfare office to visit her without an appointment, without matron knowing about it, because I’d be late home._

The PIC felt that the Inquiry was an opportunity for … people less fortunate than me to come out feeling better about themselves. _That’s really important to me … I hate to admit it but I think this has been very good for me to talk about it._

Kennion House, Anglican Church, 1886–1984

**History**

Kennion House was established in December 1886 as the Children’s Home at Walkerville, principally to care for Church of England children. In the early years, some parents or guardians were required to sign an agreement to place their child under the sole care and control of the home’s management committee. Parental contributions paid for a substantial proportion of the home’s running costs. In the early 1900s, it was decided to restrict the home to boys and it became known as the Church of England Boys Home. In 1955 the home was renamed Kennion House after the late George Kennion, who was Anglican bishop in Adelaide at the time of its foundation.

The Children’s Home had to deal with reports of sexual behaviour in the 1950s. A new superintendent had been appointed in 1951 but by 1954 had been advised to take ‘an extended holiday as soon as a replacement could be found’. Records show that the management committee ‘strongly favoured’ the appointment of a married couple to run the home. Until a replacement was found, an interim superintendent managed the home; under his watch seven boys were removed for ‘homosexual behaviour’.

Kennion House was licensed as a home in 1965 under the Social Welfare Act. By the beginning of the 1970s, it accommodated about 30 boys aged five to 17. All the boys were from ‘broken homes’, apart from one who was termed an ‘orphan’. They attended various local primary and high schools—an attempt by management to preserve each child’s individuality and prevent him from being labelled as from a boys home.

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10 Dickey, p. 56.
11 FYOW, s. 2, p. 5 and s. 1, p. 15.
12 Minutes of Church of England Boys Home Management Committee, discussion of name change, 21 July 1955.
13 Anglican Archives (AA), Box 162, Church of England Boys Home (CEBH) management committee minutes, 20 Dec. 1951; Box 162, CEBH management committee minutes, 9 Jan. 1954: it was reported in the minutes of an emergency meeting of the finance committee that, given the home’s ‘staff troubles’ and the superintendent’s reduced health, [name] had been advised to return to England on holidays.
14 AA, Box 162, CEBH management committee minutes, 21 Jan. 1954.
15 AA, Box 170, entry in Discharge Book A–J, undated.
Until 1972 Kennion House operated without significant input from the State Government or the Synod of the Diocese of Adelaide. Contact with the department had been limited to seeking subsidies for children if their parents failed to pay maintenance. However, the passing of the Community Welfare Act 1972 and establishment of the Residential Child Care Advisory Committee (RCCAC) two years later forced homes to become licensed in return for government funding. Under the licence, institutions agreed to adopt uniform procedures and provide a certain standard of care. Kennion House was to care for children aged from six to 16. From 1975, the department paid a proportion of each child’s maintenance and the salary of a part-time social worker. ‘Though still legally autonomous, Kennion House was now officially part of the child welfare network of South Australia.’ In 1976 the first group of girls was admitted to Kennion House. The home’s era as a large congregate care institution ended in the mid 1980s, when it was adapted for smaller group care.

Allegations of sexual abuse

Six PICs told the Inquiry they had been sexually abused at Kennion House between the mid 1940s and the 1970s. One PIC was the subject of a court order that placed him in State care during his time in the home. The other five had been placed in the home by their parents, mainly because of marital breakdown; the Inquiry did not receive any records to show that they were in State care at the time they lived at the home.

The sexual abuse allegedly occurred when the boys were aged from about five to 16 and included anal rape, indecent assault and general recollections of sexual molestation inflicted when a PIC was taken out by visitors to the home. The alleged perpetrators included staff members, other resident boys and visitors.

Abuse by multiple perpetrators

An Aboriginal man who approached the Inquiry was placed in State care until the age of 18 as a one-month-old baby in the mid 1960s. He lived at a government home and in foster care before being legally adopted. In the early 1970s, aged six, he was again placed in State care until he turned 18, when found to be neglected. Of living with his adoptive parents, the PIC remembered ‘discipline more than affection’, and at school he felt ‘the odd one out’.

The PIC told the Inquiry he was sexually abused at Kennion House, in foster care and at Otherway House. He spent several years living in cottage homes and placements with his family before being placed at Kennion House when he was 11, in the late 1970s. He remained there for about three years.

The PIC told the Inquiry that soon after arriving at the home he was sexually abused by an older resident, who forced him to engage in mutual oral sex on several occasions. The older boy also allegedly abused other boys at the home. The PIC said he felt ‘stuck’ because he had wanted to leave his family home and ‘it was kind of my choice to go there so I had to, like, put up with it’. After a while, he regarded the abuse as normal. He thought he might have reported the abuse to the home and, as a result, was ‘kind of separated from the others for a while’.

The PIC also told the Inquiry that after he had been at the home for some time a staff member forced him to perform sexual acts, starting with oral sex and developing into anal intercourse. He also recalled being taken out on weekends, usually in the evening, to a private residence in an Adelaide suburb by two men known to the staff member; and on occasions the staff member himself took the PIC out to this home: ‘I was taken there for them’. There was another boy about his age there. The PIC said he performed oral and anal sex with one of the men, while the other man

Notes:

17 These homes were licensed from 1965, but were not subject to the further conditions that later accompanied the provision of funding.
18 AA, Box 163, CEBH minutes, 19 May 1955; AA, Box 174, CWPRB to superintendent CEBH, 31 May 1960.
19 In 1972, for example, the State Government had provided financial assistance to the home by subsidising half the cost of building the deputy superintendent’s cottage, ablution block and northern dormitory. See AA, Box 165, CEBH minutes, 20 July 1972.
21 Ibid.
22 Ibid.
performed sexual acts with the other boy. These incidents would occur about once a month, and the PIC said he was given gifts to keep quiet.

He told the Inquiry he did not say anything about the abuse because he felt ‘it was my choice to go [to Kennion House]’. He said the staff member manipulated the situation: ‘It was turned around and they were doing what I wanted … like I deserved what was happening, you know’. The PIC began absconding. He was apprehended by police and returned, then suffered a loss of privileges as punishment.

The PIC also told the Inquiry he was taken on weekends to fancy dress parties in an Adelaide suburb, attended by men only. He recalled he ‘was always given tablets … a bit like Valium’. He said, ‘You were, like, teamed off with somebody … paired off’, and believes he was sexually assaulted at these parties; he recalls being ‘sore in the buttock’. Photographs were taken and ‘you were given things to keep quiet, sort of thing—either gifts or money’. He recalled waking up the following morning at one of the houses where a party had taken place. He said that sometimes the people involved in the abuse took him on normal outings.

With the exception of the SWIC, there are no departmental records for the period after the PIC was placed in Kennion House until he was released from State care at 18.

The PIC told the Inquiry that in his mid to later teens he became involved in male prostitution and developed a ‘really bad drug habit’. He reflected: ‘That’s what got me by, I suppose.’

As a result of the Inquiry he would like ‘the right ones to be held accountable for what they do to people’.

Abuse by staff

One PIC was placed in the Church of England Boys Home in the mid 1940s when aged five and lived there with siblings until he turned 14. He recalled being driven to the home in a black car with his siblings sitting in the back seat, walking up the steps and the door closing. He did not recall anything being said about why he was being sent there, and the Inquiry has no evidence that it was by court order. While no departmental client files on the PIC’s childhood were received by the Inquiry, other departmental records show the PIC’s mother left the family, the father brought in housekeepers, and the department assumed a supervisory role by visiting the family home while the father was away working. There were no records to show that the PIC was placed in State care.

The records show that eventually, through the Women Police Branch, the PIC and his siblings were placed in the Church of England Boys Home. A departmental probation officer recorded that the PIC’s father wanted to know ‘what kind of place it was’ and ‘he was told that it was excellent and that the matron was a very fine woman and that the boys should be very happy there’. Four days later, the matron notified the department of the PIC’s admission. It is recorded in documents received by the Inquiry from the Anglican Archives that the PIC’s father had been unable to care for him and his siblings after his mother left the family, and that he paid maintenance to the home for the care of the children.

Although the PIC told the Inquiry he had fond memories of Christmas at the home, he generally recalled a difficult and unvarying daily life, where after-school hours were spent on chores, with no time for sport.

The PIC described the arrival of a new staff member in the early 1950s who

... had a look on his face like a cat that was about to eat a canary, to put it in simple terms, and that’s about what he did.

The PIC told the Inquiry that one morning, when he was in his later primary school years, the staff member took him to his personal shower, told him to undress, bent him over, put his penis between his legs and ejaculated. There was no penetration. On other occasions, the PIC said, the staff member stood behind him and washed his back in the shower while masturbating himself. This happened almost daily for ‘a month or more; probably longer’. The PIC recalled that the staff member would say, ‘Don’t go saying this to the boys’ or ‘Don’t do this to the boys’.
The PIC told the Inquiry he started wetting his bed and did not understand why:

Sometimes you’d wake up in the morning thinking, well, you know, because we used to get a hiding, if we did … And you’d go, ‘Good. I haven’t wet my bed. You beauty’, but of course the sheets and that had dried during the night and it wasn’t until you got out of bed you’d see the little puddle underneath the bed. ‘Oh, gawd, here we go again.’ He got ‘a lot of flak’ from other boys about being with the staff member every morning, and developed a sense of shame because it started to register ‘what was actually happening’. It is recorded in documents of the home that the PIC was ‘causing trouble’.

The PIC told the Inquiry the staff member hit him on his ear one morning when he refused to go with him. This perforated his eardrum, requiring immediate and ongoing medical treatment by the home’s doctor and extended time off school. He said the staff member then organised for him to sleep in his lounge room, which was next to his bedroom, and gave him a stamp album, encouraging him in his collecting.

The PIC told the Inquiry the effects of the ear injury have continued in his adult life.

He gave evidence that he told his older brother at the home about the abuse by the staff member, and he assumed his brother would have told their father. But nothing eventuated:

… I was too frightened to tell anybody, because you’ve got to remember I had one eardrum buggered and I think probably in the case—with the home itself—when this happened to a lot of the boys I don’t think anybody was game enough to say anything really. I think the fear factor was there, because he was a very domineering type of person in respect of the way he stood over you, the way he looked at you.

However, he said that just before leaving the home, he was called out of bed one evening to give an explanation of events to three or four members of the home’s board. He does not know what came of this. He said of one board member:

I can even picture him now, just looking down at me as if to say, ‘You know, you’re an insignificant little fella. We don’t want to know about it. Get out of here.’

He said of another board member: ‘I don’t think he really wanted to know about it either that I can recall’. Another member had followed him back to his room: ‘I can recall her saying to me not to worry. You know, “Don’t worry about it”, type of thing, in a motherly sort of way.’

When a new staff member arrived to replace the alleged offender, the PIC felt distrustful and wary:

Well, this happened to me with this fellow. What’s this bloke going to be? I think that he—the defiance came out pretty quick and it stayed that way until I left the home.

The PIC told the Inquiry that the abuse

… to put it bluntly, buggered my life to a certain degree … Having said that, for 50-odd years I’ve just put it to the back of my mind and that’s where it has stayed …

He added:

… but every now and again I’ll read a case where—child abuse, you know. Something has happened to a kid and everything and this does come back. I get to the stage I do feel angry and I just go off on my own and just get out. You know, I’ll go and get a six-pack of beer or something like that and sit under a tree until I calm down. But most of it has gone now.

Another PIC lived at the home from the age of four to 14, having been placed there in the late 1940s by his father, who paid maintenance for his care. The PIC already had siblings in the home. The Inquiry did not receive any records to show that the PIC was placed in State care at the home. Records received from Anglican Archives show the boy had previously been placed in another children’s home, where other siblings had also lived. The department
Chapter 3 Allegations of sexual abuse

provided the Inquiry with a family file, but no client files in relation to the PIC’s childhood were received. The family file shows the PIC’s mother left the family home when the PIC was a toddler, and before his placement in the children’s homes the PIC had been placed with foster families under the supervision of the department.

The PIC told the Inquiry of abuse by the same staff member as the previous PIC. He recalled the arrival of the staff member at the home:

… there was a change. All of a sudden there was this authority thing … ‘Do this’ and ‘Do that’ and ‘You’re going to get it’, and [he] carried switches around, peppercorn switches, and he made sure what we were doing, we had to do. We worked every night … gardens, in general, work. Milking cows … he used to march around with a switch and, boy, if you were caught out of boredom, you got it … Even if you were working in the garden, you’d get it around your legs. You wouldn’t know really what for. It was more like prison, I guess, prison.

The PIC told the Inquiry his memories about the abuse came to him ‘out of the blue’ after he heard about the Inquiry on the radio. He has memories of the staff member taking him to the showers in the morning and of the two of them being naked under the shower, the staff member washing his back and buttocks: ‘I can still see the hairs on his back’. The PIC said this occurred on one occasion when he was in his earlier primary school years. He has a sense that there were ‘heavy investigations’ in relation to the staff member, which he believes included him, but at the time he denied what had happened. He said: ‘I believe that had I told them what was going on, I might have been one of the boys that did disappear up to Struan Farm’.

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The two PICs discussed above named several other boys who they believed were victims of the staff member’s abuse. One said the abuse started to ‘fester into the boys. It was the boys’ banter, it was boys’ talk, it was common talk.’ He said some of the boys who had been victims soon disappeared from the home, and he thought they went to Struan Farm.

The home’s records provided to the Inquiry show the staff member had been advised to take ‘an extended holiday as soon as a replacement could be found’ in the mid 1950s. Although the staff member continued to state his intention to return, the board terminated his employment. One PIC recalled, ‘It was cheers all around, I can tell you. We know why he never come back. Everybody knows why he never come back.’

The other PIC believed that the home’s management thought:

‘Well, let’s get him out of here before the damage is done’ … I think he was told to go in a quiet manner because of what basically had happened, because the home itself, as I understand it … relied on a lot of donations. I’m of the opinion that if this had got out, regardless of whether it was me or who it had been, and more or less got into the press whatever the case may be, I think a lot of those donations and a lot of those people that were donating and doing good things for the home would have stopped.
After the staff member left the home, seven boys were removed for ‘homosexual behaviour’, according to records from the home. One PIC recalled ‘five boys clearly being taken from the home’. Records show the person acting in the dismissed staff member’s role had ‘the unpleasant task of interviewing the parents of the boys who have been removed’, however ‘the atmosphere was happier without such rigid discipline’.

One former worker at the home told the Inquiry that when he arrived about the time of the staff member’s departure, the home’s secretary informed him that certain boys would be leaving because they had shown ‘inclinations of homosexuality and some were effeminate’. He also recalled being asked by a boy whether the boy’s older brother was going to ‘do [his] back in the shower’. He said that when he repeated this to the secretary he was told, ‘Yes, well, that’s what we’ll be having to deal with’. The former worker said, ‘We never thought of any abuse and what it caused and the trouble. It was not something we knew anything about really in those days much.’

He confirmed to the Inquiry that some boys did leave the home at the time, including those who had been ‘interfered with’ by the staff member.

The former worker told the Inquiry he was later told by another staff member that a newspaper had reported that the offending employee had been given ‘nine months for sexual harassment with boys at a boys school where apparently he had had a job as housemaster’ in another State.

He told the Inquiry he became part of a committee to do things at the home—‘like make more sport, better ovals, better conditions and everything to try and make a lifestyle that would try and correct things’.

There is no indication on the evidence available to the Inquiry that the home sought police involvement in relation to the offending staff member or professional assistance to counsel the boys who allegedly had been abused. While any conclusion by the Inquiry can be limited only to the evidence received, it appears there was disquiet in the home about the offending staff member’s conduct.

Accounts follow of two PICs placed in Kennion House by their fathers because of family breakdown. Both PICs independently told the Inquiry they were sexually abused by a worker at the home during their primary school years, and identified the same perpetrator.

One of the PICs told the Inquiry he was seven when his father placed him in the home in the mid 1960s. He said he remembers very little of his mother: ‘Just that she left. Came home one day, she wasn’t there, and never saw her again.’ The PIC said he stayed at the home until he was 11. The PIC alleged he was sexually abused at Kennion House and also at a later placement at the Salvation Army Boys Home (Eden Park). His SWIC shows he was placed in State care during his teenage years, however the Inquiry did not receive any record of a court order placing him in State care during the time he was at Kennion House or Eden Park.

The PIC recalled life at Kennion House:

Initially I really hated it, and I hated not seeing my mother and I hated not seeing my sisters, and I just hated everything, and I was just really alone, apart from my brother, and just this strange place, strangers … Then the regime in the home of having to get up and do this and do that, it was all just so foreign. It probably wasn’t until later in life that these things had a major effect on me.

The only solace for the PIC was going to the nearby River Torrens to fish and swim, usually by himself.

The PIC recalled one particular staff member to be a strong disciplinarian:

I was strapped by him quite a number of times for climbing up on the roof, stealing food, running away, not doing what you’re told, wetting your bed.

He told the Inquiry he had been at the home for only a few months when, as a privilege, a worker gave him a tin of almonds and let him feed his special pet. He said that one day the man—‘a very friendly guy’—started cuddling him and then fondled his penis through his clothing. This abuse...
developed into anal intercourse, which he said ‘really hurt me’. The PIC recalled an employee who used to give out clothes asking him why his underpants were dirty and had blood on them, but he said,

At the time I did not understand what was going on and I did not know how to stop him. I remember that after this happened I became very withdrawn.

The PIC said he felt he could not tell anyone what was happening. He started wetting the bed—this happened daily, according to the Anglican Archives files received by the Inquiry. As a result he was sent to the Adelaide Children’s Hospital to see a psychologist, but he said he felt he could not disclose what was happening to him because he was

... very, very scared of this person to the point where the appointment I had ... I did nothing more than stand against the wall for an hour and would not talk to this person.

On the second occasion he went there,

I even wet myself standing there, where I wouldn’t move and I just wanted to go and get out of there. I didn’t want to be there.

The Anglican Archives records show the doctor ‘agreed that [the PIC] was seriously disturbed’ and said he had ‘found it almost impossible to make contact ... [the PIC] was very much like an onion, when you peeled off one skin, there was another underneath’.

The PIC told the Inquiry the alleged perpetrator drove him in his car to the psychologist appointments:

That damn car is burned in my brain. He used to play with me, pretending that his car was an aeroplane, as he would drive me to the hospital.

The PIC remembered the man would stop near a park and say, ‘You won’t tell anybody will you?’ He said the abuse had been regular, but it stopped about this time. Describing its effect on him, he said:

I was always very scared and very worried. You’re always looking over your shoulder, and any free time you had you’d try to be out of the place. That’s why I used to try to spend a lot of time down the river as much as I could; ask [the superintendent] if I could go down the river; if I could go to a friend’s house; if I could do this; if I could do that. Just try to be away from the place.

After four years in the home, when he was about 11, the PIC left to live with his father and new stepmother, but he said he was abandoned again and was soon placed at Eden Park.

The PIC reflected to the Inquiry about the impact of the abuse:

Later on in life when I realised that—the initial hang-up was the sexual abuse. That was the big hang-up and that’s what you have nightmares about and you wake up about, but later on in life when you get more of an understanding and when you have children of your own, things suddenly click into place that, hang on, this was premeditated. He knew exactly what he was doing. He had picked a target and worked out how to soften that target to his advantage.

Records received by the Inquiry from the Anglican Archives show another PIC was six when his father placed him in Kennion House in the late 1960s. He was discharged about 18 months later. The Inquiry did not receive any records showing that the PIC was in State care when he was at Kennion House.

Before being placed in Kennion House, the PIC recalled ‘quite clearly … my father throwing my mother out naked—out the front door on to the street’. He now knows that ‘she ran away for her own safety because she was getting beaten up all the time’. The PIC recalled missing his parents while he lived at the home.

He told the Inquiry the first instance of sexual abuse was in a shed, when a worker pulled his overalls down and exposed himself, then put his hand on the PIC’s genitals and got the PIC to do the same to him. The PIC said he was ‘terrified, horrified, traumatised’ and that his ‘mind was shutting down’, but he didn’t tell anyone about the abuse:
3.1 Institutional care

‘If I’d have told anyone, I most probably would have got the strap for lying. They wouldn’t have believed a five-year-old or a six-year-old.’

On the second occasion, the same worker allegedly repeated his abuse in the same manner, but this time at the toilet during a service at St Andrew’s Church. The PIC said he had to leave the service to go to the toilet, where the worker was waiting for him. He said he was ‘scared and petrified’ again. After a third similarly abusive occasion in the boiler room, for which he said he was given five cents by his abuser, his ‘senses were shutting down’.

On another occasion, while he was lying in the sick room at the home, he had been ‘orally raped’. He could not see who this person was: ‘There was this weight upon my chest, or upon me, and I was—well, gagging ...’ The PIC said he also believes he was anally raped at that time because when he went to the toilet he noticed he had been bleeding from the anus and ‘I was very sore’.

He remembered that a particular staff member was ‘free with handing out the strap or the cane’, and told of an instance—after the second time he was abused—when he and others were caught throwing a Bible in the church, and the boys had to ‘drop our strides and bend over the bed, and straps on the rear end and caned’.

The PIC told the Inquiry that the sexual abuse ‘changed me from being, I don’t know, a fairly easygoing sort of a kid … to someone that really couldn’t trust or have any trust in adults’. The PIC said he feels shame and guilt about what happened, and ‘I thought that I had something on my forehead saying, “Abuse me”, you know’.

He told the Inquiry that when he left the home he told nobody about the abuse but would be reminded of it in his primary and secondary years at school:

All the time, especially if we had a sports day and they cut the grass. Walking to school or from school, the smell of freshly cut grass would trigger it.

He later disclosed his abuse to the Anglican Church and started receiving counselling. Several years later he started legal action, and a confidential settlement was reached. He also made a submission to the 2004 Board of Inquiry into the handling of claims of sexual abuse and misconduct within the Anglican Diocese of Adelaide. He said:

For what they’ve done to me as a child, it’s made me a stronger person and given me a very good character. I think I’ve got morals that are good and I’ve got integrity, and they’re things they can’t take.

A PIC told the Inquiry of being placed at the home in the late 1960s, when he was about five. Other siblings were also placed at Kennion House; their parents had separated and their grandmother was no longer able to provide care. The initial placement was short lived and they returned to live with their grandmother, but the PIC soon went back to the home, staying there until he was about 10. The Inquiry did not receive a copy of a court order placing the PIC in State care in the home; and the PIC told the Inquiry he cannot recall whether the department went to the home. The department told the Inquiry it could not find any records of the PIC’s childhood.

According to records received from the Anglican Archives, the PIC was reported by the home to be ‘quiet, shy, slow to mix. Slow to talk at first. V. tidy and able to dress on his own’. The PIC said he felt very disorientated in the beginning:

I had no understanding really of what was happening; just really feeling very much upset and I remember peeping in to see everyone in the dining room and I was very scared—very, very scared.

He said that soon after his arrival he was playing near the laundry when a staff member took him to a flat at the back of the teenage section; the curtains were drawn in the room and it was dark. The PIC remembered that they each took their clothes off and the staff member fondled his genitals and penetrated his anus area with his finger. ‘I knew it wasn’t right, what he was doing.’ The PIC said he became upset and cried, and the incident ended. The abuse continued, but he did not feel he could say anything:

He would visit at night … once when I was sick, he came and got me from my bed and took me … to that flat … but by this stage, he’s developed a
Chapter 3 Allegations of sexual abuse

relationship with me, where staff knew that we were close.

The PIC told the Inquiry the staff member called him ‘his pet. He made me feel special, and people just accepted that we were close’. They went on outings together.

But the PIC said he also used to hide from the staff member under the house, which was accessed through a trapdoor. Also, school for him was like ‘an escape’ from the home, but he said he ‘always had a problem of peeing my pants’ and he kept a spare pair with him. He recalled that as he got older he ‘started to feel bad about myself, knowing that it was wrong, feeling very isolated and feeling separated’ but the attention, such as riding on the staff member’s shoulders, made him feel important: ‘A sense of feeling wanted, needed, loved, maybe’.

The PIC had recollections of sexualised behaviour by boys in the home, and said it was evident to him and others at the time that the staff member was involved with other boys.

The PIC told the Inquiry that the staff member left the home and it was not known what had happened to him. Soon, he and other children were called into the office and told to say goodbye to him on the telephone. The PIC said he ‘went silent. I wouldn’t talk to him because he hadn’t been around and I felt betrayed that he hadn’t been around’.

Later, the PIC told the Inquiry, his mother asked him whether the staff member had touched him, but he denied it: ‘I felt unsafe to tell her ... in fear of my life’ because the staff member had threatened him previously in the deep end of a swimming pool when his hands were down his bathers, telling him, ‘You will not tell anyone’, or words to that effect.

The home’s visitors’ book for the relevant time reports that it was ‘an unsettled month’ because the staff member had been dismissed. The book refers to details of the dismissal being set out in a management report. However, no such report or minutes of the committee for the relevant period were located in the Anglican Archives records received by the Inquiry. Investigations by the Inquiry did result in finding articles published in The Advertiser at the time, showing that the staff member was to appear before the Local and District Criminal Court for sentencing on a charge of indecent assault on a male person. The newspaper reported that the staff member’s solicitor had said:

... there had been 18 occasions of assault against the complainant, a 17-year-old youth whose name had previously been suppressed from publication. The boy had accepted $1 each time he went into [the staff member’s] room ...

The Advertiser subsequently reported the chair of the home as saying:

On the first intimation to the committee that an offence was suspected of having been committed, the committee had directed that it be reported to the police. This was promptly done.

The PIC also told the Inquiry that one evening when coming back from Cubs in the car with another staff member, this man, who was popular among the boys, put his hand on the PIC’s leg and moved up to his ‘private area’. He said, ‘I just froze. Because of what happened with [the other staff member] ... I didn’t want to go down there again.’ But he said he felt in control and pushed the staff member’s hand away.

The PIC said he was a ‘bit nervous’ coming to the Inquiry,

... and putting myself through, you know, like, talking about dark places. I don’t open up to many people and I don’t really trust a lot of people and I don’t have a lot of confidence. I know I’ve pushed myself to get where I am today...
3.1 Institutional care

St Vincent de Paul Orphanage (Goodwood Orphanage), Catholic Church, 1866–1975

History

The St Vincent de Paul Orphanage was established in 1866 for orphaned and destitute Catholic children. It was overseen by a board of management consisting of Catholic priests and laypeople. Originally at rented premises in Walkerville, the orphanage was relocated several times, finally to Goodwood.1 Its supervision was transferred to the Sisters of St Joseph in May 1868 and the Sisters of Mercy in 1890.2

The Destitute Persons Relief Act 1866–67 permitted the government to pay financial subsidies to private institutions for the care of children; and in 1867 the orphanage was proclaimed an industrial school under the Destitute Act.3 Children at Goodwood were initially housed in temporary structures, but by the end of the 19th century work had begun on a new building. Construction continued over the next 40 years as the number of residents rose. In 1911 it was reported that six sisters were caring for 91 children; in the mid 1920s, eight sisters had 72 girls and 60 boys in their care.4 During the late 1940s and early 1950s, immigrant children, mainly from Britain, also arrived at the orphanage.5

In 1941–2, the Catholic Church decided to ‘rationalise’ the management of its homes, which meant segregating boys and girls—a policy that continued until the late 1960s. Girls were moved from St Joseph’s Orphanage, Largs Bay, to Goodwood and boys were transferred from Goodwood to Largs Bay, with older boys moving to the newly reorganised Boys Town at Brooklyn Park.6

Unlike government institutions, which increasingly emphasised the need to prepare residents to live and work in the community, the orphanage remained a ‘closed environment’.7

In 1975, as a result of the move away from large congregate care for children, the orphanage closed and residents were transferred to cottages in the suburbs, including Waverley Cottage at Dulwich, Bon Agor Cottage at Royston Park, Yaroona at Westbourne Park and Orana at Plympton.

Allegations of sexual abuse

Fifteen women gave evidence to the Inquiry that they were sexually abused as girls while placed at Goodwood Orphanage from the 1940s to 1970s. The alleged perpetrators included staff, other girls, outside carers, visitors to the orphanage and family members.

Some of the women told the Inquiry they gave evidence to the recent Senate Inquiry into child migration8 and some have sought resolution of their grievances with the Catholic Church.

From records received from the department and the Catholic Church’s Professional Standards Office (PSO), the Inquiry established that two of the PICs were in State care while at the orphanage; one was a child migrant and the other was placed in State care by a court for being destitute.

There were generally few records received in relation to PICs at the orphanage, however from the available records it appeared that 12 of the PICs were not in State care and had been privately placed. There were no available records for the other PIC, which meant that the Inquiry was unable to determine whether she was in State care.


2 Foale, p. 21; McLay, p. 199.

3 Foale, p. 18.


5 Senate Community Affairs References Committee 2001, Lost innocents: righting the record – report on child migration, Canberra, submission no. 127 by the South Australian Department of Human Services, which claims that of the children who came to South Australia during the 1940s and 1950s, ‘predominantly female’, ‘were placed in the care of the State and most girls were placed initially at the Goodwood Orphanage’.


7 Ibid., p. 211.

8 Lost innocents: righting the record.
Chapter 3 Allegations of sexual abuse

Abuse by multiple perpetrators

A PIC was about 13 when placed in Goodwood Orphanage in the mid 1950s after her parents had separated and relatives were no longer able to look after her. She stayed at the orphanage until she was 17. The department told the Inquiry that it could not find any records on this PIC and the Inquiry did not receive any records that she was in State care when she was at the orphanage. Records were received from the church PSO about her time at the orphanage.

The PIC told the Inquiry she found the orphanage 'very frightening because there were heaps of strangers there'. She was not introduced to anybody and was called by her assigned number. The orphanage 'was just a horrible place' to her:

I thought I would die before I left … The kids used to say, ‘We’ve got to get out of this place’. It was often something that was said.

She told the Inquiry of incidents of sexual abuse and attempted abuse. On one occasion she stayed with an orphanage worker and his wife and children: ‘They seemed quite a nice family’. She alleged the worker made an ‘embarrassing pass’ at her at the kitchen table, and on another occasion, when he took her back to the orphanage, she alleged ‘he tried to kiss me in the car’. However, she said his wife later questioned her because her husband ‘had told her what happened’. After she told the wife about the incidents, the PIC said, the woman pushed and hit her and said: ‘Don’t you dare tell anyone’ and, ‘You probably just stopped my daughter from becoming a nun’. She did not tell anyone about this but remembered ‘crying in bed for a couple of days’ and being given a tonic from the doctor. She said that after she had left the orphanage the worker asked her to go on an interstate trip with him, but she managed to deflect the approach. The PIC said she never told anyone about the worker’s conduct.

On one occasion, the PIC alleged, she was sent from the orphanage on holiday with a family in a regional area of the State when, at night on the bed, the father gave his daughter ‘a passionate kiss’ and insisted the PIC kiss him, explaining that he and his daughter ‘… do it all the time’. But the PIC said she refused: ‘You were very apprehensive about who you were going with in the holidays because they were strangers’.

On another occasion, in her final year at the orphanage, a priest had come in for a special mass for the nuns. The PIC said she had to get the meals and the nuns were in prayer at the time. She took lunch to the priest and as she put it on the table he chased her around the table and eventually ‘pushed’ her against the wall and ‘pushed his hands up and down’ her chest. He smelt of alcohol. She said she ‘ducked down and got under his arm and ran out the door’. After that,

…I went to mass, I’d look up and he seemed to be smirking … I just hated it … that was one of the reasons why I hated being there. Then finally I would just not look at him. I would just go in there and look down all the time.

The PIC said she recounted the incident to an orphanage visitor who ‘used to go and talk to the nuns. She used to make out that she was our confidante’. She does not know whether the visitor told the nuns about her allegations; they are not contained in the PIC’s records from the church PSO.

The PIC told the Inquiry she left the orphanage at 17 to work, and in later years studied and then worked in a profession. She says of her experiences in the orphanage, ‘I’ve always hidden and not talked about [it] and kept it quiet …’

The PIC supports the idea of appointing an advocate in whom children can confide, and she told the Inquiry: ‘I don’t ever remember anyone coming and asking us at any time at all in our life how were things, were we being treated properly’.
Church records received by the Inquiry show that in the mid 1950s, a PIC then aged six was placed in the orphanage by her father and stayed until she was 14. She told the Inquiry that after her mother left the family home to be in a new relationship, her father contacted Catholic Welfare for assistance. The Inquiry did not receive any records showing that the PIC was in State care while at the orphanage.

The PIC told the Inquiry her days at the orphanage were ‘pretty terrible’. She was a bed wetter and suffered physical punishment as a result:

… they used to belt you if you wet the bed, and I used to wet the bed every day, so every day I got thrashed, usually with a feather duster or a wooden hairbrush. The nun … used to come in about 5.30, I think, and come to my bed and pull back the blankets and thrash me, and then I had to take my sheets downstairs to the laundry and wash them.

The PIC told the Inquiry that when she was about seven or eight an orphanage girl who she believes was older than her used to get into her bed and sexually abuse her. She would grab the PIC’s hand and put it ‘in places’ on her; and she penetrated the PIC with her fingers. The girl would follow her to the toilet and do sexual things to her there as well. The PIC said this happened about twice a week over a year, and she was...

… too scared to say anything to anyone and I just kept it to myself—the girl was quite aggressive with me and she frightened me … I think feeling ashamed and also her aggressiveness contributed to me not being able to say anything about it.

The PIC reflected:

I don’t think I was educated enough … They didn’t teach you about sex there. They didn’t teach you those things. Even when I got my first period I was scared to death because I didn’t know what was happening.

She told the Inquiry that on one occasion when she was 12, she left the orphanage for a holiday with her mother and new husband, who were both alcoholics. The PIC alleged her mother’s husband raped her on her first night. She ran away and disclosed the abuse to her father but ‘I didn’t know how to tell him what had happened, and I just said that he had put his thing between my legs and that he hurt me’.

Her father took her back to the orphanage and she does not know what happened after that ‘… but, to me, it was like I’d done something wrong’. She does not know whether anybody at the orphanage knew about it. She told the Inquiry that years later she reminded her father of her disclosure but he could not recall her telling him ‘… so I don’t know if anything was ever done’.

The PIC’s records from the church PSO do not contain any allegations of sexual abuse. They show that when the PIC was 14, her father advised the orphanage that his daughter and her sibling would not be returning. The PIC told the Inquiry that living with her father was difficult because he was an ‘alcoholic’. Church records show the department was concerned about the PIC’s situation. Apart from a SWIC, the department did not provide any records relating to the PIC’s childhood. In the mid 1960s, the PIC was placed in State care to live at the Convent of the Good Shepherd (The Pines), until the age of 18, after a court found her to be uncontrollable. The PIC told the Inquiry she can recall living in a house with a prostitute just before this occurred and said she met an older man with whom she had a sexual relationship. While she was living in this house ‘the police came and took me, and it was after that that I went to The Pines’.

The PIC said she believes what happened to her sexually as a child affected her later, but it was more the ‘beatings’ and the ‘thrashings’ at the orphanage. What happened, she said, also affected her ability to make choices about relationships:
A PIC told the Inquiry she used to run away from home, and she believes she was ‘under child welfare’. She thinks she was in Goodwood Orphanage for about one to two years between the ages of eight and 12 in the late 1950s or early 1960s, but does not know whether her parents or child welfare authorities placed her there. The Inquiry did not receive a record of a court order placing her in State care, or any relevant records from the church PSO or department.

The PIC could not recall the exact name of ‘Goodwood’. She could remember ‘the space, the height of the buildings’ and the play areas but not the names of children or nuns. She remembered ‘being upstairs in a room—a big … dormitory-type place and lots of kids crying’.

She recalled that the institution was ‘absolutely horrible … The whole time I was there I had to live off my wits’. She said she had general memories of being sexually abused on several occasions by a nun who ‘used to play with me and I remember there was another nun watching’. She also recalled another occasion of a nun lying across the bottom half of her body in a sexually suggestive way, wearing her underwear only—‘I just remember her being on me and trying to push her off’—and another nun performing oral sex on her.

The PIC further alleged that a man who owned a shoe company took her out of the institution and to his home for prostitution. She has memories of running away from the orphanage and being in an unused factory with street children and adults, and being taken to a house where she got ‘sexual instruction’. She recalled living on the streets and on one occasion being taken back to the institution.

The PIC told the Inquiry she is ‘angry because I wasn’t protected’ while she was in care, but said: ‘It means a lot to me to tell my story to somebody, officially’.

In the late 1950s, a PIC was privately placed in the orphanage when she was three, according to records received from the church PSO. The PIC told the Inquiry her parents had separated and placed her and her siblings in care because of debt. Her mother was abusive and had substance abuse problems, and her father worked away from home and was unable to cope with the children. The records show the PIC was immediately placed with a foster family arranged by Catholic Welfare. She was placed back in the orphanage when she was about five in preparation for school, and stayed for about 18 months. After a short time living at her family home, she was placed in Morialta Protestant Children’s Home. She alleged she was sexually abused in both the orphanage and at Morialta. The Inquiry did not receive any records placing her in State care or any departmental client files, and the PIC cannot recall any departmental involvement at the time.

The PIC said the orphanage was

… awful, the food was awful, the other children treated you awfully. The nuns were all nasty and violent. They were all very, very—you know, just overworked. Who knows?

On many occasions, older girls would hang her from the balcony by her ankle or wrist. She believed the nuns knew about this but ‘they didn’t stop it. They actually, more often than not, left the older girls to discipline you or punish you, you know, or look after you’. She said there was never any affection.

The PIC told the Inquiry that on one occasion, a youth group took her on an outing from the orphanage to a park, where a man took her to a car, removed her knickers and raped her. Back at the orphanage, she said, she was punished because she had no knickers:

And I was punished on the day I was raped, because obviously I had no knickers when I got back to the orphanage because, I don’t know, he kept them, took them. I don’t know what he did with them.
She told the Inquiry that after the assault she started wetting her bed, for which she was ‘punished severely’. She said she did not feel as though she could talk about what happened to her and, while on holiday with foster parents, ‘I didn’t know what it was, to tell them’.

The PIC also recalled a worker at the orphanage taking her to a cottage and touching her in a sexual way. She remembered that the girls ‘weren’t allowed to go near him. If it was found out that you’d gone near him or been with him you were in huge trouble, huge’. But she said, ‘The thing that I remember—the worst experience was when I was raped, so that overpowers anything else other than going into the cottage.’

The PIC said she still cannot confide in others because ‘even in the orphanages or homes you couldn’t confide in one of the other kids, because it was one for all and all for one’.

A PIC’s father placed her in the orphanage in the early 1960s, when she was about four or five. The Inquiry did not receive a record to show that she was placed in State care. The department informed the Inquiry that no records about her exist, and the PIC said she cannot remember seeing anyone from the department when she was in the orphanage. Records from the church PSO indicated that the PIC’s mother had left her father. The PIC told the Inquiry she was sexually abused while placed at the orphanage—on holiday leave and by her father when he took her on outings—and also when she was sent to another placement.

She initially stayed in the orphanage for about four years in the late 1960s until she was about nine. One of her siblings was living there with her. She recalled the orphanage as a ‘humungous, absolutely huge, scary place’. For her, the nuns generally were ‘quite scary’ and she was hit on the hands with a cane. She said, ‘We had a few nasties’, and I remember being told I was going to go to hell a lot. That was quite a regular occurrence as we were growing up … I don’t think I was mistreated but I don’t remember being happy …

The PIC told the Inquiry she was sexually abused on one occasion when she was billeted with a family on holiday leave. She alleged the father of the family took her for a drive in his truck, parked in sand dunes, exposed himself and tried to have intercourse with her.

The PIC also told the Inquiry that when she was ‘very, very young’, her father regularly took her out of the orphanage on weekends and molested her in a caravan, making her perform oral sex on him. She thought her sibling went with her on these occasions. She said her father rewarded her with gifts and money, which she took back to the orphanage and would ‘have to sort of hide it from the nuns’.

She said that many times when her father came to the orphanage to get her, she and her sibling ran away and hid: … quite a few times they would struggle to get us. We’d be hiding, like under the beds and anywhere that we could find … They thought that we were just naughty and didn’t want to go to him.

The PIC said she did not tell anybody at the orphanage about the abuse; however she recalled being at a sports day at another home where her other siblings lived, and one of the nuns hiding her as her father approached.

The PIC told the Inquiry one of her siblings told a nun about her own abuse by her father, and her father was imprisoned as a result. However, the PIC’s records from the church PSO show that near the end of her first year at the orphanage, her father was imprisoned for indecently assaulting another child, not the sibling, and that Catholic Welfare knew this. Records indicate that ‘allegations’ were made against the father by a sibling after his release from prison, while the PIC and her sibling were still living at the orphanage. The nature of the allegations is not explained in the records and their outcome is not recorded; it is recorded that the father felt ‘disgusted’ by the allegations and wanted the PIC and the sibling who made them to be either adopted out or placed in long-term foster care. The PIC told the Inquiry that after her sister’s disclosure ‘… all of a sudden I’m fostered out and she’s fostered and that was all the beginning of another traumatic time in my life’.

3.1 Institutional care
In the late 1960s, when the PIC was about nine, Catholic Welfare placed her with a foster family, with whom she lived for about five years: ‘I hated every minute of it’. She said that the orphanage had sent her on holidays with the family before placing her permanently with them.

The PIC told the Inquiry she thought the department was involved at one stage when she went with the family. Church PSO records show the foster mother was advised that permission would have to be sought for the girl to remain permanently at the foster home, and that ‘this would mean that their home would have to be opened to inspection to the Department of Social Welfare’. The records contain a copy of a letter requesting permission from the director of the department for the PIC to be discharged from the orphanage and placed with the foster family in accordance with the provisions of section 170 (1)(c) of the Social Welfare Act 1926–1965. It is recorded that permission was received.

The PIC told the Inquiry that the foster father started to sexually abuse her while she holidayed with the family: ‘He was touching me every chance that he could get’. She said this developed into oral sex and masturbation.

The PIC remembered that on one occasion when she was 11, the foster father allowed his own father to abuse her when she was playing the piano at his house; to ‘have a grope’ and put his hand down her pants. She said: ‘I remember, like, freaking out and screaming’.

The PIC told the Inquiry that the foster father hit her with a leather strap ‘to keep my mouth shut, and I reckon it used to happen quite often as I got older because I was getting a bit more rebellious’.

Reflecting on the effects of her childhood abuse, the PIC said:

> I didn’t know the difference between having sex with someone and just making love to someone, or who I can and who I can’t, you know? That’s the sort of thing I never had because I was never taught that. It’s got to be instilled in a person, a little person when they’re growing up …

She also said she ‘went to many, many years of therapy to get rid of all this’ and ‘I lived in another person’s body most of my life. I’m just starting to come back into mine.’

Records received from the church PSO show a PIC was placed in Goodwood in the 1970s for about a year when she was nine. Her extended family was unable to care for her after her mother left the family home. The PIC recalled, however, that she ‘never felt neglected’ by her mother. She told the Inquiry her father was violent and that he and her brother sexually assaulted her before she was placed at the orphanage.

The Inquiry did not receive any records from the department in relation to the PIC’s childhood. However, PSO documents show the department paid a subsidy while the PIC was in the care of Catholic Welfare. The PIC could not recall any contact with the department during her time at the orphanage. The Inquiry did not receive any records to show that she was in State care while at the orphanage.

Although the PIC enjoyed the ‘sense of … belonging to a larger family’ that life in the orphanage offered, she recalled punishment by a particular nun who

> ... used to use the cane and ... the buckles of belts and jug cords ... without warning. [The nun would] grab you by the hair and she’d grab you by the arm, and she’d just drag you out of the dormitory and you’d be kicking ...

The PIC said that ‘sometimes you just never knew’ what provoked this behaviour. She told the Inquiry this same nun sexually assaulted her weekly; she would ‘pull the bed … sheet down and the blanket down’ and digitally penetrate her. The PIC said she believes the nun abused other children, and the children would protect each other, but ‘if you went to say anything, you’d be taken downstairs and flogged’.

The PIC alleged that after six months in the orphanage, one and sometimes two male visitors started to sexually assault her. She would

> ... hear footsteps coming up the steel stairs and along the balcony and into our dormitory. [These men] would take a young girl with them and they
would come back an hour or so later … Some of the younger girls used to refer to them as ‘the tickle men’.

She said she was often taken from her bed by the men, who made her stand facing a wall with her hands flat against it while they fondled her and also ‘entered my backside area’.

The PIC said that one night she told one of the men to leave the girls alone, and he ...

... dragged me from bed by the feet and dragged me along the floor. He took me up to the third floor attic where he took off his belt and undressed me. He made me lay across his lap while he belted me across my backside and legs. I recall him telling me if I were to say anything, no-one would believe me as I was the devil’s child.

She alleged the same man also sexually abused her and a sibling in an office after a school fete. The PIC told the Inquiry that a nun at the orphanage gave her medication at night to make her drowsy. She believes this was connected to the abuse.

She alleged that on one occasion one of the men ‘slung me over his shoulder and took me to the laundry at the back of the orphanage, where he raped me’. She started to bleed and was ‘belted’ afterwards by the man for being a ‘dirty girl’. She alleged she was then forced to take her clothes off and sit in a drain.

The PIC told the Inquiry she often spent school holidays with families while at the orphanage. She alleged that a father in one such family anally raped her in the stables on their property on two occasions. She was ‘too scared to say anything’, and he would put his hand around her mouth as if to suffocate her if she tried to speak: ‘That was one of the threats after the abuse’.

She recalled she had to return to this home on a few occasions, but she ran away during the night and followed the bus stops back towards the city. The police would find her and take her back and she would run away again. She said she was not asked why she was running away, but was punished with the cane by the nuns and told:

... that I was just naughty and that I should learn to behave, and if I learnt to behave, people would treat me better … In the end I didn’t have to go there any more.

The PIC said she saw school as an escape from the abuse, but in the orphanage,

I don’t think I felt anything really, to be honest. I know that—terrified would be a word, and scared, and silenced, and I think it’s taken its toll on me …

Although she did not disclose the abuse she suffered, she believes that the nun who medicated her and one of the nuns in charge ‘surely knew of the sexual abuse. These people were in charge and did nothing’.

As an adult, the PIC believes she still has a big problem with confidence. She told the Inquiry she had been too scared in the past to come forward: ‘My hope is that I will be seen, heard and believed’.

Abuse by staff

A PIC was six when her mother placed her in Goodwood Orphanage in the early 1940s for about four years. She told the Inquiry her mother was unable to care for her, her father was an alcoholic and there was violence in the family home. The PIC recalled her mother telling her before she went into the orphanage that she was going on holiday and would have a ‘wonderful time’. The Inquiry did not receive any documents to show that the PIC was in State care at the orphanage, however records show she was placed in State care after running away from Goodwood when aged about 11. The PIC said she was sexually abused at the orphanage and later in foster care and boarding placements. Departmental and court files show one perpetrator was convicted of indecently assaulting her.

The PIC told the Inquiry a nun who did the night rounds sexually abused her in the orphanage’s attic:

... you’re laying in bed and you’re listening for the beads and you’re listening for the angelus just, you know, to be sung and I used to think, ‘Will she come tonight? I hope she doesn’t,’ and then I’d say, ‘Our Father, and Hail Mary’ and you know, and
then you hear the click of the beads and she would come, yes, and she would take me and come up to the attic.

The PIC alleged that in the attic, the nun would ‘feel’ her ‘down below’ and want her ‘to lick and suck her breasts’. The nun swung from being loving to telling the PIC she was ‘a dirty little girl’. The PIC said the nun, who told her not to tell anybody about the abuse, also locked her in the attic sometimes. She did not know how often the abuse occurred and said: ‘Sometimes it seemed to me that it always happened and sometimes I’d make myself believe that it never happened—or try to’.

The PIC said she told the priest in the confessional that the nun had been doing ‘rude things to me’. His response was to call her around to where he was sitting and ask her to show him where the nun had touched her. She said she took her pants off and the priest patted her in the genital area and accused her of lying: ‘I lost my faith in religion then’.

The PIC said she never told anyone else what had happened to her, although she spoke to a counsellor when she was in her 70s. She said: ‘I wouldn’t even tell my sisters … because I was ashamed and it was my fault … I mean, I was so damn scared and so frightened’.

After four years at the orphanage, when she was about 11, she ran away, carrying her younger sister: ‘I couldn’t take any more’. A probation officer’s report on the PIC’s departmental file states:

She said she was unhappy [at Goodwood Orphanage] and could not bear it any longer. The mother said she would not, under any circumstances, allow the children to return to the Orphanage … she was prepared to have them committed by the State as ‘Destitute’, as she considered that to be in the future interest of the children. She was sure that the children would then not be unhappy …

Departmental and church PSO records received by the Inquiry do not contain any of the PIC’s allegations of sexual abuse at Goodwood.

The month after the two sisters ran away, a court found them to be destitute and placed them in State care until they turned 18. The PIC told the Inquiry her departmental officer asked her why she ran away from the orphanage, but ‘I wouldn’t say. No, you never tell.’ She had ‘never stopped’ thinking about her experiences.

A PIC who gave evidence of sexual abuse at Goodwood told the Inquiry she and her siblings also suffered sexual abuse, as well as alcohol abuse and violence, in the family home in the early 1950s. The PIC’s mother placed the children at the orphanage in the late 1950s, when the PIC was six, and she lived there for about five years.

Church PSO records show the PIC’s parents separated and that her mother was unable to care for the children. They show the family was ‘known to the Children’s Welfare and Public Relief Department’ and received financial assistance from the department. Her SWIC shows she was placed in State care when she was nine after a court found her to be destitute, and she was placed with the orphanage matron. The PIC alleged she was sexually abused in later placements with her family, at the Convent of the Good Shepherd (The Pines) and in foster care.

The PIC told the Inquiry the orphanage was ‘fantastic until I was raped’, and said, ‘I had good schooling, food’. She recalled a regime of harsh punishments: ‘If one person done something wrong, you all got whipped, you know. Like, they’d lock you up in things. They [the nuns] were aggressive.’

The PIC alleged a worker she did not know raped her in an upstairs bathroom when she was 10. From the available records, the PIC was in State care at this stage. She said she was alone at the time, cleaning the bathroom, when the worker entered, forced her to the floor and began,
... you know, like, pulling my pants down and things like that, and I can remember hitting my head there at one stage ... yes, he penetrated me; yes, the pain was excruciating.

The PIC remembered bleeding as a result of the assault and seeking help from a nun. She recalled being able to explain only that ‘he was rude to me ... you don’t say “rape”; you don’t know at that age’. She said the nun did not ask what she meant and ‘scruffed me; shook me … and I got told off for being down late because I should’ve been down, and that I’m not to cause trouble’. She said she was not given any medical assistance.

The disclosure is not included in her church PSO records. Her SWIC notes of her time at the orphanage: ‘No complaints. Is a quiet child’.

The PIC began absconding from the orphanage and was placed with her family soon after. She told the Inquiry that during her years in care she was missing Guidance … Discipline. Direction. Education. Privacy to my body that belonged to me. No rights; no choices—I can go on and on and on. But life was dealt that way. You know, you can’t change that.

Another PIC told the Inquiry that her mother died when she was a baby and she was placed in Goodwood Orphanage in the mid to late 1950s by her extended family, when she was about seven. She stayed for about two years.

Although no records were received from the department about the PIC’s childhood, the church PSO records indicate that an officer of the department referred the PIC and her sibling to Catholic Welfare for placement—her placement in the orphanage and that of her sibling in another children’s home are confirmed in a file letter from the welfare bureau to the department. The PIC cannot recall anyone from the department visiting her at the orphanage. The Inquiry did not receive any records to show that she was in State care when she was at the orphanage.

Of her arrival at the orphanage, the PIC recalled,

My father and [aunt] went into an office, and this nun came and took me away. I never had a chance to even say goodbye to them. I was just taken away. And I had no idea where I was. I just remember this real big door … and being led into a big hallway, this big, this huge place. Just seemed so monstrous, the front entrance of it … it had huge, high ceilings.

The PIC told the Inquiry she recalls the nuns at the orphanage as ‘very inhuman’. One nun in particular ‘seemed to get great pleasure and delight in denigrating and humiliating us’. She recalled being hit on the back with a strap ‘whichever way you were standing’ and remembered blood drying on her clothes and not being allowed to shower to wash it off.

The PIC told the Inquiry she was sexually assaulted soon after her arrival at the orphanage. She alleged a man she believes may have been a priest sexually assaulted her.

She said a nun took her to a room on the ground floor, where a man put her face-down on a table, lifted her dress, removed her underpants and: ‘The next thing I know is I’m in this excruciating pain because he stuck his fingers up my little bottom’. She said she now believes he was masturbating at the same time. He allegedly told her she was ‘worthless’ and that she deserved to be treated in this way; and she should not tell anyone because no-one would ever believe her. She said she bled badly and the man returned her to the nun, who put her to bed.

The PIC told the Inquiry this abuse occurred possibly twice a week over some time, and would follow a similar pattern. Sometimes the nun who took her to the man would beat her, and she would try to run away, only to be taken back again.

She described one occasion when the man was digitally raping her:

He pushed so hard, he pushed me off the table and I hit my head, and I was in so much pain, my head was so sore, my bottom, and flying off the table …
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She recalled retaliating on the final occasion, which was at the cottage on the premises. She tried to resist, kicking and using her fists, and the man dropped her on the floor. There was yelling and he called her a ‘worthless nothing’ and told her to go.

The PIC told the Inquiry she did not tell anyone about the abuse at the time and thought she would not be believed. She recalled that she felt

... so lost, so lonely, so sad, so worthless ... Oh, I cried every day. I cried myself to sleep every night. I used to go off into the toilet any time, and I would just sob ...

The PIC left the orphanage when she was about nine and spent the rest of her childhood in foster care. She said she did not disclose the abuse to her foster mother because by that time ‘it was all blocked, everything was blocked’.

She has recently met a person she describes as her ‘rock’, who gave her the ‘strength to come forward’. She said that in approaching the Inquiry, ‘I want to be believed. I want some form of justice …’

A PIC told the Inquiry her father was a violent alcoholic and ‘used to lay me out with an iron cord across the room’.

The PIC believes her family placed her and one of her siblings in the orphanage on two occasions when she was about 10 or 11, because her mother had to work. The few records from the church PSO show the PIC and her sibling were twice placed at the orphanage in the early 1960s, the first placement being when the PIC was 11. The department said it could not find any childhood records of the PIC and the Inquiry did not receive any records to show that she was in State care.

The PIC recalled a life of hardship in the orphanage, cleaning and scrubbing toilets and ‘being bashed and terrified and hungry’. She said nuns hit the children with sticks in the playground, and recalled eating ‘nothing decent’ and just bread and jam for dinner at night. ‘They didn’t celebrate anything,’ she said. ‘We were just nothing. We were just numbers in Goodwood.’

She told the Inquiry she slept in a dormitory with her sibling, but they were not allowed to get up at night to go to the toilet and were punished for wetting the bed. She said she would allow her sister to urinate in her bed in the morning to protect her from punishment: ‘I used to get belted every day’. When they wet the bed, the nuns would put the wet bedclothes over their heads and make them walk around.

The PIC said that during her first stay in the orphanage a ‘horrible woman’ would sexually abuse her in the dormitory in the middle of the night. ‘The woman used to stick her fingers inside me and masturbate while she was doing it.’ The PIC said the woman may have been a nun—‘she had real short hair’ and she thought she wore a habit sometimes. She alleged the abuse occurred twice a week.

The PIC said she told nobody of the abuse, including her mother:

I wouldn’t say anything because I was too scared they were going to get my [sibling], and they wouldn’t believe me anyway. They’d never believe you, you’re only a kid.

In her early teens the PIC was placed in another children’s home interstate until she was ‘thrown out’ in her mid-teens.

The PIC thinks counselling has helped her deal with her childhood experiences in care, and said: ‘I don’t think I’m nothing any more but it’s only in the past year or two that I haven’t thought that’.

Abuse by other residents

A PIC was placed by her mother in Goodwood Orphanage in the mid 1950s on her eighth birthday; she recalled her mother making her a blue birthday cake that day, then getting out a suitcase and taking her to the orphanage. The Inquiry did not receive any records that she was placed in State care.

She believes her parents had separated when she was about four, and later her mother’s boyfriend sexually abused her.
The PIC said she hated being at the orphanage, although she liked the religious side of it. There was no television, radio or ‘down-time’ and they were always making labels, polishing floorboards, at school or working. She remembered the negativity of the nuns, who would tell the girls they would never amount to anything.

She told the Inquiry two older girls sexually abused her at Goodwood. She said the girls were in charge of younger girls in her dormitory; they acted as supervisors for one of the nuns and bullied the younger girls.

The PIC said she stood up for herself against the two girls and used to say to herself, ‘I’m not going to let them break me’. In retaliation the two girls sexually assaulted her by vaginally raping her with a broom handle. The assault caused her to bleed, but she did not go to a doctor, and did not tell anyone about the incident because she ‘had no-one to go to’, so she just ‘shut off’.

She said that after about two years she left the orphanage, and told the Inquiry she was raped by a relative of her mother’s partner; and later sexually assaulted by another of her mother’s partners. She said that her mother rejected her complaints. She became pregnant when she was 17 and had the baby adopted. She said that she now has access to good counselling to help her deal with issues of rejection.

Abuse by outsiders

One woman who gave evidence was a child migrant who was placed in the orphanage after her arrival in Adelaide as an 11-year-old in the late 1940s. The PIC alleged she was sexually abused while on a holiday placement from the orphanage and again during a placement in foster care after she left Goodwood. Records received by the Inquiry from the church PSO confirm that she was a child migrant placed at the orphanage and then later in foster care. For the purposes of the Inquiry, she is considered to have been placed in State care while at the orphanage.

The PIC told the Inquiry that when she was 12 to 14 she was placed for short holidays from the orphanage with a family for whom she later worked. She alleged that a neighbour of the family took her and another girl to the beach on one occasion and ‘put his hands into my bathers’. But ‘we were never able to tell anyone about this at the time’. Years later, the other girl disclosed that the neighbour ‘had done the same thing to her’.

Another PIC was placed at the orphanage as a toddler in the 1950s when her parents separated and lived there until she was 13. According to PSO records, her mother placed her in the home. The Inquiry did not receive any records that she was in State care. The PIC alleged she was sexually abused while taken out of the orphanage and at a subsequent placement at The Pines.

She recalled having a number at the orphanage: ‘It was marked on our clothes … we were mostly called by that number’. She said that when she was young a nun came up behind her and ‘whacked me on the backs of my legs really hard because she told me that I wasn’t walking quick enough’. But she also would be “belted” with the handle of a feather duster for walking too quickly. She alleged that two nuns ‘flogged me non-stop’, and others turned a blind eye.

She alleged that, aged seven or eight, she was sexually abused when taken out of the orphanage; she thinks the perpetrator may have been her father. When trying to remember the details of the abuse, all she could recall is that ‘I had something stuck up inside of me’; she said she imitated the abuse on another girl, using a coat hanger: ‘I actually told her, “I’m going to show you what my daddy does” … I remember she cried and I said, “You’re not allowed to cry …”’.

The PIC said she did not tell anyone about the abuse: ‘He used to say, “Don’t you tell anyone”, so I never did.’ She said: ‘After what happened with my father I just sort of would block things out if anyone touched me in that way.’

The PIC said she kept running away from the orphanage, and on the last occasion, when she was about 13, she was placed at The Pines. She alleged that her father and other people sexually abused her there.
Another PIC said she was about six in the early 1950s when her father ‘kicked’ her mother out of the family home when she ‘came home from work on the back of a motorbike and the whole street was talking about it’. She told the Inquiry she spent some time living with a grandparent, and then her father and stepmother, until they ‘had to get out’ of their Housing Trust home. She alleged she was sexually abused in a foster home and then at Goodwood Orphanage. The Inquiry did not receive any records to show that she was in State care for either placement.

The PIC said she was first put into a foster home when she was about seven or eight, but cannot recall any contact with the department at this time.

She alleged the foster father sexually abused her, penetrating her one evening after she had asked him to do up her dress in his room before they went out. She said he talked of their ‘special love … our secret … and we couldn’t tell anybody because I’d be punished, and these things we don’t talk about. It’s a special type of love, you know, all this crap.’

She said she was abused many times after that, mostly in the shed at home. Her foster mother ‘had no idea what was going on’ and the PIC said she told nobody. She recalled ‘the smell of it all, and then I just remember him cleaning me up …’

The PIC told the Inquiry that as a result of the abuse she became uncontrollable and started stealing. She said she was ‘punished’ and her father placed her in the orphanage, where she remained until her 14th birthday. She again did not recall having any contact with the department while she was at the orphanage.

Of her introduction to the orphanage, she recalled:

People come to meet you, these nuns with their habits on that I’d never seen in my life, and all your worldly possessions that went in a suitcase were taken off you, and you never saw them again because you had to share everything.

The PIC told the Inquiry she started wetting the bed and was punished by a particular nun:

If we wet the bed, we had to be up and dressed and the bed stripped by six o’clock. If we weren’t, then she would start on us with a … wooden brush, clothes brush-type thing … She would give us—I mean, I’m taking six good whacks … Then we either had the sheets draped around us and paraded us on the balcony … we had to go down and wash them.

On one occasion, she said, a nun beat her with a wooden brush on her back and the backs of her legs, injuring her so severely she had to stay in bed for three days.

The PIC said that while at the orphanage she went out on a few occasions with her former foster parents. She would go with different girls from the orphanage. The sexual abuse by the foster father allegedly continued as before; he would separate her from the other girls, getting them to ‘… go and buy some lollies, and “you can stay and help me do this”, you know, sort of thing’.

She said she eventually discussed the situation with her friend at the orphanage, and thinks someone overheard them and reported them to a nun, ‘because we were talking dirty in the bathroom’. The PIC said that when the nun approached her she revealed ‘just exactly what had happened, what had been happening to me’. She claimed the nun did nothing, but assumed she must have told the mother superior.

The PIC told the Inquiry she stopped going out with the couple after this, but surmises that they continued to take out other girls. She said that more than a decade later she met her foster mother, who told her she had seen one of the orphanage girls on the foster father’s lap ‘and she didn’t like what she thought was going on’.

She said she later disclosed the abuse to her brother, who in turn told her grandmother. And then her father was told, but his response was, ‘What did you do to cause it?’ Nothing appears to have occurred as a result of the disclosures.

The PIC said she left the orphanage ‘looking for a life that I never had … looking for love in all the wrong places’.

At 17, she was charged with false pretences. Her SWIC records that the offence was proved but recorded without conviction in the Children’s Court; she was placed in State
care for two years but released earlier on petition. The PIC told the Inquiry that she disclosed the sexual abuse at the police station. ‘During all of this, they wanted my history too, and it was given to them, plus the sexual abuse, so they knew then.’

She told the Inquiry the police did nothing, although she said a policewoman later took her ‘under her wing’.

The Inquiry received minimal documentation on the PIC from the church PSO and only her SWIC from the department; none records her allegations. The documentation received from the South Australian Police also has no record of the allegations.

The PIC told the Inquiry: ‘I guess the whole thing has affected my life, because I’m not so trusting. I’m not so trusting.’

Another PIC was placed in the orphanage by her family with her sibling in the mid 1950s, just after her 12th birthday. Her parents had separated when she was a baby and her father and extended family were unable to care for the children. She was discharged from the orphanage at 17. The church PSO provided the few records concerning the PIC; the department said it could not find any. The Inquiry did not receive any records placing the girl in State care.

The PIC told the Inquiry that on her first day at the orphanage the girls had to line up their shoes and put their hands down. A nun smacked every girl on the palm with the spine of a feather duster because:

“Our shoes weren’t straight. We hadn’t put our shoes straight and there were other shoes that were crooked and, you know, they weren’t all lined up evenly.

She said she ‘hated it from then on’ and felt she could not talk to anyone in authority, ‘because we were too scared. We were terrified of the nuns,’ although she says there were ‘some nice ones’.

She recalled being found with a comic book and, as a result, being ‘belted’ with the back of a brush

... until my hands were just red raw. I didn’t cry first off ... and I think because I didn’t cry she kept doing it until I did cry. That’s probably why I got more.

She had been doing well at school, but after arriving at the orphanage ‘I just thought I seemed to go backward ... I couldn’t concentrate’.

The PIC told the Inquiry that on one occasion when she was 15 or 16, she spent her holiday with a woman who used to visit the orphanage and was a friend of one of the nuns. She would give the girls lollies: ‘... I thought she was a nice lady. I think everybody did ...’ The PIC reflected that if

Someone shows a bit of attention and sort of gives you something, you’d think that was really great because you never got love, you never got nothing —you know, unless you were told off from the nuns.

The PIC said that at the woman’s house, they shared a room containing two single beds. She alleged that the woman woke her one night, told her to take off her pyjamas and said something like, ‘I just want to show you and check just to see—I just want to show you how your mother would love you’.

The woman cried her on the lips and penetrated her. She told her to stop but the woman assured her, ‘I'm not going to hurt you. I'm just checking.’

The woman eventually stopped, and told the PIC she was not to say anything about the incident.

The PIC cannot remember what happened after that, except:

I just lied there for a while. I think I was a bit scared to go back to sleep. I was pretty much awake, I think, and thinking, ‘What's she doing? Why is she doing this to me?’ I didn’t understand anything at all at that time.

The PIC told the Inquiry that the next day, it was ‘as though nothing had happened’. She did not disclose the abuse to the nuns back at the orphanage because ‘I was too scared because she was a friend of [a nun] and I felt they’re not going to believe me anyway ...’

She said she mentioned the incident to her sibling, who then contacted the nuns. When the nuns talked with her,
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I sort of said, 'No, it's all right', because I was too scared to say actually something did happen—they're not going to believe me anyway because it's [a nun's] friend and they'd believe her before me. After that I wasn't allowed to see her, talk to her or anything.

Afterwards, the PIC said, 'we didn't see much of her. We didn't see her around much at all. So whether something was done I'm not sure'.

The church records do not contain any evidence relating to the allegations or her sibling’s alleged disclosure.

Convent of the Good Shepherd (The Pines), Catholic Church, 1941–74

History

In July 1942 the Catholic Archbishop of Adelaide proposed an eight hectare Plympton property known as The Pines as the location for a new reformatory to be run by the Sisters of the Good Shepherd. This replaced the Catholic Girls’ Reformatory at Parkside, which had been operated by the Sisters of St Joseph. By December 1942, The Pines, formally named the Convent of the Good Shepherd, was proclaimed as a private reformatory school for girls, enabling it to receive children in State care. Most girls were placed at the home after being convicted of criminal offences or found by a court to be uncontrollable or neglected. The home also took in girls placed privately. The government paid a weekly subsidy for each State child.

The Pines was required to follow regulations and keep records on the State children in its care. A letter from the secretary of the Children’s Welfare and Public Relief Board (CWPRB) to the matron in January 1943 outlined her responsibilities, which included advising the board of a girl’s illness, absconding and ‘any untoward happening’ so the board could fulfill its duty as guardian.

The CWPRB annual report in 1944 stated that:

Girls committed to this Home are accommodated in good wholesome surroundings, and keen interest is taken in their welfare by the Matron and staff. During the weekdays the girls are fully occupied with various phases of laundry work, and their leisure hours are carefully provided for by means of concerts and other features.

Three sisters initially ran the home and five more joined the staff as the number of girls increased. In 1945 the CWPRB was concerned about ‘overcrowding’ and requested that ‘steps be taken to relieve the congestion’. In 1948 departmental probation officers began monthly visits to The Pines. Their reports reveal an institution that limited girls’ contact with the outside world. While girls at the government institution Vaughan House were allowed ‘trust’ outings, the matron at The Pines refused to introduce such a system. She also refused to allow girls any contact, even by letter, with male friends. A probation officer was also concerned that girls were discouraged from discussing plans or hopes for the future. As a result of these reports, the archbishop agreed that limited trust outings in the company of probation officers would be introduced.

In the 1950s, the CWPRB became concerned with aspects of care in the home, including staff refusal to seek medical treatment for residents, refusal to allow residents to have

9 CWPRB annual report 1943, p. 4; SRSA GRG 29/124 CWPRB minutes, vol. 13, 2 July 1942.
10 Also known as the Home of the Good Shepherd.
13 FYOW, citing CWPRB annual report 1944.
14 FYOW, s. 2, p. 8.
15 SRSA GRG 29/6/1942/328, CWPRB acting chairman to matron, 17 May 1945.
17 ibid., memo CWPRB acting chairman to CWPRB, 29 May 1944.
18 ibid., senior probation officer to CWPRB chairman, 8 Apr. 1949.
contact with their families, and the ‘brief and sketchy’ reports provided to the department. A probation officer was asked to provide a summary of incidents to be sent to the archbishop for his information. The CWPRB expressed its concerns to the archbishop’s representative in July 1956.

In September 1956 the matron resigned. The new matron introduced changes—girls were to be divided into four family groups of 12–15, each cared for by a nun as housemother, with its own dormitory and recreation and dining areas. New buildings were added to provide more facilities for recreation and training. In this era, older girls still worked in the laundry, which had been established in 1942 to provide an income for the home.

In early 1961 the matron telephoned the department to say there was no vacant accommodation at The Pines. Girls were ‘sleeping on the veranda, on the floor, and a girl admitted privately had to be placed temporarily in a storeroom’. By 1965 there were 83 girls in the home, of whom about a third were State children.

The Pines remained a ‘private training centre’ for Catholic girls after the passing of the Community Welfare Act 1972. Research conducted in 1973 revealed that 90 per cent of girls had been referred either by the Women Police Branch or the Department for Community Welfare. Only a few of the girls were placed under court orders; the focus was on providing a home and training for ‘delinquent’ teenage girls who were accommodated in three semi-independent living units.

In 1973, 39 per cent of the girls at The Pines were under the care and control of the Minister. However, of the remaining privately placed girls, 65 per cent ‘were referred by or in consultation with the Department for Community Welfare’. The department provided welfare workers for girls placed under court orders and those referred by the department. Interviews conducted with girls in 1972 showed the majority were not involved or consulted about their placement and regarded it as ‘punishment’. From 1974 all referrals to The Pines were made through the Catholic Family Welfare Bureau in an attempt to increase family involvement in the decision to place a girl at the home.

In the same decade, a research paper identified the group mother—the sister in charge of a group of 10 to 12 girls—as the most significant figure in the girls’ treatment:

> On the assumption that these girls usually have a poor self image because of previous experiences of failure or rejection, the group mother/girl relationship often becomes the principal means of awakening or restoring a girl’s sense of self-worth.

In November 1974, a senior church official informed the archbishop that the church was ‘presently unable to offer residential care for teenage girls at The Pines’. The home closed as a residential care facility at the end of 1974 and the Good Shepherd sisters moved into other aspects of child care.

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20 ibid., CWPRB secretary to matron, 17 July 1956.
21 ibid., outline of girls and incidents, July 1956.
24 CWPRB annual report 1965, p. 14, records that 24 departmental children were in the home in 1964-65.
27 ibid.
29 ibid., SA historical background of the period under consideration.
30 ibid.
31 ibid., provincial superior to archbishop, 11 Nov. 1974.
Chapter 3 Allegations of sexual abuse

Allegations of sexual abuse

Four women gave evidence to the Inquiry regarding sexual abuse at The Pines in the 1950s and 60s. Three had been placed in State care by a court for being neglected, destitute or for a criminal offence; the fourth was placed at The Pines by her mother. The sexual abuse included indecent assault, unlawful sexual intercourse and rape, allegedly perpetrated by staff, other residents and outsiders.

Abuse by multiple perpetrators

A PIC born in Adelaide in the late 1940s was placed in care by her mother when she was about two. The Inquiry received evidence of some departmental involvement in maintenance payments but no records to show that she was in State care. The PIC alleged she was sexually abused at Goodwood Orphanage and later The Pines, where she was transferred when aged about 13.

An admission and discharge register from the church PSO shows that the PIC was placed at The Pines after Goodwood, but the Inquiry has not received any records specifically relating to her time there.

The PIC alleged another girl at The Pines sexually abused her, which led to her absconding and suffering further sexual abuse by her father.

I know there is a girl who molested me there once and I remember running away from that and then I had—I can’t recall the age when my father come back, but he—I went to go for visits with him and he used to drink and he molested me, but I didn’t say anything and then one day I just cracked and threw these chairs around but I never told what happened.

The PIC told the Inquiry that when she taken back to The Pines she was placed in a detention room called a ‘kuji’. She also told the Inquiry she was pack-raped on more than one occasion in the kuji but the circumstances and details of the perpetrators is unclear.

The PIC told the Inquiry she suffered further sexual abuse after leaving care, and had an abusive marriage. She said her motivation in giving evidence was ‘so that nothing ever happens to any children again’.

Abuse by staff and other residents

A woman told the Inquiry she was physically and sexually abused by family members before being placed in State care in the mid 1960s, when she was 13. After being found by a court to be neglected, she was placed at Seaforth Home and later The Pines. She alleged she was sexually abused in both homes.

The PIC was transferred to The Pines in the late 1960s at the age of 14, and said she lived there for three years. She alleged she was sexually abused by other residents, who penetrated her with objects and woke her during the night to ‘touch and play with my breasts, and they’d take us—because they didn’t wake anybody else up—they’d take us into the bathroom’.

The PIC also alleged she was sexually abused by a priest at The Pines:

He touched me on the breast and vagina ... I felt guilt because I felt like I was making him sin because I was allowing him to do it ... It was me, I wasn’t good, so I was evil.

She told the Inquiry the priest would say ‘just that it would be all right, that he just needed relief’. She said she told a nun about the abuse by the other girls and was ‘pretty sure’ she mentioned the incident with the priest, but ‘she said that that wouldn’t happen, the priest wouldn’t do those kind of things, and she wouldn’t listen to me’.

The Inquiry has received records from the Catholic Church and the department that relate to the PIC’s time in State care but do not include any allegations of sexual abuse.

The PIC said she believes the sexual abuse has had a huge impact on her life:

... it haunted me right through my life. It’s been a big part ... everywhere I seemed to go I’d been abused, but when I said anything they didn’t believe it had happened, and so in the end I think I just gave up.
Abuse by outsiders

A PIC was placed in State care in the early 1960s as a nine-year-old after a court found her to be destitute. She had lived at St Joseph’s Orphanage from the age of six and was later placed with her family before being placed at The Pines. She alleged sexual abuse in both of these earlier placements and at The Pines, and later in foster care after her release from The Pines.

She was 13 when placed at The Pines after she was charged with larceny. The PIC told the Inquiry she went to school at The Pines but was punished for her classroom behaviour and sent to work in the laundry. She said she was treated like ‘slave labour’ and also described punishments such as being locked in bathrooms and under stairs.

The PIC absconded from The Pines regularly and said she sometimes hid in the roof cavity in her family’s home, where her siblings would sneak food to her. On one occasion she travelled interstate and was sexually abused in a regional town: ‘I was gang-raped by three, pulled into a car’. The PIC told the Inquiry the incident was reported to police. She was placed temporarily in a house for adopted children and soon after was returned to The Pines. Her SWIC notes that she had absconded and was ‘working in [the town]’.

The PIC said she had been unhappy at The Pines and wanted to leave because she was made to work and denied an education. She told a staff member that she would commit suicide ‘so they ended up getting me a job’. Her SWIC reported that ‘girl is not conforming and is a real menace’ at the home.

The PIC told the Inquiry her time in care delayed her development and she took many years to recover: ‘You’ve got no direction and I had no direction until I was 31, when I started to self-improve’.

Another PIC who alleged sexual abuse while placed at The Pines told the Inquiry that her mother died when she was eight. She left school after Grade 7 and began working; not long after this her father decided to place her at The Pines:

My father, on the advice of our local Catholic priest, [name], arranged for me to go to a finishing school. My father told me that I would like it there. I would be taught sewing, cooking and be turned into a proper young lady ... My father paid those nuns for my board and keep, but I was put to work and only work.

Documents received from the Catholic Church confirm the PIC’s father placed her at The Pines when she was 14. She said she was so unhappy there that she ran away with a group of girls, and that one girl stole some property while they were on the run. She said she and other girls were charged with larceny and as a result she was placed in State care. Her SWIC shows she was charged with larceny at 15, committed by a court into State care and placed at The Pines until she turned 18.

The PIC described the court hearing:

I also tried to explain to the judge that my dad could not speak or read English, and had he known what was happening that day he would have been there for me. The judge said, ‘It is no excuse for him not to be here. It seems to me your parents don’t care about you. This leaves me no choice but to send you back to The Pines as a ward of the State until the age of 18.’

She said she found her treatment by the justice system unbelievable. We were taken to the police station, fingerprinted, mug shots taken, and branded like common criminals. I was just 13 and did not commit any crime ...

The PIC told the Inquiry she continued to run away from The Pines and seriously injured herself once when she ‘jumped out of a two-storey building’. She said she was sent to Vaughan House as punishment for running away.

She alleged she was sexually abused on an outing while still under a placement order at The Pines. She said she was about 17, had met a boy at a dance and on the way home he stopped his car to have a cigarette and then sexually abused her:
Chapter 3 Allegations of sexual abuse

Then he started kissing me, and before I knew it I was on the floor being raped against my will. I was a virgin. I became pregnant to this lad. I kept it quiet from the welfare department because they would have taken my baby from me and kept me as a ward of the State until I was 21, so I told no-one. I got married to someone that I didn’t love. I was trapped.

She claims to have suffered emotionally as a result of the abuse and generally from her time at The Pines:

I have nightmares … I suffer from claustrophobia. I have a degenerative bone disease due to never getting proper food, milk, cheese. I have chronic arthritis, tinnitus, hearing loss, and a heart condition.

Salvation Army Boys Home (Eden Park), 1900–82

History

From 1900–82, Eden Park—the name by which the Salvation Army Boys Home at Mount Barker was commonly known—provided care for the boys deemed the most vulnerable in society. Boys at Eden Park were commonly referred to in historical records as ‘uncontrollable’, ‘sub-normal’ or ‘severely emotionally disturbed’.

The home was proclaimed as a private institution that could receive State children in December 1900, when it was known as the Boys Probationary School. The Salvation Army had offered to take over the government’s Boys Reformatory, but the State Children’s Council (SCC) preferred that the Army take responsibility for two new ‘probationary’ institutions for boys and girls. These were to house children who the council believed required ‘discipline’ and ‘training’ such as habitual truants. The department was at different times closely involved in utilising, supervising, licensing, funding and advising on Eden Park’s development throughout the period it operated.

Eden Park was a farm property of about 53 hectares in the Adelaide Hills near Wistow. The boys’ dormitories and officers’ accommodation were in the main building, a 17-room stone mansion. Outbuildings provided a school and recreation rooms as well as punishment cells. After it was proclaimed, the Boys Probationary School at Mount Barker was run by the Salvation Army and staffed by its officers. However, the institution was ‘absolutely under the control of the Council’ and subject to the same ‘supervision and authority of the secretary’ as the government’s own industrial school and reformatories.

The property was a working farm, but only limited agricultural training was provided to residents. Generally, boys performed tasks such as milking, wood chopping and other general work. The CWPRB transferred boys from the Industrial School to Mount Barker for ‘bad’ conduct; boys at the Reformatory who displayed ‘good’ conduct could also be transferred there. The home took in children placed privately by their parents or referred by other non-government agencies.

Members of the CWPRB inspected the institution regularly and, in turn, the Salvation Army reported regularly to the board.

The probationary school operated in this way until it was abolished as a private institution for the reception of children in State care in January 1945. The separation between the government and the institution occurred as a result of allegations of sexual abuse at the home during 1940 and 1941.

The management style and culture of the home, as well as some individuals and particular practices, became the subject of complaints and inquiries. Investigations revealed an ongoing reliance on physical punishment at the home and a culture of older boys taking advantage of younger boys.

State Children Act 1895 defines a private institution as ‘an institution or establishment for the detention, maintenance, reformation, training, employment of destitute or neglected children, established and maintained by private persons’. Under section 22 ‘The Governor, on the recommendation of the Council, may proclaim any private institution as an institution for the reception, detention, maintenance, education, employment and training of State children; and thereafter such institution, until abolished as by this Act provided, shall be under the supervision of the Council’.

SCC annual report 1901, p. 4.

CWPRB annual report 1940, p. 10.

See entries in CWPRB minutes for confirmation of this.


92 CHILDREN IN STATE CARE COMMISSION OF INQUIRY
The first incident of ‘indecent conduct’ at Eden Park appearing in CWPRB records occurred in September 1940 and involved a staff member and three boys. Given the ‘gravity of the offences’, the staff member was arrested, tried and jailed, and the boys were committed to the reformatory at Magill. Two months later the CWPRB referred to another incident and ‘urged’ the probationary school superintendent to ‘exercise such supervision’ as to ensure similar incidents could not occur.

However, six months later, police arrested another employee of the home for ‘acts of gross indecency’. The CWPRB recorded its concern at ‘action pending against several boys for sexual offences’, and recommended that ‘serious consideration ought to be given to the propriety of leaving the boys in the institution at present’. The CWPRB secretary reported that ‘the moral tone of the home is such that I feel convinced steps should be taken to remove the present wards of the department from that environment’.

In January 1941, the Salvation Army replaced Eden Park’s entire male staff, including the superintendent. It ‘assured the department that steps would be taken to see there was no repetition of the wrong practices’. In August the CWPRB met representatives of the Salvation Army to enquire into the ‘cases of sodomy and indecent conduct’ at the school. The board was concerned that the most recent perpetrator had been able to take ‘advantage of the opportunities provided to him to indulge in acts of the most revolting indecency’. The perpetrator had himself reported homosexual practices to the officer in charge of the home, but no action had been taken. The CWPRB resolved that, while ‘aware of the good work done in the past years at the Boys Probationary School’ it would recommend the institution be closed. All State children were removed between September and November 1941, however Eden Park did not have its licence removed until January 1945. Eden Park continued to care for children placed privately.

In 1950 the institution again came under the supervision of the department. The department visited and inspected Eden Park after amendments to sections 188 and 189 of the Maintenance Act 1926–1937, which provided that all children under seven in ‘benevolent institutions’ were to be visited and thereby supervised by the CWPRB.

Departmental officers inspected Eden Park about every four months, recording notes on living conditions and staffing arrangements. The CWPRB secretary advised the department’s inspector:

> Try not to embarrass the superintendent and if possible work in harmony with him. Anything that may be wrong will be dealt with by this department and not by you.

Inspectors’ reports from the 1950s describe the home as ‘pleasing’ and ‘well run’ and the boys as ‘happy’. However, the home’s night supervision was described as ‘passive’. In 1959, after reports of a ‘dark punishment room’ surfaced, the CWPRB requested the inspector to undertake ‘discreet inquiries about the segregation room...”

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39 SRSA GRG 29/124, vol. 13, CWPRB minutes, (minute 720), 21 Nov. 1940.

40 SRSA GRG 29/6/1941/263, CWPRB chairman, to under-secretary, 24 July 1941.

41 SRSA GRG 29/124, vol. 13, CWPRB minutes, (minute 751), 17 July 1941.


43 ibid., Crown Solicitor to Attorney-General, 6 Aug. 1941, in 1. ‘Report on various inmates’.

44 SRSA GRG 29/124, vol. 13, CWPRB minutes special meeting, (minute 755), 7 Aug. 1941.

45 ibid., (minute 764), 2 Oct. 1941 and (minute 771), 20 Nov. 1941.


47 Maintenance Act Amendment Act 1950, s. 189.

48 SRSA GRG29/6/1954/4, Inspection reports on ‘Visitation by Inspectors of Salvation Army Boy’s Home Mt Barker’.

50 ibid., CWPRB secretary to Miss DM Bannear, 4 Mar. 1954.

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and for how long children are placed in it’. The welfare officer discussed ‘behaviour problems’ with the superintendent, but was ‘unable to obtain any direct admission from the superintendent that boys are locked in a dark, dingy room’. It appears from records that the matter was not pursued.

In 1961 a departmental probation officer reported on the home in response to a spate of absconding. After inspecting the home and consulting with the superintendent, the officer concluded that while Eden Park suffered overcrowding and lack of supervision, the institution was ‘sound for any boy who would not require any great or persistent supervision’.

In 1963 ‘allegations of misconduct of a serious nature towards boys at this home’ were again raised. A departmental supervisor of institutions reported that a female domestic assistant had been disturbed and distressed at night by sudden violent screams from boys in their dormitories. In the morning she has found, it is alleged, that some boys’ sheets are blood-stained. The portions of the sheeting so stained, she claims, strongly suggested sexual malpractices towards some of the boys.

The assistant had complained to ‘those in charge’ but had been told boys were ‘only having nightmares’. The staff assistant suspected that ‘some staff member could be interfering with the boys’ or that ‘boys of perverse habits’ were responsible. The CWPRB passed the information to the police, but police inquiries were ‘inconclusive’ and ‘no further action was taken’.

From 1965, with the proclamation of the Social Welfare Act, Eden Park was required to apply for a licence because it accommodated more than five children under 12. Licensing also made the home subject to regulations under the new Act. A 1968 report commented that the superintendent was ‘a little too authoritarian in his attitude toward the boys in the home’. However the officer also noted that on other visits he had found ‘the boys have enjoyed warm relationships with the members of the staff they have direct contact with’.

In 1970 the department became aware that a former Eden Park staff member had approached solicitors because he was ‘gravely concerned about some aspects of the home’. The allegations concerned a small ‘lock-up room’ with no light or windows that was used for punishment, and a staff member who regularly carried a leather strap he ‘used as a matter of routine on the children’. A field officer investigated and found the allegations to be ‘substantiated’ although ‘exaggerated’. The assistant senior welfare officer highlighted the ‘unsatisfactory’ selection of staff and recommended that the home undergo ‘careful reassessment and reorganisation’. The Minister for Social Welfare, in his reply to the solicitors who had passed on the concerns, wrote:

I can assure you and your client that, despite the fact that the children at the home are not under the control of the Minister, every care will be taken to ensure and protect their welfare.

After the passing of the Community Welfare Act 1972 licensing requirements for children’s homes became more rigorous. Positive changes were noted in inspections of Eden Park, attributed to increased funding and the retirement of the long-term superintendent, who had been described as old-fashioned and inflexible.

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52 ibid., memo, 18 Sep. 1959.
53 ibid., report from welfare officer MC Wilson, 20 Aug. 1959.
54 ibid., report from probation officer attached to memo, 3 Oct. 1961.
55 ibid., supervisor of institutions to CWPRB secretary, 13 July 1963.
56 ibid., handwritten note on supervisor of institutions to CWPRB secretary, 13 July 1963 & CWPRB chairman to Salvation Army, 17 Sep. 1963.
57 See Maintenance Act Amendment Act 1965, s. 162(a).
59 SRSA GRS 4164, file 14/6/1, Eden Park Boys Home (Salvation Army) Mt Barker (Wistow), welfare officer to assistant senior welfare officer, 18 Apr. 1968.
63 SRSA GRS 4164, file 14/6/1, inspection report, 2 July 1970.
In the later 1970s, with the closure of many large congregate-style institutions, accommodation at Eden Park was restructured to provide care for boys in smaller units. By 1976, the home had been divided into three units of 12 boys each—Aroona, Barmera and Coorong—each with its own bathroom and lounge facilities. A residential care worker supervised each unit. Staff were advised that:

Many boys coming into the home have been exposed to some grave moral behaviour and therefore the [residential care worker] should be alert to new boys coming into the home, listening to boys’ conversation, checking their language, and gestures, and also to be alert to boys ganging up for bullying or sexual behaviour.

In 1981 the department observed continuing deficiencies at Eden Park. They included the home’s physical isolation, which restricted children’s access to family and the community and the fact that staff methods and the overall management style were ‘geared to discipline and efficiency’ rather than the needs of each child. Many of the boys regarded admission to the home as ‘a punishment for bad behaviour’ and, because most children were referred to the home by outside agencies, it had largely become ‘a dumping ground for problem children’. In particular, it was reported that some older boys were unmanageable and had ‘a destructive influence on more vulnerable boys’.

In 1982 the department conducted a review of Eden Park. After inspecting the institution and interviewing Salvation Army authorities, the inspection team concluded that the program at Eden Park was ‘highly unsatisfactory’. Concerns regarding parental access and staff quality were raised. One month after this report was written, the social worker at Eden Park informed the Eden Park Special School principal of her suspicion that three boys had been ‘victims of sexual abuse’. The principal reported this to the Eden Park superintendent and the incident was reported to the department. The boys concerned were placed elsewhere and the department questioned Salvation Army authorities about supervision in the dormitories at night. It was found that once residents were settled there was ‘no adult in the immediate vicinity of the dormitories’.

Further allegations were made regarding the use of ‘punitive measures’ for disciplining boys at the home in late 1981. As a result, the department outlined ‘major concerns’ with Eden Park to its superintendent. These included the ‘punitive and controlling philosophy of care’ and ‘limited supervision at night’. The department stated that it

… considered that the overall philosophy of care is based on a staff philosophy that reflects emphasis on control and punishment rather than more modern and appropriate styles of managing difficult children.

In the same month the Salvation Army advised the department that it intended to close Eden Park. It stated that there was ‘no present need for this service’ and that ‘there is a change in the pattern of child-care which we must recognise’. The home was closed on 31 December 1982.

Allegations of sexual abuse

The Inquiry received evidence from 18 PICs who alleged sexual abuse at Eden Park. The allegations spanned 1940 to 1982; some concerned repeated abuse by the same perpetrator, while others were single instances. The allegations ranged from gratifying a prurient interest (for example, the humiliating practice of making boys stand
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naked as a punishment) to fondling and kissing, forced oral sex and anal rape.

Most allegations were against staff members and some were against other boys at the home. In two cases, the alleged perpetrators were from outside the home and in one case the perpetrator is unidentified.

Of the 18 PICs, five were placed in State care by a court or under an administrative order by the department. The remainder were placed by parents, by referral from government or non-government agencies, or by unknown sources without an order placing them in State care.

Their evidence of family life before going into care was typified by problems including fighting parents, broken marriages, alcoholism, domestic violence and sometimes sexual abuse. One PIC recalled:

> It all changed on a rainy night somewhere in the Adelaide Hills … our mother and father were in the front of the car yelling and arguing. And then my mother got out of the car and I never seen or heard her again.

Some of the PICs who alleged they were sexually abused at Eden Park said they had been given the impression before their arrival that it would be a camp-like farm environment. Most said they had little idea what to expect.

One PIC recounted the moment when he was told of the decision to send him to the home.

> The conversation was along the lines, ‘Your father and I, we’ve decided to go travelling around Australia and as you’re the last one home, that causes a problem, so we’ve arranged for you to go to a lovely place in the country where you can live there, you know, there’s cows and there is this, that and everything else’.

Most of the PICs said life at Eden Park was harsh, regimented and often violent. One PIC described it as a scary place for a young child. Another said daily activities were ‘routine, strict, and almost like … a jail sort of thing, but for kids’. A third PIC described the home as ‘like a concentration camp with the worst kinds of punishments’ and remembers ‘crying for days and days just wanting to be out of that place’.

PICs gave evidence that they were required to perform hard physical work on the rural property adjoining the home, in addition to going to school. One PIC recalled his difficulty in coping with both the physical and schoolwork: ‘I don’t think I learned anything because I was milking cows seven days a week plus whatever chores I had to do’.

All 18 PICs spoke of boys being physically punished by staff, with one describing physical punishments by one officer:

> He used to bash us all bad. He’d lose control and start sweating and just bash you until you just dropped on the ground and cowered … they had, like, a round, batony-type thing that they used to carry in their pocket.

Another PIC recalled his initial impressions of Eden Park:

> As we drove up the driveway we got our first shock of things to come. I was nine, nearly 10, and as I looked out to the yard I saw two Salvation Army officers in full uniform chasing an older boy around a yard. At first I thought it was a game until I realised they were beating him with bell-shaped batons and strapping him when he slowed or stumbled … my heart went in my mouth and I thought, ‘Where in God’s name are we?’

Abuse by multiple perpetrators

A PIC who lived with his mother after his parents separated was aged 10 when placed in State care during the 1940s after he truanted from school and committed offences. He was soon transferred to Eden Park. He had previously lived at the Salvation Army Boys Home at Kent Town, where he also alleged he was sexually abused—although not in State care at that time, he was known to the department.

Department records show the PIC was at Eden Park for eight months before being transferred for ‘misconduct’.
He alleged three people sexually abused him there. He recalled that two men in their 20s lived at the home in separate quarters and, as part of the boys’ punishment, the superintendent ‘would deliberately put you in there so that they could carry on with you’. The PIC said he was put in the room with these men on two occasions and one of them raped him: ‘I started, you know, singing out’. He reported the incident to his parent, who informed his welfare worker, ‘but nothing happened, once again’. He had been frightened that the woman’s husband would find out and harm him.

The PIC also alleged he was sexually abused by the wife of one senior staff member: ‘She’d play around with me and get me into bed and get on top of me and I was terrified’. He had been frightened that the woman’s husband would find out and harm him.

The PIC also gave evidence that an older boy regularly attempted to get into bed with him and ‘do things’. He said that as a result of the instances of sexual abuse he abscended from the home several times.

The department’s file for this PIC relates to his placements and transfers and does not record any complaint of abuse. No records have been received from the Salvation Army in relation to him.

One PIC born in the early 1950s alleged multiple incidents of sexual abuse by staff members, other resident boys and unidentified visitors to the home.

Records show the PIC was placed in State care by a court in the early 1960s for attempted larceny subsequent to his time at Eden Park. The only record received from the department is a SWIC relating to placements in the early 1960s. There were no records to show that he was in State care during his time at Eden Park in the 1950s. The Salvation Army informed the Inquiry it has been unable to locate any record of him.

The PIC told the inquiry he was placed at Eden Park when he was about five and remained there for seven years. He alleged that when he was about 10 he was sexually abused and anally raped by a staff member on several occasions:

I used to give him oral sex and then he would blow all over me and urinate all over me. I used to stink. Nobody would come near me because of what he used to do to me.

He said the staff member beat him, made him carry a heavy ball and chain and also

… used to come and just turn your custard upside down and take the plate away and we had to eat it off the table, or he’d put it on the floor and makes you get on your hands and knees to eat it off the floor.

The same man continued to abuse him over a long period and on one occasion, in ‘the lock-up’ at the home: ‘He chained me, put padlocks to me, took me to the saw bench, chained me up over the saw bench, and raped me’.

The PIC alleged he was sexually abused by a second staff member, who forced him to masturbate him and then urinated on him.

He also alleged two unknown men raped him when visiting the home one Christmas. The men took him to the hay shed, where ‘they tied me up and raped me over the barrel, over the bales of hay’.

The PIC also told the Inquiry that on separate occasions three older boys at Eden Park forced him to masturbate them.

He said he told his father about some of the sexual abuse and that his father confronted the officer in charge of the home, but nothing was done. The only record received from the department was the PIC’s SWIC; no records have been received from the Salvation Army. In the absence of such records the Inquiry could not verify that a complaint was made, whether it was recorded or what, if anything, was the response.

Following his time in State care the PIC has spent time living on the streets and been in jail. He told the Inquiry the sexual abuse has affected his marriage: ‘I was too wild, still am. Mentally I’m—I can’t hack marriage. I just can’t. I just can’t.’
A PIC alleged sexual abuse at Eden Park in the mid 1970s when he was about 10. He told the Inquiry he was sexually and physically abused by his father before going into care. Records indicate the PIC was placed at Eden Park as a result of a Child Guidance Clinic referral. The Inquiry did not receive any records to show that he was in State care at this home.

The PIC gave evidence of harsh conditions at Eden Park, including physical and humiliating punishments. He said he began wetting his bed, was placed in a special dormitory for bed-wetters and faced further punishments, including ‘the strap, standing outside all night, getting … all your hair cut off, getting the cane’. He recalled that on one occasion his head was shaved in front of all the other boys, who were told the punishment was ‘because I was a dirty little piggy that wet my bed and this is what happens to dirty little piggies’.

He said the first instance of sexual abuse was at a camp arranged and managed by the staff at Eden Park. A staff member sexually assaulted him in a tent. He pulled down the PIC’s pants and performed oral sex on him, then told him: ‘That’s how I want you to do it to me’. The PIC said he then tried to do it to the staff member but twice was told that ‘I done it wrong’. The staff member said he was going to punish him. The PIC said the man then took him down to the river and anally raped him. ‘He told me if I did tell anyone, that I’d be fucked up and I’d disappear like a little boy’.

The PIC says he reported the rape to a staff member, who said he would look into it, but nothing was done. Two or three weeks later, while he was watching television with other boys, the abusive staff member collected him and forced him to perform oral sex.

He also alleged another Eden Park employee anally raped him in a cellar and, later, in a shed at the home. He said he was too scared to resist and too frightened to report the abuse, although he did tell his grandmother but is unsure whether she took the matter further.

The PIC told the Inquiry that while at Eden Park he stayed with a man during a holiday period. After they had been swimming and returned to his house, ‘I was having a shower, and he came in halfway through my shower and escorted me to the bedroom … He had sex with me’. The PIC said he reported the incident to a staff member at Eden Park but ‘I was told I was nothing but a troublemaker and a liar, and that if I persisted I’d be punished’.

The Inquiry did not receive any records from the Salvation Army to verify whether reports were made, recorded or responded to in relation to these allegations. Files have been received from the department but, apart from confirming the PIC’s placement at Eden Park under recommendation from the Child Guidance Clinic, no reference is made to sexual abuse.

The PIC was placed in State care when he was 12 and alleged he suffered further sexual abuse during placements at Lochiel Park Boys Training Centre and Brookway Park.

**Abuse by staff**

An Aboriginal man born in the mid 1950s alleged staff sexually abused him while he was placed at Eden Park in the late 1960s.

Records received from the department show that just before his 13th birthday the PIC was charged with offences and placed by a court in State care until he turned 18. Eden Park was the first of his many placements and he remained there for nine months. The PIC said Eden Park was … a very bad place, very evil place and that’s the word that I put it—very evil. Although it was under the Salvation Army it wasn’t a very friendly atmosphere.

The PIC alleged a staff member bent him over a table, caned his bare bottom and then, while rubbing his bottom, the man exposed his penis and masturbated: ‘I seen him a couple of times sort of underneath my armpit and he was playing with himself’. The PIC said the abuse happened more than once. He also alleged that another staff member sexually abused boys:

A few times he got us in the shower, three or four of us at a time there, just so we would rub ourselves in front of him to—for us, even though we were young people, you know, he used to touch us, like, on the
penis and make sure we got an erection. I can still remember there he used to put his mouth around our penises, you know …

After his release from Eden Park the PIC was placed in foster care for several months. He said he told his foster parents about some of the incidents of sexual abuse but was unaware whether any action was taken as a result.

The PIC later spent time at other government homes and secure institutions. No records were received from the Salvation Army. The records received from the department do not record allegations of sexual abuse.

Of his time at Eden Park, the PIC said: ‘That really destroyed a lot of me, you know’.

A PIC who gave evidence about Eden Park in the 1960s told the inquiry he was the victim of violence in the family home, became disruptive at school and was expelled. He said his parents separated, he had a poor relationship with his stepmother, and his father took him to a non-government home when he was in primary school. A record has been received from that home confirming his presence there when he was 10. The PIC said he spent some time with his family and then in other non-government homes before going to Eden Park in the mid-1960s when he was about 13.

No records have been received from the department or the Salvation Army. The Inquiry did not receive any records to show that he was in State care while at Eden Park.

The PIC alleged he witnessed and suffered violence inflicted by staff at Eden Park and described the punishment as ‘floggings’, saying one Salvation Army officer used his belt:

He’d start on your legs until you went down. You’d go down and your legs would go down behind you and once you went down then he would start on your back and just keep on lashing and lashing and lashing … the welts you had after a belting like that, you were black and blue.

He alleged an officer at the home repeatedly sexually abused him, initially when he awoke in his bed to find the man fondling his penis and subsequently at various places at the home and also when they travelled to Adelaide on occasions.

The PIC told the Inquiry the officer’s sexual abuse escalated and one evening he anally raped him. When he protested he was warned not to tell anyone. The next day the officer put him into a drum of liquid fertiliser and … hosed me down like a dog … I threatened to tell. I didn’t know who I was going to tell because I had no-one to tell, but I was going to run away and just get the hell out of there.

He said he did not report the sexual abuse:

It was my dark secret. It was something I didn’t tell anybody. Once it started to happen I was more in tears and more upset and I used to lie awake and cry at night and I was going worse at school than what I’d ever gone. I was going backwards.

Another PIC said he was from a broken home and was sent to an orphanage when he was in primary school. A year or so later he was sent to Eden Park:

I just remember one night we—like, we were at the orphanage and then the next minute we’re in a dormitory at Eden Park; didn’t even know where we were. We were taken at night time.

No records have been received from the department or from the Salvation Army about the PIC’s placement at Eden Park. The Inquiry did not receive any records to show that he was in State care while at Eden Park.

The PIC told the Inquiry physical punishments were common at Eden Park, but one staff member took a particular interest in him and was kind and affectionate, hugging and kissing him:

He gave me all the attention. He promised to take me out of there. I had to meet him at the workshop area after dark. I’d be waiting for him to come. I just didn’t know back then, but I just liked the attention I was getting.

He said the staff member told him to keep their meetings secret. The man later took him to live with him and his family in another State, where he had been transferred. Initially, he said, he enjoyed family life but soon after they
moved the staff member started to sexually abuse him:

He started coming in my room and—you know, the kissing and the cuddling. Then it started—he reckons it was sex education … I’d have to take my pyjamas off and I just felt uncomfortable. After a while—the last thing I remember was I rebelled against him and he bashed me out the front of the—they had a white garage, I remember. I remember my nose was pouring blood and I got sent back to Adelaide.

The PIC said he returned to Eden Park, where he remained until he was 15. On his return he suffered violent physical punishments and on one occasion absconded.

He said he did not report the sexual abuse. He told the Inquiry he still suffers from the effects of the abuse and struggles to show affection:

I get really uncomfortable when I get hugged … I’m told I don’t show emotions or empathy, but I had to suppress that when I was in the boys home because I didn’t want to get hurt.

Another PIC who alleged sexual abuse at Eden Park during the 1960s had been under the supervision of the Department of Aboriginal Affairs.

The Inquiry has not received any records from the Salvation Army or any records that he was in State care while at Eden Park. Some records have been received from the department, including a letter from the director of Aboriginal Affairs to the Child Guidance Clinic confirming the PIC’s presence at Eden Park.

The PIC had previously been at Colebrook Home, which was run by the United Aborigines Mission, where he alleged he was sexually abused by a carer and by older boys.

He told the Inquiry an Eden Park staff member sexually abused him when he was a teenager. He alleged the perpetrator made him strip naked on several occasions and once locked him in a shed and beat him with a strap. He remembered that his mouth felt dirty but he could not recall precisely what happened.

The PIC said he had sex with other boys at Eden Park:

It was a sexual relationship. It was just for sex. I don’t know how it started or where it came from. There was a couple of other boys but I don’t know their names. We just used to just go and have it off, you know.

He had his own way of coping with a difficult childhood:

‘I used to have an imaginary world growing up. Dungeons and dragons stuff, you know. It was my escape from reality.’

He said that when he left Eden Park he was placed at the Salvation Army Boys Home at Kent Town, where he alleged he was also sexually abused.

A PIC who had an unsettled family life was at Eden Park in the early 1970s. He told the Inquiry his father, a heavy drinker, had been violent towards him.

He said that a departmental worker visited him months before he was placed at Eden Park. He told the worker about his father’s physical violence ‘in front of my mother and father … and they denied it, of course’. He said that his mother then sent him to youth camps where he said he was sexually abused by a male carer eight times over four weekend camps.

He said his behavior at home and at school deteriorated, and he insisted to his mother that he did not want to keep attending the camps, although he did not tell her about the sexual abuse because the man had threatened him. The man told him: ‘If you say anything no-one will believe you, and if you say anything I’ll just tell them that you did it to me’.

The PIC told the Inquiry he was then placed at Eden Park from the age of nine. No records have been received from the Salvation Army. Some records have been received from the department and, while they mention he was at youth camps and Eden Park, there is no mention of the legal basis for these placements. The Inquiry did not receive any records to show that he was in State care during his time at Eden Park.
Of Eden Park, the PIC recalled that he was told:

I'd be going up to a place where there would be horses, there would be a farm and it would be a more stable place for me to live for a while. That's how he described it and he told my mother that she had no choice. She either let me go or I'd be taken off her.

The PIC alleged he was heavily caned at Eden Park. On one occasion, staff members physically punished him for making a comment considered blasphemous; the wife of one staff member was 'kicking me so hard that her shoe fell off'.

On several occasions, he said, one staff member punished him physically and then kissed, cuddled and comforted him. The man then fondled him, rubbing his genitals and asking him to do the same to him.

He reported the physical and sexual abuse to a welfare officer, he said, but no action was taken. No records have been received from the Salvation Army to verify whether the complaint was made or recorded, or the nature of any response.

The PIC gave evidence that the sexual abuse has affected him in a number of ways. He does not like to be touched or hugged and at times has become suicidal and spent time in psychiatric care:

It was devastating, because the abuse that I'd suffered—I felt ashamed. It had obliterated my confidence. I felt dirty and I feel as though I had to go around with this secret that I had to hide all the time. I feel uncomfortable about [sexual contact]. I'm the sort of person that doesn't really like to be touched, unfortunately. I find it hard to hug people or have people hug me. I really like my own space.

Another PIC who alleged sexual abuse at Eden Park during the 1970s told the Inquiry his parents separated when he was about seven and he was sent to an Anglican Church home and then to Kennion House. No records have been received from the Salvation Army, and the only records from the department relate to the PIC’s teenage years, when he was placed in State care, and not to his placement at Eden Park. The Inquiry did not receive any records to show that the PIC was in State care while he was at Eden Park. The PIC alleged he was sexually abused at Kennion House and Eden Park.

He recalled that his stepmother assured him Eden Park was ‘a lovely place in the country’. He said that as a teenager at Eden Park, he was required to perform difficult physical work and staff inflicted heavy physical punishments. He recalled being put in an isolation cell, which was ‘a stone room about four feet by four feet’, and said boys would be sent there ‘for two or three days at a time’. He also alleged he was assaulted by a staff member while working in the sawmill,

... because maybe I wasn’t carrying a big enough load—a sufficient enough load as what he considered—he was angry, he picked up a lump of timber, threw it at me and hit me in the side and broke my ribs.

The PIC alleged that another officer at Eden Park sexually abused him on several occasions in a shed and a barn, forcing him to masturbate the man and be masturbated, and perform oral sex.

In a further incident, the same officer allegedly cornered him in a room, fondled him and then anally raped him. The PIC said he suffered anal injuries and severe pain. He disposed of his underpants, which were stained with blood. Another officer found them and punished the boys collectively in an attempt to get the owner of the pants to confess.

The PIC told the Inquiry he has felt shame and guilt ever since he was abused. He was too frightened to tell anybody about the incidents so no report was made. He described his time at Eden Park as

... like living in a war zone, and it’s hard to put into words the constant heightened awareness of fear that you didn’t know who the next threat was coming from or where it was coming from.

He said he still suffers the effects of the physical and sexual abuse:
Chapter 3 Allegations of sexual abuse

One thing, and I’ve had to do it over the years, is get out of the habit of when I walk into a room I make sure I know where the exits are and make sure they’re clear.

A PIC born in the late 1950s was placed at Eden Park when he was about nine after his parents’ marriage broke down. He had previously spent some time in another orphanage where, he said, he had been relatively happy. As records have not been received from the Salvation Army or the department, the basis for his placement at Eden Park is unclear. The Inquiry did not receive any records to show that the PIC was in State care when he was at Eden Park.

The PIC told the Inquiry he was specifically assigned to a particular staff member at Eden Park. He was required to perform domestic chores at the man’s private residence under the supervision of his wife, including scrubbing floors, cleaning the kitchen, preparing firewood, tending the vegetable garden and working with beehives. He said he worked every day except for Saturday afternoon and Sunday.

The PIC recalled physical punishments and other punishments, including solitary confinement in a lock-up: ‘I have been in there a few times. You couldn’t lay down. [Officer’s name] put me in there for a couple of days once when I ran away.’

He told of a humiliating incident where an officer punished boys for having a pillow fight:

He came down and turned on all the lights, made us all get out in the passage, strip off—or strip off first before he took us out into the passage. I used to hate that. I still cover myself now and I’m a full-grown man … then he walked up and down blowing [a fan] at our genitals.

He also alleged he was stripped naked by the officer on other occasions, including as punishment for bed-wetting: ‘I wet the bed in the wing once and was transferred to “wet-bedders”. He’d strip me and march me over there.’ He did not report the incident.

The PIC said he has suffered as a result of traumatic experiences at Eden Park:

I’ve always struggled in relationships because I just—I don’t know, feeling like—if the kids fall over, I just say, ‘Get up. You’ll be right.’ I don’t run up there and cuddle them.

Abuse by staff and other residents

A n Aboriginal PIC gave evidence about alleged sexual abuse at Eden Park in the 1960s. Born in the late 1950s, he said he was removed from a large family when he was 15 months old and had almost no contact with his siblings or other family members for many years.

Department records show the PIC was under the supervision of the Department of Aboriginal Affairs, which placed him in foster care at 15 months. There was no record of an administrative or court order placing him in State care.

The records suggest problems including bed-wetting developed in the foster home in the mid 1960s and the PIC was referred to the Child Guidance Clinic. As a result, he was sent to Eden Park when he was nine, staying for more than four years. The Inquiry did not receive any records to show he was placed in State care while at Eden Park.

The PIC recalled that he cried on his first day at Eden Park and was physically punished. He alleged that not long after arriving he was anally raped by six boys aged about 16 to 18. The PIC told the Inquiry he reported the matter to a staff member, who ‘flogged the shit out of—he flogged me and then threw me in a little cupboard under a set of stairs’. The PIC said he then told the staff member he was bleeding from the anus but was called a liar: ‘He rubbed my face in the poo and the pee and then belted me for that, for being dirty’.

The PIC alleged that from this time on and for about the next four years the same staff member sexually abused him, raping him in the dormitory at night and then rewarding him by giving him marbles. He also alleged he was raped by the staff member in the big hall and occasionally in the lofts in the dairy. The PIC told the Inquiry...
he did not report the abuse to the department: ‘I was frightened of the welfare and I didn’t know how to tell my mum’.

At 13 he returned to live with his mother, before being charged with offences and placed in State care by a court for two years, which was later extended by two years. He was placed in hostel accommodation.

The PIC told the Inquiry that after spending years in care he was glad to regain his sense of Aboriginality: ‘I missed 12 years of it and I liked being a Nunga’.

A PIC was initially placed in State care under a three-month care and control order in 1980 when he was nine, and was in State care under further longer-term orders for various periods until he turned 18. His parents had separated and his mother was unable to manage him.

The PIC said, and departmental records confirm, that his mother physically abused him and sought his removal from the family home.

At an early stage, the PIC was at the Northern Region Admission Unit where, he said, older girls touched him in a sexual way:

Not as in I was raped or anything ... it's just I think one of those kind of experiences that guys and girls maybe do—you have ... I just think it was nothing bad.

Departmental records show the PIC’s young age when he arrived at the unit appears to have been of concern to a staff member, who was

... a little reluctant to have [the PIC] there ... as he was only nine years and there had been a certain amount of trouble tonight amongst the older members of the unit.

After a few days the department and Child Guidance Clinic placed the PIC at Eden Park, where he remained for 18 months until the early 1980s. He was subsequently in numerous homes, including Smith Street Cottage, Slade Cottage and the Southern Region Group Home. The PIC told the Inquiry he was sexually abused in all four placements.

Although the three-month care and control order ran out during his placement at Eden Park, records show the boy was in constant contact with and under the supervision of the department.

The PIC said Eden Park was an intimidating environment like a concentration camp, with the worst kinds of punishments. He remembers crying for days and days, just wanting to be out of the place but unable to do anything about it:

... the staff were strict and they weren’t nice people. They actually thought they were the army. It was the Salvation Army, they’re meant to be Christian people.

He alleged a Salvation Army officer sexually abused him at Eden Park on about three occasions. The first time, he said, the officer took him from his bed to the television room, where he was required to polish the man’s shoes. The PIC said he rebelled using foul language and was then physically punished and raped by the officer. The following day he noticed bleeding from his anus. He said he told a schoolteacher at the home, and thinks he was taken for medical treatment at Mount Barker—but he did not tell the doctor how the injury had been caused because he was too embarrassed.

The PIC alleged that on a second occasion he remained behind gardening as a punishment while other children went to their families’ homes. He said the officer again took him to the television room where he masturbated himself and made him participate. He did not report this incident.

He said that on a third occasion when he was in his dormitory alone he awoke to find a man bending over him and penetrating his anus. The PIC said he did not clearly see the man but testified that he had the same sound and feel as the officer who had previously sexually abused him.

He told the Inquiry he did not report this incident because of the punishments and everything I’d have after it. Like, I wasn’t just being raped; after that it was made sure that I wasn’t near any other people for four days. I was up the back, either having to do hay baling—like, you know, at the age I
was, lifting hay bales that virtually weighed as much as three people, having to throw them inside a truck—or ripping blackberry bushes out around the sewerage pit.

He wondered at the time whether the carer of his unit knew ‘stuff was happening to me’, because this man used to take him for drives and ‘he knew about me being taken to the doctor. He was asking me who and I was denying it, saying, “Look, nothing’s happened to me”, rah-rah-rah’.

Salvation Army documents and departmental files received by the Inquiry do not mention the alleged abuse by the officer. The Inquiry made enquiries of medical facilities in the Mount Barker region, but was unable to locate any records relating to the PIC.

The PIC also alleged he was anally raped by a bigger, older resident in the television room at Eden Park:

He just jumped on top of me and held me down. My pants was pulled down and he done what he wanted to do ... It started off sort of like a play-fighting act. Sort of jumped on me and everyone was play-fighting, and then it just sort of turned to what it turned to.

Salvation Army and departmental records show the older boy was also alleged to have raped another boy around this time; and when that abuse was disclosed to authorities, an investigation occurred and the alleged perpetrator was removed from Eden Park.

A departmental document reveals that the headmaster at Eden Park provided a written report about the other boy’s rape allegation. It is not evident from the records available whether this alert in relation to alleged sexual abuse of the other boy occurred before or after the alleged abuse of the PIC.

Abuse by other residents

A PIC born in the early 1960s alleged he was sexually abused at Eden Park between the late 1960s and the mid 1970s. The PIC told the Inquiry he was placed at Eden Park when he was about nine because he had become ‘very antisocial’ and was getting into fights at school. The Inquiry did not receive a record of a court order placing him in State care until he was 15 and had left Eden Park.

The only record received from the Salvation Army appeared to be an admission register showing the PIC was admitted (the place of admission is not recorded) in the late 1950s, which pre-dates his birth. Substantial client files have been received from the department, including a document from the Salvation Army that reveals the PIC was admitted to Eden Park at the age of nine because his mother was not coping with him and also on doctor’s advice.

The PIC told the Inquiry he witnessed a lot of violence by staff toward boys and said physical punishments were inflicted on him regularly: ‘There was a lot of public floggings. People that had been recaptured from running away, people that had been fighting amongst each other.’ Boys were sometimes placed in a ‘lock-up’, and staff often beat boys on the bare hands with

... a leather strap, like a razor strap of black leather. If you gave way on doing that and refused to do that, it was, sort of, grabbed by the elbow or the shoulder and whacked around the back of the arse or legs.

According to the PIC, one staff member was particularly brutal: ‘He used to froth at the mouth. He was a real psycho.’ Another popular punishment was to make the boys run around the basketball court ‘until we dropped’. At night boys were made to stand outside in the cold: ‘You were stripped down to your jocks and you stood out on the front lawn out the front of [officer’s name] place’. The PIC also alleged he saw a staff member lift a boy by the ankles and place him, head first, into a drum of cow manure.

He told the Inquiry he was sexually abused by older boys at Eden Park:

I was raped within days of being there ... by the older kids ... sometimes two, three times a week, sometimes even more. It all depends what took their fancy you know; whose fancy—they took of you, you know. Sometimes there were three or four involved.
The PIC said the abuse continued until he was about 13 and better able to defend himself.

He said that at 15 he left Eden Park and soon got into trouble with the police. He was caught stealing, went to court, was placed in State care until 18 and lived in two government institutions.

During his teenage years, he said, he spent a lot of time on the streets and performed sexual favours for men at parties and homosexual beats around Adelaide for money. He used drugs and alcohol.

The PIC said he believes the sexual abuse has had long-term affects on his life: ‘It’s made me very promiscuous’.

Departmental records show a PIC was first placed in State care under a three-month administrative order when he was three years old in the mid 1970s. At this time the PIC’s mother was in hospital and his father was away from home. The records show that when he was 6½ a court found he was neglected and placed him in State care again for three years. Towards the end of that order, when he was nine, he was placed at Eden Park. The order expired while he was at Eden Park and when he was 10 another court order was made placing him in State care until the age of 18 because he was ‘in need of care’. The PIC alleged sexual abuse at Eden Park and also at a subsequent placement at Kennion Cottage, Ferryden Park.

The PIC was placed at Eden Park in the early 1980s when he was nine and stayed for about one year. He was in State care when he first arrived at Eden Park. He said he believed he was about four years younger than the other boys there, and recalled the daily activities as ‘routine, strict and almost like … a jail sort of thing but for kids’. The PIC said he has blocked out many memories of unpleasant times at Eden Park. Records show a departmental worker regularly visited him.

The PIC does not have a clear memory of the sexual abuse he alleged occurred at Eden Park. He told the Inquiry he believes he was forced to perform oral sex and was anally raped by two older males on several occasions and over a period of time. He thought he received medical attention and that one of the perpetrators was removed from the home.

Documents from the Salvation Army show the PIC reported allegations of sexual abuse to a staff member, who reported the matter to his superiors. The matter was also reported to the local police. The records show the PIC was to be interviewed by police, but when they visited Eden Park he was not there; an employee had taken him to a rape crisis centre. It is also noted that another boy at the home had also made allegations against one of the suspected perpetrators.

The Salvation Army documents include a departmental officer’s report to his director-general, in which the officer stated that the PIC was interviewed by an officer from Eden Park; the two alleged perpetrators were sent home; police were notified; and the PIC was taken to the rape crisis centre. The report also notes that boys were left unsupervised for periods during the day and, except for periodical checks, there was no adult in the immediate vicinity of the dormitories.

There is no indication in the report whether there was any follow-up investigation or action by the Salvation Army, police or the department. Police have not located any records in relation to these allegations.

Records were received from a hospital Sexual Assault Referral Centre confirming that an Eden Park staff member presented the PIC for a medical examination. The records note that the PIC made allegations of sexual and physical abuse by older boys at the home. They state that he alleged the boys had forced him to perform oral sex and threatened him with a knife. The notes on file also record that the PIC said he was scared to return to the home and that a departmental officer was notified by telephone of the alleged abuse.

In addition, while substantial client files have been received from the department, the documents relating to the alleged sexual abuse, as provided by the Salvation Army, were not located on these files. The Inquiry found only one brief handwritten note relating to the allegations.
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Documents on the department’s file reveal that the PIC was placed in foster care soon after the incident but no reason is given. The records refer to the breakdown of the Eden Park placement but do not say why it failed. They make no reference to the alleged sexual abuse of the PIC.

Another PIC to allege sexual abuse at Eden Park during the 1980s was under the department’s supervision but no records were received to show he was in State care. The PIC’s parents divorced when he was very young. He was placed at Eden Park for just under a year during his middle primary years and believed he was there because his mother couldn’t cope with him.

Departmental records show that just before his ninth birthday the Child Guidance Clinic referred the PIC to Eden Park because he was considered uncontrollable. A register received from the Salvation Army shows he was at Eden Park for just over 10 months.

The PIC considered Eden Park ‘a scary place for a young child’. He said that in addition to going to school during the day, boys were required to perform chores, mostly cleaning. He recalled a strict regime with a lot of punishment, including physical punishment:

> You got caned for your bed not being made properly; your shoes not being shiny enough; your locker not being tidy enough … I was frightened the whole time I was there.

The PIC told the Inquiry that smaller and bigger boys were housed in the same areas and that some of the older boys were sexual predators. He alleged he was anally raped by two older boys and forced to perform oral sex on many occasions. He said one of the older boys would hold him down while the other raped him, and that they would take turns. He recalled yelling in vain for help, and did not report the assaults for fear of retribution: ‘I was just confused … I was dominated so I couldn’t speak out. I was bashed and threatened so I was in fear.’

The PIC told the Inquiry that on one occasion a staff member became aware of the sexual abuse but did nothing:

> I recall one morning being in bed with an older lad and a staff member walked in and sort of seen what was going on and said to cut it out and shut the door and walked out.

No records other than a register naming the PIC have been received from the Salvation Army, thus the Inquiry is unable to check on what appears to have been an inadequate response by a staff member to an incident of sexual abuse.

The PIC told the Inquiry that after leaving Eden Park he lived with his mother and suffered violence from her partner. In this period, he said, ‘I just went off the rails more’. He started to commit crimes and said he has spent time in adult prisons: ‘I’m angry at myself. I’m angry at the people that did what they did to me’.

**Abuse by unknown perpetrator**

A PIC who alleged sexual abuse in the 1950s at Eden Park told the Inquiry he was placed at the home when aged about five because his mother had become ill. No records were received from the department or the Salvation Army. The Inquiry did not receive any records to show that he was placed in State care.

The PIC told the Inquiry he was at Eden Park for about three or four months and was sexually abused by an unknown man. He recalled that over some weeks the man regularly entered his room at night while he was crying and fondled him.

The PIC said he was confused as a result of the abuse because ‘you just couldn’t differentiate between what was love and affection and caring and, I guess, wanting to have a father and things like that’. He said he did not report the abuse because

> I was too scared to, and with the—I guess the day-by-day ridicule and that sort of stuff, you just couldn’t talk about it anyway.
He also said that when he was aged eight to 11 and outside of care he was sexually abused at home by friends of his mother and by his older brother.

As a consequence of the abuse, he said, he felt confused about his sexual identity as he grew older and even attempted suicide.

One PIC who was born in the late 1960s recalled his mother taking him to Eden Park in a taxi when he was about nine:

*She turned around and walked back to the taxi—I don’t know—and I was waving goodbye and she wouldn’t turn around and wave goodbye or nothing to me. She just kept walking.*

The PIC has vague memories of something happening to him at the home when he was in a room with three men; he thinks he was drugged and sexually abused by Salvation Army officers. He told the Inquiry his mother removed him from the home about one year later.

The Inquiry has received some records from the department but these do not relate to the PIC’s time at Eden Park. It did not receive any records to show that he was in State care at that time. No records were received from the Salvation Army.

**Abuse by outsiders**

A PIC alleged abuse at Eden Park by a visiting priest in the 1970s. He was born in the early 1960s; his parents divorced when he was two and his mother then took over his care.

The PIC said that before being placed in State care he was sexually abused by the local Catholic priest when he was about six:

*I recall at Sunday School, after Sunday School, him seeing me there and talking and paying me a lot of attention, which I liked, and I remember being fondled—just fondled outside my clothes … in my genital area, and then I remember on a couple of occasions having my genital area exposed and him playing with me there.*

The alleged sexual abuse continued and escalated to the point where, the PIC said, the priest took him to a country town and anally raped him. He recalled: ‘It was like he loved me and God loved me and I was special … he was the only man who paid that kind of attention to me’. As a result, he did not tell anybody about the abuse.

When the PIC was 10 a court placed him in State care until 18 as a result of break and enter offences, according to his SWIC. He was sent to Windana Remand Home for a short period and then placed at Eden Park.

The PIC told the Inquiry the same priest who had sexually abused him visited him at Eden Park several times. On each of those visits he was taken for a drive and there would be fondling and, on at least one occasion, anal penetration. The PIC said he was told he was special and that the priest was doing it because God wanted him to.

He said he did not report the abuse to the authorities at Eden Park or the department. Other than a SWIC, no client files have been received from the department and no records have been received from the Salvation Army.

The PIC has committed numerous criminal offences as an adult, mainly involving property and dishonesty. He expressed a desire to rehabilitate and took various courses while in custody to improve his education. With the assistance of the Inquiry, the PIC faced a victim of one of his crimes in a restorative justice session.

Although none of the sexual abuse was reported at the time, the PIC told the Inquiry that in about 1990 he made a report to an official from the Catholic Church and the Department of Correctional Services. Documents received from the South Australian Police confirm that such a report was made and indicate they declined to investigate the matter further as the report was made when there was a statute of limitations applicable to sexual offences.

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**3.1 Institutional care**

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Salvation Army Girls Home / Fullarton Children’s Home, 1900–1986

History

The Salvation Army Girls Home, also known as The Haven, was proclaimed as a private institution that could receive State children in October 1900. At that time it was known as the Girls Probationary School. The home was run by the Salvation Army but was under the control of the State Children’s Council (SCC) and ‘subject to the supervision and authority’ of the SCC’s secretary to the same extent as a government institution.

During the 1920s the school accommodated girls regarded as ‘uncontrollable’, or ‘habitually absent’ from school, as well as girls on remand and those charged as destitute or who were transferred from other government institutions.

In 1936 the Aborigines Protection Board placed three 12-year-old Aboriginal girls at Fullarton to undergo a three-year course in domestic arts and paid a subsidy for their maintenance. However, in the same year, members of the Children’s Welfare and Public Relief Board (CWPRB), which had replaced the SCC in 1927, inspected the home and found conditions unsatisfactory. Complaints led to improvements including ‘better shoes and clothing for the girls’.

In 1944, the Salvation Army informed the board it intended to close the home. The following year it was removed from the list of gazetted institutions approved by the government and the girls were transferred to other institutions. The home continued to operate, taking in children placed privately.

In 1950 the home again came under the board’s supervision as a result of amendments to the Maintenance Act requiring that the board inspect any institution caring for illegitimate children under seven. The home was inspected periodically and inspection report forms were completed. From 1965, with the passing of the Social Welfare Act, the home’s matron was required to apply for a licence to run a children’s home. The licence required the home to fulfil obligations under the Act and follow accompanying regulations.

In 1969 the Salvation Army’s Women’s Social Services department announced a plan to form an auxiliary for the Fullarton Children’s Home. The home had been renamed as it now provided a ‘substitute home’ for boys as well as girls, with the main focus on keeping siblings together where possible. The staff wanted to form the auxiliary because of the Aboriginal children in their care; ‘there are special and peculiar difficulties that are encountered only when working with a combination of Aboriginal and white children’.

In 1972 the Salvation Army reported that the home was caring for 31 children, most accommodated because of family or foster care breakdown, illness of parents, or for ‘behavioural difficulties’. Fourteen children had been referred to the home by the department.

With the passing of the Community Welfare Act and the establishment of the Residential Child Care Advisory Committee (RCCAC) in 1974, the Salvation Army entered into new licensing and funding agreements with the government. The department paid for a social worker to...
help assess and care for children admitted to the home. Each child's case was also to be regularly reviewed at meetings of the home's review board, which were attended by an officer of the department.

During the 1980s the Salvation Army made an arrangement with the Department of Aboriginal Affairs to provide a home for several Aboriginal girls who were completing high school. In 1981 the matron applied to the RCCAC for funding to hire a psychologist because of the increasing number of children admitted with ‘disturbed behaviour’. The RCCAC declined funding and suggested children be referred to a psychologist and that staff undertake further training.

During this period the RCCAC’s emphasis was on encouraging non-government agencies to move away from congregate residential care. As a result, Fullarton Children’s Home closed at the end of June 1986. The building was retained and is still used as the Salvation Army’s South Australian divisional headquarters.

Allegations of sexual abuse
Six PICs gave evidence that they were sexually abused while placed at the Salvation Army Girls Home.

The Inquiry was able to confirm from available records that three of the PICs were in State care during their time at the home; one was placed there by court order for being neglected and two were placed there under the supervision of the Aborigines Protection Board.

In relation to one PIC, the Inquiry did not receive any records and it is not known which organisation or person was responsible for her placement.

Another PIC was placed in State care by a court for significant periods both before and after her placement at Fullarton Girls Home, although it seems unlikely there were any court orders in force at the time of this placement. The basis of the sixth PIC’s placement is unknown but she is likely to have been placed by a parent.

The alleged sexual abuse ranged from vaginal and digital rape to indecent assault and fondling. The alleged perpetrators included one staff member, fellow male and female residents and, in some cases, people not connected with the home. Two PICs alleged they were abused while away from the home on a visit.

Despite their allegations of sexual abuse, some of the PICs said they enjoyed living at the home. One recalled:

*I loved the house, the atmosphere. It was the most—if I could change back time, I would have stayed there permanently because I was most wanted. It was the most warming—fair enough, things happened with the guys and that, but I never looked at that side of it. I just looked at it being a warming, caring place where you could go when you had nothing.*

The Inquiry heard evidence that the living conditions were very basic and the home was run quite strictly, with a strong religious emphasis. One PIC reminisced:

*It was a real Christian place … We used to have to clean the dining room floors and you have to get on your hands and knees and scrub all the marks off and then you’d put polish on it. We had a big open dormitory on the first floor. The doors were never closed. It was freezing cold. But I think they were kind to us.*

Another PIC recalled the atmosphere at Christmas:

*It was, like, the best time, because we used to go out to Christmas parties all the time, and it was, like, all these rich white fellas used to take us out to Christmas parties and buy us a lot of presents.*
Abuse by staff

A PIC told the Inquiry she first learned she was Aboriginal at 13. She has no recollection of her parents but thinks she was placed in care as a baby in the early 1940s. The only record received from the department is an index card that relates to the department's correspondence about the PIC; the Inquiry did not receive a record of a court order placing her in State care. The PIC told the Inquiry she was sexually abused in a foster placement (court records show the foster father was convicted of two counts of indecent assault in relation to the PIC) and then later at what she thinks was the Salvation Army Girls Home.

The PIC told the Inquiry she was placed in a Salvation Army home when she was a teenager; she was not sure which home but thought it may have been the Fullarton home. No records have been received from the Salvation Army in relation to her. The PIC alleged a handyman took her to a shed on the grounds, pulled her pants down and digitally penetrated her. She said she did not disclose the sexual abuse to anyone.

Asked how she felt about her time in care, the PIC said: ‘I just have this terrible sadness’.

Abuse by other residents

A PIC born in the mid 1960s told the Inquiry her parents separated when she was about eight and the department became involved at about that time: ‘When it suited my parents they wanted me and when I didn’t fit in with either one of their lifestyles, I was removed’. The PIC was placed under a series of short-term orders but there were periods when she was not in State care. She said she was sexually abused when placed at Pleasant Avenue Cottage and later at the Fullarton Children’s Home.

Records show the PIC’s mother placed her at Fullarton when she was 13 and she remained there for about a year. There were no records to suggest that she was in State care at this time. The PIC thinks she came to be at Fullarton because

My mum didn’t want me and she said I was better off in a foster home and so one of the welfare workers dropped me off at the Salvation Army home.

The PIC recalled of the home: ‘I fell in love with the house, the atmosphere, some of the kids ... I felt wanted. I felt needed.’ She told the Inquiry: ‘There was some kids I didn’t like and there was an episode that tore my life apart in Fullarton. I was raped by a guy called [name].’ She said the perpetrator lived at the home but she did not report the sexual abuse:

That’s one thing I never told anybody. I couldn’t. I didn’t trust—it was just that I did not know how to open up to anybody about what happened with guys, because I wasn’t the only one. There were a few other girls that [the boy] did it to. I wasn’t the first and I wasn’t the last ... he used to brag about it to all the boys.

She said she did not want to be considered a victim: ‘I’m not sitting back saying, “Oh, poor me”. I’m going beyond that. I’m facing everybody and I’m not scared to face anybody. I was back then.’

An Aboriginal PIC who was born in the 1940s came from a large family and spent her early years on a mission. She gave evidence that she suffered extensive sexual abuse by two men when she was aged between about six and nine. One of the perpetrators was her uncle, whom she remembered confronting when she was 11:

It was a responsibility that you had on your shoulders that, if you said anything, you would smash the family up. So I had a lot of trauma around that where, when I was 11, then I confronted it myself and said, ‘Why are you doing this? You’re my uncle.’

The PIC said she also confronted the second man who was sexually abusing her but did not report the abuse to anyone else: ‘No. It was satisfying enough for me to confront them myself.’
The APB placed her at Fullarton just before her 13th birthday. The Inquiry has received minimal records: only a memo recording she was to be admitted to the home from the department, as well as a file from the APB. No records have been received from the Salvation Army. The Inquiry did not receive a record of a court order placing her in State care.

The PIC believes she was at the home for less than a year in the 1950s. She gave evidence that older girls at the home sexually abused younger girls and that this happened to her on two occasions. She alleged the older girls induced her to touch their breasts or vaginas but after the second occasion she refused.

The PIC also said she was sexually abused by a man after she left the home and was in the workforce.

She told the Inquiry,

I think that people who sexually abuse children should be punished for that because they have an ability as adults to be able to stop themselves doing that and children don’t have the ability to defend themselves.

Abuse by outsiders

An Aboriginal PIC who was born in the 1940s at Point Pearce Mission told the Inquiry her mother died when she was about seven and her father was unable to care for her and her siblings. She recalled that at 10 she was put on a bus at Point Pearce and taken to the Fullarton home, where she lived for about two years before spending time in other Salvation Army homes until she was 15.

Records on the PIC have been received from the department but not from the Salvation Army. They relate only to her situation from the age of 15, and indicate she was under the supervision of the APB, which confined her to Point Pearce when she was 15. The Inquiry did not receive a record of a court order placing her in State care before then.

The PIC said she was placed with different families during holiday periods while resident at Fullarton. During a stay with one such family in a small country town when she was about 11, a male teenage member of the family sexually abused her: ‘Their son was taking advantage of me… I felt so embarrassed and frightened.’ She could not recall details of the abuse and said: ‘I never told his parents nothing about it because I was too frightened’.

The PIC recalled attempting to run away from the Fullarton home and believes this is why she was transferred to another Salvation Army home when she was about 15. She said she then got permission from the Army to live with family members; she alleged she was sexually abused while living there.

Born in the mid 1960s, an Aboriginal PIC was five when she was placed in State care until the age of 18 after a court found she was neglected and under unfit guardianship. She said she does not recall being taken away from her family because she was too young at the time. ‘I don’t really remember a lot when I went to the home. I don’t remember Welfare taking us. I don’t remember really how old I was …’

Two months after being placed in State care, the PIC was transferred to the Fullarton home with one of her older sisters and, according to records from the department, remained there for 11 years. The records indicate she was happy there: ‘No complaints, appears happy and contented’. The only documents received from the Salvation Army are identity papers.

She has fond memories of the home:

Yes, three meals a day, and because it was the Salvation Army Girls Home, they owned the Ballours factory, so we used to have cream cakes—everything. We had the bestest food. We had always good meals all the time.

The PIC alleged she was sexually abused when she was about seven while visiting her family, possibly over a weekend. She had difficulty recalling what happened in any
detail but spoke of lying on a double bed in a house with a man, and said he did sexual things to her and may have penetrated her:

I remember the next day he came around and Mum was in the kitchen and this man walked in and I seen him, so I jumped under the table, and I hid and I got into trouble, because I shouldn’t do that to our uncles ... I never told anybody.

A PIC born in the mid 1960s alleged she was sexually abused during a placement at the Fullarton home in the 1970s. No records were received from the department relating to this placement, and the only record received from the Salvation Army is a single document that shows the PIC was admitted when she was six and remained there for more than nine years. The record suggests her father admitted her. The Inquiry has not received a record of her being placed in State care.

The PIC told the Inquiry she has few memories of her early childhood but alleged that when she was very young her alcoholic father made her give him oral sex:

I think for a very long time I didn’t really understand what was happening, and it was only later that I realised what had happened and how inappropriate it was, and I’m talking years later.

She gave her impressions of life at the home:

There was no individuality. It was very institutionalised, so, you know, tea at this time, this at this time, you know, and certain times—‘This day is when you start wearing your winter clothes’ and ‘This day is when you start wearing your summer clothes’, and you did what they told you to ... Yes, just a constant memory of pies and pasties and bread and milk for dessert or, for breakfast in winter, you got it with hot milk.

The PIC said that while at the home she spent some holidays and weekends with a couple and that the man sexually abused her. She recalled him coming to her bedroom at night but not the full details of what happened. She thought the abuse involved penetration: ‘As far as I remember, I think maybe digital ... I would just lie there still and ... pretend that I was asleep’. She did not report the abuse: ‘I guess it was a sense of, well, what difference would it make and who would care anyway?’

The PIC told the Inquiry that after being released from Fullarton she went to another Salvation Army home, where she was much happier. She said she then told another girl about the earlier abuse and this girl in turn mentioned it to others, including her father.

The Inquiry received evidence from a former cottage parent from the other army home who said the PIC disclosed to her that while she was staying with a family during holidays a man had sexually abused her. She said she passed this information on to a staff member at the home: ‘The response, as I recall it, was, “Well, these people have been good to the Salvation Army. If [name] is not going we’ll have to find someone else to go.”’

Salvation Army Boys Home, Kent Town, 1929–72

History

In 1929 the Salvation Army informed the secretary of the Children’s Welfare and Public Relief Board (CWPRB) that it had purchased ‘a beautiful home, with delightful surroundings’ at 64 Kent Terrace, Kent Town. It intended to relocate the ‘smaller boys’, aged between six and 12, to this home from Eden Park to reduce overcrowding and to better separate and ‘classify’ boys.89 At that time the Salvation Army requested that the home be proclaimed a

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private institution for the reception and detention of State children, in the same manner as Eden Park.

The CWPRB refused this request. There were already seven institutions to which a court could commit children. The CWPRB also did not want to show ‘undue preference’ to any religious denomination and believed that boys committed for delinquency or truancy were better off away from the city and the ‘disturbing influences by parents’. As the CWPRB often used the isolation of Eden Park as a placement option for boys who had been committed to the Industrial School but who were regarded as too ‘uncontrollable’ to remain there, the idea that these same boys could return to metropolitan Adelaide ‘had no force of appeal to the board’. As a result, the Kent Town Boys Home opened on 27 April 1929 as a home for boys placed privately. However, by the mid 1950s the APB placed Aboriginal boys at Kent Town, paying a subsidy for their maintenance. In addition, as a result of an amendment to the Maintenance Act in 1950, Kent Town, as a ‘benevolent institution’ caring for illegitimate children under seven, was subject to supervision by the CWPRB. Periodic departmental inspection reports from March 1954 – May 1965 reveal that the home generally accommodated 45 to 48 boys, including sometimes up to eight boys who were younger than seven.

Residents attended Norwood Primary and Technical schools and received religious instruction from Salvation Army officers. The boys were sent to the Salvation Army citadel each Sunday for the purpose of mixing with other children.

The passing of the Social Welfare Act in 1965 required the manager of the Kent Town home, like the heads of all non-government institutions, to apply for an operating licence. By 1970 Kent Town was taking in boys ranging in age from five to 18. A Salvation Army report from that year stated that parents had placed five boys; the remainder being placed by the departments of Social Welfare and Aboriginal Affairs, Education and Repatriation, and the Northern Territory Administration.

The home closed in January 1972 and the boys were transferred to Salvation Army homes at Eden Park and Fullarton or to other private placements.

### Allegations of sexual abuse

Five PICs gave evidence about allegations of sexual abuse while they were placed at the Kent Town home. The Inquiry could not find any record of court orders placing them in State care. The Department of Aboriginal Affairs placed three Aboriginal PICs at the home. The department was involved in the placement of a fourth PIC who later became a State child under a court order. No records were received about the placement of the fifth PIC.

The allegations of sexual abuse were made against a staff member, other resident boys, visitors and people outside the home. Some of the allegations involved single incidents, while other PICs gave evidence about repeated abuse. The PICs accused the perpetrators of offences including anal rape, unlawful sexual intercourse, forced oral sex and indecent assault.

No client files were received from the Salvation Army for any of the five PICs, although some documents related to
one PIC. In most cases records were received from the department. None of the records disclosed allegations of abuse. None of the PICs asked the Inquiry to pass on their allegations to police.

**Abuse by multiple perpetrators**

A PIC born in the mid 1950s lived at the Kent Town home in the early to late 1960s but was unsure how he came to be in the Salvation Army’s care. Both the army and the department said they could not find any records about the PIC, and the Inquiry did not receive any records to show that he was placed in State care.

The PIC said his parents separated when he was young, and when he was about eight his father was unable to continue caring for him and sent him to the Kent Town home, where he found discipline was ‘very, very severe and that was a shock. Life was often quite vicious and brutal but it was a predictable life’.

He alleged he was sexually abused on numerous occasions while at Kent Town, and spoke of incidents involving other boys:

> I would have woken on a number of occasions in my time at Kent Town with an Aboriginal boy standing over me, putting his penis in my mouth … You’d be sound asleep and someone would hop in your bed and remove your pyjamas and begin trying to penetrate you.

The PIC alleged that sexual abuse sometimes occurred in the showers:

> We had communal showers and there would often be boys that would rub themselves up against you, that would try and soap you, that would try and grab your genitals.

He also alleged he was repeatedly sexually abused over three years by a staff member: ‘Initially it was fondling and that led to oral sex and that led to penetrative anal sex’.

On weekends he would ride with other boys to areas around the Botanic Gardens and the River Torrens, and on most of these outings strange men would talk him into participating in sex acts:

> They’d say, ‘Look, do you want to earn a dollar?’ and you’d say ‘a dollar?… yes,’ and they’d say ‘drop your daks’ and they’d perform oral sex, and sometimes they’d give you the dollar, other times they’d tell you to piss off.

He did not report these incidents because:

> It was just easier often to just not do or say anything and you know: just allow these things to happen, because you very quickly worked out it would take 10 minutes of your time, and you moved on.

The PIC told the Inquiry he left the home when he was about 15 but had nowhere to live: ‘I basically became a street kid’. He said he has tried to put the memories of his childhood behind him: ‘I’ve tried to forget an awful lot of life as a child. It wasn’t much of a childhood in many ways.’

**Abuse by other residents**

A PIC from Point Pearce Mission lived at the Kent Town home for 10 years in the 1960s from the age of about five. He did not know his father and his mother was unable to care for him.

Records show the Department of Aboriginal Affairs placed him in foster care. A few records were received from the Salvation Army and some from the department, which referred to an earlier involvement of the APB in the PIC’s foster care and Kent Town placements. Maintenance and other financial payments were made but there is no evidence of a formal transfer of control to the department.
In 1958 the APB wrote to the PIC’s mother, stating that the PIC ‘not only comes under our department but, being an illegitimate child, also comes under the children’s welfare’.

The PIC told the Inquiry the Kent Town home was a very strict place:

> There was a lot of corporal punishment going on all the time. You know, that was with a cane. You’d have to hold out your hands and you’d get six whacks on the tips of your fingers. You kind of had a choice of that or, you know, you could drop your pants and get a leather belt on the bottom.

He alleged he was sexually abused there when an older boy induced him to go outside at night, then anally raped him on the lawn:

> I don’t remember the pain. It just was the shock of it all and I tried to get away. He must have got off so, you know, there was a mess as well. I went away and cleaned myself up. That was pretty well my first introduction to sex.

He did not report the abuse: ‘I was too embarrassed about it. Even though I didn’t know what sex was, it was just embarrassing. I felt ashamed.’

The PIC also gave evidence that he saw quite a few younger boys being abused by older boys at the home.

He was released in the early 1970s when the home was closed down, and alleged he was subsequently sexually abused in the family home.

Regarding the effects of the sexual abuse, the PIC said: ‘I put on a good front. I think the psychological scars are always there in your background. A lot of things will remind you.’

### Abuse by outsiders

An Aboriginal PIC was born on Point Pearce Mission in the mid 1940s and was placed in care by his parents in the mid 1950s, partly because he had a disability.

The Inquiry received some records from the department but none from the Salvation Army. The records indicate the PIC’s mother wanted the APB to place him in a home. When the boy was seven the APB wrote to the manager at Point Pearce, stating that his mother agreed he should be placed under the board’s care and control until he turned 18. The letter also said it was extremely difficult to place any Aboriginal child in any home at the time.

Correspondence indicates that the board approved payment of 25 shillings a week maintenance. These documents suggest the PIC was not formally placed in State care pursuant to a court or administrative order but that the placements were under the supervision of the APB.

The PIC was placed at the Kent Town home when he was eight and remained until he was 16. He found the home to be very strict, with harsh physical punishments.

He said he required ongoing treatment for his disability at the Adelaide Children’s Hospital, and alleged that a hospital employee who was involved in his care started to sexually abuse him. The man would touch him on his genitals, laugh and say ‘Oops, I’m sorry,’ as though it had been an accident.

The PIC further alleged the man came to the Kent Town home and asked the officer in charge whether he could take the PIC out:

> He asked the captain if he could take me out, and the boys around me … all had their arms up to talk to the captain, because that’s what we had to do,
and I had my arm up to say no because I knew what [name] was up to, but the captain wouldn’t turn around and look at me and he gave permission for [name] to take me home.

He said the man took him to his house and told him to have a shower. While he was in the shower the man allegedly came in and started touching him and showing him how to wash himself. The PIC said the man then carried him into his bedroom, lay on top of him and ‘started loving me like I was a woman’. The PIC, who said he was about 10 at the time, alleged that similar abuse happened on one more occasion.

He said he did not report the incidents because the man had warned him not to. He also thought of the abuser as ‘someone who loves me’, even though he knew the sexual abuse was wrong.

The PIC told the Inquiry that when released from care at 16 he had nowhere to live, so he spent time on the streets and abused alcohol.

Another Aboriginal PIC told the Inquiry he was placed at the Kent Town home in the 1950s when he was about 15. No files were received from the Salvation Army in relation to this PIC. When asked how long he was at Kent Town, he said ‘Thank God, not long’. Records from the department show he was under the supervision of the APB, which also placed him at Colebrook Home and the Salvation Army Boys Home, Eden Park. The PIC alleged he was sexually abused at both of those homes. The Inquiry did not receive any record of a court order or transfer of control placing him in State care.

The PIC alleged that while he was at Kent Town a staff member from another home where he had lived picked him up and took him to an ice-skating rink. He recalled being taken to a room and given lollies and feeling dirty when thinking about the occasion afterwards. He could not recall precisely what happened but believes he was sexually abused. He did not tell anyone about the incident.

Abuse by unknown perpetrator

One PIC alleged he was sexually abused in the 1940s at the Kent Town home, where he was placed when he was about 10. He was known to the department at the time but was not placed at the home under a court order. After about a year at Kent Town he was placed in State care for offending and sent to Eden Park, where he also said he was sexually abused.

The PIC alleged that on about 10 occasions at Kent Town he woke up and found a male in his bed, touching his genitals and encouraging him to reciprocate: ‘They had men in there and half the time you’d wake up you’d find somebody in bed with you’. He believed his abuser was either a live-in employee or an older resident. The PIC did not believe that reporting the sexual abuse would have done any good: ‘If you reported it, all you got was a backhander for telling lies “because our boys wouldn’t do that”’. To escape the abuse he absconded several times and went to his mother’s house: ‘I’d just stay there until they come and picked me up’.

No records relating to this PIC were received from the Salvation Army. Documents from the department confirm he was absconding but do not indicate there was any investigation of the cause.
Homes for Aboriginal children

History

From the early 1920s until the mid 1960s, South Australian legislation permitted Aboriginal children to be treated differently to non-Aboriginal children in terms of their care. Unlike a non-Aboriginal child, an Aboriginal child could be placed in State care without any need for a court appearance.\(^{99}\)

From 1923, the Chief Protector of Aborigines, with the approval of the State Children’s Council (SCC) and its successor the Children’s Welfare and Public Relief Board (CWPRB), could commit any Aboriginal child to any institution by completing a transfer of control form\(^{100}\), which would make the child a State child.\(^{101}\)

In 1939, the role of Chief Protector was abolished and the Aborigines Protection Board (APB) was created.\(^{102}\) The APB could commit any Aboriginal child to an institution with the approval of the CWPRB, without a court appearance\(^{103}\) and such a child would be a State child (‘the section 38 process’). An Aboriginal child could be sent to live in any government or non-government institution, however they could also be placed in dormitories on mission stations run by religious organisations such as the United Aborigines Mission (UAM), a body of evangelical Christians that began in South Australia in the 1920s, and the Christian Brethren, which established the Umeewarra Mission near Port Augusta in 1937.

The Supreme Court of South Australia has found that the section 38 process was ‘a cause of ongoing tension’ between the APB and the CWPRB\(^{104}\), with the CWPRB refusing to give its approval to the process generally and the APB then acting unilaterally. This meant that Aboriginal children were removed from their parents contrary to the existing legislation.\(^{105}\)

Missionary organisations applied for and received child endowment subsidies for Aboriginal children placed in dormitories on their stations.\(^{106}\) Parents whose children lived on mission stations applied to the APB to take their children for holidays. In one case, the UAM secretary directed mission superintendents to apply to the APB to take their children for the holidays. In one case, the APB secretary refused to give its approval to the process generally and the APB then acting unilaterally. This meant that Aboriginal children were removed from their parents contrary to the existing legislation.\(^{105}\)

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Cultural attitudes toward Aboriginal children and appropriate disciplinary practices influenced life in these homes. In 1951, the UAM secretary advised a superintendent of one of the homes: ‘You sure will need to be strong with them, the brats need the strap’.\(^{109}\) In 1954 the UAM secretary recommended corporal punishment, deprivation of food and denial of ‘some pleasure’ as disciplinary measures. Returning children to their parents was a last resort: ‘We don’t like turning any child loose again, but if they will not be controlled by those who are trying to uplift and help them, then they will just have to go’.\(^{110}\) The UAM took its cue from the Chief Protector of

\(^{99}\) Aborigines (Training of Children) Act 1923.

\(^{100}\) ibid., s. 6.

\(^{101}\) ibid., s. 7.

\(^{102}\) Aborigines Act 1934–1939

\(^{103}\) ibid., ss. 38-40.

\(^{104}\) Trevorrow v State of South Australia (No 5) [2007] SASC 285 at [37].

\(^{105}\) See discussion in Chapter 1, Approach of the Inquiry.

\(^{106}\) United Aborigines Mission (UAM) Archives, records relating to Colebrook Home and children’s dormitories at Gerard and Oodnadatta missions show the UAM received subsidies from both departments for different children. See also SRSA GRS 52/1, File 663/1956, Correspondence of the Aborigines Department re control of neglected, destitute and uncontrollable Aboriginal children, APB secretary to the parliamentary draughtsman, 23 Oct. 1956.

\(^{107}\) ibid., Box 38, Oodnadatta correspondence 1949–53, UAM secretary to superintendent, 18 Nov. 1950, and 27 June 1951.

\(^{108}\) ibid., Box 72, Gerard outward correspondence 1949–53, UAM secretary to Mrs. ________, 23 Dec. 1949.

\(^{109}\) ibid., Box 38, Oodnadatta correspondence 1949–53, UAM secretary to superintendent, 22 Feb. 1951.
Aborigines: “The Aborigines protector used to say, they only know the one way and that is the lether [sic]”.

Insufficient standards of care due to staff shortages and substandard facilities were an ongoing concern. In 1953 one missionary was urged by the UAM secretary: “You must lift the standard of the home or we will loose [sic] out with the children”.

It was not until the early 1960s that the same legislative provisions applied to Aboriginal and non-Aboriginal children in terms of the way they were placed in State care. The APB and the provisions relating to the transfer of control of Aboriginal children between the APB and the SCC/CWPRB were abolished by the Aboriginal Affairs Act 1962. After this time, legislative requirements for the licensing of children’s homes affected non-government homes for Aboriginal children. Mission-run homes that were ill-equipped and poorly staffed did not receive licences, as was the case with Colebrook Home. Other homes were determined to minimise government oversight of operations.

In the 1980s, organisations providing accommodation and projects for Aboriginal youth received funding from the Department for Community Welfare as well as from the peak bodies of respective religious groups.

Summary of evidence

Ten people gave evidence to the Inquiry that they were sexually abused while placed in homes for Aboriginal children. Of those, one said she was abused in two separate homes. The Inquiry was able to determine from available records that four people were in State care at the time of the alleged sexual abuse. It was not possible to determine whether the remaining six people were in State care at the time, either because of limited records or due to the placements occurring at the time when the APB was not acting in accordance with the legislative scheme in placing children in State care.

The allegations included indecent assault, fellatio and anal rape committed by staff members, other residents and people from outside the homes.

Koonibba Children’s Home, 1913–63

History

The Koonibba Children’s Home was established in 1913 as part of the Koonibba Mission Station, established by Lutheran missionaries in 1901 near Ceduna on South Australia’s West Coast. The children’s home consisted of 14 main rooms, including sleeping quarters for the matron, other staff and children. Initially accommodating 28 children, the home was renovated and extended to house up to 70 children. A history of the home noted that it was established to help Aboriginal children be ‘removed from the camp atmosphere, and brought up in a Christian atmosphere’. The South Australian Government took over the mission in 1963 and the home closed that year.

Allegations of sexual abuse

One woman gave evidence to the Inquiry about alleged sexual abuse at Koonibba Children’s Home while she was in State care.

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110 ibid., Box 64, Oodnadatta file 1953–65, UAM secretary to superintendent, 23 Jan. 1954.
111 ibid., UAM secretary to superintendent, 27 Jan. 1954.
112 ibid., Box 38, Oodnadatta correspondence 1949–53, UAM secretary to mission staff, 28 Jan. 1953.
113 For a detailed discussion of the relationship between the State and Aboriginal people see Cameron Raynes, A little flour and a few blankets, An administrative history of Aboriginal Affairs in South Australia, 1834–2000, State Records of South Australia, Adelaide, 2002.
115 Trewren v. State of South Australia.
116 See Rev. E Harms and Rex. Hoff (eds.), Koonibba: a record of 50 years work among the Australian Aborigines by the Evangelical Lutheran Church of Australia 1901–1901, undated, in FYOW, s. 5.3.
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Abuse by unknown perpetrator

A woman born in the early 1940s alleged she was sexually abused at the home in the early 1950s. The PIC was 11 and living at Gerard Mission when a court found her to be destitute and placed her in State care until she turned 18. One month later she was placed at the Koonibba home. The PIC alleged she was sexually abused at the mission and the home.

The PIC told the Inquiry she was raped by a man at the Koonibba home: ‘Hid behind the trees up—in—when I was over at the cows. Nothing I could do about it.’ She said the abuse happened ‘three or four times’ and she did not report it: ‘I just made sure that I kept out of his way’.

Records received by the Inquiry contain a letter written by the PIC to her departmental probation officer, which conveys her distress at rumours spreading around the home that she was sexually active. The probation officer forwarded the letter to the superintendent of Koonibba Mission Station, noting the ‘rather disturbing information’ and recommending ‘any action you consider necessary’. A departmental inspection report filed at this time on the PIC noted that, ‘she will want some watching before too long with the boys around the Station’. An inspection report filed three months later noted that the superintendent had assured the department that the PIC had been encouraged to come forward with any concerns. The inspector spoke with the PIC and concluded she had ‘settled down now’. Records show the PIC was released from State care just before her 13th birthday. She told the Inquiry she moved to Adelaide not long after. She said she married when she was still a teenager and was physically and sexually abused by her husband.

Gerard Mission Children's Dormitory, 1946–61

History

The UAM established a mission station on land near the River Murray in South Australia's Riverland in 1946. The children's dormitory on the station operated with the intention of providing Christian instruction to resident Aboriginal children. The UAM received government funding to operate its mission and relied on contributions from families living on the station, as well as child endowment payments from the Commonwealth Government.117

Children living in the dormitory attended school in buildings owned by the Education Department.118 Staff included a superintendent and his wife, a teacher and a staff attendant, looking after an average of 10 children at any one time.119

The mission station staff separated children from their parents living on the station. In 1947 the superintendent wrote that ‘there is only one child in the dormitory that is there voluntarily’ and remarked on the difficulty of keeping families separated: ‘If the parents are on the station you cannot keep the children away from them’. There was no formal policy that required children to live in the dormitory until of school-leaving age and the mission lacked the staff to deal with ‘the few children there now’.120 Compelling children to live away from their parents for extended periods risked the departure of families from the mission. However, the UAM considered separation to be preferable. The dormitory was often in poor repair. In 1949 one staff member left due to ‘the lack of proper housing and facilities’.121 A letter from the superintendent in 1951 requested the UAM's assistance in repairing the children's sleeping quarters, as ‘there are holes in both the boys and
Chapter 3 Allegations of sexual abuse

girls sleeping rooms’. Another letter stated, ‘I am always ashamed of anyone coming in to see the place & the first thing they see is the dilapidated huts which serve as sleeping quarters for the dormitory children’. An indication of the disciplinary style of the home can be found in staff correspondence. A senior staff member wrote to the UAM praising a colleague in all but one respect: ‘I feel that is one thing that Sister [name] fails in, she will not use corporal punishment’.

In 1961, the State Government assumed control of Gerard Mission and the dormitory was closed that year.

Allegations of sexual abuse

One woman gave evidence of alleged sexual abuse while in State care at Gerard Mission Children’s Dormitory in the early 1950s.

Abuse by outsiders

The PIC previously spent several years at the mission and continued to live there after becoming a State child. Records received from the department show that as an 11-year-old she was charged with being destitute and placed by a court in State care. The PIC alleged sexual abuse at the mission in the early 1950s and also at her next placement at Koonibba Children’s Home.

The PIC said she was removed from her family when she was very young and placed at the mission:

I knew I was going to Gerard and didn’t know where it was. I was happy anyway. They gave me a bag of lollies ... I thought I was just going for a ride. I didn’t know I was going for that biggest ride, way up there.

She told the Inquiry she was sexually abused on different occasions by three different men who lived at the mission, but it is unclear whether these incidents occurred before or after she was placed in State care. The PIC alleged that, several times a week, two of the men entered the children’s dormitory through a hole in the wall, pulled her underwear down and indecently assaulted her. She also said a third man molested her in a separate incident. The PIC said the men were all young married men who lived on the mission station. She had been ‘too frightened’ to report the abuse, which she said went on for years.

The Inquiry received records from the UAM and also a file from the department, which confirm that the PIC was at Gerard when she was placed in State care. The UAM records also show that one of the married men the PIC said entered her dormitory and sexually abused her had previously been placed in State care when he was a teenager for indecently assaulting a seven-year-old girl on the mission. After his release from State care, the alleged perpetrator returned to the mission and married, which is when the PIC told the Inquiry he sexually abused her. The Inquiry also received documents showing that about 15 years after the sexual abuse alleged by this PIC, two of the perpetrators named by her (including the perpetrator who had been placed in State care as a teenager) were charged with the carnal knowledge of another girl who lived on the mission.

Colebrook Home, 1927–81

History

Colebrook Home opened in 1927 in Quorn as an institution for Aboriginal children, operated by the UAM. In January 1944 the home was relocated to a four-hectare property at Eden Hills in Adelaide, to escape ongoing water shortages at Quorn.

122 ibid., Box 72, Gerard correspondence inward 1950–51, superintendent to UAM secretary, 20 Feb. 1951.
123 ibid., superintendent to UAM secretary, 24 Sep. 1948.
124 ibid., superintendent to UAM secretary, 19 Apr. 1951.
125 FYOW, s.8.8.
126 Previously Oodnadatta Children’s Home, also known as Colebrook Children’s Training Home, Quorn.
127 FYOW, s. 8, p. 2.
The number of children at Colebrook varied during its years of operation, from a high of 50 in the 1940s and 1950s to 20–30 in the mid 1960s to just five children in September 1971.

From 1927–52 the home was run by Matron Ruby Hyde and Sister Delia Rutter, who then left Colebrook to form their own hostel for girls. From this time, the home experienced constant staff turnover, shortages and a deterioration in conditions. In 1953, the UAM secretary wrote that with ‘only two workers and already 40 children’ the superintendent and his wife were at ‘their wits end … I am very much afraid that if we don’t get help for them very soon they will break’. The home’s facilities were substandard. The buildings had been erected in 1912 and converted into dormitories and a schoolroom. Board of Health inspections found ‘insanitary conditions’ caused by ‘lack of funds and lack of staff’ in 1954 and ‘appalling conditions’ that constituted ‘a menace to the health, of not only the staff and inmates of the home, but to the residents living in the district’ in 1956.

Care at the home emphasised discipline and children’s spiritual training. One staff member in the 1950s routinely woke children at night for reading and prayers. A superintendent in the 1960s wrote that there were children in the home with ‘a real need for more personal contact, a home perhaps, where more time can be directed to their individual needs’. During this period, children who wet their beds were sent to school without breakfast to get them out of this habit. As one superintendent recalled:

We had some missionaries over zealous, who did great harm too, in punishing native children if bread was baked on a Sunday, by making them go hungry, and … waking children up to read the Bible and pray to them.

After inspections, the UAM’s application to have Colebrook Home licensed under section 162a of the Social Welfare Act was refused in 1966. This meant the home could not accommodate more than five children under 12. Colebrook was deemed unsuitable for large numbers of children given its poor amenities, inadequate staff and insufficient awareness of Aboriginal children’s emotional and social needs. In 1969, after community concern was raised and on the recommendation of the Aboriginal Affairs Board, the Minister for Aboriginal Affairs recommended against the renewal of Colebrook’s lease. The UAM could occupy the property until a decision was made regarding its future use.

The few remaining children moved to a nearby cottage and the buildings at Eden Hills were demolished in May 1974. Colebrook Home was closed on 31 January 1981. Over 54 years, about 350 children passed through Colebrook.

Allegations of sexual abuse

Three PICs gave evidence of sexual abuse at Colebrook Home. No records of court orders or written transfers of control were received in relation to the PICs; however the APB dealt with them during the period in which it was placing children contrary to the legislative scheme. Only limited records were available and it was not possible for the Inquiry to finally determine their status as children in State care.
Chapter 3 Allegations of sexual abuse

Abuse by multiple perpetrators

A PIC born in the mid 1950s told the Inquiry he was placed at Colebrook Home when he was about three. Records received by the Inquiry include a SWIC that shows he became a State child in his teenage years, well after his discharge from Colebrook.

The PIC alleged staff members inflicted violent physical punishments; one man would use ‘his hands, belts, sticks, whatever’.

He said that when he was about seven a much older boy sexually abused him in the Colebrook showers, alleging this boy ‘got on top of me and forced himself on me’. He did not report the abuse because he was scared.

The PIC also alleged a man with an accent who visited the home sexually abused him when he was between five and eight years old. He told the Inquiry the man

...exposed himself and got me to touch it and play with it and stuff like that... I turned around and he, like, turned around and sort of rubbed it near my backside and that.

Again, he said he did not report the abuse because he was afraid.

He alleged that on another occasion a staff member exposed himself and ‘got me to just play with his penis’, then got him to perform oral sex. Again, he was too fearful to report the incident.

The PIC also told the Inquiry another man who visited the home regularly sexually abused him. The man would take the boys out bushwalking and swimming:

He treated us, like, very well... he’d always buy us stuff, especially on the way back—it would be hot, so a nice big milkshake, icy cold, so you’d think a lot about that.

The man sexually abused him while they were swimming: ‘He’d have his penis out and, like, put our hand on it’ under the water and while the boys were swimming around his legs. He alleged the man also took him to his home sometimes and got him to masturbate him and perform oral sex.

The PIC said he has felt he was to blame for the sexual abuse and has avoided ‘being too close to or touching my children’.

Abuse by staff

A PIC born in the mid 1940s told the Inquiry she was taken from her family as a baby. A record received by the Inquiry shows her father signed her into the UAM’s care when she was only a few months old; her mother had died in childbirth. The PIC told the Inquiry that ‘the welfare came in and just whipped me away’ after her mother’s death.

She did not see her father or siblings for over 10 years so ‘I never really got to know them, unfortunately’. The Inquiry did not receive a record of a court order placing her in State care.

She told the Inquiry that one of the female staff at Colebrook would sit beside her during film nights at the home,

...and I used to go and sit there, but she used to get my hand and place my hand on her knee, and then before I knew it, my hand was going up further, further up her leg.

She said that her hand went high enough to ‘feel her private part’.

The PIC said that at 15 she went to live with two different families and was sexually abused at both placements.

A male PIC born in the early 1950s gave evidence that he was sexually abused at Colebrook between the late 1950s and early 1960s.

Records received by the Inquiry show the PIC had been under the supervision of the Aborigines Protection Board when he was placed at the home in the late 1950s. The records show he was at the home until the mid 1960s. The Inquiry did not receive a record of a court order placing him in State care.
The PIC believed he was sexually abused by one of the male staff at the home but does not have clear memories of the abuse, saying he blanked it out:

\[\text{I remember him hugging me. Whether it was a genuine hug or not, or whatever, I don’t know. But then there’s a blank and then at the end of the blank there’s a bag of lollies, and I was happy.}\]

He also alleged he was sexually abused by another staff member who followed him into the shower and forced him to perform oral sex, while telling him that Jesus loved him. He told the Inquiry he reported the abuse to police and a schoolteacher.

The PIC also alleged he was subjected to physical violence at the home, particularly after he wet or soiled his bed. He was forced to strip off in front of the other children and had his face ‘rubbed … into the shit or piss’.

At 12 he was transferred from Colebrooke to Eden Park, and told the Inquiry he was sent to the Salvation Army Boys Home, Kent Town, when he was about 15. He alleged he was sexually abused at both of these homes.

Campbell House Farm School, Meningie, 1959–63

History

Campbell House Farm School was established in 1959 on land owned by the South Australian Government at Meningie and provided to the Aborigines Protection Board. The board used the 1020 hectares to develop a training farm school for Aboriginal boys. The aim was to equip boys for employment in the farming industry, which would also help them assimilate into local communities. The existing homestead was extended and renovated and the surrounding land cleared for crop planting. Campbell House initially accommodated 14 boys and employed three main staff: a superintendent, matron and farm overseer. Three Aboriginal staff performed general domestic duties.

Boys were educated in a range of agricultural skills, including crop and livestock management. They received religious instruction each fortnight from a visiting Salvation Army missionary and attended weekly church services. Boys of primary school age were educated at the local school before being trained in farming, and many of the children were active in local sporting and community clubs.

In 1963 the newly created Department of Aboriginal Affairs reviewed the school’s operation and found that the cost of maintaining it was not justified. In mid 1963 the school was closed and its residents were transferred into foster care.

Allegations of sexual abuse

One PIC gave evidence to the Inquiry of alleged sexual abuse at Campbell House while he was in State care.

Abuse by another resident

A PIC born in the mid 1950s was placed in State care at Campbell House in the early 1960s at the age of five under an order by the APB. He told the Inquiry he was taken into care due to domestic violence and alcoholism at home.

The PIC described Campbell House as ‘… a great place, adventurous, like running outside and that. Paddocks to play in, animals, cows, sheep, chickens’.

He said an older boy who lived in another house on the property sexually abused him on three occasions. He alleged the boy touched his penis while he waited at the bus stop with the other children. ‘I kept saying, “No, no,” all the time and he said, “It won’t hurt,” but the other boys didn’t help me.’ The PIC said he did not report the abuse because he was ‘too frightened’. He said he was placed in foster care when he was seven and alleged he was sexually abused in that placement.

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Kurbingai Hostel, 1958–62

History

Kurbingai Hostel opened in Semaphore in 1958. It operated as a private hostel for Aboriginal boys aged up to 16.

In 1961 police received complaints about “inadequate supervision” and “unsatisfactory general living conditions” at the hostel. Records show that of about 20 boys living at the home in 1962, 10 were in State care. After concerns had been raised about overcrowding it was resolved that State children would be sent to Kurbingai only in special cases. Further concerns about allegations of sexual abuse prompted the transfer of State children from Kurbingai to other homes.

The hostel closed in 1962 and the remaining boys were placed in foster care.

Allegations of sexual abuse

Kurbingai Hostel was also referred to as Suttons Boys Home, as it was opened and operated by Jim Sutton. Seven witnesses gave evidence about this institution, three of them referring to it as Kurbingai and four calling it Suttons. Three of the seven witnesses alleged sexual abuse at the hostel. Because of the lack of records and the actions of the APB in the era, it was not possible for the Inquiry to determine whether they were children in State care.

Abuse by staff

A PIC born in the mid 1940s told the Inquiry he was placed at Kurbingai in the late 1950s when he was about 12. The department could not find any client files relating to him and the Inquiry did not receive any records to show he was in State care.

The PIC recalled the home environment:

At any given time I reckon there was between 30 and 40-odd boys. I reckon we had the capacity max to house about 38 to 40, at a push, because a lot of us boys, in the time that we were there, we were also part of the labour force that helped with the extensions of the place.

He said that while he was living at Kurbingai, a staff member performed bodily inspections of him, peeling back his foreskin and inspecting his anus on the basis that it was for his health and in his best interests. He also alleged the staff member took boys into his bedroom at night.

Department and APB records relating to Kurbingai Hostel show the PIC and other boys gave written statements reporting sexual abuse by the alleged perpetrator. The records also note that police were informed and the department and APB recommended the removal of all boys from the home, which was closed soon after.

A PIC born in the late 1940s alleged he was sexually abused at Kurbingai in the early 1950s.

Records received by the Inquiry show the boy was placed at the home by the APB because his parents had separated and his mother was unable to care for him. The Inquiry did not receive a record of a court order or written transfer of control placing him in State care at this home, although he was later placed in State care by a court for disorderly conduct.

The PIC alleged that a staff member at the home regularly got drunk and asked him and the other boys to go to bed with him. The manager also rubbed Vicks chest rub on the boys when they had a cold:

He liked … rubbing us down with Vicks, but then he’d be, like, feeling us all over and I was thinking this is not right … all over our arse parts … and our genitals.

He also recalled that the same man flogged the boys with a cane, belt or strap for minor things:

When there was a group of us having a shower, he’d come in the showers, too, and he’d be more...
or less saying for us to sort of masturbate, you know, and he’d be, he’d sort of make us do that, and while he’d stand there watching us …

APB and department records show the PIC made a formal written report regarding the above conduct. Other boys made similar allegations and as a result recommendations were made by both authorities to remove all boys from the home. The home was closed soon after.

Another PIC born in the late 1940s also made allegations of sexual abuse at Kurtingai in the early 1960s. He told the Inquiry he was placed there when he was about 14 as a result of a request by his mother to the APB. From the records available, it did not appear that he was placed in State care by a court order or written transfer of control.

The PIC was at the home for only a few months before it was closed down. The PIC told the Inquiry a staff member sexually abused him and other boys:

So then he started rubbing us down with the Vicks and that and it wasn’t just rubbing you down on your chest and that; it was like down between your legs and all that, yes, and that wasn’t too—it didn’t feel right.

He also alleged the staff member pressured boys into indecent behaviour while showering: ‘He’d want us to start masturbating and he’d be standing there watching us.’

Oodnadatta Children’s Home, 1924–27, 1946–74

History

The Oodnadatta Children’s Home was the first UAM mission station in South Australia.146 Established in 1924 by Christian missionary Annie Lock, the mission first housed five children in an iron shed. Matron Ruby Hyde took over care of the children in 1925 and in 1926 they moved to a cottage bought by the UAM. In 1927 Matron Hyde and the 12 children at the mission were transferred to the Colebrook Home at Quorn.147 The Oodnadatta home reopened in 1947, with two superintendents and 12 children.148

The home was a rudimentary building with two dormitories, a living area and bathing and cooking facilities. A new dormitory was completed in 1955.149 The home always housed between 13 and 17 children and there were generally two superintendents, assisted by other staff. Missionaries educated the children until they were accepted at the local Oodnadatta Public School in 1957.

In 1958 many children, some without their parents’ consent, were sent south to Colebrook Home, which had relocated to Eden Hills.150 By 1966, the Department of Aboriginal Affairs had stopped placing children at the home.151 In 1967 the director of Social Welfare advised the Minister that numerous improvements to the home’s facilities were needed before it could be licensed under the Social Welfare Act. In 1970 the home cared for six children. A Commonwealth-funded children’s hostel was built at Oodnadatta that year and was operated by the Save the Children Fund in consultation with the Department of Aboriginal Affairs. The superintendent of the Oodnadatta mission left to run the new hostel and the UAM did not find a replacement superintendent. By 1974 there was no UAM children’s dormitory in operation at Oodnadatta.

Allegations of sexual abuse

One woman gave evidence to the Inquiry about alleged sexual abuse at Oodnadatta Children’s Home.
Abuse by outsiders

A PIC born in the late 1950s told the Inquiry she was removed from her family and placed on an Aboriginal mission when she was a small child. Copies of documents received from the UAM show she was admitted to the mission at her mother’s request when she was five and the APB paid maintenance. The Inquiry did not receive a record of a court order or a written transfer of control placing her in State care at this home.

The PIC told the Inquiry that the home’s staff were very strict: ‘We were physically disciplined on a daily basis with a thick leather strap’. She also recalled ‘scuffing my shoes and getting reprimanded for that, and that would be without tea’, and that staff forbade the children to listen to music, interact with other people in the town or go to the movies. She told the Inquiry she was forced to go to church and pray.

The PIC alleged she was sexually abused at the home when she was about 10 or 11. She said a young man who was the son of a carer at the home came into her bedroom and got into her bed. He positioned himself on top of her and moved ‘in a sexual motion … I can remember something between my legs, I’m not sure what that was, and wetness’. The PIC believed that this sexual abuse may have happened more than once but she did not report it because she was afraid of being punished:

We were too scared. Too scared. It was about, you know, trying to keep the peace. I can remember doing things to try and please people, and got a beating as a result of it.

She also told the Inquiry she was injured by a staff member after she had asked boys at the home where the mop and broom were kept. The staff member assumed she was fraternising with the boys, she said, and kicked her so hard at the base of the spine that the injured area is still tender.

The records show the PIC was discharged from the home when aged 12 so she could attend secondary school in Adelaide.

Otherway House, 1983–84

History

Otherway House was operated by Catholic Welfare to provide services for indigenous children. The Aboriginal Catholic Community (ACC), an organisation that provided services including an opportunity shop, craft centre and social centre, developed the home. Its staff operated a street work program in Hindley Street in Adelaide’s CBD, focusing on the Aboriginal youth who frequented that area. In January 1983, the ACC applied for a licence to operate a home for Aboriginal boys and girls on a property leased from the Aboriginal Lands Trust in Sussex Street, North Adelaide. Otherway House provided emergency and short-term accommodation to adolescent males as an interim to independent living. 152 The licence expired in early 1984; the ACC decided not to continue the program and Otherway House closed in August that year. 153

Allegations of sexual abuse

One person gave evidence to the Inquiry about alleged sexual abuse at Otherway House while he was in State care.

Abuse by outsiders

A PIC born in the mid 1960s alleged sexual abuse during a placement at Otherway House in the mid 1980s. Departmental records show the PIC was one month old when a court found him neglected and placed him in State care. He was legally adopted as a two-year-old after living in a government institution and in foster care. The PIC was again placed in State care under his adoptive name as a six-year-old in the early 1970s, on the grounds of being neglected. He told the Inquiry he was sexually abused at Kennion House, in foster care and at Otherway House.

He was transferred to Otherway House when he was 17; his SWC shows he was at the home for just less than two months. His departmental client file does not have a record of this placement. The PIC told the Inquiry the home was...
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.run by the Catholic Church and accommodated Aboriginal boys: 'They used to get guys out of McNally, the training centre. They weren’t able to go home, but they would get released out of lock-up into the care."

He alleged he was drugged and sexually abused by men during his placement at Otherway House: 'Well, one would perform oral and then … do it to you and then you’d have to do it to someone else'. He also alleged one of the men took him and another boy interstate, where they were drugged and sexually abused.

The PIC was released from State care at 18 and told the Inquiry that for a while he became involved in prostitution: ‘I was used to men, plus I knew the men that were willing to give cash’. He said he started this when he was about 17, while still in State care, prostituting himself ‘on the odd occasion’ until he had ‘enough money to leave the State’, when he was about 18 or 19.

Homes for children with disabilities

History

Until the mid 20th century the care of children with disabilities was left largely to non-government agencies. Townsend House was established in 1874, Minda Home in 1898 and the Somerton Home for Crippled Children in 1939. Governments endorsed the provision of residential and associated care by non-government agencies and contributed funds and subsidies. Successive governments endorsed the placement and restraint of children with disabilities in adult mental hospitals from the mid 19th century to the mid 20th century. It was not until 1958, when Lochiel Park opened, that the government assumed direct responsibility for the provision of residential care to children with disabilities, including those in State care. With the establishment of the Strathmont Centre, a facility built in the early 1970s, the government displayed its awareness of the distinction between providing residential care for children with disabilities and children with mental health problems.

Summary of evidence

Twelve people gave evidence to the Inquiry that they were sexually abused while placed in homes for children with disabilities. From available records, the Inquiry was able to determine that 10 of those people were in State care at the time of the alleged sexual abuse. The allegations of the two people who were not in State care are reported in that they alleged sexual abuse in the same homes as the 10 people who were in State care.

The allegations include indecent assault, fellatio, vaginal intercourse and anal intercourse. The abuse was allegedly perpetrated by staff, other residents and adults who preyed on the children who ran away from the homes.

Lochiel Park Boys Training Centre / Community Unit, 1958–present

History

Lochiel Park opened in Campbelltown in 1958. Its initial focus was on children with borderline to mild intellectual disabilities.154

In August 1930 the CWPRB proposed that a psychological clinic be established to treat children who were considered ‘subnormal or mentally defective’. It was decided in 1943 that two such homes should be established, one each for girls and boys155, but progress in establishing the facilities was slow.156 As a result, children of ‘a mental age of less than five years’ were placed at Seaforth Home.157 Seaforth Home segregated children with disabilities in an isolation block that was intended to be used for children with infectious diseases. The home’s medical officer commented in the 1940s that:

At present there apparently exists no provision in any Government mental institution for the reception and segregation of children who are mentally defective. The need for such an institution is considered an urgent one.158

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154 Fyow, s. 4, p. 44.
156 CWPRB annual report 1947, p.3.
158 SRSA GRG 29/6 134/1948, suggestion provision of an Institution for Subnormal Children.
In 1948, about 42 children aged between two and 12 also lived at Parkside Mental Hospital. At the time, Minda accepted only children aged between six and 12. The need for specialised accommodation for children in State care with disabilities was raised again in 1952. The CWPRB recommended that ‘the provision of suitable residential accommodation for subnormal wards of the State be regarded as urgent by the Government’. Lochiel Park provided secure care for boys with mild intellectual disabilities, learning difficulties and behavioural problems. Residents lived in a large dormitory divided into small cubicles. They were allowed group excursions and occasional individual outings and were granted holiday and weekend leave to visit their families. The residents received instruction in personal care and basic living skills and were trained in handicrafts, gardening and animal husbandry. Residents were also assisted in making the transition to independent living in the community, for example in securing employment.

In 1970 Lochiel Park expanded to admit boys from other institutions. The unit became a training centre that could accommodate up to 36 residents. Psychologists and welfare officers visited Lochiel Park to help staff undertake residents’ assessments and to develop individual programs, which were to be assessed monthly. Like many other homes, Lochiel Park was affected by the shift away from large institutional care towards cottage homes and family-based foster care in the 1970s. In 1977 residential care was divided into two units, one a secure unit for new residents who received training until they had adjusted to the centre and the second an open unit that focused on individual residents’ needs. Lochiel Park stayed open during a further departmental restructure that closed cottage homes in the late 1970s. A third living unit was established in 1979, designed to help residents make the transition to independent living.

Lochiel Park was intended as a temporary residence for children with disabilities who were able to return to living in the community. Children requiring long-term care were generally placed at the Strathmont Centre, which opened in 1971, or Ru Rua Nursing Home. After Strathmont opened, Lochiel Park focused increasingly on secure care for young offenders. Lochiel Park provided care to children whose needs could not be met in a family-style care setting. However, concerns were raised in the early 1990s that the open style of residential care at Lochiel Park resulted in young offenders being placed in close proximity to younger and vulnerable residents. During the 1990s, it was alleged that residents absconded from the centre for days at a time and prostituted themselves in the city. It was also alleged that residents of Lochiel Park were sexually active with known paedophiles. In 1993 it was reported that a 12-year-old resident at Lochiel Park was raped nine times by another resident over a period of two weeks. The Inquiry heard confidential evidence that staff were not permitted to secure the facility and prevent absconding. Lochiel Park was converted to a community living unit in 1995.
General evidence

The Inquiry received evidence from a witness who worked at Lochiel Park in the 1970s and 1980s. The witness said the mixture of children was a problem:

There were very vulnerable children as well who’d clearly been physically and sexually abused and neglected, who were probably pretty fearful in many ways of living in these large facilities because there was a fair range of boys … anything from 12 to 18.

He said some boys were already hardened by experiences of living in other forms of congregate care, particularly at the Salvation Army’s Eden Park:

There was a relatively large number of young people who had made that progression through Eden Park to Lochiel Park … we were as staff often concerned about the young people who’d come through there and some of the stories that certainly told about their treatment. Generally, I think that a lot of young people had reported some pretty rough tactics by some of the other young people, and certainly there was a worrying level of sexual activity that had been reported by some.

The witness said that at night the boys were confined to dormitories without active supervision. The superintendent and the senior residential care worker lived on the property, but well away from the dormitories. The boys had unrestricted opportunity to move around the dormitories and bathrooms at night, and the witness said he has no doubt intimidation and sexual abuse occurred. In later years, with only one staff member on active night shift, there was still an inability to monitor and prevent sexual activities between the boys.

Departmental files record that in the mid 1970s a 15-year-old boy was charged with rape and admitted to Lochiel Park on remand. Although he was considered a serious offender, he was placed with other residents who were victims of sexual crimes. In the mid to late 1970s the superintendent asked for a second night officer to cover rostered days off, annual leave and sick days. His request noted that Lochiel Park was ‘experiencing problems with some particularly unsettled boys’. Later that year it is noted that another ‘serious offender’ had been living at Lochiel Park and that after several incidents he was removed and placed at Brookway Park, to be put on that home’s serious offenders list.

Other general witnesses, including former staff, gave evidence about Lochiel Park from 1990–2004. One witness told the Inquiry about the early 1990s:

When I first started, it was for children with an intellectual disability … then we started to look at broader criteria and mainly targeting the most difficult young people to house in a residential setting. They would be young people that perpetrated inappropriate sexual abuse on other children, children that had some form of diagnosed mental health issue.

The result was that children in late adolescence mixed with pre-pubescent children. Sexual offenders mixed with victims of sexual offences. Young people with depression (who required a calm and quiet environment) mixed with those who had other mental health issues that caused them to be violent, loud, abusive and difficult to control. Lochiel Park staff had difficulty with the support that this mixture of young people demanded. As a place of last resort, Lochiel Park did not have the option of refusing admission to particular children, even if they were exposed to risk.

There is evidence that staff were aware of some of the sexual contact between the children. Measures were put in place to curb this behaviour, such as a sexual perpetrators program, which was introduced in the early to mid 1990s, and an extensive therapeutic program run in conjunction with Behavioural Intervention Services and a number of other departmental agencies. However, the staff in general felt these programs, although sound in theory, were lacking in practice. A general witness told the Inquiry that no real
progress was made due to the different agencies’ ideas on policy and the low tolerance levels they applied to children who were among the ‘most difficult’ under the care of the department.

One witness emphasised that staff did the best they could with the available resources and knowledge. However, resources were stretched beyond capacity, teachers refused to teach children, staff refused to accept advice from psychologists and psychiatrists, and key staff resigned.

Lochiel Park continues to be under pressure because of co-location of children of different ages, those with disabilities and mental health issues, and those with and without criminal records. A general witness told the Inquiry:

Yes, Lochiel Park is struggling. I think, at the moment … I know that they have got a significant discrepancy in the children that are accommodated there. At the moment, they have got some very street-wise, drug-dependent older children and some very young children. It has not been by management’s design but sheer pressure on the system to take young people.

Another continuing problem for Lochiel Park through the 1990s was its inability to prevent residents from absconding. A general witness said:

They would disappear for two or three days at a time. They would come back looking like a lost, bedraggled dog, dirty, filthy, hungry … sometimes with cigarettes, sometimes with new shoes.

The Inquiry received information that paedophiles would contact the centre and demand that certain boys be allowed out:

As guardianship children, these young boys and girls were prime targets. Some of them became habitual absconders from Lochiel Park. They were available day and night in the city and the parklands and they were easy to manipulate.

Staff started to patrol the Veale Gardens area when the children ran away, and often they would find them and bring them back.

But Lochiel Park was fighting against the tide. The incentives for the children to run away outmatched the measures the department used to detain them. A general witness said:

Sometimes they disappeared into men’s homes, who would harbour them for three, four, five days at a time and then let them go. That’s when they would come back with decent clothing … they were basically prostituting for cigarettes, drugs, maybe some alcohol and a good time.

The witness said one of the boys left Lochiel Park and moved into the house of a paedophile, who

… looked after him better than we looked after him. He stopped offending, he got off the streets … this bloke sent him to school … stuck by him through thick and thin. [The boy] would run away, he’d bring him back. [The boy] would burn his house down, he’d build a new one. [The boy] would kill this man’s cat. He’d buy another. I couldn’t believe—[the boy] one day walked into the unit and he was a young man … you had a known sexual offender actually do more with this kid than the department could. It was just all bizarre.

This was not an isolated case.

At this time, Lochiel Park was an open unit and staff were unable to lock the dormitories to prevent the boys from running away. The Inquiry was told attempts were made on several occasions to detain the children by taking such action as securing the units, but the department disapproved. A departmental employee also recommended the establishment of a treatment unit designed to break the cycle of running away, but the project was never taken up. It was recorded in Lochiel Park logbooks that, on occasions, experienced boys would take other more naïve residents with them and introduce them to ‘unlawful and
inappropriate sexual behaviour’. A general witness told the Inquiry:

> Every time they run and there’s reinforcement, be it a dollar or a new pair of sneakers or a skateboard, you have lost whatever therapy you have done leading up to that … there’s a perception—again social worker driven—that unless there’s a very, very serious reason, they have a right not to be locked up and to choose what they do.

Allegations of sexual abuse

Eight people gave evidence to the Inquiry that they were sexually abused while placed at Lochiel Park. All were in State care. The alleged sexual abuse included indecent assault, gratifying prurient interest, oral and anal rape, and prostitution. The alleged perpetrators were staff members, other boys living at Lochiel Park and outsiders including a father, a mother’s husband, an Intensive Adolescent Support worker, strangers and paedophiles. Some of the abuse occurred when the children absconded from Lochiel Park.

Abuse by multiple perpetrators

A PIC born in the mid 1960s alleged he was sexually abused at Lochiel Park during his placement there in the late 1970s. He had been placed in State care by a court at 12 for being uncontrollable. He told the Inquiry that while in State care he was sexually abused at Brookway Park and then Lochiel Park. Before being placed in State care, he had been sexually abused at Eden Park.

The PIC lived at Lochiel Park for about four years as a teenager and alleged he was sexually abused by a staff member there:

> I was in the shower, in the bathroom one day and he came in and was talking about some gibberish—I don’t know what he was talking about—and just thought he’d show me the proper way to pull my dick.

He said he reported the incident to another staff member who looked into the allegation and then dismissed it on the basis that his colleague had been performing a medical check:

> I got called into the office and I was told that he was following up on a medical problem that I had complained about, and that’s all that was to be said about it.

He also told the Inquiry his father sexually abused him when he took him out on visits. He said this abuse had continued from when he was at Bedford Park Boys Training Centre. He said he reported this abuse to a departmental worker: ‘She wrote it all down on a piece of paper and then I never saw her again’.

The Inquiry has received client files from the department but they do not contain any record of the PIC’s allegations.

When the PIC turned 18 he was discharged from State care and was on his own. He said he could not read or write properly, had not received vocational training, had no job skills, did not know how to live independently and that he committed crime. He held various jobs but nothing worked out for him:

> I tried several places, but just didn’t like the authority. Tried to get one as a baker, tried one as a truck assistant, but yes, just—I didn’t like being touched or being told what to do.

A PIC born in the early 1960s alleged he was sexually abused during his placement at Lochiel Park in the early 1970s. Departmental records show that at 12 the PIC was charged with offences and placed in State care by a court until he turned 18. He was initially remanded to Windana Remand Home where, he alleged, staff required him and other boys to parade nude.

Records show the PIC was placed at Lochiel Park when aged about 13, and remained there for about six months. He told the Inquiry that on ‘a couple’ of occasions a staff member took him and other boys to a place where men would ‘take pictures of us. They’d get us to lie next to other kids and they’d take photos of us naked’. He said he reported the abuse: ‘I told a counsellor about it at Lochiel Park and she said she was going to talk to somebody about it but I never heard anything about it’.

The PIC told the Inquiry he absconded from the home on several occasions and was sent to an assessment centre.
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‘to find out why I kept running away all the time’. He alleged a staff member at the assessment centre sexually abused him:

… while I was out there another male person had tried to put his—you know, he tried to root me … I was actually bleeding from the rear end and doctors were actually involved.

At 14 he absconded from Lochiel Park—‘I shot through at the end because of the abuse. I got sick of it’—and went to live with his mother. He alleged that while living with her he was raped by her husband.

Client files received from the department do not record the alleged sexual abuse. The PIC was released from State care when he was 18. He told the Inquiry:

I just wish it had never happened, that’s all. That’s all I’ve got to say. I don’t think people realise how much it really plays on your mind. It’s not so bad when you’re in your 20s but, you know, you get older and it plays on your mind a lot. It still does … I reckon it’s a lot worse.

A woman who contacted the Inquiry was seven when placed in State care in the mid 1990s, after a court found her to be in need of care. The PIC said she experienced physical and sexual abuse before being placed in State care. She told the Inquiry she was sexually abused while placed in foster care, at Lochiel Park and then at Gilles Plains Community Unit.

She was at Lochiel Park for about three years from the age of 12. Of Lochiel Park, she said, ‘if you had a good worker, you were good. If you had a shit worker, you were fucked’. She said three staff members sexually abused her on separate occasions. She deliberately harmed herself while at Lochiel Park and was confined to her room as a punishment: ‘Due to that they used to come in my room and that and start touching me up’. The PIC named one worker who entered her bedroom at night and told her that to gain privileges, such as having a television in her room, she would have to kiss and touch him and let him touch her. She said this happened ‘numerous times there. That’s the only way I could get my TV back or supper’. The PIC was monitored closely because of her self-harming: she said that “sometimes I would have to do that [submit to abuse] so I could go and get a walk”. On these occasions, she said, the worker touched her breasts and genitals underneath her clothing; she performed oral sex on him and he ejaculated. He also allegedly purchased underwear for her to wear.

The PIC named another worker at Lochiel Park who she alleged sexually abused her. She said this man ordered her and another resident girl to his office where, initially, they thought they were to be reprimanded. But on numerous occasions he encouraged her and the other girl to perform sexual acts on one another, and touched both of them while this was happening. She said she also entered the PIC’s room, where he would ‘feel me up’. On one occasion he allegedly asked her to give him oral sex, which she did.

The PIC said a third male worker at Lochiel Park grabbed at her legs, breasts and stomach area and also asked her and another female resident to dress in short skirts for him and to wear lingerie he had purchased.

She attributed her self-harming in part to the abuse, saying, ‘I hated it’. She said of her time at Lochiel Park: ‘If I was outside alone I felt safe because no-one could come and get me, but being in the bedroom was a different thing’.

On one occasion, she said, she absconded from Lochiel Park and was away for three days. On her return, she had an escort agency’s business card and a supply of condoms. She told staff she was working for the agency, being transported by car from client to client. She was about 16 at the time and said of working as a prostitute:

… because I’ve been hurt so many times, I believe I am the scum of the Earth. Because I’m the scum of the Earth, I’ve got to do the worst job possible and the worst job possible is prostitution … So many people have abused me in the past, I just think, why don’t I get paid for it? Instead of me getting hurt by youth workers and stuff, I’ll just get paid to get hurt.

The PIC did not report the workers’ abuse to the department and came forward to the Inquiry only because
You live in a behavioural unit where you’re supposedly the naughty kids of the—State. So, how can you say anything? … If they couldn’t find you a foster home anyway, how the fuck could you say anything? If you said anything you would have the shit of the whole entire team of workers, so I learnt to keep my mouth shut.

The department’s records pertaining to the PIC include numerous opinions that she had a propensity to make false allegations of abuse.

The PIC told the Inquiry:

I just reckon there should be someone out there that people can talk to about—if they get hurt or stuff, because it’s so under the blanket, it’s so hidden.

Abuse by staff

In the late 1980s, a court placed a 13-year-old PIC under an interim guardianship order as a result of allegations that his father had been sexually abusing him. About two months later the boy was placed in State care until the age of 18 after a court found him to be in need of care or protection. The PIC told the Inquiry that before he was placed in State care his father had sexually abused him for several years.

He spent time in various homes and foster placements before he was placed at Lochiel Park at 15. He remained there for a little over two years. The PIC had positive memories of Lochiel Park, saying he believed the staff were ‘good workers. They were really nice’.

He said while he was in the home’s independent living unit, Brookway Drive, a male staff member entered his room and masturbated him:

He came into my room and I don’t know how it came about, but he wanked me off and after that I felt really stressed so I just covered myself up with the doona and waited till my care worker came in to see me.

The PIC said he told another staff member he was feeling unwell and was sent to see the doctor but did not disclose the sexual abuse: ‘I just went about my daily routine of going to high school and just forgetting’.

He said he suffers from a psychiatric illness that he believes may have been exacerbated by the sexual abuse.

A PIC born in the late 1970s alleged he was sexually abused while at Lochiel Park in the early 1990s.

Extensive client files about the PIC from the age of five were received from the department; it received reports that the boy had developmental difficulties and was at risk of physical and emotional abuse. It appears from the records that he was placed in State care when his mother signed papers consenting to his adoption, and as a result he came under the guardianship of the chief executive of the department, pursuant to section 25 of the Adoption Act 1988.

Between the ages of five and 12 the PIC was in several placements, including foster care, a private home, cottage care and an assessment unit. The records show he presented carers with challenging behaviour and as a result the placements broke down. He was placed at Lochiel Park, where he remained until he was 16.

Records show he continued his challenging behaviour at Lochiel Park and had a propensity to abscond with other boys. As a result, he was assigned an Intensive Adolescent Support (IAS) worker. The PIC alleged this worker sexually abused him on a camping trip, doing ‘sexual stuff, and I ended up in hospital because of it as well’.

Records from the department confirm the PIC went camping for a weekend with the IAS worker with the permission of his social worker. On his return he was found to be semi-comatose and likely to have been under the influence of a drug. He was taken to hospital and examined by Child Protection Services for possible sexual abuse, which could not be confirmed.

The records show that police investigated and charged the IAS worker with unlawful detention and unlawful admission of drugs. The charges did not proceed because of concern about the PIC’s ability to deal with the court process. It is
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also alleged that police discovered photographs of naked boys at the IAS worker’s home.

A report on the department’s file states that on a previous occasion a worker had entered the PIC’s room at an assessment unit and found him standing naked with an erect penis in front of the same IAS worker who is alleged to have sexually abused him. The report states: ‘This matter was reported to the acting senior who knew [alleged perpetrator] and did not report this incident to the social worker’.

In the mid 1990s, the boy was known to be absconding from the home with other boys who associated with paedophiles in places such as Veale Gardens.

At 16 the PIC left Lochiel Park to board with an older man with the approval of the department. The PIC has continued to live with the man.

Abuse by other residents

Another PIC was three when he was placed in State care by court order in the early 1960s on the basis of neglect. Departmental records show his parents were considered unfit guardians due to a poor standard of accommodation and an allegation that the father had behaved indecently in front of his children.

The PIC spent short periods at a government home and with his father before being placed in foster care. He alleged his foster father sexually abused him. Over the next seven years the PIC was in several government homes, cottage homes, short foster placements and one long foster placement.

The PIC was placed at Lochiel Park before his 12th birthday. It was noted that he had learning difficulties, which were later identified as dyslexia. He told the Inquiry that during his time at Lochiel Park and throughout his childhood he suffered extensive bullying:

Lochiel Park was full of thugs. I was never a part of Lochiel Park or the kids that were there. It was always different. There were a lot of names and a lot of bullying. I didn’t like it there much.

The PIC told the Inquiry he was sexually abused at Lochiel Park. He and another resident were near the animals housed on the grounds when ‘the boy that was with me came up behind me and grabbed me by the hips and started …’ He told the Inquiry that what happened was sexual in nature but he could not go into any detail.

The PIC was at Lochiel Park for less than four months before being placed with his father despite an earlier direction from the head of the department forbidding this to occur in light of the previous allegations of abuse.

The PIC was also placed at Kumanka Boys Hostel, where he alleged he also was sexually abused.

Abuse after absconding

A PIC born in the early 1980s gave evidence of extensive sexual abuse during a placement at Lochiel Park in the early to mid 1990s.

Departmental records include comprehensive client files and show that in the early 1990s the PIC’s parents approached the department seeking assistance because of their son’s behavioural problems, including violence and running away from home. The PIC was seen by psychologists and social workers and was diagnosed as having a borderline intellectual disability. He was prescribed medication to calm him down and make his behaviour less challenging but, the PIC told the Inquiry, his parents were unable to control him: ‘I’d been carrying on, you know, with having arguments with my parents and breaking out of the house, running away—stuff like that’.

When the PIC was 12 he was placed in State care under a temporary administrative order. During the next two years he was placed in State care under a series of temporary administrative and court orders due to continued erratic and criminal behaviour. In between orders he sometimes lived with his parents but the attempted reunification failed each time. He spent time in cottage accommodation, departmental units and an Intensive Neighbourhood Care placement.

The PIC continually absconded from his placements and the family home. He told the Inquiry he met a man who
'picked me up and introduced me to the beat. He got me drunk and started to kiss me and sex started to happen'.

Records show the man was charged with rape but the matter did not proceed to trial; the PIC said he did not want to proceed with the charges 'because I felt sorry for him'.

At 13 the PIC was placed at Lochiel Park. As it was not a secure place, he regularly absconded with other boys, stayed on the streets and began to smoke marijuana: 

I kept running away. I did this basically all the time I was there … Just wanted to be free. I wanted to be home. If I couldn’t be home, I wanted to be free.

The PIC said he begged for money on the streets and then progressed to prostitution: ‘I started to go on the beat and making money that way’. He told the Inquiry that for about five years he performed sexual favours for male strangers, often in Veale Gardens, and usually went away with these men.

He said he had sex with many men while absconding from Lochiel Park. The departmental records show its staff and the courts were aware of the PIC’s conduct but felt relatively powerless to prevent it because Lochiel Park was not a secure unit. One staff member reported that the boy was absent from the unit more than half the time. The PIC spent several periods in secure facilities due to criminal conduct but continued absconding, offending and prostituting himself each time he was released.

The records show the department invested considerable financial and human resources in managing the PIC, including a prolonged period of one-to-one care.

The records show that alleged paedophiles often telephoned Lochiel Park asking for the PIC. On several occasions charges were either not laid or were withdrawn against alleged perpetrators due to a view that convictions were unlikely or the PIC was unwilling to give evidence.

The PIC told the Inquiry he has sympathy for the men alleged to have sexually abused him: ‘They need some help. I feel for them, you know.’ He said he has had trouble with drug addiction and criminal offending since his release from State care at 18: ‘Speed and dope, alcohol. Been in trouble ever since, basically, you know. Basically, I’ve been in trouble ever since’.

He also said he has suffered as a result of the sexual abuse: ‘Just the loss of your soul. Your soul gets taken away; nothing left …’ He said he manages despite not having had any counselling for sexual abuse: ‘I still get through it day to day. I get through it without it.’

Another PIC was first placed in State care at the age of eight in the late 1980s. He was placed on several short-term guardianship orders and later under the guardianship of the Minister until he turned 18. According to his SWIC, his placement in State care was a result of his family being ‘unable to cope’ with his behaviour. He alleged he was sexually abused while in State care at Clarence Park Assessment Unit and then at Lochiel Park.

The PIC lived at Lochiel Park in the early 1990s for about two years as part of the department’s effort to reduce his absconding and offending. The department believed he was engaging in unlawful sexual intercourse during the periods he absconded from placements and that he was known to associate with suspected paedophiles.

Of his time at Lochiel Park, the PIC told the Inquiry, ‘I was never really there. I kept on running away, like I was [doing] at every other unit’. He said he absconded regularly, frequented locations in the city known for prostitution and had unlawful sexual intercourse with unknown men. He said he and another boy met a man who took them back to his home and photographed them naked. The PIC said the man was charged and tried for this offence and he gave evidence at the trial. He could not recall the man’s full name. The PIC told the Inquiry he was charged with soliciting during this period. The department’s records confirm the PIC absconded regularly from Lochiel Park and was suspected of having unlawful sexual intercourse, despite efforts to restrict his movements.
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Minda, 1898–present

History

During the 19th century children with disabilities were often placed in the Adelaide and Parkside asylums along with adults. The Minda Home for Weak-Minded Children was established in Fullarton in 1898 and was moved to Brighton in 1911. From 1898 to 1912, Minda’s income was derived primarily from charitable contributions, parents’ fees and government grants. In 1911, the name was shortened to Minda Home because many residents had become adults.173

Initially Minda’s aim was to provide services for children who were moderately or severely disabled.174 However, children with profound levels of intellectual disability were approved for admission soon after the home opened.175 By 1940, however, Minda no longer admitted children with profound disabilities; only those it considered ‘trainable’.176 One reported reason for this was parents’ reluctance to admit their children to an institution where they would be in close contact with the profoundly disabled. Restricting admissions meant Minda would be able to receive more of the “better type epileptic and feeble-minded”.177 This would be done by declining admission to children under six or over 12, and preferring those aged between six and eight.178 Twenty-six children with profound intellectual disabilities were transferred from Minda to Parkside Mental Hospital, which served to highlight the fact that the government had no institution for disabled children at that time. The superintendent of Parkside Mental Hospital (previously asylum) noted that...

...because of the inability to obtain admission to Minda Home, several cases with ages three to nine years were admitted to Parkside and must in consequence be accommodated in wards for adult patients.179

During the 1940s and 1950s Minda Home experienced a severe staff shortage, according to its annual reports.180 Further ‘chronic’ staff shortages were noted in the late 1960s, due to a staff turnover that was “far higher than desirable”.181

Moreover, the operation of Minda Home into the 1950s was marked by the absence of written procedures concerning residents’ rights and staff conduct. Staff used physical punishment as a disciplinary method, in the belief that ‘these people could not be controlled without hitting them,’ as one former staff member discovered.182 One history of Minda asserts that as recently as 1958 staff received no training in working with people with disabilities.183 The account also states that it was common practice for Minda staff to advise families to have minimal contact with children placed in Minda’s care.184 The account suggests that the Minda board was reluctant to place residents in the community who were capable of undertaking employment because residents performed valuable unpaid labour at the home.185

The first social worker was appointed at Minda Home in 1966.186 Revisions to procedures in the home followed, including arranging for residents to visit their families at

174 Crawford, p. 58.
175 ibid., p. 59.
176 ibid., pp. 81, 95.
177 ibid., p. 96.
179 In 1913 the Mental Defectives Act was passed and asylums were designated mental hospitals, Crawford, p. 81.
180 Minda Home Inc. forty-ninth annual report.
181 A Jarrocks, Social administration in South Australia: Some aspects of management, control, policy-making and responsibility in voluntary social welfare organisations, Adelaide University, 1968, p. 78.
183 ibid., p.185.
184 ibid., p. 330.
185 ibid., p. 196.
186 ibid., p.195.
Christmas. In late 1970 the Minda superintendent reached an agreement with the Department of Social Welfare that on admission, the department would provide Minda with a full history of each child and the relevant contact details of the child’s parents or relatives prior to discharge. Six months before the expiration of the governmental order of custodial care, the department agreed to contact Minda so that any extension of the supervision period could be discussed if necessary. Minda was also instructed to contact the department regarding any outings made by the child, as well as any proposals for the child to take up employment.

By 1975, the government contributed more than 50 per cent of Minda’s funding. The department’s de-institutionalisation of care throughout the 1970s affected Minda Home as children were gradually moved out of the institution. However, as one witness who provided confidential evidence to the Inquiry noted, Minda ‘changed more slowly, I think, than a lot of other places’.

Today Minda provides accommodation, training and other services for more than 1000 people living with an intellectual disability. More than 300 people are accommodated, most at Brighton, while more than 200 people who receive Minda services live in the community.

Abuse of residents at Minda

Sexual abuse of people with a handicap has figured as little more than a footnote in public discussion and policy-making.

When Donald Crawford started as superintendent of Minda in 1958 he discovered there were no written rules regarding residents’ rights or staff conduct. Staff used physical abuse against residents as a method of control under the guise of parent/child disciplinary tactics. It was understood that ‘these people could not be controlled without hitting them’.

At this stage, the staff had not received training in the area of working with people with disabilities.

Crawford painted a bleak picture of the nature and extent of sexual abuse at Minda:

There were several allegations of sexual abuse of female residents by staff. These were pursued but remained unresolved. Some aspects of male homosexual behaviour were of considerable concern. In Verco Ward, which accommodated 120 males, the men residents were sexually involved with young boys. Another interpretation of this behaviour was that it was a voluntary activity. Until adequate and appropriate staff and accommodation were provided, other than appealing to the staff to exercise supervision, the issue defied solution.

Regarding the perpetrators of sexual abuse at Minda, Crawford reported that:

There were a few predatory males who sought and engaged in sexual activities with young male residents. With a huge staff turnover of 100 per cent per annum, it is impossible to estimate how many of these people were employed, but a few managed to leave an impression. Three of these men were very bright, resourceful and socially adept persons, well-versed in middle-class ways. Legal and moral constraints prevented a revelation of the damage which one man wrought on several young lives. One man left the employment of his own accord, and it was with considerable difficulty that we were able to eventually get sufficient grounds to dismiss the others. The superintendent had no doubt about their guilt, but even in those days of relative laissez-faire in personnel management, it was not possible to act without evidence. It was the

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187 ibid., p.197.
189 Crawford, p. 87.
191 Crawford, p. 159.
192 ibid., p. 153.
193 ibid.
194 ibid., p. 155.
195 ibid, p. 157.
exercise of considerable patience and politeness and the constraints that were placed on their activities that eventually led to them providing the grounds for their own undoing.  

Crawford went on to say that:

There were grossly inadequate numbers of staff, no staff training, and the buildings were not conducive to promoting the residents’ dignity or privacy. The total situation almost suggested abuse … it is also highly likely that from 1958 to 1968 there was considerably more abuse than came to my attention and there were times when senior male staff protected offenders … With constant pressure and an inflexible policy of no abuse, change came very gradually.  

**Allegations of sexual abuse**

Three adults with intellectual disabilities provided information to the Inquiry about sexual abuse while they were living at Minda as children. Two of the adults were in State care at the time. The alleged abuse included indecent assault, attempted rape and rape. The alleged perpetrators included a teacher, staff members and other residents.

**Abuse by staff**

A PIC born in the early 1940s lived at Minda in the 1950s. The Inquiry received client files that show the PIC was placed in State care by a court before he turned three on the basis that he was destitute. He was initially placed in a government orphanage and then in foster care. When he was 11 the department arranged for him to be medically assessed. The examining doctor found he had a low IQ and learning difficulties. After receiving the report the department decided the PIC should be transferred to Minda, where he remained until he was 15.

The PIC told the Inquiry that one teacher sexually interfered with him, touching his penis and giving him lollies as a reward. He said he did not report the incident.

The PIC was placed in foster care at 15 and was released from State care at 18.

**Abuse by staff and other residents**

A PIC born in the early 1950s was three when placed by a court in State care because his family home was deemed unsuitable. Assessed with borderline intelligence, he remained in State care until he turned 19, living at Minda from age six to 17 in the late 1950s and 1960s.

He alleged that from the time he was about seven, staff members touched him inappropriately at night: ‘Staff used to play around. Come around. Checked up on you’. He said two male carers assaulted him in this way, and he also alleged he was sexually abused by older boys who tried to penetrate him.

He told the Inquiry he did not make a complaint because he was scared and he did not think anybody would take any notice: ‘There’s nothing I can do about it. I was a bit frightened, yes … They won’t believe me’.

By the time he was 17, the PIC was employed and he saved enough money to move out of Minda and into a boarding house. Social workers from Minda kept occasional contact with him over the following years.

**Abuse by other residents**

A female PIC born in the late 1940s gave evidence to the Inquiry about living at Minda in the 1950s and 1960s. Records received from Minda show the PIC was admitted when she was nine and lived there until she was 14. The Inquiry did not receive a record of a court order placing her in State care.

The PIC told the Inquiry she was placed in foster care as a baby. Minda files show her family placed her in the home and helped pay her fees. She was considered at the time to exhibit peculiar behaviour but told the Inquiry: ‘I don’t really believe that I should have been put in that home, I’m sorry to say’.

She alleged older girls at the home sexually abused her.

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196 ibid.
197 ibid. p. 158.
when she was about 10:

Well, a couple of the older girls come down from the other end, and I don’t know who their names were or whatever because it was dark and, yes, I got knocked on the floor and raped ... They used the end of a hairbrush.

These girls warned her not to tell anyone and she did not complain:

You’re telling tales and you’re in trouble anyway, so I just left it at that … If I told anybody what they did they’d kill me. If someone says that to you, even if you’re in a place like that, you actually believe them. I did get stabbed once.

The PIC alleged that similar sexual abuse occurred on two further occasions and that, subsequently, she was too scared to go to the toilet at night and sometimes wet the bed.

She told the Inquiry she is still affected by the sexual abuse:

Even now if someone stands behind me I just shake, because I can’t stand someone, you know, behind me, and that’s after all that time … like, some nights you lie in bed and everything would just come racing back to you what happened and you’d start crying and thinking, you know—then I think, you know, something really must have been mad with me for it to have happened.

The PIC was released to her family at 14 and discharged from Minda at 15.

Hospitals

History

In the late 19th century, children in State care with intellectual disabilities were placed initially in the Adelaide Lunatic Asylum, which was established in 1852. From 1902 children with disabilities were placed into the Parkside Asylum (now Glenside Hospital), which had been established in 1870. The Education Act 1911 provided that all children between seven and 16 with intellectual disabilities were to be provided with suitable education by their parents. If this were not possible, they were to inform the Minister, who would send children to the appropriate institution, for which the parents would be asked to pay maintenance. This legislation effectively transferred the care of children with disabilities from poorer families to institutions. Children with intellectual disabilities also were placed in the Northfield Mental Hospital, established in 1930 and later known as the Hillcrest Hospital. There was no provision in mental hospitals for the separate accommodation of children, nor were activities to stimulate cognitive function or interest provided.

By 1945, Parkside Hospital, Northfield Hospital and the Enfield Receiving Home were the State-run facilities that accommodated children with disabilities. Under the Mental Defectives Act 1935 the department could direct that children with intellectual disabilities who had been committed to government institutions be transferred to mental hospitals or receiving homes:

If any person while imprisoned or detained in any prison, gaol, reformatory, industrial school or other place of confinement ... appears to be mentally defective, the Minister ... may direct, by order signed by him, that the said person be removed to the hospital for criminal mental defectives.
Children with intellectual disabilities removed from departmental institutions were required to be detained in a special section of the Enfield Receiving Home with adult criminals.203

By the late 1950s concerns that children in State care were treated in this manner reached the CWPRB, which said:

*It would appear that the provisions in an Act which require State children, who may be of tender years, to be transferred to such a hospital, because they were unfortunate enough to be committed to one of this department’s institutions, are somewhat out of line with present day methods … Certifying a child as a criminal mental defective in many cases often seems illogical and repugnant.* 204

Changes to sections 46–8 of the renamed *Mental Health Act 1976–77* enabled children in State care to be admitted to receiving homes and mental hospitals in the same manner as children who were not in State care.

Historical records show that conditions in the State’s mental hospitals were inadequate. It was reported that in 1961, Parkside Mental Hospital housed 150 male patients aged between 12 and 60. Half of the patients slept on mattresses on the floor; patients who had soiled themselves were hosed down to clean them.205 The report noted that: ‘The psychotic and the developmentally disabled shared the same accommodation. Nor was age any barrier so that quite young children were in the same ward as disturbed adults’.206 A study of State-run mental health services in 1961 found that of a total population of 2500 patients, 600 were intellectually disabled and, of these, 142 were aged under 12.207 The co-location of those with mental illness and those with intellectual disability was ‘the result of a historical accident based on limited knowledge and on even more limited public funding in a small pioneering colony’, noted the study.208

The development of Lochiel Park, the opening of the Strathmont Centre in 1971 for people with intellectual disabilities and the growth and development of accommodation and community services in the non-government disability sector reflected the attempts to separate services for people with intellectual disabilities from mental health services.

**Allegations of sexual abuse**

One woman and one man gave evidence to the Inquiry about their experiences as children detained in mental hospitals.

**Abuse by staff**

An Aboriginal woman alleged she was sexually abused during her placement in Hillcrest Hospital in the mid to late 1960s. Records from Hillcrest Hospital and the department show the PIC was placed under a care order interstate when she was 12, soon after her mother’s death. The interstate welfare department placed her in Hillcrest as a ‘voluntary patient’ for psychological assessment for reported ‘disturbed behaviour’ in her community. It appears there were no local facilities available in her home community. The PIC said: ‘They put me in this nut-case hospital here, Hillcrest’. The records show she remained at the hospital for much of the following six years, although she had trial periods of leave in her community and at other homes.

The PIC’s SWIC shows that in the late 1960s, when she was 15, she absconded from an Aboriginal girls hostel and was placed in State care by court order until she turned 18, after being convicted of obtaining liquor as a minor and of drunkenness.

She was sent back to Hillcrest where, the PIC recalled, she was ‘locked up all the time’. Sometimes she was locked in what she termed a ‘blue room’, wearing a canvas gown and with only a canvas blanket on the floor and a plastic...
bucket for a toilet. She did not like the medication the hospital gave her, which she said made her ‘silly’. On one day each week she received what she thinks was shock treatment, after the staff put a chain on her arm and her leg.

The PIC told the Inquiry that when she was about 16, two, possibly three, male nurses at Hillcrest sexually abused her on more than one occasion. She believes they gave her drugs and had intercourse with her; she was sore in her genital region afterwards. She said one of the nurses held her arms and legs down and placed tape over her mouth, preventing her from screaming. The PIC recalled reporting the nurses to a Hillcrest doctor, and said a swab was later taken. She does not recall the police being called. She told her interstate welfare officer that the hospital was treating her badly, but did not tell her what had happened because she was ‘a bit nervous’. Hillcrest and departmental records provided to the Inquiry do not mention the allegations.

A social worker who worked at Hillcrest Hospital at the time told the Inquiry that the locked ward in which the PIC was placed was unsuitable for the teenage girl. Her treating medical staff also noted in hospital files that it was unsuitable. Solutions for her care were reportedly difficult to find.

The PIC was encouraged to come to the Inquiry by her friend and advocate, and she said the abuse she experienced ‘hurt my feelings and hurt everything else’.

Abuse by other residents

A PIC born in the early 1950s was placed in State care when he was 14. He told the Inquiry that when he was a teenager his father died and his mother became quite ill in the following months and could not look after the family. The PIC said they were poor and could not afford basic necessities such as clothing and books for school.

He said he stopped attending school when his physical education teacher told him to bring sandshoes and clean clothes for an activity:

I thought, well, there’s no chance of me getting sandshoes and things, so I’m not going to go any more because I’m going to get into trouble from him.

Departmental records show that at the age of 14½ the PIC was placed in State care by a court due to absence from school. The PIC told the Inquiry he recalled his mother telling the court he was uncontrollable and said no-one advocated on his behalf: ‘I didn’t even speak in the court. I ended up crying most of the time’.

Once placed in State care the PIC was transferred to the Enfield Receiving Home. The records show that several days later he was transferred to Hillcrest Hospital.

The PIC described his first impressions of the hospital:

I’ll never forget walking about 400 or 500 metres from the administration building to the ward where they were going to put me. It was like getting a guided tour of Auschwitz. That’s the only way I can describe it. I walked past people in cages, buildings with bars on the roof, just a horrible place and I didn’t know what I was doing there. The people in the cages will always stick in my mind … the ones in the cages were Down syndrome.

The PIC told the Inquiry that on his first day at Hillcrest he absconded and returned to his family home. ‘I took off as soon as—you know, I was in Auschwitz. I wanted to get out’. The police arrived in the middle of the night and his brother then took him back to Hillcrest.

The records show the PIC was at Hillcrest for the next 3½ months. He told the Inquiry that in the first two months he was in a ward full of grown men:

Could have been 50 or 100. There was a lot in there. It was a great big room, full of beds and full of people … There was people that would scare you if you seen them on the street. There was people—very disturbed people. There was people that just used to pace all the time.
Chapter 3 Allegations of sexual abuse

The PIC alleged that a man in his ward tried to sexually abuse him:

There was one fellow—he had the bed next to me, because when they took me up there and give me a bed in the dormitory, I ended up in the bed next to one of these homosexuals, I think he must have been. That's what he told me he was. That’s what he told me he was there for, and I was put in the bed next to him. Not straight away, but after a few days there was one night he tried to get in the bed with me, and he tried again a couple of times after that. During most of the time in that ward 1A, I slept with my clothes on.

The PIC told the Inquiry that soon after his admission a patient exposed himself:

Probably the third day I was there, there was one of these real disturbed fellows. He just sort of dropped his trousers and started masturbating and following me around the place. Eventually I made it to where one of the attendants was in their little room office there, and I called out to him and he come out and had a look and just said, ‘Put it away, George,’ and that was all.

He alleged a patient in his ward offered him money for sexual favours: ‘He offered me money to do things for him. He offered me a pound if I’d fiddle with him and … on about three or four occasions I took his money’.

The records show the PIC was released from the hospital and State care soon after his 15th birthday: “Eventually my mother came and made trouble and got me out. She said, “You’ve got no reason to hold him. It’s no good being here”, and she took me’.

Regarding his time in care, the PIC told the Inquiry:

The best help is to see some good recommendations and ensure that things don’t go haywire in the future … it was a pretty horrific situation in that ward.
### 3.2 Smaller group care

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Chapter 3 Allegations of sexual abuse

History

The department developed cottage-style accommodation for children from the early 1960s, as a result of changes in philosophy towards large congregate-care facilities. Departmental annual reports of the period repeatedly expressed the idea of greater individual attention for each child. The department prioritised permanent adoption or foster care, but acknowledged that this was not always possible due to a lack of available or appropriate placements. It believed children living in cottage-style accommodation would be less conspicuous as ‘State’ children. Further, each child was more likely to develop his or her potential in an environment that resembled a family home. It was thought older children or those with emotional problems would benefit from cottage accommodation. The department also found that the cost of maintaining smaller homes was considerably less than larger institutions.

The cottage home scheme promoted individualised care and living arrangements that fostered a sense of children as members of the community. Children lived in groups of fewer than 10, enrolled in schools, attended local churches and joined in other practices simulating life in a typical family home. Each cottage provided bedrooms rather than dormitories and, instead of a superintendent, a house ‘parent’ ran the cottage.

By 1972, the theory that children benefited from living in small group settings was departmental policy. The department’s administration of residential facilities throughout the State was divided into five regions to give the department closer contact with the community and encourage family reunification. The department also converted large homes and training centres into smaller living units, starting in 1971 with the establishment of units in the secure care training centres, McNally and Vaughan House.

Many children who were moving from the large institutions to the cottages were accustomed to a regimented style of care. Likewise, many staff who took charge of the cottages had been transferred from institutions and brought with them methods associated with institutional care. As one former departmental officer noted:

They were people who had come in from all walks of life and struggled with a lot of the principles … we were trying to implement. Some were rejecting it strongly … the punishment philosophy was still an undercurrent well into the 70s.

The passing of the Community Welfare Act 1972 and establishment of the Residential Child Care Advisory Committee (RCCAC) in 1974 subjected non-government homes to more detailed licensing and funding agreements than had existed previously. Expected standards of care were outlined and the department funded the homes’ social worker salaries and other operating costs. The RCCAC encouraged non-government agencies to replace congregate care institutions with smaller group homes to further more individual care and assessment of children.

During the 1970s and 1980s the government closed many of its own residential care facilities and relied increasingly on the non-government sector. By 1981, non-government agencies (church welfare agencies and independent community organisations) were managing 15 cottage homes, eight youth homes and two emergency accommodation schemes.

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2 For example, see comment to this effect in CWPRB annual report 1969, p. 19.
3 ibid.
4 ibid.
5 ibid., 1960, p. 12.
6 Department of Community Welfare (DCW) annual report 1972.
7 Central Metropolitan, Northern Metropolitan, Southern Metropolitan, Northern Country and Southern Country regions.
8 DCW annual report 1972, p. 20.
3.2 Smaller group care

The development of hostels predated cottage homes by two decades and came as a result of the need for accommodation for State children who were working. The department had seen the hostel model in the early 1940s after travelling interstate to ‘gain the latest information on child welfare practice and administration’. By 1944 it had become evident that State children who were on probation and who were working could not find appropriate accommodation; some were forced to move to country farms, while others worked as live-in domestic servants. A departmental officer wrote in 1944 that:

If hostels were available, more and more children would be placed in them as there is very little future in either domestic work or farm labouring. Boys could be apprenticed and girls also, or else take up selected factory work.

Youth shelters developed in the 1970s as a response to community concerns about youth homelessness. Voluntary agencies and individuals developed Adelaide’s first shelters. By 1979 a range of shelters was operating with financial assistance from the department. While some were ‘closely supervised hostels for difficult-to-place youths’, others offered a ‘more flexible free-living environment with minimal controls’. Some shelters were developed and run by social welfare agencies and others by ‘collectives of adults and young people in care who together came to a consensus of management style’.

While the department did not establish or run shelters, it licensed them, established standards of practice and provided operational funding, as it did for other forms of non-government residential care. The department’s Residential Child Care Advisory Committee (RCCAC) developed a youth homes policy to ensure the department was involved with each new shelter from its inception. Shelters were required to make formal submissions to the director-general, outlining the nature of the venture and providing evidence of the need for the service. To be eligible for funding, shelters were required to be ‘accountable to a policy-making body’ which would control staffing, finance and management. Staff were expected ‘to have qualifications or to be undergoing training in either social work, group work or residential care’. Shelters were required to have clear admission procedures and individual programs for children placed in their care, which would be subject to regular reviews. The RCCAC monitored shelters to make sure young people were ‘not exploited’ and were given opportunities to resolve family conflicts. The committee also stated that, ‘Corporal punishment is not to be used. Alternative methods of modifying behaviour should be sought.’ Records show the department’s control over shelters, and the children admitted to them, was less than comprehensive.

Summary of smaller group care allegations

Forty-nine adults gave evidence to the Inquiry that they were sexually abused as children while living in smaller group care. From available records, the Inquiry was able to determine that 44 were children in State care at the time of the alleged abuse.

10 ibid., 1943, p. 3.
12 SRSA GRS 4164/1/48, file 20/13/4, memorandum Minister of Community Welfare to the Premier, for Cabinet, 27 Sep. 1978.
15 SRSA GRS 714/1/P, correspondence RCCAC, Jan.–Sep. 1978, branch head circular 441, 11 June 1978.
16 ibid., Jan.–June 1977, RCCAC liaison officer, Youth homes and women’s shelters, to interim youth homes committee, 22 Feb. 1977.
Chapter 3 Allegations of sexual abuse

Government cottage homes
The Inquiry received evidence from 21 people who alleged they were sexually abused when they were children living in a government cottage home. They were all in State care at the time. The PICs named the alleged perpetrators as staff members, visitors, other residents, foster carers, outsiders and a family member. The sexual abuse included allegations of indecent assault and rape.

Clark Cottage, 1963–79
History
Clark Cottage at Clarence Park opened in 1963, the third of several properties bought by the department in the early 1960s for cottage-style living. It accommodated up to 10 children at a time until it closed in 1979. The site was then used as the Southern Region Admission Unit.

Allegations of sexual abuse
One PIC told the Inquiry she was sexually abused while placed at Clark Cottage.

Abuse by staff and another resident
An Aboriginal PIC who was placed in State care in the late 1960s when she was about eight told the Inquiry she was sexually abused at Seaforth Home, Clark Cottage, in foster care and in the family home. The PIC was eight when admitted to Clark Cottage in the early 1970s, a placement that lasted three years. She was placed at the cottage because it already housed an indigenous child and the department believed the PIC would benefit from ‘contact [with] other Aborigines’. The PIC did not know she was indigenous until she mentioned to another resident that she wanted a bath: ‘I thought my skin was just dirty and I thought if I had a bath and soaked in White King I’d be white like all the other kids’. One of the staff then explained her background.

The PIC said a male worker sexually abused her by fondling her breasts and genitals throughout her three years at the cottage. She said the abuse always happened in the same place—in a room away from the main cottage—and that she believed the same man abused ‘a few of us girls’ at the cottage.

She said an older female resident also sexually abused her: ‘She used to undo my top and make me take my knickers off’. The PIC said she became a chronic absconder over the three years, partly because of the abuse. Departmental records show she absconded from the cottage when she was eight, which precipitated a temporary transfer to secure care. There is also a note on the file indicating that, aged 11, she refused to return to the cottage from school. A note on her file reads: ‘Even in a friendly discussion (the PIC) would not say what was worrying her or why she repeatedly ran away’.

Merrilama Cottage, 1960–79
History
Merrilama Cottage at Glenelg was the first suburban cottage home developed by the department for housing children. It accommodated up to 10 children, with an average of six at one time, cared for by a cottage mother and two assistants. The children attended local schools, were given pocket money weekly, and were permitted to visit friends, entertain in the home and correspond with relatives.

Allegations of sexual abuse
One PIC alleged that she was sexually abused while placed at Merrilama Cottage.

Abuse by other residents
The PIC was placed in State care in the early 1970s at the age of three, after a court committed her for neglect. She was placed in institutional and foster care and spent a brief period with her family. After her parents experienced difficulties caring for her and foster care was deemed unsuitable, she was placed at a cottage home when she was about six. She then spent about four months in Merrilama Cottage before being transferred to several foster homes and then lived for about 12 months at

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3.2 Smaller group care

Farr House. The PIC alleged she was sexually abused at Merrilama Cottage, one of the foster placements and at Farr House.

She told the Inquiry there were only two boys, both teenagers, living at Merrilama when she was there. Soon after she arrived, the older boy, whose name she could not recall, began sexually assaulting her by simulating sexual intercourse with her against her will. She said the abuse happened in the cottage grounds about twice a week for a month. She found this distressing but did not report it to staff. She remembered that the abuse stopped suddenly, although, she said, the boy persisted in threatening her with physical violence.

Hay Cottage, 1968–79

History

Hay Cottage opened at Lockleys in 1968 and closed as a cottage in 1979. The Elizabeth Grace Community Unit, a Vaughan House unit, was then transferred to the site and renamed the Hay Community Unit.22

Allegations of sexual abuse

Four people who were in State care as children gave evidence to the Inquiry about sexual abuse while at Hay Cottage. Their allegations included rape, indecent assault and unlawful sexual intercourse and the alleged perpetrators at the cottage were residents. Two PICs alleged they were abused while out on holiday placements.

Abuse by multiple perpetrators

In the late 1960s a five-year-old girl was placed in State care until the age of 18 when a court found she was neglected and under unfit guardianship. The PIC told the Inquiry her stepfather drank and was violent and he had sexually abused her before she was placed in State care. A couple of months after the court order was made she was placed in Hay Cottage, where she remained for four years; her residency was interspersed with a series of short holiday placements. At nine, the PIC was transferred to her family’s care, where she alleged she was sexually abused. According to her SWIC, she was granted release from State care on petition when she was 14.

The PIC’s general recollection of the cottage was positive. She said the cottage parents ‘instilled morals in me that I never forgot’. She attended the local primary school as well as church. The cottage housed about 10 children; boys slept on the ground floor and the girls shared rooms on the second floor. She said sexual activity among the residents was not uncommon.

She named two male residents as alleged perpetrators. She said that after one female resident left Hay Cottage ‘they turned their attentions on to me’. The Inquiry confirmed that the female resident left the cottage about the time the PIC estimated she was abused. Records also confirmed the two alleged male perpetrators were cottage residents during this period and were some years older than the PIC.

The PIC recalled the boys’ abuse built up over time; at first ‘they come to our bedrooms at night time … and then it just become more and more and more until it was sexual’. Eventually, she said, the boys forced her to perform oral sex and to engage in sexual intercourse: ‘I hated it and it hurt’. She did not disclose the abuse because of the boys’ threats that ‘we’ll make life very uncomfortable’. The PIC said she once ‘screamed out … “This is enough, leave me alone”,’ but was told, ‘You tell anyone and you’re dead’.

She alleged another boy at the cottage, three years her senior, abused her, trying to force her to perform oral sex by ‘pulling down his pants and trying to force my head there’. She ‘ran really fast and he couldn’t grab hold of me’. The PIC said he also threatened her. She said she told another boy, who confronted the alleged perpetrator, but that resulted in a fight. Soon after, the alleged perpetrator moved out of the cottage. The Inquiry confirmed that a person with the same name as that supplied by the PIC left the cottage during the period. The PIC said she had been too scared to disclose the abuse to staff.

22 SRSA, GRS 714/1, Correspondence of the RCCAC, June–July 1979, Letter from chairman of SA Steering Committee for Educational Projects for Children in Residential Care, to director-general, Education Department, 15 June 1979.
Chapter 3 Allegations of sexual abuse

During her placement at Hay Cottage the PIC was sent out on short holidays to various families. At one home, she said, the family’s son, aged about 14, made repeated sexual advances to her, including ‘suggestions and running in when I was in having a shower or a bath’. When she was nine, she said, the son forced her to perform oral sex on him and tried to penetrate her. She did not remember whether he succeeded because ‘I remember fighting it, and he was … pushing my head into the water’. She did not tell the foster parents but said she became more disruptive, which was her way of ‘trying to tell them. I was too scared to tell them’. On her return to Hay Cottage, the PIC did not tell anyone what had happened. She said her behaviour at the cottage deteriorated but she was not asked why. Aged nine, she was returned to live with her mother.

Abuse by other residents

A PIC had been placed in State care in the early 1960s when he was aged 2½ after a court found him neglected and under unfit guardianship. Departmental records indicate his placement was based on parental illness and alcohol abuse, despite the parents’ objections. He lived in three different government institutions and in various foster care placements before being admitted to Hay Cottage when he was 10. The PIC spent about three years at the cottage and was then transferred to foster care.

He told the Inquiry he remember being ‘basically happy’ at the cottage. He attended a local school and went on short holiday placements, which he enjoyed.

He said an older boy at the cottage sexually abused him when he was about 12: ‘I was held down by [the alleged perpetrator] and he masturbated me’. The Inquiry received documents confirming that a boy with the same name as the PIC lived at the cottage at the same time as the PIC. The PIC said the abuse happened on more than one occasion; the alleged perpetrator would wait until he was asleep and then approach his bed. He said the same boy abused other residents and on one occasion forced him to participate in abuse of a female resident; he and the other boy went upstairs to the girls’ bedrooms and enlisted the help of two girl residents to rape a third girl: ‘They just forced me to lay on top of [the girl] and have sex’. The PIC said he penetrated the girl. He was unable to provide the full names of all involved but the Inquiry ascertained from available information that people he identified as an accomplice and the victim were in State care and resident at Hay Cottage when the PIC lived there.

Abuse by outsiders

A PIC was placed in State care in the mid 1960s when he was four; his SWIC records that he was committed as neglected and under unfit guardianship. The boy was placed at two different government homes, then had a series of foster placements. He was placed at a third government institution before being placed at Hay Cottage when he was eight. He lived at the cottage for five years. There were, to his recollection, about seven children in residence when he arrived. He described the cottage in positive terms and recalled several holiday placements and holiday camps.

The PIC said that his father took him camping when he was about 13 and living at Hay Cottage. There were other children at the camp and one of them anally raped him during the night, he said, but he did not tell anyone about this because ‘he said if I said anything he’d kill me’.

Another PIC was four in the mid 1960s when she was placed in State care because of neglect. Departmental records show there had been allegations of ‘indecencies’ in relation to the girl and her siblings, perpetrated by the man she thought was her father. The PIC alleged she was sexually abused in foster care, the family home, Hay Cottage and Davenport House. Her SWIC shows she was placed at Hay Cottage in the early 1970s when she was 11 and stayed for about three years. She said her cottage mother ‘was firm but, you know, she was a good cottage mother to me’. Her cottage parents were ‘good people’.

The PIC told the Inquiry that while she was living at the cottage her father watched her playing sport and sexually
She told the Inquiry:

I still to this day, sir, find myself very insecure, alone, abandoned, afraid and vulnerable ... I have asked myself often, ‘Why has this happened to me?’ and I have no answers. There are many times I have felt it’s my fault. I have deserved this. That is sad, I know, but that’s how I’ve felt. The pain and the feelings of my childhood and adulthood are without question very traumatic to say the least.

**Fullarton Cottage, 1970–79**

**History**

Fullarton Cottage at Myrtle Bank opened in 1970. It could house up to six children aged between seven and 16, with day-to-day care provided by a housemother and an assistant. Former residents told the Inquiry that boys slept on the cottage’s upper level and girls on the lower level. In 1979 the cottage became known as the Youth Therapy Unit.

**Allegations of sexual abuse**

Two PICs gave evidence of sexual abuse during placements at Fullarton Cottage.

**Abuse by multiple perpetrators**

One PIC was placed in State care by a court as a baby boy in the mid 1960s; according to his SWIC, the court found him to be neglected and under unfit guardianship. The PIC alleged he was sexually abused during a placement at Fullarton Cottage in the 1970s and also in a later placement at the South Australian Youth Training Centre.

The PIC lived in various government institutions until he was six. Throughout this period he was returned to his family for brief periods but, according to his SWIC, was often placed back in institutional care for ‘safeguarding’. At seven, in the early 1970s, he was placed at Fullarton Cottage, where he stayed for about nine years. The PIC told the Inquiry about eight children were living in the cottage when he arrived and he shared a room with two other boys.
He alleged an older boy resident who had his own room sexually assaulted him. He ‘would coax us into his bedroom and get us to touch him’. He said this boy showed him and another younger boy how to masturbate him and ‘forced me to play with him on numerous occasions’. The PIC said he believed this abuse went on for about two months, but noted that ‘it seemed to go on forever’.

He said he and the other younger boy took to sharing a bed ‘so as to ward this guy off, you know’. The abuse ceased only after the other boy physically assaulted the alleged perpetrator.

The PIC recalled that the other alleged victim was transferred from the cottage soon after this confrontation; the transfer is recorded on that boy’s SWIC. The PIC, who was 13 at the time of the transfer, said he disclosed what was happening to another resident, but did not know whether the resident reported the allegations to staff. He believed that by the time of the altercation between the boy and the alleged perpetrator, ‘I’m pretty sure it was pretty much out in the open as to what had happened’.

The PIC told the Inquiry he reported the sexual abuse to his departmental social worker, who spoke to him about ‘what was right and what was wrong’ regarding sex. The PIC summarised the talk as concluding that ‘males should not be together’. He did not clarify whether the social worker undertook to act on the information provided. In retrospect, he said, ‘there are some things I said that he should have repeated to somebody else’. There is no record of this disclosure on the PIC’s departmental file.

About one month after arriving at the cottage the PIC was placed on holiday leave with a family for almost six weeks. He alleged the foster father sexually abused him throughout the placement, rubbing his penis over the PIC’s genitals while the PIC was standing in front of the toilet, and masturbating himself to erection. The PIC said that the first time this occurred ‘I didn’t know what to think’. He remembered that such incidents happened regularly; ‘Every time you sort of wanted to go to the toilet he was there’. He did not disclose this abuse to staff at the cottage on his return, although he said he has not been able to forget it: ‘I relive it every day.’

The only mention of the placement at the foster home in departmental files supplied to the Inquiry is a report written by a community welfare worker who notes that,

"Over Christmas, [the PIC] spent his holidays with family at [name of location] who had a dull son. Since his return [the PIC] appears to have regressed a little and this could be attributed to his close contact with this dull boy."

Another PIC who alleged sexual abuse during his placement at Fullarton Cottage was placed in State care in the mid 1960s when he was a baby. After a family breakdown, the PIC was found by a court to be neglected and under unfit guardianship and was remanded to a government institution. The PIC also alleged he was sexually abused during a subsequent placement at Kumanka Boys Hostel.

The PIC was placed in Fullarton Cottage in the early 1970s when he was eight, and lived there for about five years. He alleged that an older male resident sexually abused him ‘straight after I arrived, basically’ and recalled that ‘he used to force me to do sexual things in the shed’ at the cottage. He believed this happened on at least two subsequent occasions but possibly more. The PIC said he complained to a cottage parent immediately after the first instance of abuse and she told him ‘she would get back to me with it’. He said he complained to cottage staff after the second incident, and also reported the abuse to his departmental worker, but no-one at the cottage spoke to him about the incidents afterwards.

A note written by the PIC’s community welfare worker in the departmental file states that the PIC approached a cottage parent to discuss another boy at the home ‘involving him in homosexual activities’. The boy named in the file note has the same name as the alleged perpetrator the PIC named to the Inquiry. Departmental records received by the Inquiry did not set out what action, if any, was taken in response to the PIC’s disclosure. Another notation details a telephone call from the cottage parent to the PIC’s community welfare
worker, about one month after the PIC’s request to discuss ‘homosexual activities’. The worker’s summary of the telephone call reads, ‘concerned with [PIC’s] persistent [sic] lying’. It seems the cottage parent was concerned.

About a year later a report from the cottage supervisor noted that the PIC’s behaviour had ‘deteriorated [sic] dramatically in the past six months. No explanation can be given by us or him’. A Cottage Home Review Board report on the alleged perpetrator completed by the cottage parent about seven months after the notation observed that he ‘threatens the other boys if they won’t do the things he wants them to do’. The alleged perpetrator and the PIC shared the same welfare worker, and the former’s records show the worker initiated discussions about him moving from Fullarton Cottage. There is a reference to the alleged perpetrator being ‘upset by ultimatum re [suggested government home for transfer] and that he has been accused of standover tactics at school’. Another note written about two months later reads, ‘[Alleged perpetrator] given choice of going to [a private hostel] or [a government home]’. Soon after, the alleged perpetrator was transferred from Fullarton Cottage, 12 months after the PIC’s disclosure.

The PIC gave evidence about a six-week holiday placement with a couple in his first year at the cottage, when he was eight. He alleged that while the woman was occupied in the nearby kitchen, the foster father took him to a bedroom and forced him into anal sexual intercourse: ‘I was screaming and screaming and screaming for him to stop and it didn’t stop and it kept going’. He recalled he ‘was bleeding from the anus’ afterwards. He alleged such abuse occurred three times during this placement.

He said that on his return to the cottage he was bleeding from the anus and had difficulty walking. Staff had noticed this and, when they spoke to him about it, he asked to speak to the cottage parent. After hearing about the alleged abuse, he said, the cottage parent told him to rest, assured him the matter would be investigated and said he would be told of the outcome. The PIC told the Inquiry that on the following day he lost his privileges and staff called him a liar. He said he believed the cottage parent had consulted his community welfare worker and the foster parents.

No information about this disclosure or any action in response could be found in department records provided to the Inquiry.

The PIC also alleged he was sexually abused during sanctioned leave when he visited a boy at another home. He told the Inquiry he sat in this boy’s room and a male staff member checked on them periodically, as did another man. He asked the other boy who the men were and was told that one man worked at the home and the other was not a staff member but a friend of the first man.

The PIC alleged that during the visit the other boy gave him pills, telling him at the time that they were Mandrax.

His next memory was of waking in the shower block at the home, naked and bleeding from the anus. He said his anus ‘would not stop bleeding’ and he recalled ‘sort of not vaguely remembering my name, where I was, who I was, what happened, what was going on’. The other boy had told him the two men were responsible for what had happened to him. He was showered and clothes were provided for him, and he was taken back to Fullarton Cottage. He was too drugged to remember details including who showered and dressed him. He said he reported this incident immediately to the cottage parent.

The Inquiry was unable to locate any department records about the incident or the disclosure.

The PIC told the Inquiry he began absconding from the cottage when he was about 12, as a result of the older resident’s abuse. He said he met a man in the city who befriended him, bought him food and invited him to make contact when he was away from the cottage, saying he would collect him. The PIC said he contacted the man on several occasions, leaving the cottage during the night. Over time, the man began visiting him at the cottage during the day and became known to staff there. Records confirm the department was aware of the PIC’s friendship with this man:
Chapter 3 Allegations of sexual abuse

[The PIC] recently met [the man] who has shown quite a lot of interest in [the PIC], who has been out with him several times. [The PIC] is very enthusiastic about the friendship.

The PIC told the Inquiry:

I didn’t trust him one bit. I just wanted him for his cigarettes and that he was going to give me hot coffee ... I had no parents, no nothing, he was a sugar daddy.

Another report written a month later notes:

[the PIC] has found a new friend whom the Community Welfare Worker has not met as yet ... [the PIC] recently asked if he could spend a weekend at [the man's] home, but this was denied by Community Welfare Worker until Community Welfare Worker can meet [PIC's] friend and discuss the whole situation.

The department's records note that the man visited the PIC at the cottage and the boy went on outings with him. Although there is no record of overnight stays with the man, the PIC told the Inquiry that this did happen. He alleged the man took him to his home and gave him food. He recalled feeling 'drowsy' and 'really good'. He said the man showed him pornographic magazines. On another occasion, he recalled:

I was sitting on his bed ... there was alcohol that I could have, there was marijuana I could have, there were pills I could have, there was anything I wanted ... that's when the old hand stuff used to come into it.

He also alleged that on another occasion the man drove him to another man’s home, where they gave him food and drink and then anally raped him, 'one at a time, each after each other, in the bedroom'. The PIC alleged that after this incident the first man raped him on several occasions at his home. He did not tell Fullarton Cottage staff what had happened because 'I was asked not to, because at that stage I've got no family ... he's the only family I've got and he's giving me all these goodies'.

The PIC said he continued to meet the man while he remained at the cottage:

I had no people visiting me, that was the silence I was keeping, to have that person visit me, and I felt important, and all this sort of stuff, and someone loved me so to speak. That's why I kept it quiet, because I had no-one else.

His association with the man continued for about six months. A note in the department’s records reveals that cottage staff refused the man access ‘as it seems there have been some charges made against him for molesting kids’. A review of the alleged perpetrator’s criminal history reveals a conviction for indecent interference two years earlier.

When he was 13 the PIC was transferred from the cottage to a departmental hostel. His records cite the reasons for the transfer as ‘[the PIC’s] negative attitude to the staff at Fullarton Cottage and his disruptive behaviour within the Cottage’.

Stirling Cottage, 1962–79

History

Stirling Cottage at St Peters opened in 1962 and accommodated up to 10 children, cared for by cottage parents with full-time and part-time assistants.24 In 1979 the cottage closed and was replaced by the Northern Region Group Home.

Allegations of sexual abuse

Three people alleged they were sexually abused while living at Stirling Cottage. Their allegations included indecent assault, commission by a child to commit an indecent act, and unlawful sexual intercourse. The alleged perpetrators were cottage staff, other residents and sanctioned visitors.

Abuse by multiple perpetrators

The Inquiry received evidence from a PIC who was 12 when he lived at Stirling Cottage in the early 1970s. According to his SWIC, he was placed in State care by a court at the age of eight because of neglect. The PIC told the Inquiry he experienced family violence and alcohol abuse when he was a child and said that while in State care he was sexually abused at the family home and Stirling Cottage.

The PIC lived at the cottage for almost a year initially and for another year later. He said he clearly recalled his time there. He said there were about 10 residents ranging in age from about six to 15 and remembered there was only ever one staff member on duty at night. He said one male worker watched the residents, including girls, while they showered on the nights when he was working alone at the cottage.

He told the Inquiry about an occasion when an older boy—‘the main boy’ at the cottage and ‘pet’ of the cottage parents—forced other boys to rape a girl resident, threatening them if they did not obey him. The PIC said he was forced to rape the girl, who was ‘in one of the back sheds laying on the ground waiting for each of us to go in’. The girl was, to his recollection, ‘terrified. My visions of her, the terror on her face, her constantly putting her hands—they were slapped down.’ The PIC said he lay on the girl as ordered but was unable to get an erection. On another occasion, he said, he walked into a living room at the cottage and found this same older boy trying to coerce a seven-year-old boy into having sexual intercourse with the same girl. He recalled that on this occasion another child kept watch for staff.

The PIC said a male friend of the cottage parents sexually abused him. This man, who often visited in the evening, came into his bedroom, sat on his bed and talked to him, then fondled the PIC’s penis. The PIC said this occurred on about three occasions and he welcomed the man’s sexual advances because they resembled affection. The Inquiry ascertained that this man was a foster carer registered with the department, but was not employed at Stirling Cottage. The PIC did not report the abuse to his departmental welfare worker, who he believed was not interested in his welfare. He told the Inquiry that ‘the abuse that I saw, it was just so … lonely, it’s degrading, it’s inhumane, you know, to children’.

As an adult, he said, he has struggled with relationships:

I tend to push people away … Just the fear of getting close. Fear of intimacy, fear of abuse, fear of abandonment. It’s easier to be a loner and not have to deal with any of that.

Abuse by staff

A PIC told the Inquiry she was sexually abused by her father before being placed in State care in the mid 1970s, when she was 14. After she went ‘missing from home’ then ‘refused to return’ she was placed in State care for three months, and during this period lived at Stirling Cottage for three weeks. After that, because she was found to be neglected, she was placed in State care until the age of 18. The PIC gave evidence that after she was sexually abused at Stirling Cottage she was also sexually abused at Vaughan House and in a subsequent boarding placement.

She recalled there were about six boys and one girl living at Stirling Cottage and she shared a room with the girl. On her first night there, she said, a male staff member entered her bedroom and went to the other girl’s bed:

It felt like he stayed there for a long time, and she would chuckle a little bit … To me, it just felt like this had been going on—it wasn’t her first time. He was laying over her and his hands were under the blankets … I could see he was fondling her.

The PIC said that another time she woke up to find the same staff member sitting on her bed. He had been performing oral sex on her and touching her breasts. She said she ‘freaked’ and the man got off the bed and quietened her.
Chapter 3 Allegations of sexual abuse

On another occasion, she said, the same man abused her during an outing from the cottage. She recalled that children were encouraged to go off and play by themselves ‘and then he would just come up around you, like, to make sure that you’re doing the right thing, but he wasn’t really’. She spoke of being alone among several large rocks: ‘I’ll never forget … he would take his penis out and expose his penis … I just hated that outing’. The worker allegedly exposed himself to her ‘more than once. That was normal, yes.’ He also had access to the shower block and watched her in the shower.

She did not disclose the alleged abuse—‘That was something that you just didn’t talk about’—but persuaded her roommate to abscond: ‘We just kept walking and walking and the police got us and brought us back again’. The PIC called the abuse she suffered at Stirling Cottage pivotal to her life: ‘That’s where I believe that that was it for me’.

Another PIC was placed in State care when he was six. His parents had separated repeatedly and the remaining parent did not provide adequate care for the PIC and his siblings. A court found him to be neglected and in the mid 1970s he was placed in Stirling Cottage when he was 10. He spent the next two years there, a period interspersed with various holiday placements and two brief transfers to other cottage homes. He told the Inquiry he was sexually abused at Glandore Boys Home and later at Stirling Cottage.

He said there were about six children living at Stirling Cottage and that boys and girls slept in separate areas. He went to a nearby school, and also recalled that the children were supposed to attend church services but that he and others did not; they spent the money intended for the collection plate at a nearby shop. He said residents would sneak into one another’s beds: ‘Everyone was having sex in the place’.

The PIC told the Inquiry a male staff member ‘made me do a few things to him’, forcing him to perform oral sex and masturbate him on several occasions. He said the abuse occurred in the cottage’s shower area, usually after the other children had showered and were getting ready for bed:

I was the last one because I never ate my vegetables or anything and he made me sit at the table until basically everyone had gone to bed just about. He’d still make me eat them, then I’d go to the shower by myself.

The man would appear while he was showering. The PIC recalled that the abuse ‘happened a few times’, until ‘I said I’d had enough. I decided to stand my ground and it worked, so he didn’t touch me after that.’

The PIC said another resident ‘would organise everyone to have sex and that, while he was watching them’ and have sex with female residents. He also recalled that supervising staff sent an older female resident out of the cottage at night; she did not return for several hours and he and other residents inferred that she was sent to take part in sexual activity. He could not recall her name or that of the resident who organised the sexual encounters.

The PIC remembered having a departmental social worker while he was in State care, but could not recall whether the worker ever visited Stirling Cottage. He did not disclose the abuse at the time; when asked whether there was anyone in his life he felt he could have confided in, he replied, ‘I don’t think so, no’. The PIC told the Inquiry that as an adult he ‘started having the nightmares and remembering things’. Many of his recollections of his time in State care are vague, but of the abuse he suffered at Stirling Cottage he said, ‘I’ll never forget that’.

Pleasant Avenue Cottage, Glandore, 1975–79

History

Pleasant Avenue Cottage, established in 1975, was situated on the grounds of the former Glandore Boys Home.25 It accommodated an average of six children.26 In the late 1970s, when the department reorganised its residential care facilities for children, Pleasant Avenue was closed.27
3.2 Smaller group care

Allegations of sexual abuse

One woman gave evidence to the Inquiry that she was sexually abused while placed at Pleasant Avenue Cottage.

Abuse by another resident

The PIC’s records show she was placed under two consecutive three-month care and control orders in the late 1970s, during which time she was placed at Pleasant Avenue Cottage. Her parents were separating and the court deemed she was ‘in need of care’. When the second order expired she was released from care and control and returned to her family. Two years later, she was again placed in State care due to ‘difficult behaviour’. She was under short-term orders before being placed under the guardianship of the Minister until she turned 18 in the early 1980s. It appears from the records that her mother privately placed her at the Salvation Army Girls Home, Fullarton, between court orders. She alleged she was sexually abused at Pleasant Avenue Cottage and later at the Fullarton home.

The PIC had few memories of Pleasant Avenue Cottage, recalling that, ‘I didn’t really mix with any of the kids. I really stayed by myself.’ She said she had just turned 10 when she went to the cottage, and an older boy whose name she could not remember but who she thought was about 16 ‘used to get to me all the time’. She alleged he raped her on two occasions: the first time in a basement-style room at the cottage and a second time when, she said, ‘I tried to hide under the kitchen table and he got me, and he had sex with me’. The PIC said she did not tell anyone at the cottage or her departmental welfare worker about what had happened: ‘I never told anybody. I was too ashamed to.’

Slade Cottage, Glandore / Somerton Park, 1973–88

History

Slade Cottage opened as one of four cottages on the former site of the Glandore Boys Home on 5 February 1973.28 It was moved to Somerton Park in 1975, on the site of the former Seaforth Home, which had closed as an institution for children that year.29 Slade Cottage remained at Somerton Park until its closure in 1988, when the department considered it ‘the least satisfactory physical site owned by the Department for the care of children’.30

Slade Cottage provided accommodation for up to 12 boys aged between 10 and 15, each with his own bedroom. The boys attended local schools and community clubs, including the YMCA at Glenelg. A chief residential care worker was responsible for the implementation of programs and the overall management of the cottage.

Other staff included three male and one female residential care workers, a cook, part-time gardener and nurse attendant.31

Slade Cottage was the department’s first ‘therapeutic’ cottage—intended to provide a home for the therapeutic treatment of boys regarded as ‘disturbed’. The treatment program was reportedly devised with the assistance of psychologists, doctors and social workers.32

Boys with behavioural problems, who could not remain in their own homes or easily be placed in foster care, were generally admitted to Slade. A review of the cottage noted that most of the residents were boys ‘needling caring controls’ who ‘had been let down most of their lives’.33

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28 DCW annual report 1973, p. 49.
29 ibid., 1975, p. 42.
30 SRSA GRS 10989/1 Unit, p. 1 of 4 supplied, ‘Summary of findings’ (undated and author not indicated) attached to internal memo from [name removed] to [name removed] 6 May 1996.
31 SRSA GRS 10989/1 Unit 2, Chief residential care worker, Slade Cottage, notes in file marked Slade Cottage.
The Inquiry received departmental documents that provide insight into the care of boys at the cottage. In the mid 1980s, one resident brought charges of assault against the cottage’s senior residential care worker. A court dismissed the charges and the department allowed the worker to resume his employment, although it warned him that ‘the striking of young people in departmental care is totally unacceptable’. It also imposed conditions that the worker submit to reviews and that the cottage be reviewed and be under ongoing supervision.34 Six months later a ‘concerned citizen’ sent an unsigned letter to the South Australian Ombudsman alleging physical abuse by the same worker against three residents. The ombudsman’s office took no action because the letter was unsigned. According to an internal memo, the department took no action due to apparent discrepancies in the letter.

Allegations of physical violence by workers toward Slade residents were registered at this time, including hitting with telephone books to avoid bruising.35 An internal memorandum about Slade Cottage one year after these allegations were made detailed a departmental visitor observing a child being punished by having to eat meals alone at a table facing the wall—a scene the visitor described as ‘positively Dickensian’ and ‘grossly discriminatory’. In response, the senior residential care worker issued a point-by-point rebuttal, noting the resident’s violence toward others at mealtimes.36 The notes of one staff member at this time indicated that the senior residential care worker had told him ‘that a lot of bad things have been said about Slade but no-one could prove a thing’.37

An internal memorandum filed six months after the dining room incident was critical of the care and administrative practices at the cottage. These included limited written information on boys; the cottage logbook containing insufficient detail about events; inconsistencies and irregularities in the way in which money intended for the residents was administered; poor dissemination of procedures; and the fact that ‘the standard procedures in the cottage were not filed in any order and therefore were useless’.38

One memorandum based on interviews with staff detailed disciplinary practices resulting in ‘an accusation of undue aggression’ against the senior residential care worker.39 This worker reportedly ‘gave lip service to professional interventions unless they clearly fitted his outdated unacceptable frame of reference’.40 It was claimed that the worker undermined the implementation of disciplinary and educational programs for residents. The memorandum reported staff concern ‘at the secretive way in which many of the Slade operations were carried out’. The worker imposed a ‘dictatorial’ style that resulted in staff ignorance of residents’ needs.41

The department held an internal inquiry into Slade Cottage in 1987. The senior residential care worker did not give evidence and resigned.42 The inquiry’s summary of findings stated there was:

... sufficient cause to ask further questions about the whole line of management stewardship and also the quality of care of those children who stayed in Slade while it was functioning.

34 Unsentenced record, ‘Slade Cottage various documentation’ (manila folder), provided by the department, 5 June 2006, letter director-general, DCW, to senior residential care worker, Central Southern Region, 12 April 1985.
35 ibid., Community welfare worker, ‘Allegations against Slade staff made by Mr ______ to ______’, CWW, 29 Apr. 1985.
36 ibid., Internal memorandum, manager Specialist Services, Southern Metropolitan Region (SMR), 22 April 1987; Letter senior residential care worker to manager Specialist Services, SMR, 5 May 1987.
38 SRSA GRS 10989/1 Unit [number removed], Memorandum acting senior residential care worker, Slade Cottage, to director, human resource management, DCW, ‘Situation at Slade Cottage’, 9 Dec. 1987.
39 ibid., p. 1.
40 ibid., p. 2.
41 ibid., p. 3.
42 SRSA GRS 10989/1 Unit [number removed], Author not indicated, memorandum to director, human resource management, ‘Slade enquiry – programmes’, [date removed], pp. 1–3.
43 SRSA GRS 10989/1 Unit [number removed], p. 1 of 4 supplied, ‘Summary of findings’ (undated and author not indicated) attached to internal memo from [name removed] to [name removed] 6 May 1985.
3.2 Smaller group care

The internal inquiry found that it was not at all satisfied that Slade was a unit in which this Department should take any pride at all and believe it to be an indictment of every level of management.\(^{43}\)

### Allegations of sexual abuse

Seven men who lived at Slade Cottage as children gave evidence of sexual abuse, including indecent assault, acts of gross indecency and anal rape. The alleged perpetrators included workers and other residents, as well as outsiders.

#### Abuse by multiple perpetrators

A PIC who was placed in State care in the late 1970s described sexual abuse while he was at Slade Cottage when aged about 12. He was placed under a short-term care and control order after repeated non-attendance at school and a family breakdown. Over the next few months he was at Slade Cottage for several brief periods, during which he also was placed in the Northern Region Assessment Unit. He was later remanded to the South Australian Youth Remand and Assessment Centre (SAYRAC) several times for offending. The PIC alleged he was sexually abused at the assessment unit and SAYRAC.

He recalled there were about six children living at Slade Cottage during his stay. He described systematic physical abuse, telling the Inquiry that the officer in charge of the cottage was a ‘control freak’ who used to like ‘flogging you and beating you and torturing you’. The PIC named another resident who allegedly reported this physical abuse to police; the PIC gave a statement to police but told the Inquiry he did not reveal anything to corroborate the other resident’s statements because the Slade officer had threatened retaliation if he spoke out. The PIC said he absconded from the cottage several times. Department records show at least one instance of absconding, which occurred just two hours after the PIC had been placed at the cottage.

The PIC alleged that during the physical punishments at Slade the officer tried ‘a few times’ to insert a cane into his anus. The same officer attempted to grab his penis in a feigned, joking manner. The PIC said he did not disclose the abuse. He recalled that he ‘just didn’t feel comfortable in that house one bit’.

He also recalled absconding on one occasion with two other boys and going to the home of a man one of the boys knew and had contacted. The SWICs of those two boys record them as absconding from Slade Cottage. The PIC said he did not know the man well but could name him. He told the Inquiry there were several men at the home and that he and the other boys were given alcohol. He had no memory of anything that happened after they were sitting and drinking in the living room, and awoke the

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\(^{43}\) ibid. The department advised the Inquiry that missing pages containing the report’s findings could not be located.
next morning in a bed, naked, feeling ill and with his anus sore and bleeding. He saw one of the other boys eating breakfast in the kitchen and believed the third boy was asleep in another bedroom. He recalled being in pain for the next two weeks and said he did not associate with the two boys again.

The PIC also told the Inquiry about another occasion when he had been granted a day’s leave from the cottage to visit his parents. He used the time to go into the city, where a man approached him and offered him money for amusements, which he accepted. They then walked around the city for some time; the PIC said he believed the man was looking for a quiet area. They entered a disused building, where the man ‘cornered’ him, forced him to remove his trousers and touched his genitals. At this point, the PIC said, a passer-by who had seen him being led off walked in and interrupted the abuse. This passer-by contacted the police, who returned him to Slade Cottage. Records from a secure care facility, where he was placed temporarily, show the PIC absconded from the cottage and committed offences. He alleged he was stripped naked on one occasion and his window was nailed closed to prevent him from escaping. He said, ‘That’s where my criminal offences started, at Slade Cottage … Everything from there was pure rage and violence to get locked up.’

The PIC recalled trying to convey to the Children’s Court what was happening at the cottage, that ‘they are bashing us kids there. Please don’t send me back. You send me back there I’m going to reoffend.’ His crimes included property offences, larceny and assaults. The PIC was remanded to secure care on at least seven occasions but said, ‘I got treated better by the staff in [the secure care institutions] than I did ever in any of these departmental homes I was in’.

He told the Inquiry he was sexually abused by different workers at Slade Cottage, including by one woman who, he said, grabbed his testicles on one occasion in front of his mother.

The PIC also alleged he was sexually assaulted by a cottage worker on about two occasions in the bike shed on the premises: ‘It’d turn from an assault to sex, where I was hit first’. He said that because ‘things had already happened’ to him ‘that’s just the way sh*t was when I was a kid …’ The worker would call his mother and tell her ‘I am … selling my arse out on the streets’, and he surmised that this was to deflect attention from what was really happening:

The PIC gave evidence of persistent physical abuse at Slade Cottage, saying one worker called him ‘one of our bad boys’. One witness gave evidence that she remembered the PIC after he left the cottage:

I just remember this little boy, this 14-year-old boy, and he was so distressed and, you know, you’d stroke him and … he came … from Slade Cottage and he would talk about physical abuse. I figured if it happened for one it happened for more.

Departmental records confirm the PIC regularly absconded from the cottage and committed offences. He alleged he was stripped naked on one occasion and his window was nailed closed to prevent him from escaping. He said, ‘That’s where my criminal offences started, at Slade Cottage … Everything from there was pure rage and violence to get locked up.’

Abuse by staff

Another PIC alleged he was sexually abused after he was placed at Slade Cottage for about two years in the early to mid 1980s, when he was 13. The PIC had been placed in State care for two years, which expired during his placement at Slade Cottage, and was then extended until he turned 18. The department had known the PIC since he was seven because of his parents’ separation and his mother’s inability to control him, when he was placed under a three-month order. In the six years before going to Slade Cottage, the PIC was placed in more than 11 institutions and foster homes. He told the Inquiry he was sexually abused at the Northern Region Admission Unit, the Salvation Army Boys Home (Eden Park), Smith Street Cottage, Slade Cottage and the Southern Region Group Home.
Why is he doing that? Because he doesn’t want me out running around being caught by police saying that I was raped by him or something. I never did.

The PIC told the Inquiry he said nothing about the abuse because

... maybe it had been going on for so long that ... you just learnt from, I suppose, Mt Barker [Eden Park] Boys Home with the punishments there, it was the same old routine ... sometimes it’s just better to shut your mouth.

He spoke of being punished by having to scrub floors and walls for days on end,

... from top to bottom with a toothbrush ... when you're getting punishments like that, you don’t want to say anything ... You say you’ve got to say something, you cop your punishment, you just think, well, what can you do? You try to tell people things and no-one ever wanted to listen to anything I had to say—I was a liar, I was a compulsive liar.

The PIC alleged that while at Slade Cottage he was anally penetrated on one occasion by another worker who entered his room when he was lying on his bed in the dark.

He could not recall telling anyone about this abuse. He also recalled being assaulted and ‘knocked out’ by this worker, and spoke of a volunteer carer at the cottage comforting him.

[The volunteer] ... promised me that he would get me out of [Slade Cottage] and he would help me and get me up with his family. From then that’s when he gave me his home number and started picking me up from school, when I’m wagging school, getting me to run away for long periods of time ...

The PIC described the volunteer as ‘the most loving, caring person I met in my life; I’d never met anyone like that’. The volunteer bought him expensive gifts—“he bought me everything I wanted and even the stuff I didn’t want”. The volunteer became involved with the PIC’s family, in particular his mother, and there was talk of marriage so he could adopt the boy. Records document the volunteer’s gifts to the PIC; their outings, sometimes to the home of the volunteer’s family; and the volunteer’s correspondence and contact with the department, expressing his desire to foster the boy.

The PIC alleged to the Inquiry that the volunteer sexually abused him. He said that at the volunteer’s family home they watched pornographic movies, and oral sex and masturbation occurred. This would also happen at the volunteer’s places of work, where the PIC would sometimes go after he had absconded from school or the cottage. The PIC alleged the abuse continued throughout his association with the volunteer at the cottage, and at his later placements, including the Southern Region Group Home, until about the time he left State care.

Departmental records reflect departmental workers’ concerns about this relationship, particularly during the PIC’s final six months at Slade Cottage. The relationship was initially seen as positive, to ‘build his self-esteem—someone interested in him’. However, records show certain workers’ disquiet about the apparent blurring of the boundaries between the volunteer’s role in the cottage and his ‘enmeshment’ with the PIC. One report suggests the volunteer had an ‘almost obsessive focus on wanting to foster [the PIC]’.

The PIC told the Inquiry he did not specifically disclose the volunteer’s sexual abuse to the department. He cannot recall being asked about any sexual conduct, and says that even if he had he would have denied it. However, he recalled having a meeting with departmental workers and his mother at one stage, when ‘I felt, like … everyone was on my side; they all liked me again and everything was going to be all right’. He also disclosed at the meeting that the volunteer had taken him and his brother to a cemetery and had told him that ‘this is where he was going to put my brother if I start saying shit’. The PIC recalled that the workers ‘all freaked out’, and back at Slade Cottage ‘they made me get on the phone ... and put this stuff to [the

3.2 Smaller group care
volunteer]. It is recorded that the PIC told the volunteer he did not want to see him any more, but a short time later changed his mind and started seeing him again.

The PIC told the Inquiry:

I was scared of him, you know, I really was. He was a nice guy but I was scared when he—drunk or if he flipped out … Yes, I said this stuff and—I don’t know, and then I felt bad for doing it. I tried to make contact with [the volunteer] again because [he] cared about me.

The records contain numerous mentions of staff concerns about the relationship, and it is reported that the PIC’s psychologist considered the volunteer ‘highly dangerous to children—should not be allowed near children’. It is recorded that the department warned the volunteer on several occasions about the inappropriateness of his attention to the PIC. However, despite these warnings, records show the volunteer continued his contact with the PIC, giving him gifts such as delivering a birthday cake to him in the South Australian Youth Remand and Assessment Centre (SAYRAC), and accommodating him after he absconded from Slade Cottage. Records show that formal attempts to prevent contact were unsuccessful at the PIC’s next placement, the Southern Region Group Home, and at other placements. The PIC alleged another volunteer worker with the department sexually abused him at the Southern Region Group Home.

Another former resident of Slade Cottage was placed in State care in the mid 1980s when he was 13, after a court found him in need of care. The PIC told the Inquiry he was sexually abused at Gilles Plains Assessment Unit and then at Slade Cottage. He also said he was sexually abused when living on the streets while he was in State care.

When he was 14 the PIC lived at Slade Cottage under a court order for six months, and told the Inquiry he was both physically and sexually abused there. He described one senior worker as ‘a complete animal’. The physical abuse included punishments such as ‘getting tied to a tree and left there all night’ and being beaten with a bicycle pump. The PIC said he was sexually abused at night, when there was only one staff member on duty, and recalled that he was on medication administered by staff. He said the senior worker, who he described as an animal, would come into his bedroom at night:

You’re medicated out of your brain anyway, and he used to love—he used to have a belt that he’d tie your hands up together on to the bed, and just do nasty things.

The PIC said the man would ‘force us to, you know, fondle him, give him oral sex’. The abuse occurred ‘sometimes in the staff sleeping quarters or more often than not in my bedroom or even in the office’. It happened ‘at least once a week minimum’. During the day, other staff took the residents on outings but he did not always go: ‘I would be the only one there and that’s when [the worker] would more than likely come up and want you to sit on his knee.’

He said that, at the time,

I just tried not to think about it and just stay out of [the worker’s] way, because it’s not as if he would come looking for you. You’d come walking out of the lounge room, going up to your bedroom, and he’d see you through the office door and say, ‘Hey, come here,’ you know, but only at night time he ever came into the bedrooms.

The PIC said he did not mention the abuse to his social worker because he was too embarrassed. He worried that any disclosure would become common knowledge at the cottage: ‘I’d get my arse kicked often enough as it was, never mind adding more fuel to the fire’. He said that later during his time in State care he attempted to inform staff at a secure care facility of the abuse, but

As soon as you said anything and they says, ‘Well, who was it?’ and you said [name], instantly they would say, ‘How dare you speak of that man like that. He’s a good man. He’s been in the department for so many years. He’s got a good reputation.’
Another PIC was 12 when he was placed under the guardianship of the Minister in the early 1980s for three months, after he was deemed uncontrollable. He had experienced a family breakdown and truanted regularly from school. A review panel concluded that he would benefit from the care at Slade Cottage and a court ordered him to live there. He stayed at the cottage for seven months, with brief periods in secure care and placements with his family. He also alleged he was later sexually abused during a placement in the Southern Region Group Home.

The PIC told the Inquiry there were about six residents at Slade Cottage during his stay, and described the staff as a ‘little evil clan’ and the senior residential care worker as a ‘scumbag dog’ who physically punished him. He said that after one assault, ‘I asked for my social worker … [he] basically said, “if you want to tell them about that, why don’t you tell them about this?”’ The senior worker then beat him with a bicycle pump across the legs, face and back. The PIC was not allowed to see his family or his social worker until the bruises healed. He recalled of the senior worker: ‘He wanted to be known as the one that hurt the children if they stepped out of line’.

The PIC said that another staff member at Slade attempted to initiate sexual activity with him on at least two occasions. On one occasion he went into his bedroom to find the worker masturbating. Some weeks later, during the evening, the man grabbed him by the hair and pushed him into a corner. He started screaming and the man tried to muffle his protests. The PIC’s memory of the event was incomplete; he remembered that he had lubricant all over him and believed the alleged perpetrator had analy penetrated him. He said he absconded the next day and did so ‘every chance I got, just about’. The PIC’s SWIC shows he absconded twice in his first two weeks at Slade Cottage and once in his last month. His files show concern for his safety while absconding. One report notes:

**During [the PIC’s] placement at Slade there were several episodes of his being remanded to [secure care] on safe-keeping as [the PIC] is associating with known older homosexuals when on the run and there were grave concerns for his physical safety.**

He remembered the atmosphere of the cottage at night when lying in his bed: ‘You would hear noises and just wonder, should I be grateful it’s not in my room … you would have a million things going through your head’.

A man who gave evidence about sexual abuse at Slade Cottage was first placed in State care in the mid 1980s, when he was 12. During his six years in State care he was placed on ‘in need of care’ guardianship orders and orders for offending. The PIC told the Inquiry he was sexually abused while on remand at the South Australian Youth Remand and Assessment Centre (SAYRAC) and during a placement at Rose Cottage, Prospect.

The PIC was placed at Slade Cottage for one month when he was 14. He estimated there were about five boys in residence then. He spoke of a residential care worker at the cottage who helped boys build their own bikes from spare parts and said this man also ‘made us play with his dick, made us lay down while he penetrated us’. The same worker took him out alone in the cottage vehicle to a nearby beach, where he parked and, the PIC recalled, ‘I’d have to do sexual things for him’. He told the Inquiry this abuse occurred both during the day and in the evening. The worker took him swimming, and ‘I wouldn’t go near him. The more I could stay away from him, the better’. He said the worker told him, ‘You’re my favourite little boy’.

The PIC said he felt ‘horrified’ and ‘terrorised’ during his time at the cottage. He absconded, ‘slept under the rocks’ at a nearby beach, asked strangers for money and stole food. He was found and returned to the cottage, when staff locked him in his room and struck him with a cane as punishment. He told the Inquiry his parents visited him during this period and, while he told them about being physically assaulted, he did not disclose any sexual abuse:
Chapter 3 Allegations of sexual abuse

'I was ashamed to tell anyone what happened'. The department’s files on the PIC show he absconded on more than one occasion and refused to return. A welfare worker noted after one telephone call from the PIC that he was ‘refusing to return to Slade. [The PIC] alleges some “non welcoming” by Slade—maybe a kick in the bottom? May need follow up’. The files record the welfare worker’s efforts to persuade the PIC to return to the cottage and the PIC’s refusal. They also show the department knew the PIC was associating with a person known to the department as having involvement in child prostitution; the welfare worker warned the PIC that ‘he was in danger of being exploited for male prostitution if he remained in the company of [the person]’.

The PIC was removed from the cottage as a result of his offending.

Abuse by other residents

The SWIC of another PIC shows that in the early to mid 1970s, when he was seven, a court found he was neglected and placed him in State care until he turned 18. The PIC understands that his mother was unable to care for him. He was placed in foster care with extended family when he was eight, and said he was sexually abused in this placement; the perpetrator was convicted of indecent assault and placed on a good behaviour bond. The PIC told the Inquiry he was sexually abused when he was later placed in Slade Cottage in the early 1980s, when he was 15.

The PIC’s SWIC records that he spent only a few months at the cottage before being placed with his mother. He recalled that soon after his arrival at Slade he was taught how to build a bike. He remembered ‘little punishments if you did anything … drastic’ and said he ‘tended to not act up as much’ while he was there.

The PIC told the Inquiry his time at the cottage was one of the ‘spots that I block out’, because on one occasion another boy anally raped him in the shower; he still remembers the boy’s build and distinctive hair colour. He did not disclose what had happened: ‘I never told anybody. Never thought anything of it.’ The boy did not abuse him again but would ‘blow kisses to me as he was walking past in the dining room and stuff like that’. The PIC said he felt ‘repulsed’ by what had happened, and said he ‘wanted to run away but I knew if I ran away they’d ask why I ran away and then I’d have to say something’.

Southern Region Group Home, Glenelg 1979–81, Glandore 1981–90

History

In the 1970s congregate care was dismantled and residential facilities that resembled a ‘typical’ family home were developed.44 Group homes in each metropolitan region were designed for small numbers of ‘teenage young offenders who need therapeutic care’, although initially non-offenders who were difficult to place in foster situations were also accommodated.45

The home opened in 1979 on the site of the former Merrilama Cottage at Glenelg and moved to Pleasant Avenue, Glandore, two years later. It accommodated an average of six children at a time46 until it closed in 1990.

The Inquiry received a departmental review of the home, which showed that workers faced difficulties arising from the accommodation of children of different ages, as well as offenders with non-offenders. The lack of other placement options meant that some children were inappropriately placed in the home. The review identified the need for standard procedures for community residential care and also for a special unit for children who had been sexually abused.47

Allegations of sexual abuse

Two men gave evidence to the Inquiry about sexual abuse at the Southern Region Group Home.

46 See DCWI annual reports 1979 – 1989–90 for data.
Abuse by outsiders

The Inquiry took evidence from a PIC who was 12 when he was first placed in State care in the early 1980s, after his parents had separated and neither could offer him a stable home life. The PIC constantly ran away from home and school and began offending. He was placed on several short-term guardianship and detention orders and during his time in State care lived at numerous government admission units, cottage homes and in secure care. He alleged he was sexually abused during his time at Slade Cottage. He lived at the Southern Region Group Home for about one year in the mid 1980s, when he was 14, and was released when his detention order expired.

The PIC’s departmental files show he absconded from most of his placements and frequented the city, which prompted concerns that he was at risk of being sexually abused. His social workers devised a case plan that included attendance at work and educational programs.

A staff member in one work program allegedly sexually abused him. The PIC described the worker as a man in his 60s. Their first contact was when the PIC and another resident absconded from the group home and the other resident asked the worker for a place to stay; the PIC said they stayed at the worker’s house and he showed them pornographic material that night. On a subsequent occasion at his home, the man allegedly supplied him with prescription drugs and alcohol. The PIC said he became intoxicated, fell asleep in the living room and awoke in the man’s bed, partially clothed, having been penetrated anally. The PIC recalled that the man apologised to him and gave him a large sum of money. He said the contact between them continued, with the man collecting him from the group home and driving him to the work program. The sexual abuse continued, often in exchange for money or items such as new clothes. The PIC told the Inquiry the worker kept telling him he would stop their sexual activity before penetration but that he always penetrated him anyway. He said he often stayed at the man’s home and was required to telephone before he arrived. Whenever he arrived unannounced he was turned away, and realised the man had other children there.

Records confirm the PIC’s constant contact with the alleged perpetrator, who was known to the department. Records maintained by the PIC’s social workers and group home staff show he absconded repeatedly but continued to attend the work program; that it was the alleged perpetrator who collected him after he had been arrested for offending; and that the same man had shown a particular interest in the PIC during his participation in the work program. The PIC ‘rarely catches public transport. Relies on [the alleged perpetrator] to take him to school’, reads one report. Another records that the work program ‘seemed to bring out a lot of positives’. Yet another noted that the PIC ‘formed a good relationship with a degree of trust’ with the alleged perpetrator. The worker participated in the PIC’s case reviews and encouraged him to stay in the work program. About eight months after the PIC was placed at the group home, records show, the alleged perpetrator was considered for a role as his mentor as part of the department’s Intensive Personal Supervision (IPS) program. An IPS agreement was ‘deemed appropriate with [the alleged perpetrator] as an Intensive Personal Supervision person, given his excellent rapport with [the PIC]’, concluded one assessment.

The PIC told the Inquiry his association with the man continued for about four years and that the sexual abuse persisted throughout the rest of his time in State care. The alleged perpetrator wrote character references and acted as an advocate for the PIC when he faced charges. One departmental review noted that his ‘association with [the alleged perpetrator] in the IPS contract, has proved beneficial’.

The PIC said the alleged perpetrator told him he should not disclose what was happening because both of them would be punished. He said he believed his history of offending affected his decision to remain silent:

“That’s why I’ve never, like, even thought about trying to do anything, because, like, I don’t think my word—I’m easily discredited ... That’s the way I feel, anyway.
3 Allegations of sexual abuse

Another PIC was placed in the Southern Region Group Home in the mid 1980s when aged about 15. He had been placed in State care when a court found him to be in need of care. Departmental records indicate the PIC was initially placed in care because his mother was unable to control him and there were allegations of physical abuse in the family home. The PIC confirmed this in evidence to the Inquiry, stating that on one occasion, ‘Mum sort of put the extension cord to me severely, from head to toe’ and his school ‘noticed whip marks’ on his body. He told the Inquiry he was sexually abused at the Northern Region Admission Unit, the Salvation Army Boys Home (Eden Park), Smith Street Cottage, Slade Cottage and the Southern Region Group Home.

After two years in Slade Cottage and intermittent periods in secure care, the PIC stayed at Southern Region Group Home for about three months when he was about 15. It is reported that at the time he refused to return to Slade Cottage on bail after a court appearance. Records report that the group home was the most appropriate placement for him because of a behaviour modification program and the older age group of young people there.

The PIC told the Inquiry he was sexually abused by two volunteers with the department during his placement in the group home.

In relation to the first volunteer, he alleged the abuse started while he was placed in Slade Cottage and continued throughout his next placement in the group home until about the time he was released from State care. The abuse allegedly consisted of oral sex and masturbation with the volunteer and watching pornographic videos, and occurred at the volunteer’s home or workplace, when the PIC absconded from the home.

Departmental records show that soon after the boy was placed in the group home and the volunteer was continuing to contact him, the boy’s welfare worker became concerned she could not give his mother ‘clear information or assurance that what exactly is being done to protect her son from this man’.

Records reveal that the department finally ordered the volunteer by letter ‘to have no further communication’ with the PIC pursuant to section 77(b) of the Community Welfare Act 1972–1981. This section made it an offence for a person to have any communication with a child when forbidden to do so by the department’s director-general. Records also show that steps were taken to deregister the volunteer as a community aide. Despite the letter, records show the volunteer continued his contact with the PIC. The PIC told the Inquiry the volunteer used to ‘introduce me to people as [if] I was his nephew … so people didn’t think anything bad’.

He said he continued to abscond from the group home as he had from Slade Cottage, and that the volunteer ‘actually kept me on the run for so long, so many times’. The volunteer effectively set him up in residence at different locations, including, on one occasion, in a caravan. The volunteer visited him every couple of days, bringing food and to ‘make sure I had everything’. After being in the caravan for some time, the PIC said, he became bored and called his departmental workers to see whether he could return without punishment—which he did. The PIC reflected to the Inquiry that the volunteer

... was someone I met in a department home and he said he’d foster me and they’d look after me and everything like that, and then just disregarded me when I was about 17, 18.

Department records indicate the volunteer continued his contact with the PIC until the end of his time in State care, noting the PIC was living with the volunteer in a flat about that time. These records show the volunteer was not prosecuted despite his continued breach of section 77(b).

The PIC told the Inquiry he met another volunteer when he participated in a departmental employment program. He said the volunteer sometimes picked him up from the...
3.2 Smaller group care

Southern Region Group Home and took him to the program. He came to learn that another boy was ‘already [the volunteer’s] little boy kind of thing’, and said, ‘I wanted to be [the volunteer’s] favourite’.

He said that about the first time he went to the volunteer’s house with another boy the volunteer gave them cigarettes and put on a pornographic movie. They also smoked dope there. Within a few months, the PIC said, he went alone to the volunteer’s house, where the volunteer started to sexually abuse him:

He never penetrated me but I used to give him oral pleasure. He’d make me masturbate or he used to have sex in between my legs and put baby oil there and stuff.

The volunteer gave him money and cigarettes, he said. The volunteer allegedly continued his sexual abuse throughout the PIC’s other placements after the group home; and the PIC reached a point where ‘I didn’t want to go there no more. I was growing up, you know. I realised this stuff is going on, it’s wrong.’

The PIC told the Inquiry that when he was at a later INC placement he made an ‘accusation’ about the volunteer to his INC family. He said he told the family: ‘I don’t want to go there no more because this is what’s going on. You know, what he tries to make me do and everything like that’. Records do not show this was reported to the department, but the PIC said he was pressured into retracting the allegations: ‘Then next thing I nearly had every kid from bloody McNally’s to Yatala [telling me] that my life is in danger’. The PIC said ‘[I] had to renege and said everything I said was lies’. He told the Inquiry the volunteer then ‘took me back under his wing again and had forgotten all that had happened, and he told all the kids to leave me alone’.

The PIC said the volunteer later set him up in accommodation with other boys. He was committing offences at this stage and spent time in secure care. He said the volunteer gave character references for him in court and told him he had ‘contacts’:

[The volunteer] was that well regarded and trusted among people, if [he’s] coming into court to speak highly of you, you must be decent or you had some really bad shit happen to you and he cares enough that they will assist.

He said the volunteer is

... even on my resume for a reference because that’s the only person I can use—is some arsehole that liked to touch me, and that’s all I can use to this day as a reference and it’s still on there.

The PIC told the Inquiry the volunteer’s sexual conduct continued after he left State care:

After I was 18 I was on the poverty edge of line, but I just let it continue to keep happening … I knew it was maybe wrong, but because it had been going for so long and these people honestly believe they cared about me so much and I had no-one else to turn to—no-one. No-one to turn to for anything, so I had to go back to these people who done stuff to me.

He attributes living on the poverty line to his lack of education, and said he spent many years after leaving care taking drugs, which ‘… made me forget who I was, where I was’. 

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Non-government cottage homes

Three people gave evidence to the Inquiry that they were sexually abused—by other residents and a staff member—while placed at non-government cottage homes. From available records, the Inquiry determined they were all in State care at the time of the alleged abuse.


History

Smith Street Cottage and Kennion Cottage came out of the restructure of Kennion House, which the Anglican Church had operated since 1886. Kennion House management believed that converting to cottage-style accommodation was essential to the home’s survival. In 1980, after considerable pressure from the department to operate in line with its child-care philosophies, Kennion House started to plan to convert existing buildings to house smaller groups of children. The home’s annexe was renamed Garden Cottage, which was moved to Ferryden Park and renamed Kennion Cottage in 1984. The original superintendent’s house became Smith Street Cottage (this was also later relocated to Ferryden Park and called Ross Cottage) and the deputy superintendent’s house became Fuller Street Cottage (renamed Farr Cottage in 1982). Each functioned as a separate group home.

Allegations of sexual abuse

Two PICs who were placed in Smith Street Cottage or Kennion Cottage while in State care in the 1980s told the Inquiry they were sexually abused by other cottage residents.

Abuse by other residents

One of the PICs was placed in Smith Street Cottage by the department for 12 months in the early 1980s, when he was 11. He was in State care at this time, a court having made a two-year order on residence after finding that the PIC was ‘in need of care’. The PIC told the Inquiry he was sexually abused at the Northern Region Admission Unit, Salvation Army Boys Home (Eden Park), Smith Street Cottage, Slade Cottage and the Southern Region Group Home.

After being discharged from Eden Park, the PIC lived at home but it was recorded that his mother rejected him and wanted him put back into the department’s care. A court report on the care proceedings stated that the boy ‘grew up confused and emotionally deprived … He has been told that his mother does not want him but he cannot as yet accept this’.

The PIC described to the Inquiry three small cottages or houses at Kennion House—two for boys and one for girls. He alleged that during his time there he was forced to witness and participate in sexual activity by other children. He said the children congregated in the old house, which was like a gymnasium, and here, around tea-time, ‘all the girls used to go and make me touch them and do stuff’. He said older boys and girls were

... there from another unit and they were a bit more active than what I was, but I was having my hands, like, ripped from my shoulders nearly, making me fondle these breasts.

He recalled one occasion seeing an older boy masturbate and ejaculate over fish and chips to be eaten by the other children. This boy was the instigator of the sexual conduct directed towards him by the older children, he said. While the PIC said there was no sexual behaviour by cottage staff, he recalled that one male worker tried to hold a beanbag over his head as if he were trying to suffocate him. Staff were in the units at the time but he did not know whether they saw what happened, and he did not report it.

After leaving the home, the PIC lived at numerous other placements including Slade Cottage and Southern Region Group Home, where he alleged he was sexually abused by volunteer carers.

49 Elizabeth Bleby, Kennion House: A Hundred Years of Children (Anglican Child Care Services, Prospect, 1985), p. 68.
The other PIC’s SWIC shows he was just under 14 when placed in Kennion Cottage in the mid 1980s, and remained there for about two years. Three years earlier he had been placed in State care until he turned 18, as a result of neglect and persistent physical and emotional abuse. Before Kennion Cottage, he had been placed in other institutions, including the Salvation Army Boys Home (Eden Park) where, he told the Inquiry, he was sexually abused.

The PIC said that at Kennion Cottage, two other similarly aged boys encouraged him to sign a blank piece of paper to be a member of a ‘club type of thing’. He alleged he was then physically coerced into engaging in sexual practices. He told the Inquiry that either boy would ‘lay on top of me, you know, and rub himself up and down, and a lot of masturbating’. They made him ‘masturbate while the other boy masturbated’. One boy kissed him and had anal sex with him: ‘I was quite hysterical about this’. The PIC said the abuse often happened at night when staff were on the other side of the cottage watching television. He recalled that staff often did not check on residents at night: ‘They figured we were in bed and everything was okay and they watched telly’.

The PIC said he told his cottage parent what had been happening. Departmental records report that a social worker with Anglican Social Welfare Services had said that the PIC 

... had not told the cottage parents because he had been threatened with violence ... in [the PIC’s] past a similar situation had occurred at Eden Park, where violent threats against him had been carried out. This would have made a strong disincentive to [the PIC’s] revealing to anyone what had been happening in his present situation.

The social worker was also reported to have said she believed the abuse had been going on for a long time.

According to departmental records, these events occurred in the late 1980s. The records show there was a formal notification of the abuse of the PIC and all three boys were spoken to. The PIC said one boy was moved from the home and the other left soon after. An outcome of ‘abuse confirmed’ was recorded on the department’s computerised Justice Information System (JIS). A case conference with relevant workers was held soon after the disclosure, at which appointments were made for the PIC to attend the Sexual Assault Referral Centre and therapy sessions. The PIC told the Inquiry these sessions gave him an opportunity to speak about ‘a lot of things’, including the abuse and the bed-wetting problem he had since Eden Park.

The department seems to have made a police referral, in that there is a brief handwritten entry on departmental records stating that, ‘[named social worker] has taken a copy of [PIC’s] statement to the CIB. They will make an appointment to speak to all three boys.’

A week later it is recorded, again in handwriting, that ‘[named social worker] made contact with police last week but they gave no indication of when they would be investigating’. The department’s JIS also records that the matter had been referred to police for investigation. However, there is no further reference to police involvement in the matter on the departmental records, nor any outcome of the referral, and neither is there a copy of the PIC’s statement. The Inquiry asked SA Police to provide documents relating to ‘an investigation of a disclosure of child sexual abuse by [the PIC] by a co-resident of Kennion Cottage, [named co-resident], referred to the CIB in [the late 1980s] by the Community Welfare Department’.

However, SA Police told the Inquiry it had no record, saying that, ‘All areas of SAPOL have been checked and there is no documentation available relating to this event’.
Of coming to give evidence to the Inquiry, the PIC reflected:

I never really had a chance before to talk about what happened to me and all things that was happening in my home to me, you know, and I want to use this—now that I have my own family I want to be able to use this as a positive step to my [child] growing up and me being able to help [my child].

Rose Cottage, 1988–93

History

Rose Cottage, in Rose Street, Prospect, was a residential facility owned and operated by Anglican Community Services from 1988 until May 1993. The cottage was funded by the Department of Family and Community Services, Anglican Child Care Services and the Department of Social Security; the latter paying a family allowance for each child in its care.

The cottage was an older-style villa with two bathrooms and five bedrooms. A licensing report dated May 1988 stated that it was intended to have a homely and relaxed atmosphere, with clear rules as in any household with children. In keeping with the philosophy of Anglican Child Care Services that cottages should be as home-like as possible, staff shared bathrooms with residents.

The cottage offered respite, emergency and temporary accommodation for up to 12 months for children aged up to 12 with behavioural dysfunctions. Some children were placed at Rose Cottage because they had been assessed as being unsuitable for foster placements and were involved in a therapeutic program with their families, which was aimed at reunification.

The cottage was licensed to accommodate up to six children at once and had an average occupancy of four. The children were referred to the cottage by the department. When the cottage closed, the program was moved to Farr Cottage at Nailsworth.

Allegations of sexual abuse

One man gave evidence to the Inquiry of sexual abuse while he was placed at Rose Cottage.

Abuse by staff

The PIC was 12 when he was initially placed in State care under a 28-day temporary guardianship order in the mid 1980s. He was then released, only to be placed under a further order within 12 months, and was subsequently placed in State care until he turned 18. Departmental records show he was placed in Rose Cottage during the last temporary order, when he was about 13, and remained there for six months. The PIC told the Inquiry his behaviour had been uncontrollable and he suffered from attention deficit disorder, which at the time was not recognised or diagnosed.

He said a staff member at Rose Cottage sexually abused him on more than one occasion, entering his bedroom at night and making him ‘play with his penis’. The PIC also alleged that the staff member made him lie on his stomach and penetrated him:

I had no choice. He was too big for me. He used to hold me down, hold my hands down, hold my mouth when I’d scream so it wouldn’t wake up [the other boy in the room].

The PIC said the staff member told him ‘that no-one would believe me and that they’d put me away, put me in a place back then called SAYRAC’.

He also felt he could tell nobody at school:

I think I got into a lot of trouble there and I got to the point where they wouldn’t take me out of Rose Street and the only way I could think of getting out of there was committing crimes; and I did, by breaking into the school. All the anger that was in me I took out on animals and that.

The PIC said he absconded from the cottage and returned home to his parents. His mother took him back to Rose Cottage against his wishes. He did not tell her what was happening to him there because he was ‘too ashamed’.

After about six months the PIC was placed in the first of a series of institutions; he alleged he also was sexually abused at SAYRAC and Slade Cottage.
He told the Inquiry the sexual abuse had a long-term effect on him and his ability to form lasting relationships as an adult: ‘You know, I couldn’t show love’.

The PIC has served several prison terms as an adult for crimes, and told the Inquiry:

…the years ago I was told that I was a habitual criminal, institutionalised. I did do all right out there for a while, but because of all this coming up in my head just spun me out and sent me tumbling backwards.

**Government hostels**

Twenty-four PICs gave evidence to the Inquiry that they were sexually abused when they were children living in government hostels. From available records, the Inquiry was able to determine that 23 were in State care at the time of the alleged abuse. Due to the lack of available records, the Inquiry was unable to determine whether one woman was in State care. The alleged perpetrators included staff, other residents, outsiders and family members.

**Allambi Girls Hostel, 1947–77**

**History**

In the mid 1940s the department found that older girls in State care who were working were finding it hard to secure accommodation in or near the city. To fill the need, it bought a house in Norwood and in 1947 opened it as Allambi, an Aboriginal word meaning ‘a quiet place’.

Allambi, which was also known as Norwood Girls Hostel, assisted residents in their transition to adult life. Girls paid board and their contact with departmental probation officers was limited. They were allowed to go out three nights a week and to come and go during the day, subject to the matron’s consent.

For about one year in 1956–57 and again in 1959, Allambi admitted girls from Vaughan House when the girls’ reformatory was overcrowded.

From 1961, Allambi also admitted school-age girls who were in State care. The number of residents varied from five to 20 over the years.

During its early years, Allambi received complaints from the residents and the Norwood mayor that the girls were noisy, disruptive and behaved poorly in public places. The department directed the hostel’s residents to keep the name of Allambi ‘pure, sweet and clean’; those who did not were transferred to other institutions.

According to the department, Allambi operated to ‘provide care for a large number of young people (aged 12 to 18 years), where fairly intensive involvement between staff and young people is required’.

The hostel closed in 1977.

**Allegations of sexual abuse**

One PIC alleged she was sexually abused while placed in Allambi Girls Hostel.

**Abuse by outsiders**

One of several siblings who were placed in State care, this PIC told the Inquiry of the violence and sexual abuse that marked her home life when she was a small child. Records indicate she was placed under a three-month care and control order in the mid 1970s when she was 14—although she believes she was 11 at the time—because her parents were unable to control her. A court soon extended the order, placing her in State care until her 18th birthday. She said she was taken from her house by a social worker who told her she was ‘going on a holiday’. She alleged she was sexually abused at Allambi, Vaughan House and Elizabeth Grace Hostel.

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54 SRSA GRG 29/124 vol. 15, CWPRB minutes, 2 Oct. 1947, (minute 1050).

55 Finding Your Own Way (FYOW), Nunk-warrin Yunti of South Australia Inc., July 2005, s. 4.72.

56 This occurred in 1950, when two girls who had been involved with boys outside the institution were removed to Vaughan House and Central Depot respectively. See SRSA GRG 29/124 vol. 16, CWPRB minutes, 16 Nov. 1950, (minute 1199); SRSA GRG 29/6/1948/174, ‘Misconduct of certain girls and various complaints re girls’ conduct etc.’; CWPRB secretary to matron, 31 May 1949; CWPRB secretary to acting matron, 29 Nov. 1948; acting matron to CWPRB secretary, 3 Dec. 1948; CWPRB secretary to matron, 10 July 1950.

57 DCW annual report 1976.
Departmental records show the PIC was placed at Allambi at the age of 14 after absconding from a previous placement at a government cottage home. Her departmental file records: ‘She has grown out of the cottage and needs to develop with the influence of older girls’.

The PIC recalled of Allambi: ‘There were a lot of tough girls there’. She told the Inquiry she and another girl were raped by a man who used to ‘hang around’ the high school she attended and ‘always hung around Allambi on a motorbike’. She said the man’s associates also raped her and her friend, and that the rapes occurred in the back shed of a house in the area:

I still feel dirty to talk about it … in the shed and, yes, they just all raped me and … one after another. It was really bad. I was just a kid.

She said she told nobody because ‘no-one wanted to know nothing, you know’.

The PIC’s departmental files record that ‘Allambi is proving traumatic for her after living in [the cottage home] environment’. Her SWIC shows that within weeks of being placed there she went home for the holidays, but absconded and was placed in Vaughan House and, later, Elizabeth Grace Hostel.

Of her feelings now, this PIC said:

How am I coping now? Well, since all this, I’ve come a long way … I have bad dreams that I actually yell out names … and then I’m all sweaty. I still sleep with the passage light on.

### Davenport House, 1964–77

#### History

Davenport House, in Millswood, was an open residential care centre for secondary school girls in State care for whom accommodation in private homes was not available. The building, bought by the department in 1964, accommodated 18 girls after renovations. They attended various local schools, were given a small amount of pocket money by the department and, with matron’s permission, could participate in community activities such as sport. Contact between the girls and their families was encouraged, in keeping with the hostel’s emphasis on open living. Hostel staff fulfilled some parental duties and residents were also encouraged to be responsible for their own care. Ideally, children leaving Davenport House were returned to their own families; otherwise they were placed in foster care or private hostels. Between 1972 and 1975 there were, on average, 11 girls living at Davenport House.58

### Allegations of sexual abuse

Six women alleged they were sexually abused in their early to mid teenage years while placed in State care at Davenport House in the late 1960s and 1970s. Their allegations ranged from indecent assault to rape, perpetrated by staff, immediate and extended family, or unknown people outside the home.

#### Abuse by multiple perpetrators

A PIC was five in the early 1960s when placed in State care until the age of 18 because she was neglected and under unfit guardianship, according to her SWIC. She told the Inquiry she does not remember living with her mother but can recall ‘episodes of violence and hiding’ before going into State care. She believes from case notes she has read that ‘there was some sexual abuse as a child’, perpetrated by ‘partners’ her mother ‘brought home from the pub’ and that ‘supposedly that’s why in the end we were taken and made State children’.

The PIC told the Inquiry that at Davenport House in the early 1970s, she was ‘bullied and teased a lot’ while going through ‘the normal initiation’. She remembered a staff member who ‘used to hit us, degrade us … I hated the food and she would hit me on the back of the head to make me eat the food’. She said the worker beat her when she was falsely accused of stealing money.
The PIC recalled accepting an invitation from another girl to sleep with her—'you know, like girls do, and just talk all night and that sort of thing'. But when the girl attempted to remove her bra she 'got scared and I jumped out of bed … and told her “No”'.

During a holiday period, the PIC said, she was placed in a foster home near a suburban beach that had a carnival. The PIC said, 'I had a really big attitude, and I came and went as I felt like it, and I lived at the carnival mostly'. She alleged that one day, while walking near the carnival, she was picked up by some young men in a car, driven to sandhills and raped. She bled and 'it was all over in 20 minutes'. She told the Inquiry:

I was scared, I was sore, I was angry. Haven’t been able to go there the rest of my life since. Yes, it reinforced all the things that I’d been told, that I was ugly, unlovable. I’ve lived the next 30-odd years with that. Not being able to have a relationship with anyone, not being able to trust anyone, not feeling lovable.

The PIC said she returned to Davenport House within days and told a worker there what had happened. The worker responded with something to the effect of, ‘You wear your dresses up your arse so high, what do you expect?’ She told the worker she was bleeding—‘I didn’t know what to do’—and was directed to get some pads, but was given no medical treatment: ‘No, no-one gave two shits’.

The Inquiry did not receive the PIC’s client files and the department advised that it ‘cannot provide a definite explanation why no records have been located’.

The PIC told the Inquiry that soon after the rape she ran away from Davenport House with one of the ‘street-wise’ girls from the home:

I think that’s when I decided that I had to get out, and I used to plot how that would happen, and I think it was not long after that I ran away with one of the girls there … That’s when I went to live on the streets.

This is confirmed on departmental files relating to the other girl; it is noted that police had been contacted ‘about their disappearance’. An entry in the files two weeks later shows a senior welfare officer expressed concern about ‘the recent critical situation at Davenport, where a great number of girls have absconded’, and commented that it would be helpful to ‘interview each of the girls before they return to Davenport’.

The PIC told the Inquiry she did not return to Davenport House and instead went to live with her friend’s extended family, but ‘then we lived in parks, in telephone boxes, in empty houses, wherever’. She alleged she was sexually assaulted by male relatives of a friend, and said: ‘I let them do that because I figured that’s what I had to do to pay for a roof over my head, or that’s what they told me’. She alleged she was raped almost daily by one of the men, but told no-one:

After the Davenport incident, I thought that’s what I was, a slut, didn’t deserve any better, and I had to earn my keep, he told me. I had no money, didn’t know anyone.

After staying there for about a month she teamed up ‘with normal streeties’, slept in city buildings, took clothes from clothes bins and stole milk money to survive. She got ‘mixed up with some bikers’, who gave her shelter and ‘provided I gave sex, there was never any argument’.

The PIC’s SWIC shows that several months after she absconded from Davenport House in the early 1970s she lived in boarding placements. Still in State care and in her mid to late teens, she met a young man who showed her ‘affection … in genuine terms’ but ‘I still felt I was just there for someone’s convenience, like it was my job to make him happy’. She became pregnant to this man before leaving State care.

In later life, the PIC returned to school and achieved tertiary qualifications to work with children: ‘My driving force in my life has been that I will get to a position where I will make change’.
Chapter 3 Allegations of sexual abuse

Abuse by staff

A PIC was placed in State care at Davenport House for the duration of two three-month orders in the late 1970s, when she was 15. Her SWIC states: ‘Mother does not want [PIC] home’, and ‘Mother and daughter experiencing difficulties’. The PIC told the Inquiry her mother took her to the department ‘to talk to them about not wanting me at home any more’, and that the matron and a worker came to take her to Davenport House after attempts at reconciliation failed. She had been close to and protective of her younger siblings, and her placement in the home made her feel ‘abandoned’ and ‘segregated … I didn’t know what I was in for’. She felt ‘scared’ because some of the other girls ‘seemed really rough’. At school she did not associate with girls from the home, and ‘My close friends that I’d had at school I didn’t sort of really have any more’.

The PIC told the Inquiry the worker who picked her up to take her to Davenport House was ‘handsome’ and ‘easygoing’, and ‘over time he started spending a lot of time with me’. She had had ‘very little’ previous experience with boys. She said the man wrote poems to her: ‘He gave me a lot of attention that I certainly hadn’t had before’. He took her alone on outings to different places in the city and became ‘more and more affectionate’.

She said their relationship became sexual and they started having sex every week. The first time, when she was 15, she skipped school and he picked her up and took her to his house. She said of this man:

I liked him. He was sort of nice to me … I really honestly didn’t have anybody else … I liked having somebody to talk to more than anything, I think. I was fairly isolated … I didn’t know what was going to happen to me, you know.

She told the Inquiry that other girls at Davenport House noticed the worker’s attention to her—to the extent that one performed a play about them at the home. The worker also told her the matron had told him he wasn’t to spend so much time with her alone: ‘He thought it was funny’.

He had talked ‘a lot’ about taking her interstate and staying at a friend’s place. To make sure this trip happened, he encouraged her to return home at the end of the second three-month order to avoid being made a ward of the State. She said she left school and went home, and found employment.

She recalled she ‘packed all of my things … my worldly possessions’ and started on the interstate trip in the worker’s car. They had sex on the way to their destination and went to a motel. She said the worker ‘obviously got cold feet and he rang up his wife’, and they turned around and came back to Adelaide: ‘He dropped me off down the road with all my little possessions and I went home and had to face my mother’.

The PIC said her mother was furious and forced her to leave home. She said she spent one night in Davenport House but could not continue staying there because she had been discharged. She said she stopped having sex with the worker and he ‘did not help me in any way, shape or form’.

Of the abuse, the PIC said, ‘He told me that he knew that I wouldn’t tell anybody’, but she did tell her friend at the time, and a sibling later on.

On reflection, the PIC told the Inquiry that after the worker left her:

I think it had a big effect on my self-esteem; like when I realised that I had really been used and when it all happened that we came back … after doing a U-turn … I was sort of like, ‘That’s okay’ … because it just seemed like it didn’t really matter what anybody did to me … so therefore it was okay that he just went back into a nice and comfortable life and I was going to be left totally in the shit.

She said that after meeting and talking with the worker in later years she believes he found a very vulnerable and, by his own admission, mixed-up teenager and took advantage, which had a lasting effect. Despite this, the PIC eventually returned to study, obtained tertiary qualifications and is now a successful professional, ‘worlds away from the girl I was’.
Another PIC was placed in State care in the mid 1960s, when she was four, on the grounds of neglect and unfit guardianship. Departmental records from the time show the Women Police Branch had become involved, there was concern about the state of the family home, and the girl’s mother had made allegations of ‘indecencies by her husband in the presence of and with his children’. The PIC told the Inquiry she was sexually abused in foster care and the family home, and at Davenport House and Hay Cottage.

Departmental records show that in the mid 1970s, when she was 15, the PIC was placed in Davenport House, where she remained at different times over about 12 months. She recalled that ‘Davenport House girls … used to get teased’; on one occasion she was suspended when she and another girl ‘had just had enough’ and hit another girl.

She told the Inquiry she was sexually abused at Davenport House by a person who may have been a worker or ‘had something to do with there. He was there a lot’. She recalled a dark basement area where the girls played their records, and alleged, ‘I can remember this guy having sex with me down in that basement room on a number of occasions’. She said he gave her money for this ‘because I was smoking … I always wanted to get smokes’.

The PIC had a ‘vague memory’ of this man taking her by taxi into the city and upstairs in a building, possibly a hotel, where there were about three ‘men in suits’. She believes they gave her cigarettes and she had a drink, but ‘I can’t remember leaving there. I only remember going there’. Her next memory was of being back at Davenport House, feeling tired, with a headache, trembling and waking up at night with a dry mouth. ‘I think I had the feeling of just something wasn’t right. I didn’t feel like I normally felt,’ she said, and she senses that something sexual had happened to her although she ‘had no recollection of it’.

The PIC’s SWIC shows she lived with her father for several months on one occasion during her intermittent 12-month stay at Davenport House, and again lived with him for a period after she finally left the home. During this time, she told the Inquiry, he sexually abused her, including by penetration. He made her have ‘oral sex with him, play with him and just—yes, just bad things’. She told the Inquiry that she ‘fled’ to another relative’s place but was forced into prostitution while living there.

Departmental records show that it had concerns about the father a few years after her placement in State care, when she was about six or seven. The department’s director had instructed that the PIC and her siblings were not to live ‘either full or part-time temporarily or otherwise’ with the father; and it was later reported that he was ‘unsuitable as a parent as he has interfered with them on several occasions’. However, over the following years the PIC was permitted to have contact with her father.

The PIC reflected on her time in State care:

I’ve been placed in a system that was supposed to protect me as a child, the community welfare, and that system failed me terribly … They’ve left me in very dangerous situations and dangerous homes where people abused me and I couldn’t speak out … I cried silent tears because I was afraid of the consequences and this will remain with me until the day I die.

Abuse by outsiders

A woman told the Inquiry she experienced little affection in her childhood home, was ‘just neglected’ and was sexually abused by two family members. The department monitored the PIC’s family and, after she committed a minor offence in the late 1960s, when she was nine, she was placed in State care until she turned 18. She told the Inquiry she was sexually abused at Davenport House and, later, at the Marion Units.

In the early 1970s, when she was aged about 12, the PIC was placed at Davenport House, where she stayed for about three years, during which time she attended school.
Chapter 3 Allegations of sexual abuse

and visited relatives. She described her departmental social worker as ‘lovely’ and ‘friendly’, but said that ‘in all honesty it was no better for me than being at home, except that I was more isolated from my family because I still had no emotional support’.

The PIC said that when she was about 14 a person known to her family sexually abused her on an outing from Davenport House. The person had sexual intercourse with her but ‘I didn’t really realise what was happening at the time’. She did not tell anybody about the abuse and said, ‘I was withdrawn anyway … I used to live in my own little world’. When staying with relatives on breaks from Davenport House, the PIC said, another family member sexually abused her ‘lots of times … he came into my bedroom in the middle of the night and just had sex with me. He told me not to tell anybody’. The PIC believes she was ‘taken advantage of’ but said she felt guilty about what had happened and ‘didn’t stop him’.

She also told the Inquiry another older family member whom she used to visit while at Davenport House kissed her inappropriately on one occasion; another relative had caught him and ‘told him to get away’. The family had arranged matters so she no longer visited the household and she concluded that the abuse had been her fault. ‘I didn’t say anything to anybody, like all the other instances, and I was already isolating myself from people,’ she said.

Abuse after absconding

According to her SWIC, a PIC aged 14 in the early 1970s was placed in State care by court order until the age of 18 for using drugs, and was soon placed in Davenport House for a month. The PIC told the Inquiry her parents fought regularly at home, and her father indecently assaulted her from her early primary school years—abuse she associated with his coming home drunk. She also alleged that a man in her neighbourhood sexually abused her when she was about the same age. In relation to her time in State care, the PIC alleged she was sexually abused about the time of her placement at Davenport House, while she was absconding.

The PIC told the Inquiry she became ‘pretty rebellious’ before being placed in Davenport House. Once there, according to her SWIC, she absconded four times in just under two weeks, mostly living on the streets.

She told the Inquiry it was about this time that she ran away interstate with an older girl. At this time, she alleged, several of the girl’s male acquaintances raped her: ‘Eventually they stripped me off of my clothes and threw me into this prickle bush—I’ll never forget’. She said she was bleeding and the girlfriend did not help her. One of the men told her not to say anything: ‘I was scared they were going to kill me’. She recalled being back at the place where she was staying, ‘laying in the bath and just sobbing because my back—I had all prickles in my back and it was awful’.

The PIC said she hitchhiked back to Adelaide with the girl, but felt ‘I couldn’t go to my parents, I couldn’t go to the police. I didn’t trust the police’. She also did not contact the department. After her return, she alleged, she was raped by a group of bikies. When at first she refused to take off her clothes, the other girl ‘turned on me’ and threatened to call the PIC’s parents. She said the owner of the premises where the bikie rape occurred also later raped her. She said she did not report any of these assaults.

The PIC, still aged 14, broke into a family member’s home to get clothes, was charged with breaking, entering and stealing and was placed in secure care in Vaughan House.

She told the Inquiry that while out with her parents one day she took an overdose of tablets because she did not want to go back to Vaughan House.

The PIC told the Inquiry that at 17 she entered into an abusive relationship and was coerced into the sex industry. After leaving State care she remained in contact with her social worker because ‘I always felt very close to her’. The abuse she suffered had led her to take drugs ‘to suppress my feelings’ and left her anxious about dealing with authorities. Although she believes she is ‘still institutionalised in some ways’, she is ‘working on it …’ She said, ‘I just always believe that what happened yesterday doesn’t have to make you the person you are today’.
Departmental records show that in the early 1960s, when she was two, an Aboriginal PIC was placed in State care until the age of 18 when a court found her destitute. She said she was sexually abused in foster care and later at Davenport House.

The PIC's SWIC records that she was placed in Davenport House in the mid 1970s at 14 and stayed for about a year. ‘Once I went to Davenport, that's when I really rebelled,’ she told the Inquiry. At the time she had no respect for adults: ‘I wasn’t happy with my life and I just thought, you know, “Stuff youse all”’.

At Davenport House, the PIC said she was picked on by some of the girls—‘I hated it’—and recalled that one girl punched her in the mouth. She ran away numerous times to the beach area and particularly to the city, where she ‘hung out with all the street kids—mostly the rocker kids and bikies’. At times she would stay out overnight, but on other occasions,

... the police would find me and I’d be brought back and then I’d take off again. Those few years when I was a street kid, it’s a bit of a blur, but a lot of stuff happened.

She did not recall being punished for running away or whether anyone sat down with her to ask what was happening: ‘I just felt unwanted, basically, like most people’.

She told the Inquiry that during this period a young male raped her at a friend’s house:

We were sort of dating ... The first time I had sexual intercourse I was raped. I was drunk and this guy just kind of helped himself to me ... so that was my first encounter.

On another occasion she was raped by a group of three young men who picked her up from high school, offered her a lift home and ‘then put me in the back of the panel van’ near the beach. She did not know them at the time, but said the ringleader lived on the streets and raped her again when she was 15.

The PIC also alleged that during this time she was raped by a group of bikies and was ‘sold off’ by a particular bikie into prostitution: ‘I didn’t care any more’. She soon developed a drug habit and ‘was into pretty well everything except heroin’. Of her earnings from prostitution, she said ‘most of that money went to the guy who was selling me off’. He had made promises to her about getting her into modelling and going to Paris,

... and all this bullshit, and that we were saving up all this money for that, but he was using me to get money to get his bike back on the road.

He used to take pornographic photographs of her, put her in a massage parlour and take her to old men. She thought the last time she was involved in prostitution was when she was 16.

Sometimes I’d beg for money on the streets, like, to go and buy some hot chips. Sometimes I had nowhere to stay, so I’d stay up all night and I’d just walk around the city.

The PIC remembered being offered a job as a stripper at a club in the city. On one occasion in the club she saw ‘a whole bunch of bikies watching a movie, a pornographic movie, and I ended up going home with them and they all used me’. This happened again at different times and she could not remember the numbers of men involved, but said:

I didn’t care. Once you get used and abused that much, you just end up becoming a bit numb. It ended up I didn’t care who I slept with. If I had a feed and a bed, I was right.

However, she alleged that on one occasion she was ‘conned’ by a man, and he and his friends drove her to the southern coast area and three of them raped her.

The PIC’s departmental records show concerns about her absconding, contact with boys and ‘promiscuity’ while at Davenport House. It is written on one report after she returned from absconding that the PIC ‘had been used by a number of boys sexually’. On another, it is recorded that she ‘needs constant and individual attention to keep her in...
the house at all times’ and that staff ‘try to encourage her to be selective and stabilise friendships, but this she finds difficult ….’ The records show a request was made through the PIC’s doctor for a psychiatric assessment, and this was supported by her departmental worker, who wrote, ‘This child is very much in need of psychiatric assessment and help’. However, the following month, the worker reported that, despite her request, ‘no action had been taken’.

There are two other departmental reports in the same month around this period concerning the PIC and her contact with boys. One records on a ‘running report’ that the PIC and other girls

… picked up some boys and went to a house where a number of boys forced them to have sex … Police were informed but because of conflicting stories of girls, the police did not do anything.

Another records that the PIC had to be brought back to Davenport House from a ‘bikie hideout’ where she was ‘reported to be living with a large number of bikies’. The PIC and a younger companion ‘had been pack-raped by nine bikies each’. The PIC was returned to Davenport House but had reportedly ‘given such a conflicting story that the police had disregarded her tale completely’. The home’s superintendent noted that ‘there must be some truth in [the PIC’s] story …’ and she was to be tested for venereal disease. It was also noted that the report’s author, a departmental district officer, had tried without success to locate places and people with the PIC and her companion. The PIC was also recorded to have denied that sexual intercourse took place, but was ‘in need of a visit to Wakefield Street Child Guidance’. The outcome of the Child Guidance Clinic referral is not evident on the records.

The Inquiry sought police records in relation to the rape allegations involving the PIC but was informed that the Paedophile Task Force ‘have searched historical records and have been unable to locate any documentation pertaining to the initial reporting of sexual assaults to police as alleged’.

The PIC told the Inquiry that as an adult she has suffered from depression and has experienced abusive relationships. Her memories of the sexual abuse has affected her relationships, and ‘I feel like I’ve taken on the shame of other people. I’ve taken on shame that’s not mine. It’s actually their shame and I’ve taken it on’.

However, she said of coming to the Inquiry, ‘I haven’t talked about it before, not like this. I’ve just held it for so long’.

Elizabeth Grace Hostel, 1972–79

History

In 1972 the Vaughan House secure care facility in Enfield introduced an open hostel section for girls working in the community. Three years later the unit was moved from Enfield to North Adelaide and became the Elizabeth Grace Hostel. The rationale was that it would function more effectively as an open unit if it were situated in the community. The department’s 1975 annual report commented that ‘generally, the residents have responded well to this setting’.

The department described Elizabeth Grace as a hostel that provides ‘a community-based setting for girls who require guidance and support in developing educational, employment, social, interpersonal and domestic skills to help them cope with community living’.

Allegations of sexual abuse

One woman told the Inquiry she was sexually abused when she was a child in State care and placed at Elizabeth Grace Hostel.

59 DCW annual report 1975, p. 18.
60 ibid.
61 ibid., 1976, p. 31.
Abuse by staff

In the mid 1970s a PIC was placed in State care between the ages of 14 and 18 under a court order that found she was neglected. She told the Inquiry she was also sexually abused at Vaughan House and Allambi Girls Hostel.

The PIC was placed at Elizabeth Grace Hostel in the mid to late 1970s for several months. She said that while she was living there one of the staff regularly raped her in an unused room. She said the staff member also took her into an office, showed her pornographic pictures and forced her to touch his penis. ‘It just makes me feel sick to my stomach,’ she said.

The PIC told the Inquiry, and her SWIC confirms, that she absconded several times in an attempt to escape the sexual abuse and was returned to Elizabeth Grace on each occasion. She said she did not report the abuse:

I didn’t tell anyone. Because you’re government property, they can do whatever they want, but you can’t tell no-one because if you tell someone, you still get more punishment, no matter what.

Being taken from her home and placed in institutions did nothing to improve her life, she said: ‘I was in hell and then I get put into hell, hell, hell. There was no-one there. No-one gave a shit about you.’

Nindee Hostel 1971–present

History

Nindee Hostel for Aboriginal children opened in Beulah Park in 1971. Financed by the Australian Government, it was established to provide accommodation for Aboriginal children working or studying in the city and/or suburbs. Nindee was specifically used as accommodation for remote area children who attended secondary schools in the Norwood area. The hostel was run with the assistance of an advisory committee that included Aboriginal representatives.

Allegations of sexual abuse

One woman told the Inquiry she was sexually abused while placed at Nindee Hostel.

Abuse by outsider

The PIC lived at Nindee Hostel from the age of 12 in the early 1970s for about three years while she undertook secondary schooling. The United Aborigines Mission (UAM) sent her to Nindee on leave from her foster placement where, she said, she also was sexually abused.

The department told the Inquiry there are no childhood client records relating to the PIC; however it once had a family file that was destroyed by fire. The UAM provided only a limited number of records in relation to the PIC. Due to the lack of records, the Inquiry was not able to properly determine whether the PIC was in State care.

The PIC said the people who ran Nindee were ‘lovely. We finally felt like we had a family, the children—all us teenagers at Nindee, you know; that someone understood us’.

She recalled there were about 12 to 15 teenagers living there, both boys and girls. She enjoyed her time at the hostel and made friends: ‘The Aboriginal part of me was that … I had people to identify with. So yes, it was easier for me then.’

The PIC told the Inquiry that while living at Nindee Hostel she and another girl absconded and went into the city one night. They met a group of men, one of whom offered to take them for a drive; she said they accepted, and later one of them raped her. She said he warned her that if she did not have sexual intercourse with him he would punch her in the head.

She became pregnant as a result of the rape and told workers at the hostel, who arranged a termination. She
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said she did not want any action taken against the man at the time, because she did not think her account would be believed:

I sort of knew it was wrong that he was standing over me and threatening me. I knew that was wrong. I just felt that my little word against this man—in the report my name will get slandered and he’ll end up still being the good guy, so I didn’t go there.

She told the Inquiry the abuse ‘stopped my education’. She was offered secretarial work, but ‘I felt so degraded and worthless’. She felt she couldn’t go back to school either: ‘I just couldn’t face all the girls in the school, you know, if anybody told anybody.’

The PIC left the hostel and did not complete her secondary education. She is now involved in caring for her grandchildren, and told the Inquiry she wants them and other Aboriginal children to be kept in ‘with family foremost from everybody else—I want them to have a future’.

Kumanka Boys Hostel, 1946–80

History

The department bought a property in North Adelaide in 1945 as a response to the need for accommodating children in State care who were moving from reformatory living to working in the community. It was named Kumanka, an Aboriginal word meaning ‘comrades’. The hostel was designed to accommodate working boys in State care, with provision for accepting some aged over 18 at the department’s discretion.63 By September 1945 a superintendent had been appointed and a matron was employed soon after. The existing building was renovated to provide improved bathroom facilities, a workshop and sports room. The home opened in January 1946 and by June that year 14 boys were in residence.64

Kumanka aimed to give boys a means of developing skills for living as citizens in the wider community. They were allowed to come and go, subject to the superintendent’s approval; contact with the department’s probation officers was minimised. The boys paid board and were helped in saving some of their wages.65 Social contacts were also organised, including outings from the hostel.66 From 1962, in addition to working boys, older schoolboys lacking suitable accommodation were also admitted to Kumanka and the hostel’s superintendent monitored their progress at school. In 1966 the average number of boys at the hostel was 18.67 By the mid 1970s Kumanka was one of five hostels in the metropolitan area for children aged 12 to 18.68 Kumanka closed in 1980.

Allegations of sexual abuse

Seven people gave evidence to the Inquiry that they were sexually abused at Kumanka Boys Hostel between the early 1960s and the late 1970s.

Abuse by multiple perpetrators

One PIC alleged he was sexually abused during his placement at Kumanka in the late 1970s. In the mid 1970s, when he was 13, a court placed him in State care until 15 for habitual truanting and sent him to Brookway Park for safekeeping. The PIC told the Inquiry he was sexually abused at Brookway Park and then at Kumanka. After four weeks at Brookway Park the PIC was transferred to Kumanka and stayed there for almost 18 months. He said he first experimented with drugs while at Kumanka. He also told the Inquiry that staff were often violent towards boys at the home. He said of one staff member, ‘I have several scars on the back of my head from where he hit me with his keys’. He alleged another staff member ‘grabbed me by the nuts and marched me up and down the stairs seven times’.

The PIC alleged that sexual things were happening at Kumanka: ‘I seen it and I was involved in it’. He told the
Inquiry that he and other boys at the home frequented hotels nearby and in the city, where gay men and paedophiles were common among the clientele. He also said hotel staff and police turned a blind eye to the underage drinkers and sexual activities.

He alleged he was sexually abused during his placement at Kumanka but ‘away from the house’. He said he was introduced to a man who owned a shop near the home and that the man sexually abused him and other boys: ‘He used to give us $10’. He also said there were other men at the shop: ‘They were meeting boys there and taking them with them’.

The PIC also alleged he met a doctor who took him to places where men sexually abused boys. He said the doctor and a Kumanka staff member sometimes took him and other boys to a Glenelg house where they posed nude for photographs:

He used to pay us, I think it was $15 or something, and it was nude photos and nude sketching only, no touching. $15. If you got 10 photos you get $150.

He told the Inquiry he was taken to parties where there were boys and men, and said the boys were given drugs and alcohol:

Everybody would just party. You could name your drug—it was there. You could name whatever you wanted to drink—it was there. The younger you were the more you were encouraged to drink.

At one party at the doctor’s house he allegedly was given a drug called Mandrax:

He had, like, a big pickle jar, I suppose you could call it, and it was chock-a-block full. There was thousands in there. It was, walk through a door, just grab what you want and, if you didn’t want to take them, you could sell them ... The next thing I remember I wake up. I was at a strange house that I’d never been at before in the lounge room and there was one bloke filming and another bloke was having sex with me and I remember them waking me up, saying, ‘Come on. Where do you live? Come on. Where do you live?’ and the next thing I remember is my mother going off her face because I was passed out on her front lawn, and I slept for three days.

Abuse by staff and other residents

In the mid 1960s, when he was 11, a PIC was found to be destitute and was placed in State care by court order until the age of 18. He alleged his father physically and sexually abused him regularly.

The PIC told the Inquiry that while in State care he was sexually abused at Windana Remand Home, Glandore Children’s Home, in the family home, at Kumanka Boys Hostel and McNally Training Centre.

At 15, the PIC was transferred to Kumanka, where he stayed for nearly three months. He alleged a staff member who had previously abused him at Glandore also sexually abused him at Kumanka. He also said that other resident boys sexually abused him there: ‘They seemed to enjoy beating me up and deciding who would have sex with me ... I either did it or got bashed’.

He said he absconded from Kumanka as a result of the abuse, and that he spoke to a Kumanka staff member about it but the person would not listen to him.

Files from the department reveal that the PIC was considered to be in need of psychiatric assessment and possibly treatment but because such services were not readily available, this did not occur. The records do not mention any reports of alleged sexual abuse.

Abuse by other residents

In the early 1960s a four-year-old PIC was placed in State care until he turned 18 after a court found him neglected and under unfit guardianship. He recalled there was violence and alcohol abuse in his family home and said that occasionally he ‘used to eat out of bins’. He told the Inquiry he was sexually abused in foster care, at Glandore Children’s Home and then at Kumanka.
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The PIC was 14 when he went to Kumanka in the early 1970s and lived there for almost two years. He said he suffered violence, both from staff and other boys, and that an older boy resident sexually abused him by ‘getting us to do things to him, or me to do things to him’.

He also recalled an incident in which he was abused by a group of residents. These boys ‘flipped me over, ripped my pyjamas off me, and one was having a go and four others were holding me down’.

The PIC said he did not report this sexual abuse. He told the Inquiry he has been psychologically affected by the sexual abuse he suffered while in State care: ‘I keep blaming myself for it, and that’s where I’m going to have to be, what, depogrammed, de-institutionalised?’ He said he feels ‘violated and screwed up’ and that ‘the system has let me down and let us down’.

Abuse by outsiders

A court placed one PIC in State care in the early 1960s when he was 12 for criminal offending. He said his parents separated when he was about five and his father privately placed him in different non-government homes. He told the Inquiry he was sexually abused at Windana Remand Home and Kumanka.

The PIC’s SWIC records that within months of being placed in care he was transferred to Kumanka after being in two other institutions: ‘Eventually they figured it was just that I needed a more family-orientated environment, and that’s when I wound up at Kumanka’. He stayed in Kumanka for about nine months, according to his SWIC.

The PIC told the Inquiry that while at Kumanka he went with other boys on outings, including to the theatre. During these outings he observed what he considered to be men making sexual advances to the boys: ‘We each sat with an adult between us. In most cases they would make some kind of sexual advance’. On one such occasion:

The fellow sitting next to me put his arm around my shoulder and wanted to play with my boob. I was, like, you know, ‘You go any further than that, you’re going down’.

He also said he and other boys were taken to parties where sexual things happened with men. During and between the various institutional placements the PIC was sent for holidays with a family—‘lovely people’—who later fostered him for a few months. He also was returned at times to his mother’s care, but said that:

In between stints in these homes the dickhead welfare system would send me back to my stepfather, who I absolutely hated, who would flog me more often than I’d had bloody hot dinners.

His SWIC shows the placement at Kumanka ended because he was charged with a criminal offence and transferred to secure care, including Windana Remand Centre, where he said he was sexually abused.

A PIC born in the mid 1950s alleged he was sexually abused during a placement at Kumanka in the late 1960s. His parents had previously placed him in several non-government homes. When aged nine he was charged as being destitute and then while on remand was charged with larceny and placed in State care until the age of 18. The PIC alleged he was sexually abused during placements at the Boys Reformatory, Magill, Brookway Park, Kumanka and McNally Training Centre.

At 14 the PIC was placed at Kumanka. He alleged that two other residents took him to a house where he took drugs before a man sexually abused him by having anal intercourse.

The PIC told the Inquiry that he felt ‘dirty’ after the assault and did not report it: ‘I thought I’d be safe by not saying anything anyway’. He also was reluctant to report the abuse when the same two boys again attempted to convince him to go to the man’s house:

They were going to take me back another night and I refused to go, and they tied me up naked to the basketball pole and threw basketballs at me.

Records show the PIC continued to abscond and commit offences. He was later placed at McNally Training Centre where, he said, a staff member sexually abused him.
A PIC born in the early 1960s alleged he was sexually abused while placed at Kumanka in the mid 1970s. He was charged as neglected and placed in State care by a court before he was three. Departmental records show his parents were considered incapable of caring for their children or providing proper accommodation. The PIC's mother alleged her husband had behaved indecently in front of the children, which he allegedly later admitted. The PIC spent short periods at a government home and with his father before being placed in foster care, where he alleged his foster father sexually abused him. He also alleged he was sexually abused at Lochiel Park Training Centre when he was about 12.

When he was 14 the PIC was transferred to Kumanka, where he remained for six months. He told the Inquiry his memories of Kumanka were

Horrifying … I remember one incident in the pool room. They had a pool room upstairs. They were hitting me and throwing pool balls at me; calling me ... this, that and the other thing. Everywhere I looked it seemed like someone would hit me in the back of the head or call me a name. It’s like the rest of them; it’s blank.

He said that while living at Kumanka another boy took him to an art shop in North Adelaide: 'Went out the back, behind some curtains … can’t remember what happened there. I had forgotten all about that. I remember they gave us some money.'

He regularly absconded from Kumanka and often went to the River Torrens to swim. On one occasion he met a man there:

He had a motorbike. He offered to take me for a ride. I had never been on a motorbike so I said yes. I had a lot of fun and he dropped me off near Kumanka and offered me another opportunity the next day. That was when he took me to his house … Then he talked me into having sex with him.

The PIC said he did not like the sex but continued to visit the man:

Although I didn’t like it I went back because at that time it was an escape from Kumanka where I was severely bullied by the boys. It was a refuge. It was a place I could get away from all the nastiness.

He said his father was aware of and approved of the PIC's contact with the man. He also alleged that this man introduced him to other men who sexually abused him. On one such occasion the man took him bowling with another man and let this man take him home: ‘That’s where someone forced their way into me’.

One of the men to whom he was introduced took him interstate:

The first time I went to [city] I was taken there by a friend of [the man] whose nickname was [name]. He tried to sell me in [a hotel].

The PIC said he was eventually apprehended by police and placed in a detention centre from which he later absconded: ‘The SA welfare just brought me back and forgot about it’.

Records from the department confirm that the PIC absconded from Kumanka more than once. They confirm that on one occasion he absconded to another State.

A note on the department's file states that on another occasion the PIC absconded and was

… located by police at Magill, in the company of an older man. [Name] stated to me he was in his mid 30s. This relationship will have to be watched carefully because according to [name], it has just recently taken place.

There is no further mention of this relationship on the file.

The PIC said he did not report any of the abuse but said he suffered anal injuries and required surgery. He said the department was aware of his injuries at the time he
abscended interstate. The department’s file does not record any medical treatment for these alleged injuries.

He said he lived on the streets until he was about 32. He said he still carries feelings of guilt about the abuse he suffered as a child:

*I have always been of the opinion it was my fault; that’s why I’ve told no-one … I’ve always assumed it was. I have felt ashamed and guilty all my young and adult life. It has affected my relationships, my ability to look society squarely in the face. I have always felt like a lower grade of person and believe society treats me as such.*

The PIC said he hopes that he can put his past behind him, and would also like to help others:

*I’d like to see things changed … I’d like to know that when families do break down, when children go to homes, they’re not going to be taken to motel rooms. I’d like to think that a child can feel safe wherever he is.*

### Abuse after absconding

In the mid 1960s, before his first birthday and as a result of family breakdown, a PIC was placed in State care until the age of 18 when a court found him neglected and under unfit guardianship. The PIC told the Inquiry he was sexually abused while placed at Fullarton Cottage and at Kumanka.

The PIC was placed at Kumanka not long after his 13th birthday and remained there for just under six months. He said he became a drug user while in State care: ‘I was sniffing petrol by the time I was eight, nine, 10. By the time I was out of Kumanka and Stuart House I was sniffing glue.’ The PIC said he absconded from Kumanka on more than one occasion. He alleged that during his placement he travelled to another State, where he was drugged and sexually abused.

Records from the department reveal that the PIC absconded from Kumanka with another boy for several days before being returned to the home by police. Within 15 minutes he again absconded. The PIC told the Inquiry that a man who was sitting in a car outside the home talked him into going for a drive, gave him alcohol, cigarettes and pornography, then offered him a free interstate trip by plane. He said he flew interstate and evaded police at the airport by using a false name. When he arrived at the destination he was met by a man and taken to a house owned by another older man. The PIC said he was treated to luxurious accommodation:

*I was told that I was going to be there on a holiday and that they would fly me back within the next 24 hours. So the main thing was, ‘Help yourself to anything that’s here; swimming pool, whatever you want. It’s all here, alcohol, pornography; we’ve even got videos here for you to watch.’*

The PIC alleged the two men drugged and sexually abused him on a number of occasions over an extended period: ‘I was there for three months. The whole time I was there I was their love monkey, so to speak.’

He told the Inquiry he was raped by the older man:

*I was lying on my back on his stomach and he was anally raping me from behind and playing with my penis at the same time. It was some sort of pleasure and pain sort of thing that they were into. They had a machine that they used to use on my penis as well, that used to vibrate. Like, there’s a part on my penis that gets sexually aroused when you’ve got a little vibrating machine on it, and they knew that it does that.*

The PIC alleged the younger man also anally raped him and that he suffered injuries: ‘I remember going into the pool and when my body hit the pool I remember red being in the water’.

He said the two men continued to sexually abuse him during the three months: ‘It was just ongoing, nonstop, nonstop, nonstop.’ He told the Inquiry he eventually escaped and went to a local police station.
The records show the PIC telephoned the department from the other State and told a worker that the older alleged perpetrator was sexually abusing him. The worker then collected him and took him back to Adelaide. Departmental records consisted of copies of documents from the PIC’s client file; the original files were not located. Records received by the Inquiry show the PIC was absent from Kumanka for nearly three months. They also show that departmental officers were aware he had absconded—an unidentified caller had alerted them that the boy was leaving the State. Police were notified and ‘covered the airport with no result’. The records also show that a departmental officer noted that police were looking into a possible association the PIC had with the known older man. Police reported that they were unable to locate the man.

The departmental officer’s notes show he suggested to the PIC that he give information to police. The PIC told the Inquiry that on his return to Kumanka he reported details of the sexual abuse to a worker, but said the worker refused to accept his account of events and told him:

You are full of bullshit. We know that you’ve just been on the run—whatever. We know you’ve just run away. What you are just saying is all lies.

Records show that about six weeks after returning from interstate the PIC was in and out of placements and regularly absconding. During that time, he said, several men in Adelaide and interstate sexually abused him. Records received contain a note by the departmental officer that the PIC was spending time with homosexual friends. There is nothing to suggest the department took preventative measures in relation to these associations or investigated the possibility that sexual abuse or under-age sexual activity was occurring.

Of the men who allegedly sexually abused him during his time in care, the PIC told the Inquiry, ‘All I can say is that it’s like they were training us to be sexual objects, to be actual sexual objects’. He said he has suffered and continues to suffer: ‘I still haven’t got a relationship and I still haven’t got children and when my family or anybody comes near me I get affected by that’. He also told the Inquiry he has suffered psychologically and has had thoughts of self-harm: ‘All this did to me as a kid, it just caused me to just want to end it all’.

Stuart House 1964–90 / North Adelaide Community Unit, 1990–97

History

Stuart House was a government hostel in North Adelaide that operated between 1964 and 1997. It housed older schoolboys who were in State care but had no suitable accommodation. Hostel staff monitored their progress at primary or high school, as well as ‘any personal problems’.69 The boys were permitted to join local sporting and community clubs, and outings were organised by hostel staff. Numbers of boys living at Stuart House varied over the years: the average was 23 in 1964 and six in 1977.70 An average of 11 boys lived there between 1986 and 1989.71 From 1990 until 1997 the hostel operated as the North Adelaide Community Unit.72 It was then relocated to Regency Park, where it still operates as the Regency Park Community Unit.

Allegations of sexual abuse

Seven PICs gave evidence of sexual abuse at Stuart House between the early 1960s and late 1980s. All were in State care at the time, placed by a court or by the department under an administrative order.
Abuse by multiple perpetrators

In the early 1960s, when he was 11, a PIC was placed in State care by court order until he turned 18 because he was neglected and under unfit guardianship. He told the Inquiry he was from a large family and, after his parents separated, it was difficult for his remaining parent to work and care for the children, some of whom began stealing food to try to help out. The PIC recalled the police taking him from his home to Glandore Boys Home and spoke of his father’s distress at his removal. He alleged he was sexually abused at Glandore and then at Stuart House.

The PIC said he was sexually abused while at Stuart House in the mid 1960s. He was placed there when he was 12 and remained there for three years. He alleged an older boy at the hostel sexually harassed him and other boys: ‘He was always trying to root you … you’d go in the shower and he’d be masturbating himself and then he’d come to your bed at night …’

He said he reported the boy to a staff member:

> Several occasions I would say to [the staff member] what was going on, but most of the time nothing was ever done and generally—I remember one time I was coming up the stairs and [the staff member] was up the stairs and I said about [the boy]. I said, like, ‘[boy’s name] is trying to do stuff.’ [The staff member] slapped my face and said, you know, ‘Get on’. So you sort of think, well, ‘What do I do then?’

The PIC also alleged a male psychologist sexually abused him in Stuart House. When he was about 14 he had several meetings with the psychologist, who visited the home for vocational assessments of the boys. At their first meeting, he said, the psychologist made suggestive sexual comments. At another meeting, the psychologist rubbed his groin on the outside of his clothes. At the next meeting, the man exposed his penis and induced him to do the same; this had then progressed to mutual masturbation. At a subsequent meeting, the sexual abuse allegedly escalated when the man anally penetrated him. The PIC said he ...

... grabbed and pulled my pants down. Then all of a sudden he pushed really hard and, I tell you what, it really hurt. So he penetrated and I just shot away really quick and then he come up and tried again and in the end I just, like, ‘I’m out of here,’ you know, and I got out.

The PIC said he told a staff member at the home that the psychologist ...

... is a poof and he tried to do me. He smacked me in the mouth and I got a week’s punishment. Then I tried again to tell him—again—and I got stand-out for a month.

At 16, the PIC left Stuart House and lived with his father. He told the Inquiry he became promiscuous, used drugs and got into fights. Now, about 30 years later, he says his life is stable.

An Aboriginal man born in the late 1960s alleged he was frequently and extensively sexually abused during a placement at Stuart House from the age of 11. The PIC was sent to the hostel after a court had placed him in State care until he turned 18, finding that he was in need of care. The PIC also alleged he was sexually abused in a foster placement arranged under the department’s supervision but before he was placed in State care.

The PIC said another boy sexually abused him not long after he arrived at Stuart House. He told the Inquiry the older boy induced younger boys at the home to take drugs and have sex with him: ‘He got us sniffing glue and [did] sexual acts with us’. He alleged the abuse involved anal intercourse on more than one occasion.

He said that while at Stuart House he found employment, and on one of his rounds he met a man [A] who befriended him and gave him very generous tips. The man was connected with a religious organisation, which ran youth camps. Over a period of weeks and months, he said, he continued to receive generous tips from the man and visited him at his house. After a few months [A] allegedly started to sexually abuse him—the first incident occurred under a bridge near a river:
The first time something happened with him he just groped me and stuff, you know, and, like … I was shocked at first, but he sort of, like, convinced me that it was cool—everyone done it and it was normal.

The PIC said that on several occasions [A] took him to his house, where he played records and Monopoly. He alleged that on one visit the man got him to perform oral sex and told him that,

> It was all right for people to do that and, because I’d had those experiences in the past, it made me believe that what he was saying was right, and also I think I thought that it would be okay because, like, he was always good to me, so it was okay to do that.

The PIC said [A] introduced him to marijuana and alcohol. On one occasion [A] brought another boy to his house and made him and the PIC perform sexual acts and took photos. The PIC said [A] then went into the bedroom, where he had oral sex with the other boy.

He alleged [A] continued to sexually abuse him during his placement at Stuart House and began to pass him around to other men who also sexually abused him. He told the Inquiry [A] took him to a religious centre which was a drop-in centre for homeless children: ‘I basically went there because they used to have these, like, cream cakes that were delivered, and pies and stuff like that’. He also alleged [A] had anal sex with him at the religious centre and that another man put his hands up his shorts and fondled him.

The PIC said [A] also introduced him to a middle-aged man [B] who gave him money in return for oral sex. He alleged that on one occasion [A] took him to a church where [B] analyically raped him: ‘Like, I was begging for him to stop, you know, and crying and that’.

The PIC said he suffered injuries and this resulted in a heated argument between the two men,

> … because I was, like, crying and I was really distraught and, like, there was blood coming down my legs and [A] ran—bolted inside and got toilet paper and told me to put that there—toilet paper or tissues? I’m pretty sure it was toilet paper—and went in and, like, they had loud words.

He told the Inquiry that [A] panicked when he saw he was bleeding and the next day bought him a Holden jacket: ‘I wanted a Holden jacket, everyone else had one … I was elated … I had someone caring about me … I was eager to please him.’

He said [B] abused him on a number of occasions: ‘I remember several times being drugged by him and waking up after being abused’. He alleged that [A] often passed him around to other men who sexually abused him; he sometimes received gifts from the men but said he agreed to go with them to please [A].

The PIC alleged that [A] took him to a homosexual beat near the river, sometimes in the company of other men:

> They’d take us there so they could have sex with people in the toilets and they’d try and get me and another person to go out and go into the toilets and have sex with people and that.

On one occasion, he said, [A] sexually molested him in the Adelaide Park Lands and was apprehended by police:

> He took off running and the coppers just run him into the ground and chased him and give him a couple of punches in the head and that and they dragged him, handcuffed, in front of me and the copper goes, ‘You’ve got no idea how lucky you are. This man’s a paedophile’. I didn’t know what a paedophile was.
Chapter 3 Allegations of sexual abuse

He said he and [A] both gave their personal details to police, who noted them, including the fact that he was from Stuart House. He also told the Inquiry he was scared to walk back to Stuart House through the Park Lands and asked the police to drive him back, but they refused. There is no record on the department's file indicating that police notified them of the incident.

The PIC told the Inquiry a professional man [C] sexually abused him more than once, including oral sex on one occasion. He alleged that on another occasion a man drugged him at a youth drop-in centre and took him to a house where he was again sexually abused by [C]: ‘I was pretty well drugged up. I was pretty drugged. I think he basically had to almost carry me in there’. The PIC recalled that he woke to find he was being anally raped by [C], who was dressed in women’s clothes.

He alleged [C] also sexually abused him at a party where, even though there was no swimming pool, ‘everyone was dressed just in bathers. All the kids were all in bathers and there were a number of them there, not just me’. Other men, including [A], were also at the party. The PIC said he had oral sex with [C] and was then sexually abused in the bedroom by someone he did not know.

The PIC told the Inquiry he did not report any of his allegations of sexual abuse. Records from the department show it was aware the boy was absconding regularly but there is no mention of sexual abuse and little discussion about the cause of the absconding. It was noted that the boy exhibited behavioural problems at school and frequently got into fights.

The PIC said he has become addicted to illicit drugs and committed offences to maintain his addiction.

A PIC born in the mid 1960s was 15 when a court placed him in State care until the age of 18 on the basis of neglect. Before that he had been placed under a temporary administrative order when his mother was unable to care for him. The PIC alleged his stepfather sexually abused him before he was placed in State care. He also alleged sexual abuse by a foster father when in foster care as well as during a placement at Stuart House.

The foster placement broke down after a short time and as a result he was placed at Stuart House, where he remained until he was nearly 18. The PIC alleged he was sexually abused on several occasions during this placement—the first instance was not long after arriving at the home. The PIC recalled that one night his door opened and three people came in and held him down on his bed:

One of them grabbed my pyjama pants and pulled them down, exposing my butt. He then held my legs apart while the other one was holding my shoulders and pushing my head into the pillows. I then felt something cold and hard like metal or glass being pushed into my butt cheeks.

He said he suffered injuries as a result of this incident but was too scared to report it.

The PIC also said that another boy at Stuart House told him how he could earn money if he was prepared to perform sexual favours for men. On one occasion he arranged to meet a man at a location near the hostel and was taken to a house, where there were about 10 males and females. He said he was given alcohol to drink:

Very soon the room was starting to spin and my last clear memory was looking down at [name] as he took my penis in his mouth. From then I just closed my eyes and went to my safe place deep in the back of my mind. I can’t recall too much from then. Every now and then I opened my eyes and saw other people around us just watching.

He also alleged another man sexually abused him at a homosexual beat in the Adelaide Park Lands, anally raping him and hurting him badly in the process: ‘He started getting a bit rough and I said I wasn’t really interested then. He just forced me down. Yes, just held me down and had sex with me’.

The PIC said the sexual abuse has caused him a great deal of trauma, including nightmares and an inability to have a normal sexual relationship. He said he suffers from depression, for which he takes medication, and has seen a psychiatrist. His work has enabled him to help disadvantaged children: ‘They could see that I, you know, respected them and they gave it back’.
A PIC born in the early 1960s alleged he was sexually abused at Stuart House during the 1970s. The PIC was placed in State care when he was five, a court finding he was neglected and under unfit guardianship.

Departmental records reveal that the department had been in contact with the family due to unsatisfactory housing and domestic complaints. The PIC said he has memories of being sexually assaulted when he was about three. He told the Inquiry he was sexually abused at Glandore Children’s Home, in foster care and then during a placement at Stuart House.

Following unsuccessful placements the PIC was sent to Stuart House not long before he turned 13. While at Stuart House he went to a local school, and alleged a teacher there introduced him to drugs and sexually abused him; he also started to drink heavily during this period. He told the Inquiry the abuse went on for a couple of years.

The PIC also said he obtained work at a local art shop where he was introduced to several men who paid him for sexual favours such as anal intercourse and oral sex, which occurred at various locations around Adelaide and in the back of a motor vehicle. He alleged the abusers warned him to keep quiet, although he did report these incidents to a staff member at the home:

I was telling him that they were interfering with me. He just said, 'Don’t worry about it. Just tell them not to'; sort of thing. I said, ‘But how can I?’ you know.

Records show he regularly absconded from Stuart House, sometimes for several weeks. He left school at 15, while still at Stuart House, and found employment.

He told the Inquiry he has frequently abused drugs and alcohol, and that the sexual abuse has affected his ability to form relationships: ‘Every relationship I’ve fucked up, basically. Excuse my language. I’ve damaged. You know, it’s been the reason we’ve split’.

Abuse by outsiders

Another PIC told the Inquiry that when he was about 10 in the late 1960s he was sexually abused by a stranger who lured him into his vehicle, took him to a house and forced him to perform oral sex. From this point his life changed for the worse, he said, and he started to get into trouble with the law. At 14 he was charged with offences and as a result was placed in State care by a court until he turned 18. He told the Inquiry he was sexually abused at Stuart House, Windana Remand Home and McNally Training Centre.

When he was almost 15 the PIC was placed at Stuart House for about two months, during which he absconded. He told the Inquiry that while placed at Stuart House he had a sexual relationship with a young man:

He was a paedophile but I didn’t consider him a paedophile; I thought he was closer to my age. And I was learning about sex … He sort of taught me to drive and groomed me and paedophile me … But I, to be really fair, just saw it as my first sexual experience. I now know better.

The PIC told the Inquiry he had a full sexual relationship with the man for about two years but did not report it because at the time he considered it a relationship rather than sexual abuse. He said the relationship continued while he was placed in other institutions.

A PIC born in the late 1960s was placed in State care from the age of 11 under several temporary administrative orders after he was found to be uncontrollable. He alleged he was sexually abused while at Stuart House, then in foster care.

He was placed twice at Stuart House in the early 1980s, the second time for eight months. During this second stay he met a man who was kind to him:

He was there to take kids out motorbike riding or work on his concreting foundations and that kind of thing. I thought he had something to do with the place.

The PIC said he stayed overnight at the man’s house. He said the man told him, ‘Look, you can sleep in my bed. I mean, I won’t—nothing will happen’, but when he awoke he found his hand was on the man’s erect penis. The PIC did not report the incident: ‘I didn’t tell anyone because, for a start, I felt uncomfortable about it. Secondly, who’s going to bloody listen to you anyway?’
Chapter 3 Allegations of sexual abuse

He said boys at Stuart House took drugs and did things to each other: ‘There was incidents when there was, like, boys with boys. I mean, that happened with me.’ He said this happened two or three times: ‘That’s because you’re off your face. Just totally off your face, yet you remember it the next day.’

A PIC born in the mid 1970s told the Inquiry he was sexually abused during his placement at Stuart House in the late 1980s. Records from the department show his parents separated before he was 12 and he began stealing and truanting from school. The PIC was placed in State care by a court when he was 15 for committing offences including break and enter and larceny.

Records show he lived at Stuart House for about six months. The PIC told the Inquiry he frequented homosexual beats in the Adelaide Park Lands and met men who then passed him around to other men. ‘You’d just get passed on, like, to anyone, like a parcel, you know? … It was like pass the parcel.’ Records from the department reveal it was aware the PIC was regularly absconding and prostituting himself. The PIC said that on the homosexual beats he met a man who was looking for young boys for sex. This man allegedly sexually abused him:

> He was mainly into licking arse and, you know, shoving his arse in your face and, you know, biting your damn nipples and shoving his fingers up your arse, and things like that, you know.

The PIC told the Inquiry some of the men with whom he had sex were prominent identities: ‘How do you say “No” to these people?’ The PIC also alleged he was sexually abused by a man who worked for the department and had significant involvement in the management of his case. He said the man sexually abused him ‘many times’. On the last occasion he suffered injuries and required medical attention: ‘He had my balls and sucking too hard and put me in hospital’. Hospital records received by the Inquiry show that at 14 the PIC was admitted with severe testicular pain that required surgery, but the cause of the problem was not noted.

The PIC also alleged that a man who performed volunteer work for the department helped him and then took advantage of him sexually.

He said he became acquainted with other boys who were also engaging in prostitution and performed in pornographic films with some of them when he was 15 to 16. He also took boys to men for sex and ‘got paid $80 for every delivery of every young boy younger than me in Adelaide’.

The PIC alleged that a man who befriended his mother abused him sexually many times, including raping him. He said he reported the rape to police but no action was taken. Police records reveal the allegations were reported in 2001. The alleged perpetrator was interviewed and denied the allegations. Police interviewed other potential witnesses and concluded that they were unable to corroborate the allegations. Police spoke to the PIC again and noted that he was unable to provide any further information to assist with the investigation and signed a form stating that he did not want any further action to be taken. The matter was then filed and no further action was taken.

The PIC told the Inquiry that he did not report any of the other allegations of sexual abuse: ‘Who’s going to believe your story, your word over mine? No-one will and no-one has.’

Following his placement at Stuart House the PIC was released to live with his father. However, he spent significant periods living on the streets and committed crimes. He was then placed in the Intensive Neighbourhood Care (INC) scheme, but soon absconded to the eastern states, where he lived off the earnings of prostitution.

He was eventually returned to South Australia and placed at Stuart House but absconded after one week. According to departmental records the police picked him up in another town and he admitted to them he had been ‘selling his arse’.

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Youth shelters

Six people gave evidence to the Inquiry that they suffered sexual abuse while living in youth shelters. The Inquiry was able to determine from records that two of those people were in State care at the time of the alleged sexual abuse. The alleged perpetrators were an adult resident and a staff member.

Records received indicated that four of the people were not in State care at the time of the alleged sexual abuse in the youth shelters73, although two had significant contact with the department when they were children. Their allegations are not set out in this report as they are outside the terms of reference. However, their evidence has contributed to the Inquiry’s knowledge about youth shelters and the long-term effects of child sexual abuse.

Exodus Youth Shelter, 1985–unknown

History

Exodus Youth Shelter was also known as the Edwardstown Shelter. It was developed in 1985 by a church organisation known as the Christian Family Centre. The concept came from a committee of concerned citizens formed in the early 1980s in response to violent incidents involving young people at Glenelg. The committee planned services to address what were perceived as the underlying causes of youth violence, such as family breakdown and drug abuse. Departmental records show that Exodus received a subsidy for children in State care who were accommodated at the shelter74. However, records do not indicate whether the shelter also received operating grants from the department.

Allegations of sexual abuse

One man alleged to the Inquiry that he was sexually abused while placed at the Exodus Youth Shelter.

Abuse by another resident

The PIC’s SWIC indicates he was placed in State care at 14 in the early 1980s. He was placed under several short-term ‘in need of care’ orders before a court placed him in State care until he turned 16. He lived in non-government institutions, secure care, government cottage homes and admission units, and in foster care. He told the Inquiry he was sexually abused in foster care and then at Exodus Youth Shelter.

The PIC was placed in the shelter when he was 16 and spent six months there until his guardianship order expired. During his stay, he said, he shared his room for a single day with a man old enough to be his father. This man raped him, both ‘oral and in the anus’, he said, but because he had experienced sexual abuse in other placements he had not resisted: ‘I just thought it was natural’.

Unit Living, Marion, 1974–90

History

Commonly known as the Marion Flats, this group of five self-contained units opened in December 1974 to assist young people in State care to live independently. The department’s annual report noted, ‘Care and accommodation is provided there for senior school students expected to move into the workforce within about 12 months. The young people living there have shown a capacity to carry on their responsibilities in a supervised situation.’75 From 1990, the facility was known as the Sturt Community Unit.

Allegations of sexual abuse

One PIC alleged she was sexually abused while she was a resident in the Marion Units.

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73 Adelaide Kids Shelter, Little Para House, Norwood Youth Shelter, St John’s Shelter.
75 DCW annual report 1975, p. 5.
Chapter 3 Allegations of sexual abuse

Abuse by staff

The PIC was nine when placed in State care in the late 1960s until she turned 18. Her SWIC indicates she was placed in care for a criminal offence; departmental records also indicate concerns that she was neglected. She told the Inquiry she was sexually abused by two family members before being placed in State care, and that she was sexually abused while in State care at Davenport House and then the Marion Units.

In the mid 1970s, the PIC lived at the units for about two years in her teens after the breakdown of a short placement with her family. She lived in a two-bedroom flat that she usually shared. In the units, she said, ‘the boys were ratbags’ and ‘were not people that I’d sort of had much to do with’. She ‘kept to myself pretty much’.

After living in the units for a year she alleged sexual abuse by a male worker on separate occasions. She recalled that she visited him in his office ‘all the time’ to talk to him; on one occasion he had sexual intercourse with her in the nearby staff bedroom. She was surprised but ‘I felt like it was almost expected’. After this incident she ‘used to still visit and talk to him’ but ‘I might have been a bit wary and didn’t get too close’. She said the man was no different in his behaviour towards her after the incident, although ‘he did say something like, “Well, I’m sorry” — something like that’. The PIC described the worker’s actions as ‘irresponsible’. She felt she couldn’t trust people, ‘and I still don’t’.

The PIC told the Inquiry that soon after the incident, another male worker in his 30s had sexual intercourse with her at the units, and she told him the same thing had occurred with the other man. She recalled that ‘it was a bit demoralising for me anyway’ but said this worker laughed and commented that he ‘wasn’t the first’. She said she felt ‘guilty afterwards’ that she hadn’t rejected both workers’ advances because ‘I was not in a very strong position emotionally’. She never told anyone at the time about this abuse.

After leaving State care, the PIC told the Inquiry, ‘I don’t think I had a very good opinion of myself at all’. In giving evidence she said, ‘All I really wanted for myself was just to be able to talk to somebody that would listen, because I haven’t had it’.
## 3.3 Residential care units

### History

### Summary of residential care units allegations

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History

Although the department’s accommodation of children since the 1960s had included smaller group care, the shift towards decentralising community residential care and creating flexible, smaller group care increased from the 1970s. New philosophies informed the way children in State care were assessed, cared for and accommodated. The belief that children were individuals with differing needs became the guiding principle in providing care and a process of ‘assessment, programming and evaluation’ was instituted, both before a child was placed in a residential care facility and during placements. Given the variety of facilities available by the 1970s — smaller group homes, hostels and larger institutions run by the government and non-government agencies — the department determined that assessment of each child’s needs was instrumental to the provision of appropriate residential care.

The department restructured residential care in line with this policy shift. Each of its administrative regions was to offer a similar group of facilities and services. Existing departmental cottages and hostels were closed or redeveloped and in some cases purpose-built residential care facilities were established. Each metropolitan region was provided with a regional admission unit for ‘short-term crisis care’, assessment and outreach facilities for teenage young offenders, and a regional group home for teenage young offenders who required ‘therapeutic care’.

Community units provided longer-term residential ‘care and support’ to a range of children in State care, such as young people remanded by the Children’s Court or those who the department deemed as being at risk. Some units catered for children in State care with severe behavioural problems. Longer-term units also assisted young people to ‘make the transition to independent living where appropriate’. Although the range of types of units increased, the number of available placements did not.

By the mid 1980s the department had fewer available residential care alternatives for children. This was the result of changes in the late 1970s, when the department developed ‘custodial, intermediate and non-residential facilities designed to match the needs and characteristics of each child’. For example, the Intensive Neighbourhood Care (INCO) scheme trained families to provide specialised foster care for young offenders assessed as being suitable for non-residential care.

The department also encouraged non-government providers to close down large institutions and offer cottage or foster care. As a result, the availability of placements for children requiring residential care diminished — and some children were placed in inappropriate facilities. A report commissioned by the department expressed concern at the long-term housing of children in units designed for short-term accommodation, the ineffectual results of the units in treating behavioural problems, high absconding rates and the units’ high operating costs. Concerns were also raised that ‘difficult’ children were placed in admission units with offenders. Further reviews observed that children placed in units persisted in ‘difficult behaviour’, that younger children were exposed to older children’s ‘at risk behaviour’, that there was a lack of stability for children entering departmental units, and that units were ‘dumping grounds’ for children.
3.3 Residential care units

During the 1990s, purpose-built community units at Campbelltown and Enfield, and assessment units at Gilles Plains and Sturt, began operating.13 Other existing units were relocated, for example the North Adelaide Community Unit moved to a new facility at Regency Park.14 Problems of insufficient placements in foster and residential care continued in the 1990s: children as young as eight were sometimes placed in units and young children were placed with older residents, including some who may have committed sexual offences.15 Six residential units operate today (two assessment units and four community units).16 In 2004 the department received approval to establish 10 transitional accommodation houses, designed to house hard-to-place children. According to a recent history of the department, staff are trained to manage child perpetrators of sexual abuse in smaller group units and to assess residents’ behaviour for signs they are being threatened.17

Summary of residential care units allegations

Eighteen people alleged that they were sexually abused during their placement at a residential care unit. Of these, 17 were in State care at the time of the alleged sexual abuse, according to available records. The Inquiry was unable to determine whether one man was in State care because of the destruction of departmental files. Three people said they were abused in more than one unit. The allegations included anal rape, digital rape, unlawful sexual intercourse and acts of gross indecency. Alleged perpetrators included staff, other residents, sanctioned visitors to the units and unknown people encountered by the PiCs away from the units.

16 Ibid., p. 36.
17 Ibid., p. 37.
History

The Gilles Plains Community Unit operated from 1979 to 1990 as an open unit for school-age boys from Brookway Park, a secure-care facility for boys aged nine to 15 years. The unit provided long-term accommodation for up to eight boys considered capable of living in the community, although in 1982 the average number of residents was five. Five residential care workers staffed the unit, which was managed by a senior residential care worker. The unit operated under the department’s Services for Young Offenders, Central Northern Region. In 1992 a new facility, the Gilles Plains Assessment Unit, was built at the same address. The unit, which still operates today, provides short-term emergency care.

Allegations of sexual abuse

Nine people gave evidence to the Inquiry about being sexually abused while living at the Gilles Plains community or assessment units between the 1980s and the early 2000s. Of those, eight were children in State care at the time of their alleged abuse. The Inquiry was unable to determine whether one person was in State care due to the destruction of departmental files. Their allegations included anal rape and indecent assault. The alleged perpetrators included staff, sanctioned visitors and unknown people encountered by the PICs when away from the units.

Abuse by multiple perpetrators

A PIC was placed in State care at the age of 12 in the late 1980s when a court found him to be uncontrollable. The PIC’s records show a history of family instability; his mother refused to have him home due to his offending. The PIC spent time in government admission units, foster care and secure care. He was directed to reside in Gilles Plains when he was 13, after previous care placements had broken down. The PIC spent eight months in the unit, during which he absconded about 10 times and was remanded to secure care on several occasions. The PIC told the Inquiry that he was physically and sexually abused while at Gilles Plains. He alleged that a staff member disciplined him by using physical violence. A departmental report written during the PIC’s time at Gilles Plains refers to an ‘incident with one of the staff where excessive force was alleged. This matter has been resolved.’ No details are given about the identity of the worker or the circumstances. The PIC said: ‘The very first time I tried to commit suicide was at Gilles Plains’. He said the same worker who had physically abused him found him after the suicide attempt. The worker ‘called me an idiot and threw me on my bed and told me not to be stupid’.

The PIC told the Inquiry that a residential care worker ‘used to come in the shower and ask me if he was able to wash me down’. The PIC let the man do so: ‘I was a kid. I didn’t know what to think of it.’ He said the worker washed his entire body ‘on many occasions’. Once, the PIC developed an erection, which he found embarrassing. The PIC absconded from the unit as a result of the unwanted attention from the worker. He went to the city and was approached by a man who, he believed, operated a city nightclub. He said:

I was scraggy and stuff because I’d been on the streets for a couple of days, because I ran away from Gilles Plains group home, and he just gave me some money one time and then told me … ‘go and get something to eat and if you need anything else, come back and see me’.

The man later allowed the PIC to sleep in rooms above the nightclub and ‘he told me I had to go in through the back way because, you know, if anyone seen him letting a kid up there he’d lose his licence’. The PIC stayed in these rooms and remembered that ‘things started happening’. He alleged that the man performed oral sex on him and forced him to reciprocate. The man attempted to forcibly

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18 Children and youth under institution care, Appendix 1 ‘Services for young offenders in South Australia’, p. 3.
19 DFACS annual report 1991–92, p. 19, notes the completion of the Gilles Plains Assessment Unit.
3.3 Residential care units

The PIC told the worker at Gilles Plains who had sexually abused him about the abuse he suffered at the hotel, and the matter was reported to police. The departmental records indicate that the police conducted a full investigation and the man was arrested and charged. The department referred the PIC to a psychiatrist, who put him on medication. He was also referred for medical tests and counselling.

The PIC said he could not go ahead with the charges against the man because he was terrified of him. He told the Inquiry that he

... would get on a train ... and turn around and he'd be standing there watching me ... with a real aggressive look on his face ... I didn't know if he was going to kill me or anything, and I knew what I was doing to him. He lost his [business] and everything. The Welfare should have put me under some sort of protection or something back then.

The departmental records provided to the Inquiry indicate that police did not proceed with the charges because the PIC was unwilling to take any part in the proceedings, and because of concern for his welfare.

A man alleging abuse by staff at Gilles Plains Assessment Unit was first placed in State care in the early 1980s when he was 11, after a family breakdown. He was placed in emergency foster care for about a month and also made allegations of sexual abuse during this period. Two years later, he was charged as being in need of care and placed in State care until he reached 18. The PIC said he was also sexually abused during a placement with his family and also when absconding from placements.

The PIC lived at Gilles Plains for about eight months when he was 13 and said he was sexually abused within a month of arriving. He said a residential care worker aged in his late 40s gave him back tickles and hugs. The PIC said he enjoyed the attention, having experienced very little affection as a child. He said the activity progressed to kissing, with the worker inserting his tongue into the PIC’s mouth. He said the worker performed oral sex on him in the unit’s living area four times. On some of these occasions, he also masturbated the PIC and digitally penetrated his anus. In return, the worker would give the PIC cigarettes, and tell him that he loved him and would look after him. The PIC said the sexual abuse occurred when the worker was on night duty.

He said the worker also took him to his rural property at least four times, where he also sexually abused him, and that the visits were ‘getting more frequent towards the end’ of his time at Gilles Plains. He told the Inquiry that the worker warned him to keep silent about what was happening:

He basically said that, ‘No-one’s going to listen. Don’t tell anyone,’ or I wouldn’t like what would happen after that. Children like me can go missing very easily. ... [The worker] knew I didn’t want to [but] I was scared, so I just gave in.

The PIC told the Inquiry that a man known to the department, who visited the unit and took boys out, also sexually abused him. This man ‘wasn’t a staff worker there; he was just sort of what they’d call a friend to the unit. In other words, he’d come and take us for outings’. The man took the PIC and other boys on several outings and to his home. On the first weekend the PIC stayed at the man’s house with another resident and slept on the couch; the man came out of his bedroom during the night and rubbed the PIC’s back, telling him how much he liked having him around. The PIC was suspicious of this behaviour, having been abused previously: ‘I knew what it was leading up to’. On subsequent visits to the man’s home over a period of months, the PIC said, the man forced him to perform and receive oral sex and raped him digitally and with his penis. The PIC was the only visitor to the home on these occasions. He alleged that the abuse happened on each visit.
The PIC informed the Inquiry that he absconded from the unit for several days as a result of the sexual abuse. He said he did not tell anyone what had happened because of the pressure placed on him by the alleged perpetrator, who told him:

‘You don’t want to cause me any dramas’ because he could have one of a number of things happen to me. That really scared me; scared me to the point where I just … yes, back then I thought I wouldn’t tell anybody.

In the late 1990s, a court placed a PIC, then 10, in State care until he turned 18. His mother had struggled to care for him due to his difficult behaviour. The PIC had multiple foster care placements before being at Gilles Plains Assessment Unit, where he alleged he was sexually abused in the early 2000s.

The PIC lived at the unit for three periods over 2½ years, when aged 11 to 13. He told the Inquiry that he liked Gilles Plains initially. ‘I was okay for three weeks, then trouble started and then things just went wrong.’ The PIC said that other residents sexually abused him, which included performing oral sex on, and masturbating, each other.

He also told the Inquiry that he absconded repeatedly, going to the city and suburban shopping centres. He would make the casual acquaintance of various men at these times and often had sexual intercourse with them. ‘I just started to give my body away whenever I used to get depressed.’ The abuse had occurred in public parks, in cars and at men’s homes. Occasionally he had received money for sex. He said he sometimes reported this activity to staff at the unit.

Departmental records indicate staff counselled the PIC about why he was continuing to put himself at risk and the dangers involved. A departmental report on the PIC’s absconding and sexual activity noted that he had a history of ‘inappropriate sexual behaviour, consequently the potential for an incident like this has always been considered as highly possible’. The report noted that the behaviour management plan devised for the PIC aimed to ‘minimise his vulnerability without completely denying him the freedom to participate in age-appropriate activities in the community … In response to this incident, the care plan will be revisited.’

The PIC had just turned 13 when he reported sexual abuse at a swimming pool while on sanctioned leave on two consecutive days. Unit staff took the PIC to a scheduled activity at the pool and left him alone until collecting him at the end of each day. On both days a man performed oral and anal sex on the PIC and masturbated him in a toilet. The PIC performed oral sex on and masturbated the man. The PIC reported the abuse to staff at Gilles Plains, who contacted police. As a result, the man was convicted and jailed on four counts of unlawful sexual intercourse.

The PIC also named a residential care worker, known as ‘a respectable staff member’ who he said ‘had a sexual thing with me’. He said the abuse ‘didn’t start for quite some time’ and that it occurred on three occasions over a six-month period. Information provided to the Inquiry from the department suggests that the abuse occurred towards the end of the PIC’s time in the unit, when he was 13. The PIC said the worker had visited his room at night and the two had talked, which progressed to sexual contact. The worker had ‘taught me things I didn’t know’. They had performed oral sex on one another and masturbated one another. The PIC said the worker had been worried ‘he’d get in trouble and lose his job. I didn’t want him to lose his job because he was really good at it’. The PIC said he considered the worker to be kind and caring towards him and other residents and he had felt guilt ‘that I had let it happen, that I shouldn’t have’.

The PIC did not report the abuse at the time. However, it ‘did stick with me for quite some time’ and he reported it two years later, when he was a resident at another government unit. He said the allegation was reported to police who told him that his word was the only evidence. The PIC said the department had indicated its willingness to investigate the allegations and he had remembered that two departmental investigators had spoken to him. He said he had not been informed of the outcome.
The department’s report of the internal investigation could not substantiate the PIC’s allegations because he refused to be interviewed by police. It also referred to a lack of any independent witnesses, the delay in making the allegations, the lack of any physical evidence and the alleged perpetrator’s denials. The report recommended an increase in the number of residential care workers on night shift at units, as ‘this would assist in ensuring a prompt response to critical incidents etc. and assist with the timely supervision of staff in isolated situations’.

In addition to Gilles Plains, the PIC alleged sexual activity with other children in the Sturt Assessment Unit, Campbelltown Community Unit (Cornerways) and the Regency Park Community Unit. He said that he was sexually abused repeatedly after absconding from Cornerways and Regency Park, when he would frequent a city park and engage in anal and oral intercourse with men he did not know. He did not provide details about these incidents.

**Abuse by staff**

One PIC was placed in State care at the age of seven in the mid 1990s, after a court found her to be in need of care. She had experienced physical and sexual abuse and neglect in her family. She told the Inquiry she was sexually abused in foster care, at Lochiel Park and then at the Gilles Plains Assessment Unit.

The PIC lived at Gilles Plains for a year in the early 2000s when she was 16, and said a departmental worker sexually abused her there. She described the worker as a ‘jackass’ who ‘used to do sexual stuff to me … He used to come and sit next to me in bed and try rubbing me all over’.

The PIC described how the worker touched her breasts and groin area and ‘used to try and get my hand and put it on his—thing’. She said his visits to her bedroom lasted about 30 minutes each time and occurred ‘quite often. He was known for it with me’. The PIC said there was only one worker on the night roster. At the time, she did not disclose the abuse, believing ‘there was no point in us saying anything’.

The PIC told the Inquiry that she self-harmed almost daily while she lived at Gilles Plains.

*I hated him with a vengeance … sometimes I would cut just before night shift, if I knew he was on night shift, so I could get away from him, so I could get away from that hurt.*

She said:

*Every kid in the units are scared shitless of those workers, are scared of those workers because if the workers do anything, who’s going to believe a self-harmer? Who’s going to believe someone who runs away, who’s violent—against a youth worker who’s paid to care and love us and look after us and be there for us? Who’s going to believe that? You think about it. Who’s going to believe us? That’s the thing in care. No-one believes you, so you run away.*

An Aboriginal PIC alleged she was sexually abused at Gilles Plains Assessment Unit when aged 14 in the late 1990s. The PIC told the Inquiry she had experienced physical and sexual abuse in the family home before she was placed in State care. After receiving a series of child protection notifications relating to physical abuse, the department placed the PIC into emergency foster placement when she was 11, with her mother’s consent. The PIC was later placed under a 12-month order while attempts were made to reunite her with her immediate family. When these failed, she was placed in State care when aged almost 14 until age 18. The PIC alleged she was also sexually abused in foster care and at Sturt Assessment Unit. She alleged a male relative, whom she sometimes stayed with when she absconded, sexually abused her.

The PIC recalled that three girls and between three and five boys were living at Gilles Plains, each with a single room. A note on the PIC’s residential care file refers to her previous sexual activity and advises staff that she is at risk with the young males in the unit.

The PIC said a male residential care worker befriended her and left cigarettes in her room when she ran out, which
was against the rules. When the worker was on night shift he would go into her room and, ‘after the first couple of weeks being there’, this contact had became sexual. She said the male worker initiated sex in her room and in the unit’s living areas: ‘He used to wake me up and have sexual intercourse, get me in the lounge, saying, “Come on, the kids are asleep. Let’s go and watch cartoons.”‘ The night residential care worker was the sole staff member on duty. She said it occurred ‘whenever he was on night shift’. This worker ‘asked me not to do anything to ruin [his] career’. He subsequently ceased his employment at the unit but maintained contact with her, a fact confirmed by departmental records. The PIC said the former worker left letters and cards that contained poems ‘at my window’.

The PIC alleged that another male worker at Gilles Plains made sexual advances to her while she lived in the unit. She said he attempted to kiss her on one occasion and later he came to her room to apologise. Over time, this worker went to her bedroom when he was on night shift and woke her up. He touched her and this gradually escalated to penetration, which occurred in her bed.

    I know on one occasion [the worker] was up to no good [another resident] had stuck his head over the glass in the door and seen what was going on and done nothing.

The PIC said that the unit’s staff became aware of her contact with these workers. She said another resident observed her outside the unit, holding hands with the first worker. As a result, a senior member of staff ‘pulled me aside in a little discussion and asked if the worker was doing anything and I said, “No.” I’d say “no” about everyone’.

The department’s records show that unit staff, in conjunction with the department’s nearby district centre, initiated an internal investigation about three months after the PIC’s arrival at the unit. Other residents were interviewed and provided information about the PIC’s meeting with the first worker outside the unit, after his employment had ceased. Records show an investigator repeatedly tried over five days to contact the former worker, without success. The investigators interviewed the PIC, who denied any sexual relationship with the former worker, denied knowledge of the circumstances under which he had ceased employment at Gilles Plains, and denied maintaining contact with him after he had left.

The department investigated the second worker mentioned. Allegations included that this worker provided cigarettes, alcohol and marijuana to the PIC and showed her preferential treatment. The department’s investigators interviewed the PIC, who denied having anything other than a ‘normal’ relationship with the worker, although she confirmed that he gave her cigarettes. The staff member was also interviewed. He said he supplied her with cigarettes to avoid her placing herself at risk by going to local hotels to obtain them but denied supplying her alcohol and marijuana or making any sexual comments to, or in reference to, her. The investigators assessed that both the worker and the PIC denied all allegations and concluded that the PIC ‘needs closer supervision and monitoring of her behaviour’. The Inquiry received files that detail disciplinary action against this employee while he was in the department’s employ.

About a month after the investigation, the unit’s records show the PIC disclosed to staff that an [ex-department worker] has come to her window several nights and has left her cigarettes and a card stating he loved her’. The records show contact at this time between the PIC’s social worker and unit staff, who ‘raised major concerns about an ex-staff member hanging around and allegedly having contact’. The PIC absconded from Gilles Plains for about four months and lost her placement at the unit. Records show the department requested the ex-employee to cease his contact with residents of government admission units. The files show the department had earlier taken action against the then staff member relating to his conduct while at the unit.

The PIC said she felt ‘ugly’ at Gilles Plains and that once the abuse had started she “felt like I might have done something just to bring it on myself”. Of her motivation for coming to the Inquiry, she said: ‘I wasn’t after payments or anything or suing anyone so
much, but more just to stop them before they do it to another person’.

The Inquiry received limited records relating to a man who alleged he had been sexually abused at Gilles Plains in the 1990s—the department advised that his client files were destroyed by fire. It was not possible to verify that the PIC was placed in State care under any court orders. However, the Justice Information System (JIS) indicates that the department was involved with the PIC through child protection matters from the age of 14. The JIS also refers to his departmental social worker and placement at the Gilles Plains unit. The PIC told the Inquiry that he was sexually abused at the unit, in foster care, at the Magill Training Centre and when he lived on the streets. The PIC estimated that he was at Gilles Plains between two and four weeks, and in that time a night worker who was rostered to sleep at the unit sexually abused him. He recalled that the abuse happened on about five or six occasions. The alleged perpetrator would enter the PIC’s bedroom, which was at the end of the residents’ rooms, and ask if he was awake. He would then force the PIC to perform oral sex. The PIC told the Inquiry he did not tell anyone about the abuse...

... because I thought they were the department and they wouldn’t believe you because they worked for them. So it didn’t matter what you said to the department. The department didn’t care. They were all workers. I think you had some of the workers what did care but when they would discuss it, well then they knew they were just bashing a brick wall.

The PIC suspected he was not the only resident who was targeted, as he occasionally overheard residents asking one another if the worker had visited their rooms the previous evening.

Abuse by other residents

A man born in the late 1960s was placed in State care by a court on a three-month order when he was 12 because his parents were unable to control him. He had already been exposed to the effects of alcohol abuse, severe family dysfunction and breakdowns in home and schooling. He was then in State care over various periods for the remainder of his childhood.

The PIC lived in government admission units, foster care and secure care. He alleged that he was also sexually abused at the Gilles Plains Community Unit, the South Australian Youth Training Centre (SAYTC) and in one foster care placement.

The PIC was admitted to the Gilles Plains unit in the early 1980s after breaking a bond by truanting from school. His departmental records note that the placement was intended to ‘modify his behaviour and get him to attend school’. He was released after six months to his family but was readmitted a month later after a family breakdown. The PIC then alternated between his family home and the unit. The PIC’s placements at Gilles Plains spanned a period of about 10 months, before he was transferred to a secure care institution when he was 13.

The PIC said that his initial impression of Gilles Plains was positive, but that he soon wanted to leave. He said other residents physically assaulted him as a form of intimidation and punishment when he did not comply with their demands, and that on one occasion a male resident came to his bedroom, locked the door and raped him. The PIC could not remember the alleged perpetrator’s name. He said he told his community welfare worker he was unhappy at the unit and that his worker made efforts to arrange foster placements for him. He told the Inquiry that he absconded regularly from Gilles Plains.

Departmental records confirm that the PIC was a regular absconder and that efforts were made to place him into foster care from Gilles Plains. Records note that he was a cooperative and ‘compliant’ resident at Gilles Plains and that he was often influenced or dominated by those around him.

Abuse after absconding

A man who alleged sexual abuse after he had absconded from the Gilles Plains Community Unit was placed in State care aged 13 in the mid 1980s, after being found by a court to be uncontrollable and at risk. He told the Inquiry that he was also sexually abused at Slade Cottage and while living on the streets during the time he was in State care.

The PIC said that when he was at Gilles Plains in the mid 1980s about eight residents were able to come and go
from the unit with relative freedom. He said he had never attended school, but instead frequented amusement parlours. ‘They could drop you off at the school, but they couldn’t make you actually walk through the gate.’

The PIC told the Inquiry that on one of his days away from the unit he went to a beachside suburb and was offered a lift by a man in a car. The man drove around and the PIC recalls that he reached his hand over and

... started putting it in my lap, all that sort of stuff, and, like, [I was] freaking out, you know, and drove around the corner, and before I knew it, he pulled my T-shirt over my head, pulled my strides down and …

He said the next thing he recalled was being raped in the back seat of the man’s car. He told the Inquiry that he did not tell anyone about the abuse at the time because he was ‘too embarrassed’. He said that at the time, he ‘just forgot about it. There was nothing I could do that would change anything.’ The PIC said that the rape affected him. ‘Normally before it was like this, and oh, yes, fun, and like this, and then that happened, and everything’s not fun and games.’

A PIC who alleged he was sexually abused at Gilles Plains Community Unit was first placed in State care at 13 in the early 1980s. He was placed under a short-term guardianship order because of a ‘long-standing behaviour problem’, according to his SWIC, and was initially placed with his family. When he was 14, the PIC was deemed ‘in need of care’ and placed under the guardianship of the Minister until he reached 16. He told the Inquiry that he was sexually abused when he absconded from the Western Region Admission Unit and Gilles Plains, and later when he absconded from foster care.

At 14, the PIC was placed in Gilles Plains several times over about eight months. He said the residents would smoke in a shed on the property. He said occasionally male residents would masturbate in the shed and the senior residential care worker ‘used to get off looking through the keyhole’. The PIC alleged:

My first instance of sex in that place was, I was asleep in my bed and I woke up about two o’clock in the morning and … found [an older boy] on top, sucking me off, just as I was waking up.

The PIC said he absconded regularly from Gilles Plains and would frequent city hotels and clubs. He said one venue had buzzers that were triggered when police entered. ‘All the street kids would go vroom, disappear into the dark corners.’ He said one venue was ‘corrupt’ and police received money from the owner. The PIC said that one police officer encountered him in this club and ‘rammed his dick down my throat’ in the back-of-house area.

He told the Inquiry he attended parties in Adelaide suburbs with men and boys. ‘Most of the time it was … being fed alcohol and pot and stuff.’ He said that during his time running away from Gilles Plains he became involved in sexual activities with men and drug-taking. He told the Inquiry: ‘I have too many nightmares. I can’t get away from my nightmares. I have too many.’

Hay Community Unit, 1979–88

History

Hay Community Unit opened in 1979 at Rowells Road, Lockleys, on the site of the former Hay Cottage, which closed the same year. The unit had its origins in the Elizabeth Grace Community Unit, which was moved from North Adelaide to Lockleys and renamed the Hay Community Unit.

Departmental records show that by 1980 the unit had been renamed the Western Region Admission Unit, although the Hay Community Unit was listed in departmental annual reports after this date. Available records suggest that the Hay unit was moved to Mile End in 1983, when the Western Region Assessment Unit opened at the Lockleys site.

The department described the Hay centre as its unit for adolescent girls, which provided ‘care, support and guided development’ for young offenders who did not require

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20 DCW annual report 1979, p. 79, shows Hay Community Unit as still being at Lockleys; annual report 1980 shows both Western Region Admission Unit and Hay Community Unit in existence but no addresses are provided—this is still the case in annual report 1986–87, p. 74.
The unit catered for a maximum of six girls aged between 14 and 18, although the average number of weekly residents sometimes fell to two. The unit was managed by a senior residential care worker who reported to the supervisor, Services for Young Offenders, Central Western Region. Six residential care workers were on staff.

A 1983 departmental report described the Hay unit as a place for girls who were ‘emotionally disturbed, self-destructive, violent and runaways’. This report described residents’ self-abuse, promiscuity, truancy, habitual absconding, minor offending, low self-esteem and high vulnerability. Hay developed a reputation as the ‘end of the line’ before secure care, and residents considered extreme behaviour to be the norm rather than the exception. In 1989 Hay’s residents were relocated to the facility at Sturt known then as Marion Flats.

Allegations of sexual abuse

One woman told the Inquiry that she was sexually abused during her placement at the Hay Community Unit.

Abuse by multiple perpetrators

The PIC was first placed in State care by a court in the mid 1980s, aged 14. Her SWIC notes that her mother was unable to control her. After several short-term guardianship orders, records indicate that the PIC was found to be in need of care and was placed in State care until the age of 18. The PIC told the Inquiry that she was sexually abused at the Western Region Admission Unit and then at the Hay Community Unit.

The PIC spent seven months at the Hay unit when she was about 15, during which time she said she had a sexual relationship with a man who was about 35. The PIC said she let the man into the unit through a window at night; on one occasion staff found out and called the police. A report in the PIC’s client file mentions that the PIC refused to cooperate with police and that the unit’s security was inadequate.

The PIC also told the Inquiry that a residential care worker at the unit raped her one night in the staff bedroom. She had gone to his room and asked for a condom. She said that the worker counselled her to avoid sexual activity and that ‘he grabbed the condom, that’s when he grabbed me and put me down. I thought he was just going to give [the condom] to me.’ Instead, she said the worker ‘grabbed me, put me on the bed, held me down and he raped me’. The worker was alone on the shift. The PIC absconded and went to the city ‘and just wiped myself out ... That was a pretty bad night.’

The PIC alleged the same worker raped her again some days later. The worker allegedly told her that if she disclosed the rape she would not be believed and that any disclosure would complicate his personal life. She was intoxicated.

I remember going off at him and I remember him slapping me and [he] pushed me on the bed … and this time he didn’t even bother with a condom ... I just remember walking out of the room.

The PIC said she absconded again.

She alleged that she disclosed the rapes to two members of staff and was assured that her allegations would be investigated. According to the PIC, some investigation was made, but she suspected that ‘they wanted it swept under the carpet as quick as possible’. The PIC’s client file contains a child protection notification on the incident and an internal report. The report states that the ‘C.W.W. [community welfare worker] did not persue [sic] specific information re: abuse as [the PIC] was considerably angry at having to relate the incident several times’. The report notes that the PIC and unit staff were interviewed and the staff liaised with police. The PIC refused sexual assault counselling and a medical examination, and the allegations were recorded as ‘unconfirmed’.

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22 Children and youth under institution care, Appendix 1, p.3.
24 ibid., Appendix J.
The PIC stayed at the Hay Community Unit for a short period after these events, “but I caused that much trouble that they got rid of me. They didn’t get rid of him’. The PIC became increasingly violent at the unit ‘because none of them believed me and I’d just had enough. I was crying out for help and none of them would help’.

Clarence Park Assessment Unit, 1989-90 – 91-92

History

The Clarence Park Assessment Unit opened in 1989–90 on the site of the former Southern Region Admission Unit at Clarence Park. It provided short-term accommodation to children in State care while their residential and care needs were assessed. The unit closed in 1991–92 and its functions were transferred to the Woodville and Sturt assessment units.

Allegations of sexual abuse

One man gave evidence to the Inquiry regarding sexual abuse during his placement at the Clarence Park Assessment Unit.

Abuse by outsiders

One PIC was first placed in State care at the age of eight in the late 1980s. He was initially placed on several short-term guardianship orders and then placed under the guardianship of the Minister until he turned 18. According to his SWIC, his family was unable to cope with his behaviour. He told the Inquiry that he was sexually abused at Clarence Park and later at Lochiel Park. The PIC lived at Clarence Park for two years from the age of eight. He recalled absconding from the unit and going to the city numerous times. The department’s records confirm that the PIC absconded from Clarence Park at least 12 times. He said he would go to Veale Gardens in the city to prostitute himself for money. He alleged that men frequenting the gardens approached ‘on foot and [in] cars. They would park their cars inside [the gardens] or outside and walk through.’ He alleged that a ‘few times’ one frequent visitor to the gardens ‘forced me into the car and I tried to run away’. The visitor also had asked the PIC to...

... get other boys for him and he’ll pay me money and I say to him, ‘No, I don’t want to do that because I can get into trouble for it’.

The PIC said he frequented Veale Gardens for a short period and believed it was not a very nice place. ‘That’s why I stopped going there.’

The PIC said that on another occasion he had been in the city alone when a man he did not know attacked him. The PIC’s recollection of the event was incomplete but he alleged that he had been anally penetrated and taken to hospital. The Inquiry obtained records from an Adelaide hospital that confirm his attendance and medical examination for allegation of sexual assault.

The department recorded the PIC’s disclosure and his examination at the hospital. The PIC’s file notes show that the department’s Crisis Care unit workers attended with the PIC at the police station. His file reads, “[the PIC] did not appear (outwardly) traumatised by incident according to staff at unit”. The PIC’s social worker was to follow up with the hospital’s Child Protection Services unit and was to receive a Crisis Care report on the incident.

Northern Region Admission Unit, 1979–90

History

The Northern Region Admission Unit opened at St Peters in 1979 on the site of the former Stirling Cottage. It offered short-term accommodation for up to eight children. A program was developed for each child, in consultation with the child, his/her community welfare worker and unit staff. In the early 1980s the unit was moved to Enfield. It was replaced in 1990 by a purpose-built unit on an adjoining property, which became known as the Enfield Community Unit.

27 Information supplied by Families SA, 4 May 2005, via email.
Allegations of sexual abuse

One man alleged that he was sexually abused while in State care and living at the Northern Region Assessment Unit.

Abuse by other boys

A PIC was placed in State care in the late 1970s when he was 11 because he was running away from home and school. The Northern Region Admission Unit was his first placement until other accommodation could be found. For almost six months he moved between placements at the unit, Slade Cottage and the South Australian Youth Remand and Assessment Centre (SAYRAC). He alleged he was sexually abused at all three placements and, later, the South Australian Youth Training Centre (SAYTC), where he spent time for offending.

The PIC remembered that most other residents at the Northern Region Admission Unit appeared to be about 16. During the months he lived at the unit, the PIC said he was held down and digitally raped by these older residents, one of whom he named.

Southern Region Admission Unit, 1979–90

History

The Southern Region Admission Unit opened on the site of the former Clark Cottage at Clarence Park in 1979. It provided emergency care for up to eight children aged 10–17. The department’s 1982–83 annual report stated that these children were those ‘whose behaviour or situations are such that they cannot remain at that time in their own homes with their families’. In 1989–90 the admission unit became the Clarence Park Assessment Unit.

Allegations of sexual abuse

One man gave evidence to the Inquiry about sexual abuse while he was placed at the Southern Region Admission Unit.

Abuse by multiple perpetrators

The PIC was first placed in State care aged 13 in the early 1980s, when his parents had trouble controlling his behaviour. The PIC was placed under several short-term guardianship orders and detention orders between the ages of 13 and 17. He was placed in government admission units, cottage homes, foster care and secure care, and also with his family. The PIC alleged he was also sexually abused at a foster care placement.

The PIC was sent initially to the Southern Region Admission Unit for two weeks in the early 1980s to give his parents respite. He stayed at the unit for two subsequent periods of about one month each in the next two years. The PIC recalled being placed in the unit:

‘I remember walking up the street and there was a strange car in the drive … and I wasn’t allowed in the house … the next thing I knew I was living in the unit’.

He told the Inquiry he was at the unit for only a few days before a worker sexually abused him. The PIC said most of the other residents had been on a weekend outing and he could not afford to go. The worker had discovered the PIC smoking, which was forbidden, and searched his clothing for cigarettes. As part of the search, the PIC said he was ordered to strip and place his hands in front of him on a table. He said the worker stood behind him and began masturbating while the PIC was naked. ‘I had no idea what was going on … I knew it was weird. I knew it was strange.’ The worker ejaculated on the PIC’s back and the PIC realised ‘he’s had a wank while I was bent over … he never rooted me but, yes, the dirty bastard had a wank on me’.

The PIC told the Inquiry, ‘I never brought up nothing’ about this incident with unit staff or with his social workers. He remembered that at the time he was not angry. He said, ‘It was more fear. It was more embarrassment … Not being able to say, knowing it was wrong and knowing that, what the hell is going on here?’ When the Inquiry asked how the

incident affected him at the time, the PIC said, ‘I knew my life had gone to shit at that moment’. He said the worker had continued to be employed at the unit but the two had not interacted during the PIC’s later placements there.

The PIC gave evidence that he absconded repeatedly from placements, including from the Southern Region Admission Unit. When he absconded he visited hotels in the city and occasionally prostituted himself for money. He described a small group of children, some in State care, who sold themselves for money in city hotels. By the time the PIC was 15, he was recruited into a network of underage prostitutes. He said: ‘I had a beeper … I would be in boys homes and my beeper would be going off at the table, you know? No-one said nothing.’

He said prices were fixed depending on ‘how [the operator] sold us’:

> If we were underage and we were—it depends what kind of person. Like, we could come home some nights with five or six hundred dollars after a couple of hours or we could come home with two or three hundred dollars.

He was sent to men’s homes and to parties. He said that couples attended the parties but ‘people left and things changed as nights went on. Drugs would come out. Things would happen … that’s when these parties used to take ugly little turns.’ He said he was given drugs at these parties; he recounted one episode where two men at a party anally raped him, tied him up and then physically assaulted him. As a result he required medical attention at an Adelaide hospital. Hospital records show the PIC was seen, but do not give treatment details.

He said he was truant from school, in and out of institutions, shoplifting and in trouble with the police. He said he prostituted himself to survive before he became an adult.

The PIC said he wanted ‘to have a normal house, normal life … I just want to be the bloke who lives next door. I want to mow my lawns on a Sunday morning …’

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**Central / Western Region Admission Unit, 1979–86**

**History**

The Central Region Admission Unit opened in 1979 on the site of the former Reception Cottage at Somerton Park. Its name was changed to the Western Region Admission Unit in 1980, although in several departmental documents it is referred to as Central / Western. The unit was moved to Lockleys in 1983 and closed in 1986.

**Allegations of sexual abuse**

Two people gave evidence to the Inquiry about being sexually abused while placed at the Western Region Admission Unit.

**Abuse by staff**

A female PIC was placed in State care in the mid 1980s, aged 14, after her mother had difficulty controlling her behaviour. The PIC told the Inquiry that she was sexually abused at the Western Region Admission Unit and later at the Hay Community Unit.

The PIC’s first placement was in the Western unit, where she stayed for three months. The PIC said a male residential care worker sexually abused her within about one month and that she continued to have sexual intercourse with him for the rest of her stay. The sex occurred ‘three, four times a week, even on day shift’ and each time the worker was on night shift. The PIC told the Inquiry that on the first two occasions she objected ‘but then I was—what’s the point?’ She said that the sexual intercourse occurred in the staff bedroom and the unit’s living areas. On one occasion, the PIC said she was kneeling on the living room floor and the worker was in a chair. She had just finished performing oral sex on the worker when a female residential care worker entered the room. The PIC said, ‘[the worker] knew something happened, but she didn’t say anything. She just walked out’. The PIC did not speak to the female worker about the incident.
The PIC told the Inquiry she disclosed the abuse 10 years later to a departmental employee, who helped her make a statement to police. The PIC recalled that the police advised that they would not follow up the allegations due to the amount of time that had elapsed. The PIC said she contacted the department about the allegations. Her client files contain 1996 correspondence from the chief executive of the Department for Family and Community Services requesting advice from the Attorney-General on conducting a ‘full and impartial investigation into the matter’. The PIC provided a statement to a government investigation officer in the Attorney-General’s Department, a copy of which is on her client file. The PIC’s client files do not contain any other information that refers to the investigation or its outcome.

Abuse after absconding

A male PIC who alleged sexual abuse during periods of absconding from the Western Region Admission Unit was first placed in State care at 13 in the early 1980s. According to his SWIC, the PIC was placed under a short-term guardianship order due to his behavioural problems and was placed initially with his family. The court later placed the PIC in State care until the age of 16 as a consequence of his offending and family violence. He told the Inquiry that he was sexually abused when he absconded while at the Western Region and Gilles Plains admission units and also in foster care.

The PIC was placed at the Western unit for almost three months in the mid 1980s, when he was 14. He was again placed at the unit the following year, but regularly absconded. He said:

It was one of those places where, at nine o’clock in the morning they say, ‘Right, out you go’. Bang. So they put you with all the riffraff … and they expect you to come home at five o’clock without being in trouble, which is ridiculous.

The PIC told the Inquiry that while absconding he would visit city hotels and on one occasion he met a man with whom he began associating. He said that he was 14 when the man sexually abused him for the first time after he was invited to the man’s home. He alleged that:

[The man’s] usual routine … in the early days was get you stoned, get you drunk on wine. By the time you hit the spa bath … with the spa bath and the alcohol, you’re just totally off your face basically.

The man then had sexual intercourse with the PIC. The PIC said this abuse occurred repeatedly over an extended period. He said he stayed at the man’s home on several occasions when he absconded.

A lot of times I’d be on the streets, on the run or something like that, and I’d end up at [the man’s] place, you know, at night-time, nowhere else to go.

The PIC said that he also saw the man in his place of work, where on one occasion the man was ‘rubbing me up … and I swear that he got busted … and [the man] was really nervous about getting caught’.

The PIC said he became involved in prostitution during his second placement at the unit when he was 15. He alleged that another boy recruited him and took him to the city. He said ‘My first job down there … I didn’t know how to do anything, mate. A crash course is what they call it’. He prostituted himself whenever he needed money or shelter. He recounted several incidences, including going to a reputed paedophile’s house ‘for 100 bucks’ and performing oral sex on a man who reputedly frequented areas in the city where men met for sex. ‘These people … they’ll sit there all night long … Waiting and waiting and waiting.’ The PIC’s records show that his social worker advised the unit to discourage the PIC from associating with the youth who allegedly recruited him into prostitution and recommended that the PIC ‘be moved immediately (as soon as possible) to another admission unit in another area’.

Another man the PIC described as a businessman sexually abused him during this period. The PIC was doing it with ‘heaps of people … bloody surviving’. The PIC said he had previously rebuffed the man, who
3

Chapter 3 Allegations of sexual abuse

... used to cruise past all the time and like, ‘How about 30 bucks, man? How about 30 bucks?’ … I didn’t do it for money type thing. I wasn’t interested at that stage in my life.

The PIC said other boys warned him to avoid this man. The PIC did so until the point when, he said, ‘I had no choice, sort of needed the money; went to [the man’s home] for 30 bucks and a bag of dope’. He then stayed periodically at the man’s house when he had absconded from the unit and continued to have sex with him until he left State care. The PIC told the Inquiry that he did so for food and money only.

During the PIC’s later placements at the unit he was permitted to work for a local businessman. The PIC told the Inquiry that the man was involved in child prostitution and had attempted to indecently assault the PIC when he was 11 — another person had stopped that assault, saying ‘No, he’s too young yet’. The PIC said he stayed for a week at the man’s house and alleged the man masturbated in front of him and later persuaded the PIC to allow him to rub his penis against the PIC’s anus. The PIC said: ‘Once I had the weight of him on me, mate, I was pinned’. He said the man anally raped him. Another resident at the house interrupted them and, despite the PIC’s agitation, ‘didn’t do a thing about it’. The PIC’s departmental records show that his family expressed concern at his contact with the businessman. The PIC told the Inquiry that his social worker ‘knew all about’ the man. Records show the PIC’s social worker advised unit staff that the PIC was ‘not to work [for] or have contact with [the businessman]’. Unit records show that male residents made ‘sexual remarks about what they’d done with [the PIC]’, in her presence.

The PIC said a male resident raped her in her bedroom. ‘He just let himself in … He basically just had sex with me, let himself go, then walked out of the room apparently without the staff even realising.’ He told her ‘just to shut my mouth’. The alleged rape occurred during the day, when staff were at the unit. ‘I don’t think they really cared, if they did know.’ She absconded from the unit and was later transferred to another government community unit.

Allegations of sexual abuse

One woman told the Inquiry that she was sexually abused while placed at the Sturt Assessment Unit.

Abuse by another resident

An Aboriginal PIC told the Inquiry that she had experienced physical and sexual abuse before she was placed in State care. She came to the department’s attention in the mid 1990s, when she was 11 years old. Records show the department received several child protection notifications relating to physical abuse and placed her in emergency foster care. She was placed under several short-term guardianship orders until, aged almost 14 in the late 1990s, she was placed in State care by court order until 18. The PIC lived in foster care, and the Sturt and Gilles Plains assessment units. She alleged she was sexually abused in all those placements, as well as by a male relative, to whom she often ran when she absconded.

Departmental records show the PIC was placed for a month at the Sturt Assessment Unit when she was 13. The PIC described the unit as ‘pretty bad’ and her records note that the placement was ‘difficult’. The PIC told the Inquiry that male residents made sexual advances to her but she resisted them ‘because of the stories. I heard what they did to the other girls, you know.’ As a result, she was verbally taunted and became involved in several physical altercations with other residents. Records from the unit note that male residents made ‘sexual remarks about what they’d done with [the PIC]’, in her presence.

The PIC said a male resident raped her in her bedroom. ‘He just let himself in … He basically just had sex with me, let himself go, then walked out of the room apparently without the staff even realising.’ He told her ‘just to shut my mouth’. The alleged rape occurred during the day, when staff were at the unit. ‘I don’t think they really cared, if they did know.’ She absconded from the unit and was later transferred to another government community unit.

Sturt Assessment Unit, 1995–present

History

The purpose-built Sturt Assessment Unit opened at Diagonal Road, Sturt, in December 1995 and continues to operate today.\(^{30}\)

\(^{30}\) Families SA email, 4 May 2005.
Enfield Community Unit, 1990–present

History
The Enfield Community Unit was purpose-built in 1990 and continues to operate today. It was previously known as the Northern Region Admission Unit, which occupied an adjoining property.

Allegations of sexual abuse
One person told the Inquiry that she was sexually abused while placed at the Enfield Community Unit.

Abuse by other residents
A PIC was placed in State care at the age of 10 in the early 1990s on an interim guardianship order following notifications of physical abuse. She told the Inquiry she was sexually abused at Enfield Community Unit and in foster care.

The PIC had two placements at Enfield. The first was for three months in the mid 1990s when she was about 14. Nine months after that placement she returned to Enfield for a further six months. The PIC told the Inquiry that while living at Enfield, 'I was really, really depressed'. She said staff were aware that she had begun self-harming, but they did not make counselling available. She said that her drug use and offending began at Enfield: 'It started there … It was kind of the norm that the kids would do all that sort of stuff'.

The PIC said there were only two other female residents at Enfield. She alleged that male residents persistently touched her breasts and coerced her into sexual contact. She told the Inquiry, 'I would do things just to sort of be accepted'. She said this was her first experience of sexual activity and she felt ‘disgusted’. She alleged that male residents would expose their penises to her and the other female residents and masturbate in the unit’s living area. The males ‘never did it in front of staff but it was in front of us girls’. The PIC told the Inquiry that staff were aware of the male residents’ behaviour through ‘word of mouth’. She said she made a general complaint to unit staff about other residents touching her breasts, saying ‘Can you get them off me?’ and that staff told her that there was not much they could do. Of the masturbation, she said: ‘I’d tell the staff and the staff wouldn’t do anything’.

The PIC’s departmental files include a reference to her telling staff that male residents pressured her into sexual activity. The notes record staff advising the PIC that, should other residents pressure her, she was to immediately notify unit staff. Another note reads: ‘[The PIC] is being pressured by [another resident] … she is put at ease knowing her rights’. The files note that both the PIC and a male resident were interviewed separately, however the substance of the conversation with the male resident is not reported.

Campbelltown Community Unit (Cornerways), 1995–present

History
The purpose-built community unit at Campbelltown, known as Cornerways, was opened in 1995 and continues to operate.

Allegations of sexual abuse
Two men gave evidence of alleged sexual abuse during their placements at Cornerways. Each made allegations of unlawful sexual intercourse while absconding.

Abuse by multiple perpetrators
A PIC who was first placed in short-term care when aged seven in the 1990s told the Inquiry there was physical violence and alcohol and sexual abuse in his family. After the short-term orders, a court found the PIC to be in need of care and placed him in State care until the age of 18. The PIC had several different placements before being transferred to Cornerways in the late 1990s, when he...
Chapter 3 Allegations of sexual abuse

was 13. He spent almost two years there. He alleged that he was sexually abused while absconding from placements including Cornerways.

The PIC recalled Cornerways in a positive light but said that particular staff were overly aggressive with residents. He told the Inquiry that another resident of his age indecently assaulted him, although he was not penetrated. The PIC said nothing to workers at the time.

The PIC said he ran away from Cornerways ‘all the time’. His records show that he absconded repeatedly during his placement, sometimes twice daily. He was gone for hours, days and sometimes weeks. He was reported missing to police and returned to the unit of his own accord, or was transported back. The PIC said he went into the city, sometimes with residents from Cornerways or other units. ‘It depends how many people felt like going out that night’. After absconding, he said, ‘I went into town and slept on the streets’ or stayed with friends. He said he and other residents frequented city parks known to be places where young people could make money from sex. He said that men were constantly in cars near a city park: ‘Ten or 15 cars were always there at once, you know’. One of the other residents engaged in prostitution and, on one occasion, ‘he tried to make me … to do some stuff with him’ but he refused. The PIC’s records show departmental concern about his vulnerability to sexual exploitation while on the streets.

Abuse after absconding

The department had been aware of a PIC since he was three years old due to notifications of neglect and violence. He was placed under a short-term care and protection order when he was 13 in the mid 1990s. He was then placed under the guardianship of the Minister until he reached 18.

The PIC was directed to live at Cornerways in the mid 1990s after his previous placement broke down. He lived there for about three years until he was 16, during which time he was also remanded briefly to secure care and placed at home with his family.

The PIC said he absconded from Cornerways constantly. He remembered: ‘They’d catch me and fine me and take me back and then they’d try and lock me in there but I’d always escape’. The PIC went to the city, sold drugs and became engaged in prostitution. He said that older women approached him and other youths:

- We’d meet them outside, like, the pubs and that and we would start talking to them … They’d ask, ‘Where do you live?’ All right. We’d tell them, ‘On the streets.’ They’d go, ‘Do you want to come home? Take you somewhere nice to sleep.’

The PIC went to women’s homes and had sexual intercourse with them. He told the Inquiry he was about 14 at this time. Occasionally, he saw other children at the residences.

- Sometimes there would be a few women there and they would have all their little toy boys—that’s what I like to call it now. They’d have all their little toy boys there and I’d rock up and there would be kids of my age there and we’d go in, we’d talk, we’d sit down, we’d smoke our cigarettes, drink a little bit of piss. They’d go, ‘Do you want to come to bed?’ ‘Yes.’ ‘Well, we’re going to bed.’ Do the deed.

In addition to gaining a place to sleep, the PIC said that the women gave him money. He said that he never reported the activity because he had consented to it. ‘I was pretty much willing to do what we were doing with them … We used to do what we were doing and so we used to get by.’

Before being placed at Cornerways, the PIC’s departmental workers expressed concern at his absconding from placements, truanting from school, violent behaviour and offending. One report noted: ‘[The PIC] is considered to be at risk if he continues to frequent Hindley Street due to his age’. His workers registered concern that ‘[the PIC] is heading increasingly to Hindley Street where he is at sever [sic] risk of offending, sexual exploitation etc.’

Workers during the earlier placements agreed that ‘all efforts will be made to keep [the PIC] away from
undesirable areas’. Case notes during his time in Cornerways note that the PIC ‘spent a lot of time running away from the Unit’.

North Adelaide Community Unit, 1990–97

History

The North Adelaide Community Unit operated between 1990 and 1997 on the site of the former Stuart House in North Adelaide.33 The unit closed in 1997 and its functions were transferred to the Regency Park Community Unit.34

Allegations of sexual abuse

Two men gave evidence to the Inquiry of sexual abuse while placed at the North Adelaide Community Unit.

Abuse by staff

A PIC born in the late 1970s alleged he was sexually abused at the North Adelaide Community Unit, formerly Stuart House. The PIC lived most of his childhood with his father and had virtually no memories of his mother until he was about 15, when they were reunited. He alleged that when he was between four and 12 he was sexually abused by his grandfather, including ‘sexually penetrating me and making me, you know, touch him and things like that’. When the PIC was 13 his father felt he could not continue to look after him and signed an application for him to be placed in State care under a short-term administrative order. Records from the department show that over the following months the PIC was in several placements including foster care, a youth shelter and an assessment unit. Records show that about five months after the initial short-term order he was placed in State care by a court until he turned 18. At 14 the PIC was placed in the North Adelaide Community Unit, where he remained for just over a year. He said he experienced violence at the unit: ‘There was a lot of bashings. I was still coping a fair bit there’. He also alleged he was sexually abused while at the unit, the first time in the showers:

I’ve gone to the showers and that person was there and basically, you know, I was doing what I was doing and this bloke just decided to basically have his way with me and sexually.

The PIC said he believes the perpetrator was a staff member.

He also alleged that following the abuse he was sent to see another staff member in his office:

I’ve walked in there and there’s this older man just standing there in, like, a robe, you know, and had his business hanging out and he says, ‘Have you got something to say?’ And I said, ‘Well, yes, I do.’ I said, ‘Well, this bloke here has just basically had his you know, way with me. You know, he’s just raped me.’ And he goes, ‘Well, if I was you, I’d keep my mouth shut, or else there’s plenty more of that, where it comes from’.

The PIC committed offences while in care and as a result spent time in SAYRAC. Following his release from care at 18 he spent significant periods in adult prisons.

Abuse by outsiders

The department had been aware of an Aboriginal PIC’s family since the mid 1980s because of domestic violence issues. The PIC was placed in State care in the early 1990s when he was 12, after his mother signed a voluntary care agreement. As well as in foster care, the PIC lived on the streets for a significant period of time and also at government hostels and admission units, and in secure care. He made allegations of sexual abuse while at the North Adelaide Community Unit and in foster care.

The PIC lived at the North Adelaide unit under a voluntary care agreement when he was 14 for about three months. He said staff accepted the fact that residents often left the

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33 ibid., 1990, Stuart House no longer listed, appears as North Adelaide Community Unit.
34 ibid., 1995–96, p. 25.
The PIC said he was in the city one night with another youth who introduced him to an older man. The man supplied both children with drugs. The PIC began staying occasionally at this man’s house and on one such evening the PIC got drunk. He fell asleep and ‘I remember waking up to him stroking my penis’. The PIC assaulted the man and returned to the unit. The police were called and the PIC provided a statement. The department’s records contain a report of sexual assault on the PIC by a known paedophile. It appears from police records that the matter proceeded to court with a conviction in relation to supplying the drug but no conviction in relation to a charge of indecent assault.
## 3.4 Foster care

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History

The Government has placed children in State care into foster care since the 19th century. Children were boarded out, as the foster care system was known originally, with families from the early 1850s under arrangements made by the Destitute Board.1 In the 1860s a group of concerned citizens began to lobby for children to be placed in family homes rather than institutions.2 This campaign led to the formation of the Boarding-out Society in 1872 "for the supervision of the children when placed out".3 This system of foster care was formalised in 1872 when the South Australian Parliament passed a Bill allowing any child who had been committed to a reformatory or industrial school to be placed out with a family until the age of 12, with a government subsidy paid to the family.4 From 13, children could be "licensed for service" until they reached 16 if female or 18 if male.5

Concern that children who were boarded out were being exploited as unpaid labour led to a State inquiry. The findings of the 1883–85 Way Commission led to the establishment of the State Children’s Council (SCC) in 1886.6 The SCC licensed ‘fit and proper’ people to care for children under the age of two years and licensed foster parents to whom older children in State care were placed out or apprenticed. The SCC had powers regarding complaints against foster parents, the removal of a child from a foster placement and for regular inspections of placements.7

Both the SCC and its successor from 1927, the Children’s Welfare and Public Relief Board (CWPRB), believed that placement in a family environment rather than an institution better prepared children for adult life. The CWPRB stated in 1938 that boarding out was still its preferred option for most children in State care: “A substitute home and parents is believed by the Board to be preferable to any institution”.8 Boarding out also saved the government the cost of staffing and maintaining residential institutions.

However, concerns that children were being exploited persisted. In 1926, for example, the department defended the boarding out system, noting that inspectors attempted ‘in every way to make friends with [children], win their confidence, and directly and indirectly gain a full insight into their school progress, home duties, pleasures and interests’.9 Children were also encouraged to communicate with police officers, clergymen, schoolmasters, or any other suitable person if any issue arose between inspections.10 However, the department controlled parents’ access to children in foster placements. Parents could not contact their children directly and could only see them by arrangement at the department’s offices.11

Efforts to protect children from exploitation continued over the decades. In the 1930s, the department’s inspectors reportedly regularly visited children placed with licensed foster parents. The inspectors also visited the schools these children attended and inspected the homes of people applying to care for children in State care. The role of inspectors was to ensure that younger foster children were not being overworked and that those placed out for service were working satisfactorily, receiving wages regularly and had adequate leisure hours.12 In addition to information from inspectors the department received

3 Way, pt II, para. 80.
4 Destitute Persons Relief Act and Industrial and Reformatory Schools Act 1872, pt II, s. 59.
5 Way, pt II, para. 57.
6 Way had two main concerns: that the Destitute Board increasingly used the demand for children in the community as a reason not to pay subsidy to families and the absence of official inspections of placements, pt II, para. 74.
7 State Children Act 1895, ss. 52–79.
8 CWPRB annual report 1938, p. 3.
9 SCC minutes and CWPRB minutes, vol. 6, (minute 856), July 9, 1926.
10 Ibid.
12 Government of South Australia, Report of the committee appointed by the government to inquire into delinquent and other children in the care of the State, Sep. 1939, p. 15.
reports from other sources such as schools and local governing authorities. By 1940 the department had initiated a procedure whereby children were visited within a month of a placement starting. In 1954, the CWPRB secretary stated that increased supervision of the 300 children in foster care (from a total of 1215 State children), had ensured that they were boarded out ‘only to good foster parents’. However, historical records between the 1930s and 1950s reveal that some children were still placed in unsatisfactory homes or in placements where foster parents were guilty of exploitation.

Housing shortages post-war and into the 1950s reduced available placements. However the newly created Department of Social Welfare reiterated its commitment to foster care in 1965: ‘For more than 100 years in South Australia children under State care have been placed individually in suitable private foster homes … The Department believes that most children are best cared for as members of a family group.’ The Social Welfare Act 1926–1965 introduced several protective measures relating to foster care. The Act increased the penalty for ill-treating, injuring, or neglecting a child in State care and for a foster parent who transferred the care of a child to another person without the consent of the director of Social Welfare. Whereas in the past members of voluntary visiting committees could inspect placements, the new Act stipulated that only officers of the department could do inspections.

After the passing of Social Welfare Act the department focused on preventing family breakdowns to reduce the need to remove children from their homes, especially for long periods. The aim was to use short-term respite or emergency foster care, which allowed children to be placed back with their families as soon as possible. This policy shift resulted in greater demand for foster care, particularly short-term care. During the late 1960s, 87 per cent of children in State care were placed into foster homes, however the department remarked on the continuing shortage of foster carers. When the new Department of Social Welfare and Aboriginal Affairs assumed responsibility for Aboriginal communities in 1970, it identified a shortage of culturally appropriate placements for Aboriginal children.

The needs of foster carers received increasing attention in the 1970s. The department had welcomed the creation in 1969 of the Foster Parents’ Association, which provided a forum for carers to exchange information and provide mutual support. The department stated in 1971 that training would assist foster carers to ‘develop their understanding of the problems that the neglected child’s experiences produce’. It initiated its first 12-week pilot training program, based on foster parents and social workers working in tandem to improve standards. However, annual reports from the 1970s show that the shortage of available placements and the limited amount of foster care training remained areas of concern.

In 1972 the new Department for Community Welfare decentralised its services by designating metropolitan and country regions. In each region district offices assumed responsibility for foster placements so that placements were handled at the local level, thereby increasing ‘the immediacy of foster placing’. In 1973 the government...
worked with a non-government provider to develop the first Emergency Foster Care (EFC) scheme, which initially provided emergency foster accommodation from overnight to up to three months for any child or young person under 18. By 1979 the scheme was working with 120 approved foster parents supported by two placement officers and two clerical officers. The service found emergency placements for more than 40 children a month and was regarded as “an effective alternative to residential care”. The department brought the scheme under the supervision of the Residential Child Care Advisory Committee (RCCAC) and it was funded under contract between the Minister of Community Welfare and the non-government service provider. This contract allowed the program to be ‘conducted primarily but not exclusively for children up to the age of 12 who require foster care (up to a maximum period of three months)’.

By the end of the 1970s the department had increased subsidies and training for foster carers and developed procedures for the placement and monitoring of children in foster care. It supported the establishment of the Aboriginal Child Care Agency, which recruited and supported Aboriginal foster families and ensured the culturally appropriate placement of Aboriginal children unable to live with their birth families. The department also introduced the Intensive Neighbourhood Care (INC) scheme to provide ‘family’ style care for young offenders. Under this scheme, children were placed with families that had received specialised training in dealing with young offenders. However in 1979 a senior member of the department highlighted issues of continuing concern, including assessment, selection and training of carers, professional support for foster parents, carer support and the needs of children with disabilities. The departmental officer noted: ‘I feel that it is true to say that foster care has been undertaken on an ad hoc basis without any evident precision or consistency’.

At this time the department was working in tandem with 800 approved foster families caring for nearly 1000 children. More than half of those were children under the official care and control of the Minister. In the following decade the department increasingly outsourced foster care to non-government providers. It licensed and approved non-government agencies to perform assessments of foster parent applications and issued revised procedures relating to foster care that addressed the involvement of non-government agencies in this process.

In the early 1980s, the foster care system received closer attention. The Residential Child Care and Support Advisory Committee (RCCSAC, successor to the RCCAC) was established and raised concerns about the unsuitable placement of children in foster care because of the lack of vacancies in residential care, which it linked to foster placement breakdowns. The department examined emergency foster care, respite care, temporary foster care and long-term care. It found that short-term care was
effective but required increased monitoring to ensure that there was "no unplanned drift from Emergency Foster Care into longer term care". In addition, long-term care was not being carefully planned or scrutinised, which resulted in multiple placements and a lack of permanency and stability for children. The Children’s Interest Bureau (CIB) reiterated these concerns, noting that the demand for emergency foster care was increasing, while children in long-term care were ‘being moved too frequently’ among placements. At a meeting of the CIB, the deputy director-general of the department stated that she was ‘appalled at the number of children who have been in a number of placements’. A departmental report from 1987 stated:

> There is a growing recognition that the system of care is itself ‘abusive’ because of the number of placements the child can have, the failure to deal with problems facing the child and the subjection of children to physical and sexual abuse.

Reviews undertaken in the early 1990s spurred the department to entrench its outsourcing of foster care in the latter part of the decade. In 1997 a program for planning, purchasing and delivering alternative care services was implemented and foster care services were put out for competitive tender. In 1999 an evaluation of the alternative care services outsourced through this program revealed ‘significant difficulties’. A growing demand for placements was not matched by an increase in carers. Instead there was a decline in carer numbers and limited residential care alternatives. The evaluation report noted: ‘The scarcity of appropriate placements meant that it was impossible to match placements to children’s needs leading to placement breakdowns and instability for children.’

Criticisms of departmental policies regarding foster care continue to the present. For example, an article written in 2001 by an academic working in the field of social administration and social work criticised the outsourcing of foster care through competitive tender. He suggested that outsourcing—part of a national policy of minimal government intervention and the result of reductions in funding to the public sector—was flawed. The article cites tension between department social workers and contracted foster care agencies and a ‘burdensome and frustrating amount of paperwork’ brought about by foster care referral procedures. The article also argued that departmental district centre workers lacked an understanding of the problems faced by foster-carers. The author referred to a ‘decimation of residential care’ in the 1980s and 1990s. This led to a nationwide reliance on foster care, with South Australia depending on foster care more than any other State. The scarcity of placements for children with behavioural problems and those with disabilities was endemic.

The 2003 Layton review of child protection in South Australia acknowledged the problems in the alternative care system. Layton concluded that competitive tendering, referred to as the ‘funder-purchaser-provider’ model, was incompatible with the provision of welfare services and had resulted in ‘significant mistrust’. She recommended that the system “be modified” to allow for ‘realistic quality participation by an expanded number of alternative service providers’, along with a definite system of ‘prescribing and monitoring’ their performance.
In 2004 the Government responded to the Layton report with its *Keeping them safe* policy agenda. The 2004 agenda and its follow-up in 2006, *Keeping them safe – in our care* acknowledged the need for stability and security for children in foster care and the demands on carers.

At 30 June 2007, 47 per cent of children in State care were in foster care. Evidence to the Inquiry indicates that the department has considerable difficulty in recruiting and retaining foster carers.

### Summary of foster care allegations

The Inquiry heard evidence from 103 people (72 females, 31 males) who alleged they were sexually abused while in State care and placed in foster care. A further nine people are included in this report as, due to the unavailability of records and/or the historical actions of the Aborigines Protection Board (APB) in removing Aboriginal children contrary to legislation (see page 14), the Inquiry was unable to properly determine whether they were in State care.

The allegations included acts of gross indecency, acts to gratify prurient interest, indecent assault, bestiality and oral, vaginal, digital and anal intercourse and rape. The alleged perpetrators were foster fathers, foster mothers, foster sons, other fostered boys, boarders, relatives of the foster parents and outsiders, including friends of the foster family, a teacher, taxi driver, camp worker, student social worker, police officer, priest, neighbours and strangers.
1940s–50s

The Inquiry was able to confirm from available records that 12 people who gave evidence that they were sexually abused while in foster care in the 1940s–50s were in State care at the time of their allegations. Ten were placed in State care by a court for being destitute, neglected, illegitimate, uncontrolled, under unfit guardianship; one PIC was placed in State care for a criminal offence, while the other was a child migrant who came to Australia without the care of a parent or relative. Eleven were female; one was male. Due to the lack of available records, the Inquiry was not able to properly determine whether an additional two people were in State care at the time of their allegations.

The allegations of sexual abuse include indecent assault, including masturbation, acts of gross indecency, vaginal and oral sexual intercourse, digital penetration and rape. The alleged perpetrators were foster fathers, sons and relatives of the foster parents and outsiders including a priest, a neighbour and male boarders.

**Evidence from females**

In the mid 1940s an 11-year-old girl was placed in State care until the age of 18 by court order for being destitute. When she was six, her mother had placed her at the St Vincent de Paul Orphanage, Goodwood, where she lived until she was 11. Her mother had been unable to care for the PIC and her siblings, and her alcoholic father had left home. The PIC said she was sexually abused at Goodwood orphanage and ran away, refusing to return. As a result, she was placed in State care and, during that time, alleged she was sexually abused in foster care.

Departmental records show the PIC was placed in a foster home with a woman who had other foster children. The PIC said:

>The house was there and they had the rooms and the nice beds and everything, but they were there for when [social worker] came to visit, you see, but we all really lived in the sheds. She stabbed me once with the scissors, but on the whole I was that used to being knocked around, beltings, sort of.

The PIC said that a relative of her foster mother—who lived at the home—sexually abused her. She said he was ‘always drunk’.

>He used to say to us, ‘Come here. Jeez, look at this,’ you know? And then he’d expose himself and, you know; ‘Touch it, touch it.’ All right, I touched it. ‘If you kiss it, I’ll give you a penny.’ ‘Oh, righto, yep.’ So I did. I wanted that penny, I did, but I hated it …

The PIC said she left the foster placement at 14, at the same time as leaving school. ‘… the Welfare seemed to think that I didn’t like school and couldn’t wait to leave, but I did like school.’ She said her departmental officer placed her in a regional town where she worked. She said:

>... the Welfare seemed to think that I didn’t like school and couldn’t wait to leave, but I did like school. She said her departmental officer placed her in a regional town where she worked. She said:

>I was looking for love, and boys were looking for sex … you know, boys wanted to have sex, and I think, ‘Right, if he wants to have sex with me, he loves me, and if he loves me he’s going to marry me, and then we can all go away,’ you know? Wrong.

Records show that in the early 1950s, when she was 15, the PIC was placed with another foster family. The PIC told the Inquiry the foster father sexually abused her. ‘Would you believe … he [the foster father] starts touching … and up the knickers comes the hands …’ She said she was made to masturbate him.

>He told me to do it. I didn’t want him to touch me but, I mean, he had absolute power … I even asked for the [foster parents] to adopt me so I belonged to somebody; and that’s sick.

The PIC said she became friends with a young man while she was living with this foster family. ‘I wanted to get married and leave.’ According to records, the young man was three years older than the PIC and was charged with indecently assaulting her when she was 15. He pleaded guilty and was given a suspended sentence. The PIC said she became pregnant to him and refused to allow the baby to be adopted. ‘I wouldn’t sign it away. I wouldn’t.’ She was moved to a few more placements, where she worked as a domestic and raised her child.

For many years, the PIC said she battled alcoholism, but she later went on to further study and community work. She told the Inquiry she was still deeply affected by her childhood.
Chapter 3 Allegations of sexual abuse

Living in a dream world is what you do when you’ve been hurt so much, and you live in a different world. But the thing is, you live, don’t you?

She said the Inquiry gave her a voice:

… for a person like me and a lot of children that, like me, grew up the way we did, we didn’t have a voice, did we? We didn’t have power or anything … you lived in fear and you got very good at hiding feelings.

In the late 1940s, an Aboriginal girl who was almost 13 was charged with neglect and placed in Seaforth Home. Her State ward index card (SWIC) shows that the charge was withdrawn a few weeks later and she went back to her mother’s care. At 14 years she was placed by court order in State care until the age of 18, charged with being uncontrollable. During the next four years she was in various homes and foster placements. She alleged she was sexually abused in one of the foster placements and also while she was living in the family home.

She was placed at a foster home as a domestic about one year after being put in State care. She told the Inquiry that her foster father and another man sexually abused her.

[The foster father] pestered me and fingered me. Many times he’d come into our room. I was put in what we called the nursery, with the two kiddies, and my bed was in there and he’d make out that the kids were crying and he’d come in there, but he was putting his hands under the blankets and fingering me …

Even though the foster father did this ‘heaps of times [and] he was a pest’, the PIC said she did not think he penetrated her with his fingers, but she did not know for sure. ‘I just remember being sore.’

She said her foster mother

… brought the doctor in because I complained that I was sore, so I don’t know whether she thought I was out playing up or whatever, but she didn’t catch on that apparently it was him.

She told the Inquiry that some time after the doctor’s visit, the foster father had chased her around the house with his exposed erect penis. She said she had been ‘petrified’ and had run over to a male relative ‘and I wasn’t there long, and he had me on his lap, and then his hands were coming through my pants, too’. She said that she reported it to her probation officer.

Oh, I was the worst in the world. I was a liar, I was a lazy gin, I was only saying these things because I didn’t want to work. I did want to work and I did love the little boys. I was quite happy there, but I just couldn’t put up with him all the time.

Departmental files relating to the PIC do not record any disclosure of sexual abuse. It was reported that the foster mother had told the probation officer that the PIC ‘would not tell [the foster mother] what was worrying her’.

A PIC told the Inquiry that in the mid 1940s, when she was about two, her mother placed her at the St Vincent de Paul Orphanage, Goodwood, for about four years. She said she was then placed with a foster couple. The minimal records received by the Inquiry from the Catholic Church’s Professional Standards Office (PSO) and the department do not show how the placement came about. As a result of the lack of records, the Inquiry was unable to properly determine whether the PIC was in State care at the time of her foster placement.

The PIC said the atmosphere in the foster home was ‘very stern, very strict’ and she would ‘get a belting’ at the dinner table if she misbehaved. She said the family refused to use her name and insisted she change it.

The PIC said the sexual abuse started when her foster father would bathe her and rub ‘very hard in my private parts …’ She said that while he was touching her,

… he would talk into my ear and say to me that I had been letting the boys at school play with me down there and that is why I was sore.
She said:

He then said that it was our secret, that he would not tell the mother because she would give me a belting and send me back to the orphanage for telling lies because the nuns and my mother had told them that I told lies.

The PIC said that on one occasion, the foster father woke her in her bed at night, after he had apparently masturbated on her. ‘... I started to cry and he put his hand over my mouth, but I vomited.’ She said: ‘I never said anything to anyone about this’. She told the Inquiry that this abuse was often repeated. She also alleged that the foster father would perform oral sex on her and make her do the same, and that ‘it would really hurt when he put his fingers inside my private parts’.

The PIC told the Inquiry that the couple’s two teenage sons also sexually abused her.

They did not hurt me like the father but they would put their hand inside my pants and tickle me on my private parts and get me to play with their penises. ... I remember I would always be scared in case the mother would come in and catch me and I felt dirty and bad.

The PIC gave evidence that she left the foster home when she was about seven; she is not sure why.

She told the Inquiry that the sexual abuse has had a significant impact on her adult life. She said that she felt ‘uneasy about sex and it’s taken me many, many years and counselling to accept that, you know, it wasn’t my fault’. She also said:

Because of the way I was treated in the Goodwood orphanage and the other institutions, foster homes and by my mother, I find it difficult to believe that anyone could truly respect me. I still feel at times that I am no good, dirty, and that I have no dignity, worth or value.

An Aboriginal woman told the Inquiry that she was removed from her mother when she was less than two months old in the early 1940s. She did not know her father, who she believed was white. She was placed at a privately run babies home and, when she was four, in foster care. When she was about eight she lived briefly with relatives and was then transferred to another foster placement when she was about 10, where she alleged she was sexually abused.

The Inquiry received limited records in relation to this PIC, with the department providing one index card relating to correspondence about the child. Historically, the department maintained index cards showing subject matter and file number in order to track its correspondence files. The index card for this PIC shows that correspondence files in which she is named did exist, but no actual files could be located. The card lists one of the PIC’s foster placements as a subject of correspondence. A record from the former Aborigines Department showed that the PIC was placed at the private babies home and from the babies home to a foster family. The United Aborigines Mission was unable to locate any records. As a result of the lack of records, the Inquiry was unable to properly determine whether the PIC was in State care when she said she was sexually abused.

The PIC told the Inquiry that she spent about three years at the foster care placement. She said she was punished if household duties were not fulfilled to the foster mother’s satisfaction or if she wet her bed. She estimated that a few months after her arrival, her foster father sexually abused her. She alleged that he took her to see baby farm animals in a loft and indecently assaulted her, ripping her clothing in the process. She said that he decapitated three of the baby animals and said, ‘Now, that’s what happens if you don’t do what I ask you to do’.

The PIC alleged that the sexual abuse continued for months and that her foster father fondled her genitals, digitally penetrated her, performed oral sex on her and made her perform oral sex on him. She said she was
abused in the loft and taken for drives in the farm’s paddocks then abused in the parked car. At one time, she said that her foster mother was hospitalised and the abuse became more persistent.

I was sound asleep in bed one night and he came in, in the middle of the night or early hours of the morning, and he picked me up and put me in his bed and did all those things to me there.

She said the abuse occurred ‘most days’ during the foster mother’s absence. The PIC said she was 12 at this time. She told the Inquiry that she disclosed the abuse to her departmental worker. The PIC said she had become agitated, thinking her first menstruation was the result of the foster father’s abuse. The worker...

... took me out of the room and, whoever it was, sat me on her knee and she said, ‘Has [he] been hurting you?’ and I said, ‘No,’ and she said, ‘You must tell me’.

The PIC said she remembered her departmental worker telling her foster mother, who denied that any abuse could have occurred.

... she told me that her husband would not touch me because I was a nigger and I was 12½ or 13. That’s the first time I knew that I was part Aboriginal.

The PIC was moved to another foster family, ‘... but they sent me back with them ... I’ll never forgive them for that ... To this day, I just can’t for the life of me work out why.’

Due to the lack of records, the Inquiry is unable to determine when or why that occurred. The PIC said she was sexually abused again by the foster father when she was returned to the foster family. She recalled being transferred to another foster family after that and the abusive foster father and his wife visited the new foster home to see her. She said she hid for hours to avoid them.

She recalled some sort of legal action against the foster father when she was about 14. She believed that the alleged perpetrator escaped penalty. She said when she was older she asked her foster parents at the time:

I kept asking why—you know, what happened?
Was he punished? When I started to grow up and realise that in my mind it was a bit of a crime, I was just told that I’d made it up.

Courts Administration Authority records show that in the mid-1950s, the foster father was charged with two counts of indecently assaulting the PIC, who was recorded as being 13 at the time of the assaults. The charges proceeded to trial before a jury, the PIC gave evidence and the foster father was convicted of both counts.

The PIC later lived briefly at the Salvation Army Girls Home, Fullarton, where she said she was also sexually abused.

In the mid 1940s a PIC was placed in State care as a newborn baby until age 18, when a court found her neglected and illegitimate. The PIC told the Inquiry that as an adult she had initiated contact with her mother and learned that her father was in jail at the time of her birth. Records show that within a couple of months of being placed at Seaforth Home the PIC was fostered to a couple, who raised her. The PIC said that her mother did not consent to an adoption, as she ‘wouldn’t relinquish me’.

She said that the place she lived in was ‘a wonderful place to grow up because the beach in those years was beautiful’. However she said both her foster parents would say words to the effect, ‘If you don’t be a good girl you’ll be sent back’. She said she had no idea what ‘back’ was. ‘It was a terrible black hole of unknown terror.’

On one holiday the PIC, then aged five, and the rest of the household stayed with another family, whom she called ‘uncle’ and ‘aunty’. The PIC said she and other children were asleep in a double bed when ‘uncle’...

... ran his hands under my nightie, all over my body, especially the breasts and between my legs ...
I was terrified ... I had no idea what he was doing, and I lay on the edge of the bed and clung to the mattress.

She said she sensed what was happening was wrong but she did not tell anyone about it because she felt "very guilty" and "very ashamed". She said she felt that she had done something wrong and that it was her fault.

The PIC said that when she was about nine, a local man sexually abused her when she offered to show him her cat and newborn kittens. She said she took him to her back garden where he digitally penetrated her. He...

... was pushing me into the fence, and I was struggling. He was holding me very tightly and I was struggling and trying to pummel at him to get free ...

She said she went "sobbing, terrified" into the house and told her foster mother, who said, "I mustn't tell Daddy because I'd be sent back ... She said no-one would believe me and, in fact, I don't think she believed me, either.'

She did not tell her foster father or social worker about the assault because they "would have taken me back to this unknown place'.

She also told the Inquiry that when she was in her second year at high school, her teacher sexually abused her after he had given her gifts. She said that the sexual abuse included kissing, simulating sexual intercourse, and digital penetration. She said he once visited her foster home and asked if she was pregnant. She said she never told her foster mother because "I was afraid I was pregnant, and what then? I'd certainly be sent back then." She said that at that time her foster mother had not yet told her "about the facts of life. I was never told.'

She also told the Inquiry that after she was 15, her foster sister's husband forced himself on her by kissing her and touching her breasts. The PIC said she told her foster mother about the abuse when she asked why the PIC was so rude when the couple came to visit. The PIC said that in recent years her foster mother...

... has forgotten that, because ... she said to me, "Why don't you take me out to see [foster sister and husband]?" I would say, 'I never ever want to see [him] again as long as I live. I hate him.' It's not a word I use flippantly.

In the late 1940s, an 11-year-old child migrant spent her first three years in Adelaide at St Vincent de Paul Orphanage, Goodwood, where she said she was sexually abused. The PIC then went to live in foster care arranged by the Catholic Social Services Office, where she alleged she was also sexually abused. As a child migrant who came to Australia not in the care of a parent or relative, she is considered by the Inquiry to be a child within the terms of reference.

She told the Inquiry that one night while her foster mother was in bed, her foster father asked her to go outside with him. "The next minute I'm in his arms and he is kissing me like I've never been kissed before ... I could have been 14 going on 15." The PIC said she told her foster mother the next morning, "I don't remember her saying much at all.'

On another occasion, the foster father sexually abused her in a garage that had a cement floor and walls.

He grabbed me, and he's trying to put his hand in my skirt ... and I was stopping him and I was screaming ... he was banging my head on the cement wall—on that cement wall.

She told the Inquiry that he stopped when he saw a police car coming. She said that the police officer took me to the bedroom and he sat on the bed with me, and I told him what happened. She told the Inquiry that to her knowledge, nothing came of her report to the police. She said that her foster father sent her back to Goodwood orphanage, where she told

Mother [name] what the man did, and she just made the sign of the cross and walked away and that's the last I ever heard about it.
Records show that in the mid-1950s when she was 17, she was placed with a Catholic family for some weeks. She said that one Sunday after Mass, ‘I’d been singing in the choir’ and the visiting priest ‘came up to me and he said, “Can I talk to you about your singing afterwards? Can you stay behind?” And I did.’

She said that he raped her on the vestry floor. ‘Everything happened so quickly … I’d never had sex before … I was bleeding.’ The PIC said that the priest did not say anything to her. ‘I think he took me home.’ She told the Inquiry:

I didn’t tell anybody because no-one did anything about [the foster father’s abuse] so why would anyone want to do anything when you tell them it’s a priest? So I never told anybody.

The priest ‘was sort of good to me’, the PIC said. She said that she had sexual intercourse with him on two or three subsequent occasions. ‘I’ll be honest with that, but he was the only person I had as a friend.’

Later, she said she tried to commit suicide

… because of the confusion with life itself … because I couldn’t tell anybody, I didn’t tell anybody, I had nobody … no friends. So I just tried to commit suicide because I thought that would be the best.

The PIC took out civil proceedings against the Catholic Church, which has settled.

A PIC born in the mid 1940s told the Inquiry her father was an alcoholic and the family lived in poverty.

We had no food. We had no clothing, just rags. And I think I went out and I pinched some money and I pinched a bike and from there I was taken to court and from there I was put under the Child Welfare Department …

Records show that in the mid-1950s the PIC, aged 13, was placed in State care until aged 18 by court order for being ‘uncontrolled’. She was placed in three institutions before being placed in foster care a month before her 15th birthday.

The PIC told the Inquiry that after she had been on the carers’ farm for a few months, her foster father, whom she called dad, walked into the milking shed when she was about to start milking the cows. He stood in front of her and, without saying anything, interfered with her clothing and digitally penetrated her.

I can remember that it didn’t feel very nice, it felt terrible. I stood there because I was scared and I was too frightened to move until he had done what he had wanted to. I didn’t know or understand what he was doing to me at all.

She told the Inquiry that this abuse continued intermittently over the three years she lived with the family. She did not report it to her foster mother or anyone in authority: ‘I don’t know why, I can’t really say why. I just kept it on my shoulders …’ She said she felt ‘violated’.

Knowing about sexual abuse now I’ve been grown up, you know, I—yes, had I known then that it was wrong and somebody from the department to come and see me and ask me how I was, I could have said, ‘Look, this is what he’s doing to me’. But I seen nobody.
An Aboriginal PIC was placed in State care until the age of 18 in the mid 1940s when she was seven years old when a court found her destitute. She told the Inquiry that she has a memory of her father being cruel and violent towards her mother and sibling. The PIC recalled the police taking her father away. She also remembered the police coming to the mission where she lived, looking for ‘half-caste’ children, and hiding under her grandmother’s skirt.

She told the Inquiry that she was sexually abused at Seaforth Home and then later in foster care when 14, she was ‘propositioned’ by her foster brother who exposed his penis when he was drunk. She said she recalled officers from the department calling at the foster home but she did not tell her foster parents or anyone from the department about the incident.

An Aboriginal PIC who was born in the early 1940s was placed in State care at 15 months until the age of 18 when a court found her neglected and under unfit guardianship. She was sent to a government home for three months before she was placed in long-term foster care. Records show that not long before her 14th birthday, the PIC was placed with another family and then, after a short time, with that family’s adult son and his wife. The PIC was in this foster arrangement for about a year, before being moved because she was ‘impossible and uncooperative’. The PIC told the Inquiry that she ‘wouldn’t stay there’ because the adult son ‘made a pass at me’ by coming up behind her and putting his hands on her breasts on the outside of her clothing. The PIC told the Inquiry that she told her long-term foster mother, with whom she still kept in contact, and together they ‘went off up to the Welfare in town here. I can remember that … They didn’t believe anything I said, of course’.

Departmental records contain a note stating that the long-term foster mother had telephoned to advise that ‘when [PIC] spent a weekend with her recently, the girl stated that she had been interfered with by [foster father]’. The PIC had told the long-term foster mother that she ‘was afraid to say anything before as she felt it would not be believed against’ her short-term foster father. It was reported that the short-term foster mother had found out about it and had asked the PIC ‘to forgive her husband’.

A departmental note shows that the PIC was questioned about the sexual abuse allegations at the department’s offices when she was aged 15½. The note says that she said her short-term foster father had ‘tried to interfere with her indecently twice within the week, approximately two months before she left the home’.

The note says that its author considered the PIC was telling the truth. A handwritten notation on this report is to the effect that the chairman recommended the foster home ‘be closed to State wards’. The recommendation was approved.

In the mid 1940s, an Aboriginal PIC was about four years old when a court found her neglected and under unfit guardianship, and placed her in State care until the age of 18. She was placed in Seaforth Home for a few months and then sent to a foster mother, with whom she stayed for her school years. At a later placement at Vaughan House when she was 17, she said other female residents sexually assaulted her.

The PIC told the Inquiry that when she was a teenager and living with her foster mother, a neighbour aged in his 30s came in the back door, and

... he just started asking a few questions. Then he came over close to me and started touching me and I started crying.

She said that ‘he just pulled my pants down’ and raped her.

She said that about five or six months after the sexual assault, the department asked her to come to its office. She told the Inquiry:

They said I’d had an affair with somebody and I was under age and first of all I had to have an examination, and then they said, ‘Well, it was true’ and I said, ‘No’. I said, ‘I never had an affair with
anybody, but the man next door came into my place when everybody was out’, and I said, ‘And I was raped by him’. I said, ‘And that’s the only male—if you’re referring to me having an affair’.

The PIC said that the department would not tell her how they knew. ‘It’s then that I had an examination and they found out that I had been with somebody.’ She said she had not told anyone about the sexual assault because she was ashamed.

She denied to the departmental officer that she was having an affair but ‘they didn’t believe any of us State wards, didn’t matter what you said’.

Departmental files contain a record that there were ‘statements obtained from the girl by the Women Police concerning her conduct’. However, those statements were not on the file. The PIC said she was not aware of any investigation into the alleged rapist.

A

n Aboriginal PIC was 13 when she was placed in State care until the age of 18 by a court for larceny in the early 1960s. She told the Inquiry that her first memory was of living in a house in the city with a woman, her children and a boarder. ‘I think I was there from day dot.’ She recalled departmental officers coming to the house to see her. Prior to being in State care when she was between eight and 10, she said, one of the woman’s sons tried to get her to perform oral sex and he and others did things that frightened her, including tying her to a chair and singing songs with lyrics such as ‘Get back to your mother, you black-haired bugger. You don’t belong to us.’ She said she started having ‘behavioural problems’. The PIC said she was physically abused if she returned home late; to avoid being late she stole a bicycle and would ride it home to be on time, then hide the bicycle for use the next morning. The PIC’s SWIC shows she was charged with larceny.

After being placed in State care she was transferred to Vaughan House, then sent as a service girl to a foster care placement where she said she was sexually abused. The family needed domestic help as the foster mother was pregnant with her fifth child and was ill.

She told the Inquiry that on one occasion the foster father tried to get her to place her hand on his exposed penis while he was driving the car.

When I got back [to the foster home] I went straight into the room and I started packing, and I sat up all night. Then I rang the welfare the next day and said, if they weren’t there to pick me up, I was going.

She said that a departmental officer came, but she did not tell anyone about the abuse as the foster mother was sick. Departmental records note that the man continued to visit her and the ‘girl admits being familiar with him’.

In the 1950s, a PIC aged two was placed in State care until 18 by court order due to neglect and unfit guardianship. A departmental record states that the PIC’s mother had been ‘deserted’ by her husband. The PIC was placed at Seaforth Home for a short time before going to the first of several foster placements where she was sexually abused as a very young child.

The PIC alleged that her foster father sexually abused her at a foster care placement where she had been placed with her older sister. She remembered her foster father taking her on her own in the car and abusing her, but could not recall the details. ‘It was definitely a sex—you know, sexual acts …’ The department’s records show that when the PIC was three, one of its workers spoke with the foster mother because the PIC’s sister was extremely destructive and had shown sexual tendencies. A departmental inspection of the foster care placement stated that everything was ‘satisfactory and well-cared for’.

Departmental records show that when the PIC was six the department learnt from the police that the foster father had ‘shot through’, having sold the car and resigned from his job. ‘He has left [foster mother] almost destitute.’ The department report goes on:
She admitted that [foster father] had interfered with [PIC] and [PIC'S older sister]. She also admitted that she had caught her husband playing with [PIC'S older sister] in the bathroom over two years ago … later admitted that [PIC] told her that [foster father] interfered with her when he was supposed to be reading a story to her in bed … [foster mother] stated that her husband has not had intercourse with these girls but has only relieved himself against them and admitted that she should have known that something was going on as he has made no demands on her for months.

A note from the chairman of the department later that month states:

The desirability of having a police investigation made into the matters contained in the Welfare Officer’s report … was discussed with the psychologist and the principal of the Women Police. In consequence, a copy of the report was forwarded to the Principal of the Women Police for further investigation.

As a result, the PIC and her sister were returned to Seaforth Home. Later that month, the department sent a letter to the birth mother saying that her daughters had been returned to Seaforth but there was no mention of sexual abuse.

The PIC told the inquiry that in another foster placement she and her older foster sister shared a bedroom. Records reveal the PIC was then 10. She said her foster sister indecently assaulted her many times by forcing the PIC to touch her genitals and also touching the PIC's genitals.

I didn’t like it. I mean, I don’t think at that stage that—I didn’t know, like, it was wrong, it shouldn’t be done or that, but I never spoke about it. And I did tell her I didn’t like it, but it didn’t make no difference … I always wondered whether they found out, and that’s why they sent me back and they never admitted to it, her parents, because I was quite happy there, too.

After being transferred to at least five different placements—like being on a ‘mini merry-go-round’—the PIC, then 15, was placed with a female foster carer who also had two male boarders. The PIC alleged one of the boarders digitally raped her and the other forced his way into the bathroom when she came out of the shower and violently raped her. She said she did not report these incidents to her foster mother or anyone in the department.

She said she was ‘scared of [the rapist]’. A departmental file note states that just before the PIC turned 16, her probation officer ‘had overheard [the two boarders] talking. [One boarder] had said: “I had a Pepsi bottle chock-a-block up [the PIC]”.’ As a result, a departmental worker visited the foster placement and raised the issue of the boarders without directly saying what she had been told. In the note, the departmental officer reports that the PIC told her that the boarders made themselves objectionable, … but when I pressed the point about physical interference, she replied that it was not so. I told her that I would take her word for this, but that a conversation between the boys had been overheard and this had left [sic] me to believe that they may have interfered with her in an abnormal way. [She] still denied this, so I accepted her word.

As a result of this home visit, the department noted that the foster mother now understood what the trouble was between the PIC and the boarder, who had been asked to leave.

She said she was a virgin before the rape and was ‘devastated’ by it.
Evidence from males

In the late 1940s, a six-month-old boy was placed in State care until the age of 18 for being destitute. The PIC told the Inquiry that he had spoken with his mother about their family circumstances at the time, and had learned that his father “was always drunk” and had a criminal record. The PIC alleged he was sexually abused in foster care, at Glandore Children’s Home and at Struan Farm School.

The PIC spent his first six months of State care at a government institution and was then sent with his sister to a foster family, where he lived for the next 10 years. He told the Inquiry that when he was aged about four to six, the father of his foster father took him to the back garden and tried to play with his penis.

The [perpetrator] used to take one of us down the shed or one of us to the dog kennels and try to play around … And it didn’t work. We always used to scream and all this, and carry on. But both of us stuck together as much as we could.

According to his SWIC, the PIC became “too difficult” for his foster parents to manage at the age of 11 and he left the family.
1960s

From available records, the Inquiry was able to determine that 29 adults who gave evidence that they were sexually abused in foster care during the 1960s were in State care at the time of their allegations. Nineteen were females, 10 were males. Twenty six were placed in State care by court order for neglect, unfit guardianship, being destitute, uncontrollable and/or illegitimate; three were placed in State care after committing criminal offences. There were a further six people in relation to whom the Inquiry was not able to properly determine whether they were in State care, because of a lack of available records and/or the historical actions of the APB in placing Aboriginal children contrary to legislation (see page 14).

The allegations included gross indecency, indecent assault and digital, oral, vaginal and anal intercourse, rape and bestiality.

The alleged perpetrators were foster fathers, a foster mother, a foster mother’s de facto partner, foster brothers, male relatives of foster parents and outsiders including a neighbour and acquaintances.

Evidence from females

In the mid-1940s, an Aboriginal PIC was taken to Colebrook Home when she was about one month old, after the death of her mother. She told the Inquiry that she was sexually abused at Colebrook and later in two foster care homes. The United Aborigines Mission (UAM) arranged her placements, in conjunction with the APB. The Inquiry did not receive a record of a court order placing her in State care. Due to the lack of available records and the historical actions of the APB in removing children contrary to legislation (see page 14).

Each of the two foster placements was for about one year. The first placement was with a white family when the PIC was 15. The APB paid the family maintenance for her care. She briefly attended school before being removed to perform household chores at home. The PIC alleged that the foster father, who was a minister, committed acts of gross indecency. She said he exposed his penis in her direct view. She told the Inquiry that he made no effort to cover up, although he was aware of her presence and the two were often at close quarters. To the PIC, the alleged perpetrator had,

Not a care in the world. No dignity, you know.

Probably thought, ‘Oh, well, this is a little black woman here. I can do what I want to do’ … he used to deliberately just have his fly open.

She said, ‘I used to be so humiliated and shamed, you know. I didn’t know which way to turn or who to tell.’ She did not mention the behaviour to the man’s wife.

She was then placed with another white family a year later, where she did domestic duties and lived in separate quarters. She said that on one occasion she was outside doing her chores and approached the foster father, who was masturbating himself and continued to do so in her presence. He did not speak to the PIC, who said, ‘I just dropped everything and just ran back to the house’. She said that her foster father began looking through her room and habitually loitered outside her quarters on the nights his wife was out. While outside, on two separate occasions, he told her how to masturbate herself:

… he was telling me to lie on the sheets with my breasts touching the sheets, to be excited’. She said:

All I used to do is just lay in bed and just freeze, you know, with fright—‘Gee, I hope he doesn’t’—I used to lock the door and all that, ‘I hope he doesn’t come in.’

She said that on one occasion her foster father put her on his bed in his bedroom and

... he did try to force himself on me, but I remember flying up off the bed—I was terrified—so he actually didn’t have intercourse with me. I ran to my bedroom.

Soon after, she said, her foster father had her transferred from his home. The PIC did not tell anyone about the abuse.
In the early 1960s a three-year-old girl was placed in State care until the age of 18 by court order, having been found to be neglected and under unfit guardianship. Departmental records note alcohol abuse in the household and financial pressures had led to the family being evicted. According to a court document the parents sought ‘suitable accommodation so that they may apply for [their] children’s release’. The parents did not maintain contact with the department, however, and ‘repeated attempts to locate them were finally abandoned’.

The PIC was sent to a government home and then placed with a foster family when she was about five, staying there for about six years. The PIC told the Inquiry that her foster father ‘did bad things’. She said she told a social worker during a visit to the foster home but she did not believe that any action was taken.

Departmental records show that in 1970, when the PIC was eight, her sibling complained to her carer that the foster father had abused her and the PIC during a holiday they had spent together a year earlier. When notified of this, the records show that departmental workers met with police and ‘discussed our suspicions without actually reporting any offence’. Two female departmental workers subsequently spoke with the foster family and then separately spoke with the PIC, who ‘had not confirmed any of our suspicions’. The departmental workers recorded that they would keep the accusations ‘in mind, and if any shred of evidence of immoral practice in this home is discovered it will be reported immediately’. Since the alleged sexual abuse occurred 12 months previously and was not confirmed by the PIC the department recommended that ‘no further action be taken except to record mention of this allegation on the foster file of [the foster parents]’.

However, records show that later in 1970, the department first learnt of a complaint made by the PIC to the police about her foster father when she was seven years old, that is, prior to the complaint made by the sibling. Her foster mother took her to the police after a man with a knife allegedly indecently assaulted the PIC on her way to school; a police doctor examined her and reported that she ‘was not damaged internally although her genitals were swollen’. When she was interviewed about the indecent assault, the PIC told the police officer that ‘she had been in bed with daddy’ and she described his penis.

On learning of this disclosure by the PIC to the police, a departmental worker wrote in a report that ‘in view of the accumulation of evidence that all is not well in this home’ a ‘direction be made for the withdrawal’ of all the children from the foster home. The author of the report noted that the police were ‘most concerned’ about what the PIC said about ‘daddy’ but did not think there was enough proof for a charge. The report recommended that the PIC and the other foster children be removed from the home. Records show that early in 1971, the PIC and two other female foster children were removed from the foster home.

An Aboriginal PIC born in the late 1950s was placed with a foster family by the APB when she was four months old, according to records received by the Inquiry. Records from the former Aborigines Department that name the PIC include a list of children for whom maintenance was being paid by that department and a correspondence record showing her placement with the family.

I was told that I was taken away because my father was a white man, unknown, and my mother was a drunken Aboriginal woman, that was—[she] probably died … I didn’t even really know that I was fostered out until I started going to kindy.

She said the truth was ‘my mother and father were married’ and lived in a regional area. Due to the lack of available records and the historical actions of the APB in removing children contrary to legislation, the Inquiry is unable to determine whether she was a child in State care when she was placed with the foster family.

The PIC told the Inquiry that the father of her foster father sexually abused her when she was of kindergarten age. She alleged, ‘He once sat me on him’ on his tractor and his penis went inside her. ‘I ended up in some kind of ward … I remember when I woke up and [the welfare officer] and the
doctor was there.' From the scant records obtained by the Inquiry, it is not possible to say what, if any, investigation was conducted or whether the police were notified.

The PIC told the Inquiry that when she was seven, ‘it happened again with my foster brother’, who was about 15. He

... was coming into my room all the time and then he actually raped me ... He only really raped me once, but he used to come in the room at night and try and muck around with me and I always used to scream and my foster father would stop him.

The PIC said that after her foster brother sexually abused her, a departmental officer became involved. ‘She tried to say that I was lying. I just wanted to leave that house.’ The PIC said that her foster brother continued to touch her ‘sort of like a daily thing’. This continued

... until I left. I tried to kill myself when I was about 10 or 11. I took my foster father’s heart tablets. Another time I set fire to myself. It should be in my records.

The department’s records show these self-harming events occurred when she was about 13. She spent months in a general hospital and Hillcrest Hospital. She said she did not tell any of the doctors that she had been sexually abused.

The PIC said she ‘hated it’ at the foster placement ‘but, at that time, I didn’t think I had anywhere else to go’. She was frightened but ‘after a while you stop being scared. You just don’t get scared any more.’

Records show that after she was placed in State care, she spent time at Vaughan House, where she gave birth to her first child when she was 16.

[Vaughan House] was like a second home ... and I went in there because I knew I was going to go into labour soon—because there was a lot of drink at my aunty’s in that time—and I went into Vaughan House and had [my son] from there ... I just used to like it. I used to feel safe there.

The PIC had another child when she was 17. She said that as a result of her sexual abuse, ‘I don’t trust anybody. I couldn’t trust anybody with my daughter and I feel like that with my granddaughter now.’

A PIC was placed in State care by court order in the early 1950s when she was aged 18 months, charged with neglect and being under unfit guardianship. She had three different placements before the age of three and then spent about 10 years with foster parents. During this placement, she alleged, a neighbour sexually abused her, but she was

... not clear what actually took place. I remember certain things in a car and him doing something and that’s about it, but I believe things did happen. In detail, I can’t remember.

A PIC born into a large family in the early 1950s was placed in State care from the age of five to 18, when a court found her neglected and under unfit guardianship. She told the Inquiry that her father was often out of work because he was an alcoholic. Departmental records show she had several different placements by the age of 10 and was then placed with a foster family, where she stayed for one year. She said the foster father sexually abused her.

The PIC described the foster placement as

... the worst time of my life ... I was continually abused [physically] by their daughter and yelled at by the mother ... I was alone and very afraid. Each day [foster father] would take me to school and have his pleasure. I tried to tell the daughter once but got belted up for being a liar … I was constantly told I was stupid.

The PIC recalled that the foster father’s sexual abuse began not long after she had been placed in the home and continued until she left. He made her touch his penis and perform oral sex on him in the car. She said he never abused her inside the house. Records suggest the placement ended because of ‘excessive bed-wetting’. The PIC said she did not know why the foster placement had come to an end.
Chapter 3 Allegations of sexual abuse

The PIC said the next foster placement, which began soon after she had turned 11,

... was one of love and to this day I consider them as my parents ... I’d say they virtually treated me as they should have—you know, a child should be treated.

The PIC said her former foster parents visited her at this placement and asked her to go on holidays with them. She did not tell her new foster parents why she was extremely upset and they did not pressure her to go. She said she did not have any more contact with her former foster parents.

Her new foster parents eventually adopted her. She said that the effect of the sexual abuse was helped a lot by ‘having a good foster family afterwards’.

A PIC born in the early 1950s was nine when she was placed in State care until the age of 18, after a court found her neglected and under unfit guardianship. She was fostered out to a couple within a year, and stayed for six years. She said she reluctantly called them mum and dad.

She alleged that her foster father soon started to touch her and continued to abuse her until she was in her mid-teens.

When I used to go to the drive-in with my dad, I’d just hang on to my dad all night. I guess that’s when it kind of started ... what happened after that ... and then I knew that it was a different sort of love, different altogether. But, yes, to start with I kind of thought, ‘Yes, he’s being kind and loving’.

The PIC told the Inquiry that on one occasion in the lounge room he digitally penetrated her and threatened her with being sent to Vaughan House if she told anyone. He said that he had to do it so she would not wet the bed anymore. The PIC said that his action caused her pain and she screamed. Her foster mother came in and asked what had happened. He replied that he thought he had hurt her leg. She remembers she was bleeding. The PIC said that on other occasions the foster father would digitally penetrate her while she sat on his knee. She said he also sexually abused her in her bedroom, particularly when her foster mother was at church on Sundays. She told the Inquiry the sexual abuse included ‘quite constant’ sexual intercourse.

... that was just expected of me ... I had to lay there and just shut up ... I remember saying once, ‘Please, have you finished?’ He just put his hands around my neck, you know? That happened quite a few times, that he’s just—he didn’t actually strangle me but he’d go to put his hands around me ...

She alleged that on one occasion her foster mother was at a sewing class at a nearby high school. The PIC was having a shower and he broke the door:

... And I grabbed my gown. She was ... over at [the high school], which is not very far away. I remember running over to there and getting her, you know. I was, like, upset and crying and this and that, and still nothing was done about it. It was like—you know, it was almost like she treated it like an argument, like a disagreement between youse and, like, ‘Get over it’, basically, but she wouldn’t say that.

The PIC told the Inquiry that her foster mother knew the foster father was having sexual intercourse with her because it was

... a concern of my foster mother, ‘Did he leave anything inside of you?’ ... She asked me that once. ‘What if you got pregnant?’ ... I guess she knew about it but she didn’t want to know about it ... she saw him one time ... She caught him so she knew I wasn’t making it up ... [she] was like upset and everything like that. But I don’t know. Once again it was all hushed and ‘can’t talk about it’.

The PIC said she could not tell anyone at school what was happening.

I just didn’t talk about it ... That’s how I learnt from the beginning, ‘You don’t talk about it. No-one will believe you’ ... I felt ... probably ashamed. I used to
I feel physically sick especially when I started high school and we were, learning about reproductive systems and things like that … Guilty, too, because, like I said, in the very beginning I thought he was touching me and caressing me. I almost thought that was a nice thing for him to do, but it went further than that. … when I thought about it this morning it was almost like, you know, ‘Did I encourage him to do that?’ … So, yes, I guess there was some guilt. But I don’t think I felt guilty in the end. I just hated him. As I got older I knew that, no, he shouldn’t be doing it. That’s when I found this strength.

She said that when she was about 15, there was an incident that resulted in her going to the police, although she could not recall the details. She had been in trouble with her foster father and had been crying. At the police station, she said she told the officer her foster father had been having sex with her.

I remember sitting in the room alone and then they came in and basically said, ‘What’s your story?’ and I remember [the police officer] saying, ‘Yes, he told us you would say this story, that you tell lies,’ or something to that effect. Yes, they had spoken to him before me … and I don’t know if I protested and said, ‘I’m not lying’. I don’t know. That was the end of it … The police officer’s attitude was a ‘Go home and behave yourself’ attitude.

She cannot recall if she signed a police statement. The police advised the Inquiry that they were ‘unable to locate any historical records’ that were relevant to a report of an investigation alleging sexual abuse by the foster father.

The PIC told the Inquiry she is not sure why she left the foster home. She said she was in subsequent foster placements, including one that she really enjoyed.

A PIC born in the early 1960s was placed in State care before she was three until the age of 18 when a court charged her with being neglected. She said she did not see her brothers until she was in her mid teens and did not recall if she signed a police statement. She said the police officer’s attitude was a ‘Go home and behave yourself’ attitude.

She said it was a ‘big thing’ to be disbelieved after having told the police. The PIC said that at the time of going to the police, she had a boyfriend (whom she later married).

I think that’s when [the abuse] … started to stop, because that’s when I had, like, this person that actually cared about me. Not that I ever told [my boyfriend] what happened; I couldn’t tell him. But I just found inner strength, I guess, to be able to stand up for myself because I had someone that did actually care about me, and just felt different.

In the early 1960s a PIC then aged 13 was placed in State care until the age of 18, when a court found her neglected and under unfit guardianship. She said that before she was placed in State care a man known to her family sexually and physically abused her. The PIC told the Inquiry that she was also sexually abused in State care while placed at Seaforth Home, Vaughan House and in foster care.

The PIC was placed with a young foster couple for about six months when she was 15. She told the Inquiry that her foster father used to touch her in a sexual way and on one occasion, when his wife was not home, he set up a projector in the kitchen and showed her pornographic slides of his wife. ‘He was creepy … I hated him.’

The PIC said that she recalled him coming into her bedroom when his wife was not home. The foster father would sit talking with her and offer her cigarettes. He also ‘would touch you. He didn’t actually have sex with you.’ He would … walk past you and grab you on the breast and things like that … Just grab you and touch you. It was more like he was pinching you. He was a horrible man.

The PIC told the Inquiry she is not sure why she left the foster home. She said she was in subsequent foster placements, including one that she really enjoyed.
not meet up with her mother until she was in her 20s. She told the Inquiry that she was sexually abused while in foster care.

Departmental records show that within days of being placed in State care she was sent to a foster family, where she lived for more than three years. Her memories of that time are vague:

… something wasn’t going very good because I distinctly remember [the foster father] coming into the room when it seemed sort of nearly dark … For some reason he used to come in the room and hold me by the top of the arms and, like, pin me down on the bed … I was lying on my back … It’s, like, I can’t physically see what he was doing, but I was trying to get away … It’s, like, all blanked out.

She said she probably did not tell her foster mother about what the foster father was doing

because she was rough with me in the daytime as well. Because, I mean, as far as I was concerned, I wouldn’t have known if it wasn’t normal.

The PIC said that she wet her bed for many years. ‘That’s embarrassing … I’ve been basically wetting the bed for as long as I can remember.’

At 6½ the PIC was returned to Seaforth Home and subsequently placed with a widow. The PIC said that was ‘great, a totally different thing … there was just her and me. So she had all the time in the world, so to speak, to spend with me’.

A PIC aged six in the late 1950s was placed in State care until the age of 18 by court order for being neglected and under unfit guardianship. She said she had been verbally and physically abused at her family home. She told the Inquiry that she was sexually abused at Seaforth Home and in foster care.

When she was 14, the PIC was sent to a foster family for six months. One note on her departmental file records a comment that the foster family was ‘the type of people who wanted cheap labour by taking State children’. The PIC told the Inquiry that the foster father regularly sexually abused her. She said:

He was building a house … I used to go with him while he was doing the work. He had intercourse with me then. He said that when I was 18 he would meet me and we would run away together.

Records show that the PIC absconded from the foster placement. When located, she was sent to another placement.

A PIC was aged nine when she was placed in State care by court order in 1960 for being destitute. She told the Inquiry that she was sexually abused while living at St Joseph’s Orphanage, in the family home, at the Convent of the Good Shepherd (The Pines) and in foster care while placed on probation with a couple in a regional area when she was 15.

The PIC told the Inquiry that she had been unhappy at The Pines and wanted to leave. She believed that the placement on probation was a response to her complaints. The placement lasted about six months. She said, ‘I was under threat there the whole time, that if I didn’t give sex to [the foster mother’s de facto partner] that I would be sent back to the orphanage’.

She alleged that she was raped fortnightly and that the same man also abused another child in the household. The PIC recalled that she attempted to tell her departmental worker about the abuse but she ‘raised her voice and didn’t want to listen to what I had to say’. The PIC said, ‘I wanted to tell her’ but ‘I didn’t get it out’.

A n Aboriginal PIC was placed in foster care when she was about nine, after her mother died in the early 1960s. Limited records show that she was known to the Aborigines Protection Board and later received student financial assistance from the Aborigines Department. She said her childhood before being placed with her foster family was one of ‘fun, safety, security’. The records show that the PIC’s relatives instituted foster care arrangements through the Department of Aboriginal Affairs (DAA). She said her first foster home was ‘horrible. They used to beat us, or certainly beat me.’ The DAA transferred the PIC, then aged 12, to a new family registered to receive State children, where she alleged she was sexually abused. Due to the limited records, it was not possible to properly
determine whether she was in State care at the time of her allegations.

In relation to that placement, she said:

> How was I treated? There was no bedding. I got sexually abused. There was no comfort there. There was no—I didn’t feel safe there; no trust there.

DAA records show that her relatives applied to the department to have her for a holiday; a memorandum on the subject notes that since the PIC was ‘now settled [in the foster home] this action may not be advisable’. She said the foster father sexually abused her.

> … my bedroom was right next door to theirs. He would come in at night and just touch me. You know, if we were in the lounge room, I remember being touched by him while [the foster mother] was in the kitchen.

She said he would enter her bedroom at night and forcibly perform oral sex on her once or twice a week. The PIC told the Inquiry that during the placement her foster mother attempted suicide and an ambulance was called, during which time the PIC was sent to her room. She recalled that later in the day a DAA officer removed her from the home. She was uncertain if the foster mother suspected the abuse but ‘I did a lot of blaming of myself for that’. The PIC told the Inquiry that there was ‘no way’ she considered disclosing the abuse at the time it was occurring, only telling family members 20 years later.

A PIC who was placed in State care until the age of 18 when she was three years old in the mid 1950s, was charged by a court with being neglected and destitute. The PIC told the Inquiry she had no recollection of her natural parents. She alleged that she was sexually abused in her first foster care placement, where she stayed until she was about seven.

The foster mother, who was ‘cruel and violent and used to frequently beat us badly with a wooden spoon’, became ill and the PIC was sent away for a couple of years.

During her second stint with the family, she said her foster father began to sexually abuse her when she was about 13. One weekend, she was in a caravan and

> … I’d gone to bed. He came in and he turned the light on—I remember that—and then he came up to me and he give me a hug and he said, ‘I’m the only one that loves you’. He put his hands down my pyjamas and then that was it—it went from there … he penetrated me.

The PIC said the sexual abuse would occur once or twice a week, and then sometimes not for a month or so. She said she did not tell anyone at the time. The foster father had threatened that if she did, she would never again see her brother, who was living on the property ‘… I’d already lost my brother and sister, of course I believed him’. The PIC said she recalled a departmental officer visiting the foster home when she was 14 to 15, but he did not speak to her apart from an initial greeting.

She said the foster father never had sex with her when the foster mother was in the house. However the foster mother walked into the PIC’s bedroom just after he had assaulted her and

> … he was pulling his trousers up … She called me a slut and told me it was an affair and said, ‘Dad’s told me everything’, and I said, ‘Does that mean I’ll lose [my brother] now?’ and she just grabbed my hair and did the normal bash-into-me shit …

The PIC said this incident occurred when she was 16 and near the end of Year 11, which she completed. She then left school and the foster home, and began a career. ‘For many years I carried a lot of guilt and felt that it was my fault that this had happened to me,’ she said.

In the mid 1950s, a PIC then aged two was placed in State care until 18, when a court found her neglected and under unfit guardianship. Records show that before the court order was made, the Women Police Branch had visited her family because of allegations of domestic violence. The PIC told the Inquiry that she was sexually abused in foster care.

Departmental records show that the PIC was placed with a foster family just before her third birthday, and lived there
Chapter 3 Allegations of sexual abuse

for about 13 years. The PIC told the Inquiry that a son of her foster parents was 10 years older than her. She said he sexually abused her many times when she was aged about five to seven. A departmental report states that the PIC started bed-wetting at about this time. She said that the sexual abuse by the son involved digital penetration. 'It hurt a lot.'

The PIC also said her foster father indecently assaulted her in the bathroom on two occasions when she was a teenager.

He said, ‘I’ve come to give you a wash’. I felt very uncomfortable … He washed around my genital regions … then insisted on drying me afterwards … I remember that I felt really dirty.

The PIC told the Inquiry that when she was about 14, a male school friend visited her at home and her foster father found them kissing. She said he was very angry and later that evening he took her for a drive ‘to have a talk with her’. The foster father stopped the car and started fondling her breasts and then digitally penetrated her while she masturbated him. She said she was ‘too scared or frozen to defend myself in any way … I knew it was wrong … but I still didn’t know how to say no’. When it was over he said, ‘Don’t tell your mother … this will not be spoken of, ever’. The PIC told the Inquiry that she did not say anything to anyone about what her foster father did to her because she was not ‘old enough’.

An Aboriginal woman born in the early 1950s alleged she was sexually abused while in foster care arranged by the United Aborigines Mission (UAM). According to UAM records, the PIC’s parents signed an authorisation for her placement in a mission home when she was five. There had been ill treatment by her father. The UAM records note that the authorisation signed by the parents ‘doesn’t hold water legally’. Due to the lack of available records and the historical actions of the APB in placing Aboriginal children contrary to legislation, the Inquiry was not able to properly determine whether this PIC was in State care.

The PIC stayed at the mission home until she was eight and was then placed with a foster family, where she alleged she was sexually abused. The PIC said she was put on a train to the foster placement without being able to say goodbye to her mother, ‘I was, like, couldn’t stop the tears, because I knew I wasn’t going to see her and she wasn’t allowed to come to the station.’

The PIC stayed at the foster placement, which she described as ‘a torture house’, for eight years. She recalled a harsh disciplinary regime and petty cruelties, including being made to walk to church while the other foster children living at the home rode in the car, food deprivation and physical beatings. After being beaten on the legs with a shoe, the PIC said she showed the welts to her schoolteacher, who took no action. ‘She just told me, “Sit down”. She didn’t want to do nothing about it.’

The PIC told the Inquiry that her treatment had sexual overtones. Her foster parents stripped her naked to beat her, taking turns to hit her with their hands. The PIC said that on one occasion she ‘turned around and caught [the foster mother] peering, looking … lifting my buttocks up and looking’ at her genitals. She said that every morning one of the foster parents would inspect her body in the shower, to make sure she had soaped herself, before she could rinse off. ‘I tried to hide—you know, hide myself.’ The PIC said the foster parents told her she was dirty, which was the reason for the ‘inspections’ but to the PIC ‘it was an excuse just to see me, my naked body. That’s how I see it. I didn’t like it at all.’ She said that workers from the Aborigines Protection Board visited the home ‘all the time’, but the PIC did not disclose how she was being treated. She said she was transferred when she was nearly 17, because she had begun to defend herself against the ill-treatment. Oral historical records indicate that friction contributed to the irretrievable breakdown of the placement by the time the PIC was in her late teens.

In the early 1960s, a two-year-old Aboriginal girl was placed in State care until 18 by court order, charged with being destitute. Departmental records state that her mother had abandoned the family and her father had left

55 General records received at the Inquiry suggest that many parents were not informed that children were removed and taken to Adelaide. Timed summary of TRC 5000/161, National Library of Australia, Bringing them home, Oral history project.

56 Ibid., Timed summary of TRC 5000/272.
her in the care of another family while he moved about looking for work. The PIC told the Inquiry she was sexually abused in a foster placement and later at Davenport House.

After almost two years in State care, the PIC was transferred to a foster home where she stayed for about 10 years. She said:

*I just wasn’t a happy person back then. … I felt really lonely … there were happy times but there was also quite a bit of violence, and alcohol, and they were very strict, especially my foster mother.*

She alleged that her foster father tongue kissed her, and ‘when he was drunk he was pretty crude’.

The PIC also alleged that on one occasion, her foster mother’s brother molested both her and her sibling.

*He touched us and got us to touch him ... I just remember it feeling bloody horrible… It was outside on the veranda … sitting one each side of him.*

She said she does not recall telling anyone about the incident. I was too ashamed.

The PIC told the Inquiry she left foster care because her foster mother could not handle her and her siblings and said, ‘I’m putting you girls in a home’.

An Aboriginal PIC was placed in State care from the age of seven to 18 in the early 1960s, by court order for being destitute. Her mother had left the family. The PIC said her father sexually abused her before she was placed in State care and, later, her foster mother also sexually abused her. She was placed in foster care with one of her siblings within a few months of being placed in State care and remained there for eight years.

The PIC told the Inquiry that her foster parents drank heavily and were violent towards each other. She said the foster mother was strict, often inflicting severe physical punishment. After one violent incident, she was sent to another placement but returned to the first foster placement in the early 1970s. She said she became upset with the foster mother and absconded. This is confirmed by the PIC’s SWIC; the only further entry is a note that her term in State care had expired. The PIC said that after absconding, she had no contact with the department. She said that one night when she was interstate after absconding from her placement, she accepted an invitation to a party from a

*... very nice looking man. I thought, ‘Oh, I’ll go to a party with him then. He looks nice’, and I was young and naive. I shouldn’t have got into the car with them, because they took me to a bungalow and gang raped me for eight hours and I was in terrible pain. It was terrible suffering.*

The PIC said the police took her to a women’s prison for safekeeping. She does not recall hearing anything more from the police about the rape. She was unable to identify her attackers.

One evening the owner of the block had placed his hand inside her clothes at the dinner table. She said that:

*... later that night I was in his room ... I remember him trying to penetrate me that night [with his penis] ... I was pretty scared of him after that. I didn’t want to tell mum. I was too scared to tell mum … I might have told [my sister] actually. I can’t remember.*
She told the Inquiry that the rape had a terrible effect on me. As a young teenager, as a child, that had a terrible effect on me as far as trusting men goes but I’m not scared of men. I wouldn’t trust to be with a stranger alone.

In the early 1960s, when she was five, an Aboriginal PIC was placed in State care until 18 when a court charged her with being destitute. The PIC and her older sister were placed in foster care soon after; she lived with this family for more than 10 years before being placed with another foster family. She alleged she was sexually abused in both foster placements.

The PIC told the Inquiry that she really loved her first foster mother and had learnt a lot of things from her. She said that when her foster father got drunk, he ‘would kiss with his tongue and that sort of stuff, but he was never trying to be sexual with me’. The PIC said one of her foster parents’ sons had sexually abused her after a drunken party.

That night we all slept in the lounge ... I woke up with [foster son] like just being sexual with me. I woke up and I went, ‘I have to go to the toilet’, and I went into the toilet and I sat there for ages. Then I came back out and ... I just went up to mum ... laid at the end of her bed. I didn’t tell her anything and at first dawn I got out so she didn’t know I was there.

She said the foster son had put his hands inside her clothing and had touched her vagina and breasts.

When she was about 15 and living with this foster family, she said, a man aged in his 20s raped her. She said the man and his male friend drove her to the shops and on the way home they stopped at another house. The perpetrator’s friend went out the back, while the man and the PIC went inside the house. She told the Inquiry ‘he fully raped me’. 

... whenever I try and remember more clearly, I just go numb and that’s how I coped with it at the time; just shock and went numb ... I didn’t tell anybody and then somewhere down the track, a few days later ... I told [two of my sisters] and I remember what I said to them—’I’m a woman’. That’s all I said.

According to departmental records, a second foster placement was arranged when the PIC reached the end of year 11 at school. She told the Inquiry that life in this home involved ‘a lot of alcohol ..., like drunken parties and people jumping into bed with each other ...’ She said that one evening when the foster mother was away, the foster father sexually assaulted her. She said that he ‘grabbed me by the hand’ and took her into a bedroom. She said that he ‘didn’t actually penetrate me, okay ... but he bit me hard enough around my personal space to bruise me’. She did not tell anyone.

The PIC said that on another occasion, her foster father’s brother sexually assaulted her in bed by touching her breasts and vagina. ‘He came in ... telling me that I was a precious jewel, you know, all this sort of thing, and it was really confusing.’

In the early 1960s, an Aboriginal PIC was placed in a United Aborigines Mission (UAM) home. According to UAM records, she was less than six months old and her mother had requested assistance. The UAM records show that it organised a foster placement for the PIC just before she turned five; she lived there until the age of 12. The PIC had a departmental family file, but the department advised that it was destroyed by fire. No record of a court order was received by the Inquiry showing the PIC was placed in State care. The PIC alleged she was sexually abused at her foster placement and later at Nindee Hostel. Due to the lack of available records, the Inquiry was unable to properly determine whether the PIC was in State care at the time of her allegations of sexual abuse.

The PIC said of her foster parents: ‘I loved them’. She told the Inquiry that the son of the foster family sexually abused her during her years there. She alleged that when she was eight, he took her into a dark cupboard on the property to play with what he called ‘Plasticine’. However, she said, ‘I don’t think I was playing with Plasticine’. She said he would instruct the PIC how to
‘play’. ‘He would say, “Touch it this way” or “That’s nice” or “Rub it a bit more. Do it a bit smoother.”’ She said he often exposed himself to her.

The PIC said that in addition to her being ‘young, naive, gullible’, her foster mother taught her never to question instructions. She said the son once told her to strip from the waist down and crawl through a paddock. He stripped and crawled behind her. ‘I just thought it was a game,’ she said. The two were caught by the foster father and caned.

The PIC said she was sent to live at Nindee Hostel in Adelaide for her secondary schooling, but returned to this placement for holidays. She told the Inquiry that the son continued to abuse her. She alleged that he watched her bathe and also digitally penetrated her.

I was really upset and disgusted because he was my brother. He was meant to be my brother. I knew it was wrong … but because he was older and talked his way, you know—I just knew it was wrong but I couldn’t stop it.

The PIC said she never told the foster mother because the boy ‘was her only son, her favourite child. I couldn’t say anything about [her son] that wasn’t always my fault, anyway.’ Later she tried to speak about what had happened with the foster son, but he claimed that their interaction was consensual.

In the mid 1960s a PIC then aged 14 was placed in State care until she turned 18 by court order as a result of a larceny charge. She said that she was falsely accused. After the court order, she was placed with her mother, who had separated from her father years earlier. She said she was sexually abused while she was living with her mother and later in foster care.

She said that after living with several relatives, the department placed her in foster care when she was 16. She said the foster parents had an older, teenage son who put her under a lot of pressure to sleep with him, which she eventually did. She became pregnant and married him before she had turned 18. She told the Inquiry her welfare officer ‘said I had to get married because I was pregnant. My sister pushed me down the aisle.’ Records note that the department gave the PIC permission to marry. She told the Inquiry that her husband had bashed her.

He did some awful things to me. He used to come home and kick me with his steel-capped boots; take the housekeeping off me again to go gambling; he used to rape me. He was sick.

The PIC said she divorced him and later remarried.

In the late 1960s, at the age of 11, a PIC was placed in State care until 18 when a court found her to be neglected and under unfit guardianship. She told the Inquiry that as a child she had witnessed her parents’ alcohol abuse and separation. According to her SWIC, after being placed in State care she lived at a government institution, which sent her on a holiday placement. This became a two-year foster placement. She told the Inquiry she was sexually abused in the foster placement and also later at Vaughan House.

The PIC said that she missed her family a great deal and wet her bed at her foster home. At night her foster mother would ask her foster father to wake her and another child placed in foster care at the home, to take them to the toilet. After about six months the PIC said that her foster father started to sexually abuse her:

…. she told him to wake us up and take us to the toilet … but with me he’d take me into the lounge and then just strip me off and then rub himself up and down, ejaculate all over you …. Then, yes, he’d get a face washer and a towel, wipe me over and put your pyjamas back on you and put you to bed, back to bed … Sometimes he wouldn’t even take me to the toilet. Sometimes he’d take me to the toilet and then—I’d always pretend I was asleep so he’d have to guide me.

The PIC said that once the sexual abuse began, it happened most nights during the two years. She said she tried to tell [her probation officer] that I didn’t like [the foster father] and I didn’t like, you know, being there and I wanted to go home, but nothing was ever done.
The PIC gave evidence of attempted disclosures to her foster mother.

I think I tried to—I couldn’t understand why she wasn’t asking me why I— because I wouldn’t go near him … she seen it all, but nothing was never asked. I think they used to think I was just depressed and just wanted to go home.

She said the foster father threatened her with returning to the children’s home. The PIC said that she recalled crying one day at primary school and a teacher spoke to her.

I just said I didn’t like being with the [foster family] … he asked me why and I said—I think I just shrugged it off—‘Oh, nothing. No-one listens to me anyway. And that was it.

The PIC said she rebelled and at 13 was involved in the theft of a carton of cigarettes and a sum of money. She was sent to secure care for ‘safekeeping’.

A PIC born in the mid 1950s was placed in State care at 14 under a voluntary custody agreement signed by her mother. The PIC alleged that her stepfather sexually abused her before she was placed in State care. She said her mother, who was a ‘fairly heavy drinker’, called her a liar when she told her about the abuse. The PIC had several placements but, due to her continual absconding, she was charged at 15 with being uncontrolled and placed in State care by court order until 18. She told the Inquiry she was sexually abused in foster care and Vaughan House.

The PIC said she was placed in foster care for a short time. She said she is not clear about the sequence of events, but believes an incident of sexual abuse in foster care occurred before the alleged abuse in Vaughan House.

I’m sure I went into foster care and a man tried raping me in the bathroom, and I said to him—I was in the bath and he said, ‘Let me in, I need to get my shaver,’ or something like that. And I let him in and he tried raping me in the bathroom of his home. Now, I just have a vague memory that man was a priest, but I’m not sure, you know. I could—I’m just not sure.

She said:

He had a wife, and I think he had other children there as well. I wasn’t the only foster child. But I remember that distinctly. I mean, you can’t forget what happened to you in them days, but I remember the fear that I had in that bathroom.

She said she had not told anyone about the incident because her mother had disbelieved her when she had disclosed the stepfather’s sexual abuse.

In the late 1950s a PIC aged eight was charged with being neglected and under unfit guardianship and placed in State care by a court until the age of 18. She told the Inquiry that her parents had some problems: her father was either drunk or unemployed. ‘Certainly there were issues around money...’ According to departmental records, she was variously placed in an institution, with her father, in secure care and in several foster placements. She alleged sexual abuse in a foster placement.

In the late 1960s the PIC was placed with a foster family and said that she was sexually abused by her foster grandfather and her foster sister’s husband:

I would wake up at night with the grandfather trying to kiss me on the mouth. I remember fighting him off. I don’t know whether I’ve blocked out anything else that happened, or nothing else happened, or I was wiry enough to fight him off, but that’s vaguely what I remember of it.

The PIC told the Inquiry she was in this placement for a couple of months. She slept on her own in a sleep-out that was separate from the main residence. She said the foster sister’s husband would repeatedly enter the sleep-out and attempt to kiss her. The PIC told the Inquiry she had blocked out most of the details of the alleged abuse. She recalled that she told someone about the abuse.

I think that’s where the whole thing of ‘you’re a liar, you’re a rotten, dirty liar’ came into it; just the anger and the abuse from the daughter and the wife at the house, just accusing me of being a liar, basically, about it.
A PIC then aged seven was placed in State care until the age of 18 when a court found her neglected and under unfit guardianship. She said that a family member sexually abused her before she was placed in State care. She told the Inquiry that she was sexually abused in a foster care placement and at Vaughan House.

At 10, the PIC was placed with a foster family in Adelaide. She said: ‘It started off quite good there, but then the foster father started doing strange things’. Some days her foster father would be ‘in the driveway in his car, whilst the family’s inside, he’d get me to touch him’. She did not recall if he touched her. ‘I just know that he got me to touch him in places that I thought was a bit bizarre at that age.’ The foster father’s abuse, which included exposing his penis, ‘happened on a few occasions’.

He tried to grab my hand and put it on him, and I tried to pull away and he’s there trying to convince me that it was okay. All I could think about was, ‘This isn’t right’, and, ‘What about the house bit? There’s people in there.’

The PIC told the Inquiry that the foster father’s son ... started doing outrageous stuff in the house. I remember the son exposing himself on a few occasions in the house and I’d see it, be shocked and try and run for shelter.

Records show that she was in this foster placement for about 3½ months. She said that she did not tell her foster mother or welfare officer about the abuse because I didn’t know what was happening myself. I didn’t feel that I could actually go to somebody and say because then I’d just be classed as a liar, troublemaker, something. I’m just a Welfare child.

The PIC told no-one about the sexual abuse ... because [the alleged perpetrator] turned around and said, ‘If you ever tell anyone, and if I’m still living, I’ll kill you’. That still terrifies me.

However, the foster father noticed some marks on the PIC.

He said, ‘What happened?’ and that’s when we told [the foster father]. We knew we could trust [him].

The PIC said that as a result of their disclosure:

there was a raving great argument ... I remember [my foster father] turning around and saying, ‘I don’t give a damn if he’s your brother or not. I don’t like it. It’s wrong. Get out. Get out now. I don’t want to ever see you again.’

As a result, the PIC said that the relative left the home. The PIC also left this foster placement soon after. ‘I just couldn’t settle after that. I was mucking up something shocking; wetting the bed and [I was] very unhappy.’ The PIC said he

Evidence from males

In the early 1960s a PIC then aged four was placed in State care until the age of 18 by court order, after being found to be neglected and under unfit guardianship.

Departmental records show that he spent about two months in a government home before being placed in foster care, staying in one placement for six years. The PIC said he was sexually abused in foster care, at Glandore Boys Home and Kumanka Boys Hostel.

The PIC said that at his first foster placement, his foster mother’s brother ‘slept in the same room as we did’. He said this man tied him and his brother to the bunk by the wrists.

... we were stripped naked, and then he used to stick his finger up our arse and suck us off ... [the foster parents] used to go out most Friday and Saturday nights, and this is when he would—I don’t know the word—have his way with us or whatever ... He used a brush, a brown wooden one ... shoved it right up my arse ...

The PIC told no-one about the sexual abuse ... because [the alleged perpetrator] turned around and said, ‘If you ever tell anyone, and if I’m still living, I’ll kill you’. That still terrifies me.
never disclosed his sexual abuse to his social worker, who was in contact with him and the foster family. ‘She was a sheila. I couldn’t.’

In the mid 1950s, a PIC found by a court to be neglected and under unfit guardianship when he was almost 10 was placed in State care until the age of 18. Departmental records show that he was placed initially in the Glandore Industrial School and, at about 12, transferred to a foster placement, where he lived for 18 months. He alleged he was sexually abused in both placements.

The PIC believed he had lived in the foster home for ‘seven or eight months’ when his foster father entered his bedroom and indecently assaulted him ‘one night when the missus was asleep’. The PIC’s recollection of the incident was incomplete but he said he ‘kicked up a big fuss’. He could not recall if he disclosed the abuse but remembered being transferred from the foster placement. The only note on record of the transfer is: ‘Dept—to go to [hostel].’

In the mid 1950s, after the death of a parent, a PIC then aged eight was placed in State care until the age of 18, after a court found him neglected and illegitimate. The PIC’s SWIC shows that he spent the next three years at the Glandore Industrial School, during which he was placed out for short holidays with foster carers. He alleged he was sexually abused at Glandore and later in a permanent foster care placement.

In the early 1960s, the 12-year-old PIC was placed on holiday with a family that legally adopted him a year later, with the continued supervision of the department. The PIC told the Inquiry that his foster father sexually abused him the year before his adoption and for years after. The abuse first occurred at night in the PIC’s bedroom, which he shared with other children. He said:

\[\text{It was pitch black and next thing I could feel somebody touching me down there … you couldn’t see it was him. It was dark. He said to me, you know, ‘Shh! Be quiet’ … I knew it was him.}\]

On that occasion, the PIC said, ‘I told him to go away and leave me alone’, but the foster father did not leave immediately. The PIC said that before his adoption the foster father did not penetrate him but ‘he’d just grab me on the willy, you know, put his hand down your pants’.

After his adoption the PIC said that his foster father moved him into his bedroom, which his wife did not sleep in, under the pretext that the children were too crowded in their shared bedroom. The PIC said he was ‘forced’ to sleep in his foster father’s double bed for ‘about seven years’ until he left the home. He said the foster father penetrated him ‘every second or third night’ or ‘he used to make me do it to him’. The PIC said:

\[\text{I just told him I didn’t like it. He said, ‘Well, you are going to like it. As long as you are under my roof you’ll do as you’re told, or you can go back to the boys home.’ I didn’t want to do that.}\]

The PIC told the Inquiry that he did not disclose the abuse to his foster mother. ‘I just didn’t want to upset her … she is meek, mild, sweet.’

A PIC born in the late 1940s was placed in State care under a custody and control order when he was nine. He had experienced alcohol abuse and violence in his family. The PIC was first placed at the Glandore Children’s Home, where he alleged that he was sexually abused during an eight-year placement. The PIC also spent about three weeks in a foster care placement, where he alleged he was sexually abused before he absconded.

The PIC said that when he was 17 his foster father ‘sexually assaulted me several times’. He said that he worked at the family’s small business and rose early each day.

\[\text{In the early hours of the morning, I remember he had me in the truck—lying on the seat of the truck—and then lying on the ground and that, and he also made me give him oral sex.}\]
The PIC said that the foster father anally penetrated him on more than four occasions. He said that he attempted to resist the foster father, finally stealing his car and absconding. The PIC drove interstate and was arrested for the illegal use of a motor vehicle. He told the Inquiry he was raped while in prison interstate. The only record the department could locate was his SWIC, which notes his absconding from foster care. He remained a child in State care during his time in jail interstate, however there is no information about this in the records supplied to the Inquiry.

A PIC aged 12 in the mid 1960s was placed in State care until 18 by court order, after being charged with a criminal offence. The PIC said that he had been physically abused as a result of alcohol abuse at home from the time he was small. ‘I’ll never forget it … I never will forget it.’ During one period when he was ‘way too scared to go home’ the PIC broke into a local house for food, which resulted in a charge of stealing. ‘That was the last I ever seen of home.’ He alleged he was sexually abused in foster care and at Struan Farm School.

The PIC’s first placement, which lasted for two years, was with a foster family known to his own family because, he said, they used to ‘drink with them’. The PIC alleged that two foster brothers, who were much older than him, sexually abused him by forcing him to ‘suck them off’. He said this happened twice with one male and ‘all the time’ with the other. The PIC alleged that during the night one foster brother would wake him and make him

... get in his bed with him … He’d make me suck him off and stuff like that all the time … when this took place it made me feel dirty, worthless, not wanting to know people or be around them, not having trust or letting people get close to me. And the stench. It is one smell that lives with a person for many, many years, including the taste. I do remember the corners of my mouth being split and sore, which they used to—all in here. They used to be really cracked open. And the jaw used to ache for days later, like, hurt.

The PIC said he reported the abuse to his foster parent, who ‘laid into me’ with a ‘toasting fork’ and called him a ‘troublemaker’. The PIC alleged that the abuse persisted after he had disclosed it, ‘probably twice, once—it could be three times a week’ for weeks to follow.

The PIC said he did not tell the department about the abuse. In the 2000s, he confronted one of the perpetrators and reported the abuse to a police officer. He said:

I wanted to get it all out in the open and just have it all dealt with. To tell you the honest truth, I don’t think [the police officer] was really interested in it.

The Inquiry’s investigations confirm that the police did not investigate the matter any further. The police told the Inquiry they were unsure whether the PIC wanted the allegations pursued at the time. No formal complaint was made and no statement was taken from the PIC.

A PIC was placed in State care until aged 18, when he was seven in the mid 1960s, by court order after being charged as uncontrollable. The PIC’s SWIC shows that he spent most of his time in State care in a government children’s home. However, when he was eight, he was placed in a foster home for about a year, where he alleged he was sexually abused. He then asked to return to the children’s home.

The PIC alleged he was at the foster placement for five months before he was sexually assaulted. He said his foster parents went out and left him in the care of their son, a youth aged about 17. He and the son had a verbal altercation and the son took his belt off and hit the PIC with it. When the PIC started crying, the foster son pulled the PIC’s trousers down and struck him with the belt. The PIC said he then felt a sharp pain and realised that the foster brother had penetrated his anus. After the assault, the son ‘said if I tell anyone he’d kill me’.

The PIC said his foster brother physically abused him on several occasions. He said attendants at the local swimming pool once had to pull the youth off him when he almost drowned him. ‘Whether he thought he was just trying to scare me or not, I don’t know, but at that age I took it that he was quite serious.’
Chapter 3 Allegations of sexual abuse

The PIC spent another few months in this placement and then asked to go back to the government home. He said that a week or two later, a welfare officer visited the house and

... probably the first time that I’d actually seen a welfare officer the whole time that I’d been with them, to my recollection. They tried to talk me out of it and at that stage I said, ‘No’, I wanted to go back to the boys home.

The PIC said that about two months after his return to the institution,

I was re-approached by a welfare officer stating that they [the foster family] would like me to come back again and I emphatically refused to have anything to do with them.

He told the Inquiry that on a subsequent holiday foster placement, he went to one home with a swimming pool and he would ‘go screaming, kicking, whatever, just not to get thrown in that pool because I still couldn’t tell anyone’.

A PIC charged as destitute when he was six in the early to mid 1960s was placed in State care until 18 by court order. The PIC’s mother had been unable to care for him due to ill health. The PIC was placed in Glandore Children’s Home, where he alleged sexual abuse. He spent time in several foster placements, including about four years in the family where he alleged he was sexually abused; he told the Inquiry the abuse included bestiality.

The PIC’s SWC shows that he was placed with the foster family when he was about nine in the mid-1960s. The PIC alleged that his foster father ‘introduced me to sexual practices’ about six months into the placement. The foster father worked part-time as a farmer. The PIC said the foster father became sexually aroused and masturbated himself when he watched the bull and cows mate. He said he

... moved closer to me and he started to fondle my own pants. My fly—I don’t know whether I undid it or was asked to undo it, but my penis was taken out and he was masturbating and then he started to masturbate myself. That then led on to—at

nights, when we would go down to the dairy to milk the cows—it was just him and me.

The PIC alleged the foster father penetrated the cows and sheep and forced him to do the same. He would fondle the PIC and then the PIC would have to penetrate the sheep.

The foster father initiated this ritual and it continued for about one year.

The PIC said he did not know why the abuse stopped. He recalled that the foster father warned him, ‘You will get into big trouble’, if he told anyone what had been happening. He also threatened the PIC with not being able to see his family. The PIC recalled having contact with his departmental social workers. He said his foster mother ‘primed’ him for these interviews, saying,

‘When you go in there, or when you see this person, they are going to ask you questions about how you are going. So tell me, what are you going to say?’ And I’d say, ‘I like it. Everything’s fine.’ And she would state to me, quite clearly, ‘That’s all you will say, that everything is fine’.

The PIC told the Inquiry that his acceptance of the sexual abuse was related to the physical abuse he suffered at this placement. He said that soon after arriving at the placement the foster mother physically abused him daily.

‘Having dirt and eggs and rubbish tipped all over you; being strapped with a buckle belt, to the point of blood coming out of our legs.’ The foster mother allegedly used her fists and household implements to beat the PIC. He accepted the sexual abuse

... because I could get away from the physical tortures that I was going through ... Sexual fantasy and sexual pleasure was something that I could indulge in to get away from the physical punishment.

He did not tell anybody about the abuse at the time.

He recalled that when he was released from State care at 18, he was walking down the street

... with a suitcase with my belongings, absolutely crying my eyes out because I’d left home … I was
very upset actually … because that’s who mum and dad had been, the department, for so long, and I was very, very confused as well.

The PIC told the Inquiry:

A debriefing would have been really nice; an ability to properly terminate and have an understanding of what was before me, and why things had happened the way that they’d happened … Someone to say goodbye and someone to say, ‘Look, I’m sorry it didn’t turn out the way that it should have turned out’ … I do look back and I know the pain, the suffering and the struggles that I’ve gone through, and that still persists.

Coming to the Inquiry gave him an opportunity to turn around and say to the department: ‘I’m angry about it. That’s what you did because you didn’t institute a level of care that was appropriate for children.’

A PIC told the Inquiry that a family member and a schoolteacher had sexually abused him before he was placed in State care until age 18 for offending when he was 14 in the late 1960s. He alleged that he was then sexually abused at Windana Remand Home, McNally Training Centre, Struan Farm School and later in foster care.

The PIC was placed in foster care in the late 1960s when Struan Farm School closed. The PIC said that his foster mother approached him for sex within a few days of his arrival. ‘I was a bit shocked but, at the same time, it was better than what had happened to me in the past.’

He said a female in State care also lived in this foster placement and was having sexual intercourse with the foster father. This girl allegedly advised the PIC to comply with the foster parents’ demands for sex.

It was made quite clear by [the foster girl] … She told me straight out, ‘If you don’t do what you’re told here, you may as well say goodbye and go straight back into [the institution]’. He said that he did not disclose the abuse to anyone.

A PIC was placed in State care until the age of 18 as a two-year-old, after being charged by a court for being neglected and under unfit guardianship in the early 1950s. Due to the early separation from his large family he was unaware of all his siblings until he was an adult. The PIC told the Inquiry that he was sexually abused at Glandore Industrial School and in a foster care placement.

The PIC’s written evidence to the Inquiry notes that he was unable to recall the date of the foster placement, or the exact events, but said he was in foster care in the late 1950s and early 1960s. He recalled that the foster father abused him. ‘I woke up one night to find this man in bed with me. I don’t remember if anything else happened.’ He said the foster mother had discovered the foster father in bed with him and that he had been returned to Glandore soon after.

I was never interviewed by anyone … I think I would have just clammed up at this stage in my life for I had a deep mistrust of [anyone in authority] and I would have feared being caned again for being such a problem to them. I am sorry to draw a blank on this event, but that is what it is to me, and maybe that’s the way I wanted it.

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The Aborigines Protection Board placed an Aboriginal PIC at Campbell House Farm School when he was five in the late 1950s. The PIC was transferred from Campbell House to a foster placement when he was seven. He alleged he was sexually abused in Campbell House and foster care.

In relation to the foster placement, the Inquiry did not receive a record of a court order placing the PIC in State care, however records show that the director of Aboriginal Affairs approved maintenance payments to the foster mother for his care.

Due to the lack of available records and the historical actions of the APB in placing Aboriginal children contrary to legislation, the Inquiry was not able to properly determine whether this PIC was in State care.
The PIC said that his hair and mouth were inspected before he was selected for the placement. The PIC alleged that another boy living in the foster home ‘tried to get a bit sexual at times’. A third boy ‘intervened and told him where to go’. The PIC remembered, ‘We’d get in trouble for retaliating’. He said sexual advances happened ‘just now and then’.

The PIC said that in a later placement, when he was a teenager, he absconded at night and visited the city over several months. He alleged that during this period a man he did not know anally penetrated him on two separate occasions. He said that he thought the man worked in a city nightclub. He did not tell anyone about the sexual assaults because he was ‘frightened of what would happen to me’.

He told the Inquiry that he went off the rails as an adult, and believed this was...

... because of what happened to me. Pushed from pillar to post, unsettled, trying to find my way, find my real self, who I was, what I was going to do with my life.

An account of two siblings

A brother and sister gave evidence to the Inquiry together about sexual abuse they suffered after a court placed them in State care until the age of 18 in the mid 1960s, due to neglect when they were both less than five years old.

They were placed in foster care together and both alleged physical, sexual and emotional abuse at that placement as well as in other placements. The male PIC also alleged sexual abuse at Lochiel Park Boys Training Centre and Kumanka Boys Hostel, and his sister alleged sexual abuse at Hay Cottage and Davenport House, and in the family home.

The female PIC recalled the police removing her and her siblings from the family home. She and her younger brother were taken to a government home for about three months before being placed in foster care in rural South Australia.

A departmental file on these foster carers contained a letter from the foster mother several years before the placement of these children suggesting that there had been problems in the past with the foster home’s standard of care: ‘I realise that in the past reports have not been good’, the letter stated.

About two years later, in response to a further request from the foster carers for a child, the secretary of the department wrote: ‘The department is not prepared to place any more children with you as things are at present’. About one year later a report stated that, ‘There has been great improvement in the home’. The PICs were placed with the carers after they had made several more requests for foster children.

The PICs lived in the foster placement for 16 months. The female, who was four when she was fostered out, told the Inquiry that the foster mother was ‘a very, very sadistic lady [who] used to bash us quite often’ but she did not inflict any sexual abuse on them—unlike their foster father.

[The foster father] used to get my brother and I out of our beds and ... sit us on mantelpieces in this room as if we were ornaments ... for a very long period of time in the night ... He used to put us in the bath; sometimes by myself, sometimes with my brother or sometimes just my brother. He used to push us with our faces under the water until we could hardly breathe. I remember being so frightened that we were going to die; that this man was going to kill us ...

The female PIC told the Inquiry that their foster father ‘did sexual things to both of us’.

He used knives on my brother and myself. The knives were old knives. They had, like, bone on the end of them. He used to insert them into my brother’s bottom and mine ... yes, and into my front parts. He also put honey or strawberry jam, or something that was sweet, on [his penis] and made my brother or I take it—lick—take it off him.
She said these things happened in the home and in a nearby park maybe twice, three times a week, if not more. ‘I can’t recall exactly, I’m sorry.’

The female PIC said her foster father...

... used to get my brother to touch me down there and he used to get me to play with my brother ...

He used to also take photos if I recall.

She said the foster father...

... got my brother’s hands and he put them in a hot boiling tub; in a boiler. He actually put them in there and I can see my brother screaming in pain. I was so terrified. He threatened me that he was going to do it to me, and I remember I screamed.

The male PIC said he ‘put them in a copper’. The female PIC told the Inquiry that her younger brother went to the local hospital. Records confirm that in April 1965, the boy, aged three years and four months, was admitted to the local hospital for a month.

The female said she could not recall telling anyone at school or the department about the abuse being inflicted on her and her brother. She said that the foster father used to tell her ‘that no-one would believe us if we told anybody what was happening: that we were trouble children’.

In relation to the allegation that the male PIC’s hands were put in boiling water, an inspector’s report noted:

With regard to the boy’s hands, it appears that a container of boiling water was put on the floor in an emergency and this lad had probably put both hands in it. Does not appear to have been any suspicion of foul play.

During the placement the foster mother wrote to the department stating that she had started taking some evening work and her husband was at home alone to mind the children. She said she was sorry if she had done wrong. She said, ‘I didn’t know you didn’t approve until [welfare officer] called a few days ago’.

A few weeks later, in March 1966, the children were removed from the foster home and admitted to a government home. The departmental records mention a letter received from the foster mother explaining her decision to return the children, however the Inquiry could not find a copy of it on the departmental files.
Chapter 3 Allegations of sexual abuse

1970s

Nineteen people (12 females, seven males) gave evidence that they were sexually abused while in State care and placed in foster care during the 1970s. Fourteen were placed in State care by a court after being found to be neglected, under unfit guardianship, destitute or uncontrolled; five were placed in State care after committing offences. The allegations included exposing of the body to gratify prurient interest, indecent assault, vaginal rape, anal rape and oral intercourse. The alleged perpetrators were foster fathers, foster brothers, relatives of foster parents, boarders and outsiders, including a neighbour and strangers.

Evidence from females

In the early 1970s a 14-year old girl was placed in State care by court order until 18 after being charged with breaking and entering with intent to steal. She was released into the care of her father, with whom she stayed for about two months. The PIC told the Inquiry that he ‘would try and molest me and I’d … take off to friends’ houses, but when I come back I got a belting’. The PIC said that just after she turned 15 she decided to run away. While hitchhiking to another town she was picked up by an older couple who invited her to stay with them. Records show that the couple knew the PIC and her family.

When the police tracked the PIC down she pleaded to be allowed to stay with the couple. She told the department that for the first time in her life, she had ‘the love of somebody as she had expected she should get from a mother’. As a result the department arranged for her to be formally fostered by the couple. The PIC told the Inquiry, ‘I sort of felt like I finally got a mum and a dad’. But she later realised ‘they were a couple of old rogues. I ended up working in their opal mine.’ The PIC claimed she was put to work full-time at the mine and lived in a ‘tiny wooden caravan’ with no running water or electricity. She said she didn’t receive any visits or phone calls from the department. Records show that she wrote regularly to her probation officer.

The PIC told the Inquiry that she enjoyed operating the heavy equipment and preparing the explosive materials. ‘To me it was a big adventure.’ Her foster parents eventually shut down their operation and moved interstate. She worked for their neighbour, a single man in his 60s who drank heavily, and said that when the couple moved he stopped paying her wages. ‘It was like I became his possession.’

The PIC alleged that the man frequently sexually abused her and belted her if she refused to cooperate. The first sexual assault occurred when she was working in a mineshaft ‘eighty feet under ground, miles from anywhere’. She said she didn’t have any contraception.

Records show that the department released the PIC from State care just before her 17th birthday. The recommendation for release noted that ‘she has matured to such an extent’ that she should be permitted ‘to have complete control over her own affairs’. Department workers expected that she would join her foster parents interstate and noted that she had $250 in her bank account and planned ‘to set up a small gem shop’.

However the PIC remained with the neighbour for the next seven years. Soon after her 17th birthday she gave birth to her first child. Her second child was born about 16 months later. A third baby was stillborn due to an infection and she ‘nearly died’ in the process. She told the Inquiry that she was totally dependent on the neighbour and that she could not even drive. She eventually moved interstate to escape him and never saw him again.

In the mid-1970s a 12-year-old girl was placed under a three-month care and control order because she refused to stay at home. According to her SWIC she then was placed in State care until the age of 15 by reason of being neglected and was placed at home under her father’s supervision. The PIC told the Inquiry that her father sexually abused her, including digital penetration, before and after her placement in State care.

The department subsequently moved her into a foster placement. She already knew the foster family, having become friends with their daughter at school. Records show she stayed with this family for several months. She
said that after she settled in the foster father started to sexually abuse her. She alleged that about twice a week, ‘maybe a few more’, he would come into her bedroom and lift up my nightdress ... and touch me very sort of gently, I guess, so as not to sort of wake me, and masturbate over me. ... I would just lay there pretending I was asleep.

She claimed that he also grabbed his own daughter’s breasts ‘in a very playful sort of manner’. She said that one day he talked openly in front of the PIC and his daughter about how he ‘knew I wasn’t a virgin ... because of the colour of my nipples’. The PIC said his daughter ‘didn’t seem bothered by this at all’. She told the Inquiry that she felt ‘betrayed ... I lost my trust and I lost my ability to sleep properly’.

The PIC said she did not report the alleged abuse.

A PIC came to Australia with her parents as a little girl in the early 1970s. Records show that she was placed in State care at the age of five until 18, after a court charged her with neglect after her mother left home. The department placed her with a foster family for more than three years.

The PIC told the Inquiry that her foster mother ‘was great’ but the foster father started sexually abusing her not long after she arrived. She alleged that while he read her bedtime stories, he would slip his hand up the blankets and playing between my legs, and if he heard someone come up the hallway he’d quickly pull all the blankets down and keep reading.

She alleged that he abused her about once a week in her bedroom, in the bathroom and at his workplace after hours. The abuse eventually involved penetration. She recalled also being abused in the family car when she was about six:

He used to get me to sit on his lap and have his penis between my legs, and I’d be steering the car. ... At first I remember enjoying that, until I knew what was going to happen, and then I didn’t want to do it.

... the boys would always try to have sex with me, the older boys, because I was sexualised ... because I’d been around and abused I just let men abuse me ... It was always about their needs, never about me.

The PIC said she couldn’t tell anyone about the abuse because the foster father told her that ‘he would go to jail and then he would have to come out and hurt me’.

When the PIC was eight her foster mother became seriously ill. The department removed the PIC and placed her with her birth father and his new family. She was released from State care at 11.

The PIC told the Inquiry that in her mid-teens she confronted her foster mother with the sexual abuse but ‘she just didn’t want to believe it. ... I think she felt in a way maybe she’d let me down.’ A few years later she also met up with her foster father, who had ‘repented and was heavily involved with the church’. He offered to go to the police and have charges laid against him but ‘it just spun me out ... and I just said, “Look, I forgive you. Just leave me alone,” ... I haven’t seen him since that day.’

In the mid 1960s a baby was placed in State care by a court until age 18 after her mother claimed that she was ‘unable to maintain the child’. The reason for committal listed on the PIC’s SWIC was ‘neglected’. After several placements, departmental records show that she was placed with a foster couple for three years, when she was seven.

The PIC told the Inquiry that a relative of her foster mother sexually abused her several times. She alleged that he would take her on drives around his farm ‘and where we would go there would be nobody around. ... he would expose himself and I’d have to do things to him and then he would do things to me’. She did not report the abuse to her foster mother, even though she kept in touch with her for many years after leaving the home.

In her late teens she was placed with a foster parent who had several children. She told the Inquiry that she became a ‘party animal ... taking drugs and alcohol, very promiscuous’. She recalled that...
In the mid 1970s an Aboriginal PIC then aged 12 was placed in State care until 15 by a court because she was unmanageable at home. Then, as a result of an assault charge when she was 15, she was committed to State care until 18.

The PIC provided a statement to the Inquiry but died before she could give oral evidence. According to her statement, while she was living at a government institution she met a woman ‘who took me on’. Departmental records show this woman and her partner, who lived in a regional city, were keen to look after her. The department recommended that the PIC be placed with the couple for a six-week trial as it was felt they could provide her with a better environment than the institution. A report noted ‘the risks associated with the … options and those risks inherent in [the PIC’s] present personality development’.

The PIC alleged that during the placement, whenever her foster mother was drunk, a male friend of her foster parents would come into her bedroom and engage her in sexual activities, including sexual intercourse. She said that her foster father also sexually abused her. She recalled that

I didn’t tell anyone and [my foster mother] never knew … When one of them was dead drunk the other one would come in and vice versa. They both told me not to tell anyone. They said they’d get me and [my foster mother] if I said anything.

In the mid 1970s a 14-year-old girl was placed in State care until 18 by court order after being found to be neglected and destitute. She told the Inquiry that her father had drinking and gambling problems. She was remanded to a government home for a short time and then placed in a foster home, where she stayed for the next 15 years.

The PIC said that her foster family often took holidays with another family. She alleged that during a holiday at a seaside caravan park when she was 13 or 14, the father of the other family sexually abused her. She stated that they were playing in the water when he began ‘touching me between my legs and kissing me more passionately than adults would normally have done’.

She recalled feeling ‘very excited about this person being interested in me. I probably sought him out.’ She alleged that later that day he fondled her in a more intimate way. She said she didn’t disclose the incident to anyone. Since that time

... it’s become a source of great shame to me … because it was the only time I ever received any attention, any sort of physical attention, affection, which is the way I stupidly interpreted it.
A 13-year-old girl was placed in State care until 18 in the late 1960s by court order, charged as being uncontrolled. The PIC told the Inquiry that her alcoholic father ‘used to hit us all the time … When he was drinking he was very abusive mentally, physically, every way you could think of.’ She alleged that she was sexually abused while in State care at Vaughan House and in foster care.

Records show that the department placed the PIC with a foster couple when she was 14. She told the Inquiry that a few weeks into her placement the foster mother went out one evening. The PIC alleged that while she and her foster father were watching TV he started to touch her in a sexual way and then he took her into the bedroom. She remembered screaming but said he put his hand over her mouth, hit her over the head and then had intercourse with her.

The PIC said her foster mother was really nice but she did not tell her about the sexual attack because the foster father ‘threatened to kill me if I ever tell anyone anything, so I didn’t say anything. I just thought the best way is to get away.’ She absconded from the foster home. When the authorities picked her up she did not tell them why she had run away because she ‘was scared’.

She told the Inquiry that ‘my life would have been a lot better than what it is today’ had the foster father not abused her. ‘That had a terrible effect on me. It was frightening, you know.’

In the early 1970s a PIC aged 12 was placed in State care until 18 by court order, for being neglected and under unfit guardianship. She told the Inquiry that both her parents had been mentally ill and drank, and that her mother committed suicide. The PIC alleged that a relative sexually abused her while she was living with relatives in foster care.

Records show the department sent the PIC to a government home for a short while and then placed her with relatives, paying them a subsidy to support her for more than two years. She told the Inquiry that the male relative touched her inappropriately.

He’d say, ‘Give us a kiss’, and I’d just kiss him on the cheek and he’d say, ‘Do you know what a real kiss is?’ and then he’d do that, and then it got to the stage that he was penetrating me.

She alleged that the male relative also got her drunk before he abused her. She said: ‘I thought he loved me, like a Cinderella love story … but it was all manipulation’. After more than two years, she told her best friend, who apparently told her mother. As a result, the PIC stayed with her friend and her mother. The PIC said she told her departmental case worker about the sexual abuse.

I said that [male relative] was touching me in the wrong places and ‘I don’t think it’s right, what he’s doing’. She said ‘don’t be silly. They’re grown-up people; they wouldn’t do something like that.’ … she just didn’t believe me.

Records show the PIC was moved to several different placements, including with her father. She said that when she was placed with her father, the male relative visited her ‘dozens of times’ and attempted to abuse her. She said he ... used to come around …and he would say things, ‘You’d better not tell anybody’ … That was one of the reasons I went from dad’s place. I couldn’t tell dad because I know dad would have killed him.

The PIC absconded from her father’s house and was found by the police in a rural South Australian town. She was returned to Adelaide and placed in a government institution. She said that years later, when she was an adult, she encountered the male relative. He sought to explain the alleged abuse, saying ‘I didn’t mean to do it. It was the clothes you wore.’

In the late 1960s a seven-year-old Aboriginal girl was placed in State care until 18 when a court found her to be neglected and under unfit guardianship. She told the Inquiry that she did not know why she was removed from her family and taken to Adelaide. She alleged that she was sexually abused at Seaforth Home, Clark Cottage, in foster care and in the family home.
When she was 11, the PIC was placed in foster care with relatives for more than three years. She told the Inquiry that she received occasional visits from a departmental worker who was ‘really good’. She occasionally ran away from the placement and ‘would cop a hiding for running away’ from her relatives after the worker returned her to them. She alleged that the male foster carer ‘would expose himself to me’. She recalled she

... had to walk past their room to go to the toilet and when my [foster mother] was in hospital he would have the light on and he’d make a noise so [I would] look and he’d be there wanking.

She said she did not tell her departmental worker because ‘I don’t know, I think you just accept it’.

Another PIC was aged 10 in the late 1960s when she was placed in State care by court order until 18 by reason of being neglected and under unfit guardianship. The PIC told the Inquiry that her mother drank heavily and her siblings tried to ‘hide the grog’. Her parents separated and her father died several months before she was placed in State care. She told the Inquiry that she was sexually abused at Windana Remand Home and then in foster care.

When she was 11 the PIC was placed for more than four years with a foster mother who was known to her father. The PIC said the foster mother made her have sexual intercourse with her and the foster mother’s friends. This occurred from when she was about 13 for a period of approximately two years. As far as she knows there was no money involved but she was given alcohol for sleeping with the men.

The PIC said she ran away frequently from the foster placement to her birth mother’s house. ‘Mum was always passed out when I went there … the police would bring me back [to the foster home].’ She said she told the police that

I hated [the foster mother’s] guts. I didn’t want to go there. I didn’t want to stay with her. I told them that all the time. I just wanted to stay with my mum. … I never told them why, though.

She estimated that she slept with about six different men while living in the foster placement. ‘I just let it happen. I just thought it was part of life; just part of the world you had to play it in.’

Records show that after the placement broke down, the department sent the PIC, then 15, to live with a relative. Departmental records show that the PIC reported:

She is happier than she has been for the last four years. … [The PIC] has on several occasions mentioned the past few years she spent with [foster mother]; apparently there was much more going on there than was ever written in the file. [The PIC] deals with this as … history and is ‘glad that she is out of it now’.

The PIC told the Inquiry she had not told anyone about the sexual abuse. ‘Do you know the answer to why we haven’t said nothing? … shame.’ She said she wanted to tell her story in order to ‘help other kids’ in similar situations. ‘If I can see an end result, that will be all I ask.’

Evidence from males

In the mid 1960s a PIC then aged five was placed in State care until 18 by a court for being neglected and under unfit guardianship. Records show the department had previously been in contact with the family due to unsatisfactory housing and domestic complaints. The PIC told the Inquiry that he was sexually abused at Glandore Children’s Home, in foster care and at Stuart House Boys Hostel.

The PIC said that when he was 11 he stayed with a foster family for about eight months. He alleged that his foster father came into his bedroom and ‘put his hand under the covers and just sort of stroked me … just down the legs’. He also claimed that a foster brother, who was a few years older and slept in the same room,

... tried to root me. … I ended up sleeping in the hallway, the lounge room. They said, “What’s wrong?” I said, “He won’t leave me alone”, so they built me a bedroom out the back.
The PIC said that when he ‘couldn’t stomach [the abuse] any more’ he stole a couple of dollars from the home so that he would be moved out. He said he did not tell his departmental worker about the abuse ‘because you get hurt … that’s what you learn everywhere, in all the government homes. You don’t say nothing, otherwise you get a kicking or worse.’

Departmental records show that the foster placement was initially considered a success but the PIC’s behaviour at home and school started to deteriorate. He was said to be erratic and disruptive and it was noted that he damaged property and stole. A report by the departmental worker stated that the foster father had isolated himself from the family by defending the PIC. There was also a suggestion in the report that the PIC said that he intended ‘to break down the placement’.

In the early to mid 1970s a seven-year-old boy was placed in State care until 18 by court order when found to be neglected. The PIC told the Inquiry that his mother had been unable to look after him because he had a medical condition. He alleged that he was sexually abused in foster care and later at Slade Cottage.

Departmental records show that the PIC was placed in foster care with relatives for a few months when he was eight. The relatives had a son, who was several years older than the PIC. The PIC told the Inquiry that at first he liked the son and ‘we used to do everything together … He was my hero.’ He alleged that one afternoon the son took him to a cubbyhouse, where he tied him to a table and anally raped him. The PIC recalled screaming and being very frightened. He said the son then cut the PIC’s chest with a piece of glass ‘and said if I tell anyone that “I’ll do worse”’. The next thing the PIC remembered was ‘sitting with a blanket wrapped around me in a police car’.

Departmental records show the perpetrator, who was also a State child at the time, was found guilty of indecent assault in the Children’s Court. He was discharged on probation subject to being of good behaviour for 15 months and remaining under the supervision of a departmental officer.

The PIC was then returned to his mother.

Police advised the Inquiry that documents relating to this allegation of sexual assault have been destroyed. The departmental files contain no information about the assault, despite the fact that the PIC reported the matter and the perpetrator went to court.

The PIC told the Inquiry:

For all my years I thought it was a dream … until I seen the proof on the piece of paper. … [The assault] plays on my whole life. … every time I see something that’s happened to a kid on TV I can’t stop crying.

A 15-year-old boy was placed in State care in the late 1970s under a temporary administrative order when his mother became unable to care for him. The order was then extended by a court to the age of 18 on the grounds of neglect. The PIC told the Inquiry that his stepfather had physically and sexually abused him as a child before abandoning the family. Records show that his mother contacted the department and reported that she felt ‘incapable of caring for [her] children’ and ‘may harm them’. A social worker subsequently became involved with the family and the PIC was placed in State care. He alleged that he was sexually abused in foster care and at Stuart House.

The PIC said that his foster father sexually abused him while they were praying and also when he was in the bath. The abuse included anal penetration, both digital and penile. He said the foster father ‘told me that it was just between us’. It is unclear precisely when this occurred and it may have been during an emergency placement before the PIC was formally placed in State care.

The PIC recalled a departmental worker coming to the house but he said he didn’t tell him about the sexual abuse.

I was afraid of what might happen to me … I didn’t know what was going on. I was confused, I was scared, didn’t know who to trust. And adults were becoming, you know, pretty frightening to me by this stage.
Chapter 3 Allegations of sexual abuse

The PIC said that he did tell the worker that the foster father was hurting him and he wanted to be somewhere else. A few days later the department moved him to another foster home. He said that about this time ‘I met some kids and started running away and being on the streets’. He subsequently lived at Stuart House, where he alleged he was sexually abused.

In the mid 1970s a 14-year-old boy was placed in State care until 18 by court order after committing an offence. He told the Inquiry that he was sexually abused as a child before being placed in State care and later when placed at Brookway Park and in foster care.

He told the Inquiry that one of his foster homes was ‘a very confusing place’ where ‘there was a guy there that was abusing other girls, other foster kids’. He claimed that the foster father gave him drugs. Departmental records show that about this time the PIC exhibited behavioural problems and was involved in offending.

The PIC alleged that when absconding from this placement, when he was about 15, he met a man in the city who ‘took me home to his place and I slept at his place for the night … the next morning there he was masturbating in bed’. He told the Inquiry he often lived on the streets and ‘slept in public toilets because that was the only place I could sleep to keep warm’. He also said he was approached by a man in an Adelaide park, who performed oral sex on him, and invited him into a public toilet; when the PIC entered he saw four men waiting and ran off. He said he did not disclose the alleged abuse.

An 11-year-old boy was placed in State care in the late 1970s under a short-term care and control order by reason of being uncontrollable. The PIC was later remanded to secure care for short periods several times between the ages of 15 and 17. He told the Inquiry that he was sexually abused while at Stuart House and in foster care.

The PIC said that in his early teens he was placed in foster care at an INC placement, which was initially happy. ‘I was actually laughing, having a good old time, you know. [The carer] was being a father figure, tickling me, you know, laughing with me and stuff.’ He alleged that the carer pushed the PIC’s face on to his penis; an incident that made him leave the home:

‘It just put me back to where I was. Like, who do you trust, you know? I didn’t trust anyone. … I certainly felt ashamed, yes. Absolutely.’
The PIC said that he spent intermittent periods living on the streets between his care placements and was propositioned by men. He alleged that on one occasion he went with another boy to a man’s house in North Adelaide to exchange sex for money.

The PIC said he did not feel he belonged at his various foster placements ‘even though they’d try their best to make me feel comfortable and everything … it just wasn’t where I wanted to be’.

A PIC was privately placed in a non-government institution when he was 10 in the late 1960s and lived there for six years. His SWIC shows that at 16 he was charged with breaking, entering and stealing. He was sent to McNally Training Centre for two weeks and then transferred to Lochiel Park Boys Training Centre, and was placed in State care until 18 by court order.

The PIC told the Inquiry a residential care worker, whom he had briefly met at McNally, visited him at Lochiel Park. The worker told him that he had come to look after him. The PIC said he frequently stayed with the care worker and his son at weekends. His SWIC records that after about four months in Lochiel Park the PIC was boarding with the worker which, for the purpose of the Inquiry, is treated as foster care.

The PIC alleged that his foster carer committed a series of sexual assaults on him. They initially involved regular instances of touching and fondling.

He just come into the room there and started slapping your backside, and it’s like, okay, and then it was just like touchy-feely stuff … basically around the private areas. You think, okay, because I wasn’t in the boys home then anyway, and I thought, “Well, okay, I’ll not worry about that”, and then it basically got to the stage where it was just becoming, I suppose, more constant … it might be a week, it might be twice in the week … and it was, like, you freeze.

The PIC told the Inquiry that he went on a trip with the carer and his male friend. He said both men molested him by touching him and fondling his genitals.

On one occasion, the PIC said, his foster carer took him ‘around the throat’ into the bathroom and raped him. He told the Inquiry that after that incident the foster carer again tried to rape him in the kitchen. The PIC said he picked up a knife when the foster carer was

... coming towards me one day, and I just had the knife in my hand, and it was the one time in my life I actually felt good about sticking up for myself.

He told the Inquiry:

I just said, ‘It ain’t going to happen again’, and it’s like he just tried to butter it up by way of, ‘What do you mean?’ … ‘She’s cool’, rah-rah.

The PIC subsequently moved to another placement. He said that giving evidence at the Inquiry was the first time he had ever disclosed the alleged abuse.
Chapter 3 Allegations of sexual abuse

1980s

Twenty three people (14 females, nine males) told the Inquiry that they were sexually abused after they were placed in State care and living in foster care. Twenty two were placed in State care by a court for neglect, unfit guardianship or being found to be in need of care; one was placed in State care for committing a criminal offence. The alleged abuse involved indecent assault including masturbation and digital, vaginal, oral and anal intercourse and rape. The alleged perpetrators were foster parents, foster mothers, foster brothers, other foster boys, relatives of the foster parents, partners of foster mothers and outsiders including a police officer, student social worker, camp worker, acquaintances and strangers.

Evidence from females

A PIC was five in the mid to late 1970s when she and her siblings were placed in State care until 18 by court order, having been charged with being neglected. The PIC and her siblings were placed with foster parents, with whom she lived for more than four years. She told the Inquiry this placement was ‘a nightmare’ and that they endured significant physical and psychological abuse at the hands of the foster mother, who would ‘always drink alcohol, all the time, every day’.

The PIC’s SWIC records that when she was about 10 she was placed with another foster carer for three years. She told the Inquiry this placement ‘started off okay’, and then the foster mother ‘started to change’, becoming threatening by saying, for example, ‘she was going to stab the scissors in the back of our neck and cut our heads off’.

The PIC alleged that the foster mother started ‘thinking sexual … everything that we did meant that we wanted sex’. She said she did not know what sex was at the time. ‘We were never taught.’

The PIC said the foster mother’s son once exposed his penis to her in his bedroom and ‘was trying to get me to touch his private area. He pulled my hand towards it … I touched it slightly and I tried to pull away.’ She said she ran out of his room and did not say anything about what she had seen or experienced because ‘we were scared to do anything’.

The PIC also alleged that on one occasion her foster mother called her into the bathroom, and told her to take off her clothes and lie on a towel on the floor.

That’s when she told me that she used to [masturbate] in her bedroom all the time … she tried to put her hand down on my private area. I was screaming and kicking her hands away … She then told me to get in the bath and she purposely dropped the soap in the water, and she was fishing around the water and she put her hand on my private area. I … pushed it away.

The PIC said she did not tell anyone about this incident. She told the Inquiry she cannot think of ‘one moment of happiness’ during her time in foster care. She said she felt, ‘pretty much still the same now. Like a nobody’.

In the mid 1970s, a five-year-old girl was placed in State care until the age of 18 by court order, charged as neglected. She alleged that she was abused in two foster placements and at Birken Lodge.

The PIC’s SWIC shows that when she was eight, the department placed her in a government-owned home. She told the Inquiry that a year later she moved into care with a foster family where she stayed for the next seven years.

The PIC said an older foster male at the home twice ‘touched my private parts’ and penetrated ‘with his hands’. She said she disclosed the abuse to a daughter of the foster mother. Departmental records show that when the PIC was nine, the foster mother reported that a young foster male had ‘sexually assaulted’ the PIC. (Other records show the man was 19 and boarding at the house.) They state that the male had reportedly undressed himself in front of the PIC, told her to take her pants off and had then ‘played with her’. The PIC told the Inquiry that her foster parents reprimanded her for letting this happen; the second time she ‘got a hiding’ from her foster mother for ‘letting him do that’.

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The PIC's departmental records do not show whether she was questioned or counselled about the allegations. There was apparently no police involvement. Her records seven months after the incident describe it as ‘unfortunate’, that the ‘young man’ was ‘temporarily staying at the home’ and that he had ‘exposed himself and made indecent suggestions’. It is recorded that the PIC ‘seems happy and content in the care of the foster parents’. It is not evident that he was moved from the placement after the reported allegations.

The PIC also said that when she was 12 she did some cleaning for pocket money on three or four occasions between 2am and 10am at a nightclub where her foster father worked. On one of these occasions, the PIC alleged, she and her foster father were ‘mucking around … and he pinned me down and started touching my breasts and things like that’. He had warned her not to tell her foster mother. On another occasion, she alleged that her foster father had ‘stuck the skipping-rope into my private parts’. The PIC said she told her school counsellor about her foster father pinning her down and fondling her breasts at the nightclub.

Departmental records show that in the early to mid 1980s, when the PIC was 15 and still with the same foster family, the department investigated the foster father. He admitted offering a monetary bonus for a cuddle to a former foster child, but he denied the PIC’s allegations. The records also show that departmental workers interviewed three of his previous foster children. The investigation concluded that because of the foster father’s ‘unblemished record’ and the PIC’s two previous accusations about other people (that a teacher was playing with himself and a friend’s father exposed himself), the allegations were found to be unsubstantiated. ‘However, we would continue to monitor the situation on an ongoing basis … as has been the practice for the past seven years’. There is no record that the department passed on her allegations to police.

The PIC was then moved to an INC placement, where she stayed for about 15 months. The PIC alleged that her new foster father had sexual intercourse with her initially once a week and then twice weekly when his wife was out of the house.

She was then moved to Birken Lodge, which she described as like ‘a concentration camp’. She recalled that most of the residents were elderly and that the home was for people with mental health problems. She said she had been receiving treatment for ‘behavioural’ issues. She said the son of a staff member sexually abused her more than once:

He was touching me and … masturbated over my sleeping bag, because at one stage I was allowed to sleep in the day room. He used to touch my private parts.

Departmental files contain a record by the PIC’s social worker that she told him she had been raped by a staff member’s relative, and then ‘withdrew the accusation’. The records indicate that the worker consulted the Intellectual Disability Services Council (IDSC) and there was ‘no specialist available’. He then approached a psychologist who was ‘happy to assess the situation’. It is recorded that the worker discussed ‘the rape allegation’ with the PIC, who ‘did not wish to discuss the situation”; and then, “Said we are looking at providing some special help for her to discuss sexual problems—very non-committal’.

The PIC said that after about six months, she had disclosed the abuse to a staff member at a child care centre where she was working. Records show that the PIC had attempted to cut her wrists at this time. The police interviewed her and organised for her to have a medical examination at a hospital. However, the PIC told the Inquiry that a staff member at Birken Lodge, where she was placed at that time, told her that, ‘They’re going to be sticking probes into your private parts’, and she ran away from the hospital before being examined. The PIC retracted the allegations, and the police did not proceed. The PIC said she felt ‘intimated’ and ‘frightened’ that she wouldn’t be believed. ‘No-one believed me with the first one [the foster father] and so when I went there, I said it didn’t happen.’
On reflection, she said she feels she
… pushed my way into other people’s houses …
but the main thing is to go somewhere where I was
safe and be able to tell people stuff … You always
think you smell, you know, that you’re not worth
anything, because you’re told at an early age when
you’re in there. ‘You’re not worth anything, you’re a
mental case’.

A PIC aged 14 in the late 1970s was in State care
when she was placed in the South Australian Youth
Remand and Assessment Centre (SAYRAC) and then put
in an INC foster placement while the court adjourned
criminal charges against her. Her SWIC does not record the
terms of her sentence. She told the Inquiry that she was
sexually abused in the INC foster placement when she was
15.

The INC foster mother gave evidence to the Inquiry that
she introduced the PIC to a local police officer because she
thought he might be a good influence on her. The PIC said
the police officer [PO] sexually abused her when she was
15. The PIC said she and [PO] would go to a remote
location to drink alcohol and sometimes smoke marijuana.
Sexual activities, including penetration, occurred against
her will.

He would tell me not to tell [foster mother] and
things like that. If I ever did, me being a street kid in
the past and have told lies to police and been a
naughty girl, that not only would I do the rest of my
[bond] time in SAYRAC, it would go a lot further
than that because being such serious accusations
against a police officer it would be years
imprisonment.

The PIC said she left Adelaide at 16 and returned when
she was 17. She said she went out with [PO] a few times
and they continued to have sexual relations. The PIC told
the Inquiry that at about this time she disclosed the abuse
to her foster mother, who contacted the police.

The PIC said that the police internal affairs branch told her
and her foster mother that [PO] had a brain tumor and
there would be no prosecution. Disciplinary charges were
laid against the police officer, who then resigned.

In 2003, however, charges were laid in the District Court.
The matter was listed for trial, but a defence application for
a permanent stay, partly because of the delay in the
charges being brought, was granted. In his decision, the
judge said that after the disciplinary charges were laid and
the police officer resigned, ‘No further action was taken by
police at the time and it is not clear why this was so’. The
judge said that if police told the complainant that nothing
further could be done because the police officer had a
brain tumour, this was not true. Documents produced to
the District Court show that in the mid 1980s the South
Australian Police Internal Investigation Branch (IIB) received
a complaint against [PO]. The police disciplinary review
officer decided that there was insufficient evidence to lay
criminal charges and recommended that disciplinary
charges be laid. However, a signed witness statement by a
senior retired police officer who, at the relevant time, was
responsible for disciplinary matters involving police officers,
states that ‘I believe I was absent from work and the
[disciplinary] charges were approved by’ another senior
officer. The statement also says that he had since read the
IIB file and its summary ‘and I am absolutely appalled of the
recommendations that were made’. The statement
continued:

If I had seen the file I would have rejected these
recommendations and would have instructed that
[PO] be charged criminally … In my view now, after
reading the file the recommendations and
determination to proceed with [it] as a disciplinary
matter was wrong.

Another reason for the judge granting a permanent stay
was the fact that the PIC had destroyed her memoirs. It
appears from the judge’s ruling in court records, that after
the investigating officer sought the memoirs in order to
disclose them to the defence as part of the trial process,
the PIC destroyed them.
A 12-year-old girl was placed in State care in the late 1980s until she turned 18, when a court found her to be in need of care. She was sent to a foster placement, where she alleged that she was sexually abused.

The PIC told the Inquiry that one day her foster father came into her bedroom, sat on her bed and showed her...

... these little books, like pornographic books ... he told me that he was going to leave them there on my bed for me ... he touched me and ... told me it would make me feel better.

The PIC said he came back later and ran his hand up her leg. He tried to touch her breasts and vagina, and she had “just flipped out”. On another occasion he made inappropriate comments about her body while she was wearing bathers. She also said that he used to walk into the bathroom and ‘would walk around nude, telling me it was natural’.

The PIC said that on one night she ‘decided enough was enough and ... I shoved him out of the way and just took off’. She did not report the abuse to her departmental worker or to her foster mother.

The PIC said that when she was about 19, she told her parents that

I don’t want to talk to [the foster parents] because we used to always run into them ... I just told Mum, ‘I don’t like them. I don’t want to talk about them.’ ... basically I said, ‘Dad, stuff happened there that I’m not happy with and that shouldn’t have happened, but it’s not a good time to tell you,’ and that’s all I said.

A PIC told the Inquiry that her stepfather had sexually abused her two or three times a week from the age of 10. As a result, she said, she started running away and stealing.

... trying to get myself into trouble. I’d steal things from school. Nothing that I needed, just ... I wanted to be taken away. I didn’t want to be there. I wanted to get locked up.

By the age of 14, in the early 1980s, the PIC was placed in State care by a court under an interim order after it was found that she was in need of care. She told the Inquiry that she had reported the sexual abuse to the police and was placed in State care as a result. She was released from the order about eight months later. She said, however, that she was pressured by her family to drop the charges.

The PIC said she was sexually abused in foster care during her time in State care.

She told the Inquiry her foster father sexually abused her. She said it started with ‘sitting on his lap by the pool and he started touching me’ and developed into sexual intercourse. She said that the sexual contact continued for about six months. ‘He was telling me he loved me and nobody would ever hurt me, and he’d look after me forever.’ She recalled that her foster mother threatened him with taking the children away and she was moved to another foster home, where she tried to commit suicide.

I didn’t understand why I was being shoved out to nowhere. I didn’t know. I just felt lost. I didn’t understand why he could go back and live a happy, healthy everyday life like he had been living and I was back in turmoil again.

The PIC said that on one occasion she ran away from the placement and stayed a night at the home of her friend’s male relative. She slept in the lounge room and alleged that during the night the relative penetrated her with his penis and fingers. She said she reported the incident to the police. Court records show that the man was charged with rape but the Crown accepted a guilty plea on a lesser charge of indecent assault. The relative was sentenced to six months’ imprisonment, which was suspended upon entering an 18-month bond and doing 120 hours of community work. The PIC said that she ‘never had counselling’. The sentencing judge told the defendant that the PIC’s account of the incident differed ‘in material respects’ from his, but,

The prosecution is content that I should sentence you upon the version of the incident which you gave to the police. ... It was not by any means the most
serious type of indecent assault and you desisted from it when the girl's objections were made clear. However, you are 41 years of age and the girl was only 15 …

The PIC also told the Inquiry that she had sex with a student social worker whom she met at a departmental suburban office when she was about 14 or 15—she is unclear about the timing. She said her departmental worker introduced her to the student worker ‘to help me and to then help him learn’. She said she and the student worker had consensual sex at his house more than once, but he ended the relationship because it could have jeopardised his employment.

A five-year-old girl charged with being neglected and under unfit guardianship in the early 1970s was placed in State care until the age of 18 by court order. The PIC told the Inquiry her parents had separated and her mother suffered from mental illness. She alleged that while in foster care she was sexually abused on a camp at the age of seven.

The PIC said that the alleged abuse occurred on the first night of the camp. She recalled feeling scared because she was alone and shy. One night in the dormitory, she was still awake and a worker asked if she was all right. She said she was uncomfortable because she felt too hot; he invited her to sleep with him and she accepted because she often shared a bed with her mother. She told the Inquiry that the alleged perpetrator made her strip her clothes off. He began touching her body and put his penis between her legs. She said he tried to penetrate her vagina but did not. She remembered: ‘I was very scared and I didn’t know what was going on and didn’t understand why [it was happening]’. She said: ‘He told me that it was a big secret and not to tell anyone’.

Records show that although the PIC was released from State care at nine, the department continued to keep in touch with her. She was returned to foster care when she was 12–15 due to her mother’s mental condition but was not in State care. She told the Inquiry that her foster father sexually abused her over about two years.

A five-year-old girl was placed in State care in the mid 1980s by a court under a succession of short orders, because she was in need of care. About 15 months later the orders were extended to the age of 18. The PIC alleged that family members had sexually abused her before she went into State care. One family member was convicted of sexual offences in relation to her. The PIC told the Inquiry that she also was sexually abused in various foster homes over a six-year period.

In one of the foster homes, the PIC said, a teenage boy sexually abused her when she was eight. She said the boy, who was her foster parent’s son, “used to say a lot of sexually explicit stuff” and he sexually interfered with her, including digital penetration. ‘We were playing hide and seek … He got me behind one of the silos, pulled my pants down and started doing stuff.’ She said she told her mother ‘straightaway, I saw her the next day’, during an access visit. Records reveal that the mother notified the department and the police. The PIC was medically examined and removed from the foster family. The family’s registration as foster parents was suspended but later reinstated.

Departmental records also reveal that when she was nine the PIC told her mother that a social worker had touched her in a sexual way, but no further details of the alleged abuse were noted. Records show the department conducted an investigation but could not substantiate the allegation. The PIC told the Inquiry she could not recall the allegation.

She also alleged that when she was about 10 and living with another foster family, her foster father would insert his fingers into her vagina as he gave her a piggyback ride every morning over a few months. She said that she did not tell anyone.

When she was about 11, the PIC was placed with another foster family who, she said ‘were really good and they treated me just like part of the family’. According to departmental records, after about 18 months her foster mother arranged for the PIC to spend a respite weekend
with her friends, ‘who were approved foster parents’. The PIC told the Inquiry she woke up to discover one of the sons ‘was on top of me. He had taken my pyjama bottoms off. I couldn’t scream. I couldn’t do anything. I couldn’t move.’ She said that she reported the sexual abuse to her foster family. ‘His stepfather dragged me into the bedroom where the son was and he made me watch him horsewhip him.’ Records show the department investigated this incident and as a result the PIC was counselled and police started an investigation. The PIC was moved to a new placement. The department deregistered the respite foster parents on the basis of the boy’s ‘ongoing abuse of children’ and the subsequent severe beating by his stepfather.

The PIC was then moved to another foster couple where, she said, the foster father made sexual suggestions and lurid comments to her. She said he ‘didn’t do anything. He was just a dirty old man’. Records show that she told her social worker and as a result the department and police investigated and she was removed from the placement.

In the mid-1970s a court found a six-year-old girl to be neglected and placed her in State care until the age of 18. Departmental records show she was returned to the care of her mother at home on at least two occasions after being placed in State care. She alleged to the Inquiry that she was sexually abused in the family home and then later in foster care.

The PIC’s SWC shows that the department placed her in a foster home when she was nearly nine, and she stayed there until she turned 18. She said it was a good family but she sometimes had nightmares and she did not know if the foster parents knew of the sexual abuse she had experienced in the family home. She told the Inquiry that an older foster boy who lived in the foster home ‘touched me around my boobs’. She said that this boy would buy gifts for her and another girl who lived in the home. ‘He used to buy us something to hush, hush, you know. … I never liked him.’ She did not tell her foster parents about the abuse because ‘we were too scared to say anything’. She believes that her foster mother found out, however, because she kicked the boy out after ‘an incident’.

An Aboriginal PIC told the Inquiry she ‘might as well say my grandmother grew us up. Mum was only there part of the time.’ In the late 1970s, at 11, she was subject to a three-month court order because she was uncontrollable and running away. Later that year she was charged with theft and was placed in State care until 18 by court order for being in need of care.

When she was 12 the PIC spent several months with an Aboriginal foster family. She alleged that the foster father sexually abused her. She told the Inquiry that whenever she did something wrong she was made to go into the bedroom and stand for ‘what felt like a couple of hours’. She said her foster father told her to take off her clothes and to get on the bed. She recalled that ‘I was like crying and upset and I didn’t want to’. She alleged that he would ... lay on the bed first and stare at me ... and then he’d get up and walk past me and stand really close to me, like breathe heavy on me and touch me on the breasts ... and then I started growing a bit of pubic hair down there as well, and he was doing the same thing down there, just rubbing it really softly. ... And then he’d say like, ‘it’s no good running to the police because they won’t believe you because I’m a very well respected man in this town,’ and I felt, like, I just was sick.

The PIC said she did not report the abuse, which occurred ‘more than once’. She told the Inquiry that she became an alcoholic by the age of 13. She said that when she was 16 she was placed with relatives who made her attend school and refused to allow her to drink. She said she was grateful to them for that.

Departmental records show that in the early 1980s a seven-year-old Aboriginal girl was placed in the care of extended family members, who were registered foster parents, when her grandmother was no longer able to care for her. No records were received to show that she was in State care at that time. The PIC told the Inquiry that her foster father sexually abused her about four or five times a week when ‘he reckons I was being naughty or stuff like that, and that was my punishment’. 

3.4 Foster care
In the mid 1980s the PIC, aged 10, was placed in State care under a 12-month court order, after being found to be in need of care. The order was extended to the age of 18 the following year.

The PIC told the Inquiry that in another foster placement, a male relative of her foster parents tried ‘to touch my body’ while she was in bed.

*I woke up and just screamed that loud so everyone in the whole house could hear me, because after everything that happened before I just didn’t want to go through all that again.*

She said she told her foster family what had happened and a foster sibling ‘ended up punching into him’. The foster parents set up a bed for her in their room for a few nights until she ‘felt safe’. Records show this placement lasted seven months when the PIC was 12.

In the mid 1980s an 11-year-old Aboriginal girl was placed in State care by court order until 18 by reason of being in need of care. She told the Inquiry that she was sexually abused before going into State care by various relatives. She said she tried to tell her mother about one relative ‘but [mother] always used to bash me with the broom and mop and say, “Shut up, you little cunt. I’m not going to listen to you.”’

The PIC said that one day she told a staff member at her primary school about the sexual abuse. Records show that the Sexual Assault Referral Centre examined her and confirmed that she had been sexually interfered with. One report stated that the PIC provided a clear account of sexual abuse involving intercourse by four perpetrators at home. The allegations were reported to the police, who investigated, but records show the PIC refused to give them a statement because she was scared of violence from her family. No further action was taken. The PIC said departmental officers visited her while she was in foster care ‘but I would never say anything … because I was scared’.

A PIC told the Inquiry she was born in the mid 1970s to a teenage mother and a father who was in and out of prison. She was placed in State care under three-month care and control orders when she was aged one and three. When she was six she was placed in State care until 18 by a court after concerns were raised about the quality of care within the family. The PIC alleged she was sexually abused in one foster placement while in State care.
The PIC and a sibling were then placed with a foster couple, to whom they were related. She alleged that her foster father began to sexually abuse her several months after they came to live at the house. She said he touched her ‘in the bathroom while I’m bathing’ and made her ‘perform sexual acts on him’ including oral sex and masturbation. She said he penetrated her with ‘his fingers and sometimes other objects … bottles and candles and things like that … quite regularly’ but he never tried to penetrate her with his penis. She alleged the sexual abuse happened once a week for most of the four-year placement.

Just before she turned 10, the PIC and her sibling told their mother during a visit that the foster parents subjected them to substandard living conditions and physical abuse. They did not mention the sexual abuse. Their mother told the department and the children were not returned to the foster parents.

The PIC said that some years later she and her sibling disclosed the sexual abuse to their mother, who contacted the police and the department. The PIC said:

> It was hard enough then just to tell them the small things that we did tell them. As it was, when we did tell them … it was a long while before it actually even went to court or even to the police to get written up as a statement.

Records show that charges were laid against the foster father but the Director of Public Prosecutions eventually withdrew them. Departmental records show that during the time the PIC was in foster care the department received anonymous reports, which were documented, of brutality, neglect and physical abuse by the foster family towards the PIC and her sibling.

In the early 1970s a two-year-old girl was placed in State care until 18 with her siblings by court order on the grounds of being neglected. The PIC lived in many places of care. She alleged that her stepfather sexually and physically abused her in the family home, and while she was placed in foster care. She also alleged she was sexually abused at Merrilama Cottage and Farr House.

After several placements, the PIC, then 15, was placed in foster care with a sibling in the same town as her mother and stepfather. Departmental records show the PIC wanted to reconnect with her mother, who had remarried, and that she had ‘unrestricted access’ to her mother while living at the foster placement. She told the Inquiry that her mother had told her that her stepfather had been in jail on two occasions for ‘molesting children’ and so she tried to avoid him during her visits to her mother. However, she said her mother was often sick and he was frequently at the house. According to departmental records, a departmental worker reported that the PIC’s stepfather had ‘a past history of sexual interference with children’.

The records show that during her seven month foster placement the PIC became involved in substance abuse, had a disruptive year at school and was suspended for smoking. It was reported she was sexually active and had ‘poor self-esteem’. A family therapist reported that ‘she was currently experiencing some sexual turmoil’. She left the foster placement on the therapist’s recommendation.

The PIC recalled feeling ‘shoved from pillar to post. By that stage I’d pretty much had a gutful.’ Records show that the rest of her time in State care, about 2½ years, was spent in at least nine further placements. Departmental records show that 14 months after the departmental worker had noted the past history of the PIC’s stepfather, the PIC told her new departmental worker that her stepfather had sexually abused her. The record notes that:

> Every time [the PIC] visited her mother and stepfather, the father had made sexual advances towards her. She stated he often touched her breasts and tried to kiss her on her mouth. She also said that [he] asked her for details of her sexual relations.

The PIC reportedly stated that ‘his behaviour makes me sick’ and that she had seen photographs of him and others in sexual acts. She confirmed this abuse to the Inquiry.
The records show the department was informed immediately of the sexual abuse and the PIC was taken to the police. Despite her worker’s reported encouragement and counselling, however, the PIC decided not to pursue charges. She told the Inquiry that she was discouraged from pursuing charges and was told by the police and her worker that they would be difficult to prove.

The South Australia Police informed the Inquiry that it could not locate any record of the PIC’s allegations; however, the Inquiry received records showing the stepfather’s convictions for sexual offending in the 1970s.

Evidence from males

As a result of constant offending, a 14-year-old boy was placed in State care in the early 1980s on a series of short-term detention and in need of care orders. The PIC told the Inquiry that he was sexually abused when placed in foster care and later at the Exodus Youth Shelter.

After going into State care the PIC was placed in an INC foster home, but said he ran away and frequented the streets. During this time, he said, he was approached by a man, with whom he stayed for several months. The PIC alleged the man sexually abused him regularly, injecting him with heroin and rendering him semiconscious before each assault. The man raped him three times a week, he said, and also prostituted him to other men in the city. The PIC said he made a statement to police about the alleged perpetrator, and was then removed from the home and taken to hospital. The man was arrested, charged and jailed for sexual offences. The PIC told his departmental workers he was sexually active while living on the streets. A social background report in his departmental file reads,

A most disturbing development is [the PIC’s] associations with older, single males … he admitted to [a departmental worker] today that he ‘sucks cocks’.

The PIC said he was sent to another foster care placement when he was 15. One evening he went to a city hotel, where a man sat next to him and then took him for a drive. He did not recall exactly what happened because, after being in the hotel, ‘the next minute’ he woke with his head ... in this bloke’s lap in the car, and I think they slipped me a mickey or something—I’m not sure ... He took me back to a house and ... administered alcohol and more drugs to me.

The PIC said he passed out and woke in a very groggy state with his clothes on.

... he [the man] was lying on the bed with me and I could hear other voices in the house ... I got up and said, ‘Listen, we’ve got to go,’ because I didn’t trust the house ... So we ended up at a pinball parlour and that’s where I collapsed and went into an overdose.

He said an ambulance took him to hospital, where his stomach was pumped. He was released back into the care of the same man, who had ‘passed himself off as my social worker’. The man had then ‘dumped’ him at the front of his foster home.

The PIC said he absconded frequently from care placements and abused alcohol and prostituted himself, usually while living on the streets. The department’s concerns about his engaging in prostitution, being sexually abused and having a high level of resistance to departmental intervention recur throughout his records.

After a series of one-month court orders, a 13-year-old boy was placed in State care by a court until the age of 15 for being in need of care. While the PIC was in a foster care placement, he said he was taken to the Adelaide Hills, where he met a man in his mid 30s who ‘gave me his phone number’. The PIC began seeing the man socially on weekends; he recalled his social worker raising concerns about the propriety of a man in his 30s seeking out a relationship with a young person in this manner, telling him ‘it probably wasn’t a good idea’. The PIC said his foster parents at the time ‘weren’t overly happy about it’. The PIC told the Inquiry: ‘I was [young] and [the man] was offering friendship and love and everything I was looking for at the time, so I grabbed onto it’.

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According to the PIC, the alleged perpetrator ‘made inroads to the Department of Community Welfare to try and have access to me’. Records show that the foster placement broke down after 11 months and within six months the department placed the PIC, then 14, with this man and paid the man a carer’s subsidy. Departmental files note that social workers planned ‘to discuss thoroughly with [the man] the implications of fostering’ and that fostering approval was contingent on him passing a fostering orientation course. Concerns were raised about the long-term suitability of the placement for the PIC, however it was also noted that the PIC appeared to respect the man and that he might benefit from the placement.

The PIC was at this placement for five months. He said initially he enjoyed the placement. However, during his time with the man,

… we’d be at parties and stuff, and he’d get me really drunk and he’d talk about how he’d just be down at the local rose garden, as he used to call it, and had big dicks in his mouth and stuff … He made it seem that homosexuality was the thing to do, and to be fun with and happy with … he was manipulating me, grooming me to try and grow up as a gay man …

The PIC said the man

… used to call me up to the bedroom and have little chats to me and he would be naked. He also left pornographic material in his bedroom when he was at work … It was just a bunch of young boys all naked, all sitting around playing guitars and stuff. He used to hug me, and he used to grab my bottom and stuff and squeeze my buttock cheeks, and he goes, ‘All right, [name]. It’s all right, mate’.

Records indicate the PIC spent about five months in this foster placement before it ‘broke down’. The PIC did not report the abuse at the time. He told the Inquiry that he was aware of his social worker’s reservations about the PIC’s placement with the alleged perpetrator. He said he told the worker: ‘Well, look, you know, it’s the only home I felt comfortable with at the time, so I had to, I had to’.

In the mid 1970s a PIC then aged three, was placed in State care until age 18 by court order because of neglect: his mother had died and the father’s whereabouts were not known. The PIC lived in a foster family placement for at least 12 years.

The PIC told the Inquiry his foster mother started sexually abusing him when he was six or seven and continued until he was about 14. He said initially she would ask the other children to keep him awake until she came home so she could put him to bed, by which time he was ‘always extremely tired’. He said about three times a week she would take him to her bedroom and ‘put me on to her boobs and encourage me to suck and fondle them’. He said he was ‘confused. I didn’t know anything about sex and I thought that it might be normal. I felt bad about it and it felt strange and funny.’ The abuse developed into ‘getting me to rub her and putting my fingers in’ and, when he reached puberty, intercourse. The PIC said he ‘never talked about it outside’.

Departmental records show he had behavioural and learning problems at school, including falling asleep. He was seen by, among others, a consultant paediatrician, senior welfare workers and a psychologist. He said that when he went to see these people he was usually accompanied by one of his foster parents, but he did not tell his foster father or the professionals what was happening. He felt ‘scared and didn’t want to feel bad, you know, and I’d have to go back there and then I’d be in trouble’. The PIC said he did not tell his teachers at school for ‘pretty well’ the same reasons.

He said he started running away from his foster home when he was about 13 because of the abuse. He committed some offences while on the run and was expelled from primary school.

He left the foster placement when he was about 15, living with a relative before the department arranged Housing Trust accommodation for him. The PIC said that he did not tell the department about the abuse:
Chapter 3 Allegations of sexual abuse

I had lots of them [social workers]. They’d come and go just like the INC placements. You’d never be friends with one for long because they’d go; you know there’d be somebody else.

A PIC had come to the department’s attention before he was six months old due to ‘generalised neglect and physical abuse resulting in bruising’, according to departmental records. At 21 months, he was placed in State care until the age of 18 by court order, because of physical abuse and neglect at home.

The PIC spent the next seven years in a foster care placement. Records indicate that after a few years his foster parents separated and the PIC lived with his foster mother, who had other children. The PIC told the Inquiry that from the age of eight his foster father sexually abused him by inappropriate touching, usually when he went to the toilet with him.

From there, like, he’d try to make it into a messing-around game and says, ‘Here, hold mine and squirt it around’ sort of thing … I think I probably told somebody and then I had enough of it and climbed out my window and ran off.

Reports indicate that when the PIC was 11 he received psychiatric treatment for the sexual abuse. A letter from a hospital to the PIC’s welfare worker says the boy told his treating psychiatrist of this abuse and that the information was passed on to the department. It is not apparent from the department’s records whether the police were notified. It is recorded that the PIC had told the principal of his primary school that his foster father watched ‘rude films’ at home.

In the early 1980s a PIC was first placed in State care at the age of 13 for 28 days when his parents had trouble controlling his behaviour. The PIC told the Inquiry that when he was about 12, before he was placed in State care, he was absconding from home and prostituting himself. The PIC was placed in State care under several short-term guardianship orders and detention orders between the ages of 13 and 17. He said he was sexually abused in a foster care placement.

While in State care, the PIC said, he was sexually abused in an INC foster placement and at the Southern Region Admission Unit, and while he was absconding.

Records show the foster care placement was during his first 28-day court order. The PIC said his foster mother was ‘absolutely fantastic’ but her male partner would sit next to the bath and masturbate while the PIC was bathing.

An Aboriginal PIC born in the mid 1960s was placed in State care as a newborn and was then adopted at the age of two. About four years later his adoptive parents asked that he be placed in State care. He was found by a court to be neglected and was placed in State care until he turned 18. The PIC told the Inquiry he was sexually abused at Kennion House, in foster care and at Otherway House.

In the early 1980s, when aged about 14, the PIC was placed with a foster family in a rural area for just over two years. The PIC said the family also cared for other foster children. He enjoyed the placement but said his foster father, who was aware he had earlier been sexually abused, soon began abusing him by inappropriate touching: ‘It could be anywhere. Watching TV … but a lot of the time it was in the bathroom at shower time.’ The PIC said the abuse went on for ‘a while’. He said the foster father never penetrated him, although ‘he wanted to … but I hadn’t done that before and I wasn’t going to let him’.

He said he told his foster mother about the abuse because he was concerned about the welfare of a younger foster boy who was living in the house. The PIC said the department took him to the police station, where he made a statement. According to police records, no action was taken against the foster father. Soon after the report to the police, the PIC was removed from the foster family.

A PIC was first placed in State care at 13 under a short-term guardianship order in the early 1980s because of behavioural problems, according to his SWIC. When he was 14, he was placed in State care until 16 by a court after it found he was in need of care. He alleged he was sexually abused when he absconded from the
Western Region and Gilles Plains admission units and then when he absconded from an INC placement when he was 16.

He told the Inquiry:

When I was in INC, parents … none of those people were too bad. It was just the people that were coming around picking you up, taking you out.

The PIC said a man who had abused him in earlier placements started taking him out of his INC home and got him a job at the business where he worked. The man would buy him meals, then persuade him to go back to his home in an inner Adelaide suburb. He described the man ‘as a violent person—violent sex. He held me down and fucked me one night.’

The PIC absconded from his INC placement and during this period stayed with several men, one of whom ‘come on too heavy for sex every night’. He said he began living with the man who had got him a job, and although he had sex with him, living there ‘wasn’t that bad, even though that he’d … forced me once’. He told the Inquiry: ‘I hung around him there for a while’.

A PIC was born in the mid 1970s to a teenage mother, and during his childhood his father was in and out of prison. Departmental records show that when he was two the PIC was placed in State care by the department under a temporary administrative order because his mother was found to be unable to care for him.

Just before his fifth birthday the PIC was charged as being in need of care and placed by a court in State care, for four months under temporary orders and then until the age of 18.

The PIC and his sibling were then placed with a foster family, where they shared a bedroom during a four-year stay. The PIC said that his foster father became physically and sexually abusive towards him and his sibling in the last two years of the placement:

He’d take his belt off and fucking leave welts across my back and across the back of my legs … well, the bashing was basically to tell us to shut our mouths and if we said anything to anyone what we coped was only a minor detail of what we would have coped …

The PIC alleged the foster father had anal sex with him ‘every fucking week for about two years’ in the man’s car. He said he was scared of his foster parents and did not report the abuse until after the placement ended:

That’s why I didn’t tell anyone at school or outside of school, let alone the social workers and stuff like that. You always used to get prepped before we went to [the department]; if we said anything we’re fucked, basically.

The department’s records indicate that during the time the PIC was in foster care the department received anonymous reports of brutality, neglect and physical abuse by the foster family towards the siblings.

One Christmas, the PIC and his sibling visited their mother and told her about the physical abuse only. Their mother reported the allegations to the department, and the foster placement ended as a result.

The PIC said that some years later he and his sibling confided in their mother about the sexual abuse and she contacted police and the department; this is confirmed in records received by the Inquiry. The PIC said:

The police came down … I think I made a four or five page statement, or longer than that … when we went to court … I asked if I had to go in and they said no, and basically from that we left. … [I felt] disgusted … I didn’t even have my chance to say my bit. I didn’t even have the chance to get the shit off my chest.
Records show that the Director of Public Prosecutions decided not to proceed with the charges against the foster father.

An 11-year-old boy was placed in State care in the early 1980s, after a family breakdown. He was placed in emergency foster care for about a month, where he alleged he was sexually abused. Two years later he was charged as being in need of care and placed by a court in State care until he turned 18. The PIC alleged he was sexually abused in foster care, at the Gilles Plains Assessment Unit, in the family home and when absconding from placements.

He said that his emergency foster carers were “the worst, the absolute worst. If I’d ever at a time felt like an outsider, it was [with] them”. He shared a bedroom with another foster son, who was about 17, and said this boy forced him to perform oral sex:

He told me basically he was just going to beat my head in, and I still said sort of no, and he punched me two or three times, and I sort of gave in ... the abuse happened, I think, two or three times.

Departmental records confirm the PIC was placed with this family for three weeks, and that during this time a teenage boy was also living there. Records also show that another child living with this foster family made allegations of physical and sexual abuse to the department. An internal investigation was conducted but records received by the Inquiry do not indicate what action was taken.

The PIC said that when he was a teenager he was placed in foster care for a few days with another family. He said the foster father

... tried to have his way with me, and I wasn’t going to have it ... I basically told him I didn’t want that sort of affection ... He did [stop], but not before trying.

He said he disclosed the abuse to former foster parents with whom he remained in contact but they did not believe him.
1990–2004

Twenty people were children in State care and placed in foster care during the 1990s to 2004 when they said they were sexually abused. Available records show they were placed in State care by a court after being found to be in need of care or neglected; two were placed in State care by voluntary care agreements. Sixteen were female; four were male. One additional male is included in this report because the Inquiry was not able to properly determine whether he was in State care, as his departmental files were destroyed by fire.

The allegations include indecent assault and vaginal, oral and digital intercourse and anal rape. The alleged perpetrators were foster fathers, foster brothers, other older fostered boys and outsiders including friends of the foster family, a teacher, a taxi driver and strangers.

Evidence from females

An Aboriginal woman born in the mid 1980s was three months old when placed in State care until 18 when a court found her in need of care. Departmental records indicate she had been physically abused and neglected at home. After being placed in State care, the PIC was put into foster care with an Aboriginal family, where she alleged she was sexually abused.

The PIC told the Inquiry that when she was eight, two male acquaintances of her foster mother raped her on separate occasions. The Inquiry received a police apprehension report detailing the offence. A male family friend allegedly told the PIC to go into a backyard shed. He followed her in and told her to take down her underwear, which she did. She told the police that he told her to lay on a bed that was in the shed and she did so. He then penetrated her anally with his penis. On the other occasion, she was at home and her foster parent was in the backyard with friends. A man known to her foster parent entered the kitchen and inserted his finger into the PIC’s vagina, then pulled his trousers down and penetrated her vagina with his penis. The PIC told police that after he removed his penis there was ‘all of this milk’ on it.

The PIC told the Inquiry she did not tell anyone of the assault at the time because she was ‘scared’, but her mother noticed bruising around her vaginal area during an access visit and ‘asked questions and then I told her’. Her mother contacted police and the department however the PIC did not confirm any abuse. Six months later, the PIC’s caseworker spoke to her alone during a home visit and the PIC disclosed the abuse. The departmental files show that the police interviewed the PIC on several occasions; on one occasion the foster parent watched from another room via camera. When the PIC asked about the camera and was told her foster parent was watching the interview, she became evasive. When told that the foster parent had ‘gone for a walk’ the PIC proceeded to recount the abuse in detail. Departmental workers also liaised with Child Protection Services to ensure that the PIC was offered counselling.

Police charged one man with unlawful sexual intercourse and the other with unlawful sexual intercourse and rape. The charges were referred to the Director of Public Prosecutions, who determined that there is no reasonable prospect of conviction in relation to either suspect of any offence in relation to [the PIC] on account of inconsistencies in her evidence and medical reports.

The PIC’s case files detail notifications of concern about the care provided by the foster parent that pre-date this incident by up to six years. These include: that the PIC was found wandering on a main road at the age of three years, unattended; that the foster parent had large groups of people at her house and that large quantities of alcohol were consumed on a regular basis; that the PIC exhibited sexualised behaviour six months prior to the abuse being disclosed. The department removed the PIC from the foster placement. The PIC told the Inquiry that the abuse left her ‘sad and scared’ as a child.

One PIC was placed in State care in the mid 1980s, initially under a series of short-term orders when she was two, then a six-year order at the age of three, finally being placed under the guardianship of the Minister until the age of 18. The PIC was deemed to be in need of care after her mother’s partner physically and sexually abused her. While in State care she alleged she was sexually abused in one foster placement where she lived for almost 15 years.
Chapter 3 Allegations of sexual abuse

The PIC said her teenage foster brother sexually abused her between the ages of eight and 10. She said the abuse was sporadic, occurring ‘for a few months and then … he just stopped’. She said the abuse, which included intercourse, happened on ‘probably four or five’ occasions.

She said that about this time her relationship with her foster mother deteriorated and, probably, her own behaviour changed: ‘I didn’t trust them after that … I didn’t want to be left alone with him any more’. The PIC said she did not disclose the sexual abuse to her foster parents but she could ‘pretty much guarantee that they knew’ a second foster son was sexually abusing another foster girl in the home.

The PIC said she left the placement after an altercation with her foster mother ‘and she’d hit me. I just couldn’t go back any more.’ The PIC later made allegations of physical abuse, which the department investigated. The records show that in late August 2001 the PIC disclosed abuse allegations against her foster carers and, at her request, was removed. She was placed with another foster family. The first foster parents were subsequently restricted in relation to the age of future foster children, although they were still allowed to foster. A criminal injury compensation claim was finalised before the PIC turned 18.

Departmental records show that a PIC was placed in State care in the mid 1980s when she was five because her mother was ‘concerned for the safety of child’. The PIC was placed under a short-term guardianship order and voluntary care agreement, and was later placed in State care until she turned 18 because she was in need of care. The PIC alleged she was sexually abused in a foster placement where she lived from the ages of about four to 12, before being transferred to another foster placement.

She told the Inquiry her foster father sexually abused her from the time she was seven, including touching her inappropriately, making her stand naked in front of him or watch a pornographic movie with him, and ejaculating on her. She said she thought he had sexual intercourse with her once ‘but it’s very confused’.

The PIC said her foster father’s sexual abuse continued until she left the placement. She recalled a female teacher asking if everything was okay; she did not tell the teacher of the abuse because ‘I knew that … I’d be in a lot of trouble when I got home. It wasn’t worth it’. She had been afraid to tell anyone about the abuse until she left the placement. She subsequently told her new foster mother and the police were alerted, but the matter did not proceed: ‘I remember I was scared, because I didn’t want to go to court and see them again’.

Departmental files show the PIC’s case workers removed her from the placement after another girl who had lived with the foster family alleged that she and other children had been sexually abused while living with the family.

As part of an investigation, the department interviewed the foster parents and their former foster children, including the PIC. Police later interviewed the PIC and, as a result, the foster father was charged with sexual offences. Two other former foster children told the department they had been reluctant to disclose the abuse to their social worker because the worker was on good terms with the foster mother.

The department interviewed the foster parents about their use of discipline and other issues. The allegations of sexual abuse were not raised because a police investigation was under way, however the alleged perpetrator made unsolicited comments denying any improper contact with children. The department’s report noted several matters that ‘raise a range of practice and policy issues which need to be addressed’. It noted that allegations had been referred to police in the past but no action had been taken. The report noted the ‘consistency in the statements given by these children, which is cause for real concern. It is felt that these allegations cannot be discounted as they have been in the past.’ It stated that the foster parents intended to withdraw from the fostering program and, if this was not the case, ‘we would be recommending de-registration as foster parents, on the evidence presented’.

The departmental file did not contain any reference to the outcome of the charges laid against the foster father. The South Australia Police were unable to locate their file concerning the PIC’s allegations.
A PIC born in the early 1980s experienced family breakdown and sexual abuse before being placed in State care when she was seven, under an interim guardianship order after being found to be in need of care. She had three different foster placements during her year in State care.

The PIC alleged she was sexually abused at the third placement, which lasted for several weeks. She said her foster father watched her shower, and an older boy who was also fostered to this family ‘used to play with my vagina’ and one night made her and another young foster girl masturbate each other. The PIC told the Inquiry they were ‘terrified’ because the foster brother had told them: ‘Don’t you dare tell anyone … My mum won’t believe you … if you say anything then I’ll burn your dolls.’

She said the foster father and the foster brother also derived sexual pleasure from watching her in the backyard: ‘We were made to wear skirts with no undies on and made to jump on the trampoline’. The PIC alleged that on one occasion her foster parents had sex in front of the children, locking the lounge room doors so they could not leave.

She said she disclosed this abuse to a schoolteacher, who contacted the PIC’s social worker. The PIC said the worker visited the foster home and ‘told me to go and play, that everything would be okay and that no-one would ever hurt me again’. Later, the PIC said, ‘I was playing, and [the foster mother] came in and I got the biggest slap across the face I think I’d ever had’.

The department continued to monitor the PIC’s welfare on her return to her family and for the next seven years, due to the sexual abuse notification that precipitated her placement in State care. Her client files relating to her period in foster care note that she became agitated when other foster children were placed in the home where she alleged the abuse took place. The files note there was friction in the home and the foster mother asked for the PIC to be removed when she was required to care for sick relatives. The files viewed by the Inquiry contained no recording of a disclosure of sexual abuse.

In the early 1980s a PIC then aged 10 was placed in State care on an interim guardianship order after notifications of physical abuse. She told the Inquiry she was sexually abused at Enfield Community Unit and in foster care while under the order.

The PIC was placed in foster care for a brief period of respite from an admission unit when she was 14. She described the placement in positive terms, but said she ‘felt kind of coerced’ into having sex with the foster parents’ son, with whom she stayed up late watching TV and drinking alcohol. She said she had to ‘… have sex with him on two occasions’ but did not tell anybody as ‘I felt pretty ashamed’.

At 15 the PIC went to court for offending, and part of the court order was that she live with a volunteer youth worker and his wife, who had expressed their willingness to have her live with them. The PIC told the Inquiry she and her new foster father grew very close and she felt he supported and understood her. She said that within one month, he began physical contact with her, kissing her and exposing himself. She said the abuse progressed to vaginal and oral sex, and occurred twice a week.

I … accepted it because I thought, ‘Oh, well, like, if I let it happen, well, then everything will be happy, right, then everyone will be happy’. … I didn’t want to go back to the units, I didn’t want to go to jail.

She said he told her she could report him if she wanted but she declined; she believed he was testing her but also felt ‘I was completely dependent upon him. I had nobody else. It was moral support. I didn’t have any family, it was just him.’

The PIC left this placement after 10 months due to friction in the family. She said the foster father visited her at her new home and continued the sexual relationship until she was 17. She tried to alert her counsellor when the abuse ‘was just getting a bit much’, saying she ‘sort of talked in a roundabout way without giving out great detail, but she didn’t get it’. The department’s files contain a note, written when the PIC was 16, that members of her new foster family had raised concerns about the closeness between her and her former foster father. The social worker had directly asked the PIC whether she ‘fancied’ her former foster father, which she denied.

In the early 2000s the PIC made a signed statement to police, detailing her sexual relationship with the foster
father. In the statement, she said she ‘had sex over 100 times’ during the 10-month placement. Police investigated the allegations and the foster father was charged, but he committed suicide a short time before he was to appear in court.

A
n Aboriginal PIC born in the mid 1980s was the subject of several child protection notifications received by the department regarding alleged physical abuse. When the PIC was 11 her mother signed a three-month voluntary custody agreement (VCA). After several subsequent VCAs and numerous foster placements, the PIC, then 13, was placed under a 12-month order in the hope that she could be reunited with her family. However, according to departmental records her mother was ‘unable and unwilling to exercise adequate supervision and control over the child’ and, when nearly 14, the PIC was placed in State care by court order until the age of 18. The PIC alleged she was sexually abused in foster care, then at the Sturt and Gilles Plains assessment units, and when placed with a male relative.

The PIC was placed with a registered INC family and told the Inquiry her foster father ‘just flopped himself out one day and said, “You know what you want to do to it”.’ She told her foster mother, who replied, ‘Oh, my husband wouldn’t do that to you, you lying little so and so’.

The PIC said the foster couple’s son, aged in his 20s, sexually abused her when she was aged between 11 and 13. The son had recently separated from his wife and lived in a unit next to the family home. ‘Quite a few times’ he had unscrewed the screen on her window, climbed into her bedroom and had intercourse with her. On one occasion, she said, he sexually abused her in a public park near the foster home. She did not disclose these incidents; he told her to stay silent, ‘not to mess things up between him and being able to see his kids’. She said she felt ‘sickened’.

A
n Aboriginal woman born in the early 1980s was 11 when a court found her in need of care and placed her in State care until the age of 18. The department placed the PIC with a series of relative foster carers, one of whom allegedly sexually abused her.

The PIC told the Inquiry that she was living in one particular placement for about three years. She said her foster carer began to have sexual intercourse with her about 18 months after the placement started—the first time when he entered her bedroom was when she was about 14. The PIC said she was abused when her foster mother was ‘not around, probably once a week.’ The PIC remembered that the foster father ‘told me not to tell anyone’ and ‘he said it’s all my fault’. After the abuse started, she said, ‘I started getting into fights at school, getting sent to [detention]’. When asked if she reported the abuse to her teachers she said, ‘I was too scared’. She also said she did not feel she had a trusting relationship with her departmental worker.

The abuse ended just before the PIC’s 16th birthday, when the foster mother found her in bed with the foster father. The PIC said that the foster mother ‘had seen what was happening’ and went ‘crazy’ at the foster father. The PIC said: ‘I just ran away’. Records indicate that the police notified the department and that counselling was arranged for the PIC through a hospital child protection unit. The foster father was charged with several sexual offences, the Director of Public Prosecutions accepted a plea of guilty to attempted unlawful sexual intercourse and he was sentenced to three years’ imprisonment, which was suspended when he agreed to a bond. The PIC told the Inquiry that she was never told of the outcome.

Departmental records indicate that it conducted a review panel forum when the PIC was 15, 18 months after the previous review. A member of the panel expressed the opinion that it would have been appropriate to visit the PIC, whose foster placement was in the country, before reviewing the file.

A
PIC found by a court to be in need of care was placed in State care until the age of 18 when she was nine. The PIC told the Inquiry she was sexually abused before being placed in State care and also was abused in foster care and at Lochiel Park Community Living Unit and Gilles Plains Community Unit.

The PIC told the Inquiry she stayed in one foster family ‘for a year, two years’ when she was 10 to 11. She said the foster father was ‘creepy’ and would stare while she undressed in the bathroom: ‘He used to try touching me and that, but I used to jump in the water’. The PIC told the Inquiry she had social workers looking after her but did not
tell anyone what her foster father was doing until ‘the end. I told the school … because he was hurting me. He was hitting me also …’

As a result, she was placed in another foster home, where she stayed for just over a month in the mid 1990s. She recalled that the foster father was an intimidating presence and that her foster mother frequently took her out ‘to get me and her away from him’. During this placement, the PIC said,

[The foster father] touched me numerous times in the shed when I’d go up to the shed to play with his [dog] … He used to just touch me, because I was starting to get boobs. He would touch me around there and stuff like that … He got me a couple of times down below. He mainly just was fascinated with my chest and that.

She said this happened ‘probably five times’ before she ran to a neighbour’s house to telephone the department’s Crisis Care helpline. She said she recalled telling Crisis Care ‘that he was hurting me and that he used to drink … I can’t remember if I mentioned about him touching me.’

The department’s records for the PIC note she was a runaway from this foster home. The notation was made three days before the placement was due to end, although the reason listed for its termination is ‘planned move’. The PIC said she was then placed with foster parents whom she knew and trusted.

The department’s client files for this PIC show she told school staff and her social worker about her discomfort with the foster father’s behaviour. She disclosed that he drank, used drugs and was verbally abusive but did not indicate there had been any sexual abuse. The worker noted that the information presented did not constitute a child protection issue but also that the PIC had not raised these concerns previously. Additional notes show the PIC was often left for extended periods at home alone, which she found distressing, and that ‘she is scared of her foster father as he comes into her room’. Crisis Care workers went to the home, found the PIC alone, waited with her until her carers arrived home, then counselled them about leaving the girl unattended. The issues of alcohol and drug use were raised with them, and the foster father denied the use of drugs in front of her. One day later the PIC absconded. Her social workers collected her from a neighbour’s home and took her back to the foster home, noting that she was ‘scared’ to return and feared retribution for absconding. The file does not record whether the workers interviewed the PIC alone on their way back to the foster home; rather, on their arrival the workers had a discussion with the foster mother and PIC together. The foster father joined them later. The notes show the discussion centred around the man’s manner of speaking to the PIC, that ‘he jokes a lot, however sometimes he takes the joke too far’. The departmental worker noted that the discussion went smoothly and that the girl seemed more at ease. The next day, the foster mother contacted the social worker and indicated that the foster father did not want the PIC to remain in the house. The file records no information that relates to possible sexual abuse. The records provided do not show that the workers followed up the PIC’s claim that the foster father entered her bedroom.

One PIC born in the mid to late 1980s had an early history of notifications of physical abuse and neglect, according to departmental records. She was then placed in State care by court order for two years when she was nearly five and three years later was found to be in need of care and placed in State care until the age of 18.

When the PIC was almost nine she was placed for about four years with a foster couple who fostered several other children. She said it was ‘the longest placement I’d stayed in’. She told the Inquiry that one year into this placement, when she was about 10, another foster child in the home, a boy of about 16, abused her. ‘I woke up to him standing … with his dick in my face … He was slapping me with it and then he got me to suck on it.’

She alleged that on four occasions this boy rubbed himself against her and ejaculated. She said another boy fostered to the family ‘started doing the same thing’ and ‘got me to give him a hand job’.

The PIC told the Inquiry she saw her mother ‘once every fortnight or something, but I never told her anything’. She told a friend about the abuse and her school became aware of the allegations and contacted the police. The police interviewed her—‘I told them I lied’—and she said she found them to be ‘very scary’. The department’s records show the PIC’s social worker was involved in the
Chapter 3 Allegations of sexual abuse

A PIC was about six in the mid 1990s when she was placed in State care under an interim court order as a result of sexual abuse in the home. Records indicate she was placed with several foster families. The PIC alleged her foster father sexually abused her at her first placement, which lasted about six months.

The PIC said the foster father touched her inside her clothing at the breakfast table almost daily. She did not understand at that time whether this was right or wrong.

I don’t think I ended up telling anyone until I came to Mum’s place. I think a couple of years down the track I ended up opening up a lot of stuff.

Several years after the PIC left this foster home, her former foster father was arrested and charged with various sexual offences relating to another child. He was subsequently jailed.

When she was nearly 10, the PIC was placed with another foster family who gave her, she said, support and encouragement. The foster mother in that placement told the Inquiry that the PIC ‘couldn’t stand anyone sort of touching her’. She said she spoke to the department and ‘they only told me what they wanted to tell me, which was just, “We think that she may have been abused”’.

A PIC born in the mid 1980s was initially placed in State care under voluntary care agreements and short-term court orders due to parental abuse and neglect. She spoke to Inquiry staff, who obtained her records, but did not give evidence in a hearing. The records indicate that in the late 1980s the department placed the PIC in emergency foster care due to parental abuse and neglect. In the early 1990s, aged five, the PIC was placed in State care until she turned 18 and lived with the same foster parents. Guardianship was transferred to the foster parents when she was 10.

Records indicate that in the late 1980s, before the PIC turned three, the department investigated allegations that her foster father in an emergency foster care placement had sexually abused her. It was suggested in the file that she had spoken of sexual interference by her ‘daddy’ but it is stated in the file that the departmental office

matter, contacting the foster family and advising of the incident and its outcome.

The PIC said that when she was living in the same foster home and attending the local primary school, a male who instructed school students as a private provider sexually abused her when she was about 10. This man ‘used to feel our legs and stuff and try and get hugs and feel us up around our boobs and stuff like that’. She and other students complained and school staff notified the police, who interviewed the students. The instructor was charged with indecent assault and offensive behaviour. His services were withdrawn from schools. The DPP did not proceed with the matter, however steps were taken to ensure that schools did not engage the alleged perpetrator.

In the late 1980s a six-month-old baby was first placed under several interim care orders until, aged four, she was placed in State care until she turned 18 by reason of being in need of care. She spent her entire placement with a female foster carer, apart from having regular respite weekend placements and participating in programs to help her cope with her intellectual disability.

She alleged she was sexually abused in this placement when her foster mother arranged for her to be transported to primary school. She said she often had the same taxi driver who digitally penetrated her on the way to school ‘a few times’ when she was about 10.

The PIC said she ‘told people at the school and I told my foster mum’. She also spoke to the police, ‘and they said it was my word against his. They didn’t take me seriously.’

The department’s records show that the PIC disclosed this incident in the late 1990s. She alleged a taxi driver attempted to force her to touch his penis and that he ‘massaged’ his penis on two or three occasions. The records state that the driver tried to touch the PIC’s vagina and that he told her not to reveal what had happened ‘or he’d get cranky’. Police were notified. A subsequent note on the PIC’s file indicates that ‘the driver has been sacked and a medical has confirmed the assault’ and charges were laid.
‘have absolute support and faith in the integrity of the foster parents’.

Two years after the allegations were made the foster couple were reapproved as foster parents. In the early 1990s the PIC was placed under the legal guardianship of the foster parents until the age of 18. While the PIC was no longer in State care, the foster parents remained approved foster carers. The department’s file reveals that in the mid 1990s, allegations of sexual abuse were made against the foster father, relating to an unnamed eight-year-old girl in the foster family’s care. Around the same time, another foster child who had recently been placed with the family alleged sexual abuse against the foster father. Police were informed, but the notes on the file state that ‘there are no reasons for concern for the safety of these [children]’. A handwritten note says: ‘Police unlikely to proceed. No substantiation by other children. Work with family about concerns.’ The report concludes:

It is [the department’s] view that, given all the information, the uncertainty which surrounds both the allegations and the unclear outcomes, and the now negative views of the foster mother; that ongoing fostering by this family may not be considered appropriate for either the family or future children placed in their care.

The outcome of the investigation in relation to the allegations by both foster children is recorded as ‘uncertain’. Despite the department’s view that ongoing fostering by the family may not be appropriate, about 18 months later it reapproved the foster parents to care for children aged two to seven in emergency care. About three years later their foster status was terminated.

At 14 the PIC made disclosures about alleged sexual abuse by her former foster father, who was at this time her legal guardian. He was charged, convicted and imprisoned for an indecent assault and several counts of unlawful sexual intercourse. The offences were committed when the PIC was aged between 10 and 14.

Departmental records show that a PIC’s family came to the department’s attention when she was five in the early 1990s, because of reports that her mother frequently drank and behaved erratically. A court declared the PIC to be in need of care, and placed her in State care under interim guardianship. At six she was placed in foster care with foster parents.

Records indicate that about a month after being placed in foster care the PIC made a report of sexual abuse by the foster father. At that time, the foster parents had other girls in their care. The department conducted an investigation; a child protection summary report in the records notes that there was sufficient cause for concern and the matter was referred to the police. The PIC received support from the Child and Adolescent Mental Health Service (CAMHS) and was seen by a clinical psychologist.

The department’s investigation of the PIC’s allegations reached an ‘uncertain’ conclusion: investigators believed something happened between her and the foster father and said her allegations had substance, but they could not conclude that sexual abuse definitely occurred. Records show the foster father was interviewed by police and was reported for two counts of indecent assault, but was not arrested or prosecuted.

The foster parents were not deregistered but, rather, there was a two-month non-placement time. Records indicate that in the mid 1990s they were reapproved to provide emergency care for children aged two to seven.

In the early 2000s, the foster father was convicted of indecent assault and several counts of unlawful sexual intercourse in relation to another girl in his care, who had been aged 10–14.

The PIC did not give oral evidence to the Inquiry but wrote to the Inquiry:

Growing up I always felt dirty. From the age of six I was made sexually aware. Sexuality, sex, innuendo—all related—are things in life a six year old shouldn’t be aware of. As well as being aware, there was the issue of not understanding—both what happened and why. Due to the assault my small developing personality was affected and preoccupied with questions about my assault, about my body … Where the hell were they to protect me when I was six years old? Do you know what I mean?
Chapter 3 Allegations of sexual abuse

A PIC born in the late 1980s was first placed in State care at the age of 12 years for her care and protection. She was then placed in State care under two 12-month court orders when she was about 13, after the department received allegations of physical and sexual abuse by a relative. The PIC lived in a government admission unit as well as foster care.

When she was 12, the girl went into foster care with a couple. She told the Inquiry the foster father ‘kept going into my room and he just raped me every Thursday’ when she got home from school.

The last moment when I told [my foster mother] when she got home, she didn’t believe me. She kicked me out the back and I stayed out there and just yelled out to her and said, ‘[foster dad] did do it to me’, and she didn’t believe me. She said, ‘You can piss off.’

The PIC said her foster mother then came outside and asked her, ‘Do you want to come back inside and sort it out?’ She said the foster mother phoned the police ‘and she got me moved’.

Departmental records indicate the PIC made allegations against the foster father about a year after arriving in the foster home. The police investigated, as did the department’s Special Investigations Unit (SIU). About six months after the allegations were made, the outcome of the department’s investigation was inconclusive, but it did not support the foster father continuing as a foster parent. He resigned and the SIU recommended that he not be considered for future registration. The police report stated that there was insufficient evidence to proceed with a prosecution due to ‘nil further evidence’ to corroborate the girl’s version of events that was ‘vague’ because of her mild intellectual disability.

Her parents, who separately gave evidence to the Inquiry, said the department never sought their views about where their daughter should live or who should look after her. ‘It was all done by the [department]. We had no say whatsoever.’

An Aboriginal PIC aged three in the late 1980s was placed in State care for five years—she told the Inquiry members of her immediate family had sexually abused her. Records show that subsequently she was placed in State care by court order until she turned 18 for ‘care and protection’ because she was deemed to be at risk.

The PIC made a statement to the Inquiry that she was raped twice by an adult son of her foster parents in the late 1990s when she was 16. She did not want to proceed to a hearing, finding it too traumatic to talk about.

A n Aboriginal PIC born in the late 1980s was placed in State care at 10 when her mother signed the first of a series of voluntary care agreements. The girl was also placed under several one-year guardianship orders into the 2000s. She told the Inquiry that her stepfather had sexually abused her. Records indicate she disclosed this alleged abuse to the department when she was about 16 and the department notified the police.

Just before she turned 14 in the mid 2000s, while she was still in State care, the department sent the PIC to a foster placement where, she alleged, a son of the foster parents, aged in his 20s, had come into her ‘little cabin out the back’ and raped her. She said she tried to stop him but he ‘like, kind of suffocated me with a pillow … I thought I was going to die’. After that incident, she stayed in the foster home for about two more weeks, during which the son … kept trying to get into my room … and I’d tell him, ‘If you come anywhere near me, I’ll scream, mate. I don’t give a fuck, I’ll shoot you or something. I don’t care.’ But he used to keep trying and I just got sick of it, and I started abusing his parents and stuff.

Records show the PIC was in this placement for only nine weeks. They show she told her next foster mother about the sexual abuse and that the department and police were advised and the alleged perpetrator was charged. But the records state the PIC did not want to proceed with the complaint. She told the Inquiry, ‘I just didn’t want to go through with it any more because I was too scared of what was going to happen, so I just left it’. 
Evidence from males

A PIC was seven in the early 1990s when he was placed in State care under an interim court order because he was in need of care. He was later placed under a two-year care order before being placed in State care until he turned 18.

While in State care the PIC was placed in a foster home for about six months. He told the Inquiry that while he was there a teenage boy who was a friend of the foster family sexually abused him twice. He said that during a sleepover the boy stayed in the PIC’s bedroom and climbed into his bed and fondled him. The next day, outside the foster home, the boy demanded oral sex when they were ‘down the river’. The PIC could not go into detail. He said, ‘It’s just hard for me to even kind of tell that story again … then down the river … I just, yes, fucking got told to do shit and done it’.

A PIC born in the late 1970s was placed in State care at the age of 10 as a result of his constant absconding from home and refusal to attend school. The PIC was placed initially under the guardianship of the minister, on a short-term order. He told the Inquiry that his father and stepfather sexually abused him before he went into State care. At 12 he was placed in State care until he turned 18 by a court which found him to be in need of care. He spent time at several government admission units, where he said he was sexually abused, and also engaged in child prostitution while living on the streets.

His evidence to the Inquiry and his departmental records show that he continued to run away from his placements, and that he associated with known paedophiles. Records indicate the department knew of these associations when the PIC was assessed by the Child Protection Service for a Youth Court application for an INC placement at the age of 12. The records say he had been subject to chronic emotional abuse and was at risk on the streets because he was ‘naive paedophile bait’.

Departmental records show that when the PIC was nearly 16 the department asked a man whether he would be willing to foster him. According to those records, the department knew, from information provided by the police, that the man was a known paedophile and had been charged with sexual assault of an underage boy. About three months later, the records show that the man advised the department that the PIC was known as a ‘rent boy’. Almost two months after that, the records show that the man advised the department that the PIC was staying with another man, who allegedly had a history of giving young people pills before having sex with them.

The PIC told the Inquiry that—when he was aged 15 or 16—he met a gay man in Adelaide who, along with his male partner, sexually abused him ‘back at his place … maybe a couple of times’. The PIC said that he went to their house and they did sexual things to him. He said he was not given drugs but stayed the night and in the morning felt ‘only hung-over; that would probably be about the only thing’.

The mother of an Aboriginal PIC born in the mid 1990s gave evidence to the Inquiry that her son was sexually abused while in foster care. It appears from her evidence and documents from the Flinders Medical Centre Child Protection Service that the boy was under a 12-month guardianship order from about the age of seven. While under that order, he was placed with a foster family, which also fostered a 14-year-old boy. The department knew that this teenager, who had a mild intellectual disability, had previously been sexually abused.

The PIC and the teenage boy shared a bedroom. Records show that after the teenager’s placement with this foster family broke down he went into another foster placement, where he made a disclosure that resulted in the involvement of the department’s Special Investigations Unit and police. The police interviewed the PIC, who was then eight, but it appears he did not make any clear disclosures. Records indicate that a few days after the PIC’s interview with the police, his foster mother contacted the department and said the boy had told her he was unable to tell police what the teenager had done because of a threat that he would be beaten up. The foster mother also said that, in her opinion, the PIC was scared and wary of the police and was not comfortable talking with them.

The PIC’s mother told the Inquiry that police charged the teenager with sexual assault of the PIC but, due to his age, the matter was resolved in a family care meeting in the...
Youth Court, to which she was not invited. However, she understood that as a result of the meeting the teenager was required to write a letter to her son, and that a department worker was to ensure the letter was appropriate before posting it. Instead, she said, the teenager posted an inappropriate letter direct to the PIC after being given his address.

The Inquiry was unable to verify whether an Aboriginal PIC who gave evidence was placed in State care under any court orders because a fire destroyed his client files. However, the government’s Justice Information System’s (JIS) computer records show the department was involved with the PIC from the time he was 14, due to child protection matters. The PIC, born in the late 1970s, came to notice when JIS was still under construction, so a comprehensive client history could not be recovered from this source. The PIC told the Inquiry he had been sexually abused when placed in foster care, at the Gilles Plains Assessment Unit and Magill Training Centre, and when living on the streets.

He said he experienced violence, and alcohol and sexual abuse in his family, and that his family had been transient. At 14 he left his family to live with friends and on his own, and became involved in child prostitution.

The PIC told the Inquiry he was abused in a foster care placement when he was 14. He had been placed with a woman who had several other State children in her care and was lax in disciplining them. She had worked shifts and often asked an older male friend to stay with the children during her absence. The PIC said this man forced him on about 10 occasions to perform oral sex, but he did not disclose this abuse to his foster parent or to the department.

A PIC who was placed in State care under several voluntary care agreements and interim guardianship orders from the ages of 10 to 18, had been known to the department since he was three years old in the early 1990s, due to concerns about sexual abuse and domestic violence.

In the early 2000s, when he was 14, he was placed in foster care with a man who, a couple of months later, forced his way into the toilet and anally raped him.

Afer he did it, he said to me, ‘If you tell anyone, I’m going to make your life a living hell and your family’, and then I was scared that it was going to put my life and … my mum and my sister’s life in risk, and I didn’t want to do that.

The placement ended a few weeks later when the department and police were notified that the man had punched the PIC. The PIC said the first time he spoke about the anal rape was months later, when he confided in a friend. The next day he reported it to police; records show this was about seven months after the alleged assault. A month later, the alleged perpetrator was charged and the matter proceeded to trial but was later withdrawn. The PIC said the office of the Director of Public Prosecutions ‘did believe me, but then we found out that … there wasn’t enough evidence’. He told the Inquiry that when he was told the case was not going ahead he felt ‘quite pissed off’.
### 3.5 Family home

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Chapter 3 Allegations of sexual abuse

History

South Australian children in State care have been placed 'on probation' to live with their family under legislation since the 1900s. In the early 1900s, the government felt that placing more children with their families would be a significant cost saving, as it would not be financially responsible for their maintenance. Legislation provided that the children were subject to departmental supervision. Children in State care could also be placed in the family home for other reasons, such as holidays. Today the Children’s Protection Act 1993 permits the Minister to place a child in State care, or allow the child to remain in the care of a guardian, who may be a member of the child’s family.

Summary of family home allegations

Thirty-five people told the Inquiry that they were sexually abused while in State care and placed at home. From available records, the inquiry was able to confirm that 34 were in State care at the time of the alleged sexual abuse; due to the lack of records and/or the actions of the Aborigines Protection Board (1934–63) (see page 14), the Inquiry was not able to determine whether one person was in State care at the time of the alleged abuse.

The sexual abuse included gross indecency, indecent assault and oral, vaginal and anal rape. The alleged perpetrators included fathers, stepfathers, male relatives and the male de facto partners of mothers, as well as outsiders including a doctor, community group leader, community centre worker, regular driver, acquaintances and strangers.

1 State Children’s Council annual report 1908, p. 12.
**1940s–60s**

*Evidence from females*

A 12-year-old Aboriginal girl was placed in a government home in the late 1940s, charged with being neglected. Her State ward index card (SWIC) shows that a few weeks later the charge was withdrawn and she was returned to her mother’s care. About a year later, aged 14, she was found by a court to be uncontrollable and was placed in State care until age 18. She spent time in various homes and institutions as well as with several foster carers over the next four years. She alleged she was sexually abused in foster care and while living in the family home.

She told the Inquiry she returned home from time to time in the late 1940s and early 1950s to help with domestic duties while her mother was pregnant. She alleged that while she was at home her stepfather repeatedly performed oral sex on her and tried to penetrate her. She recalled trying to tell her mother:

> I was sore, and I remember saying to him, to my mother, that he done it, and I remember there being a big argument, and she hit me and my nose started bleeding.

The PIC said both her mother and stepfather accused her of lying. She was disappointed that her mother ‘stood by him and she didn’t stand by me’. She did not tell anyone else about the abuse for fear of not being believed.

The PIC said she believed she had been in State care at the time of the abuse. After consideration of the departmental records, it is unclear whether the period in State care coincided with the period of abuse.

She also alleged her stepfather abused her as a much younger child and that she reported it to police when she was about seven. She remembered going to the police station because she had ‘had enough of being interfered with by my stepfather … I didn’t want to go back home any more’. She did not know what, if anything, happened as a result of this. The Inquiry was advised that there are no police records of such a report.

In addition, the PIC told the Inquiry that in her mid teens a male relative sexually abused her when she ran away to his home to escape an abusing foster parent.

At the time of the Inquiry she had several grandchildren. She said she was concerned that one of them was the target of sexual abuse and that ‘history is repeating itself exactly the same way as it did with me with my stepfather’.

A 18-month-old girl was placed in State care in the mid 1930s as a result of being found by a court to be neglected and illegitimate. She had various placements, including in a government cottage home and with numerous foster carers, before being returned to her mother’s care in the early 1940s at the age of nine. She alleged her stepfather sexually abused her while she was at home.

The PIC’s mother suffered from mental health problems and was admitted to a mental health facility, leaving the PIC and her sibling in the stepfather’s care for some months. The PIC recalls sitting in the lounge room with him one day:

> Suddenly … there he was with an erect penis and wanting me to touch it. You know, that was the beginning of it. Then it was … a little bit more the next time.

She said the abuse continued as she grew older and the stepfather would ‘blackmail’ her if she didn’t cooperate: ‘He would say, “We won’t go to the pictures this week,” because I hadn’t come across’. She didn’t tell anyone because it had become ‘a sort of secret between us’.

Her SWIC indicates she was released from State care when she was 12 but continued to live at home. At 17 she finally revealed the sexual abuse to a woman who had been her foster carer years before. The woman helped the PIC find alternative accommodation and took her to the department, where she disclosed the ongoing abuse.

Police did not interview the PIC and to her knowledge nothing was done about the matter. There is no record of a police report or of any criminal charge being laid against the stepfather.
The PIC told the Inquiry the abuse ‘was always sort of a shadow’ in her relationship with her husband and may have contributed to the eventual break-up of the marriage.

A woman who alleged sexual abuse while placed at the family home was first placed in State care for a minor offence in the early 1950s when she was nine years old. The department initially placed the PIC with her mother for nine months. She later lived at Seaforth Home and alleged she was also sexually abused there.

The PIC told the Inquiry she was sexually abused over several years by a man with whom her mother lived, and that the abuse began before she was placed in State care. He touched the PIC’s genitals and attempted to penetrate her. She said, ‘It was hurting me, but he didn’t—he had to stop because it was hurting his penis’. The PIC alleged that this abuse occurred until she left the family home. She said the department ‘didn’t know about’ the abuse.

The PIC said she was abused on two other occasions while living at home. On one occasion her mother sent her to the home of her employer’s son, who was married with children. While there, the PIC said, the son showed her comics, which she loved. She gave evidence that ‘He said, “Do you want these?” and I said, “Yeah”, and he said, “All right. You pull your pants down and I’ll pull mine down”’. The PIC recalled that, ‘Something told me to get the hell out of there, so I did’. She said she later told her mother what had happened but her mother hit her in the face and told her not to tell lies.

On another occasion when away from the family home, the PIC and two other girls encountered a male friend of her mother’s partner. This man told the girls they could earn 10 shillings if they went into a public toilet with him. All three girls went into the toilet. The PIC said, ‘I did go in there and he stuck his penis between our legs; he pulled our pants down’. She did not tell anyone about this incident at the time, but told the Inquiry that the other girls’ parents asked where their daughters had obtained the money and she later told her mother what had happened.

Departmental records stated that ‘home conditions do not appear to be good for child’. Her SWIC noted that the mother’s partner ‘dislikes girl and she should not be left in the home alone with him’. Records give the reason for the PIC’s transfer to a government institution: ‘Home unsuitable’.

A seven-year-old girl arrived in Australia as a child migrant in the late 1940s, accompanied by a woman she called ‘aunty’, although they were not related. As she was a child migrant she is considered by the Inquiry to be in State care until the age of 21. The PIC recalled that departmental workers came to the farm where she lived and to her school from time to time.

The PIC told the Inquiry that in the mid 1950s, when she was about 14 to 16, ‘aunty’s’ husband repeatedly sexually abused her. She said it started one day when he followed her to the milking shed. He ‘squeezed my breast … but then it just got worse … he pushed me against the railing and exposed himself to me’. He told her ‘that I was slut, that I was a whore, that I was a temptress … I didn’t even know what the word meant’.

She could not avoid going to the shed as milking the cows was her job. She alleged the man continued to sexually abuse her there for about two years and eventually digitally penetrated her. He threatened her into keeping quiet by saying:

*You tell aunty and she’ll die … No-one will believe you because I am a respected member of the community, a [member] of the church … and who’s going to believe you, that nobody knows?*

She said she did not tell departmental workers about the abuse because they never spoke to her alone. After about two years on the farm she left to go into a career.

At the time of the Inquiry she said she found it helpful to talk about her past ‘because holding a secret like that for so many years is debilitating’.
A young Aboriginal girl was placed under the supervision of the Aborigines Protection Board (APB) for several years from the mid to late 1950s. Due to the lack of available records concerning placements and the actions of the APB in placing children without the approval of the Children’s Welfare and Public Relief Board (see page 14), it was not possible for the Inquiry to properly determine whether the PIC was placed in State care. She told the Inquiry she was sexually abused both before and after being placed under APB supervision. She remembered very little of the abuse she experienced as a toddler but clearly recalled being sexually abused when under APB supervision at the age of seven or eight by a male relative whose family lived nearby. She told the Inquiry that she and her siblings ‘used to all go and sleep at [their] place … he come into the room and he was standing over us and touching us’. She alleged he also digitally penetrated her on several occasions. She did not tell anyone about it for many years.

The girl believed she was taken away from her mother soon after this but there are no records of a placement. When her mother died in the early 1960s she and her siblings lived with their grandmother. Some time later the APB decided the grandmother was too old to care for them adequately. The PIC was brought to Adelaide and sent to several places of care until she was about 15. It was only as adults that the PIC and her female relatives discussed the abuse by their relative when they were children: ‘We never talked about it [before]’.

A nine-year-old girl was placed in State care in the early 1960s after a court found her to be destitute. She had lived at St Joseph’s Orphanage since she was six and alleged she was sexually abused there. Her SWIC indicates she had multiple placements. She told the Inquiry she was later sexually abused at the Convent of the Good Shepherd (The Pines), in foster care and in her family home.

A senior probation officer placed the PIC with her mother for almost two years when she was 11. She told the Inquiry that on her first day back home her stepfather, who was violent and abusive towards her, called her ‘a slut’ in front of the family, which ‘sort of gave the green light for them to treat me badly’. She alleges she was sexually abused ‘all the time’ by three male siblings. One of them ‘regularly raped me over a two-year period’ and beat her severely.

She said she didn’t tell anyone about the sexual abuse because ‘you’d get a handful of hair ripped out if you said anything’. One sibling threatened to ‘shoot me if I told anybody’. Departmental records show that the stepfather complained about the PIC’s behaviour at home and said she was ‘leading his sons astray’. When she was 13 the PIC was charged with larceny and remanded to The Pines.

She told the Inquiry that as an adult she ‘lived in fear’ and had difficulty trusting anyone or forming relationships ‘in the sense of intimacy’. A few years ago she decided to get some counselling to ‘re-educate myself on feelings, emotions’.

In the mid 1960s a four-year-old girl was found by a court to be neglected and was placed in State care. According to departmental records there were allegations that the PIC’s father had behaved inappropriately in front of her and her siblings. She was sent to multiple places of care over the next 14 years. She alleged she was sexually abused while in foster care, in the family home, at Hay Cottage and at Davenport House.

Records received from the department show the PIC was seven when she was placed with her mother.

The PIC told the Inquiry that her mother’s live-in partner sexually abused her for over a year when she was about eight. She said ‘he raped me in the house, in the barn and also on a boat’. The alleged perpetrator also forced the PIC to watch him have sexual intercourse with her mother. The alleged perpetrator threatened the PIC with a stockwhip and threatened to ‘shoot my brains out if I ever told the welfare what was happening to me’. The PIC said she believed her mother was aware of the sexual abuse, because she caught them in the shed one day when the PIC’s ‘dress was up over my head’, but her mother’s only reaction was a dismissive remark. The PIC said she was too afraid to tell her departmental worker about the abuse, but she recalled pleading to be returned to the government.
home where she previously had stayed, even though she had hated it there.

According to departmental records, the PIC’s mother and grandmother both reported incidents of sexual abuse against the child by the partner. The department investigated the mother’s allegations and found one of them ‘proved to be unfounded and the mother had admitted that she’d made it up out of spite’. The department noted that the mother also asked to retract the second allegation against her partner, saying she had been ‘mistaken’.

On more than one occasion, visits by an officer of the department revealed that the PIC’s mother had left her partner and gone to live with her husband. On one such occasion the officer told the mother the PIC could not remain living with the partner. The records state that the mother immediately agreed to return to her partner, which sent the PIC ‘into a fit of hysterical crying’. On the same day the PIC was returned to the government home, requiring constant reassurance that she was not being taken back to her mother’s partner.

The PIC alleged that her father also had sexually abused her when he took her on outings from Hay Cottage when she was 11. Aged 15, the PIC moved in with her father, with the consent and knowledge of the department, and she said he continued to sexually abuse her in his home. A departmental worker noted that although the father ‘was suspected of having interfered sexually with the children … [he] states that this allegation was made by his wife out of spite’.

Within a year the PIC ran away from her father and moved in with a female relative who worked as a prostitute. She said she had nowhere else to go, and told the Inquiry that the relative’s partner forced her into prostitution and sexually abused her regularly.

Departmental records indicate the PIC’s father alleged the relative’s partner was sexually abusing the girl and the partner made similar allegations against the father. The records contain several notes suggesting the PIC was engaging in prostitution while living with her relative. There is no indication on the file that the department took any steps to prevent this. The PIC’s departmental worker commented on her living arrangements, given the allegations and counter-allegations by the PIC’s father and the other man. She stated that despite the allegations of sexual abuse, ‘it seemed the only alternative at the time’.

The PIC told the Inquiry she wished that she had been able to grow up in a normal, loving family, to be nurtured by good parents, to have been able to have had a decent education … to have not lived in fear.

She hoped her evidence might benefit others:

If I can help just one child in State care not to have suffered the way I have suffered … then I have achieved some good in my life.

In the mid 1960s a 14-year-old girl was charged with larceny and placed in State care by court order until she turned 18. The PIC told the Inquiry she had been falsely accused of the offence but no-one believed her. She was placed under the supervision of her mother, who had separated from the PIC’s father several years earlier. She alleged she was abused while in her mother’s care and in a later foster placement.

She said that while she was living at home, and not yet sexually active, her departmental officer sent her to a doctor who prescribed her contraceptive pills. She alleged that while the doctor was examining her, he forcibly subjected her to ‘full-on sexual abuse’ by digitally raping her while he masturbated.

She said she told her mother about the incident and her mother told her to ‘stop romanticising’. She did not disclose the abuse to her departmental officer. ‘Who would listen?’ she said. ‘My mother didn’t. And that’s an embarrassment that you don’t want to talk about with anybody.’
Evidence from males

A seven-year-old boy was placed in State care by a court order when he was found to be destitute in the early 1940s. He was placed at the Glandore Industrial School for about three years, during which time he had various holiday and foster placements, returning to the school between each. Just before his 10th birthday, the PIC was placed on probation with his family and alleged he was sexually abused during this placement and also at Glandore.

He told the Inquiry that while he was on probation with his family his mother operated a brothel from the family home. The PIC described it as ‘the most debauched house that ever a human being could live in’. He said his mother took him out of school in the mid to late 1940s, when he was in his teens, and put him to work providing sexual services to female clients in return for his board.

He recalled a departmental worker coming to the house only once to check on him. His said his mother ...

... made me stand outside on the front fence ... I wasn’t allowed to let the welfare man in, and they stood behind their front door listening to what I had to say.

The PIC told the worker only that he was ‘all right’ because ‘I didn’t know to say anything different’.

The PIC’s SWIC contains the note: ‘Home and boy well cared for’.

However, notes on the PIC’s client file suggest the department believed the PIC needed sexual education. One notation reads:

I spoke to [PIC’s mother] re sex education ... she did not really think there was much he did not know.
I told her that often when boys discussed matters without receiving the proper instruction they obtained the wrong views.

A note from a senior officer instructs the PIC’s probation officer to supervise the PIC ‘for the purpose of imparting sex instruction ... and a report made to me’. The file does not note the reason for this instruction or contain a copy of the report.

The PIC was 13 in the late 1940s when he left his family home—while still on probation with his family—to work on a farm outside Adelaide. The PIC told the Inquiry he moved between places of employment and ‘I eventually got in trouble with a farmer’s wife who I was working for. She was 35 and I was about 14’. He said he walked in on the farmer’s wife when she was naked. As a result, the farmer planned to send the PIC back but instead had to go to Adelaide himself for long-term medical treatment. The PIC remained on the farm—where he was employed for another year—and said that ‘before that year was up I was sleeping with [his employer’s] wife’. After the employer returned to the farm, he took the PIC back to Adelaide.

The PIC’s records show his departmental probation officer—who had only recently been assigned to him—was unaware he had left Adelaide to work. The file records a visit by the officer to the family’s home:

Mother informed me that boy was at [country town] working and I complained that I should have been informed and asked her to write to the boy straight away asking him to write to me.

The PIC wrote back, ‘I’m very sorry I didn’t contact you before I left. I didn’t know your name or where about’s to send it’. A reply from the probation officer requesting the PIC’s employment details reads:

I do not intend to contact your employer ... so long as you do the right thing there is no need for your employer to know that you are under the control of this department. Try and remember to write to me once a month.

The PIC said that sex was ‘the way I was taught, the only thing I knew’. When he attended school,

They caught me in the girls’ toilet, trying to interfere with them. Now, not only that—a female teacher came along to drag me out and I put my hand straight between her legs. You know, I thought this was how people lived.
Chapter 3 Allegations of sexual abuse

He said it affected not only his childhood, but also his adult years; his sexual activity was ‘non-stop, all the time. Everyone was a target.’

A nine-year-old boy was remanded to a government home for a few days in the early 1950s after stealing some food from a lunch room. He was charged with larceny and placed in State care, but allowed to live at home under the supervision of his mother. He told the Inquiry his mother was very poor and said that two men sexually abused him while he lived with her. Later there was an attempt to sexually abuse him at the Magill Boys Reformatory.

The PIC told the Inquiry that while he lived with his mother a male leader of a local community group sexually abused him on three occasions. The man took him into a dark room, reached inside his pants and rubbed his upper legs, and on the third occasion also touched his genitals. A departmental worker noted in a report that during an interview with the PIC ‘he said he did not like [the community group] any more’. The PIC told the Inquiry he had been afraid to go back to the community group because of the abuse.

He also alleged that at a later date he was sexually abused once by a clergyman, who invited him to sit and talk with him and then touched his thighs beneath his clothing. The PIC said he did not report the abuse.

An 11-year-old boy was found to be destitute by a court in the mid 1960s and was placed in State care until he turned 18. His parents’ excessive drinking and violence had marred his home life and there was little food for the children. Records received from the department show the PIC was in foster care and at four institutions over the next seven years. He told the Inquiry he was sexually abused at Windana Remand Home, Glandore Children’s Home, Kumanka Boys Hostel and McNally Training Centre, and in the family home.

At 10, the PIC was returned to live at the family home for two years. He told the Inquiry that during this time he solicited money from a man he met in a public park who engaged him in sexual activity: he ‘sat me on his knee, played with my penis, hugged me’. He said they met and engaged in sexual activity on three more occasions; the man once attempted to have anal intercourse with him, but stopped when the boy said it hurt. The PIC said he never told anyone about the abuse because he found it ‘comforting and enjoyable … it was nurturing almost’. He later realised he had been seeking only affection and an adult’s attention, but ‘I didn’t need my dick played with. I needed a hug.’

He said his father was a ‘very violent man’ who told him: ‘If you ever tell anyone our secret I will kill you and bury you so no-one will ever find you’. I believed him and nothing more was said.

The PIC told the Inquiry he pleaded with his departmental worker to take him out of the family home because his father ‘was doing the sex thing all the time’, but the worker accused him of lying. There is no departmental record of this complaint. Records received from the department confirm that the PIC asked to be removed from his family, however a note states that he came into the office saying he wanted to return to Glandore, that he had been a slave to his mother and accused of being a thief.

In the late 1960s, an eight-year-old boy was placed in State care after a court found him to be neglected following the breakdown of his family. The PIC told the Inquiry he experienced family violence and alcohol abuse when he was a child. He was sent to several government institutions, cottage homes and foster placements over the next decade. He told the Inquiry he was sexually abused during placements at Stirling Cottage and his family home.

At 13 the PIC returned to live with his parents for a few months. He alleged that during this time his father regularly touched his genitals, anally raped him and engaged him in oral sex. He recalled that it happened... as often as two or three times a week, whenever he got the chance ... It was always after [my mother] was either drunk or she’d gone to sleep.
A four-year-old boy was placed in State care by court order in the mid 1960s as a result of his being neglected and under unfit guardianship. He was sent to a government home until the age of five, when he was put into hospital for treatment and then placed with his mother—he alleged he was sexually abused while in her care. He was released from State care in the early 1970s, aged 10. At 14, he was again placed in State care and told the Inquiry he was sexually abused during a placement at Brookway Park in this period.

The PIC told the Inquiry that while in State care and placed with his mother, she forced him to engage his sister in oral sex and to take part in other sexual acts while his mother watched. He alleged she subjected him to brutal physical and psychological abuse.

The PIC said his mother made his sister ‘suck me off nearly two hours a day’. He also said his mother made him cut the lawn

... with the scissors ... no lawnmower ... as a punishment. And it was cold and windy and raining ... I didn’t have nothing on, nothing, just underwear ... Then she spit on my food, she give me kerosene to drink. She gave me some tomato poison, some tomato poison to drink ... I fall over, I went unconscious, went to the hospital and then my mother come along and she says, ‘If you tell the nurses that I gave you that drink, when you come home, you’re going to get [a] big hiding ... ’ So I lied to the nurse that I took [an] overdose.

Departmental records indicate the PIC told staff about his mother’s abuse but the departmental worker noted that there was no direct evidence. The supervisor’s observation report notes that the PIC wanted to stay at Brookway Park rather than return to his mother’s care.

The PIC told the Inquiry that in later years he suffered from flashbacks of his mother’s abuse and had sought psychiatric treatment. He said he felt confused, angry and depressed about what happened to him in the past: ‘I just keep thinking about whatever happened to me can happen to somebody else’.
1970s

Evidence from females

A seven-year-old Aboriginal girl was placed in State care in the late 1960s after a court found her to be neglected. The PIC said she did not know why she was removed from her family. Over the next 10 years she lived in government institutional care, foster care and with her family. During this period she absconded several times and returned home to be with her mother. She told the Inquiry she was sexually abused at Seaforth Home, Clark Cottage, in foster care and in the family home.

The PIC alleged that when she was about 15 and living at her mother’s home, two male relatives sexually abused her. One man indecently assaulted her and the other ‘tried to rape me in the bathroom’. She said she didn’t tell anyone about the incidents because her mother had not believed her when the PIC told her about being sexually abused as a young child, and another relative had ‘just said, “Don’t be silly”’. The PIC told the Inquiry that ‘you just didn’t have anyone to trust. You just didn’t know where to go’.

As an adult she has a positive outlook on life and does not want to be bitter about her past experiences:

I want to use everything I’ve gone through in my life and let it benefit other people. I can’t change anything I’ve gone through in my life, but I can make a decision about how I want my life to be.

In the late 1960s, a court found that a five-year-old girl was neglected and under unfit guardianship and placed her in State care until she turned 18. The PIC told the Inquiry her stepfather drank and had been violent and she believed he had sexually abused her before she went into care. Soon after the court order, she was placed in Hay Cottage, where she alleged she was sexually abused.

Aged nine, she left Hay Cottage and returned home. She told the Inquiry that life had been ‘relatively normal’ for a couple of years until her mother became addicted to drugs and started working as a prostitute, which involved taking the PIC to meet clients by the river at night. She recalled that in her early teens while in State care her mother had tried “to coax me into doing it as well”. She agreed to have paid sex with a client on one occasion when her mother was ill but ‘when he pulled his pants down I ran out of that room so fast’. She told her mother and ‘got a slap across the face’.

The PIC said a departmental worker occasionally visited her at home but there was never an opportunity to speak to her alone, ‘so I couldn’t really tell her what was going on’. She was released from State care on petition at the age of 14. The PIC said she was about 15 when her mother was sent to prison; the department had helped to arrange a flat for the PIC, who had become addicted to morphine. She said she had taken up with ‘bad sorts’ and had been sexually abused around this time. In her late teens she said ‘hung around with abusive men because I thought I wasn’t good enough to be with anyone normal’. She also told the Inquiry: ‘I have never had any counselling or told anyone about any of these events’.

A 14-year-old girl was placed in State care until the age of 18 in the late 1960s by the court as a result of offending. She spoke of violence and alcohol abuse by her father and said that while in State care she was sexually abused at Windana Remand Home, Davenport House, in foster care and in the family home.

She returned to the care of her parents from time to time while in State care. She told the Inquiry that when she was about 15 and living at home, she was gang-raped by five young men who were part of her social circle. She said she tried to fight them off but ‘I had been drinking, which … made me physically not strong enough’. After experiencing sexual abuse several times, the rape was ‘the last straw … I just went, “Oh, I just can’t take it any more”’. She took alcohol and drugs to ‘cover the pain’ and attempted suicide, but didn’t tell anyone about her experiences.

She said that some of the young men who raped her had recently apologised to her. She felt ‘it was really good to hear … they were sorry’ because she had felt ‘a lot of guilt’ about the incident.
She told the Inquiry it was difficult to come forward with the allegations of sexual abuse, as she was fearful about not being believed. Giving evidence to the Inquiry was ‘the first time I’ve actually told a man, other than my … partner’.

In the mid 1970s a six-year-old girl was placed in State care until the age of 18, after a court found her to be neglected. She said the department had been involved with her family before her placement in State care, due to concerns about her mother’s parenting abilities. The PIC told the Inquiry she was sexually abused during her time in State care when placed back at the family home and then later in foster care.

After the PIC was placed in State care, her departmental records show she was returned to her mother’s supervision on at least two occasions before she was nine. The PIC told the Inquiry her mother sexually abused her from her early primary school years. She alleged that while she was at home her mother forced her to perform sexual acts on one of her siblings and with an animal, while her siblings were made to watch. She also alleged that one of her older siblings raped her.

In addition, the PIC said her mother subjected her to harsh beatings and urged her siblings to inflict violence on her—she said that in the first eight years of her life she was ‘in and out of hospital constantly’. She told the Inquiry that at home, she would have to sleep in the chicken shed, eat dogs’ faeces and insects and drink her own urine.

When she was about nine, the PIC was placed in foster care, where she alleged she was again sexually abused. She told the Inquiry that because of the abuse she was unable to have lasting relationships as an adult, and that she attracted the ‘wrong kind of men’. She felt that ‘the department didn’t do enough regarding the protection of us, and our mother should have been charged’.

A 12-year-old girl was placed in State care by a court in the mid 1970s after being found to be neglected. The care order was initially for three months, and then extended to age 15. Her SWIC indicates she had several foster care placements and was returned to the care of her mother about six months later. She told the Inquiry she was sexually abused by her father both before and after being taken into State care, as well as by a foster parent.

The PIC alleged her father began sexually abusing her when she was eight. She said he touched her and digitally penetrated her when he drove her to her sporting commitments and while her mother was in the shower. She told the Inquiry he threatened that if she said anything her mother would become jealous and throw her out of the house. He promised to give her a bike and other gifts if she allowed him to do sexual things to her, but he never kept his promises. The PIC said she began to act violently at school, in the hope that someone would ask her what was wrong, and often ran away from home. It was because of this behaviour that the department first placed her in State care.

The PIC told the Inquiry, and it is confirmed by records, that she disclosed the sexual abuse to the department just a few months before being returned home to her mother’s supervision. She also claimed her mother told her she had spoken to police about the sexual abuse. The Justice Information System (JIS) does not indicate any investigations of, or charges being laid against, the father in relation to the PIC. It does show that he was wanted in relation to an unrelated sexual assault in the early 1970s.

The PIC claimed that within weeks of arriving back home aged 13, her father recommenced sexually abusing her but was ‘a lot more aggressive’ than before. She recalls that ‘I was a little bit more reluctant to allow him to but he would overpower me’. She said he waited for her to come home from school and made her expose herself while he rubbed himself or made her masturbate him. She complained to her mother, who said she would leave him. She did not leave the home, however, until the PIC turned 18.

The PIC told the Inquiry that in her late teens she became addicted to heroin: ‘I certainly didn’t choose to be a drug addict … I just couldn’t handle the feelings’. She said she stole to support her habit and got into trouble with the law. She claimed her father visited her a few years ago and sexually assaulted her. When she reported it to the police they told her she would not make a credible witness due to
her drug and criminal history. This ‘just reinforced to me that I was worthless, which is something I’ve felt my whole life’.

At the time of the Inquiry she was off drugs and focused on being a ‘good mum’ to her children. She decided to give evidence to the Inquiry because she would like things to change in the future.

A seven-year-old girl was brought to Australia in the mid 1970s by prospective adoptive parents. She lived with the couple but was placed in State care until her adoption was formalised. According to departmental records, within a few months of the PIC’s arrival the prospective mother notified the department of a breakdown in the marriage and left the household. She also informed the department that her husband was neglecting the children. An investigation was conducted and a report several months later states:

While the children are well cared for at the moment, I remain suspicious of [the father’s] motives for wanting these children. The little girl is in need of adequate ‘mothering’ and clings to any female … For the children’s sake the situation needs resolution as soon as possible.

About 18 months later, the father was granted adoption orders for the PIC and another child. The PIC then ceased to be in State care.

The PIC told the Inquiry that during and after her placement in State care her adoptive father sexually abused her by photographing her naked, encouraging her to walk around topless or wearing a short negligee, and showing her pornographic movies and pictures. She also claimed that he made her sleep naked in his bed on several occasions and that he touched her.

The PIC alleged that he beat her and her adopted sibling regularly and that she was terrified of him. After one particularly brutal beating, the PIC ran away and told an adult friend about the violence at home. The friend took her to the department. The PIC does not recall whether or not she told anyone there about the sexual abuse but she and her sibling were again placed in State care and moved to a foster home.

A 10-year-old girl was placed in State care by a court in the early 1970s after being found to be neglected. She told the Inquiry she suffered severe physical abuse at the hands of her alcoholic father before being taken into care. Her SWIC indicates that she was sent to multiple placements and stayed with her mother during holidays.

She told the Inquiry that while living at her mother’s home between the ages of 10 and 12 she was sexually abused by a man who lived in the neighbourhood. She said the man enticed children into his shed by offering them sweets and she recalled seeing children in a bed in his shed. She said he also would drive around in his car and encourage children to get in with him.

The PIC said she went with him in his car on one occasion: ‘He somehow got me off the street and I was on my own’. She alleged the man removed her underwear and fondled her. She recalled that two police officers later visited her at home and questioned her about the incident. Records confirm that the man was charged and sentenced to jail.

The PIC also told the Inquiry that while she was living at home several males, including a local shopkeeper and a deliveryman, engaged her in sexual activities in exchange for money. She said she used the money to buy food for the family. She didn’t tell anyone about the abuse.

The PIC told the Inquiry that for many years, ‘I really told people as less as I could about my past and stuff. Some of it was very uncomfortable to bring up.’

An account of three sisters

Departmental records show that in the mid 1970s, three sisters aged about 11, nine and three were placed in State care for reason of neglect. The PICs told the Inquiry their father was violent and was often away working interstate, and their mother had left the family home. One sister said that before their mother left, the mother ‘was constantly entertaining male guests and the house was filthy’. Two sisters alleged they were sexually abused while initially placed at Seaforth Home, and all three alleged ongoing sexual abuse by their father after being placed in the family home while in State care. Two told the Inquiry the abuse began before they were placed in...
State care, and two alleged the abuse continued while in foster placements, when their father would take them out.

In the early 1970s, before the girls were placed in State care, departmental records show that the police and the department were aware of allegations by the two older siblings that they were victims of incest by the father. No action was taken for reason of reliability of evidence. However, the police reportedly warned the father about his behaviour.

Several months later a charge of neglect was brought before the court. The three sisters were placed in Seaforth Home. Departmental records show that a report prepared by the department for the judge alerted the court to the allegations of incest in relation to the two older siblings and also to a previous suicide attempt by the father.

Two months later, the neglect charge was reportedly withdrawn on the proviso that the father found an approved housekeeper. He complied and the three sisters were returned to his care. Records show that seven months later an older sibling returned from interstate and became the housekeeper. However, the records also show that the older sibling soon contacted the department alleging sexual abuse of sisters [A] and [B] by their father. The court was notified of this, temporary custody orders were made in respect of [A], [B] and sister [C] they were placed in different foster families.

Records show that a departmental worker interviewed the older sibling, who confirmed that [A] had told her that the father ‘sticks his dick in mine’, and that [B] had told her that the father had ‘put a white thing on and then put his finger in my thing’ and that he had threatened to smack her if she did not get into bed with him. The older sibling also told the worker that the father had interfered with her and that he had attempted to hang himself. After this he had threatened more than once to kill her and shoot himself with his rifle.

Departmental records show that the departmental worker interviewed [A] and [B] separately, and [A], then aged 11, reported that the father ‘sticks his dick in mine’. She said this had happened on four or five occasions and that he had ‘put his dick a little bit inside’ and that it had hurt. [A] said she had done this because he would hit her with his belt if she did not and that he previously had hit her with the belt.

The records show that [B], then aged nearly nine, reported in an interview with the departmental worker that her father had pulled down her pants and felt between her legs and told her to ‘rub his sausage’. Her father had tried to ‘put his sausage in’ but ‘it would not go in and then he put his finger in’, hurting her. She said her father had told her not to tell anyone and that the police would lock him up if they found out and she would go into a home until she was 18. [B] recalled that ‘I drew stick men with penises. I think there were sexual acts involved.’

She told the Inquiry that she believed the departmental worker knew she was being sexually abused but didn’t do anything about it ‘because they betrayed me immediately. Straight after that report I was sent back home’. The departmental worker notified the judge of the allegations in a report, but commented that [A] was ‘most reluctant to divulge what had taken place with her father but was quite definite in the details’ and that [B] had been ‘less reticent initially … but has recently become more reticent’.

About two months later, in the mid 1970s, the court ordered that the three sisters and other siblings be placed under the guardianship of the Minister until they turned 18. It was reported that the court made no decision about the allegations of sexual abuse because it was satisfied the other evidence presented was sufficient for the order to be made. The court said that to hear the evidence of sexual interference ‘may prejudice future jurisdiction if and when the police charge [the father] with these offences. Consequently it is possible that the police may charge [him] and the children may yet again have to appear in court.’ A month later it is mentioned in an internal departmental report that ‘[the father] has not yet been charged by the police’ in relation to the offences ‘although statements have been submitted to the police prosecution department, and it could be that they will decide that there is insufficient evidence with which to charge him’.

3.5 Family home
In accordance with the records discussed above, all three sisters told the Inquiry they could recall an occasion when their father was reported to the police for sexual abuse. Each recalled independently going to the police and being examined. However, they said the older sibling encouraged them to withdraw their statements. [A] said she refused to change her story, ‘so my father said that I had betrayed the family and he didn’t want me back’. No records were received by the Inquiry from the South Australian Police in relation to the reporting of the allegations.

About 11 months after being placed in State care, all sisters were placed back in the family home with their father, reportedly ‘on a trial basis’. [B] recalled that the sexual abuse became worse and the father penetrated her. She said he always put them in separate rooms to isolate them.

I used to have to masturbate him … and then he had [one of my siblings] and I involved with the masturbation act jointly, and that’s when the penny dropped.

[B] recalled that apart from the persistent sexual demands of the father, there was little food in the home: ‘We scrounged for whatever we could have … essentially we were starving.’ He never bought them clothes, so they stole from shops and raided mission boxes. During frequent rages, he would beat them across their backs and legs, leaving welts that would last for days. He was also suicidal and constantly threatened to kill himself, as well as the children. ‘We were pretty terrified of him but, at the same time, we didn’t have anyone else to rely upon.’

Five months after the sisters were placed back with the father, it is recorded that a housekeeper informed the department that [B] and [C] slept with the father on occasions and that he walked around the house naked. It is reported that [B] denied any sexual activity took place.

Only a few months later, another housekeeper reported that the father had [B] in his bed behind closed doors and played in a sexual manner with the girls. It was reported by the departmental worker that ‘… five housekeepers had left because of the father’s “sexual advances and uncouth remarks”’.

Sisters [B] and [C] were then placed in foster care and [A] in cottage care, reportedly ‘until the situation became clearer’.

A departmental record shows there was a discussion between the departmental worker and his superior, in which it is noted:

… it was felt that as there still remained a great deal of reciprocal warmth and affection between [the children] and their father, it would be less traumatic and damaging for them to return to the care of their father and his housekeeper, albeit with certain provisos.

That same record notes that [A] had expressed a desire not to return and the father was ‘not keen to have her back’. [A] continued living away from the family home and was transferred from cottage care to foster care, where she remained until released from State care.

The department placed [B] and [C] back with their father. By this time [B] was 10 and [C] five. Records provided to the Inquiry do not indicate the department made a report to the police to investigate the housekeepers’ allegations regarding the sexual abuse.

About one month later, the departmental records show another housekeeper informed the department that the father had exposed himself to her and the children, and played with his genitals while they were present. It was also alleged that [B] spent long periods in the father’s bedroom. [C] was placed in her former foster home. The department reportedly again conducted interviews, and [B] and [C] denied there were any problems. One sister recalled that when departmental workers came to their home,

Dad would sort of shove me out in front of him … and then he’d stand behind me …. I had no choice but to say everything was fine.

The father denied the allegations. Again, there is no information on the departmental records to suggest these allegations of criminal conduct were referred to the police. [B] remained in the care of the father with another sibling.
When she was six, [C] returned from foster care to live in the family home with the father, [B] and another sibling. [C] recalled that the sexual abuse worsened: ‘He would put his fingers inside of me and he would perform oral sex’; and he continued to beat her—‘most often it would be around the face or arms or chest’. She tried to cover up the ‘cuts and bruises’ with her hair and her shirt, but a teacher once saw the marks when she was changing for physical education. ‘They asked me how it had happened and I said that it was an accident, because I was frightened of saying what had really happened.

Her father had told [C] that no-one would believe her if she said anything or, worse, that she would be ‘taken away and never to come back’, just like her older sibling. Sometimes he said he would kill her if she talked about it.

He’d keep me home from school, usually every Friday … you knew that you’d get hit or he’d threaten you with the gun … it was going to happen and there was little you [could] do about it.

She recalled one occasion when she was about 11, when her father took her to a doctor ‘and asked him to put me on birth control pills’. The doctor asked her whether she wanted to have sex. ‘I said, “No, I don’t”. He said, “Well, I don’t have any reason to” [put her on contraceptives]. But Dad carried on demanding until the doctor gave in.’

[C] attempted to commit suicide more than once but made no allegation to the department of the sexual abuse. She left the home in the mid 1980s, when she was nearly 14, and went to live with [B], who had left when she was 16. The father, who is now dead, was never charged with sexual offences against any of his children. In 2001, the sisters obtained access to their departmental records. Two sisters subsequently made a complaint alleging that the department had failed in the exercise of its duty of care. They were each awarded an ex gratia payment on the basis that there was no admission of liability by the State.

All three sisters told the Inquiry that the sexual abuse had profoundly affected their lives as adults. One said:

You feel worthless … Once you give up on yourself … you turn yourself into a doormat and everyone will treat you so … It’s a bit like an abused dog. I mean, if it considers a kick to be attention, well, then it is going to play up like hell to get another kick.

Another sister said she found it hard to make friends or be intimate with others:

I don’t want anyone to touch me in a sexual way. I even find it hard to let people give me a hug … if you get close to people you just get hurt, so I try to keep my distance.

The third sister said that ‘even as an adult I felt that I couldn’t protect myself against him’. When the father died, she went to the funeral home with her sisters to see his body:

I really needed to see that he was dead, and I took a photograph of him in the coffin so that any time I was feeling a bit unsafe I could look at it and know that he was really gone.

Evidence from males

In the early 1970s, an 11-year-old boy was placed in State care until the age of 18 as a result of a criminal offence. He told the Inquiry his family was very poor and he stole to support himself. His SWIC indicates he was placed in various institutions and at his family home.

He told the Inquiry he was sexually abused while placed in his family home on release from Windana Remand Home when he was nearly 12. A man in a car driving through the PIC’s neighbourhood asked directions and ‘tricked’ him into getting in the car to show the way. He said the man drove him to a remote area, anally raped him at gunpoint and threatened to kill the PIC and his family if he told anyone about the rape. The PIC remembers being ‘afraid to tell anybody because I didn’t want anything to happen to my mum, my [siblings]’. He said he never saw the man again but after the incident he ‘didn’t trust anyone … I suppose it really hardened me’.

The PIC said he lived on the streets from the age of 13 and prostituted himself to make money: ‘I was just trying to survive’. He told the Inquiry of two particular older men, both professionals, with whom he had ongoing sexual relationships in exchange for money and food. He alleged a third man forcibly performed oral sex on him and he
Chapter 3 Allegations of sexual abuse

A seven-year-old boy was found by a court to be neglected and sent to a government cottage home for six months. He was then placed in State care under a temporary order and put under his mother’s supervision. He alleged his mother sexually abused him and his siblings while he was at home.

The PIC told the Inquiry his mother suffered a mental illness and that she touched him in a sexual way when he was in the bath, penetrated him with objects and forced him to perform sexual acts with his siblings. He did not tell anyone about the abuse at the time.

The PIC and his siblings also suffered considerable violence at the hands of their mother. Departmental records indicate they were taken to hospital with severe physical injuries consistent with being beaten. Despite this, they were not removed from the mother’s care for some time, and were then returned to her care from time to time.

The PIC did not tell anyone about his mother’s sexual abuse but he did tell police and departmental authorities that he didn’t want to go back home because he was not happy there.

The PIC was removed from his mother’s care when he was nearly 10 after a court found him to be uncontrollable. He was placed in State care until the age of 18 and sent to several placements. He told the Inquiry he wished… that I didn’t go through what I went through as a child… the welfare should have stepped in a long time ago because we could have had a better life.
In the mid 1980s, a 14-year-old girl was placed in State care under temporary orders and interim guardianship when her relationship with her adoptive father, with whom she had been living, broke down. She was moved to several places of care and then placed with her adoptive mother and stepfather for a trial period of several months. Records show the PIC had come to the attention of the department in the early 1980s after she had made allegations of sexual abuse against her stepfather. The PIC, who was then about 10 or 11, told the Inquiry her stepfather had tried to penetrate her over a period of months when her mother was out of the house. She told the Inquiry that, in response to the allegations, department workers assured her they would speak with the stepfather and monitor his behaviour. She recalled that ‘they told me they investigated it and they just said everything would be all right’. Records indicate the PIC was medically examined at the Sexual Assault Referral Centre about this time, when the evidence was ‘consistent with some interference’. South Australian Police records show that after questioning the stepfather, who denied the allegations, it was determined there was insufficient evidence to support charging him.

When the department placed the PIC with her mother and stepfather for the trial period, records note that the PIC had expressed a strong desire to live with her mother and that she should be supervised because of the previous allegations. The PIC told the Inquiry she suffered sexual abuse while living with her mother and possibly while in foster care. She alleged the abuse was perpetrated by a man who used to regularly drive her to and from school and also, when she was living in foster care, drove her to visit her mother. The PIC told the Inquiry she believed the department arranged the man’s driving services, because she once visited a departmental office with him. She said the man and his wife befriended her mother.

The PIC alleged the man showed her pornographic videos and photographs of himself engaged in sexual acts with a woman. She said he videotaped her naked and in her underwear, and she alleged the abuse also included oral sex. She said he would sometimes give her money. She claimed the abuse occurred mainly at the man’s house and continued until she was in her early teens, when the man suddenly died.

The PIC told the Inquiry: ‘I was distressed. I was always scared … I was never scared that he was going to hurt me or anything, but I just knew that it was wrong.’ She recalled being visited by her departmental worker while in foster care and at home with her mother, but she didn’t tell anyone about the abuse because she didn’t know who to trust and ‘I felt that it was my fault … I was a kid. I was embarrassed. I didn’t want people to know’.
Chapter 3 Allegations of sexual abuse

Departmental records received by the Inquiry show the department contracted a volunteer of the same name as the alleged perpetrator given by the PIC to the Inquiry to help transport the PIC for the duration of the order placing her in State care. The records show that soon after the initial interim order was issued, he was transporting the PIC to appointments and to visit her mother, while the PIC was in foster care. The records also report that the man ‘became very supportive of [the PIC’s mother]’.

Police records show this man had prior convictions for indecent assault at the time of his engagement by the department. It is not apparent from the PIC’s departmental files that any prior checking of the man’s criminal history was conducted. No personnel file was received from the department to assist in determining whether the department conducted a criminal history check of the man before engaging his services.

The PIC recalled that in her mid-teens she started taking drugs, left school, and ‘picked a lot of very bad people to be in relationships with’. She also developed eating disorders. She said she told her mother about the abuse at that time, and that it was good to tell her story to the Inquiry

… so that it doesn’t happen to other people.
I did want some kind of closure about this because it’s never really happened and I’m sure I still have issues.

In the mid-1980s a six-year-old Aboriginal girl was placed in State care until she turned 18, after being found to be in need of care. Departmental records show that while in State care she was placed in various foster homes, detention and also lived from time to time in her mother’s care in the family home.

The PIC told the Inquiry that when she was about seven or eight and placed in the family home, her mother’s male de facto partner would have sexual intercourse with her. She said this abuse continued into her teenage years. She said:

‘He treated me like shit’ and told her not to tell her mother. She said she didn’t tell anyone about this until much later because ‘I was sniffing glue, I was taking pills, to block it all out’. When at 17 she finally told her mother about the abuse, her mother accused her of telling lies.

Departmental records indicate there were concerns about possible sexual abuse of the PIC by the de facto partner when she was nine. She was referred to the Sexual Assault Referral Centre (SARC). The physical findings suggested abuse but it was not possible to say how long ago it occurred; the report stated that the interview with the PIC was ‘quite inconclusive’.

A departmental psychologist’s report written the same month as her referral to SARC about whether the PIC and her sibling should return to live with their mother shows the department was concerned about the PIC’s ‘age-inappropriate sexualised behaviour, suggestive of sexual victimisation’. The report shows the department knew the de facto partner had been ‘confirmed as having sexually abused his own children’. The psychologist wrote: ‘I have my concerns that [the mother] does not acknowledge the possibility of them being at risk with her lover [named]’.

When the PIC was in her mid-teens, the department noted concerns about the mother’s partner and the earlier suspicions of his sexual abuse of the PIC. It also noted, however, that the PIC refused to clarify the allegations and would not discuss the matter with departmental workers.

The PIC told the Inquiry the de facto partner has ‘ruined my life … I felt like killing him when I saw him …’ She feels she never had a childhood and that the physical and sexual abuse has contributed to her engaging in substance abuse.

At the time of the Inquiry she was continuing to sniff glue: ‘I sniff glue when I’m at home to try and block everything out’.

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Evidence from males

A 11-year-old boy was placed in emergency foster care for a brief period in the early 1980s. Two years later he was found to be ‘in need of care’ and was placed in State care until he was 18. The PIC alleged he was sexually abused when placed with his family, as well as in foster care, at the Gilles Plains Assessment Unit and when absconding from placements.

The PIC gave evidence that when he was 15 and placed in the family home, he was sexually abused by a man who had earlier visited him at a government admission unit and ‘tracked me down’ to the family home. He alleged the man forced him to engage in anal and oral sex over a period of six months, usually at the man’s home. The man gave him food, clothes and money and warned him not to disclose the abuse. One day, when the man took him flying in a small plane, he threatened the PIC:

... that if I told anybody about what had happened
... ‘things could happen, like you could fall out of a plane’ … it absolutely scared the wits out of me and that’s when I thought I would never say anything to anybody.

The PIC said he ran away from his family home, absconded from other placements and lived on the streets, working as a prostitute for several months in his mid-teens. He said another boy suggested that instead of being abused in care, ‘we could get money for doing it and live our own way’. He frequented a bar in the city, where he met clients. He alleged he performed oral sex on the bar’s proprietor in exchange for free drinks. He went to the homes of several men and performed oral and anal sex in exchange for money.

He told the Inquiry he came forward to give evidence because he believed that abusers should be stopped. ‘It can be at least brought to light that the authorities know that they’re doing this.’

A 14-year-old boy was placed in temporary State care in the mid 1980s after being found to be in need of care. His SWIC indicates he initially was in care for one month and then was placed in State care when he turned 18. He spent time at a government institution and then went to live with an older sibling with the permission of the department.

The PIC told the Inquiry he was sexually abused by family members from the age of six, before being placed in State care, and that he had come to believe this was normal and what was expected of him. He also alleged that while he was living with his sibling and in State care, he was sexually abused by a man known to the sibling. He claimed that while staying with the man on a weekend, he ‘began to fondle me’. He said this happened several times in bed but he couldn’t leave because ‘I was basically stuck there the whole weekend because I had no transport’. The PIC later stayed with the man and had a continuing sexual relationship with him. He said he had no other accommodation as he had fallen out with his sibling and his father refused to have him at home.

The PIC told the Inquiry he did not tell anyone about the abuse because ‘I was always scared’ and he did not know who he could confide in due to ‘a whole change of all people all around’ the department.

He married very young but the marriage did not last long and he returned to live with the man who had previously sexually abused him.
Chapter 3 Allegations of sexual abuse

1990s

Evidence from females

A woman born in the late 1970s alleged she was sexually abused in State care as a teenager living in a family home and a unit organised by the department. She had come to the department’s attention as a five-year-old due to her sexualised behaviour, parental neglect and housing need. The department monitored the child and, when she was 12, placed her with relatives, who received payments for her care. About two years later she was placed in State care until she turned 18. She then had many different placements including briefly with a family friend and then in her own unit. Both are reported as abuse in a family home placement for the purposes of this Inquiry.

The PIC told the Inquiry she began living with the family friend after the closure of an assessment unit in which she was living. During this period the PIC was convicted of an offence and required to undergo a community work program as part of her sentence. The PIC said she was sexually abused at the centre where she undertook this program. She remembered that a worker connected to the program approached her from behind, lifted her skirt and fondled her inside and outside her underwear. He also allegedly abused her on one occasion when he stopped at a building site while driving her home. The PIC did not return to the work program and did not tell her departmental worker about this abuse: ‘I didn’t think they’d believe me’. However, the PIC’s client file noted in the mid 1990s that she ‘alleged sexual abuse by a worker at one of the Community Service Order placements that she was at’. There was no further information.

When she was 17 the PIC lived independently in a small unit, where her departmental worker visited her regularly. She alleged she was raped by two male acquaintances one night in her bedroom. She called the department’s Crisis Care line and was taken to hospital. Police went to the hospital and the PIC recalled being placed in an interview room. She did not recall the events that followed, nor whether she was medically examined, saying she became agitated and passed out. She later gave a statement to police and identified one of the alleged perpetrators as a member of an organised crime gang, but told the Inquiry she would not give evidence against this man for fear of reprisals: ‘You don’t give evidence against people like that … there’s not much I can do about it’.

The Inquiry received client files that show the PIC reported the rape to the department. Her departmental worker visited the PIC at her home and observed her injuries. The worker recorded that the PIC had some support from a friend, and also offered support.

In the early 1990s a young girl came to the attention of the department due to her mother’s inability to properly care for her. When the girl was 10 she was removed from her mother’s care under a voluntary custody agreement, following allegations of sexual abuse by her mother’s partner and his teenage son.

The department arranged for her to live with her father, whom she did not know. It was noted on a file that she was to receive counselling regarding the abuse. It appears she had regular contact with a departmental worker but this ceased after several months in her father’s care. She told the Inquiry her father sexually abused her for the two years she was with him, and remembers him saying that ‘if I ever told anyone, they wouldn’t believe me, and that he would kill me’.

In the late 1990s, when the PIC was 13, she came to school with a black eye. School staff alerted the police and the PIC reported that her father had physically abused her. It is unclear from the Justice Information System (JIS) records whether she also reported her father’s ongoing sexual abuse. She was immediately placed in foster care. Her father signed a voluntary custody agreement and was charged with assault.

The PIC spent the next three months in foster care. She told the Inquiry she was abused in one of her foster placements. She returned to live with her mother between the ages of 13 and 15; her mother then moved interstate and abandoned her. She subsequently lived on her own and became involved with bikies and drugs.

She told the Inquiry that after so many placements and moving around she felt she had ‘no stability in my life, at all.'
So … I don’t really know who I am. I’m a bit lost.’ She said she also felt angry about the way she was treated by the department:

The government knew that they weren’t safe places for me to go but they kept putting me there. Like, that’s the kind of the things that have ruined my whole life.

Evidence from males

A boy whose parents had separated when he was very young was placed in State care between the ages of seven and 12 as a result of voluntary care agreements. He was then placed in State care by court order until the age of 18. He told the Inquiry that when he was eight his father sexually abused him while on a weekend visit.

He recalled being driven to his father’s place by transport arranged through the department. He alleged his father forced him to share the same bed and then anally raped him and fondled his genitals during the night. He said the experience was ‘disgusting’ and he demanded to be taken home the following day. When he disclosed the sexual abuse to his mother she contacted the department and took him to the police station, where he made a statement. Departmental and JIS records show the PIC complained of being indecently touched but did not disclose that he had been raped. As a result, there was no medical investigation.

The JIS records indicate that police interviewed the PIC’s father, who denied the allegations and said he suspected that the PIC’s mother fabricated them. The PIC said he did not see his father again until he was 19. Some time later he was placed in foster care, a government unit and a remand centre.

The PIC told the Inquiry the sexual abuse had an ongoing impact on his life: ‘I feel it’s just caused me to shut down all my life … I’ve never let anyone in; I’ve just pushed everyone away’. At the time of the Inquiry he had a child who had been placed in care with a relative. He said he didn’t want to be like his father: ‘I want to be a better father and a different father, but I don’t know how’.
Chapter 3 Allegations of sexual abuse

2000s

Evidence from females

An 11-year-old girl was placed in State care by a court in the early 2000s after an allegation that her mother had assaulted her—an allegation the PIC later denied. The PIC had come to the attention of the department as a toddler and, once in State care, she was sent to various placements. She told the Inquiry she was sexually abused while living at home with her mother.

The PIC had a long history of absconding from care and returning to her mother’s residence or staying with acquaintances. She said that her mother’s male de facto partner sexually abused her regularly during weekends at home, when she was aged between 10 and 13. He had told her to keep their relationship secret, but she eventually revealed the abuse to her mother, who reported it to the department. The police questioned the PIC but she refused to provide a statement or give any details.
## 3.6 Secure care

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History

The remand and detention of young offenders in secure care—reformatories and training centres—has been an integral part of State care in South Australia since the 19th century. During the first half of the 20th century, secure care reflected attitudes towards children as ‘delinquents’ requiring ‘reformation’. This approach changed during the second half of the 20th century to one of training and rehabilitation of young offenders.

Children were sent to reformatories for a variety of reasons, mainly for committing criminal offences. They could also be transferred from another institution for misconduct. Children placed in foster care might be transferred to a reformatory if regarded as ‘vicious, incorrigible or not amenable to the influences of foster parents’. They could also be sent for absconding from other placements.

Reformatories were established under the Destitute Persons Relief Act 1866–67, which gave the government the power to establish reformatory schools for children convicted of offences. When the Industrial School for neglected and destitute children opened at Magill in 1869, the boys reformatory was moved from temporary accommodation to the new site. The government reformatory for girls was moved to the Magill site in 1880, at which time boys were moved to a ship at Largs Bay fitted out as a reformatory.

In 1891 the State Children’s Council (SCC) established a new reformatory for girls at Edwardstown and boys returned to the reformatory at Magill. In 1896, the Industrial School and reformatory were separated to different sites to protect children at the Industrial School from exposure to older boys with ‘knowledge of crime and vice’ and to separate teenage boys and girls. The SCC also sought to separate children of different religious faiths and accepted the Catholic Church’s offer to manage a Catholic reformatory under State control, the Roman Catholic Boys Reformatory at Brooklyn Park. The reformatory in Brooklyn Park accepted the Catholic boys from Magill, which operated as a reformatory for Protestant boys. Girls were also separated according to religious faith; Catholic girls were sent to a reformatory run by the Sisters of St Joseph at Kapunda and non-Catholic girls were moved to a government reformatory near Burra. Concerns about the cost of operating the Burra reformatory prompted the SCC to make arrangements with the Salvation Army to establish the Barton Vale School at Enfield in 1921.

In the late 1930s, the ‘Delinquent’ inquiry reported that secure care institutions used “regimes of discipline, impressed by force and inflicting mental and physical distress”. It likened the Boys Reformatory at Magill to an adult prison operated by untrained, poorly paid staff and criticised conditions at private reformatories such as Brooklyn Park. In 1940s the SCC successor, the Children’s Welfare and Public Relief Board (CWPRB), severed most ties with the Catholic Church and the Salvation Army. For example, children in State care at...
Brooklyn Park were transferred to the Boys Reformatory at Magill in 1941. The CWPRB also established a government reformatory for girls, Vaughan House, in 1947 on the site of the former Barton Vale School, which had closed earlier the same year. From 1948 the CWPRB allowed probation officers to visit children in institutions as soon as they had been committed. The idea was to foster goodwill in the hope of preventing future offending.

From historical records, it is evident that sexual abuse was a known problem in secure care. For example, in the late 1940s and early 1950s the CWPRB was aware of several incidents of sexual ‘misconduct’ among boys at the Magill reformatory. The board handled these cases in institutions such as the Industrial School by transferring offenders to reformatories; these boys often continued to abuse in secure care. The board also transferred boys involved in what was described as ‘subnormal sexual misconduct’ at the Industrial School to the reformatory.

During the 1950s and 1960s, larger numbers of children were being committed for offences. The need to protect younger children from older offenders prompted the planning of a separate wing for small boys at Magill. Crowding became such an issue that in 1961 temporary facilities were established at Bedford Park for girls from Vaughan House and boys from Magill. In early 1965, a new facility at Glandore called Windana accommodated young male and female offenders on remand; the facility also functioned as a receiving home for non-offenders who were being transferred among institutions. In 1973, girls were transferred out of Windana, which continued as a remand home for boys until its closure in 1975.

From the 1960s, the focus shifted towards the training and rehabilitation of juvenile offenders rather than punishment. In 1965, a new facility, Brookway Park, was established in Campbelltown to provide ‘reformatory training’ for younger ‘delinquent’ boys who were transferred there from the Magill reformatory. In 1967, the Magill reformatory was renamed the McNally Training Centre. Institutions such as Brookway Park and Windana provided education, guidance in ‘everyday living’, ‘character building’, ‘meaningful activities and close personal attention’ to residents.

In the 1970s, there was increasing emphasis on prevention of juvenile crime. Training centres introduced ‘differential treatment techniques’ based on a ‘careful assessment of each youth’s personality and maturity’ to devise suitable training and treatment programs. Superintendents of remand and training centres were required to reward positive behaviour. Other changes included the conversion of large-scale congregate institutions to smaller group living facilities. Additionally, a greater effort was made to avoid placing children in secure care, with larger numbers of children convicted of offences placed out on probation. This practice reflected concerns at the

15 The Catholic Church requested closures due to small number of boys; the Salvation Army’s Eden Park home was closed due to sexual abuse. Delinquent report, pp.16–21; SRSA GRG 29/124, vol. 13, Children’s Welfare and Public Relief Board (CWPRB) minutes, 6 Feb. 1941 and 3 Apr. 1941.

16 SRSA GRG 29/124, vol. 15, CWPRB minutes (minute 1002), 26 Sep. 1946.

17 CWPRB annual report 1949, p. 6.

18Girls and boys were transferred for one and four years respectively. Most of the boys were transferred from the Magill Reformatory but boys from other institutions who required ‘discipline and training’ and boys on remand were also placed there. CWPRB annual report 1961, p. 4; 1962, p. 12.


20 Methods Committee, ‘Recommended methods and procedures for the operation of Brookway Park, the Junior Boys’ Reformatory at Campbelltown’, p. 1; DSW annual report 1966, p. 15.


22 ‘Recommended methods and procedures for Brookway Park’, p. 1; ‘Methods and procedures for the operation of Windana’, p. 1.


24 SRSA GRG 29/6, file no. 12/1/20, 30 Nov. 1972; DCW annual report 1972, p. 3.
increased absconding and violence at Vaughan House and McNally and a desire to avoid high operational costs as much as a shift in philosophy.\textsuperscript{29} There was more use of community service orders, and placement of children on probation to their families or in the community under the Intensive Neighbourhood Care (INC) scheme.\textsuperscript{30}

By the 1980s the focus was on keeping young offenders with their parents, using secure care for temporary therapeutic intervention and training.\textsuperscript{31} New approaches to the assessment and treatment of young offenders were reflected in the renaming in 1979 of Vaughan House as the South Australian Youth Remand and Assessment Centre (SAYRAC) and McNally as the South Australian Youth Training Centre (SAYTC). SAYRAC accommodated girls and boys in separate units, while SAYTC continued to accommodate boys aged between 15 and 18.\textsuperscript{32}

Despite such efforts, problems in secure care remained. Historical records from the 1980s show that punitive measures were still used to control residents in SAYTC, a facility ill-equipped to accommodate high-needs children.\textsuperscript{33} One senior care worker observed in 1985: ‘There has been a certain overuse of punishment as the main tool to improve the situation concerning residents’ behaviour’.\textsuperscript{34}

A 1985 departmental report suggested that secure care facilities ‘seriously contravened[d] established standards and guidelines for custodial care’. SAYTC and SAYRAC were deemed ‘unacceptable buildings that were an inefficient drain on Government resources’.\textsuperscript{35} A 1986 report to the Minister of Community Welfare concluded that the system for dealing with young offenders was ‘a system designed for lawyers and social workers, but not necessarily for children’.\textsuperscript{36}

In the early 1990s the numbers of children being held at SAYTC, particularly those serving longer detention orders, increased.\textsuperscript{37} A new 36-bed purpose-built secure care centre, the Cavan Training Centre, was opened in September 1993 for older offenders and SAYTC was renamed the Magill Training Centre to cater for younger children.\textsuperscript{38}

Today, Cavan Training Centre is a secure custody centre for males aged 15–18 on detention or remand and the Magill Training Centre is an admission and assessment centre for male and female offenders aged 10–18 entering custody. Magill accommodates males aged 10–18 on remand and aged 10–14 on detention orders; and females aged 10–18 on detention orders.

**Summary of secure care allegations**

Sixty-two people gave evidence to the Inquiry that they were sexually abused while in secure care institutions. All of them were in State care at the time. Nine of those people said they were victims of sexual abuse in more than one secure care institution. The allegations included indecent assault, gross indecency, and anal, digital, vaginal and oral rape.
Secure care for boys

Boys Reformatory, Magill, 1869–1967

History

The government established a reformatory for boys at Magill in 1869. In 1880 the Magill site was used as a girls reformatory and the boys were moved to temporary accommodation on a moored hulk at Largs Bay. Boys returned to the reformatory in 1891 when a new reformatory for girls was established at Edwardstown. 39

Criticisms of the Boys Reformatory at Magill were raised in the 1930s. A former police superintendent characterised the reformatory in 1933 as ‘an institution for bad boys to make others bad’. 40 Members of the 1939 inquiry into delinquent children inspected the reformatory and found the buildings to be outdated, there was ‘undesirable mixing’ between older and younger boys, staff were untrained and supervision was ‘more like that of a prison’. 41 The inquiry’s report argued that ‘the welfare of the child, not the vindication of the majesty of the law, must be the primary object’ in dealing with children in State care. 42

Concerns were also raised at the reformatory itself. The superintendent stated in the late 1930s that it was ill-equipped to deal with the older offenders; ‘the limited staff necessitates the whole school being in the care of one man all night’. 43 In the early 1940s, several incidents of absconding exacerbated concerns about separating ‘the bad boys from the reasonably good boys’ and staff shortages created a ‘grave danger of the position getting out of hand’. 44 Writing in 1945, the superintendent reported that his ‘biggest worry is keeping track of the boys who are inclined to sexual perversion, which for some reason seems to be more in evidence now’. 45 Despite such concerns, the CWPRB continued to transfer boys involved in ‘subnormal sexual misconduct’ at the Magill Industrial School to the reformatory. 46 For example, one boy was transferred because he was ‘sexually inclined’. His transfer record notes, ‘his behaviour has a detrimental effect on the other children’ at the Industrial School; there is no comment about how the reformatory managed him. 47

Despite the CWPRB’s concerns about deteriorating ‘general discipline’, it transferred boys from the Industrial School to the reformatory for ‘sexual misconduct’ in the 1950s. 48

A press report of ‘alleged misconduct’ among boys at the reformatory prompted a CWPRB investigation in 1952. The superintendent reported he undertook:

... to warn all Officers, as they were employed at the Reformatory, and to instruct them to keep a close watch on the boys at all times in regard to sexual matters and that everything possible was done by the Staff to avoid any misconduct. 49

The CWPRB sought ‘detailed particulars and numbers of all boys who had been involved in unusual sexual misbehaviour’ at all institutions and undertook research into methods of dealing with sexual activity in institutions. 50

In 1956, a new dormitory was provided to separate older and younger boys. 51 The opening of Brookway Park for junior boys in 1965 left about 150 older boys at Magill. In 1967, the original Magill reformatory building was demolished and a purpose-built institution erected on the site. The new facility was renamed McNally Training Centre.
Allegations of sexual abuse

Ten PICs told the Inquiry that they were sexually abused when placed at the Magill reformatory in the 1950s and 1960s. From available records, all had been placed at Magill as a result of criminal charges.

The PICs alleged sexual abuse was perpetrated by staff and older boys and included indecent assault and oral, anal and digital rape.

The evidence from the 10 PICs is indicative of a culture of sexual abuse perpetrated by staff and older boys and brutal physical punishment. Another man made a written submission to the Inquiry about sexual abuse at the Magill reformatory, although he was not sexually abused himself. He was placed in State care when he was 15 for a criminal offence and sent to the Magill reformatory. His submission supported the evidence of the 10 PICs who had been sexually abused. He said that the boys regularly talked among themselves about other boys ‘going down on different screws’, referring to oral sex. He recalled that boys were taken into the annexe individually and it was well-known among the boys that this was for the boy to perform oral sex on the officers. He believed another boy was taken to hospital to have his bowel repaired as a result of anal rape by an officer.

Abuse by staff

An 11-year-old boy was sentenced to the reformatory for criminal offences in the early 1960s and told the Inquiry he spent 12–15 months there. Electronic police records show the PIC was convicted of charges in the Adelaide Children’s Court in the late 1950s and early 1960s, however the penalty is not recorded. The department was unable to locate any files relating to him.

The PIC said that his home life had been unhappy. His father had a gambling problem that caused severe poverty for the family. He recalls that the electricity was disconnected regularly and there was no heating. From the age of eight he started stealing small amounts of money and truanting from school to go to the movies.

The PIC told the Inquiry he was sexually abused by a carer working at the reformatory, who befriended young boys and gave them gifts before assaulting them. The carer targeted young boys who had limited contact with their families, telling them stories about his war experiences. The PIC said that once the boys trusted the carer, he would begin playing with their genitals, and would proceed to anal penetration with his finger. He told the Inquiry the carer played with his genitals, but did not anally penetrate him.

He said he liked the man, who showed him affection and was the only person who took an interest in him as a child ‘... just friendship, storytelling, from time to time he’d bring in bags of lollies’. He said the carer was arrested and charged, and that he had to give evidence against him in court. The PIC said he felt ‘embarrassed, disgusted and ashamed’ at having to give evidence about the abuse.

A PIC who was committed to the reformatory in the early 1960s told the Inquiry his home life had been marred by extreme violence from his father until he was about eight. His father then left the family, and his mother was forced to work seven days a week to support the children. As a result, the PIC had little parental supervision and regularly truanted from school, mixing from an early age with older boys who were involved in petty crime. He was placed in State care by court order as a result of criminal charges when he was 14. The reformatory was his main placement for the next five years.

He told the Inquiry that during his first stay he was placed in the section for younger boys. He was aware that staff selected boys to be taken out of the dormitory each night, and they were returned, crying, soon after. He was not selected during that stay, but was constantly fearful.

During his second placement he was put in the section for older boys and told the Inquiry he was woken one night by one of the officers grabbing his penis. The officer told him to get out of bed and meet him in another part of the dormitory.
He didn’t have to tell me why. He grabbed me on the penis and half touched me up. I decided right there and then that wasn’t going to happen.

The PIC said he hid in another dormitory until morning. Once it was empty, he took a pillow and jumped through the window, landing two storeys below and breaking bones. He told the Inquiry he spent months in the Royal Adelaide Hospital, and his injuries continue to plague him as an adult. His SWIC (State ward index card) shows he was admitted to the RAH from the reformatory for three months. Departmental files record his hospital admission, noting that he is ‘progressing satisfactorily’ with his leg in plaster.

This PIC also described physical punishment at the reformatory. He said that as a result of an attempted break-out, he was stripped naked and placed in a room referred to as the ‘dungeon’ for three days:

… it’s something you don’t forget. It had about six inches of water in it—on the floor, of course—and it had one large, thick slab for a bed and it had half a crate type of stool with a toilet bucket and two rolls of toilet paper, so it wouldn’t get wet, up a little bit higher, and I had to use the toilet paper for a blanket because I didn’t have a blanket.

A PIC spent three years from the age of 15 at the reformatory in the early 1960s when he was charged by a court with criminal offences and placed in State care. He told the Inquiry that staff required all boys to run for long periods in the gym and also encouraged him to fight Aboriginal boys:

We were openly promoted to inflict as much pain as we could on the Aborigines. I had never heard it—you know, I had never, ever met an Aboriginal boy until I went to reform school. I didn’t hate anyone. The situation was where [the staff member] would say, ‘Right, they’re boongs and you’re whites. You’ve got to do better than those boongs. You’ve got to run faster, you’ve got to do more. You’re going to run those niggers into the ground.’ This is from a man, telling 14-year-old boys and 15-year-old boys what we had to do.

The PIC said an officer who came to his bed one night and invited him down to the showers sexually abused him. He thought he was being taken there for cigarettes. Instead, the officer asked the PIC to masturbate him, and he was raped when he refused:

He then pulled me towards him, pushed me over on the bench and—we didn’t have cords in our pyjamas because kids hang themselves—pulled my pants down and raped me. When I stop and think about it, I think of all this trauma for 40 years for such a short amount of time, but I don’t know whether I passed out or not, because I was just gasping for breath. I thought I was going to die.

After telling another boy the next day that the ‘screw wanted him to wank him’, he was told that all the boys did that with him in return for cigarettes. The boy did not say the officer had raped the boys, and the PIC said he did not reveal he had been raped because of the culture of shame among the boys and the fear that to reveal sexual abuse would make them appear weak and lead to them being targeted by others. He did not understand why he was targeted for sexual abuse:

I don’t know whether it was just because I always in the back of my mind wondered whether I was homosexual or whether I expressed myself a little different to the rest of the boys, because I didn’t swear and carry on. My mother taught me good manners.

He told the Inquiry his doubt about his masculinity has led him to ruin relationships with women who he should have treated with more respect:

This is a strange thing, it has plagued me all my life. The first time I spoke to [the Inquiry] I got quite emotional. You know, I’ve burnt out … beautiful relationships with women because … I always had to prove myself, that I wasn’t homosexual.
The PIC also said Magill had a culture of sexual abuse by older boys against younger boys, who were preyed on at night and in the shower block.

A PIC lived at the reformatory in the early 1960s when he was about 14. He was placed in State care at 10 when a court found him to be in need of discipline. Soon after, he was sent to Glandore Children’s Home, where he alleged he was sexually abused. After absconding from various placements, he was transferred to the reformatory, where he also alleged he was sexually abused. He absconded from the reformatory when he was 17, and was charged with criminal offences and remanded to the institution until he was 19.

He said he had been aware that Aboriginal boys from the Point Pearce region had been sexually abused at the reformatory: ‘They got the brunt of it’.

He also described a physically brutal regime that involved boys being forced to run around the gym for long periods. He said an officer would beat them with a cane for disobedience and seemed to enjoy his role. He said he was regularly beaten with the cane for absconding:

The usual cuts across the backside with the cane from escaping every time—that’s after you’ve been to court, of course—and other officers making other boys’ and making your life bloody hard.

He said a night officer, who sat at the far end of the dormitory, sexually abused him. As soon as the boys had gone to sleep the night officer would ‘have his selected little boy for the night’. The officer selected him one night and when he attempted to sexually abuse him, touching him on the genitals, he (the PIC) ‘bashed him’. The PIC said there were no repercussions as a result of his attack. Many years later, the PIC contacted police about his allegations and was advised there was insufficient material for charges to proceed.

One PIC was at the reformatory in the mid 1960s after being charged with criminal offences at 16. He absconded several times and was charged with other offences. He was eventually released from State care at 18.

The PIC alleged he was sexually abused by relatives before being taken into State care, and had experienced domestic violence and alcoholism in the family home.

He described the reformatory as ‘… an extremely daunting place and extremely abusive, extremely violent and just not a nice place to be’. He recalls that the guards forced the boys to run for long periods. If they couldn’t run they were punished by having to run a lap holding a long wooden bench. ‘We used to put the benches above our heads and run a lap with them, then pass them back to the next bloke, so everybody wore the punishment.’

He recalled other forms of punishment, including frequent canings and violence by officers. ‘You were stripped naked and bent over a table—usually [caned] across the backside, but up the back, down the legs.’ He said boys to be punished were placed in a loft containing three cells or in a separate security block.

He told the Inquiry that night staff would take him from his bed to an office and anally rape him. He said one or more of three different officers sexually abused him ‘about half a dozen times’. He did not report the abuse as he ‘just felt that I couldn’t trust any of them’.

Looking back on the sexual abuse, the PIC said:

Those people took away any chance I had of believing in people, caring about people or loving people for a long, long time, and it’s something I’ve had to work very, very hard at.

Abuse by other residents

A 12-year-old boy spent about six years at the Magill reformatory in the late 1950s, after a court placed him in State care for committing a criminal offence. He occasionally was permitted to go ‘on holiday’ with his parents, but sometimes he committed more criminal offences during these breaks.

The PIC told the Inquiry of reformatory officers grabbing him by the ears and forcing him to do push-ups or run. He described the ‘scrubbing line’ of boys, who would have to scrub the wooden floors all morning and run for the rest of the day.
inside a big annexe. Some of those officers, I’ll call them, were really sadistic. They would make you run around all day. If the guy in front of you started going slow—well, half the time we’d knock him out of the road to make him go faster. Half of them couldn’t keep up. It was sadistic, you know?

He said that if he wanted to go to the toilet, he would have to wait until an officer granted him permission.

The PIC said he was forced to masturbate an older boy at the reformatory: ‘When I first went in there as a young kid there was [an older boy] … he used to stand over me and make me masturbate him.’

The PIC spent a short time in prison as a young adult but then stopped associating with the older friends who had encouraged him to offend.

A PIC told the Inquiry that in the 1950s, as a 12-year-old, he was committed by court order to Magill until he turned 18. He said he spent a lot of time away from home to avoid his father, who gambled and was violent towards his mother. No departmental records have been found in relation to the PIC, although police computer records indicate that as a child he was detained in several institutions after committing offences.

The PIC said the reformatory’s practice of placing all boys under 16 in a dormitory overnight, with only one officer seated at the far end of the room, allowed the older boys to prey on the younger ones:

Most of the time [the officers] would go to sleep or read a book, and be right down the other end. But if you were up this end, that’s where things happened, in the back row. People would slide out of bed and go underneath the beds ...

He said it was common for the older boys to force younger children to perform oral sex or masturbate them in the shower block. Officers supervised the showers from the corridor outside. He said the younger boys had a culture of silence and did not report the abuse: ‘These sort of things people don’t talk about. They hide it’.

The PIC said an older Aboriginal boy had sexual intercourse with him about three times. ‘I tried to [object] … He was bigger than me … he forced me.’ He also said he was forced to perform oral sex on another older boy and masturbate two older boys in the exercise yard.

The PIC did not tell anyone about the abuse as he was threatened with violence by the perpetrators: ‘You would have had to have been there to see what went on to know that people don’t talk about it’.

The PIC said he regularly absconded from the reformatory to try to escape from the sexual abuse.

Another PIC told the Inquiry he committed a criminal offence at 16 in response to his father leaving the family; his father had been violent towards his mother and had beaten the boy. A court remanded the PIC to the reformatory in the late 1950s for a few weeks while he waited for sentencing. He was then released to live with his mother. Months later he was charged with another offence and a court placed him in State care until he turned 18.

He told the Inquiry that three other boys raped him at knifepoint during his second placement at the reformatory. A few days earlier he had seen the same boys raping a younger boy in the toilet block but he felt helpless and too afraid to intervene. The PIC said the boys were waiting for him in the toilet block and anally raped him on three separate occasions. They warned him not to say anything and he was afraid to do so.

He said he had several good friends during his time in the reformatory but could not tell them about the abuse. He had only recently been able to tell his wife and struggles to talk about the effect the abuse had on his life:

It’s always been on my mind. Every time something was mentioned—you know, on the wireless or TV or newspaper, or what have you—I would get bloody angrier and angrier.
Chapter 3 Allegations of sexual abuse

After being charged with larceny in the early 1950s, a nine-year-old boy was placed in State care until he turned 18, and returned to the care of his mother. He was again convicted of criminal offending at 16 and sentenced to the reformatory until he turned 18.

The PIC told the Inquiry his mother raised him and his siblings in extreme poverty. Before he was placed in State care he became extremely disturbed when he witnessed a teacher sexually abusing a young girl at his primary school, and said the teacher victimised him as a result.

The PIC said he was sexually abused when placed at his family home, and again at the reformatory. The night before his release from Magill in 1959, he was beaten up by a group of boys who, for the previous couple of days, had threatened to rape him. About 11pm, five boys attacked him in bed, punching him about a dozen times. He said this was a practice known as ‘musclies’, where boys would punch the boy who was to be released. ‘But I had to fight here. I was threatened all day that they’re going to rape me.’ The PIC said he believed he would have been raped if a staff member had not responded to the noise.

A PIC born in the mid 1950s alleged he was sexually abused during a placement at the reformatory in the mid 1960s. Departmental records suggest the PIC’s parents separated when he was four, and they placed him in several non-government homes for significant periods until he reached 10. At nine, the PIC was charged as destitute and remanded to the care of his father, who was ordered to find a suitable placement for the boy. While in his father’s care he was charged with a criminal offence, placed in State care by a court and sent to a government institution until he turned 18. The PIC alleged he was also sexually abused during placements at Brookway Park, Kumanka Boys Hostel and McNally Training Centre.

Departmental records show the PIC absconded from his first government institution 26 times in a few weeks. While a runaway, he committed offences and faced charges. Records show that in one court appearance the magistrate asked the PIC why he was absconding and he replied that other boys at the home were bullying him. As a result of his offending, the PIC was transferred to the Magill reformatory for six days just before his 12th birthday.

The PIC alleged he was sexually abused on his second day at Magill:

… an officer came and got me out of bed and he told me to go and clean up the ablution area, and he locked the door, and then he opened it and let four blokes in and then he locked the door and went away.

He said the group held him down and raped him. He did not tell anyone about the incident.

McNally Training Centre, 1967–79

History

The McNally Training Centre, named after a former chairman of the CWPRB, was opened on the site of the former Boys Reformatory, Magill, in November 1967. The new centre could accommodate 164 boys, but by 1969 174 boys were resident.52 The boys, aged between 15 and 18, attended a school in the institution run by two Education Department teachers.

After 10 boys absconded from McNally in December 1969, the secretary of the Department of Social Welfare and the superintendent at McNally discussed the reintroduction of corporal punishment for absconders.53 The superintendent advocated ‘the reintroduction of caning’ and the Minister approved the policy over the objection of the acting director of Social Welfare, who held that caning was ‘degrading’ and ‘contrary to modern methods of treatment of offenders’.54

After the absconding, additional security measures were taken, such as installing grilles on dormitory windows.55 Absconders, if not publicly caned, were placed in the

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53 SRSA GRG 29/6/1969/105, see correspondence on ‘Corporal punishment of absconders’.
54 The policy was abolished at the end of 1970. SRSA GRG 29/6/1969/105, see correspondence on ‘Corporal punishment of absconders’, DSW a/director to Minister Social Welfare, 5 Mar. 1969, and handwritten reply from Minister, 6 Mar. 1969.
‘cabin’, a solitary confinement cell, for up to 48 hours. Some boys were placed in the cabin if they were distressed and regarded as potential absconders.

A 1973 report by a consulting psychiatrist who studied the centre for six months provides an insight into conditions at McNally. The Department of Community Welfare held the philosophy that ‘treatment is paramount rather than punishment of the offender’ and that McNally was supposed to provide a ‘therapeutic community’. However the report noted that ‘hostility and anger’ permeated the centre. Accommodation was described as ‘locked units of incarceration’, while punishments reinforced ‘anti-authority attitudes’ among residents. Boys on remand were locked up, ‘bewildered and bored’, feeling ‘anxiety and apprehension due to ignorance about their fate’. Residents in the security section were ‘locked up’ under ‘grossly anti-therapeutic’ conditions. The report noted that probation officers were ‘not well integrated into the McNally structure,’ which was problematic because ‘... they are part of the treatment programme—perhaps a vital part as they are often the link between family and institution, which by both parent and child is seen as punitive.

A 1976 government investigation prompted by abscondings from the centre's security section found that residents were not supervised to the degree stipulated in the department's procedures. Instead of providing ‘constant supervision’, as the procedures required, staff permitted some residents to move about the facility and checked on them only if they were absent ‘for any unreasonable length of time’.

The supervisor of the report on absconding from McNally alluded to operational problems. Of principal concern were divisions among staff, some of whom ‘were openly hostile towards other care workers and critical of their methods, even in front of boys’. The supervisor stated that the treatment of residents in secure care at McNally was ‘... very little changed from that of many years ago ... the prevailing ethic is still one which speaks of ‘if you do the right thing by me, I will do the right thing by you’.

In the mid 1970s departmental annual reports described McNally as a secure residential centre for youths aged between 15 and 18 who were committed for offences, those on remand or requiring assessment. The centre was divided into six units, each with a maximum of 16 residents. Three units provided shorter-term accommodation for residents on remand and in short-term secure care, while the other three provided ‘longer-term programs for boys committed for a period of treatment’.

The centre also had a ‘maximum security unit for disturbed boys’.

General records obtained by the Inquiry show that the mother of a boy held at McNally in the late 1970s applied to the Youth Court for bail for her son after he disclosed to her that he was forced to perform a sexual act on three other residents under the threat of violence. The senior judge referred the matter to the department and sought an assessment report by a review panel consisting of social workers and centre staff. The documents indicate that McNally staff failed to complete a critical incident report and did not refer the matter to police, as staff noted that the boy ‘... does not wish to lay charges in relation to the incident’. The senior judge told the department that the matter should have been referred to police.

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58 ibid., p. 2.
59 ibid., p. 3.
60 ibid., p. 4.
63 ibid., 1975, p. 18.
64 SRSA GRG 29/6 file 12/10/3, ‘Incidents involving staff and youths at McNally Training Centre and Brookway Park’. 
65 SRSA GRG 29/6 file 12/10/3, ‘Incidents involving staff and youths at McNally Training Centre and Brookway Park’. 
Chapter 3 Allegations of sexual abuse

Allegations of sexual abuse

Nine people gave evidence to the Inquiry that they were sexually abused when placed at the McNally Training Centre. They alleged sexual abuse perpetrated by staff, other boys and outsiders. The allegations included indecent assault and oral and anal rape.

All people giving evidence referred to the institution as Magill, however records obtained by the Inquiry indicate it was named McNally at the time.

One man gave evidence regarding sexual abuse of boys by staff members but said he was not sexually abused himself. He confirmed the evidence of some of the nine PICs when he told the Inquiry that a night staff member woke other boys and took them to the office, where the staff member had sex with them before returning them to bed.

Abuse by staff

A PIC born in the mid 1950s was charged as being destitute and remanded to his father’s care when aged nine. He was charged with larceny while on remand and placed in State care by a court until the age of 18. The PIC alleged he was sexually abused during placements at the Boys Reformatory, Magill, Brookway Park and Kumanka Boys Hostel, as well as McNally Training Centre.

After absconding from Kumanka in the 1960s the PIC was sentenced to spend two years at McNally for criminal offences. He told the Inquiry he had previously absconded from other homes because of sexual and physical abuse and that at McNally he was ‘touched’ by a staff member in a sexual way in his bed. He said he did not report the incident.

Records show the PIC was at McNally for nearly two years, a period punctuated by further absconding. He said that after leaving McNally he went to live with a relative and also lived on the streets. He told the Inquiry a man who ‘... used to cruise the streets of Adelaide and pick up street kids and that’ abused him. He went with the man in his car to a place near the river and masturbated him for ‘about 20 bucks or so’.

The PIC was released from State care on probation at 17.

A PIC told the Inquiry he was sentenced to two years in McNally for criminal offences in the mid 1970s. According to his departmental file, although he was nearly 18 when convicted and could have been sent to an adult prison, it was considered he would benefit from the psychological and psychiatric support that McNally could provide. His SWIC indicates he spent 16 months there.

The PIC said a female staff member sexually abused him when she took him on day leave:

Once we got to [her house], we both went inside. I walked into the lounge room and she walked into the bedroom. She came out of the bedroom with some papers. Then [the staff member] walked over to me and said, ‘You haven’t had sex for a long time’. She placed one hand on my groin. She fondled for a couple of minutes. Then she used her other hand to pull out my penis. She then proceeded to fondle my penis. I grew alarmed to this and decided to pull away. I said, ‘This is not right, and I would like to go now’. She said, ‘Don’t tell anyone what I did to you’. I said, ‘No, I won’t’.

He told the Inquiry he did not report the abuse and the staff member twice told him not to tell anyone; the first time was at her home when the abuse occurred and then again on returning to the institution.

A PIC who alleged sexual abuse at McNally was placed in State care by a court for criminal offences when he was 11. He told the Inquiry he had been sexually abused by family members before the court order. He was regularly sentenced for criminal offences between the ages of 13 and 19, when he was released from State care. He told the Inquiry he was also sexually abused at Windana Remand Home, Adelaide Jail and Yatala Labour Prison.
The PIC was sent to McNally in the early 1970s, aged 17, as a result of criminal offending but regularly absconded. He was sent to the Block for punishment:

That’s where the bad boys like me—bad boy, right. There’s no bloody schooling. All you do is you go into the big hall … or go in that other part and smoke your cigarettes or sit down on the floor, on the wooden floor, and just be bored and just talk or kick a soccer ball around or what, you know.

He told the Inquiry he was raped by officers at McNally in the Block and also in a staff office: ‘I got raped in the Block. I got raped in Magill in the cells, and in the screw’s office’. He said that when he returned after absconding he was never asked why he had left.

One Aboriginal PIC with an extensive criminal history told the Inquiry that ‘… this sort of offending started happening after what was happening to me in McNally’. He was remanded for short periods in the mid 1970s on criminal charges. Later in the 1970s, he was in State care when he was remanded to McNally for a few weeks when he was 15 and then for three weeks a year later on criminal charges.

He described the McNally regime as tough with harsh punishments, such as being made to stand in one place or run for long periods, and sleep on bare mats on the floor. He said an officer often put him in a separate room from the dormitory ‘where sometimes they forced kids to sleep … they segregated a kid in that room at any time they wanted, for any reason’.

He alleged the officer forced him to have sexual intercourse—‘I lost count of the number of times’. He also alleged that another officer would take him into a storage area and force him to have sex. He recalled that this happened about a dozen different times, ‘usually around seven o’clock at night, dark and nobody else around’.

The PIC told the Inquiry there was no-one to talk to because ‘you couldn’t trust any of the other staff’. On one occasion when he did complain about the sexual abuse to an officer, he said he ‘got a lecture about making allegations, and all that sort of stuff, and nothing ever happened about it’. The alleged disclosure of abuse to staff does not appear to have been recorded in the departmental files or the Department for Correctional Services files that were provided to the Inquiry.

Abuse by staff and other residents

One of the PICs who spent time at McNally in the early 1970s was placed in State care in the mid 1960s when he was 12 for being destitute. He told the Inquiry he had been sexually abused and physically beaten by his father before being placed in State care. He said he was sexually abused while in State care at Windana Remand Home, Glandore Children’s Home, Kumanka Boys Hostel, McNally Training Centre and in the family home.

According to departmental records, he was placed at McNally in the early 1970s for seven months when he was 16 and, later, for six months after he committed a criminal offence while living with a family member.

The PIC alleged he was violently raped by a group of boys at McNally, suffering injuries and bleeding from the anus. He said he was threatened that if he told anyone he would be killed. A staff member had discovered him bleeding and crying in his bed that night and had helped him to get cleaned up and changed into clean pyjamas. He alleged the staff member said to him, ‘… the best advice I can give you is to forget all about what happened tonight’.

The PIC also said that several McNally staff members sexually abused him. The abuse included rape and forcing him to perform oral sex on individual staff at different times. He recalled a staff member demanding that he perform oral sex each time they were in a vehicle together. On returning to McNally, the staff member would tell him: ‘You know the fucking rules; one word and you’re dead’.
Chapter 3 Allegations of sexual abuse

He said he did not tell anyone about the abuse. Previously he had told his social worker about sexual abuse at the family home, but said he had been disbelieved and accused of lying so often that he did not see any point in complaining about the McNally incidents.

The PIC described his time in State care as ‘just one big nightmare which will not end. I missed out on my childhood.’ He said he had attempted suicide numerous times and also self-mutilated in an attempt to stop having nightmares:

[It] was getting rid of all of the horror that had happened to me. But it was still in my head, and so I still had the nightmares, I still had the horror.

Abuse by staff and outsiders

A 14-year-old boy was placed in State care by a court as a result of criminal offending in the late 1960s. The PIC told the Inquiry he had been sexually abused by a family member and a schoolteacher before being placed in State care and that he was sexually abused at Windana Remand Home, McNally, Struan Farm School and, later, in foster care.

The PIC said that when he left Windana his mother was ‘not interested’ in having him return home, and he was transferred to McNally in the early 1970s on a safekeeping order. He described the brutality of punishments at McNally, which lasted from 7am until 10pm every day for up to a month. Residents were forced to ‘duck-walk’ (walk bent over, holding ankles with opposite hands), scrub the ablution block and stand to attention or run for hours at a time, stopping only for meals.

He recalled telling one of the officers at McNally he had been sexually abused at Windana, and said the officer used that information against him by threatening that if he ‘did not come across he’d tell the rest of the kids’ about what had happened to him. He said he was placed in the cabins and that the officer sexually abused him anally and orally repeatedly. He said the officer threatened that if he told anyone about what was happening he would be sent to the Block, which the PIC described as a place ‘you just didn’t want to go’.

The PIC told the Inquiry that at McNally a man regularly visited the boys and took them out to various activities. He said he formed an attachment to the man, who often took him out for weekends. On one occasion, while staying at the man’s home, he was given alcohol and next remembered waking up in bed in a bedroom with three or four men:

I woke up with nothing on … next day sometime … I knew I’d been abused … anally. I had love bites around my neck. … obviously I was conscious but in and out of sleep.

The PIC told the Inquiry he was again warned not to disclose the sexual abuse: ‘I’ve been threatened that many times by that many different people, I forget who’s who’.

The PIC’s departmental files confirm that he stayed regularly with the man. Notations include that the PIC was accused of ‘stealing money from [the man’s] home’, that he had ‘prospects of a job with [the man]’ … and could ‘possibly live with this man’, although it is also noted that ‘[the man] had made a pass at him’. The file does not indicate where that information came from or what, if any, action the department took.

Abuse by other residents

A PIC recalled his stepfather’s violence at home before he was placed in State care aged 10 in the 1970s, after committing a criminal offence. He was ordered to stay in State care until he turned 18. He was placed with his mother but then committed further criminal offences and was sent to various institutions. He alleged he was sexually abused at Brookway Park and McNally.
The PIC told the Inquiry that when he was 14, a boy attempted to sexually abuse him on his first day at McNally:

I got bashed up a few times in the shower room, and then the dormitory; he was trying to force sex on me and then I just made a big fuss, screamed, and then he punched me for screaming.

He said he believed that the same boy had earlier sexually abused him at Brookway Park. He did not report the McNally incident. He told the Inquiry he hid on the McNally grounds for up to three days at a time in an attempt to avoid the perpetrator, rejoining the other boys when he was hungry. ‘I’d stay there because I was in fear, and they couldn’t find me.’ As a result, he said, he was often punished for absconding, despite the fact he never left the home.

The PIC said of the sexual abuse at the two institutions: ‘I reckon it stole my emotions, you know; it stole a lot of things. That’s why I can’t hold a girlfriend long.’

A PIC who was aged 15 at McNally in the early 1970s alleged another resident sexually abused him. He had been placed in State care at nine after a court found he was uncontrolled. The PIC told the Inquiry he also had been sexually abused by staff at Windana Remand Home and then by staff and other boys at Brookway Park. The PIC was too embarrassed to give further details of the alleged sexual abuse. He said he did not report the abuse at the time.

A PIC born in the late 1950s was placed in State care by a court when he was 14 as a result of criminal offending. The PIC told the Inquiry that a stranger sexually abused him when he was about 10, which changed his life for the worse and he started to get into trouble with the law. He told the Inquiry he was sexually abused at Stuart House Boys Hostel, Windana Remand Home and McNally.

In the mid 1970s, aged 15, the PIC was charged with illegal use of a motor vehicle and as a result spent a week at McNally on remand. He described his short time there as ‘the worst eight days of my life’, alleging he was sexually abused by other boys at the home:

The first night I woke up in the dormitory, my head—whole face—was covered in semen and there was boys all around my bed except they were much older than me, and I jumped out of bed, bashed on the windows and went out into the dining area and the officer basically told me to go back to bed and I screamed and told him what was happening. He said, “Go back to bed. I don’t want to hear tales, this sort of stuff”.

The PIC alleged that sexual abuse of this nature continued:

After about the third night of this sort of crap, including waking up with a dick in my mouth and stuff like that, and more screaming and bashing on the windows, then I’m sure they put me into a cell.

He told the Inquiry that after his release from State care at 16, he worked as a child prostitute interstate and became involved in drugs and violence. He has spent time in prison as an adult on several occasions. He believes the abuse has affected his ability to have any lasting relationships and contributed to the breakdown of his marriage: ‘I was totally unclear on my sexuality, who I was, what I was’.

South Australian Youth Training Centre (SAYTC), 1979–93

History

In 1979, as part of a redevelopment of its programs for the ‘treatment and management of young offenders’, the McNally Training Centre was renamed the South Australian Youth Training Centre (SAYTC).68 It was organised into five units: three for short-term accommodation and two for long-term. Greater emphasis was placed on dealing with offenders through community-based initiatives rather than committing children to secure care.69

67 DCW annual report 1979, pp. 9, 37–8.
During the 1980s SAYTC provided accommodation for up to 90 young offenders on court orders in a ‘living environment that is safe for staff and residents’.69 A 1982 report on children in institutional care described the centre as providing a ‘closely supervised developmental training and support program’ run by welfare and educational staff. This program consisted of remedial education and activities that developed ‘social, vocational and recreational skills’. The concept behind the training was to provide an ‘individual program with specific behavioural goals’ for each resident to increase their ability to cope in the community:

Residents are taught to take responsibility for their behaviour, to accept consequences for inappropriate actions and to seek rewards for achievements … Inappropriate behaviour is confronted and dealt with. Appropriate behaviour is encouraged and rewarded.70

Records from the centre reveal a focus on punishment. The most common forms of discipline were issuing residents with work programs or placing them in ‘isolation’.71 In 1985, a senior care worker commented that staff resorted to punitive measures ‘in an effort to sort out those not doing the right thing’. The worker writes in the observation log that in addition to punishment, ‘constructive programming … and discussions (not lectures) is also required’.72 In the same period another care worker stated: ‘The staff here are employed to change behaviour—this requires more than just punishing’.73

In 1983, punishment at SAYTC was governed by regulations under the Community Welfare Act and by departmental standard procedures for secure care. Corporal punishment was prohibited. Deprivation of privileges and detention of children over 15 in a detention room for up to eight hours was permitted. Children were required to be strip-searched before being placed in detention and then checked at regular intervals. If not searched, they needed to be under constant surveillance.74

In 1985 SAYTC operated with four living units: two providing care and assessment for residents on remand and two for young offenders in detention for two to 24 months. In that year the department reported that the ‘downward trend in the numbers of young people detained at SAYTC continued’; the average number of residents a day was 43.75

The following year the department reported on renovations to the interior of the SAYTC buildings ‘to provide more privacy for residents and a more relaxed and appropriate physical environment within the constraints of the stark architecture of the centre’.76 It also reported on plans to replace SAYTC and SAYRAC with smaller secure care centres.77 By 1986–87 one of the units was closed due to low numbers, leaving three units operating: one for short-term care and two for longer detention.78

During 1988–90, in response to the suicide of an Aboriginal boy at SAYTC and the findings of the interim report of the Royal Commission into Aboriginal Deaths in Custody, building alterations were made to the interior and exterior of the centre to ‘reduce the risk of self-damaging behaviour and to improve the quality of living conditions’.79 Exterior additions included an outdoor living area with a pergola.80
Additional procedures were implemented to ‘better deal with people trying to harm themselves while in their sleeping quarters’ and ‘greater effort’ was aimed at reducing the number of Aboriginal children in custody.\textsuperscript{81}

The numbers of children being held at SAYTC, particularly those serving longer detention orders, increased in the 1990s.\textsuperscript{82} In 1993 a new purpose-built secure care centre was opened at Cavan for older offenders and SAYTC was renamed the Magill Training Centre.

**General evidence**

A former worker at SAYTC told the Inquiry she was disturbed by the attitude of some of her co-workers:

> There was a lot of abuse happening there; physical abuse. The workers would lock the kids into the staff room and you could hear them belt them; belt the crap out of them … because they just couldn’t—they didn’t know how to deal with them effectively. They felt that the only way—and I have to tell you, the attitude of a lot of these men was ‘… get over it; all we’re doing is getting these kids ready for Yatala’ and that was the ethos that I was working in. They’d given up on these kids, literally given up on these kids. All they had to do was get them ready for Yatala, and part of that getting them ready for Yatala was to toughen them up and part of that toughening up process was some quite awful physical abuse. It’s just terrible.

**Allegations of sexual abuse**

Four PICs gave evidence to the Inquiry about being sexually abused while they were in State care and placed at SAYTC. One alleged he was sexually abused by older boys and after absconding, one after he absconded from SAYTC and two by older boys in the shower blocks.

**Abuse by multiple perpetrators**

A PIC was first placed in State care on a short-term care and control order in the late 1970s when he was 11. He then committed a criminal offence and was placed in State care for 12 months. He spent time at Slade Cottage and SAYRAC and alleged he was sexually abused at both. In the early 1980s, he was placed twice at SAYTC for criminal offending, spending more than six months there.

The PIC described SAYTC as a place where ‘they’d treat you like an animal’. He recalled the various punishments meted out to residents, notably deprivation of privileges and a regime of ‘mental games’ to exacerbate punishments.

While in SAYTC, the PIC said two older boys sexually assaulted him repeatedly in a toilet block. He described being held down and having a toothbrush inserted into his anus, and being digitally penetrated by the boys, who also attempted anal intercourse with him. The PIC alleged a staff member witnessed one instance of abuse but took no action.

The PIC said he absconded from SAYTC when he was 16 and lived on the streets with another boy. He said they went to a city hotel where the other boy introduced him to a man. The two boys accompanied the man to his home in an inner Adelaide suburb. On the way, the man asked the PIC if he had any identification: ‘I remember that. He wanted to know my proper name for a reason’ and, the PIC believed, ‘he was a bit concerned about my age then as well … he wanted to check all that out’. The PIC alleged the three had a drink at the man’s home and then he and the man went into another room. They watched a pornographic movie, after which the man touched the PIC’s genitals and attempted to perform oral sex on him. The PIC told the Inquiry he ‘pushed away’ from the man and left the house. He said he saw this man in the central city area several times; the man approached him but the PIC made an effort to ‘show that I wasn’t interested’.

**Abuse by other residents**

When he was seven years old, this PIC’s parents separated. Neither parent was able to provide stable care and the PIC was exposed to the effects of alcohol abuse, severe family dysfunction and suffered breakdowns in home and schooling. The department supervised the PIC from the age of 11 and placed him under a temporary guardianship order when he was 12.

\textsuperscript{81} ibid.

Chapter 3 Allegations of sexual abuse

He was then placed on a series of supervised bonds due to his truancy and offending. The PIC alleged he was sexually abused at Gilles Plains Community Unit, SAYTC and in one foster placement.

The PIC had a short placement at SAYTC in the early 1980s when he was a teenager. He told the Inquiry he was raped by another inmate in the shower block. He did not report the abuse as there was a culture of bullying at SAYTC and other boys had bashed him on several occasions. He said boys would demand cigarettes, and if he couldn’t provide them they would insist on sexual favours.

A PIC was placed in State care when he was 14 in the early 1990s, the court finding that he was in need of care. After various placements he was sent to SAYTC in the mid 1990s after committing criminal offences. He told the Inquiry he was pinned down and anally raped by a group of three to four other residents in the shower block. He believes he may have blacked out as he woke up on the floor after the attack. He did not report the abuse and was too ashamed and embarrassed to seek any medical assistance.

He also told the Inquiry that SAYTC was particularly ‘rough’ and spoke about regular beatings, being thrown against the walls and having his head banged against the walls by staff, including one officer in particular. ‘Screws—officers grabbing us and dragging us around and stuff, if you didn’t do things right … twist your arms, bang your head against the walls.’ He recalled that he was nursed from unconsciousness in the cabins by two or three female staff members and received no medical assistance, because they claimed he had had a fit. However, he said he had never suffered from epilepsy before or after the incident.

He said he was made to feel small and petty, and that it was hard to hear every day of your life that you were ‘just a piece of shit’. He now feels the system let him down.

Abuse after absconding

One of the PICs had spent almost his whole childhood in State care, as did his siblings. He was placed in Seaforth Home when he was a baby after a court found that he was neglected and under unfit guardianship. He was moved from there to various placements and released from State care as a 19-year-old. He told the Inquiry he was sexually abused by a foster father, by other residents at Fullarton Cottage, and while on the run from SAYTC and SAYRAC. He absconded regularly from placements and told the Inquiry he was running ‘from everything that had happened to me, I guess’.

He was placed at SAYTC in the early 1980s, when he was in his mid teens, after being charged with a criminal offence. He told the Inquiry he absconded from SAYTC ‘just to be free at the time’ but was sexually abused by an older prisoner in interstate police cells. He said he reported the abuse to a police officer at this police station, and the officer suggested he leave town, which he did. He travelled to another State, where he was arrested and returned to secure care.

He told the Inquiry that ‘it was a very real issue that I face these demons—this bad shit that happened in my life’.

Magill Training Centre, 1993–present

History

The Magill Training Centre had its origins in the Boys Reformatory, Magill, which opened in 1869 and became the McNally Training Centre in 1967. The centre was renamed the South Australian Youth Training Centre (SAYTC) in 1979 and Magill Training Centre in 1993. It continues to operate today but the department acknowledges that ‘due to its significant age, the facility at Magill has not been conducive to the rehabilitation and care of young people’. The department has identified the facility ‘as an urgent priority for redevelopment’.83
Allegations of sexual abuse

One PIC gave evidence to the Inquiry that staff and outsiders sexually abused him while he was at Magill Training Centre.

Abuse by multiple perpetrators

An Aboriginal PIC was placed in State care in the early 1990s as a result of criminal charges. Records received from the department show that from the age of 12 the PIC was regularly charged with criminal offences and frequently appeared in the Children’s Court. The PIC alleged he was sexually abused at SAYRAC when he was on remand, and also at the Magill Training Centre.

After having been placed on several court-imposed bonds and under the supervision of the department, the PIC was sentenced to a period of detention at Magill in the mid 1990s for illegal use of a motor vehicle. He said he stole cars for attention and acceptance among his peers:

I think most of it would’ve been like, I think, a cry for attention. And I think some of it would have been—I felt like I was accepted into that crowd and I felt like they were like brothers.

The PIC alleged a staff member at Magill sexually abused him:

I was in the cell and he used to come in there late at night… at one stage it was, like, easily once a week and then it started slowing down … He used to just come in there and he used to make me give him oral sex … He used to penetrate me from behind and stuff like that.

The PIC said he suffered injuries from the alleged sexual abuse but did not report it: ‘I was too ashamed to go and talk to anyone about it’. He also alleged that a man who had helped him and supported him during his court appearances groomed him and sexually abused him. He said he first met the man when he was about 12 and the abuse started when he persuaded the PIC to masturbate him in his car. The PIC alleged that on another occasion the man took him to a place outside the city and anally raped him in a caravan. Records received by the Inquiry confirm that the man was regularly in attendance at the PIC’s court hearings.

The PIC said that after his release he lived on and off on the streets:

I went back to stealing; stealing money and stealing property, and selling it … Then I met up with some of my friends from Magill Training Centre who I’ve known since SAYRAC … They basically told me that there’s easier ways that we could make money without getting into trouble.

The PIC said he started to frequent Veale Gardens in the South Park Lands with his friends and performed sexual favours for men in return for money, and on some occasions men took him to private houses. He told the Inquiry that once he went to a large white house where he was sexually abused:

I remember being at that white house and there was a room. It had … it looked like some sort of swing and it had a leather sort of backing, and chains that went into the ceiling … I never saw any of their faces because they had a full face mask and a zip where their mouth should be. They used to just put us on that swing and just, like, they had a video camera there, and they used to penetrate us on that swing.

The PIC said he went to this house about six times but he never saw the men’s faces. He said he also went to other houses:

Sometimes people used to come down and pick us up from the Veale Gardens area and other times people like [name] would have, like, lifts that were already organised for us to go.

He also said he was taken to a gay men’s sauna club in the city, where he would have sex with men.

The PIC alleged that in his mid-to-late teens, a man who had offered him support and assistance when he was in detention sexually abused him. He said he would meet the man at a drop-in centre for Aboriginal boys:
Chapter 3 Allegations of sexual abuse

He used to sort of take me and some other boys sort of around … [to] his house and stuff … [and] have sex and stuff with us … he used to say it's, like, a favour for him and all this sort of thing … he was sort of our knight in shining armour sort of thing. Like, he would come every time—if we was in the watch-house cells and stuff, he would come in then. Like, we felt safer that he was there and stuff like that, and he would always say the right thing, like ‘Stick with me. I’ll look after you’.

By 1966, the institution was full and the buildings were extended. When admitted, boys were provided with clothing and their own clothing was sent to their parents. Each boy’s dormitory placement was based on his progress in the institution; dormitories for the ‘honour’ group were furthest from the staff station. The daily routine was highly regimented. At night, staff undertook ‘active supervision of the boys’ and patrolled the institution using several watchmen’s clocks to mark their progress.

Staff woke bed-wetters at 11 pm and 3 am. All punishments were authorised by the superintendent and recorded in a punishment book, with caning kept to a minimum.

Children could receive visits under a visitor’s permit system, but the superintendent retained discretion to allow visits without a permit. The institution was required to maintain a file for each boy, which contained medical, psychological, behavioural and critical incident reports. A logbook was maintained on the boys’ movements to and from Brookway Park.

Problems were evident in Brookway Park’s operation from its inception. In late 1965, the deputy superintendent resigned, citing staff shortages, overcrowding, an insufficient focus on allowing children to build effective relationships with adults and an age range among residents that meant ‘older boys have had direct influence homosexually on the younger boys’.

In 1966, the director of Social Welfare expressed his concern to the Minister about the ‘general deterioration in the condition of the institution’.

During the late 1960s, regular counselling and group discussion sessions were introduced and in the 1970s…
the buildings were altered to allow boys to be separated into different residential units based on their treatment needs. One unit was designated as ‘secure’ for residents who needed ‘intensive treatment’ and another as ‘open’ for trusted residents who attended school locally. In 1975, when the Windana Remand Home was closed, a residential assessment unit was built at Brookway Park. Brookway Park closed on 1 September 1978 and its residents were sent to the South Australian Youth Remand and Assessment Centre (SAYRAC).

Allegations of sexual abuse

Thirteen PICS told the Inquiry they were sexually abused in Brookway Park. They were all in State care and had been placed at Brookway Park after committing a criminal offence or being found by a court to be uncontrolled or a truant. They alleged that staff, other boys and outsiders perpetrated the sexual abuse, which included gross indecency, indecent assault and anal and oral rape.

Abuse by multiple perpetrators

In the mid 1970s an 11-year-old Aboriginal boy who had committed break and enter offences was placed in State care until he turned 18. This PIC told the Inquiry he committed the offences because of his family’s poverty: ‘We were poor. Like, we sometimes used to get food rations from the welfare and we’d be eating chips instead of real meals.’ He said that before going into State care he truanted from school. He alleged that a man assigned to deal with his truanting exposed himself more than once and asked him to touch his penis, but he refused. He told the Inquiry he was sexually abused during a placement at Brookway Park.

Department records show the PIC was at Brookway Park for about two years in the late 1970s and during that time also spent periods in foster care. The PIC alleged a staff member at Brookway Park indecently assaulted him.

He always used to get me in corners and I used to think he was joking, and fucking around. He would always have his hand in his pocket. Thinking back, you know, like, I didn’t realise what was going on for years, I didn’t think about it, but looking back now I know what he was up to, especially, you know, like, he’d rub up against me.

The PIC said that on another occasion the same staff member took him to his house, where the man ‘pulled out his cock … playing with his cock in front of me at the kitchen table’.

When he was 10 or 11, he told the Inquiry, he absconded with another boy from Brookway Park and was picked up by a man who drove him to another State. He alleged the man indecently exposed himself.

During his time in care the PIC committed numerous offences and was also placed in other government institutions, including secure care. He also told the Inquiry that when he was about 15 he was required by a court to attend a youth centre, where he met a volunteer worker. He alleged the man took him to his house and indecently exposed himself: ‘He pulled his cock out. I told him I wanted to get out of there … he took me home’.

The PIC was released from care when he was 15. Of the sexual abuse, he told the Inquiry: ‘It’s an innocence, you know, that you don’t—you know, it’s innocence, and somehow they’ve taken it away from you, haven’t they?’

Abuse by staff

A PIC who was at Brookway Park in the late 1960s told the Inquiry he was subjected to ongoing nightly sexual abuse by one male staff member. His parents had separated, leaving him and his siblings with little supervision, so, aged 11, he was placed in State care by a court until he turned 18 as a result of being found to be uncontrolled. He spent the next year at Brookway Park, sometimes being allowed to go on holiday to his father. He said that within months of being placed at Brookway Park he was taken from his bed by a staff member to the office during the night and given a cup of Milo, which he now
suspects was drugged. ‘He’d make me undress and I’d be put over his knee, and he used to bring out this ointment. He reckoned it would relax me.’ He said the abuse involved anal penetration and fondling his genitalia. He said he woke up in the mornings after this occurred, feeling ‘spaced out’.

He told the Inquiry he did not report the abuse to anyone:

I thought I’d get into trouble. I didn’t really know the difference, whether he was trying to give me comfort or not. I don’t know. He sort of came across as a big—as the long-lost uncle, sort of thing, you know, and showed a lot of empathy towards me, and I just, I don’t know, I thought I had this misguided sense of—I don’t know what you’d call it—but, no, I didn’t say anything.

The PIC described the effect of the sexual abuse at Brookway Park:

I really didn’t know what was going on. I just thought I was getting my bum rubbed, but it stuffed me up for all my life. It is what I don’t know that worries me.

A PIC born in the mid 1950s was placed in State care until the age of 18 by a court when he was aged nine after being charged with larceny and being destitute. He alleged he was sexually abused during placements at the Boys Reformatory, Magill, Brookway Park, Kumanka Boys Home and McNally Training Centre.

Records show the PIC was placed in a government institution, from which he frequently absconded and committed offences, resulting in a short placement at the reformatory, and then, aged 11, he was sent to Brookway Park, where he remained for 16 months. Records received from the department show he behaved poorly at school and in the home and continued to abscond. With some improvement, he was released to live with his mother when he was 13. However, he continued to truant from school and committed numerous offences, so was readmitted to Brookway Park for about nine months.

The PIC told the Inquiry he regularly absconded from Brookway Park because of sexual abuse by a staff member, which he alleged occurred during both of his placements at the home. The PIC said the abuse first occurred when he was 12 years old in the mid 1960s; Brookway Park had not been open long. He said: ‘I woke up a couple of nights and there was an officer fondling me when I woke up. He said: “Just go back to sleep” and he’d walk off.’ The PIC said the officer was touching his genitals. The alleged abuse occurred on nights when the officer was on duty.

The PIC did not report the alleged abuse: ‘I thought I’d be safe by not saying anything’.

Another PIC was remanded by a court at Brookway Park for one week when he was 13, very soon after his father’s death. He was then charged with truancy and placed in State care until the age of 15. He said he was anxious and unsettled after his father died.

He said of his time at Brookway Park:

I only stayed there for a little while, and I didn’t like the place … there was boys crying down the end and stuff, and there was older boys as well and they were picking on the younger ones and stuff and that. I knew I had a bed-wetting problem so I was a bit scared of that, plus my dad had only just died not long anyway, and I just wanted to go home.

He told the Inquiry he was sexually abused by a night officer wearing a white coat. He said he was in bed and the officer came in to comfort him:

He sort of, like, put his hands on my knee, on my leg, and then he was talking to me, telling me it was okay and this, ‘I’ll look after you. You’ll be all right. You’ll be going home soon,’ and stuff.

The PIC said the officer, while masturbating himself at the same time, moved his hand down to his groin area, and when the PIC moved the hand away, the officer said, ‘If you tell anyone this, you’ll be in trouble and you’ll be here for a
He said he did not eat while in the home and his weight dropped rapidly. He did not tell anyone about the abuse: ‘No, no, I couldn’t talk to no-one’.

In the early 1960s, when he was 12, an Aboriginal PIC was placed in State care by court order until the age of 18 as a result of stealing three pens; he said he had been with an older boy who had stolen some pens, so he had taken some too. His SWIC records that in the six months after this offence he mainly lived at Glandore Children’s Home, where he alleged he was sexually abused. After committing other criminal offences, the PIC, aged 15, was placed in Brookway Park, where he said he was sexually abused.

He told the Inquiry he had been ill and had gone to the Brookway Park infirmary, where a staff member visited him: ‘They got me face down and the other officer sat on my back and shoulders and [the officer] raped me’. He said he told the matron and his welfare worker of the incident but neither believed him and no action was taken. The department advised the Inquiry there were no medical records available for Brookway Park. The PIC’s client file does not record any alleged incident.

The PIC said that for several years he had the same welfare worker, who visited him occasionally at home or in detention. His impression was the worker got on better with his parents than with him. He did not recall having discussions with the worker without other adults being present. He told the Inquiry that as a teenager he would have liked ‘... just someone to sit and listen to what’s going on and do something about it, or at least try’.

Abuse by staff and other residents

The PICs who gave evidence to the Inquiry about sexual abuse perpetrated by staff members spoke of a sense of being drugged and of photos being taken.

One PIC told the Inquiry that before he was placed in State care in the mid 1960s when he was 10, his mother would take him and his siblings out of the home at night and walk the streets of Adelaide to avoid his stepfather’s violence, hoping he would be asleep when they returned. He recalled other occasions at night when he and his siblings were left unsupervised while his mother worked and his stepfather was away. The children wandered the streets alone, looking for something to do. When he was 10, he was placed in State care by a court for a criminal offence until he turned 18. He told the Inquiry he was sexually abused at Brookway Park and then at McNally Training Centre.

The PIC was at Brookway Park for 11 months in the late 1960s when he was 11. He told the Inquiry he was taken from the dormitory at night by staff members and older boys to a hobby room. He alleged the older boys sexually abused him by forcing him to have oral and anal intercourse with them. He said the staff members took photographs and watched the sexual abuse; he recognised one of the men in the hobby room as a staff member from another home.

The PIC said he told his mother and aunt about the abuse several times. He recalled that his mother went to the Brookway Park office and spoke to staff about the allegations. The PIC’s departmental records do not record his mother making an allegation of abuse. The PIC said he also spoke to one of the other boys who he thought had been abused at the same time at Brookway Park. This boy told the PIC to ‘just keep it to ourselves, okay? Don’t say nothing to anyone’.

Another PIC was placed in State care for a brief period after a court found him to be uncontrollable when he was 11. The order was extended a few weeks later after he committed a criminal offence and he was placed in State care until he turned 18. He spent the next four years in secure care, occasionally being released for holidays to his mother.
Chapter 3 Allegations of sexual abuse

He told the Inquiry that at Brookway Park unknown men abused him once a week for six weeks. The first time this happened: ‘I got woken up by a staff member and he grabbed me and he said, “Come with me and don’t make a sound or I’ll throw you in the cells”’. The staff member asked an older boy to take the PIC to a storeroom, where two unidentified men were waiting, one with a camera. The PIC said a boy he did not know was already there, naked and lying under a blanket, ‘all curled up in a corner. He didn’t say a word. He was frightened.’ The two men ordered the PIC to take his clothes off and the older boy also took his clothes off. The men photographed the PIC in various sexual poses with, and being sexually abused by, the older boy and the boy in the corner. He told the Inquiry that one of the men anally raped him.

I remember I was screaming and they got—tied a knot in a rag and put it in my mouth and tied it around my neck, so I wouldn’t scream out.

He said he returned to his bed and was ‘sore all over’. The PIC alleged the abuse by the two men continued, with the same member of staff waking him. He did not report it because he did not know whom to trust. The men in the room threatened him: ‘If you say anything we’ll keep you here forever’. He told the Inquiry that one of the staff members heard him crying in his bed one night soon after the first incident and dragged him to the shower block, held him under the tap and whipped him with his belt until he dropped to the floor. ‘I was always frightened there,’ he said.

A PIC was 13 when placed in State care by a court order as a result of habitual truancy. Department records show he had an unsettled childhood and attended many different schools. When the PIC was 12 his mother approached the department, concerned that her son was constantly truanting from school. The PIC said he was often getting into fights at school and that his mother supported the decision to place him in State care because she felt she could not control him. He was placed in Brookway Park in the mid 1970s. The PIC alleged he was sexually abused there and later at Kumanka Boys Hostel.

He told the Inquiry that when he was admitted to Brookway Park he was required to take a bath and a staff member photographed him naked.

One night he was taken out of the dormitory by men he believed were staff at the home and forced to have oral and anal sex with another boy while the men took photographs:

I was sort of pushed into the cubicle with the other kid and we were told basically what to do … basically I was forced to have sex with the other person that was in the cubicle with me.

The PIC said this happened several times and on one occasion a member of staff raped him:

That went on—the fourth or fifth time I think it was when I was taken into the cubicle. There were no other boys there—there was just me there and I was told to get on my knees. I got on my knees and one of the men came up and I was forced to do oral sex on him and then I was told to turn around and they bent me over the bed.

The PIC said that on one occasion after the sexual abuse he was bleeding from the anus and reported his injuries: ‘I talked to one of the staff members there and they just said it was probably haemorrhoids. “You were constipated and you’ve strained too hard.”’

He told the Inquiry that after this he did not report the abuse:

You don’t talk about things that happen. If the other kids find out and you get labelled ‘faggot’ you get the crap kicked out of you every day. It just goes on and on and on. You can’t understand it unless you have been in the situation.

Records from the department do not reveal any allegations of sexual abuse or of a report by the PIC of anal bleeding.
In the late 1960s, at the age of nine, one PIC was placed in State care until he turned 18, after a court found he was uncontrolled. He was placed in various institutions and alleged he was sexually abused in Windana Remand Home, Brookway Park and McNally Training Centre.

According to his SWIC, in the early 1970s the PIC was first placed at Brookway Park. He absconded six times over four years: ‘No-one ever sat me down to find out why I was running away’. He told the Inquiry he was sexually abused at Brookway Park by both staff and other boys, but was too embarrassed and ashamed to give further details to the Inquiry.

Abuse by other residents

One Aboriginal PIC said he was physically brutalised by his stepfather before being placed in State care. In the late 1960s, he was sentenced by a court for criminal offending and, aged 14, was placed in Brookway Park, where his SWIC records that he spent eight months.

He told the Inquiry he was attacked by an older, stronger boy at Brookway Park:

_We were going in the morning to breakfast and I was always watching my backside for this (other boy) and I remember that morning. I had (the other boy) behind me and I had the officer at the door and he turned around and shut the door and let (the other boy) pull me into a cupboard where he raped me._

He said the incident left him bleeding from the anus and that the nurse applied ointment to him for four nights. He did not tell anyone about the abuse but was certain the staff were aware, given that his injuries were treated. He told the Inquiry this experience had alienated him from society throughout his life. He did not seek friends and said, ‘I don’t think I was ever happy. If I could have killed myself if I’d had the chance, I would have—long time ago’.

The files provided by the department to the Inquiry did not contain any Brookway Park medical records relating to the PIC.

An Aboriginal PIC told the Inquiry he was sexually abused by another boy at Brookway Park. He had been placed in State care as a baby in the late 1950s until the age of 18 after a court found he was neglected and under unfit guardianship.

He spent time at a government home in the late 1960s when he was 10. He told the Inquiry he was caned several times for being naughty. He also said he witnessed sexual abuse of younger boys by older boys, but did not experience it himself because he believed an older relative who was resident there protected him.

Aged 11, he was transferred to Brookway Park in the late 1960s after committing a criminal offence. He was there for one year, and returned a year later for a further nine months, absconding once. He described Brookway Park as a dangerous place:

_We could have lit a fire in that dormitory and no officer would have come down. There were no alarms, no security, no bells, no nothing. You just relied on the officer doing his hourly duty, walking around and checking. That’s all. We could have set a massive fire and killed people there … There was no care, no duty of care._

He said older boys bullied the younger, weaker boys, particularly the Aboriginal boys, in the dormitories and in the shower block. Boys were forced to perform oral and anal intercourse.

The PIC said an older, stronger boy attacked him in his bed. He described being bashed in the face,

_… and all of a sudden I knew I was being turned over and he just raped me then and there … I couldn’t yell out or nothing, he had my head in the pillow … there were 30 people in that room and not one person got up to assist me or help me or said a word; they all cowered under their blankets._
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The PIC said he did not report the incident: ‘I couldn’t … they just didn’t care’. He said he was never the same after that incident and wanted to commit suicide: ‘Death was nothing to me in there, you know … Then I became angrier and angrier’.

Some of the children were visited by family and friends. Each week, this PIC prepared for a visit but nobody turned up and he recalled that staff said to him, ‘You’re not getting a visit today, your family are not coming and they don’t love you. That’s why you’re here.’ He did not understand why he had been taken away from his family and was not told when he could return to them. He said he ran away in an attempt to return home. He was moved between various institutions until he was released from State care aged 18. His SWIC records that he absconded 22 times from placements while in State care.

In the mid 1960s, when he was 10, a PIC was placed in State care by a court until he turned 18 after committing a criminal offence. He lived at two other government institutions before being transferred to Brookway Park when he was 11 and a year later was placed with his mother. He also alleged he was sexually abused during a placement at Windana Remand Home.

He told the Inquiry that at Brookway Park one of the older boys used to con me to get into his bed, you know, like, sort of be friendly to me. Then he would just rape me. It went on frequently … about three or four times a week … these kids are going to bash you if you don’t do what they say, and you can’t go anywhere to get away from it.

He described how the sexual abuse increased over time, and

… after a while it wasn’t just him, it was other kids, and it wasn’t just at night. We used to have a toilet block at the parade ground. So the kids would get me in there and sort of make me go down on them.

The PIC was unsure whether staff were aware of this alleged abuse; he recalled he did not want any other residents to know what was happening.

Abuse by outsiders

In the mid 1960s a four-year-old PIC was first placed in State care by court order until he turned 18, after being found to be neglected and under unfit guardianship. He alleged he was sexually abused while placed in the family home. He was released from State care at 10, but four years later a court found he was uncontrolled and placed him in care until the age of 18.

The PIC’s SWIC records that he then spent almost a year at Brookway Park. He told the Inquiry that while he was there, his employer sexually abused him over many years: ‘When he was driving a truck he asked me, “Can you do my zip? Can you do my zip and start pulling my dick?”’

The employer threatened that he would pay to have him killed if he refused. The PIC said he did as he was asked because he felt he had no choice. This sexual abuse continued for many years, he said, and he felt powerless to stop it, even as an adult:

He keep calling me back all the time, you know, because he couldn’t get somebody else to work for him. So he keep calling me back, but I didn’t want to go back because of sexual assault. And he even says to me, “Can you let me grease your arse? Can I have sex with you?” … I said to him, ‘No, no, no,’

He did not report the abuse because ‘I know he probably would get somebody to kill me. He’d probably kill me himself.’

A PIC was placed in State care when he was 12 when a court found he was uncontrolled. Department records show that before being placed in State care he spent time in the Salvation Army Boys Home (Eden Park), where he alleged that he was sexually abused. He also alleged he was sexually abused while in State care at Brookway Park and Lochiel Park Boys Training Centre.

According to department records, the PIC was placed at Brookway Park for a few weeks when he was 12. He told the Inquiry that while there, the staff released him to his father’s care for weekends and his father had anal intercourse with him in the car.
This PIC said that during a later placement he told his social worker about the abuse and that she made a note of it, but nothing was done. Departmental files relating to the PIC record visits to his father but no allegations of sexual abuse. The PIC alleged the sexual abuse by his father continued in his next placement in Lochiel Park.

**Secure care for girls**

**Vaughan House, 1947–79**

**History**

Vaughan House opened on the site of the former Barton Vale School, a reformatory operated by the Salvation Army between 1922 and 1947 under the control of the State Government. During the 1940s the CWPRB became concerned about the ‘unruly conduct’ of girls at Barton Vale. During this period there was a move to bring the operation of private, denominational institutions under government control. The Salvation Army closed Barton Vale in 1947 and the government bought the property, reopening it as Vaughan House to mark an ‘entirely fresh start’ in the secure care of girls.

As well as the usual education curriculum, the residents at Vaughan House were taught housework, cooking, dressmaking, music appreciation, dance, physical education and handicrafts. In its first year, the reformatory had 13 residents between the ages of 14 and 20. By 1960 the number had increased to between 40 and 50 girls, prompting the construction of a new building to increase capacity to 72. Building additions in two stages were completed by 1965. However, the pressure for additional space continued because of the greater numbers of children being committed for offences. At the beginning of the 1960s, Vaughan House was still the departmental reformatory for girls who had been committed to a reformatory by a court.

By the 1960s Vaughan House was providing more vocational education. The institution provided a ‘commercial education’ and a ‘basic education’ to each girl. Residents were allowed to receive certain visitors, such as family, friends and members of church and sporting groups. Towards the end of a resident’s time in the institution before her release on probation, frequent ‘trust outings’ were permitted. By the end of the 1960s, probation officers visited Vaughan House regularly and assisted staff to prepare residents for their release. Probation officers were expected to inform the department of any problems.

In the late 1960s Vaughan House underwent a change in direction. During 1969–70 differential treatment assessment procedures were implemented to identify each girl’s needs and assign an appropriate treatment and training program. A review board met regularly to re-interview residents, re-evaluate their programs and goals, and recommend release dates. The emphasis was on preparing residents for their eventual return to the community. Probation officers were appointed to provide individual and group counselling and to facilitate closer links between staff and residents. Psychologists also visited Vaughan House regularly.

The revised system of individual assessment and programming was not an unqualified success. In August 3.6 Secure care
1972 a series of incidents at Vaughan House was reported in the media when residents attacked staff members. A staff member was facing disciplinary action. A report from the director-general of Community Welfare to the Minister stated that smaller group care was preferential in the treatment of residents at Vaughan House, as some were ‘severely emotionally disturbed.’ The report prioritised the need for ‘establishing better communication and better relationships with girls as a control measure rather than requiring staff to exercise control by keeping girls in small confined areas’.

In 1972, the institution was modified in line with changing philosophies of secure care. A belief prevailed that the establishment of separate units in Vaughan House, each with varying functions, would help promote stability. During early 1973 Vaughan House was remodelled to provide unit style accommodation including two assessment units—one catering specifically for recurrent offenders. Three other units were for training, pre-release and one for girls who were deemed to have a “low commitment to delinquent behaviour” or were not an absconding risk. In June 1973, 11 girls on remand at Windana were moved into new remand and assessment units at Vaughan House. Windana continued as a remand home for boys only. The new focus was on treating each resident as an individual and the long-term goal was to prepare residents for their return to the community.

In 1979, the State Government renamed Vaughan House the South Australian Youth Remand and Assessment Centre [SAYRAC].

Allegations of sexual abuse

Sixteen women gave evidence to the Inquiry that they were sexually abused while in State care and placed in Vaughan House. They alleged sexual abuse by staff members, including by the institution’s doctor (a visiting professional sanctioned by the home), by other residents, and by people from outside Vaughan House. The sexual abuse included gross indecency, indecent assault including masturbation, digital penetration and rape.

Abuse by multiple perpetrators

A 14-year-old girl was placed in State care in the mid-1970s after a court found her to be uncontrollable. She was placed at Vaughan House for about a year when she was almost 15, during which time she alleged that a staff member sexually abused her. Her memories of Vaughan House are ‘just sadness’. She described being locked in her room each night:

You had to put your bedspread outside the door when you go to bed at night, and that way the staff knows that there’s a girl in that room. There’s bars on your window and your beds were bolted to the ground, metal bed, metal cupboard, that’s all you had, all bolted. And there’s a bell to press if you need to go to the toilet or something like that, and if you’re lucky you’re allowed. The radio would come on from downstairs for about 20 minutes, and that’s all.

The PIC said one of the male staff members entered her bedroom and, after placing his hand over her mouth:

I remember getting raped by the male staff and there was blood everywhere on my sheets and all that, and it hurt, and I wasn’t allowed to say anything or tell anyone because they’d just flush your head in the toilet, and you’d just keep getting punished … Because you’re government property, they can do whatever they want, but you can’t tell no-one because if you tell someone, you still get more punishment, no matter what.
She said that this abuse occurred once or twice a week throughout her year at Vaughan House. The PIC said two other male staff members also raped her. On one occasion, two of the men attacked her when she went to have a shower and forced a broomstick into her ‘private parts’. She said she was forced to take medication before she went to bed and would awaken ‘very uncomfortable and knowing I’d been raped’.

She told the Inquiry that after absconding from Vaughan House she was picked up in Hindley Street by the police. She alleged they told her that ‘I was government property and that they could make me do what they wanted me to do’. She said that she was forced to perform oral sex on them. They then delivered her to a police station where she made a complaint. She was not believed and was returned to Vaughan House. The Inquiry asked the police for any records of the complaint made by the PIC but was advised that any records have been ‘culled’ and there are no records to disclose.

The PIC also alleged she was sexually abused by a staff member while living at Elizabeth Grace Hostel, which was an annexe of Vaughan House. She said she is not clear about the date and that the department records are incorrect about her placements and when she was in each. She said that a senior staff member at the hostel would take her into his office, show her pornographic magazines and then touch her under her clothing. He raped her several times in his office, the dormitory and an unused dormitory. ‘I never told anyone because I knew that we were classified as troublemakers and no-one would believe us.’

As an adult she said she still thinks about the sexual abuse and doesn’t understand why it happened.

Was I a bad girl? ... No-one has the right to touch you, but what was it about me? ... I still feel like people will think that I am a slut if I tell them what happened to me. I feel like I have the word ‘slut’ tattooed on my forehead.

In the mid 1970s a 14-year-old girl was charged with being neglected and destitute and placed in State care until the age of 18 years. She told the Inquiry that her father had sexually abused her before the court order. She alleged sexual abuse at Vaughan House, in an earlier placement at Stirling Cottage and a later boarding arrangement. She also said she was raped while a runaway from Vaughan House.

According to her SWIC, the PIC was placed at Vaughan House for stints of two weeks and six months when she was 14. She told the Inquiry that on admission the institution’s doctor gave her an internal medical examination. She said she told him there was no need, but he went ahead. She said she was naked and no-one else was present. ‘You got your breasts checked, your body checked, you had an internal examination.’ She said this was repeated each time she transferred between the institution’s three units or was returned after absconding.

The PIC also alleged a male staff member sexually abused her while she was physically restrained. She said he would use his knees to pin residents and ‘out of the blue, he would get your arm and put it up your back’. He once removed his knee from her back and lay on top of her, rubbing his groin against her. Later that night, he came to her room and warned her: ‘I hope you’re going to behave yourself tomorrow. I hope you’re going to be good tomorrow.’

The PIC told the Inquiry she was raped after she absconded from Vaughan House. Departmental records confirm that she ran away when a Vaughan House worker arrived to collect her from her mother’s house, where she had been on leave. While she was on the streets an adolescent male came to her defence when other girls threatened her. He told her, ‘Now you’re with me’ and that she ‘owed’ him.

She said the young man took her to a nearby hostel and raped her. The PIC told the Inquiry she left as soon as she could and ‘never told nothing to a soul’. She gave the reason as being
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... scared I’d be killed because apparently this person … had such a reputation of being quite a nasty person and raping women and getting away with it.

She also said that he seemed very familiar with ‘ward of the State shelters and homes’.

Vaughan House records show police returned her to the home and her behaviour was monitored. The alleged perpetrator visited her at Vaughan House and gave her a gift, which the records show was discussed by staff. She said she was very apprehensive and made it clear ‘I didn’t want to see him at all’.

A woman told the Inquiry that before being placed in State care in the early 1970s she often had run away from home to escape her father’s physical abuse. She initially was placed in State care after her mother signed a voluntary custody agreement. Within a year, when she was 13, a court placed her in State care until she turned 18 for being uncontrolled. She told the Inquiry she was sexually abused at Vaughan House and later in foster care.

She alleged that the doctor who visited Vaughan House gave her regular medical check-ups and digitally penetrated her. ‘He would fool around, you know, up your vagina.’

She also alleged that a male staff member gave her injections that made her drowsy or caused her to lose consciousness and then he sexually abused her. She said she described to a female staff member how he injected her, grabbed her from behind and held her breasts. She said he placed her in solitary confinement and threatened her when he found out:

_He hit me and he said, ‘Don’t you ever, ever go and tell workers that I’ve been grabbing you by the breasts again, because no-one’s gonna believe you. You’re not to talk to any women.’_

She said that he then raped her in the solitary confinement cabin. She told the Inquiry that he continued to rape her two or three times a week and sometimes two or three times a day, and would force her to perform oral sex on him. She did not make any further allegations for fear he would carry out a threat to kill her.

She told the Inquiry that the same staff member arranged for the doctor to examine her when she missed her menstrual period. The doctor confirmed a pregnancy and gave her pills to cause an abortion. The staff member threatened that if she did not take the medication, the visiting doctor would give her an injection that would have the same effect. She said that after she aborted, the doctor gave her what she believes were iron tablets. Department files do not mention a pregnancy or abortion.

Her SWIC records that she absconded from Vaughan House 39 times in three years and often lived on the streets. ‘Of course I was frightened, but it was better than being in Vaughan House. Anywhere was better than being in there.’ She told the Inquiry that the police regularly returned her to Vaughan House. She said that on three separate occasions she was sexually abused by young police officers who forced her to perform oral sex on them. ‘I told them I didn’t want to do it and they said “Well, you’ll have to do it”’.

She gave birth when aged 16. Department records show the child was placed in foster care. The PIC told the Inquiry that she later spent time living on the streets as a young woman and did not see much of her children. ‘I’ve failed them, I suppose, like the system failed me. I didn’t know any better.’

A 11-year-old girl was placed in State care in the early 1970s after a court found her to be neglected. She told the Inquiry that before this she was sexually abused by a man who visited her mother when she was six or seven. Her SWIC records she had three placements before, aged 12, being committed to Vaughan House where she lived at various times until she turned 18.

She told the Inquiry that an adult male relative of a Vaughan House staff member sexually abused her during a visit to the staff member’s home. She alleged that the staff member left her alone with his relative, who chased her and forced her to perform oral sex on him. She remembers ‘fighting, but you’re still choking and you’re fighting; then you choke and then you’re not there’.
She said she complained of the abuse to another staff member and was no longer permitted to associate with the first staff member. She also told the Inquiry that she was forced to masturbate an older girl at Vaughan House. She claimed that the staff knew about the abuse and that she told the man in charge of the institution, but nothing was done.

There is no record of weekend leave with a staff member nor allegations of sexual abuse by the PIC in department records provided to the Inquiry. They do record that she was admitted to hospital several times with psychiatric issues and that there were questions as to whether Vaughan House was suitable for her.

Abuse by staff

An 11-year-old girl was placed in State care in the 1960s when a court found her to be neglected, illegitimate and destitute. She spent time in various foster placements and said she was happy in one of them, but her alcoholic mother had a habit of tracking her down and causing trouble. When the PIC was 16, she returned home at her mother’s request, but ran away soon after. As a result, she was remanded to Vaughan House for ‘safekeeping’ until her 18th birthday.

The PIC alleged that the doctor who regularly visited Vaughan House sexually abused her. She told the Inquiry that all the residents ‘had to be thoroughly checked out … internally, whether you were a virgin or not, so it was pretty invasive’. She said that he conducted the medical examinations alone, in the surgery at Vaughan House. She was required to completely undress and lie on a bench with her legs open. She alleged that the doctor touched her breasts and digitally penetrated her while he stood close to the bench, rubbing himself against it. She did not report the sexual abuse because ‘I thought he was a doctor so he must have known what he was doing’.

Another 11-year-old girl was placed in State care in the mid 1960s after a court found that she was neglected and under unfit guardianship. She told the Inquiry that she was sexually abused while in foster care and during a later placement at Vaughan House.

According to her SWIC, the PIC was placed at Vaughan House for almost a year in the early 1970s after she committed a criminal offence at the age of 13. She told the Inquiry that she saw the visiting doctor after experiencing leg pain. She claimed that he gave her an internal examination:

I didn’t understand why he wanted me to strip down and get on the bed. I just wanted something to stop the aches and the pains. It was like … when you are pregnant and things like that—you know, giving you an internal. … There was no need for it … it made me feel really grubby … you’d have to go for a shower because you felt creepy. It wasn’t just an examination, you could see he was, yes, getting off on it.

She said she did not tell anyone about the abuse, although the girls talked among themselves about the doctor’s behaviour. ‘I didn’t make a big deal out of it because you’re in Vaughan House and who’s going to care?’

In the late 1960s, a 15-year-old girl was placed in State care until she turned 18 after a court found her to be uncontrolled. At 14 she had been placed in temporary State care under a voluntary custody order signed by her mother. She told the Inquiry that her stepfather had sexually abused her before this, but her mother did not believe her. She alleged that while in State care she was sexually abused at Vaughan House and in foster care.

She said that at Vaughan House a laundry worker asked me to come to the toilets with him. He was very, very friendly and asked me to fondle him and as a child I did. … He had his penis out and he just asked me to fondle it and touch him.

She did not report the sexual abuse to anyone because ‘you didn’t dare open your mouth in them days, you know, because you were put down and you were told that you were a liar’.

The PIC also told the Inquiry that it was common practice for the girls to be given an internal medical examination upon admission and readmission to Vaughan House.
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She described this as ‘very painful and uncomfortable’. She said she wondered ‘why they’re doing things like that to you, when you know that you haven’t been sexually active’.

In the early 1970s a 13-year-old girl was placed in State care when a court found that she was uncontrolled. She told the Inquiry that she often ran away from home to escape alcohol-related violence in the family. After various placements she was charged with a criminal offence and committed to Vaughan House. According to her SWIC she spent almost seven months there and absconded twice.

The PIC told the Inquiry that a male staff member would sexually abuse her by telling her to put her hand in his pocket to get lollies or cigarettes. His pockets would be empty but he would push her hand ‘through the holes in his pocket’ on to his genitals, forcing her to fondle him. She said she tried to report the abuse to a female staff member by telling her that he was ‘a dirty old man’. She was locked in solitary confinement for speaking in that way about a staff member.

She said that the same male staff member picked her up after she spent a weekend with her mother, pulled the car over while driving back to Vaughan House and tried to force her to perform oral sex on him. She said she didn’t want to and vomited on him. On returning to the home, she said, he made her wait at the front door until it was opened. She wet her pants while waiting. When she was eventually let in, she called the staff member names, and was locked up in a cabin as punishment.

The PIC told the Inquiry she was abused by another male staff member at Vaughan House. She believes he gave her an injection that caused her to black out for 72 hours. She believes she was raped while unconscious and said the staff member concerned was well known for giving the girls injections that caused them to black out.

She also told the Inquiry that the visiting doctor gave her an internal examination on three occasions. She said that it did not matter what illness the girls appeared to have, the doctor always conducted an internal examination while staff waited outside.

A 14-year-old girl was placed in State care until the age of 18 by court order as a result of criminal offences in the early 1970s. She told the Inquiry that before being placed in State care she was sexually abused by a family member and was beaten regularly by her stepfather. She recalled that after a teacher asked about her bruises, departmental workers spoke with her mother and stepfather at her home. Her mother committed her to an institution under a voluntary custody agreement, but she absconded. She then had various placements including Vaughan House, where she alleged she was sexually abused during her year-long stay.

She told the Inquiry she would hide her sheets when she wet the bed because the staff at Vaughan House would rub her nose in them. She also recalled spending a lot of time locked in the isolation cabins as punishment and claimed that when the girls misbehaved they were given injections to calm them down.

She alleged that a male staff member sexually abused her:

He used to come up and say, ‘Would you like a lolly?’ and you’d say, ‘Yes, I’ll have a lolly’. He’d say ‘Put your hand in my pocket’. A lot of times there wasn’t a lolly in his pocket.

She also told the Inquiry that while visiting her family home for a weekend she had a confrontation with an abusing family member and threatened to tell the police if he touched her again. She said that on her return to Vaughan House she was locked in her room for bad behaviour. She recalled smashing the window, cutting her wrist and being taken to a local doctor, who put 18 stitches in the cut. When she returned she was told to clean up the blood in her room. She refused and was again placed in solitary confinement.

The PIC also alleged that the visiting doctor sexually abused her:

You’d go to him, like, if you weren’t feeling well and you’d say, ‘I’ve got a headache’. The next thing you know he’d have you up on the bed and be giving you an internal.
She did not report any of the sexual abuse because 'we weren’t allowed to question anything. If we questioned things and didn’t like it, we’d get punished'.

Aged 16, the PIC was released from Vaughan House into the care of a male who had been taking her out and by whom she was pregnant. She lived with him for a couple of years before the relationship broke down.

Another PIC who alleged sexual abuse by a doctor at Vaughan House was placed in State care after being found by a court to be in moral danger and uncontrollable at 15. She told the Inquiry a relative had sexually abused her before she was placed in State care.

She said that while at Vaughan House she was sent to have regular medical examinations. The doctor would give her tablets, examine her breasts and give her an internal examination. She said that on one occasion he performed an anal examination, saying that if he had to do it again he would give her an injection for the pain.

She did not report the abuse to anyone:

It was embarrassing, you know. I didn’t know if he was doing it with other girls or, you know, giving them internals or that, and I was embarrassed by it so I never ever said nothing.

This PIC had two children before she was released from State care at 18.

A 16-year-old girl was placed in State care until the age of 18 for committing criminal offences in the mid 1970s. She told the Inquiry she had been sexually abused by her father before being placed in State care and had started stealing 'silly things like shoes and clothing' when she was 14. She alleged she was also sexually abused during a six-week placement at Vaughan House.

She told the Inquiry she was regularly examined by the doctor at Vaughan House, who

... would ask you to undress and he said, ‘I need to examine you’, and he’d lie you down on the examination bed and then he’d start pressing around your tummy area and that and slowly work his way around.

She said he digitally penetrated her while ‘he would rub himself with his other hand through his pocket’.

Abuse by staff and other residents

In the 1960s a court found a 17-year-old girl to be uncontrolled and placed her in State care. She told the Inquiry she had frequently run away from home because her father was violent. According to her SWIC she lived at Vaughan House for almost a year. She alleged that a doctor at the institution sexually abused her on several occasions. She claimed he forced her to undergo medical examinations that seemed unnecessary and intrusive and that he touched her inappropriately. She said: ‘I certainly didn’t tell my parents and I certainly [didn’t] tell any of the staff’.

She also told the Inquiry that two other female residents sexually abused her. She said that while they were in the shower one girl grabbed her around the throat while the other girl fondled her. She did not report this abuse because

... back then it was very hard to tell on someone … Because one, would you have been believed; two, was you just trying to cause trouble; and three, you’re only a welfare kid.

Abuse by other residents

In the mid 1940s an Aboriginal girl aged about four was placed in State care until she turned 18. A court had found her to be neglected and under unfit guardianship. The PIC alleged that a neighbour sexually assaulted her during a decade-long placement with a foster mother. She was placed at Vaughan House in the 1950s following a charge of being uncontrolled.

She recalled her first night at Vaughan House:

A couple of girls attacked me and I wondered what on earth was going on, because they had girlfriends and they wanted me to be their girlfriend. I went absolutely berserk. I was screaming and crying and so they came and got me and put me down in the cell. I was there for four days in the cell. I had no bed, the floor was the bed, and a bucket.
She said she did not report the attempted sexual abuse and was not given an opportunity to explain why she was so upset. As an adult, she said, she has ‘tried to block out a lot of those days’.

A 13-year-old girl was placed in State care until the age of 18 when a court found she was neglected and under unfit guardianship in the 1960s. She told the Inquiry that before being placed in State care she had been sexually and physically abused by a man known to her family. She also alleged she was sexually abused while placed at Vaughan House, Seaforth Home and in foster care.

The PIC was transferred to Vaughan House from Seaforth at the age of 14 for misconduct. She told the Inquiry that during her two-year placement she was sexually abused by two older girls who had been assigned to her as mentors and who had assumed total control over her. One or other of the girls would get into her bed at night and ‘… they used to sort of have sex with you with their hand’. She recalled that this occurred ‘pretty well every night’ and she believed ‘the matron and other staff knew it went on’. The girls would stay in her bed all night unless staff caught them. When they were caught, staff would place her, rather than the older girls, in a solitary confinement cell, which she described as a bare room with ‘not a thing in it, no beds, no blankets’. She also recalled being punished on one occasion by being made to stand at the foot of the bed of two female staff members while they had sex.

The PIC said that although her departmental worker visited Vaughan House, she did not report the abuse and does not know why. She considered telling a church worker, but thought she would just be told to ‘read your Bible and you’ll never go wrong’.

A seven-year-old girl was placed in State care in the 1960s after a court charged her with being neglected and under unfit guardianship. She told the Inquiry she was sexually abused by a family member before being placed in State care and that she was sexually abused while placed at Vaughan House, Seaforth Home and in foster care.

Her SWIC records that she was committed to Vaughan House in the early 1970s, when she was 13, after several placements in institutions and foster homes. Over the next two years she absconded from Vaughan House four times. She told the Inquiry an older girl sexually abused her at Vaughan House, and described the sexual assault as ‘being educated’ by that girl:

\[ I \text{ found that a lot of girls that came from there [Vaughan House] in the later years—even from Windana [Remand Home] and Seafort [Home]—ended up being either prostitutes or lesbian, or dead. } \]

She said she didn’t tell anyone about the abuse because she felt as though she didn’t have ‘a voice as a child’ and she was under the control of people who ‘get to do whatever they want to do with you, and you don’t have a say of anything’.

The PIC said that as a teenager she absconded from care facilities and foster homes and became involved in prostitution. She had a child at 17, while living in a foster placement. She told the Inquiry she had been unable to care for her young child due to her involvement in the drug scene:

\[ I \text{ thought I just couldn’t live off of love and that I want to do the best thing for her so I gave [her daughter] to the care of the welfare. } \]

She said her daughter committed suicide in her teens.

Abuse after absconding

A 12-year-old girl was placed in State care in the early 1970s by court order because she was neglected and under unfit guardianship. She told the Inquiry she was sexually abused while placed at Vaughan House and in foster care.

Her SWIC records that she was placed at Vaughan House for ‘safekeeping’ when she was 14. Her SWIC records that one month after being placed in a cottage home at Vaughan House, she absconded. The next record is three years later: ‘Released term expired’. The PIC told the
Inquiry that, while a runaway, she was sexually abused by an older man, with whom she travelled interstate. She said she became pregnant to the older man when she was 15 and living interstate. She said he physically abused her, causing her to miscarry. When she was admitted to hospital, he insisted that she give a false age to hide the fact that she was only 15. She said she became pregnant to him again and that he continued to sexually and physically abuse her. When she threatened to leave, the man told her, ‘Go on, leave. You’ll go in a home.’ She said she left him when she was 18 and returned to South Australia, pregnant and with her surviving child. ‘I knew [the department] couldn’t put me in a home then.’

Departmental records confirm the PIC had no contact with the department after absconding at 15 with an adult male.

Secure care for boys and girls

Windana Remand Home, 1965–75

History

Windana Remand Home, which took its name from an Aboriginal word meaning ‘which way’, operated from 1965 until 1975 on the grounds of the Glandore Boys Home. It provided a secure institution for children arrested by police and on remand, waiting to appear before the Juvenile Court. Windana also provided temporary accommodation for State children being transferred between institutions or foster care placements. Occasionally children were housed there for ‘safekeeping’.

Windana could accommodate up to 108 children aged from two to 18. Most children stayed for up to three weeks. Residents’ care and accommodation needs were assessed before they were transferred to other forms of care.

Reports on each child were issued; the standard report on the child’s time at Windana listed, under personal habits, ‘Homosexuality — present, absent, not known’. Also listed under ‘group participation’ and ‘relationship with younger children’ were ‘standing over and bullying’, suggesting that staff were required to assess the possibility of children being perpetrators of abuse on other children. Windana also had a school, which was run by a teacher from the Education Department. Children received religious instruction from visiting clergy and their recreation included sport, craftwork and hobbies. Parents and relatives were allowed to visit with the department’s permission.

Children admitted to Windana were interviewed by a senior officer and a social worker, and examined by a medical officer, usually within 72 hours of admittance. The institution’s operating procedures did not explicitly address sexual abuse but provision was made for the reporting of ‘significant incidents’ in an ‘incident book’.

In 1965 the deputy superintendent of Windana resigned after less than one year. He listed several problems, including staff shortages, and charged that the wide age range of boys, nine to 16 years, meant that: ‘The older boys have had direct influence homosexually on the younger boys’.

According to a 1966 annual report, despite the intention to separate children committed for different reasons: ‘The section for delinquent boys was consistently full or almost so throughout the year and it was necessary to accommodate many younger boys in the neglected boys section’. The department also reported that ‘occasionally children are accommodated for longer periods but this is considered to be undesirable’. During 1968–69 the institution was extended to provide more space for juvenile male offenders, but this did not solve the overcrowding problem.
In 1972, Windana became a remand and residential assessment centre for boys only. Girls on remand were sent to Vaughan House for assessment and neglected girls were cared for in the Glandore Family and Reception Cottage.\(^{120}\)

In December 1972 a memorandum, ‘The operation and use of restrictions as a control measure’, was sent to supervisors of remand and training centres. It directed all residential care staff to keep in mind that rewards and working with young people was often more effective than dictating and punishing. It set out the acceptable restrictions to be imposed on children, which included verbal reprimands, a report on the child’s file, forfeiture of privileges, ‘standing out’ for 15 minutes, or detention.\(^{121}\)

The latter—detention in a confinement cabin for up to eight hours—was the most serious punishment at Windana and could be imposed only by the superintendent. The main residential care worker checked the restrictions each day to ensure they were ‘consistent and just’.

A former staff member who gave general evidence to the Inquiry recalled that Windana was ‘a lock-up place and it was managed in that kind of environment … very disciplined, very strong controls over kids’.

Windana closed in June 1975 when changes to assessment procedures reduced the time spent on remand. The residential assessment process later took place at Brookway Park and the McNally Training Centre.

### Allegations of sexual abuse

Fourteen people gave evidence to the Inquiry that they were sexually abused while in State care at Windana. The sexual abuse, which was allegedly perpetrated by staff members and other older residents, included indecent assault, digital penetration, and oral, anal and vaginal rape.

**Abuse by multiple perpetrators**

In the late 1960s a 10-year-old girl was placed in State care until the age of 18, when a court found her to be neglected and under unfit guardianship after the death of her father. She told the Inquiry her mother was an alcoholic. According to her SWIC she spent two months at Windana and then went on to other placements, including foster care. She alleged she was sexually abused at Windana and in a foster care placement.

The PIC told the Inquiry that two Windana residents, a boy and a girl, attacked her in the toilet block while a man stood watching by the door. She recalled that one of the children held her down on the floor while the other vaginally penetrated her with an object. She said the man did not help her. After the attack, she remembered waking up one night, screaming, to find staff members sitting on her bed, including the man who had watched the attack. She did not know who the man was and could not say whether he was a member of staff. She said she suffered recurring nightmares and recalled ‘waking up and screaming, in like, a trance’ and feeling ‘petrified, absolutely petrified. I couldn’t understand why the hell I was there.’ She could not recall telling anybody about the abuse.

In the early 1960s a seven-year-old boy was placed in State care until the age of 18, having been found by a court to be neglected and under unfit guardianship. He told the Inquiry his father was violent towards him before he was placed in State care. He alleged he was sexually abused at Windana and Glandore Children’s Home.

According to his SWIC, he spent three months at Windana when he was 15 for an offence. He told the Inquiry a male officer sexually assaulted him every night by touching his genitals. The PIC said that when he resisted the officer physically assaulted him.

He also told the Inquiry he was sexually abused by one of the medical staff when he accompanied the man out of Adelaide for treatment. He alleged the man drugged him on the journey back to Adelaide and he woke to find the man anally raping him. He said he was too frightened to tell anyone.

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\(^{120}\) FYOW, s. 4, p. 70.

\(^{121}\) SRSA GRG 29/6, file no. 6/65/65, DCW, ‘Complaints, criticisms: administration of Brookway Park.’
The PIC told the Inquiry that in later years his behaviour became increasingly sexualised and he became involved in prostitution:

After a while being involved in this environment, because I had no love, you think in the long run that the sex part of it is love, so therefore it becomes a way of life and you don’t know any difference.

Abuse by staff

In the early 1970s a 14-year-old girl was placed on remand for three weeks at Windana and then into State care until the age of 18, after committing a criminal offence. She told the Inquiry her brother had sexually abused her before she was placed in State care. She alleged she also was sexually abused at Windana, Vaughan House and while living on the streets.

She said there was considerable racial tension at Windana between the white and indigenous girls:

Instead of locking up the Aboriginals, [staff] locked up the white girls because they had more cells for the white girls. I remember in Windana as being locked up a lot in the cells. We weren’t allowed out with the Aboriginals because they used to beat us up.

She alleged a female staff member sexually abused her while she was locked in isolation. She said:

She once gave me a head job and she used to play with my breasts. If I let her touch me I was all right. I got, like, privileges. If I didn’t let her touch me and I used to get upset and cry about it, then I used to get in trouble. She used to hit you really bad and hurt you. She ripped all my earrings out of my ears one day.

In the late 1960s a 14-year old girl was placed on remand by court order after committing criminal offences. One month later the court ordered she be placed in State care until the age of 18. She alleged that while in State care she was sexually abused at Windana, Davenport House, in foster care and in the family home. The PIC told the Inquiry that before going into care she had often ran away from home. She said her father was ‘a practising alcoholic’ who often beat her, and her mother instructed her to say she had fallen into a rose bush if anyone at school asked about the bruises.

The PIC’s SWIC shows she absconded two weeks after arriving at Windana. She told the Inquiry she was apprehended and put into solitary confinement for a week, and that an officer told her ‘they were going to break me if it was the last thing they did’. She also spoke about a partial memory of ‘nightly visits by an officer’ while she was in bed in the dormitory. She said that although she blanked most of it out, the memory still causes her fear. She said she suppressed a lot of other memories of being abused at Windana, which only recently have started to surface.

The PIC also told the Inquiry that two staff members, one male and one female, regularly strip-searched her after cleaning up from dinner. She recalled being digitally searched both anally and vaginally:

One day I asked why they did that all the time, and the female … just laughed and said, ‘Oh, well, you know, you might be hiding spoons in there’.

In the mid 1960s, a 13-year-old boy was placed in State care until the age of 18 after a court found he was neglected and under unfit guardianship. He said his mother had left him and his siblings alone for several days without money or food while she went out of town. His SWIC records that he spent three weeks at Windana before being placed at another institution.

He described physical punishments at Windana that included ‘cold showers’, ‘running around in the nude in the exercise yard’ and what was described by many PICs as ‘duckwalking’ which involved ‘walking up the corridor … squatting and hanging on to your ankles. Just keeping going up and down until you cried with burning pain.’
He told the Inquiry that one of the staff members regularly sat on his bed at night. The PIC said the man would place his hand under the bedcovers and masturbate him. He said the staff member also forced the PIC to masturbate him. If he resisted, the man would tighten his grip on the PIC’s wrists and threaten to put him in the cold shower if he did not do as he was told. The PIC said the staff member would pick boys randomly in the dormitory each night to repeat this abuse.

He told the Inquiry that as a result of the abuse, he felt throughout his adulthood that he has had to prove he is not gay. He finds talking about it very difficult. ‘I’ve spoken a fair bit about it with my mate and a little bit to my wife, and I don’t think it gets any better.’

Another male who gave evidence was placed in State care by a court as a result of criminal offending when he was 11 in the mid 1960s. He told the Inquiry he had been sexually abused by family members as a young child. He remained in State care until he reached 19 and said he was sexually abused at Windana, McNally Training Centre, Adelaide Gaol and Yatala Labour Prison.

The PIC was first placed at Windana when he was 13 and lived there at different times during the next four years. He alleged that two staff members anally raped him and subjected him to severe physical beatings. He said one officer in particular did this quite a few times. He also said he was forced to take medication that disrupted his coordination and mobility and alleged that he was subjected to electric shock treatment twice. He told the Inquiry he attempted to disclose the abuse. ‘I tried, honestly I did. … Then they put the machine back on to me to zap me again’.

One PIC said he and his siblings were placed at Windana in the mid 1960s. He was placed in State care when he was three and then spent three weeks at Windana in the mid 1960s for ‘safekeeping’. He recalled that ‘there was no food’ at home and his mother ‘used to stick me in the cot, close the door and leave the light on’. He remembered one occasion when his mother didn’t come to pick him up from kindergarten and he was left there until dark.

The PIC told the Inquiry he was sexually abused while placed at Windana and when he was on his own as a teenager.

He recalled that his father took him and his siblings to Windana. The Inquiry did not receive any departmental client files in relation to the PIC’s childhood, however one record of a member of his family states that the children were placed at Windana for ‘safekeeping’ for four weeks in the mid 1960s, when the PIC was about 4½. No court orders or written agreements appear in any documentation provided to the Inquiry in relation to the PIC’s time at Windana.
The PIC said that on the first day at Windana, while he was taking a bath, a male staff member asked him to give him a kiss. He said he kissed the man ‘like a normal child would give a person a kiss on the cheek’. The worker said, ‘No, not like that’ and told the PIC to stick his tongue out. Then he drew the PIC’s tongue into his mouth and bit it. When the PIC started to cry the worker ‘got quite upset and told my [siblings] to quieten me down, otherwise, and he made some sort of threat’. The PIC said, ‘The memory of my tongue bleeding and my crying hasn’t gone away’.

The PIC also told the Inquiry that one night he woke up to find someone getting into bed with him from behind. He remembered that the person placed a hand over his mouth—‘I could smell the tobacco on this person’s fingers’—and he could hardly breathe.

I was sort of pinned half on my side and half on my chest. I had excruciating pain after he put his hand over my mouth. I was just filled with pain. I thought I was having my legs sawn off … below the buttocks … I can still recall reaching down to see if my legs were still there.

The PIC told the Inquiry that he later spoke to someone about the incident and was told something like, ‘Don’t worry … he does that to all the new kids. He does it once or twice, and then he leaves you alone.’

The PIC alleged that he experienced a second incident, when he woke up to find someone

... pushing my face into the pillow to the point where I couldn’t actually breathe, and I guess I must have passed out because I guess I  white. … I believed I was going to die.

The PIC said the sexual abuse has ‘left me emotionally less than adequate for dealing with emotional issues’ and that it was ‘pretty difficult’ to come forward to the Inquiry.

A nine-year-old PIC was placed in State care in the late 1960s when a court found he was uncontrolled. He told the Inquiry he was sexually abused at Windana, Brookway Park and McNally Training Centre. He alleged that a night officer at Windana dragged him out of bed and forced him to do sexual things to him. The PIC said he was still too embarrassed and ashamed to further describe the abuse. He said he had not reported the abuse to anyone other than the Inquiry.

Abuse by staff and other residents

In the late 1960s, a 14-year-old boy was placed in State care by a court for committing a criminal offence. He told the Inquiry his father had sexually and physically abused him from a very young age. The PIC spent one month at Windana before his charge was dismissed. Later that year he offended again and was placed in State care until the age of 18. Over the next four years he was remanded to Windana for several brief periods for offending. He also lived at McNally Training Centre and Struan Farm School, and in foster care. He alleged he was abused in all of those placements.

The PIC’s initial impression of Windana was positive: ‘Being perfectly honest, at the start it was better than being at home.’ He told the Inquiry that later, however, he was sexually abused by both staff and other boys. He alleged that an officer arranged for him to be sent to the sick bay for several days: ‘I allegedly had spots all over me, but I’d had no spots.’ While the PIC was quarantined, the officer allegedly sexually abused him, including oral and anal sex. The same officer made him and other boys walk naked along the corridors like a duck for his gratification: ‘Basically, you squat down and you put your hands on the opposite ankles and you’ve got to go up and down corridors.’

The PIC also alleged an older boy forced him to have sex with him. He recalled informing a member of staff about the sexual abuse by both the officer and the older boy. The departmental files, however, did not contain any record of the allegations.
Chapter 3 Allegations of sexual abuse

Abuse by other residents

A PIC then aged 10 was remanded to Windana for one month in the mid 1960s because of criminal charges and then placed in State care until the age of 18. He was placed at Brookway Park, where he alleged he was sexually abused. During the 1960s he was placed at Windana several times while in State care and alleged he was also sexually abused there.

The PIC claimed that non-consenting sexual activity was common among the Windana residents. He alleged that other residents anally penetrated him and forced him to perform oral sex on them. He said ‘it went on all the time. I didn’t seem to have any choice. I was terrified.’ The PIC told the Inquiry that a member of staff was aware of the abuse. The PIC’s files do not contain any record of him being sexually abused.

A 12-year-old boy was placed in State care in the early 1960s by a court for criminal offending. He told the Inquiry his parents separated when he was about five and his father put him in several non-government homes before he was placed in State care.

He alleged he was sexually abused at Windana and then Kumanka Boys Hostel.

The PIC’s SWIC shows he was initially at Windana for about two months before being placed back with his mother. Six weeks later he was returned to the institution for ‘safekeeping’. The PIC alleged he was sexually abused by older boys at Windana who wanted him to masturbate them:

“They’d come over the wall and go, ‘Play with this or I’ll punch you out.’ Most times I very violently told them where they could go, and they figured it was easier to pick on someone else than pick on me.”

The PIC told the Inquiry that on one occasion two boys ‘beat the living shit out of me and forced me to masturbate both of them’. He said he did not report the sexual abuse because ‘nobody had the guts to tell the officers; they were too afraid of the consequences’.

Another PIC was 14 when he was remanded to Windana in the early 1970s on criminal charges. He said he had a very unhappy childhood with an abusive father and had been stealing for several years. ‘I was angry. I was doing things to hurt people.’ According to his SWIC, he spent three weeks at Windana before being sentenced and then placed in State care until the age of 18. Although he enjoyed going to classes at Windana, he recalled that ‘it was very foreboding. You really had the sense you were in a high security place.’

He told the Inquiry that one night a Windana resident asked him to perform oral sex on him in the dormitory. He refused loudly, a staff member heard the noise,

...dragged me out, pushed me up against the wall, punched me in the gut and slapped me across the face, or punched me in the face, and made me bleed there. He told me to shut up.

A 14-year-old boy was placed in State care by a court until the age of 18 after being convicted of criminal offences. He told the Inquiry he had started to get in trouble with the law after a stranger raped him, which ‘changed his life for the worse’. He alleged he was sexually abused while placed at Windana, Stuart House and McNally Training Centre.

The PIC said he was committed to Windana three times after absconding from Stuart House or committing offences. He alleged he was physically assaulted by staff and other boys, and described the punishment regime, such as forcing boys to stand with their arms out in front of them for long periods, as ‘ridiculous and bordering on torture’. He added: ‘If I did something wrong everybody would get punished, and so therefore I’d get bashed up’.

The PIC’s second placement at Windana, at the age of 15, lasted two weeks. As a result of his absconding he was placed in a section for older boys, who forced him to give them oral sex in the exercise yard, which was largely unsupervised. An older boy offered to protect him from the others in return for sex and so the PIC began ‘prostituting
for protection’. He said his only reprieve was when one particular officer was on duty. This man seemed to sense that something was going on and stayed close during his shifts. ‘I never got molested or anything when he was around.’

In the mid 1960s a five-year-old boy was placed in State care when a court found he was neglected and under unfit guardianship due to domestic violence in his family home. According to his SWIC, he spent five months at the Glandore Boys Home in the mid 1960s and two weeks at Windana in the early 1970s, when he was 10. The PIC told the Inquiry he was sexually abused at both placements.

He remembered feeling confused and upset and could not understand why he was sent to Windana when he had done nothing wrong. He said some of his siblings were sent to the same institution, but they were not allowed to see each other or have any contact. He told the Inquiry that ‘we used to masturbate the older boys … we were intimidated by the older boys then’.

He also told the Inquiry of his disappointment and distress at growing up without knowing some of his siblings, who were fostered out separately. He believes the government ‘wrecked our whole family’.

**South Australian Youth Remand and Assessment Centre (SAYRAC), 1979–93**

**History**

In 1979 Vaughan House was closed and replaced by the South Australian Youth Remand and Assessment Centre (SAYRAC). The centre accommodated boys and girls between the ages of 10 and 18. It had two units for girls on remand or undergoing training and two units for boys on remand. Children who had not committed an offence but were under the care of the department for their own protection also were accommodated at the centre for assessment. Staff from the Education Department provided instruction in music, craft and physical education. SAYRAC operated until 1993, when older offenders were transferred to a new purpose-built facility at Cavan and younger children were placed at Magill Training Centre.122

**Allegations of sexual abuse**

Four male PICs alleged sexual abuse while in State care and placed at SAYRAC—three by staff members and one by prisoners in a police station cell. The sexual abuse included indecent assault, and digital, oral and anal rape.

**Abuse by staff**

One PIC was first placed in State care in the mid 1980s when he was 12. Over the next six years he was the subject of various court orders as a result of being found to be uncontrollable and in need of care, as well as for offending. He told the Inquiry he was sexually abused at SAYRAC, Slade Cottage and Rose Cottage.

The PIC’s SWIC indicates he was placed at SAYRAC many times during his time in State care. He told the Inquiry a volunteer worker at SAYRAC regularly took him to his home, gave him snacks, and anally and orally penetrated him. The PIC did not report the sexual abuse because, he said, ‘no-one believed me back then because I was just a troublemaking kid’.

As an adult, however, the PIC reported the abuse to the police, who conducted an investigation. The alleged perpetrator was still actively involved as a volunteer with youth programs and worked with children.

The department determined that, due to the volunteer’s poor health, the risk to children was ‘probably, but not necessarily, low’. The department sought legal advice and then advised the alleged perpetrator of the allegations; he stopped his involvement with the department pending the outcome of the police investigation.

The volunteer informed the department that he suffered from a serious health problem that had prevented him from being sexually active for some years. The police

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122 FYOW, s. 4, p. 59.
investigations revealed that the volunteer had a criminal history and was an associate of a known paedophile. The departmental records show the police were willing to follow up the PIC’s initial statement, however the PIC was unable to attend further police interviews due to health problems. Because of this, the police lacked sufficient evidence to proceed and closed the investigation.

Because the allegations concerned a departmental volunteer, the department’s Special Investigations Unit (SIU) was required to conduct an internal investigation into the department’s knowledge and checking of the volunteer. This investigation revealed that another man who identified himself as a victim made allegations against the volunteer in 1998 and other allegations about the volunteer’s improper contact with children had been raised in 1991. The SIU questioned whether any police background checks had been done on the volunteer. A staff member of the department’s Youth and Juvenile Justice section advised the SIU that records did not show that a background check had been done. The SIU raised concerns that the 1991 allegations ‘were never investigated’ and that internal investigations of the 1998 matter failed to discover the volunteer’s criminal history and his links to a known paedophile. The alleged perpetrator resigned during the internal investigation.

Another PIC became involved in petty crime as a young teenager in the 1980s after escaping from a violent home life. At 15 he was charged with stealing and remanded by a court to SAYRAC. He subsequently was sent to other places of care.

The PIC alleged that a night officer at SAYRAC molested him every couple of days. ‘He frisked me and then he’d, like, play with my genitals and feel my arse. It was fucking terrible.’ The PIC told the Inquiry that ‘I was a troubled kid. No-one could fucking work out what was wrong with me.’ He said he did not report the abuse.

A n Aboriginal PIC was placed in State care in the early 1990s as a result of criminal offending. Departmental records show that from the age of 12 he was in constant trouble with the law and appeared in the Children’s Court on multiple charges often involving illegal use of a motor vehicle. He was frequently remanded on bail or in custody and spent several periods in secure youth detention centres. Departmental records show the PIC was remanded to SAYRAC for assessment when he was 13. He alleged he was sexually abused at SAYRAC and the Magill Training Centre, in between periods of detention and while living on the streets.

The PIC alleged that two older female residents at SAYRAC regularly forced him to have sexual intercourse with them and threatened to harm him when he told them to stop. The PIC said it was his first sexual experience: ‘I felt like I was … violated sort of thing.’ He thinks he told a youth worker about the abuse but he recalls that the worker ‘sort of just laughed’. Records received by the Inquiry, however, did not note any report of sexual abuse alleged by the PIC at SAYRAC.

After his release from SAYRAC the PIC continued to commit offences, which progressed from stealing cars to breaking into shops and stealing.

*Most of it would have been, I think, a cry for attention … I was dragged back into Magill Training Centre easily within about three months. Everyone I’ve known from SAYRAC was in Magill and everyone I knew in Magill was at Cavan and everyone I met in Cavan that knew me from SAYRAC was in the remand centre and Yatala.*

He said he became involved in prostitution as a teenager.

**Abuse by outsiders**

A n 11-year-old boy was placed in State care in the late 1970s due to offending. He told the Inquiry he was sexually abused at SAYRAC, the Northern Region Admission Unit and Slade Cottage.
The PIC described SAYRAC as a place where staff ‘could do whatever they wanted to you’. He said he initially was trusting of others in institutional care ‘but that soon diminishes’.

The PIC recalled being transported from SAYRAC to a police station for processing on offending charges when he was 13. He said he verbally taunted police, who placed him in a cell with adult males. He alleged that these men told him, ‘We haven’t had young meat for a while’, and that they digitally penetrated him and forced him to perform oral sex on a prisoner.

The PIC believed that he disclosed this abuse on his return to SAYRAC. The Inquiry received evidence showing that the PIC was detained in SAYRAC at the time of the alleged incident but there were no SAYRAC records which noted a report of sexual abuse by the PIC. The PIC told the Inquiry: ‘You lose interest when you tell people, and nothing is really done about it. You’re trapped in a system’.

### Secure care for adults

**Adelaide Gaol (1841–1988) and Yatala Labour Prison (1854–present)**

#### History

The Adelaide Gaol opened in 1841 and was the main prison in South Australia accommodating male and female debtors and felons. It was a place of retention rather than correction so that prisoners whose sentences were longer than seven years were transported to other colonies. However, such transportation was abolished in 1852 and, as a result, Yatala Labour Prison was established to provide such additional accommodation. Yatala continues to operate today as a high to medium security institution for male prisoners.

#### Allegations of sexual abuse

One male PIC gave evidence that he was sexually abused while detained in adult prisons.

**Abuse by staff and other residents**

The PIC was placed in State care after offending as an 11 year old in the mid 1960s and was not released until he turned 19. He told the Inquiry he had been sexually abused by family members as a younger child. He also alleged sexual abuse at Adelaide Gaol, Yatala Labour Prison, Windana Remand Home and McNally Training Centre.

The PIC told the Inquiry he was transferred to Adelaide Gaol from McNally because he had escaped so many times. His SWIC does not reflect an admission to Yatala and is unclear about an admission to Adelaide Gaol. He alleged that a group of inmates at Adelaide Gaol forced him to perform oral sex on them and then analy raped him in the shower block. He also alleged that two officers raped him at Adelaide Gaol, but he did not give details of the abuse.

In addition, he alleged he was beaten and analy raped by two police officers before being taken to Adelaide Gaol. He claimed the abuse took place in a padded cell at police headquarters where ‘you can bash and do anything, but you can’t hear nothing’. He recalled that the police officers involved took their badges off to avoid identification.

The PIC also told the Inquiry that inmates and staff at Yatala Labour Prison sexually abused him. He alleged that

> I asked for the screw, who hit me across the head, split my head open … so I’m lying down, bleeding from the head, plus I’m bleeding down my arse.

He said he was taken to the prison hospital, where a doctor treated his injuries, but he did not report the abuse. He said that boys were threatened to keep quiet about things that went on inside the institutions and prisons:

> The reason the public don’t know is that the kingpins in there [say] ‘you open your mouth, you’re dead.’ … so what happens to the poor kids in there, stays in there.

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Evidence given to the Inquiry demonstrates that from the 1940s to 2004, children in State care have been sexually abused regardless of their age, gender, race or the type of placement, whether large congregate care in institutions, smaller group care, residential care units, foster care, secure care or the family home. The evidence from people who were children in State care (PICs) shows that the State must

- implement strategies to prevent such sexual abuse
- provide an environment to encourage children in State care to disclose
- respond appropriately when disclosures are made.

Only in recent decades has child protection assumed prominence as a community and government issue. Even so, child protection measures initially emphasised physical rather than sexual abuse and tended to cover all children; it was not until the 1980s that children in State care were identified as a distinct group.

In 2003, the Layton report made some recommendations concerning children and young people in State care, as well as many recommendations for the overall child protection system. In the following year, the State Government released its policy for the reform of the child protection system and, in 2005 and 2006, published its reform agenda dedicated to children and young people in State care. As the first specific South Australian Government policy in child protection, the reform agenda is a significant development and a sign of positive change.

Despite this, there is still much to be done to recognise and repair the human damage inflicted and to rebuild confidence in the State’s system of caring for and protecting the children under its guardianship. The momentum and goodwill evident in the improvements to government policy must be maintained and underpinned by the necessary resources. It is hoped that the evidence from this Inquiry will inform the State about the sexual abuse of children in its care, and result in important additions to its reform agenda, along with sufficient resources to fund them.

Child sexual abuse

As set out in the submission from Relationships Australia (SA), reports and studies from as early as the 1950s demonstrate that child sexual abuse is a significant international problem, even taking into account the lack of standardised data collection. Overseas studies estimate that prevalence rates range from 20–35 per cent for females and 7–20 per cent for males; Australian studies put the incidence at 20–27 per cent (females) and about 16 per cent (males). In Indigenous communities, studies describe an ‘epidemic’, at rates far exceeding those for other communities.

1 The Inquiry relates only to conduct before 18 Nov. 2004, see terms of reference (3), schedule 1.2
2 Department of Human Services 2003, Our best investment: a State plan to protect and advance the interests of children, report prepared by Robyn Layton QC, DHS, Adelaide.
3 Department for Families and Communities (DFC) 2004, Keeping them safe.
4 DFC 2005, Rapid response: whole of government services for children and young people under the guardianship of the Minister; DFC 2006, Keeping them safe – in our care.
non-Indigenous communities.  

Research shows that most perpetrators of childhood sexual abuse are adult males, although there is growing awareness of abuse by siblings and males under 16. Most offenders also engage in multiple offences, against more than one child.11 The Relationships Australia (SA) Respond SA helpline for adult victims of child sexual abuse reports that the vast majority of perpetrators were immediate and extended family members (77 per cent), followed by acquaintances and authority figures whom the child knew and was encouraged to trust (14 per cent) and the remainder were strangers, members of clergy and residential care workers.12

To ensure the child keeps the sexual abuse a secret, perpetrators use various tactics, from threats, bribes, punishment and blackmail to the more subtle process of gradually gaining their trust by ‘grooming’, which involves treating them as someone special and giving them gifts and compliments. These tactics can lead to a great deal of confusion in the child’s mind about what constitutes abuse and who is responsible. A common tactic in regard to intrafamilial abuse is to create alienation in the mother–child relationship by telling the child that the mother is inadequate, unloving or in some way bad or fragile.13

The debilitating effects of child sexual abuse can continue throughout adulthood, especially if the secret is kept by the victim or disclosure is met with an inappropriate or inadequate response. A practitioner working with child victims of sexual abuse told the Inquiry:

The psychological impact has the ongoing impact on the rest of their lives … there is a particular problem with sexual abuse of children, and that is the secrecy with which it’s engaged … [the victims] internalise the responsibility for it faster than children with other forms of abuse … I think that’s partly because they don’t tell anybody so they carry it for longer alone.

There was debate among the various experts who gave evidence to the Inquiry about the science of explaining the effects of child sexual abuse and the diagnostic labels for the symptoms. However, they agreed that although the effects of child sexual abuse vary, it often has significant lifelong consequences, especially if appropriate immediate treatment is not provided.

### Sexual abuse of children in State care

The evidence to the Inquiry from 242 people demonstrates the grim reality that many South Australian children were sexually abused while in State care from the 1940s. During the past eight years in Australia, there have been several investigations of the historical abuse (including sexual) of children in care. The reports indicate the prevalence of abuse among this particularly vulnerable group of children.

Dr Jan Breckenridge, director of the Centre for Gender-Related Violence, University of NSW, told the Inquiry:

... kids in care are absolutely a captive audience for people who are interested in sexual relationships with children. I think that when you’ve got male and female children who have been abused before ... may not be given a lot of credibility by other staff. They may have even disclosed and not been

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9 Referred to in J Breckenridge et al, Respond SA evaluation report. DPC WA Putting the picture together; OSW Non-reporting and hidden recording of sexual assault; NT Govt Little children are sacred, p. 16.


11 Relationships Australia (SA) submission, Apr. 2007, p. 9, citing its own client data from Respond SA; and citing Kelly, Regan and Burton (1991), which estimated that 85 percent of peer sexual abusers and 95 percent of adults who sexually abuse children were male; and citing a Canadian study (Abel et al. 1995), which found that convicted male sex offenders reported an average of 533 offences and 336 victims each. This is consistent with Laing’s data from the New South Wales Pre-trial Offender Diversion Program (1999).

12 Relationships Australia (SA) submission, p. 9; information covers the period July 2004 – June 2006.

13 Ibid., p. 10.
believed in the past. It’s very easy to take advantage of their situation.

In 1999, the Forde Inquiry reported on the abuse, mistreatment or neglect of children in Queensland institutions. It heard what it described as repeated reports of physical and sexual abuse in government and non-government institutions over decades, resulting in irreparable damage to lives. It heard complaints of sexual abuse perpetrated either by other residents, staff or visitors to institutions, with many victims saying their disclosures of abuse were met with disbelief and often punishment.14

The Forde Inquiry also found that children with a history of abuse are ‘especially vulnerable to further abuse and neglect’ in out-of-home care (when a child lives in a care placement away from the family home) and may be reluctant to complain if earlier disclosures were not believed or kept safe.15

In January 2004, the Tasmanian Ombudsman’s interim report on the abuse of children in State care16 found that sexual abuse accounted for 25 per cent of abuse in out-of-home care. In June 2006, the final report stated that 189 adults had made claims for compensation based on their sexual abuse as children in State care.17

Also in January 2004, the Crime and Misconduct Commissioner reported on the abuse of children in foster care in Queensland18, which included allegations of sexual abuse.

The Commonwealth Government, in its Forgotten Australians (2004) report on children who had experienced institutional or out-of-home care19, received ‘extremely graphic and disturbing descriptions of sexual abuse and assault on girls and boys by a wide range of perpetrators’. The report described the abuse as ‘widespread’ and covering all States and types of institutions (government and private, including religious), as well as foster care.

Perpetrators included other older children, however most perpetrators were staff members, including religious and lay, or adult workers.

Dr Jenny Pearce, Professor of Young People and Public Policy, University of Bedfordshire, gave evidence to this Inquiry about the experience in the United Kingdom. She said she believed sexual abuse figures for children in care are ‘high’ because

… a large number of the young people who come into local authority care are there because they have been sexually abused previously, and often it’s a repeating pattern, that the young person is vulnerable to further sexual abuse because they have already been sexually abused. The sexual exploitation context of sexual abuse, which often is linked with young people who run away from care, is high.

The role of the State Government in child protection

The 20th century

As mentioned, the State Government has long played a role in protecting children. The Children’s Protection Act 1899 outlined penalties for neglecting or ill-treating children. Government inspections of institutions and foster homes for ‘destitute’ children were mandated in the State Children Act in the early 20th century, however monitoring of these children was often irregular or inadequate.

Government reports of the period downplay the mistreatment of State children; one annual report suggests that ‘any State child who is not well treated for more than four months … only has himself to thank’.20
Until the 1960s there were no standard government procedures for preventing sexual abuse of children in State care, or supporting and responding to disclosures, which led to an ad hoc approach. Government employed a range of possible responses, including removing the victims or child perpetrators from placements, firing or transferring staff perpetrators, closing institutions, or revoking foster care licences. In extreme cases of persistent allegations of abuse, institutions were closed; for example, Kurbingai Hostel in 1962. Sexual activity among children in institutions or foster care was viewed as ‘sexual perversion’ or ‘subnormal sexual misconduct’ requiring psychiatric treatment or punishment. There was rarely an appropriate therapeutic response for the child.21

The issue of child protection assumed increasing prominence from the 1960s. The Social Welfare Advisory Council, created in 1966 as part of the Social Welfare Act, prepared for the Minister the first official departmental report into non-accidental physical injury to children. The report advocated a register of all cases of maltreatment and called for the introduction of reporting of abuse. In 1969, amendments to the Children’s Protection Act provided for mandatory reporting for the first time.

Following the Community Welfare Act 1972, a central register of reported cases of abuse was established and was maintained in the department’s research unit. The first departmental report recognising sexual abuse as a form of non-accidental injury was issued in 1976. In the late 1970s, the department formalised its procedural response to child abuse, which defined non-accidental physical injury or maltreatment as including sexual abuse. In 1979, the department issued a child abuse resource manual to staff, which contained one article on sexual abuse.22

A departmental report into child sexual abuse prepared for the Minister in the early 1980s23 argued for increased staff training relating to child abuse and recommended that the definition of ‘maltreatment’ in the Community Welfare Act be amended to include ‘sexual abuse’. It was the first report to discuss State children as a distinct group. The department also introduced educational and preventative programs, operated child protection panels in metropolitan and country areas, and devoted a specific section in its annual reports to child protection.24

Several bodies investigated child protection in the 1980s. From 1981, the Children’s Interest Bureau conducted research into physical and sexual abuse and lobbied for independent advocacy for children. The inter-agency Child Sexual Abuse Task Force (1984–86) recommended coordination across agencies, expeditious legal processing, community education and therapeutic residential care for vulnerable children. Another department-commissioned report (Bidmeade 1986) advocated the appointment of a commissioner to promote children’s rights both at the systemic level and in specific cases. The South Australian Child Protection Council (1987–95) reported to the Minister and a joint Health and Welfare Child Protection Unit was established among several government agencies.25

In the 1990s, the focus was on protection of children generally, with little specific reference to children in State care. A 1991 Select Committee on child protection reported that many issues identified in previous studies still required action. The Children’s Protection Act 1993 extended the types of people required to make mandatory notifications and established a Children’s Protection Advisory Panel as a statutory body.26 In response to the Act, the department initiated several procedural changes, including the development of new procedural guidelines, new training courses for staff and efforts to increase inter-agency coordination.


Chapter 4 State response

The South Australian Child Abuse Prevention Strategy (1996) focused on all forms of child abuse and issued 17 recommendations dealing with community involvement, resources, education, accountability and children’s rights. The department revised its child protection response practices, developed a central intake service for reports of child abuse and instituted a multi-tiered risk assessment system. Many advisory committees, including the Children’s Interest Bureau, recommended a focus on children in State care. In response, the Minister acknowledged that children in State care were particularly at risk of sexual exploitation, and should be empowered ‘to raise issues or make complaints’ and educated in protective behaviour.27

2003: Layton report

The next major review of child protection in South Australia, undertaken by Robyn Layton QC in 2002–03, had a broad community focus as its terms of reference. Layton’s report (Our Best Investment, 2003) made 206 recommendations spanning government agency practices, justice system reforms, public education, screening and monitoring of workers involved with children, and legislative reform. Several recommendations addressed sexual abuse28, while others dealt with physical and emotional abuse.29 A chapter30 on children in State care noted expert opinion that these children have ‘much higher levels of need’ than children in general. The report recommended the appointment of a Children and Young People Guardian31 to focus on the more than 1200 children under the guardianship of the Minister, stability in care placements32, a ‘whole of government’ approach to case management33 and transitional arrangements for young people leaving long-term care.

2004: Keeping them safe – State response to child protection

In May 2004, the government responded to the Layton report with Keeping them safe: the South Australian Government’s child protection reform program. It was introduced as the government’s ‘bold program to reform our child protection services and systems’, articulating ‘the policy choices we have made’. It recognised that ‘the system has, in some areas, fallen out of step’ and that ‘our key agency responsible for child protection lost capacity when it was subsumed in the Department of Human Services and it lost its way’.

Keeping them safe noted that during the previous decade there had been increasing notifications of suspected child abuse and neglect, including sexual abuse, on a national basis. As a result, resources were so overstretched that it ‘has become untenable and puts at risk our capacity to keep children safe’ and ‘the child protection system has reached a point where it is no longer sustainable to continue without significant change to the current practices’. The government stated that ‘the need for change is indisputable and our commitment to change unequivocal’; ‘there is now a need for a fundamental culture change and a new sense of direction’.

The reform agenda referred specifically to the ‘Minister’s children’, acknowledging that they ‘often are missing out’. It stated that many guardianship children do not have an allocated caseworker or a case plan and have not been given a baseline medical, dental or educational assessment. It gave undertakings in various areas, including improvements to case planning and review processes; complaint mechanisms; special investigation processes; individual plans in education; transition for young people leaving care; and support, training and consistent payments for foster carers.

29 ibid., recommendations 22–23.
30 ibid., ch. 12.
31 ibid., recommendation 4.
32 ibid., recommendation 68.
33 ibid., recommendation 67.
2005: Rapid response – State response to protection of children in State care

In October 2005, as part of Keeping them safe, the government released Rapid response: whole of government services, which focused on children in the care of the Minister. The document recognises a need for change, confirming that “it is widely recognised that children and young people removed from their family of origin have much higher levels of need than other children”. As part of its discussion of general reforms, the document also covers sexual abuse, including prevention and the State response to its disclosure. The document says it is likely that children and young people in care have suffered “serious developmental delays or significant trauma associated with physical or sexual abuse and neglect” or “serious dysfunctional family relationships or abandonment”. The development of this reform agenda involved a working group and an across-government guardianship steering committee, plus consultation with services providers, young people under guardianship and two Guardianship Regional Service Network projects (southern and northern regions).

In December, the government released Rapid response progress report 2007, which summarises progress made by various departments in implementing the reform agenda.

The Rapid response reform agenda includes five main strategies with corresponding recommendations.

Strategy 1 – to provide a system of robust management, case planning and review. Recommendations included:

- completing and implementing a case management model that takes into consideration the cultural and spiritual needs of Aboriginal children and young people (recommendation 1.1) and complements the case management models used by Disability Services (1.2)
- CYFS (Children Youth and Family Services) to endorse and implement the Life Domain Tool as part of the case planning process (1.3)
- formalising case planning every six months (1.5), with children and young people to participate and be informed (1.4)
- making [each child’s] statutory annual review open to external examination by the Office of the Guardian (1.6)
- permitting all children and young people to view the contents of their case file (1.7).

Rapid response noted that by June 2005, CYFS had started developing a case management model to “facilitate a consistency of approach to managing the needs of children and young people under guardianship within DFC [Department for Families and Communities] and other agencies”. It reported that the Life Domain Tool (1.3) was awaiting endorsement/implementation and that the Guardian was attending, at a minimum, six annual reviews a quarter (1.6). While Families SA noted in the December 2007 progress report that it was still undertaking “a major service and practice reform” through its new case management system, it did not specifically address how that model was taking into consideration the cultural and spiritual needs of Aboriginal children and young people (1.1) and the models used by Disability Services (1.2). It also did not address the implementation of recommendations 1.3–1.7 since June 2005.

Strategy 2 – to increase the capacity of the system to provide psychological, developmental, physical health and educational assessments. Recommendations included:

- increasing the capacity of CYFS psychological services to ensure a comprehensive court-ordered assessment with input from school staff (2.1)
- relevant staff from schools to provide input to CYFS psychologist to assist in assessment (2.2)
- CYFS psychologists to provide strategies to education staff to work effectively with children and young people (2.3)
- direct involvement of Aboriginal education coordinators (2.4)

34 DFC, Rapid response.
35 ibid.
36 The Life Domain Tool is a mechanism for social workers to gather information from young people and others involved in their care and use that information in case planning. There are eight domains to be considered: Placement/relationships with caregiver family; connections with family/kin; education and employment; health; identity; emotional, behavioural; social skills and peer relationships; and life skills.
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- creating a register of general practitioners with specific interest in child development, abuse and neglect, who are willing to provide basic health assessment when entering care (2.5, see also 3.2)

- DECS [Department of Education and Children’s Services] to actively support children and young people in community sport and recreation (2.6).

Rapid response noted that at June 2005 no progress had been made towards ensuring that all children and young people coming into care had their psychological and developmental needs assessed (2.1) because of difficulties in filling existing vacancies in psychological services. CYFS was identifying a range of workplace strategies to address the issue. It was reported that the Department of Further Education, Employment, Science and Technology (DFEEST) and CYFS were working to involve DFEEST’s Aboriginal education coordinators in assessment and case planning for young Aboriginal people (2.4); and that engagement in physical education and recreation (2.6) is specifically targeted in individual education plans. The Children, Youth and Women’s Health Service was reported to be working with various organisations to explore how to establish lists of general practitioners (2.5) as a matter of priority.

In its 2007 progress report, Families SA reported that since it had established a separate business unit, Psychological Services, in late 2005 the recruitment and retention of psychologists had improved ‘markedly’. It stated that the unit provided family assessments, baseline psychological assessments, consultation services to Families SA non-psychological staff, training on psychological issues and some therapeutic intervention. The department did not specifically address whether all children and young people coming into care now had their psychological and developmental needs assessed (2.1) or what progress had been made in relation to 2.3. DECS did not report on 2.2 or 2.4 and DFEEST did not report on 2.4.

**Strategy 3** – to increase the capacity of the system to provide services required by children and young people under guardianship through all relevant government departments. Recommendations referred to:

- therapeutic services, psychological (3.1), including giving priority attention to a more assertive response to the therapeutic needs of children and young people; health regions to support foster carers to provide effective and responsive parenting; increasing the number of Families SA psychologists to enable them to provide therapeutic services; health regions to arrange for the transition of young people to adult mental health services, where required

- medical and allied health services (3.2), including annual health care plans for children under guardianship and a recording system to enable easy transfer of information between health agencies

- country services (3.3), requiring health regions to manage the health response to children and young people in their geographic boundaries

- hospitals (3.4), requiring hospitals to develop and implement a policy of rapid response within hospital units and developing an identifier for children and young people under guardianship

- dental services (3.5), requiring SA Dental Service (SADS) to develop and implement a policy to provide priority access for orthodontic treatment

- disability services (3.6), including the requirement that the Intellectual Disability Services Council (IDSC) and Novita Children’s Services will, as a priority, accept referrals from CYFS psychologists

- education (3.7), including identifying guardianship status in schools, developing individual education plans, data tracking education outcomes, using suspension/exclusion from school as the last resort, involving Aboriginal education coordinators in the education needs of Aboriginal children and young people, and waiving TAFE fees
4.1 State response to sexual abuse of children in State care

- recreation and sport (3.8), facilitating participation
- preparation for successful transition from care to independence (3.9).

Rapid response noted that at June 2005, in relation to 3.1–3.5, health regions had extended therapeutic services to children and young people involved in the child protection system; Child and Adolescent Mental Health Service (CAMHS) Southern Region was providing additional direct services with children and their families between the ages of two and 12 where abuse had been confirmed and the child was under guardianship; Child Protection Services was providing direct intervention with children aged two to 12 (some of them under guardianship); CAMHS, Inner Southern Community Health Centre and Child Protection Services were providing training for foster parents and schools on the needs of children under guardianship; CAMHS Northern Region was creating a liaison position for CYFS officers to provide consultation and informal training on mental health issues to CYFS staff; therapeutic groups for children under guardianship had been negotiated with CYFS; and a small number of youths between 16 and 18 were receiving counselling through the newly established sexual assault counselling service.

In relation to country services, it was reported that the Port Augusta and Whyalla hospitals and the South East Regional Community Health Service were giving informal priority to guardianship children. It was also reported that the SA Dental Service had been prioritising access by guardianship children to orthodontic services and dental clinic services for the previous 12 months.

The 2007 progress report noted, regarding 3.1–3.5, that the health regions and Families SA had released in that year a set of health care standards to clarify what children and young people under guardianship and their carers could expect from the health sector. Health regions had made an initial health assessment available to all children and young people within two months of being placed in care and an assessment practice guide had been distributed to Families SA staff. Also, a small pool of private medical specialists experienced in abuse and neglect had agreed to bulk bill for services provided to guardianship children. A protocol also had been developed to facilitate the transition of children and young people in care to adult mental health services where needed.

The Children, Youth and Women's Health Services (CYWHS) reported that data exchange between the Women's and Children's Hospital (WCH) and Families SA to identify guardianship children was complete, enabling the hospital to provide the department with monthly reports, as well as automatic information on inpatient and emergency presentations. The Central Northern Adelaide Health Services (CNAHS) and Southern Adelaide Health Services (SAHS) had each established a working party to implement various matters, including data and information exchange with Families SA.

Country Health SA (CHSA) reported that it had taken the lead role in implementing these reforms across country health units, including ensuring that the units were aware of Rapid response obligations and participating in information sessions. The next stage was reported to be the development of checklists and compatible information technology systems to assist in identifying and providing services to guardianship children.

The SA Dental Service had agreed to develop and implement a policy to prioritise orthodontic treatment for guardianship children who met certain criteria.

The 2007 progress report noted, in relation to 3.6, that the Office for Disability and Client Services (ODACS) had created a Central Intake team to provide immediate information and support to the individual and/or their family being assessed, with guardianship children given the highest priority. Also, ODACS reported its commitment to ‘engaging Families SA in the delivery of service improvements’ with the release of its Joint service review for children and young people with disabilities under the guardianship or care of the Minister.
In relation to 3.7, DECS noted in the 2007 progress report that training in individual education plans was provided to 1500 people from DECS and Families SA in 2005 and was also being given to preschool directors and DECS district early childhood initiative coordinators. It reported that about 62 per cent of students had an individual education plan.

As well, DECS had adapted its database to record details of children and young people under guardianship so that schools were aware of the guardianship status, the Families SA district centre and the name of the caseworker. DECS had presented information about its discipline policy to 750 Families SA staff and delivered a training program, ‘Working with students at risk’, to 300 educators, primary school counsellors and leaders. It had provided SMART (strategies for managing abuse-related trauma) training to 60 Families SA youth workers and residential care workers from Community Residential Care and Families SA houses; to preschool staff; and to staff working on Aboriginal lands.

Also, in relation to career planning, school counsellors were providing advice, assisting students to complete their transition plans and liaising with TAFE where necessary.

DFEEST reported that fees would be waived for students who embarked on their negotiated training and employment plan before their 26th birthday. Along with automatic entry into preparatory education or non-competitive courses, five per cent of places in competitive courses would be quarantined for guardianship students.

In relation to 3.8, the Office for Recreation and Sport stated in the 2007 progress report that it encouraged organisations in the industry to apply for funding to conduct programs for guardianship children and young people. It funded the Service to Youth Council and Baptist Community Services, and also gave financial assistance to a young person in foster care.

Housing SA noted in the 2007 report that, in relation to 3.9, it had developed with Families SA and Disability SA an agreed housing services referral/access model for young people transitioning from guardianship to independent living. Service delivery guidelines had been developed and it had been using guardianship as an indicator on application forms since July 2006.

**Strategy 4** – to increase information sharing and continuity of information relevant to the child’s and young person’s education, health, wellbeing and life opportunities.

Recommendations included:

- a sharing agreement between agencies for relevant information on children and young people under the guardianship of the Minister (4.1)
- guidelines on the transfer of records between agencies on health and educational history, assessments, interventions and expected outcomes (4.2)
- CYFS case managers to keep accurate and up-to-date records of the child’s or young person’s health, educational and family history (4.3)
- the consent of the child or young person to be sought when disclosure of sensitive personal information is contemplated (4.4)
- informing the child or young person of the purpose and occurrence of any medical, psychological or additional educational support services and appointments by the CYFS case manager or carer (4.5)
- CYFS to provide carers with the level of information necessary for them to provide effective and safe parenting for the child or young person in their care (4.6)
- information to be shared with the child or young person in a way that is respectful to them and is appropriate to their age and development (4.7)
- the development of an electronic information and recording system to enable the easy transfer of information between health agencies and CYFS (4.8)
In 2006, the government released its Information sharing and client privacy statement: For children and young people under the guardianship of the Minister.37 In the 2007 progress report, Families SA noted in relation to 4.2, 4.3 and 4.8–4.10 that it was reforming its case management system and one of the outcomes would be links to key agencies in education and health.

**Strategy 5** – to adopt collaborative, holistic, multi-agency regional service networks responding to children and young people under the guardianship of the Minister.

Recommendations included:

- establishing the regional guardianship service networks (RGSN) (consisting of agencies that provide services to children and young people under guardianship) within regional geographical boundaries (5.1)
- where appropriate, linking existing networks in order to avoid duplication of the RGSN (5.2)
- RGSN to establish a memorandum of understanding detailing their commitment to Rapid response (5.3)
- agencies providing services to children or young people under guardianship to develop policies and guidelines that are responsive to their needs (5.4)
- each agency represented on the RGSN to articulate a rapid response in their service agreements (5.5)
- RGSN to ensure that their regional service system remains responsive to the needs of children and young people under guardianship.

In its December 2007 progress report38, Families SA reported that it had established three guardianship service coordinator positions (one for each region) to lead the development of the RGSN. It also reported on the progress of two networks, including the northern region, which has launched its Working together agreement for children and young people under guardianship, which has been signed by the South Australia Police, various health services, SA Dental Service, DFEEST, Drug and Alcohol Services, Families SA, Housing SA and Disability SA.

2006: *Keeping them safe – in our care:* State response to protection of children in State care

In September 2006, the government released *Keeping them safe – in our care: draft for consultation*. It related specifically to children in State care, and stated that: ‘We have not always taken on board what we have learned as a nation from major inquiries like the Forgotten Australians and Bringing them home: the stolen generation and what we are learning now from the Mullighan Inquiry in South Australia’.39 It set out eight actions, each divided into ‘principles’, ‘what we know’ and ‘what we will do’. They were:

- Stronger families
- Care planning
- Care packages
- Getting it right for Aboriginal children
- Connected care
- Children with complex care needs
- Valuing foster carers and foster parents
- Residential and leaving care.

In May 2007, the government released *Keeping them safe – in our care: consultation responses*. The consultation phase had received 42 written submissions (from 33 organisations and nine individuals) and held face-to-face sessions with more than 600 people.40

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37 For more details, see ‘Helping the carers to care’ in this chapter. In Dec. 2006, the government released its *Keeping them safe – child protection: information sharing protocol, practice guidelines* with the first guiding principle being that ‘the child’s right to safety overrides the adult’s right to privacy’. The guidelines apply to all children in South Australia, rather than specifically to children and young people under guardianship. The guidelines were written as a joint venture between the DFC and the Department of Health and apply to Families SA employees and defined Health services.

38 DFC, *Rapid response*.


40 DFC, *Keeping them safe – in our care*, executive summary.
At the same time, the government also released *Keeping them safe – in our care: implementation*, which set out immediate and medium-term actions. This document stated that the government would publish a yearly report outlining the previous year’s achievements and identifying priorities for the following year. It stated that ‘there is still more to be done if we are to make inroads on the longstanding and complex challenges associated with our care system’, noting that there had been a 50 per cent increase in the number of children in care during the previous 10 years and that in each of the previous three years growth had been more than 11 per cent (double that rate for Aboriginal children).

**Guardian for Children and Young People**

The establishment of the Guardian for Children and Young People (GCYP) was an important response to the Layton report. The GCYP, like this Inquiry, is focused on children and young people in State care, rather than children generally.

Layton recommended the establishment of the GCYP to ensure that those children who are most vulnerable and who are under the statutory guardianship of the Minister or otherwise in care away from their parents have their rights articulated and safeguarded. It was envisaged that the GCYP would be part of a larger office of a commissioner for all children and young people, however the government did not implement this recommendation.

Pam Simmons was appointed GCYP in June 2004 and started her role two months later. The Inquiry had discussions with Ms Simmons in January 2005, when both organisations were in their early stages. Ms Simmons provided the Inquiry with a submission in August 2005. The following February, legislation to establish the GCYP was passed, giving the office six statutory functions. They are to:

- act as an advocate for the interests of children under the guardianship or in the custody of the Minister
- monitor the circumstances of children under the guardianship or in the custody of the Minister
- provide advice to the Minister on the quality of the provision of care for children under the guardianship or in the custody of the Minister and on whether the children’s needs are being met
- inquire into, and provide advice to the Minister in relation to, systemic reform necessary to improve the quality of care provided for children in alternative care
- investigate and report to the Minister on matters referred to the GCYP by the Minister.

The Inquiry took evidence from Ms Simmons in December 2007. At that time, the GCYP office employed the full-time equivalent of 3.4 paid positions, made up of the full-time guardian and three part-time staff: a senior advocate, project officer and office administrator. The office also had five unpaid youth advisers. The office is funded by the child protection reform program and administered through the Department for Families and Communities. Revenue for the 2006–07 financial year was $435,200.

The Inquiry endorses the establishment of the GCYP. In a short time, Ms Simmons and her staff have put into place some important, practical methods of communicating with children in State care, including staff visits to residential units and secure care facilities; booklets and contact cards; backpacks; ‘rights’ wristbands; the Oog (a safety symbol for children in care); a charter of rights; and working with volunteer youth advisers, the advisory groups of young people in care and the CREATE Foundation. The CREATE Foundation was established in 1993 to provide a ‘consumer voice’ for children and young people in care in Australia. It encourages direct participation by children and young people in care in informing governments and agencies with a view to addressing systemic problems. The GCYP also has monitored the circumstances of children in State care by auditing some of the annual reviews of...
particular children and young people, and provided advice to the Minister on secure care facilities, individual education plans, accommodation for children with disabilities, the Aboriginal child placement principle (ACPP) policy, refugee children, the review of domestic violence laws, the accommodation of children in motels and legislation for rights of children in care.

Commitment to reform

In order to achieve long-overdue reform to the protection of children in State care, there must be commitment from the whole of government, as well as non-government organisations and the community.

The adults who were sexually abused while children in State care have demonstrated their commitment to reform by giving evidence to the Inquiry about their own individual trauma; a process they hope will help to ensure that children are better protected.

The Inquiry has received support from the Minister for Families and Communities, Jay Weatherill, and the Shadow Attorney-General and Shadow Minister for Justice, Ageing and Disability, Isobel Redmond, both of whom have had several meetings with the Commissioner.

The Department for Families and Communities (DFC) has provided ongoing assistance to the Inquiry during the past three years. The department quickly developed an efficient process to meet the Inquiry’s many requests for records. DFC chief executive Sue Vardon and Families SA executive director Beth Dunning met periodically with the Commissioner and were willing to consider and address issues raised by the Inquiry without waiting for its completion. Ms Dunning and executive members of the department also met with the Commissioner in November 2007 to answer specific issues. The Inquiry heard evidence from 137 departmental managers and staff and received 86 presentations. The department also provided an extensive written submission in response to the Inquiry’s issues paper and responded to ongoing requests for specific information.

The Inquiry has also taken evidence from various non-government organisations working in the area of child protection, as well as from carers, including foster carers, who have indicated their concern for, and willingness to participate in, an improvement of the care and protection system for children.

In the Guardian for Children and Young People 2006–07 Annual report, the guardian said progress during the year had been ‘driven by the government’s commitment to give priority access to this group of children for whom we have a special responsibility’. She said: ‘In my view there is no doubt of the intention and goodwill across government and non-government agencies to support families and protect children, including the provision of high-quality care when children are removed from their immediate families. I am deeply impressed by the passion and commitment of people who work for and care for children who are at risk.’

Crisis and resources

Commitment alone will not achieve the necessary reform of the child protection system. In 2005, the director of the Australian Centre for Child Protection, Professor Dorothy Scott, said of the problems facing the nation’s child protection systems:

> Most of the statutory child protection services in Australia are in crisis. They are potentially harmful to the children and families they are designed to serve. The dedicated people doing this excruciatingly difficult work operate under hazardous conditions. Media moral outrage which erupts when children die or are hurt, and which politicises that which should be above politics, further weakens fragile services and exacerbates staff vacancies. In some States child protection systems are imploding. They have become like huge Casualty departments unable to cope with a flood of referrals.

45 This was coordinated by Marilyn Spence, manager, projects and customer relations, Families SA.

46 GCYP annual report 2006–07.

47 ibid., p. 4.

48 ibid., p. 3.

The Inquiry has heard evidence to suggest that the system in South Australia is in crisis. The present continues to suffer from the consequences of poor past practices. The number of children being placed in care has increased; there is a shortage of foster carers and social workers; there is an inability to place children according to suitability rather than availability; and children are being placed in serviced apartments/bed and breakfast accommodation/motels because there is no other accommodation. Such a state of affairs cannot properly care for an already vulnerable group of children, let alone protect them from perpetrators of sexual abuse.

In her 2006–07 annual report, the GCYP stated that ‘goodwill alone will not be enough’ and that there are ‘signs of system failure and evidence of under-investment’. The observations made by the GCYP are timely and confirm the evidence to the Inquiry. They are of such importance that the Inquiry reports them in full:

From my perspective as a monitor we are witnessing too few improvements in the quality of care overall [note 1] and an alarming growth in the numbers of children coming into care, 15 per cent in the last year alone. I have serious doubts about the state’s capacity to offer most children in care the basis for a life that other South Australian children enjoy.

It is a commonly held view that most children in care are adequately cared for and I have no reason to challenge this. However, we should do more in overcoming obstacles to educational attainment, providing emotional and cultural security and treatment for trauma. This is especially so for children who have been seriously damaged by abuse and who experience many home changes and no secure relationships.

The growth in numbers in care tells us that the safety net for children is there. Sadly and simply, it also tells us that intensive family supports are lacking for families in crisis, whether from drug and alcohol abuse, mental illness, disability or other causes. The choice for safeguarding a child who is at unacceptable risk of further harm seems weighted towards removal.

In the past five years the state government has made a significant additional recurrent expenditure of $69.7 million specific to child protection and out of home care [note 2]. The problem is that much of the additional expenditure is meeting demand from the previous year [note 3].

Other states and territories, Victoria, New South Wales, Queensland, ACT, Northern Territory and now Western Australia, have taken decisive action to invest more substantially and sensibly in both child protection and intensive family support in the expectation that this will curb the growth in numbers of children in care and provide better care to those who need it [note 4]. The benefits are becoming evident in a slowing of growth in the numbers of children on care and protection orders in Victoria and New South Wales [note 5].

I believe, in the foreseeable future, that we can expect growth in the numbers of children in care in the order of 8–10 per cent per year, but not the 15 per cent and above we have now. Unless we build the capacity now to reduce the rate of growth and prepare for what we can normally expect in growth we will continue to see children barely cared for while in state care.

South Australia is working from a very low base of expenditure compared with other states and territories. Our expenditure on child protection and out of home care per child (all children) in this state was $185.50 in 2005–06, 35.4 per cent less than the national average at $287.11. No other state or...
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As I write I am hearing of the impact of these serious financial constraints. Its effect is felt in the impending closure of programs that provided educational support, community services for adolescents and self-development for children in residential care. There may be other reasons for these decisions but the strong impression I have is that there is not the money to continue. Financial under-investment is also evident in the long delays in services to families and escalating problems. Despite the best efforts of staff, the focus in child protection and family services is sadly narrowed to short-term intervention in crises.

Doing right by our children is a priority for the government and the commitment to early childhood services in universal programs will have benefits for all children. However, the intention to do right by our most vulnerable children will not be realised without significant increased financial investment.

Notes

1. This observation is supported by a July 2007 report from the Special Investigations Unit (Department for Families and Communities) which shows a 24 per cent increase in notifications to the unit due to a rise in the number of concerns about quality of care.

2. This includes an additional $25 million per annum allocated in the 2007–08 budget. Excluded from this figure is $7m for the universal home visiting program, $1.5m for sex offender treatment, $2.5m for school counsellor training, $0.4m and $0.23m for this Office and the Child Death and Serious Injury Review Committee respectively. The figure does include $1.68 million provided to the Department of Health for therapeutic services. These were all funded under the Keeping them safe initiatives. This is an approximate increase of 140 per cent since 2003–04.

3. $48.7 million of the additional money allocated was for meeting budget shortfalls and staffing to meet the demand of increased numbers of children coming into care.

4. Since 2003–04, Queensland has provided a 203 per cent increase, or $369.3 million, in child protection, New South Wales a $1.2 billion increase or an extra $240 million per annum, and Victoria has invested heavily in family support services with a 164 per cent increase since 2000.


It is not this Inquiry’s role to analyse the resources to be made available to the child protection system or to estimate the future growth in the numbers of children placed in State care. However, the evidence to the Inquiry demonstrates that more resources must be made available to deal with the crisis created by the past as well as implement necessary reforms for the present and future.
Prevention of sexual abuse of children in State care

Evidence given to the Inquiry establishes that before being placed in State care, many children and young people had already suffered some sort of abuse (sexual, physical or emotional) in families made dysfunctional by drugs, alcoholism, violence, transience, mental illness or poverty. Their vulnerability arising from the effects of such abuse made them prime targets for perpetrators of sexual abuse when placed in a care and protection system that was deficient in its knowledge, understanding and recognition of child sexual abuse.

For some children and young people, their susceptibility was increased because of their sense of dislocation and loneliness. As one PIC who was separated for many years from his family said:

\begin{quote}
To put a child in State welfare, in a home—make sure that they have more contact with other siblings as much as possible because the heartache, the heartbreak and to wait so long [to be reunited with siblings] is devastating.
\end{quote}

One woman told the Inquiry she absconded constantly from care placements because she wanted to be reunited with her mother. She said: ‘I just wanted my mum. I wanted mum. I didn’t want to live with somebody else. I didn’t want to be with somebody else.’ An Aboriginal woman who was removed from her family recalled: ‘I would have just liked to have a family. I’d have just liked to have been with my mum.’

This isolation was compounded for some PICs who did not understand why they were removed from home in the first place. A PIC removed from home as a young boy said: ‘All I know is I just ended up in a home. I just had no say, and it was a pretty traumatic experience for me because I missed my mother.’ Another recalled that he was removed from home when his parents were out one evening. His State ward index card (SWIC) records that he was under unfit guardianship but to the PIC it appeared that:

\begin{quote}
I was at home with my parents. The next thing I knew, I was in Glandore Boys Home. It took me a week—you know, quite a while for it to sink in where I was and why I was there and what happened and what I was supposed to have done … it’s my family that I missed.
\end{quote}

Another PIC who lived in institutional care reflected:

\begin{quote}
The worst thing was probably for a lot of the young kids who have been to [institutions], on reflection, is the fact that they missed their parents. They couldn’t understand why they were there. They couldn’t understand what they had done to be there.
\end{quote}

The PICs also expressed concern that a lack of screening of carers during their period in care left them completely exposed. One man said:

\begin{quote}
If you are declared a ward of the State or anything, I’d like to see them check [placements] out properly. I mean, as it was, they were putting you out of the frying pan into the fire as far as I’m concerned.
\end{quote}

This sentiment was shared by a man who experienced a violent, unstable home life as a boy and was then sexually abused in care: ‘I can understand the State stepping in, but in that sense I was basically taken out of the frying pan and thrown into the fire’.

Another man who was sexually abused as a boy in State care said:

\begin{quote}
 Whoever they get to look after kids, because it’s screened better, the whole lot, and then they’ve got to follow them up with social workers to make sure none of this goes on because this actually blows a kid’s mind apart and it’s got to stop.
\end{quote}

Prevention through early intervention

... it has been really researched in a number of the investigations in child abuse inquiries in this country, that the sudden removal of a child from a suspected abusive situation can be as damaging to the child as leaving them there.

Evidence from Dr Jenny Pearce, Professor of Young People and Public Policy, University of Bedfordshire, UK.
Witnesses gave evidence to the Inquiry in favour of shifting the focus of the child protection system to early family intervention aimed at preventing child abuse, recognising warning signs and keeping families together if possible. Support for such a focus came from people in the government and non-government sectors who work with children and young people, including Aboriginals and those with disabilities. For example, representatives of Disability SA told the Inquiry that

... particularly down the early intervention and prevention end of the spectrum; to be able to put more intensive supports into a family situation in a preventative model would be a good investment.

Similarly, one Families SA employee working with relative and kinship carers said 'it is really about early intervention' and children ‘becoming resilient adults into our communities, which of course is what we’re wanting for these kids’. She said, however, that while in the long term it can save money, in the short term it is ‘a huge challenge because it’s a huge resource area’.

In Keeping them safe in 2004, the government stated that ‘the reform agenda is about intervening earlier, before the abuse occurs or becomes habitual’.53 Later, in Keeping them safe – in our care: draft for consultation, the government’s first stated action is ‘Stronger families’:

There is an international body of evidence to support early intervention strategies with children and their families as the most effective way of keeping children out of the statutory care and protection system by tackling the risk factors of abuse and neglect before they occur.54

In Keeping them safe – in our care: consultation responses, it was reported that there was

... widespread support for a shift of focus ... towards an increasing emphasis on prevention and supporting children and young people in their families, where this can be done safely.55

The department informed the Inquiry56 about the implementation of some recent initiatives focused on prevention through early intervention, including:

- children’s centres, a program also involving DECS and the Department of Health (discussed below)
- the High Risk Infants’ Program, overseeing the management, development and training of the Infant at Risk policy, procedures and practice standards
- Strong Families Safe Babies, providing practical support for families with infants in vulnerable or high-risk situations through two teams: in the south at Noarlunga and north at Parks
- the Vulnerable Infant Service plan, with the Department of Health, aimed at providing a ‘service framework for a cross sector system response for families with infants (conception to three years) whose situations range from little or no risk through to very high risk’57
- the development of a Strengthening Vulnerable Families policy, to be completed in 2007–08.

There are currently five children’s centres—Enfield, Elizabeth Grove, Hackham West, Wynn Vale and Angle Park—and the intention is to build a total of 20.58 The centres focus on ‘improving access for vulnerable children and their families, and provide a range of services such as counselling, parenting programs, family support and service coordination’.59 Family services coordinators were to be employed in January 2008 to identify children and families at risk and intervene earlier to avoid out-of-home care. A further 10 centres are at various stages of development—Campbelltown, Cowandilla, Gawler, Marion, Murray Bridge, Port Augusta, Renmark, Salisbury, Taperoo and Woodcroft.

53 DFC, Keeping them safe.
54 DFC, Keeping them safe – in our care: draft for consultation, p. 15.
56 B Dunning, Families SA executive director, letter, 23 Nov. 2007, p. 11.
57 Ibid., p. 13.
58 On 14 Mar. 2007, the SA Government announced a $23m investment over four years to develop 20 children’s centres, <www.ministers.sa.gov.au>
59 Families SA executive director letter, 23 Nov. 2007, p. 11.
The Commissioner visited the children's centre known as CaFE (children and families everywhere) Enfield, which is adjacent to the Enfield Primary School grounds. CaFE Enfield’s manager and the school principal both gave evidence to the Inquiry. The manager described CaFE Enfield as a community-driven, family-friendly children’s centre that aims to provide education, health and family wellbeing services for families with young children, plus additional services such as speech pathology and family counselling.

The manager responds to families’ needs by seeking additional community services and partners to bring into the centre. As a result of shared arrangements and services, a wide range of programs is available for children aged up to 12 and their parents. Examples include a weekly healthy ways program (which has a focus on indigenous culture, health promotion and involves an Aboriginal support worker); a weekly program, Learning Together, focusing on families experiencing disadvantage including isolation, such as those who have recently arrived in Australia and young parents; training for volunteers in its community program, including information about mandatory notification; and hosting a Good Beginnings program, where children who are removed from their families return to the playgroup creche room to have supervised access visits. The manager also told the Inquiry about the value of informal activities such as a craft group, when parents can

... blow off steam, release certain feelings, and it’s an entry point for them to access other services with the parent support worker being there, with a parent volunteer being there and the creche being there, which is often the first respite that parent might have had for many weeks, months ...

The free creche was initially funded under the Local Answers initiative but was not successful in gaining a second grant. The manager gave the Inquiry an example of how the extent of outreach has been affected by time-limited funding:

The creche is such an important entry point for families to develop a trusting relationship with an outsider for their child. Often a good experience in the creche was the reason why people would continue to be engaged in the site, and that can’t always be facilitated by volunteers.

The grant had enabled the part-time engagement of a psychologist to contribute to parenting programs, a parent support worker, a worker to assist parents find meaningful volunteer opportunities and a maintenance worker.

Describing the children's centres model, Professor Scott of the Australian Centre for Child Protection told the Inquiry:

That’s about best practice for the country, is the community development [of] multi-agency strong collaborative links and doing it in a non-stigmatised setting, which makes it accessible to vulnerable families. And they can actually be providing a little bit of support to quite well-functioning families and they can be providing an enormous amount of support to very dysfunctional families, more or less in the same site and using it as the base. That’s wonderful … So it’s trying to build on the platform of the universal services, a capacity to respond to more vulnerable families … but I think you’d go a long way to find a better example of that in this country.

The Inquiry supports ongoing funding for children’s centres based on its observations and evidence provided, particularly on CaFE Enfield.

Prevention through early intervention: Aboriginal children and young people

I’ve never lost the feeling of being institutionalised. It stays with you forever and then you’ve got to force other institutions to put our cases. What a bloody joke in the 21st century. This country doesn’t protect us. Until they acknowledge what they did …

Aboriginal man placed in institutional care in the 1960s speaking at the Inquiry’s Aboriginal Information Day, December 2006
The need for early intervention strategies to protect children in their families rather than a general policy of removing children is most critical for the protection of Aboriginal children and young people. Past government policy of forcible removal of Aboriginal children to achieve assimilation, resulting in the stolen generations, has caused widespread damage and mistrust of government.60 For example, the Inquiry heard evidence from Aboriginal men and women who, as children in the 1950s–60s, were taken away from their communities, placed in care and sexually abused. The present challenge is how to protect Aboriginal children and young people from sexual abuse given the legacy of the stolen generations and indications of widespread sexual abuse of children in some Aboriginal communities.

The terms of reference for the Inquiry related to the sexual abuse of children in State care. While the Inquiry’s initial investigations of regional Aboriginal communities revealed evidence of child sexual abuse, there was no evidence those children were in State care. Hence the Inquiry’s recommendations to the government for broader terms of reference61, which were later extended only in relation to the Angangu Pitjantjatjara Yankunytjatjara (APY) Lands. The problem of child sexual abuse in Aboriginal communities, however, is not restricted to the APY Lands. For example, a health care worker told the Inquiry that about 50 per cent of Aboriginal girls in Coober Pedy had been sexually abused on one or more occasions. The worker said that the perpetrators included young males who first get the girls intoxicated. The Inquiry also received information about young Aboriginal girls in Coober Pedy being used by older men as prostitutes in order to get money or alcohol. Another health worker told the Inquiry she had seen evidence in Oodnadatta suggesting sexual abuse of very young Aboriginal children and behaviour by older children indicating they had been sexually abused. The Inquiry also received information that at Point Pearce some members of the Aboriginal community were using drugs as a way of dealing with the pain of sexual abuse; suicide of Aboriginal persons who were sexually abused as children was also disclosed. This is important information that requires extensive investigation, but was outside the mandate of this Inquiry.

The need for a focus on early intervention aimed at keeping Aboriginal families together is apparent from the number of Aboriginal children in care. In Keeping them safe – in our care: draft for consultation, the government reported that Aboriginal children made up 23.9 per cent of children in care but only 3.2 per cent of the general population.62 While notification rates in general increased by 43 per cent between 2001 and 2005, they increased for Aboriginal children by 53 per cent. There was an almost 30 per cent increase in the number of children receiving an alternative care placement between 2001 and 2006, however the rate of increase for Aboriginal children and children living in regional South Australia was ‘significantly higher’. The Draft for consultation stated that there is to be ‘a renewed priority and commitment to developing effective and culturally appropriate responses to the high numbers of Aboriginal children in our care’.63

Under action one, Stronger families, the Draft for consultation stated that ‘Aboriginal parents and their families need to be supported in ways that are culturally sensitive and build capacity so they can work out their solutions for themselves’.64 The government said it would work with Aboriginal organisations to identify gaps in family support services and the needs of Aboriginal family support workers, and to develop joint programs across government agencies.65 Under action four, Getting it right for Aboriginal children, focus is placed on the over-representation of Aboriginal children and young people in the child protection system, which is said to be the result of the ‘legacy of the intergenerational trauma and disadvantage experienced by Indigenous Australians’.66 The government stated that it ‘knows’ that Aboriginal families must be supported to find their own way forward.67 The government said it would
continue to support work at a national level; to contribute to work by the Secretariat of National Aboriginal and Islander Child Care (SNAICC) on minimum standards for the care, protection and support of Aboriginal children; to work with Aboriginal families, communities and organisations for guidance on culturally appropriate responses; and expand culturally appropriate early intervention, parenting and family support programs.68

In *Keeping them safe – in our care: consultation responses*, it was reported that most responses supported proposals to ‘tackle the high numbers of Aboriginal children and young people in care as a priority, in collaboration with Aboriginal families and communities’.69 Responses ‘overwhelmingly showed that people felt we cannot “get it right” for Aboriginal children and young people without considering the historical context of the stolen generations’. Responses included specific suggestions, including early intervention services to support families, prevent family breakdown and prevent children and young people entering care, and the expansion of Aboriginal family preservation programs.70

However, in *Keeping them safe – in our care: implementation* the section ‘What we’ve done so far’ made no reference to initiatives for Aboriginal children. The ‘Immediate actions’ section stated that ‘each action area gives priority to developing effective and culturally appropriate responses for the high numbers of Aboriginal children and young people in care’71 but made no specific reference other than finalising a new policy to promote stability and continuity for children and young people in care, which would include recognising the significance of the Aboriginal child placement principle.72 The section, ‘Medium term actions to be put in place over the coming years’, made no specific reference to Aboriginal children.

The Inquiry heard evidence about recent early intervention strategies. For example, the Metropolitan Aboriginal Youth and Family Services (MAYFS) runs the Taikurtina malertoendi (Families to remain together) program, which has been operating since June 2004. The coordinator, Sharon Letton, told the Inquiry that the program is responsive to child protection reports received through the child abuse report line (CARL). Two Aboriginal family practitioners work with the families. Ms Letton said:

> We provide a holistic response to Aboriginal children and their families, whole-of-family case management service, so we don’t just deal with the children of concern, or in regards to that intake; we deal with the whole family within the home there … it’s a culturally appropriate accountable service … we aim to improve the level of functioning with the family, so we work quite intensively with them in the service.

Ms Letton told the Inquiry that from June 2004 to November 2006, the program had received 134 referrals. At November 2006, the workers had a full case load, with 11 more people on a waiting list. At that time, it only received referrals of notifications from the department’s Woodville and Enfield district offices and ‘a barrier’ is that people cannot self-refer. She said that the ‘good thing’ is that ‘we’ve been able to engage with families, and their willingness to work with us’.

**Training of educators**

> I only ever had one schoolteacher that took any care at all with who I was and my situation, and that was at [school] many years later. I’d been in and out of homes by this time and she took me under her shoulder, or whatever, and she knew what was going on, but she never intervened or anything like that …

Evidence from PIC placed in State care in early 1960s, aged about 10

Evidence to the Inquiry reinforces the important role of the education sector in regard to child protection. As stated in the Layton report, education plays ‘a critical role in early detection, early intervention and in the prevention of child
4.1 State response to sexual abuse of children in State care

abuse and neglect … [and] in supporting children and young people who have been victims of abuse and neglect.73

Following recommendations made in the Layton report74, the Inquiry received evidence that DECS75 arranged for universal training of its employees and volunteers, and targeted training for specific employees.

The universal training was a one-day course in mandatory notification. DECS modified the generic training provided by Families SA in order to ‘deliver an education specific training package to its employees and volunteers’.76 The main modifications were the inclusion of a session on workplace awareness; scenarios that explored staff duty of care in responding to sexually abusive/inappropriate behaviours between children and young people; scenarios that explored the needs of children in care, Aboriginal children, children as carers and children with disabilities; and examples of open-ended questions to help notifiers feel more confident about giving children support to disclose, without undertaking an ‘investigation’.77 In 2006, 25,000 employees and invited volunteers from all DECS preschools and schools attended the one-day program. In 2007, similar training was provided for out of school hours care, child care and family day care personnel. A DECS employee working in the area of child protection policy told the Inquiry, ‘I think I speak on behalf of the majority of people in the education system in saying that the process of mandatory reporting for us is absolutely critical’. Updated training is required every three years and is a requirement for teacher registration with the Teachers Registration Board of South Australia. Participation in the training is recorded on the DECS human resources database.

The targeted training program arising from the Layton recommendations is called SMART (strategies for managing abuse-related trauma) and was developed in collaboration with child protection experts from the Australian Childhood Foundation78, the National Research Centre for the Prevention of Child Abuse and the Indigenous Health Unit at Monash University to ensure that school welfare personnel have the skills to support children at risk of abuse and neglect, and to promote and implement school policies and programs that have a focus on child abuse prevention and child protection.79 SMART aims to:80

- effectively communicate with children and young people about their experiences of abuse, family violence and neglect
- build integrated and collaborative interventions that engage schools in a team approach to address the support and protective needs of children and young people who have experienced abuse, family violence and neglect
- contextualise exchanges with children and young people within an up-to-date understanding of developmental theory, trauma psychology and family system models
- promote individual recovery for children and young people, as well as changes to abusive family dynamics
- consider strategies to build commitment to whole of school approaches to child abuse prevention and child protection.

The project included 20 two-day professional education seminars (attended by 750 teachers, school services officers and other professionals involved in the education of students in DECS schools), 18 one-day collaborative practice forums (attended by 632 professionals across sectors), an abuse-related trauma intervention resource package, an online self-paced learning package and evaluation81. By the end of 2006, 350 professionals had registered for the online training package.82

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73 Layton, ch. 19.2.
74 ibid., recommendations 61, 147.
75 Submission from the Department of Education and Children’s Services (DECS), 18 May 2007, p. 2.
76 ibid.
77 ibid.
78 ibid.
79 Final evaluation report, SMART Project Tear 1, Australian Childhood Foundation, Feb. 2007, p. 5.
80 ibid., p. 6.
81 ibid., p. 7.
82 ibid., p. 8
A DECS employee who works in the area of child protection curriculum told the Inquiry:

I think that, over the last 18 months or two years, I’ve actually seen a real shift in educators and I think it is because they have had the mandated notification updated training. Many of them have accessed the SMART program and they’ve also had the curriculum and I think that the shift has been around, ‘Oh, we just report it to the report line and that’s all we need to do or should do,’ to really looking at individual scenarios and saying, ‘How can we support the family or the child in this situation?’.

Chief executive of the Australian Childhood Foundation, Joe Tucci, told the Inquiry that South Australia has ‘led the way on this around the country’:

If you look at the feedback from people who have attended the training … it makes them almost, for the first time, reinteret children’s behaviour in a way that they’ve never done before because they’re understanding what the impact of trauma does on the brain and therefore what they can expect the behaviour to follow. I think it has been quite a surprise to many.

… I think to see it as a one-off training initiative only partly addresses the problem … it really only starts to expose people to the ideas, but it needs to be integrated into school culture, school practice and it needs to be followed up. There need to be changes to the disciplinary protocols and approaches to understanding why children are misbehaving … I would think that it needs to continue.

The Inquiry received one negative submission about SMART concerning a person who had received ‘very negative feedback … because it was not delivered by people with teaching experience’.

Relationships Australia (SA) submitted that the government should be commended for introducing it into schools.

The Association of Independent Schools of South Australia (AISSA) informed the Inquiry that the revised mandatory notification training ‘is a significant improvement on the previous mandatory notification training’. It stated that:

The challenge for those responsible for the course’s contents is to develop refresher courses and further versions of the training that are not repetitive but informative, address current developments on child sexual abuse and other child protection matters, and build on the knowledge of participants.

AISSA submitted that it provides professional development on child protection issues and that many independent schools provide additional professional development in areas related to child sexual abuse. It stated that aspects of the SMART program have been used in independent schools.

The Inquiry supports the universal mandatory notification training program. It also supports the SMART program and believes it should be ongoing, with updated refresher courses.

RECOMMENDATION 1

The SMART (strategies for managing abuse-related trauma) program should be ongoing, with the development of updated, refresher professional development seminars and collaborative practice forums.

Educating children and young people

… education for the children, sit them down, educate them, show them that it’s all right to speak up, and you’re not alone. …

Evidence from PIC placed in State care in early 1970s, when aged seven

As recognised in the Layton report, ‘research and practice internationally indicates that the education and children’s
services system is an essential part of the child protection system. These services play a critical role in early detection, early intervention and in the prevention of child abuse and neglect. In its submission to this Inquiry, DECS stated that ‘educating children and young people about their rights to physical and emotional safety and their responsibilities towards others’ is one of three main ways in which it contributes to the identification, intervention and prevention of child abuse and neglect.

The Layton report stated that while personal safety and protective behaviours programs had existed since the 1980s, the provision of such education in schools had ‘fallen away over recent years’, and submissions to Layton criticised the program as being ineffective. The Layton report recommended that DECS update its personal safety/protective behaviour programs delivered in schools. In its submission to this Inquiry, DECS stated that as part of its response to the Layton report, it had developed new materials, \textit{Keeping safe: child protection curriculum}, to replace the protective behaviours program that had been taught in DECS preschools since 1985. It said the new curriculum was developed in consultation with practitioners and academics across primary, secondary and tertiary education as well as representatives from government and non-government agencies. It has four areas of focus:

- The right to be safe
- Relationships
- Recognising and reporting abuse
- Protective strategies.

\textit{Keeping safe} has texts and resources appropriate for levels of learning from preschool to year 12, and includes the issues of internet safety and intrafamilial abuse. There is also a seven-hour program for preschool educators, teachers and school support officers, which a witness told the Inquiry was about updating their own skills and capacities in delivering the curriculum. DECS submitted that the curriculum would be fully implemented in 2008.

DECS told the Inquiry it had closely consulted with the Catholic and independent school sectors in the development of \textit{Keeping safe}. A DECS employee said:

\textit{About two years ago we formed an agreement with the non-government school sectors that we would collaborate on all child protection initiatives; that we wouldn’t undertake any of that work separately. We agreed that if we were talking about a child protection standard, it ought to apply equally to any school, whether it was government or non-government.}

This was confirmed in the submission from the Association of Independent Schools of SA (AISSA). It indicated the benefits resulting from the collaboration on child protection between DECS, Catholic Education SA and AISSA, which started after the Layton report. In regard to the specific topic of educating children, however, AISSA stated:

\textit{Education about these matters already occurs in the education of students at many Independent schools. A new child protection curriculum is expected to be available soon, which schools may choose to use to enhance the knowledge of students regarding issues related to child abuse. Any training needs to be age specific and have regard to the school ethos and the wishes of parents. The AISSA does not support particular school student curriculum contact being imposed by governments.}

The Inquiry commends the recent work undertaken by the government and non-government education sectors to update the curriculum on self-protective behaviours and the commitment to deliver that curriculum in all schools to all children and young people.

\textit{Educating children and young people in State care}

\ldots something that would have been extremely beneficial to children living in care. That is, someone to nurture, someone to teach, someone to provide

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\textsuperscript{85} Layton, ch. 19.2.

\textsuperscript{86} DECS submission, p. 1.

\textsuperscript{87} Layton, recommendation 137.
decent parenting, to instruct in what was right and what was wrong, to teach some stuff around protective behaviour … I think to have been able to hear from someone else who could have reinforced the message that there are things that you can say no to, and you can tell people, that you don’t have to live in a life of secrecy.

Evidence from PIC placed in State care in the 1960s, when aged 6

In focusing on educating children and young people in State care on self-protective behaviours, the Inquiry recognises the important point made by the Guardian of Children and Young People (GCYP) in her submission: ‘Self-protective behaviours have been taught in schools for some time. Due to disrupted schooling, children in care have often missed out on learning these skills.’

The need for special attention to the education of children in State care was the subject of discussion in the Layton report, resulting in a recommendation that all children under the guardianship of the Minister have a negotiated curriculum plan throughout their schooling. Individual education plans for children under the guardianship of the Minister are now being introduced as part of the Rapid response reform agenda.

This sentiment is reinforced in Report card on education 2006, published by the CREATE Foundation after interviews with 297 children and young people in care about their education. CREATE stated that,

A large portion of the more than 30,000 children who spend time in care each year in Australia perform poorly in school. On average, they lag behind their peers academically and are also more likely to have experienced disruption through relocation or exclusion.

CREATE’s report cited research in 2002 indicating that those who experienced abuse or neglect in childhood were more frequently absent from school, and had lower levels of academic performance and more behavioural disturbances than their peers, even after the abuse had ceased. From its own survey, it reported:

The majority of participants indicated that they missed periods of school during 2005. Disturbingly, almost one in three participants missed more than 20 days of school during 2005, which based on a school year of 40 weeks equates to over 10 per cent of total attendance days.

In 2005, 174 of the 297 students interviewed missed school due to illness, 33 (13.4 per cent) due to being suspended and 26 (10.5 per cent) due to placement or school change. When extended across their school life, 146 (49.2 per cent) said they had been previously excluded from a school.

In her submission to the Inquiry, the GCYP stated:

The imperative for teaching self-protection to this particular group of children and young people is arguably stronger than the general school population because they are in high-risk circumstances. These circumstances include disrupted formal and informal networks, low self-esteem, some with difficult and sexualised behaviours, and close contact with a wider range of people.

The GCYP told the Inquiry that in the past 12 months in 2006–07, the department had engaged youth health service Second Story to teach protective behaviours to children and young people in three of the residential care units. However, with six residential care units and 10 transitional accommodation houses and secure care facilities, ‘it’s still a fairly minimal program’. She was unable to comment on the content or the quality of the program. She went on to state that ‘certainly every residential care and secure care service unit should have such a program available for the residents’. She also indicated that it is necessary to consider how such a program is to be tailored to children and young people in foster care.
The immediate introduction of group training programs for children and young people in residential and secure care was ‘strongly encouraged’ by the Careworkers Coalition in its submission to the Inquiry.

The Inquiry considers that any such teaching should include providing information to children and young people about how to respond to disclosures by their peers or younger children, as well as protective responses specific to Aboriginal children in care.

The Inquiry received evidence about the education of children and young people in care with disabilities. Factors that increase the vulnerability of these children include a lack of sexual knowledge, limited ability to communicate, behavioural difficulties and a focus on compliance teaching. Head of the Centre for Behavioural Sciences at the University of Sydney, Associate Professor Susan Hayes, told the Inquiry that a disabled person’s own ignorance about sexual abuse may inhibit disclosure. Often, an individual is ‘not going to tell anybody because he doesn’t even realise that there’s anything to tell’. She said, ‘I think the provision of sex education to every person with a disability from a very young age is probably a really important key to the prevention’ of abuse. The GCYP also stated that the likelihood of disclosure may be lessened when children with disabilities are not given sexual education.

**RECOMMENDATION 2**

That the self-protective training being taught by Second Story be reviewed to ensure that it covers the *Keeping safe: child protection curriculum* developed for teaching all children in schools and is adapted to target the specific needs and circumstances of:

- children and young people in care generally
- Aboriginal children and young people in care
- children and young people in care with disabilities.

That such self-protective training is then delivered to children and young people in State care living at their residential or secure care facility.

## Child safe environments

*National screening*

… maybe if back then they had some sort of screening process for, you know, people that were taking out kids on weekends or what have you, maybe some things wouldn’t have happened, you know.

Evidence from PIC placed in State care in the mid 1960s, when aged six months

For the purpose of creating child safe environments, the Layton report\(^92\) recommended that a coordinated and comprehensive screening and monitoring system be put in place\(^93\), a working group be formed to consider a legislative and policy response in light of the National Paedophile Register\(^94\) and that agencies working with children develop child protection policies and guidelines.\(^95\)

In 2004, the Commonwealth Government announced the Australian National Child Offender Register (ANCOR). States and territories then enacted legislation to be part of the register. In 2006, the South Australian Government introduced a Bill that was passed as *The Child Sex Offenders Registration Act 2006*. It came into operation on 18 October 2007.

The Act aims to protect children from sexual predators by preventing such people from engaging in child-related work.\(^96\) Registrable offenders are prohibited from engaging in or applying for child-related work, with a penalty of up to five years in prison.\(^97\) This includes work involving contact with a child in juvenile detention centres, residential facilities and foster care.\(^98\) It is an offence punishable by fine for any person who is engaged in, or applies for, child-related work to fail to disclose that certain charges against him/her have been filed or that charges are pending.

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\(^{92}\) Layton, ch. 17.

\(^{93}\) ibid., recommendation 130.

\(^{94}\) ibid., recommendation 131.

\(^{95}\) ibid., recommendation 132.

\(^{96}\) *The Child Sex Offenders Registration Act 2006*, S.3.

\(^{97}\) ibid., Part V, ss. 64–8.

\(^{98}\) ibid., s. 64(1).
A registrable offender is a person who has been sentenced (either a term of imprisonment or supervised sentence) by a court for certain defined offences against children (including sexual offences) or who is, or has been, subject to a child sex offender registration order (a new sentencing option for the court if satisfied that the person poses a risk to the sexual safety of any child or children). Registrable offenders do not include a person sentenced more than eight years ago for a ‘class two offence’ or more than 15 years ago for a ‘class one offence’.

Registrable offenders must annually report their personal details (including address, vehicle registration, employment, names of children living at the address or with whom the person has unsupervised contact, affiliation with any clubs or organisations that have child membership or participation in their activities) to the Commissioner of Police and must report any changes to those personal details within 14 days. The registrable offender must also report travel interstate with an absence of 14 days or more and any overseas trips. When making a report, the registrable offender may have their fingerprints or photograph taken. Depending on the length of the child sex offender sex registration order, the type of offence for which the person was sentenced or the number of offences for which the person has been sentenced, the reporting obligations may last up to a lifetime. The registrable offender is able to apply to the Supreme Court after 15 years to suspend a lifetime reporting obligation.

It is an offence punishable by fine or two years imprisonment to fail to comply with the reporting obligations or to provide false or misleading information. By the end of 2007, six males had been arrested in South Australia for failing to comply with the reporting obligations.

The Commissioner of Police is to maintain a register of the registrable offenders in South Australia. The register must include any information on the national ANCOR, which is managed by the CrimTrac Agency. At 7 November 2007, there were 6188 registered offenders nationally.

Access to the South Australian register is to be in accordance with guidelines developed by the Commissioner of Police and approved by the Minister.

South Australian organisations

Organisations which place a high priority on child safety should promote their commitment to it as part of their public accountability.

Guardian of Children and Young People submission to the Inquiry

Another response by the South Australian Government was to introduce amendments to the Children’s Protection Act 1993, entitled ‘Child safe environments’, in parliament in 2005. These came into operation on 31 December 2006.
Section 8B of the Act requires certain organisations to obtain a criminal history, or police report from the Commissioner of Police or CrimTrac for people holding, or to be appointed to, positions that involve regular contact with children or close proximity to children (or supervising/managing people in such positions) or access to records relating to children. They include an employee, volunteer, agent, contractor or subcontractor. The section applies to all government organisations and only to those non-government organisations named in regulations. Current regulations\(^\text{120}\) only extend the operation to non-government schools within the meaning of the Education Act 1972. Also, it is not clear whether or not the criminal history report would include information that the person is on ANCOR.

Section 8C requires certain organisations to establish (as soon as practicable after 1 January 2008) appropriate policies and procedures for ensuring (a) that mandated reports of abuse or neglect are made under the Act; and (b) that child safe environments are established and maintained within the organisation. There is a penalty of up to $10,000 for non-compliance. This has much wider application than the previous section, applying to an organisation that

a) provides health, welfare, education, sporting or recreational, religious or spiritual, child care or residential services wholly or partly for children; and

b) is a government department, agency or instrumentality or a local government or non-government organisation.

The policies and procedures must include any provisions prescribed by regulation and address any matters prescribed by regulation. Current regulations\(^\text{121}\) require the policies and procedures to:

- reflect the appropriate standards of care for ensuring the safety of children as defined by the chief executive; and
- reflect the standards developed and issued by the chief executive to be observed in dealing with information obtained about the criminal history of employees and volunteers.

The chief executive has published two documents arising from this legislation:

- Child safe environments: dealing with information obtained about the criminal history of employees and volunteers who work with children (relevant to section 8B(3), which requires that organisations deal with the information in accordance with the relevant standards; and the regulations made pursuant to section 8C(2)(b), which requires an organisation’s policies and procedures to reflect these standards)
- Child safe environments: principles of good practice—standards of conduct and care for adults in dealing with children and ensuring the safety of children (relevant to section 8C(2)(b), which requires an organisation’s policies and procedures to take into account and reflect these standards).

It is evident that section 8B does not require all the organisations referred to in section 8C to obtain a criminal history report. The obtaining of such a report is discretionary for non-government organisations other than non-government schools as defined in the Education Act 1972. This discretionary approach is reflected in the chief executive’s document Child safe environments: principles of good practice, which states:\(^\text{122}\)

In some cases, obtaining a criminal history report is neither practicable nor proportionate to the resources of an organisation. In these cases, it is recommended that the organisation requires the applicant/employee/volunteer to sign a statutory declaration stating that the individual has no relevant criminal history. While a statutory
The chief executive is required by section 8A(i) of the Children's Protection Act 1993 to monitor progress towards child safe environments in the government and non-government sectors and to report regularly to the Minister. The legislation does not, however, require the various organisations as defined in section 8C to provide the chief executive with a copy of their policies and procedures or for the chief executive to maintain a register of them. It is considered that such a process is essential in order to adequately monitor the progress of the organisations and ensure compliance with the legislation. A register would also be of benefit if there was a relevant complaint made to the South Australian Ombudsman or the Health and Community Services Complaints Commissioner.

RECOMMENDATION 4
That the Children's Protection Act 1993 be amended to require organisations to lodge a copy of their policies and procedures established pursuant to section 8C(1) with the chief executive and that the chief executive be required to keep a register of those policies and procedures.

Screening by Families SA
… we must be screening and assume that paedophilia is part of what our kids are very, very vulnerable to; screen every person that comes in. Rather than assuming they’re the good guys, you have to actually assume our kids will be a magnet because of their victimology, because of their easy vulnerability and because the system is not always a good carer.

Evidence of departmental manager

The department advised the Inquiry that its screening of carers, employees and volunteers is undertaken by the Screening and Licensing Unit Branch, which is now an accredited agency with CrimTrac. This means that the

RECOMMENDATION 3
That the application of section 8B of the Children’s Protection Act 1993 be broadened to include organisations as defined in section 8C.

That consideration is given to reducing or waiving the fee for an organisation applying for a criminal history report in order to comply with section 8B.

That a criminal history report be defined as a report that includes information as to whether a person is on the Australian National Child Offender Register (ANCOR).
4.1 State response to sexual abuse of children in State care

department is able to obtain information directly from CrimTrac.

There is a memorandum of understanding between the department and the South Australia Police under which the police must disclose to the department whether an applicant to undertake child-related work has been charged with a serious offence even if not convicted. The department is also able to obtain information about the particular offences from the police. Once that information is obtained, the screening of carers is to be guided by the recent standards set out in Child safe environments: dealing with information obtained about the criminal history of employees and volunteers who work with children. This sets out a process for assessing the suitability of employees and volunteers. The department also advised that a policy titled Screening and Licensing Branch – carers assessment policy is in progress.

The Inquiry considers it critical that Families SA is informed whether a proposed carer, employee or volunteer worker is on ANCOR.

RECOMMENDATION 5
That Families SA, as part of the screening process of employees, carers and volunteers, obtains information as to whether or not that person is on the Australian National Child Offender Register (ANCOR).

In relation to children and young people with disabilities, Families SA submitted that it uses several processes to screen proposed carers, including a police check, a ‘factual review’ of department records and checks on the electronic client information system (CIS) for any previous contact and allegations. However, the Centre for Behavioural Sciences’ Associate Professor Hayes told the Inquiry that research has indicated that a large percentage of perpetrators of sexual abuse against children and young people with disabilities are people with incidental contact, such as taxi and bus drivers who provide transport on a regular basis. Those people who have incidental contact come to know the disabled person and their carers, who in turn develop a trust in those people.

RECOMMENDATION 6
That Families SA extends its screening processes to cover known regular service providers to children and young people in care with disabilities, such as regular bus or taxi drivers.

Empowering children and young people in care

I didn’t have an opportunity to have my voice heard. You know, I understand that some people do speak up but I didn’t speak up. That’s something I regret. I regret that I didn’t give a voice to it, that I allowed all this silence, that I didn’t speak up about how I felt and what it was that I needed and what I wanted.

Evidence from PIC placed in State care in the mid 1960s, aged two months One of the most important aspects to the prevention of sexual abuse is the empowerment of children and young people in all parts of their lives. This recognition has recently begun to appear in policies throughout Australia and is being implemented to varying degrees.

The NSW Commission for Children and Young People undertook a comprehensive literature review of 1998–2002 on the benefits of the participation of children and young people in their own lives. Two key points were that participation empowers children and young people, and it can help protect them.

The failure to listen to children and young people is a recurring theme in many inquiries into abuse.

In 2001, the NSW Commission published Participation: sharing the stage, a practical guide to involve children and young people in decision-making, which set out five

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key elements of effective participation. It stated that ‘Participation is more than just giving the younger members of our community a say—it is about listening to their views, taking them seriously and wherever possible giving practical effect to their ideas and suggestions’.

The South Australian Office for Youth is part of the Department of Further Education, Employment, Science and Technology (DFEEST). It employs up to 28 staff, about one-third of whom are aged 25 years or younger. The office is responsible for:

- a youth participation register (a contact database listing young people who want to become involved in decision-making)
- the Minister’s Youth Council (consisting of young people aged 12–25 who directly consult with and advise the Minister for Youth at monthly meetings)
- the youth consultation toolkit (which contains practical advice on planning and running consultations with young people)
- youth participation training (free for all agencies who are interested in how to involve young people in decision-making)
- youth participation grants (provided to agencies to support consultation with young people).

In August 2006, the South Australian Government released the Premier’s memorandum on youth participation, which aimed to increase the numbers of young people involved in government and community decision-making processes. It set out four principles underpinning meaningful and effective participation—participation as a fundamental right, youth empowerment, valuing diversity and inclusiveness—and encouraged organisations to become signatories.

This important theme of empowering children and young people was recently echoed in the Council for the Care of Children annual report 2006-07, which indicated an eight-point plan for the next year—the first point being “listening and responding to the concerns of children and young people”. It stated:

The rights of children and young people to express their views and opinions in a range of different ways is central to the United Nations Convention on the Rights of the Child’s underpinning principle—that children are citizens. The Council will explore ways to hear the voice of young South Australians, including the potential of existing mechanisms in other organisations. In particular the Council will promote the importance of hearing the voice of children and young people across major service sectors, but with a particular focus on children who are more vulnerable to violation of many of their rights, including for example Aboriginal children, children with disabilities, children in the care and protection system, children at risk of suspension and expulsion from school, and children in conflict with the law. The Council will continue to monitor trends and patterns about the concerns expressed by children and young people in key reports and research studies.

The same comments and initiatives also apply specifically to children in care. In her submission to the Inquiry in 2005, the Guardian for Children and Young People (GCYP) stated that:

arginably the most fundamental and significant change we can make is to listen to and act on what children and young people have to say about their lives in care.

She also said that while there is a need for a structural response to abuse in care that focuses on regulation, monitoring and scrutiny, the important issue of power imbalance needs to be addressed:

Unless the organisational culture supports the power of children and young people, emphasises their rights and has a positive child-focused orientation, any obligatory procedures such as complaints mechanisms are tokenistic and ineffective.

127 The predecessors to the Office for Youth were the Youth Bureau (1979–89); DETAFE Youth Affairs Division (1989–93); DETE Office of Employment and Youth (1989–2002); DHS /DFC Office for Youth (2002–06).
128 A copy of the memorandum and a list of signatories is available on the Office for Youth website <www.officeforyouth.sa.gov.au>.
Importantly, in its *Keeping them safe – in our care: draft for consultation* (September 2006), the State Government stated:  

*We must build a care system … that acknowledges the entitlements of children and which has a culture that encourages the genuine participation of children in decisions about their care. This is more than giving children a say. It is about listening to their views, taking them seriously and wherever possible giving practical effect to their ideas and suggestions. We know that listening to children is crucial in relation to the prevention and detection of abuse and fundamental to promoting a child safe environment.*

In December 2007, the GCYP, Ms Simmons, reinforced this point to the Inquiry, stating that a child-safe environment ‘involves a lot more than police background checking of any volunteers or paid staff working with children or having access to records of children’ and that such checks are only ‘one part’ of creating a child-safe environment. She said:

*It’s very easy for all of us to slip straight into the regulation structure, regulation rules, policies, procedures. The greater protection always will come from the less tangible things about the environment, and that is the perspective that people take, the notice they take of children, the involvement of children in regular activities, not just child activities. Those are the things that actually make the bigger difference for a child’s safe environment rather than the regulation. I’m not saying do away with the regulations about safety and screening, but I am saying that the bigger challenge is actually an attitude and environmental—social environment—change in organisations, and we still have a long way to go.*

By way of illustration, Ms Simmons said that in two secure care facilities (Magill and Cavan), advisory committees for young residents had recently been introduced with ‘complaints mechanisms which are very clear and very private’. She said those advisory committees were ‘very much about, “What do you think about the environment that you’re in and what would you like to see changed?”’

She said:

*It is about perspective. It is making sure that signs and words and so on are actually inclusive of children—all of those things, which we’re much more used to doing for adults in different ways; adults with disabilities perhaps or adults from different cultural backgrounds. I’m not so sure that we are terribly good at doing that yet with children for making environments—for them to feel that they are part of the environment and not just a kind of add-on to that.*

Ms Simmons has undertaken several initiatives to empower children and young people in care. Section 52C(2)(a) Children’s Protection Act 1993 states that in carrying out her functions, the GCYP must ‘encourage children who are affected by issues that the Guardian has under consideration to express their own views and give proper weight to those views’.

Ms Simmons told the Inquiry that she now has five voluntary youth advisors to assist her. They are aged from 15 to 24 and are either in care or have been in care. Their roles have involved leading on public image projects; developing the *Being in care* material and Oog, the safety symbol for children in care; and mentoring young people. They involve other young people in projects and work closely with the CREATE Foundation, which also brings in some of their young people to assist.

For example, the GCYP youth advisors and CREATE developed the *Charter of rights for children and young people in care* in consultation with other children and young people, carers, social workers and people from government and non-government organisations. The design of the resulting printed materials relied significantly...
on the input of young people in care or who had been in care. The Minister launched the charter in April 2006 and by the end of 2007 it had been endorsed by 42 organisations.

The young people wanted the charter of rights in legislation. The GCYP and CREATE supported the youth advisors in mentoring a team of young people in care through Youth Parliament in 2006. Ms Simmons told the Inquiry that they drafted a bill for a charter of rights that passed both houses of Youth Parliament. She said that the young people did it themselves: ‘It was led by them’. Ms Simmons said the Minister had supported it being passed in parliament and she understood it had gone to parliamentary counsel. The Inquiry supports a legislative endorsement of the charter of rights in the same way that the parliament passed Schedule 1 South Australian carers’ charter in the Carers Recognition Act 2005.

RECOMMENDATION 7
That the Charter of rights for children and young people in care be the subject of legislation in South Australia.

The Inquiry also considers the role of the youth advisers to the Guardian of Children and Young People to be so important to the empowerment of children and young people in care that it should be formalised in legislation as the Youth Advisory Committee. The GCYP may consult with the committee as she considers necessary.

RECOMMENDATION 8
That the Children’s Protection Act 1993 be amended to provide for a Youth Advisory Committee, established and appointed by the Guardian for Children and Young People. The committee would consist of children and young people currently or formerly under the guardianship or in the custody of the Minister. Membership should include an Aboriginal person/s and a person/s with a disability.

The Inquiry has direct knowledge of the mutual benefits of such participation. In mid 2006 it established a Young People Advisory Group with the objectives set out in Appendix A.

The committee initially had 13 members aged 16–26 and 10 when it wound up. The committee met the Commissioner nine times. It received important support from Sean Lappin, community residential care manager with the Department for Families and Communities, Margaret Bonnar, social worker with the Port Youth Accommodation Program, and Lina Varano, social worker with Street Link. Three invited guests were Career Start recruitment consultant Belinda Cook, who spoke about education and training for youth; a former child in State care who lived on the streets; and ABC-TV’s Stateline presenter, Ian Henschke, who worked with the committee to teleview a meeting where members had the opportunity to express their views. Responses to the television program from teenagers, parents and other adults were all favourable and emphasised the importance of hearing youth through the media.

The committee’s experiences, views and ideas appear throughout this report. Members told the Inquiry that no-one asks children in State care what is best for them. Of their participation in the Inquiry, members said ‘it feels that something happens’, ‘it was a change to be believed’ and it was good to have their views heard and to meet together ‘because we have a mutual understanding’.

The CREATE Foundation and GCYP have already established a close working relationship. CREATE is about the participation of children and young people in the making of policy and decisions that relate to them: ‘CREATE believes in the spirit of youth participation and as such is run by, with and for children and young people in care’. It began as a small volunteer organisation but has grown to a ‘national, professionally staffed organisation with 27 staff and over 150 trained Young Consultants (young people in/ex care) who actively participate in national and state-based project work’. 131

As part of the Keeping them safe – in our care: draft for

131 CREATE Foundation, <http://www.create.org.au>
consultation (September 2006), the South Australian Government commissioned CREATE SA to report on the views of children and young people in care or previously in care. CREATE's report, Keeping them safe – in our care: feedback from group consultations with children and young people about the new directions document, was finalised in November 2006. CREATE held five group consultations with 18 participants aged from 13 to 21 (eight male and 10 female, including three Aboriginals). It also sent out a questionnaire to a random sample of children and young people, which elicited 15 responses from people aged eight to 17, five of whom were Aboriginal (gender was not recorded). Respondents said they wanted to participate in making decisions about their care.

The Inquiry endorses the commissioning of the CREATE report as part of the Keeping them safe consultation process. The report contains important information and recommendations from the participants. At its conclusion, CREATE recommended that

... children and young people are given every opportunity to participate in the implementation of the New directions action plan. Young people should be supported to make a contribution in working groups, forums, reference groups and any other mechanisms put in place in a meaningful and purposeful manner ... All children should be given the opportunity to participate to a level that matches their skills and abilities. It becomes the responsibility of adults to find suitable strategies to engage children and young people.

The Inquiry considers it imperative that children and young people in care participate directly in the continuing formulation and implementation of the government's Rapid response initiatives.

One of the five key elements of effective participation identified in the NSW publication Participation: sharing the stage was 'Participation is part of the organisation's culture':

Participation of children and young people should not be viewed as a one-off exercise (or a series of one-off projects). It needs to be integrated as a core activity and considered in every project affecting children undertaken by the organisation.

The Inquiry considers that the Department for Families and Communities should establish a Minister's Youth Council—similar to that run by the Office of Youth—consisting of young people in care or previously in care aged 12–25, who directly consult with and advise the Minister for Families and Communities. It is considered that a youth advisor to the Guardian for Children and Young People should be a member of the council.

RECOMMENDATION 9

That a Minister's Youth Council be established to directly advise the Minister for Families and Communities. Council members must be children or young people aged 12–25 years currently or previously under the guardianship or in the custody of the Minister. The membership must include an Aboriginal child or young person; a child or young person/s with a disability; and a youth adviser to the Guardian for Children and Young People.

Another of the five key elements of effective participation identified in the NSW publication Participation: sharing the stage, was 'Adults adapt to kids' way of working'. Under this heading it was stated that it is necessary to 'remove financial barriers'.

Make sure that the ability of children and young people to participate is not limited by financial barriers. Reimburse participants for out of pocket expenses and look at the possibility of arranging sponsorship or subsidies for conferences and forums arranged by other organisations. Some young people may need cash up front, just to make it to the group or meeting.

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133 ibid.
Recommendation 10

That resources be allocated to ensure that the participation of children and young people on the Youth Advisory Committee appointed by the Guardian of Children and Young People (see recommendation 8) and on the Minister’s Youth Council (see recommendation 9) is not limited by financial barriers.

Empowering children and young people in care with disabilities

... if they know that something is wrong, how do they manage to be able to get that information to somebody who could protect them?

Evidence from representative of Independent Advocacy SA Inc

Evidence to the Inquiry demonstrates that the empowerment of children and young people in care with disabilities requires special consideration. In particular, the provision of specialist advocacy was considered to be important to such empowerment and to the protection of children with disabilities from abuse. Also, it is noted that submissions to the Keeping them safe – in our care: consultation responses highlights the need to identify ways in which children and young people with disabilities ‘are able to tell us what they think and wish’.134

The Inquiry received evidence from members of three advocacy agencies—Independent Advocacy SA Inc, Citizen Advocacy South Australia and the Disability Advocacy Complaints Service of SA—operating in the disability sector in South Australia. They receive funding from the Commonwealth Government under the National Disability Advocacy Program. It is evident that advocacy takes different forms and the advocate’s role varies, depending on the need of the child.

Independent Advocacy provides advocacy services for people with intellectual disabilities based on individual, not systems, advocacy. Its priority is the development of relationships, protection and healing. Key roles for the agency include advocacy for children with disabilities in foster care, parents with intellectual disabilities and people with intellectual disabilities in congregate care; advocacy and support for people with intellectual disabilities who are sexually abused; and support with transition issues for people with intellectual disabilities in late adolescence and reaching adulthood.

Citizen Advocacy works predominantly with people with intellectual disabilities who have high dependency, including people who are homeless, in boarding houses or in prison, and children with special needs. Advocates are unpaid and they are matched to the person with a disability, called a protege. The relationship is generally a sustained, long-term engagement for the provision of advocacy and support on a range of issues.

Disability Advocacy Complaints Service of SA initially provided advocacy primarily to people with physical disabilities. Its work has expanded and includes advocacy on behalf of people with mental illness, advocacy on disability issues, and representation in cases in the Guardianship Board and the Human Rights and Equal Opportunity Commission. Its focus is on advocacy on short-term specific issues, rather than ongoing advocacy for clients.

Representatives from the advocacy agencies gave evidence to the Inquiry about abuse of children with disabilities, including sexual abuse, physical abuse, bullying, verbal abuse and harassment, emotional abuse, detention and isolation, and theft of money and property. They agreed there is a need for specialist advocates for children with disabilities:

Specialisation is very, very important because it takes time to build up your knowledge, your networks, which will mean that the support that you can provide advocates is relevant and it’s knowledgeable.

There is a need for experienced advocates who are trained in techniques for communicating with children with disabilities. For example, children with intellectual disabilities may encounter exceptional difficulties in having their need for advocacy acknowledged and implemented. The child might be non-verbal or might have some verbal communication, but be difficult to understand.

Challenges of this kind reinforce the need for advocacy to address a fundamental problem that ‘people with intellectual disabilities are not believed because they have got an intellectual disability’.

The difference between the role of the advocate for a child or young person in care with a disability and the role of departmental volunteers or caseworkers was emphasised in evidence to the Inquiry. Departmental program managers generally use volunteers to provide transport for children and assist with supervised access—93 per cent of volunteers’ time is dedicated to these tasks and has often been ordered by the Youth Court. Volunteers also provide assistance to children in alternative care with the development of skills such as literacy and numeracy, assistance with access to recreational activities and support to children in the development of relationships with family and friends. Witnesses made the point that the departmental volunteers were not advocates.

Also, witnesses expressed concern about a perception in the department that caseworkers were advocates for the child. One advocate gave evidence to the Inquiry about trying for two years to convince the department that a caseworker could not act both as advocate for the foster child and caseworker for the foster family:

The caseworker constantly kept telling me, ‘it’s nothing to do with you, we’re the child’s advocate’. I said, ‘You can’t be the child’s advocate because it would be a conflict of interest if there was an issue between you and the foster parent. Exactly that.’ ‘No, no, no, we’re the advocates, we’re the advocates.’ I said, ‘You can’t possibly be because you can’t stand aside; you’re being paid by the organisation to present this case in this way, and you can’t do that. It’s impossible.’

Representatives from the three advocacy agencies agreed that they are not accepted as advocates by the department, because they are not regarded as ‘legitimate stakeholders’. One of the advocacy agency representatives said this view was entrenched in the department:

... there is this kind of belief that if they’re involved then they have got the person’s best interest at heart … a child in alternative care doesn’t need an advocate because Families SA are their advocates.

The representatives from the advocacy agencies said they have appealed to the department, without success, to obtain standing and recognition as advocates in particular cases for children in State care. They said the office of the Guardian for Children and Young People is weakened by its actual and perceived lack of independence from the Minister and the department. This is one of the reasons for this Inquiry’s recommendations concerning the GCYP’s independence. (See recommendations 27–30.)

The Inquiry believes a special role to address the empowerment of children in care with disabilities should be created in the GCYP office. The Children’s Protection Act 1993 currently provides that the GCYP ‘must pay particular attention to the needs of children under the guardianship or in the custody of the Minister who have a physical, psychological or intellectual disability’. The role would be focused on ensuring that appropriate individual and systemic advocacy is provided for children with disabilities in care, which would include drawing on the expertise of existing advocacy agencies and giving that expertise the appropriate standing.

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135 Families SA presentation to this Inquiry, Volunteering in Families SA, 7 Dec. 2006.
136 Children’s Protection Act 1993, s. 52C(2)(b).
Chapter 4 State response

RECOMMENDATION 11

That there be a special position created in the office of the Guardian for Children and Young People to assist the GCYP in addressing section 52C(2)(b) of the Children’s Protection Act 1993 and ensuring that both individual and systemic advocacy is provided for children with disabilities in care.

A community responsibility

There is a need for wide community awareness of child sexual abuse and acceptance that it is a whole of community responsibility. Such a shift in understanding and sense of responsibility must necessarily be underpinned by comprehensive and extensive community education.

Submission from Relationships Australia (SA)

Children and young people can only be empowered if parents/carers (including the Minister as legal guardian or custodian of children and young people in care) and the community enable it to happen. Parents/carers and the community must be educated about the nature of child sexual abuse so they are aware of, and understand, what children and young people need to be protected from.

Research shows that misconceptions about child sexual abuse persist, including the incidence, what constitutes abuse and the likely perpetrators. Many in the community are unable to identify perpetrators’ tactics, lack awareness of the cognitive and emotional impact of abuse on children, are unable to recognise the signs of abuse and are unsure of what action to take. Almost one-third of 720 adult respondents in a 2005 survey said they were not likely to believe a child’s disclosure of abuse, based on a belief that children made up stories. Almost one half of the respondents in the same survey reported significant discomfort when viewing news reports related to abuse.\(^{137}\)

The survey found that the general public ‘actively forgets and emotionally distances’ itself from the issue.\(^{138}\)

Child abuse was perceived as less concerning than the rising cost of petrol and problems associated with public transport and roads.

The Inquiry received eight submissions on the issue of publicity concerning child sexual abuse\(^{139}\) in response to its Issues paper. All of the submissions supported an extensive media publicity campaign on child sexual abuse as a community education initiative. The South Australia Police and Families SA also emphasised the preventive role that such a campaign could play. The Premier’s Council for Women, the Australian Childhood Foundation and Relationships Australia (SA) highlighted the need to deal with enduring misconceptions about child sexual abuse. For example, Relationships Australia emphasised that ideas about the sanctity of the family unit and reluctance to acknowledge that caregivers and other persons known to a child could be perpetrators contributes to enduring misconceptions.\(^{140}\)

The respondents listed several topics essential to any education or publicity initiative. The Premier’s Council for Women advocated the inclusion of information about the myths and facts that surround child sexual abuse; and information on how to recognise perpetrator tactics such as the shifting of responsibility on to the victim or non-abusing adults in the child’s life. The council also submitted that education should target perpetrators with the message that abuse would be detected and punished as a crime.\(^{141}\)

Relationships Australia submitted that the community should be educated that the child is never to blame and about the importance of acknowledging disclosures of abuse.\(^{142}\) Families SA submitted that information should aim to assist the community to learn appropriate ways of responding to sexual abuse; the Guardian of Children and Young People submitted that publicity was needed on avenues for raising complaints, the range of available responses and protection for notifiers.\(^{143}\)

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138 Tucci, Mitchell, Goddard, Out of sight, out of mind, p. 2.

139 CISC Inquiry, Issues upon which the Commission seeks submissions, 2.4.

140 Relationships Australia (SA) submission, p. 10.

141 Premier’s Council for Women submission, pp. 3–4.

142 Relationships Australia (SA) submission, p. 14.

143 GCYP submission, p. 22.
Respondents emphasised that any publicity or education initiative should target the entire community. The Association of Independent Schools of SA submitted that this would highlight the fact that protecting children is the responsibility of the entire community. The Premier’s Council for Women advocated that education highlight that all members of the community should know that sexual abuse is a crime. Other evidence to the Inquiry referred to the need to inform people about recognising signs that someone might be offending or might be going to offend; and informing people that there are places, such as the Sexual Offenders Treatment and Assessment Program (SOTAP), where treatment can be provided. Relationships Australia echoed this point, submitting that ‘while we must ensure that children are informed, the onus of responsibility cannot be placed on the child to ensure their own safety’. The Careworkers Coalition argued that a whole of community focus ensures that no one single group, such as caregivers, is singled out.

Any effort to educate the community about child sexual abuse has implications. Families SA’s response to the Inquiry’s Issues paper highlighted the difficulty in defining ‘suspicious circumstances’ to assist the general community in reporting concerns, without giving the more complex task of risk assessment to non-experts. Families SA submitted that efforts to increase community awareness may result in increased inquiries, reports and notifications. It is important that adequate resources exist to meet any increased demand for services arising out of increased notifications.

The need for a coordinated approach to a publicity campaign was emphasised by various respondents. For example, the Premier’s Council for Women submitted that broad community education requires a systematic social marketing approach to ensure the message and campaign resources achieve the best results. Some respondents referred positively to the ‘Listen and believe’ gender violence campaign coordinated by Women’s Health Statewide in 2002.

As representatives from ASCA (Advocates for Survivors of Child Abuse) told the Inquiry:

> You want to achieve the fact that there is a notoriety of abuse in our culture that needs to be cut out for a start by education, awareness.

**RECOMMENDATION 12**

That an extensive media campaign be implemented to educate the community about child sexual abuse—its prevalence, existing misconceptions, perpetrators’ tactics, services for victims, and treatment for offenders—and highlight that child protection is a community responsibility.

**Prevention programs**

**Stopping the offender**

... the criminal justice system is one way of containing sexual offenders, but it doesn’t address the problem, and our whole sort of recidivist experience is that people will come out of prison or out of containment and will continue to abuse.

Evidence from Dr Jenny Pearce, Professor of Young People and Public Policy, University of Bedfordshire, UK

Often the view is expressed that the best form of prevention is to lock up the offenders and ‘throw away the key’. Indeed, a prisoner told the Inquiry that when he was locked up for sexual offences ‘I was actually at peace. As weird as that sounds, being in that place I was at peace because there was nothing else that could happen ... I couldn’t reoffend.’ While indefinite sentences are occasionally imposed on convicted sexual offenders, the key is not thrown away; they are released from custody to
live in the community. Convicted offenders of child sexual abuse as well as professionals working with offenders and possible perpetrators all told the Inquiry about the importance of prevention programs.

Prisoners gave evidence to the Inquiry about the effect on them of such treatment programs. One prisoner referred to his experience of an overseas program:

How to explain? It was a mixture of confronting your crimes, admitting it, owning it; talking about it in groups; examining the reasons and feelings behind it; aversion therapy ... I was totally disgusted in what I’d done ... It gave me the ... ammunitions to confront my feelings.

Another prisoner referred to the benefits of an interstate program:

... basically in the 12 months I did that program I grew up 25 years that I needed to grow up ... to fully understand myself and to get to know myself.

Other prisoners referred to their desire to receive help:

It sort of amazes me, even these days, there’s more people that help you give up smoking, which you only do for yourself anyway, than there is to help with this [sexual offending], the big problems of life.

A significant number of prisoners who gave evidence to the Inquiry said that they were sexually abused as children. One prisoner who sexually abused two children said ‘I became a perpetrator, not a victim’ and said that before receiving any treatment what he did was

confuse lust and love ... it must be something you do to express your love. I know that’s a real screw-up now, but at the time I think that’s the way I thought. I don’t think that way any longer.

Another prisoner said he was not given any therapeutic assistance when he was first arrested as a teenager for a child sexual offence. He said that his father sexually abused him and

I had a feeling that a lot of problems stemmed from the abuse ... I’ll accept that. The abuse that I suffered sexualised me to an extreme degree at a very young age. That may have led me toward seeking younger victims, I guess, in a lot of ways or whether it led me towards some more predatory behaviour, I don’t know.

This prisoner wondered whether his “offending against boys was my way of trying to heal myself”.

Another prisoner who was raped as a child said that he committed sexual offences against young people in his 30s because ‘I have never got over what happened to me when I was 4½ ... I’ve been angry all my life about it’. He said:

If it didn’t happen, I would have had a different outlook on life. I would have stuck to a job, been successful and that, but I couldn’t trust anyone.

He told the Inquiry that ‘I would like to see someone else who was sexually abused looked after, so that they don’t turn out like I have’.

Another prisoner said that his father sexually abused him at a very young age. He said as a young boy he then started sexually abusing a young girl: ‘I thought it was normal because dad was doing it to me’. He said that later he sexually abused another young girl. He would have liked to have been able to tell someone what his father did to him ‘because it would have stopped and I wouldn’t have probably gone on to offending myself’.

Professionals working in the area of treating offenders of child sexual abuse confirmed that there are a significant number of perpetrators who were sexually abused as children.

The manager of the adolescent sexual assault prevention program Mary Street and director of Nada Counselling, Consulting & Training, Alan Jenkins, told the Inquiry that its data showed that about 40 per cent of people who had perpetrated sexual abuse had been sexually abused as children.

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He said:

Generally the data around the world where people have collected this – and it depends on where you sample your people from, but if it’s in a community setting, it’s usually 30 to 40 per cent, somewhere in that mark. If it’s in a criminal justice setting, like a
prison or a custodial-type setting, it’s generally much higher, and it ranges from 50 to 80, I think, some of the different studies that I’ve seen. But ours is a community setting. It’s about the 40 per cent mark.

The manager of the Department for Correctional Services Rehabilitation Programs Branch, Dr Michael Burvill, told the Inquiry that

… particularly for men who have been abused when they’re younger—they sort of get a bit trapped in a time warp in a sense of where their psychosexual development starts and there’s a tendency to seek that experience again, even if it was traumatic.

Chapter 16 of the Layton report discussed the need to protect children through ‘sex offender treatment’ and recommended developing a specialised prison-based treatment program; extending the Mary Street program to ensure that all young people who offend sexually against others be appropriately treated and counselled; and extending SOTAP to include offenders who are deemed suitable by the court for treatment in the community.153

In 2003–04, the government allocated $6 million over four years to establish treatment programs for adult sexual offenders.154

Offenders in custody

I would still like to know why it happened or if there’s other people like me. My own concern—and this is just for myself—but I wonder why when we come to prison we don’t get a course until just before we leave. … Just from my perspective, I come into prison … fully ready to admit as I did in court that I’ve done the wrong thing, but I expected to get some kind of help. I thought, well, at last—it was a bit of a relief actually when I got arrested. I thought, well, at last now I’ll get some answers, you know, and get some help, but all they’ve done is locked me in with a heap of really bad guys and I haven’t learnt anything productive since I’ve been here.

Evidence from prisoner

In regard to the Layton recommendation for a specialised prison-based treatment program, the Inquiry heard evidence from the RPB’s Dr Burvill, who has a masters degree in clinical and forensic psychology. The branch was established under the government’s 2003–04 funding for adult sex offender treatment programs and has now secured permanent funding.155 It is responsible for providing treatment for sex offenders and violent offenders and specific interventions for Aboriginal offenders. The branch’s Sexual Behaviour Clinic (SBC) provides the treatment to sex offenders in custody and the community. The treatment is an intensive group-based intervention developed in Canada. Groups typically run for between six to nine months with three to four sessions per week. The key issues addressed in the program are self management; cognitive distortions; emotion management; empathy and victim awareness; deviant sexual fantasy and arousal; intimacy, relationships and social functioning; and maintenance/relapse prevention. Most of the staff are psychologists and social workers, including four senior Aboriginal programs officers who ensure that Aboriginal offender participants are provided with intervention in a culturally appropriate manner.

The custody-based program is run at Yatala (B-Top) and Port Augusta prisons, where about half the group is Aboriginal. Dr Burvill told the Inquiry that the service is not provided at Mount Gambier prison because of a lack of resources and offenders there must travel to Yatala for the treatment. He said that he hoped the program would be conducted at the new prison at Mobilong and offenders ‘who need access will be rotated there when the time comes for their turn.’

153 Layton, recommendation 129.
The community-based program, which is run at Adelaide Community Corrections, is aimed at men who have sexually offended against adults, to avoid an overlap with SOTAP. For those who have completed the SBC program, an ongoing group-based and/or individual intervention program is provided at Mount Gambier and Port Lincoln prisons and in the community at Adelaide Community Corrections.

Dr Burvill told the Inquiry that one of the reasons for using the Canadian model was its data on recidivism rates. He said: ‘The Canadians have got data covering about 40,000 offenders and have been able to genuinely establish that the approach they’re using is reducing reoffending, so it’s logical to not reinvent the wheel’.

SBC is able to treat 60 offenders a year and targets men who are assessed as either medium or high risk of reoffending. However, it is limited to men in the last two years of their sentence, which means that the offender who is sentenced to a long term has to ‘wait a long time at the moment till he gets any treatment’. Dr Burvill hoped that within five years the program could be provided to offenders at the start of their sentence ‘so you can target people as they come in and then before they leave again’.

Dr Burvill told the Inquiry that one of the challenges is that the treatment is not compulsory. He said ‘it’s only when men are in the community that you can actually require them to receive treatment. You can’t force a person to receive treatment while they’re in prison.’ He referred to a few men in 2007 who had served their full term without treatment but were released into the community despite being considered ‘very, very high-risk offenders’. He said that the recent amendments to section 23 of the Criminal Law (Sentencing) Act 1988\(^{156}\) ‘provide a bit more of an incentive’ for offenders to engage in treatment as they will not be released until they have done so. The application of section 23 to an offender, however, is still an exception rather than the rule. Dr Burvill said that treatment could occur in the community if there were longer parole periods, however, he acknowledged that ‘we have to raise the confidence in people’s perception of supervision in the community’. He also referred to a system in New Zealand that provides an opportunity to place people on extended supervision in the community after the expiration of their head sentence.

Dr Burvill said two RPB staff are evaluation officers, who follow up with every offender. He said there would always be offenders who didn’t think it was worth ‘a hill of beans’, but that most offenders have found it of great benefit.

The proof will be in the pudding in terms of reoffending rates. I mean, we consider ourselves a child and adult protection agency. That’s our main number that you’re looking at—is reducing the reoffending rates for these chaps. If they also go on to have more fulfilling lives and are happier, well, that’s a bonus. But the main aim is to reduce offending.

Finally, he told the Inquiry that ‘the RPB is here to stay, so we’ll be expanding and providing treatment as best we can within our budget’.

The Inquiry supports the ongoing funding of RPB and its expansion to provide treatment to more offenders in custody and at an earlier stage of their sentence.

**RECOMMENDATION 13**

That the Sexual Behaviour Clinic of the Rehabilitation Programs Branch, Department for Correctional Services, be expanded so that all child sex offenders may attend the program while in custody and at any stage of their sentence.

**Young people in the community**

We were working with him about trying to understand what he did was something that needed to be addressed in some way, but no-one was having contact with him. No-one who was

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\(^{156}\) Criminal Law (Sentencing) Act 1988, s. 23 – ‘Offenders incapable of controlling, or unwilling to control, sexual instincts’; the Supreme Court may order that a person be detained in custody until further order; that period of detention may be after completion of the sentence.
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caring for him was actually encouraging him to even understand or appreciate or even work out—why would he even bother to understand, because he was just thrown into chaos.

Evidence from Alan Jenkins, manager, Mary Street, about a young offender.

In relation to the recommendation in the Layton report for the expansion of the Mary Street program, the Inquiry heard evidence from manager Alan Jenkins. Mary Street aims to help young people aged 12 to 18 stop sexual abuse and sexual harassment of others by encouraging the young person to take responsibility for their actions, to respect others, build appropriate relationships and make restitution to help heal harm caused by their actions. Young people may be referred to Mary Street by parents, caregivers or themselves; police, the Youth Court or Family Conference Team; Families SA; health and welfare workers; or schools, churches and other community groups. It provides counselling without charge; assessments for the Youth Court or organisations such as Families SA; training and consultation for health/welfare/justice/education workers; and consultation for policy development. Nada, which is co-located with Mary Street, provides therapeutic services, training and consultative services to other workers and is run in partnership by five professionals.

Mary Street promotes restitution with the ultimate aim of stopping abusive behaviour. Mr Jenkins told the Inquiry that the program is about helping the young person understand … the impact this has had upon [the victim] and to see also what it means for you and … what it’s doing to the kind of person that you aspire to be.

Many young offenders, while understanding that they have committed an offence, exhibit limited understanding of the effects of their abuse on others. Mr Jenkins said, ‘Restitution requires a capacity to be able to understand something about what you’ve done and the effect on others’.

The program has an important role to play as part of the family conferences in the Youth Court. Mr Jenkins told the Inquiry that following the Layton report, Mary Street received funding for another two positions: one focuses on Aboriginal young people and the other on residential care. ‘We filled those last year, so we’re sort of really developing, and it’s effectively doubled our program.’

Adults in the community

I’d like to see a recognition … that one of the best ways to stop future children being offended against sexually is to treat perpetrators and to treat them in the community

Evidence from Dr Andrea Louis, director, Sexual Offenders Treatment and Assessment Programme (SOTAP)

In relation to the Layton recommendation for the extension of SOTAP, the Inquiry heard evidence from the program’s director Dr Andrea Louis. The service was established in 1990 and is now part of the statewide specialist Mental Health Services. It provides a treatment service for adult perpetrators (aged 18 onwards) of child sexual abuse and has about 150 clients. It receives mandated referrals of offenders made by courts, the Parole Board and under the direction of their corrections officer, as well as voluntary participants. In particular, Dr Louis referred to an existing group of voluntary participants who have not offended but ‘recognise an inclination to sexually offend against a child’. She said that is one of the reasons why she has proposed a change of name to ‘Owenia House’, which does not say what the service is:

… That’s all part of the process of trying to get as many people as you can into the service and making it as easily accessible as possible. To have that term ‘offender’ in the title is very stigmatising and … you’re sort of hammering somebody’s self-esteem down their boots before you even get there,
so that's work you've got to do to bring it up; to sort of get them to the level that they start to take responsibility and start to address their relapse prevention plan. You don’t want to start behind the eight ball if you don’t have to, so the name change I think is quite important.

Dr Louis said it is also important for the treatment to be where it is—‘under a health umbrella and treating them in the community’—because it helps to ‘destigmatise and normalise the process’.

Most of SOTAP’s program is delivered via group therapy, which is considered best practice, and clients also see a primary therapist as they go through the program. The program involves clients’ attendance at least one to two hours per week, usually for 12–18 months.

Dr Louis said SOTAP recognised ‘that one of the best ways to stop future children being offended against sexually is to treat perpetrators and to treat them in the community, where they are eventually going to become part of the process’. As part of that she said it is important that there be easy access for people who haven’t perpetrated child sexual abuse to get treatment and ‘I think we can do that’.

She said that SOTAP has begun receiving referrals of clients as a result of the court imposing it as a bail condition. She indicated that it is important for the judicial system to know more about SOTAP and can mandate referrals so that at least the offenders or alleged offenders find out about its existence. She indicated that SOTAP is not partisan and does not provide reports for the defence or prosecution, only court ordered reports.

Arising from Dr Louis’ evidence, it is part of recommendation 12 that the community awareness program regarding child sexual abuse include the provision of information about treatment for offenders or possible offenders.

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**Promoting disclosure by children in State care of sexual abuse**

You couldn’t complain. Who do you complain to?

Evidence from PIC placed in State care in the 1970s, aged 13

The evidence to the Inquiry is that many PICs did not disclose the fact that they were being sexually abused when they were children in State care. They gave several common reasons for not telling.

Some PICs believed they would not be perceived as credible because of their age. ‘They’d never believe you, you’re only a kid.’ Some were first abused at a young age and told the Inquiry they were unaware that what had occurred was in fact abuse. One man who alleged abuse at several government institutions remembered, ‘I didn’t realise until probably 15 or 16 or something that I was doing something that I was not supposed to be doing and then, you know … the officers were getting away with it.’

Alleged perpetrators often depicted abuse as normal. One man told the Inquiry that when he complained to his holiday foster carers about alleged abuse, he remembers being told, ‘this is the done thing. This is what happens between all adults and children.’ Some witnesses recalled feeling confused as to whether the activity was abusive or consensual. One man who alleged abuse by a visitor during his placement at Brookway Park recalled:

I’ve never had [the alleged perpetrator] charged or brought it up because I’m still confused as to was he a paedophile … I thought we were having a relationship. I thought he was my boyfriend.

Another man told the Inquiry that he did not report the abuse he said he experienced at Colebrook Home because the same thing ‘had happened at home previously anyway’.

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Some PICs referred to the power imbalance. Many of the alleged perpetrators were persons in authority or an associate of an authority figure. A PIC who alleged an officer at the McNally Training Centre abused him on an outing told the Inquiry:

When we got near McNally’s [the officer] said to me, ‘You know the fucking rules, one word and you’re dead’, and that was it.

One witness who alleged abuse in an orphanage said:

I didn’t tell anyone. I was too scared because she was a friend of the mother superior and I felt they’re not going to believe me anyway, so no, I didn’t tell anyone. I was too scared to tell anyone.

Another woman, who told the Inquiry she was sexually abused by a foster carer when she was a teenager, described how the carer formed a close bond with her, to the exclusion of other foster family members. She said she became ‘infatuated’ with the carer and believed ‘[the alleged perpetrator] was the boss, right? What he said went.’

Some PICs referred to their dependence on the perpetrator. A woman who alleged her father abused her from the age of three—not stopping when she was placed in State care—told the Inquiry that she was terrified of him but, at the same time, [I] didn’t have anyone else to rely upon, so it’s the hand that feeds you and puts a roof over your head, so you have these conflicting thoughts even as a youngster.

Some PICs said they remained quiet because the perpetrator told them not to say anything. It was reported to the Inquiry many times that the perpetrator said ‘it’s our secret’. Another tactic was to say that disclosure would hurt another. A woman who alleged rape by a worker when she was a child at a residential unit told the Inquiry that after the alleged rape,

I remember him opening the door and saying—he said something to me, ‘I don’t want you to actually do anything about this’, you know. ‘My girlfriend is pregnant.’

Another tactic was to use bribery and prey on vulnerabilities. Some witnesses informed the Inquiry that they were provided with money, clothing, food and gifts, either in exchange for sexual activity or to continue the relationship. A man who alleged a two-year period of abuse by a senior volunteer with the department said that the alleged perpetrator

… helped me out over the years when I’ve needed something; a house or food or clothes or whatever.

… if I needed $20 or $40 I’d just go to his house, you know, and there was no question or doubt about it. He gave it to me. It wasn’t sex at that time.

It was sex when he wanted it.

The use of threats was another reported tactic used to prevent disclosure. One type of threat was that the disclosure would not have any result. For example, some witnesses said that they were told they would not be believed if they disclosed. A female in State care said that the perpetrator used her fear of her stepfather to threaten her, ‘If you scream out, [the stepfather’s] not going to believe you. He’s going to believe me.’ One man said about the worker at Glandore Children’s Home who he alleged sexually abused him, ‘He told me that if I told anybody that he would beat me up’. The PIC alleged that after he disclosed the abuse, the worker broke his nose. Several witnesses told the Inquiry that alleged perpetrators threatened to kill them. One man recalled of his alleged rape in Glandore Boys Home, ‘I’m five-and-a-half years old. I’m terrified—you know, scared shitless—and there’s this bloke threatening to bloody kill me’.

A more subtle form of intimidation was the experience of living in State care itself. For many, institutional care was synonymous with violence. One man who lived at Glandore Boys Home remembered, ‘apart from the sexual harassment was the physical violence [which] was unbelievable’. Not only did efforts to resist sexual abuse from staff or other residents in institutions often result in physical violence, but hours of forced rigorous exercise as
a form of psychological intimidation and punishment were routine at institutions such as Glandore and McNally Training Centre. Many witnesses who gave evidence about their experiences at the St Vincent de Paul Orphanage, Goodwood, used the word ‘terrified’ to describe their fear of the nuns. Some witnesses described a culture in institutions that punished disclosures. One man who alleged sexual abuse at Glandore Boys Home remembered, ‘They had a thing in there if you were a telltale, you suffered for it. You’d really get bashed up and everything else to go with it.’

Frequent transfers among placements gave children few opportunities to build trusting relationships. One female who alleged abuse while on visits away from Vaughan House said that on her return she never disclosed because ‘I didn’t trust anybody in there enough to tell them’. A man who alleged abuse in several institutions remembered, ‘You didn’t know who you could trust one day to the next’. Most witnesses described feeling isolated, not having a person in whom they could confide. Many reported having brief contact with their allocated social workers; some could not recall any visits from their departmental worker. One witness said, ‘I had lots of them. They’d come and go … You’d never be friends with one for long because they’d go; you know there’d be somebody else’.

The Inquiry’s Young People Advisory Group spoke about isolation and the importance of siblings being able to keep in contact once placed in care. They believed the current system splits families. One member said that she was stopped from seeing her brother and they are now estranged. She said, ‘It causes trouble’. She said she saw her sister against the department’s wishes and had maintained a relationship with her. It was said, ‘Sometimes foster parents do not like siblings getting together, or parents try and stop it, and the department discourages it’. The group suggested ways of ensuring that siblings kept in contact. These included camps or ‘get togethers’ for two nights or creating a place where children and young people could sit around and talk with each other with supportive staff. They said that children and young people in care could get together to discuss their experiences and seek help, guidance and peer support.

The Inquiry received seven submissions in response to its Issues paper about how to ‘encourage’ disclosure of sexual abuse158; five from organisations and two from individuals.

Professor Freda Briggs, Director, Centre for Child Protection, University of South Australia, submitted that children can be assisted to report abuse if they are given ‘an explicit, open, honest child protection program that tells them what is reportable behaviour’.

In its submission, the Careworkers Coalition was concerned about the way in which this issue was expressed submitting that ‘encouraged’ can be interpreted as being at odds with sound professional practice where disclosures should be made freely without a social worker soliciting for allegations.159 This is an important point that emphasises the need for social workers and care workers to be properly trained in this area.

Other submissions referred to the need to empower children in their lives generally and the need for the child or young person to have a suitable person they could trust. The department said ‘children disclose abuse in supportive environments’.160 The GCYP said:

Disclosure is more likely to occur in the context of a trusting relationship with an adult or a peer, emphasising the importance of consistency and proximity in the child’s relationship with carers and caseworkers …

The importance of the caseworker

I would have liked to have had someone that I could’ve talked to; someone that I could’ve related to there, you know. I think it might have helped if I saw my welfare worker a bit more often than never. Yes, someone that I could have formed a bond with.

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159 Careworkers Coalition submission, pp. 7–8.
because the other boys there were a lot older than myself, I remember, and there wasn’t that type of bonding happening.

Evidence from PIC placed in State care in the mid 1970s, when aged three

An important adult in the life of children or young people in care is their social worker. Departmental social workers have the case management responsibilities for children and young people under guardianship.\textsuperscript{161} Some of the PICs who gave evidence to the Inquiry spoke about receiving minimal visits from social workers and constant changes of staff. The Inquiry’s Young People Advisory Group also identified a lack of contact from social workers, stating there was a need for more one-to-one support.

In May 2004 in Keeping them safe – in our care, the government acknowledged that ‘many guardianship children do not have an allocated social worker or a case plan’.

In Keeping them safe – in our care: draft for consultation (September 2006), the government set out Action 5\textsuperscript{162} as ‘Connected care’. It referred to the ‘development of new and enhanced models of connected care’ that build a care team around the needs of the child. It stated that the government will ‘develop and implement care team protocols’ including:

- Identifying care team members who might include, in addition to the case manager, the child’s teacher, birth family member/relative, a clinician, a youth worker, a cultural or community link
- Defining roles and responsibilities of members of the care team including the care team leader who is responsible for ensuring the team is, like a parent, attending to all of the needs of the child so that he or she flourishes
- Communication and decision making processes that recognise and value the participation of each member of the team, including developing appropriate ways for children to participate.

Keeping them safe – in our care: consultation responses (May 2007) stated that there was strong support for initiating a ‘care team’ approach but responses indicated a need to properly define the concept, the membership of the team and individual roles and responsibilities. There was also some concern expressed about harnessing the right people and establishing a coordinated team.

As part of that consultation process, the CREATE Foundation was commissioned to prepare a report on the draft policies. CREATE’s report, Keeping them safe – in our care: feedback from group consultations with children and young people about the new directions document, was finalised in November 2006. The responses are important because they come directly from current and former children and young people in care. The responses relevant to social workers were:

- All of the participants said that having a good social worker was one of the most important things for young people in care
- Participants wanted to have a good relationship with their social worker
- The following were recognised by participants as the things that made a good social worker –
  - Someone who listens to you
  - Someone who visits or rings you regularly
  - Someone who spends time with you
  - Someone who takes the time to get to know you, what you like and what you do
  - Someone who calls you back when you call them
- All of the participants recognised the social worker as someone who gives them money
- The following were recognised by participants as the problems they had experienced with social workers –
  - Changed so often that they often did not know who their worker was

\textsuperscript{161} DFC, Rapid response, p. 47.

\textsuperscript{162} DFC, Keeping them safe – in our care: draft for consultation, pp. 26–8.
– Changing workers so often made participants feel that there was no confidentiality
– The location of their worker made it difficult to communicate with them; five participants had workers working in country regional district centres and they were in placements in the metropolitan area
– Took too long to call them back or help them organise things
– Did not involve them in making decisions about their care
– Did not always tell them about decisions that had been made about their care, such as why they were moving from a placement or how long they would be in a placement
– Worked with too many young people at a time contributing to not having enough time to get to know them
– Did not take them to a new placement, had them transported in a taxi
– Did not help them get to know their carer
– They did not help them resolve problems.

The participants recommended that:

• Social workers need to spend more time with young people, getting to know them and doing things with them
• Children and young people have one social worker from the time they come into care until they leave
• Social workers have less children and young people that they look after
• Social workers visit them regularly
• Social workers listen to young people and talk to them more about decisions that are made about their care.

In its written submission to the Inquiry in May 2007, the department acknowledged that, in relation to social workers, ‘current best practice promotes one-to-one contact with children and young people in care’. It stated that its Alternative care practice guidelines do not specify the minimum amount of personal supervisions and contact with a child or young person in care, but that they will be reviewed. It advised that current informal practice is at least a monthly visit, noting that it is important to remember that each child’s situation is unique so that frequency of visits should be dictated by the needs of the individual child or young person.

The Inquiry received several submissions in response to its issues paper regarding the difficulty in recruiting and retaining social workers. One submission stated that ‘social workers have a high burnout rate and they are often young and inexperienced and feel threatened by experienced carers’ with a ‘bullying culture’. Another submission stated that there has been ‘a long history of high turnover of social workers due to large case loads, lack of community recognition, poor supervision, support and stress’. The submission from the Care and Protection Unit of the Youth Court stated that ‘there is a high turnover of caseworkers and some departmental practices regarding transfer between teams contributed to discontinuity’. It submitted that family members comment on the negative impact on the child and family of frequent changes in social workers, which in turn has a negative impact on social workers and that it is difficult for children and young people to establish trusting relationships with a succession of workers, especially inexperienced ones.

The Australian Association of Social Workers, (AASW), submitted that there is a serious difficulty in recruiting and retaining social workers, referring to several factors:

• Stressful nature of the work: Child protection work is well recognised as a stressful and challenging field of practice. If social workers do not receive adequate supervision, support and ongoing professional development, they are likely to seek employment in other fields or suffer such things as burnout.
Inexperience: Base-grade graduates have the most direct contact with clients but many are young and inexperienced. The AASW stated that there is a lack of critical mass of experienced, competent, mature social workers in the department such that ‘a worker of six months experience is seen as an old hand’.

Supervision and mentoring: There needs to be professional supervision rather than procedural or administrative supervision, with mentoring by an experienced social worker, from an external agency if possible.

Qualifications: Historically the department was not seen as an employer of choice for qualified social workers. This is not assisted by the employment of people as social workers who do not have any professional social work qualification. The AASW indicated that it strongly advocates that the basic minimum requirement for a social worker should be a social work degree.

Continuing professional education: Another important factor in retention was considered to be training and ongoing professional development, however, the AASW stated that attendance at its own continuing professional education has declined in recent years reportedly due to an inability for social workers to gain approval to attend during working hours.

Code of ethics and practice standards: The AASW also referred to the fact that the social workers are not required to be part of a professional registration system. It stated that it supports registration and was in discussion with the State and federal governments.

The AASW submitted that there were high workload demands due to inadequate resources and recommended the development and monitoring of standards for workload levels and working conditions.

Families SA’s submission referred to recent research by the University of South Australia 163 and quoted its finding that:

The community services sector is one of the fastest growing in Australia … this means that the whole sector faces a critical knowledge gap with insufficient trained workers available and an environment where sectors are competing for limited human resources.

Families SA submitted that in 2007, it had about 60 per cent of the resources needed to respond to statutory requirements in the area of care and protection. It also stated:

Turnover of social work staff within the care and protection system is an inevitable consequence of highly difficult and emotionally challenging work. Families SA seeks to address the needs of our staff by providing relevant and timely support to staff including induction training for new staff. Specifically, Families SA 2006–07 business plan highlights recruitment and retention strategies such as core competency training.

Families SA advised the Inquiry that there were 19 vacancies for social workers at 30 June 2007.

In November 2007, the Guardian for Children and Young People told the Inquiry that every child and young person in care did not yet have an allocated caseworker:

… There are some children that are unallocated … they don’t have a social worker specifically allocated to them or, in some cases, they might be nominally allocated where they’re allocated to a supervisor or senior practitioner who is not meant to carry a case load but who can make the decisions essentially if something happens, but it does mean often that the relationship with the caseworker is seriously limited.

She said that while a good model involves the social worker making sure that the child or young person has a relationship with everybody in the social worker’s team, to

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cover for inevitable absences of the allocated social worker, nevertheless each child and young person in care

... should have a caseworker and should also have a face-to-face visit once a month by that caseworker, should have a caseworker who knows about the child and knows the history and knows their circumstances, knows their dreams of what they want to be and actively works towards that. That’s the ideal.

The GCYP told the Inquiry that social workers carry heavier workloads than they should. She said that while there had been a 15 per cent growth of children placed in care in 2006–07, ‘they haven’t had an equivalent number of additional social workers by any means’.

In summary, the evidence to the Inquiry indicates that there is a problem with recruiting and retaining social workers, which has resulted in a lack of experience; inexperienced social workers having insufficient professional support and supervision; workloads being too high; and a staff shortage. This is not a recent phenomenon. The importance of allocating resources to this issue, concerns arising from a high turnover rate of social work staff and the problem of workload management have been raised consistently with the department from the 1960s to the Layton report in 2003.164 The department has made some attempts to address the issues in terms of formal workforce planning, discussions with universities to review student placements to encourage students to consider employment with the department, establishing professional networks for staff in country areas to encourage staff to be willing to work in these areas, and undertaking four bulk recruitment processes a year.165

However, since the Layton report, the Inquiry has heard important and consistent evidence from former and current children and young people in State care about the importance to their protection of having regular contact with a caseworker. It is acknowledged that the following recommendation has significant resource implications; however, the lack of a trusted social worker to whom a child or young person could complain about sexual abuse was such a strong recurring theme in the evidence to the Inquiry that it is considered a priority.

RECOMMENDATION 14

That the following be formalised in, and implemented as part of, the Keeping them safe reform agenda:

- Every child and young person in care has an allocated social worker
- Every child and young person in care has regular face-to-face contact with their allocated social worker, the minimum being once a month, regardless of the stability or nature of the placement
- The primary guiding principle in determining the workload of each social worker is quality contact between each child and young person in care and their social worker, which includes face-to-face contact at least once a month and the ability to respond within 24 hours if contact is initiated by the child or young person.

As part of implementing the above, it is recommended that:

- Sufficient resources are allocated to recruit and retain qualified social workers
- Emphasis is placed on the professional development and support of social workers including –
  - The reduction of team sizes to a maximum of seven or eight, to increase the capacity for better supervision of social workers and their own professional development
  - Mandatory training in supervision for all social workers employed in supervisory roles
  - The introduction of a system of registration or accreditation for social workers, which requires ongoing professional development and training.

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165 Families SA, written response to this Inquiry, May 2007, p. 87.
4.1 State response to sexual abuse of children in State care

Training of social workers

I only ever have a recollection of one visit of a worker and I had a chat with the worker. I can’t remember much of it. It was really just, I think, ‘How are you going? Are things okay?’ Where I’d splutter out a few little stories about, you know, ‘Everything’s going okay’. I know that I was primed before any visit …

Evidence from PIC placed in State care in the early to mid 1960s, aged six

PICs also told the Inquiry about bad practices when a social worker would visit, which inhibited the establishment of a trusting relationship. For example, one PIC said, ‘When [my social worker] used to visit [my foster parents] … they would talk about other stuff and I seemed to be left out’. The Inquiry’s Young People Advisory Group raised a similar theme. Members said that they never saw their social worker without their foster parents. As one member said, ‘When you are six or seven years old how could you stand up in front of your abuser and tell your social worker you are being abused?’

It is crucial that social workers are trained in the nature of sexual abuse of children and young people in care, including recognising the signs, promoting disclosure and responding to such disclosures.

The department told the Inquiry that in 2005, it started the College for Learning and Development as its primary staff development program. The college has the status of an Enterprise Registered Training Organisation, which means that all learning programs and qualifications offered by the college are ‘designed, delivered and assessed to support the jobs that DFC staff actually do’.

It advised that the Families SA faculty of the College had developed four qualifications:

- Certificate IV in community services – targeted at financial counsellors
- Certificate IV in youth work (juvenile justice) – targeted at youth workers
- Certificate IV in community services (protective care) – targeted at para-social work positions
- Diploma in statutory child protection – targeted at social workers who have a social work degree. This includes child safe environments (addresses the indicators of abuse and neglect in children and mandatory reporting requirements); the justice information system (JIS); introductory care and protection; work safely; Aboriginal cultural sensitivity and respect; multicultural diversity; foster and enhance children’s development; and attachment and operate in a legal context.

The department stated that the college is required to review all learning programs annually and maintain active qualification advisory committees.

The department advised that several other specialist programs have been developed to support Families SA’s work, including attachment theory; cultural awareness and sensitivity; the justice information system (JIS); child safe environments (previously mandated notification); high risk infants; and parenting capacity.

In November 2007, the department informed the Inquiry about its current training for social workers. It advised that all social workers do not do all the listed programs and their learning plan is ‘constructed around their job role, job requirements and knowledge gaps’.

New social work staff undertake an induction, do their learning plan with the facilitator and their line manager, and complete a five-day introductory care and protection program. They may do the JIS and child safe environments programs ‘if required’. During the next 2–3 years they proceed through their learning plan, completing learning programs in a minimum of 15–20 training days.

Existing social work staff may do any learning program from the diploma that they and their line manager identify as appropriate in their performance development meetings and set out in their learning plan.

166 ibid., pp. 7–12.
167 ibid., p. 7.
The department stated that it has two key manuals of practice (Families SA Child Protection Manual of Practice 1 and 2) both of which “support staff in understanding and responding to situations of childhood abuse”.169

The Inquiry received nine submissions on the issue of training in response to its Issues paper. Five were from government (including the department) and non-government organisations; four were from individuals.

Professor Briggs told the Inquiry that the social work courses conducted at Flinders University and the University of South Australia simply did not prepare graduates to work effectively with children. She submitted that, as a result, Families SA had to introduce a postgraduate diploma course to make graduates employable. She was concerned that child development specialists had not had input into this course. One submission also expressed concern that the content of Australian university social work courses are ‘conspicuous by the absence of the child abuse topic in general and the topic of sexual assault of children in particular’. It referred to the United Kingdom, where an additional year of study focused on childhood in order to ensure that there are specialist social workers graduating.

The Australian Association of Social Workers, South Australia (AASW), submitted that the social work degree courses ‘include elements of child development and recognition of child abuse, including sexual abuse’.170 It advised that there is a research project currently being conducted to ‘map the child protection curriculum content in social work courses across Australia’. AASW said it offered a range of continuing professional education opportunities but attendance of departmental social workers has declined over the years. It understood that:

Internal training provided by Families SA has a procedural or operational focus which, while organisationally essential, may be insufficient to support social workers in their long-term professional career development.171

Relationships Australia (SA) submitted that front-line worker education programs172 coverage of sexual abuse should include:

- what constitutes child sexual abuse
- that it is a crime and a breach of human rights
- its prevalence in family and other contexts
- statistics on different perpetrator groups
- the tactics that perpetrators use to secure silence
- the abuse of power inherent in child sexual abuse
- that adult perpetrators are solely responsible for the abuse
- that children, by definition, are incapable of giving informed consent to sexual abuse
- that children should be able to tell trusted adults about any abuse they are subjected to
- what others can do if they suspect that a child is at risk (for example, reporting to police, Families SA)
- that child sexual abuse is a community issue requiring vigilance and appropriate responses
- how to respond to a disclosure
- how to understand the dynamics involved in disclosure (for example, a child disclosing has usually identified some quality in the confidant that they can trust—people who have been abused are often very attuned to ‘reading’ people’s likely responses)
- understanding needs beyond mandatory reporting protocols and requirements (that is, the needs of the person or child who has been subjected to child sexual abuse).

In oral evidence to the Inquiry in April 2007, Relationships Australia (SA) advised that it had provided training to juvenile justice workers and some residential care workers for about 10 years since 1997. The department now conducts that training. The training by Relationships Australia was always provided with a panel of children and

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169 Families SA, written response to this Inquiry, May 2007, p. 11.
170 Australian Association of Social Workers (SA) submission, 13 Apr. 2007, pp. 2–3.
171 ibid., p. 7.
172 Relationships Australia (SA) submission, p. 17.
4.1 State response to sexual abuse of children in State care

young people. It said, however, there were complaints about the training because workers considered they were being ‘told what to do by these kids who have no idea how hard their job is’. It said workers had the same reaction when foster carers were involved in providing feedback during the training.

It’s not that I would agree with everything that the foster parents or the children said, you know, but the fact that the workers couldn’t hear it without their own over-reaction was of great concern to us. The witnesses from Relationships Australia also said it was necessary to alert the Inquiry to

… the fact that [these ideas] have been operating and yet they are not readily accepted, and sitting behind that are a whole range of attitudinal things.

… what you’re asking of the services is very complicated … You cannot hear the criticisms or the concerns of people in care because you then feel responsible for it all, so therefore you deflect it; you get very defensive in relation to it. Whereas we need to encourage workers to be able to open their ears and listen and sit with the problem, knowing that they’ll have probably an inadequate response.

Relationships Australia stated that within that context there have been managers who have been very supportive. The witnesses made the point ‘that we need to keep thinking further about how to develop the skills of listening to children’.

Like training, ‘Oh, training, the best thing to do with a child, da, da, da, da, da,’ it misses the boat. It’s actually about speaking into those things and in a much more complex way. It puts that at the heart of it, the importance of that child’s voice in the system we’re talking about.

On the issue of the participation of children and young people in such training, the department advised that the current practice is to engage the CREATE Foundation to inform the training of social workers about matters relevant to children and young people in care. The department said, however, that as CREATE had limited numbers of young people available and could not attend all training sessions, an alternative was being discussed to invite CREATE to provide a series of stand-alone intensive workshops covering a range of staff roles. The department said, however, that:

It can also be a traumatic experience for any young person to stand up in front of a room of strangers and share intimate details of past life. To address this possible trauma, Families SA offers briefing and debriefing to non-professionals who present to training sessions. This may be managed by the allocated social worker or facilitator of the training session.

Former children and young people in care, as well as members of the Inquiry’s Young People Advisory Group, informed the Inquiry of their willingness to be involved in such training.

In summary, it is clear from evidence to the Inquiry that there is limited ongoing training to social workers specifically related to child sexual abuse and what is available is not mandatory; there is a need for children and young people to continue to participate directly in the training; and for the training to include the participation of professionals working in the area of child sexual abuse.

173 Families SA, written response to this Inquiry, May 2007, p. 87.
174 Ibid., p. 88.
RECOMMENDATION 15
That the training of social workers by Families SA in regard to child sexual abuse be reviewed to include:

• what constitutes child sexual abuse
• that it is a crime and a breach of human rights
• its prevalence in family and other contexts
• statistics on different perpetrator groups
• the tactics that perpetrators use to secure silence
• the abuse of power inherent in child sexual abuse
• that perpetrators are solely responsible for the abuse
• that children, by definition, are incapable of giving informed consent to sexual abuse
• that children should be able to tell trusted adults about any abuse to which they are subjected
• what others can do if they suspect that a child is at risk (for example, reporting to police or Families SA)
• that child sexual abuse is a community issue requiring vigilance and appropriate responses
• how to respond to a disclosure
• understanding the dynamics involved in disclosure (for example, a child disclosing has usually identified some quality in the confidant that they can trust—people who have been abused are often very attuned to ‘reading’ people’s likely responses)
• understanding needs beyond mandatory reporting protocols and requirements (that is, the needs of the person or child who has been subjected to child sexual abuse)
• listening to children and young people
• empowering children and young people
• caring for a child or young person who has been sexually abused.
• the role of the Guardian for Children and Young People generally and specifically as an advocate for a child in care who has been sexually abused
• the role of the Health and Community Services Complaints Commissioner as an independent investigator.

Input in regard to the content of the program and its delivery should be received from current and former children and young people in care and professionals working in the area of child sexual abuse.

The training program should be mandatory for all social workers.

The importance of suitable and stable placements

I shouldn’t even have been in that place. I should have been in a stable home—in a stable family home—and I should have been given a chance in life.

PIC placed in State care in the 1970s, aged 13

Based on submissions to the Inquiry, it is evident that disclosures of sexual abuse are also more likely to occur if the child or young person in care has a suitable and stable placement. In Keeping them safe – in our care: draft for consultation (September 2006), the government stated:

Above all else, we must deliver stability and certainty for children and young people in our care. This is about providing children and young people with a sense of security and safety; the capacity to form and maintain meaningful relationships; a strong self belief and the ability to reach their full potential; and an understanding of what their future holds.\(^{175}\)

There is no doubting the principle. In its submission to the Inquiry, Relationships Australia (SA) emphasised that a child ‘who is placed in care needs to have a consistent and reliable “protective cocoon” provided by a range of appropriately skilled interested parties’ and ‘needs ongoing relationships with skilled, empathic adults who are consistent, and readily available’.\(^{176}\)

Since 2004–05, the types of placements for children and young people in care in South Australia have been family-

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\(^{175}\) DFC, Keeping them safe – in our care: draft for consultation, p. 11.

\(^{176}\) Relationships Australia (SA) submission, p. 25.
Based care, residential care and emergency/short term care. In 2006–07 the number of children in those types of care was as follows:

- Family-based care, 87.3 per cent (consisting of foster care, 54.2 per cent; relative/kin care, 32.9 per cent; financially assisted adoption, 0.2 per cent)
- Residential care, 6.4 per cent (Families SA and non-government facilities). (There are six purpose-built Families SA community residential care facilities in metropolitan Adelaide—Gilles Plains and Sturt assessment units for new referrals; Lochiel Park, Campbell Town, Enfield and Regency Park community units for long-term care)
- Emergency/short-term care, 6.3 per cent (department housing, non-government organisation emergency, interim emergency).

According to the department, no children were placed in emergency/short-term care in 2002–03 and 2003–04, and four were placed in 2004–05. This rose sharply to 106 in 2006–07 because of the increasing number of children being placed in State care and the shortage of foster carers.

The Inquiry heard evidence about the inability of the child protection system to accommodate children in suitable care placements. In 2005, the Australian Centre for Child Protection’s Professor Scott, said that there is a shrinking capacity to care well for children in care:

There is such a shortage of placements that in some States children are now put in motels. The number of foster families is rapidly decreasing while the number of children coming into care continues to increase. The out-of-home care system is thus under tremendous pressure and also at risk of collapse.

The government acknowledged the problem in September 2006 and again in May 2007, stating that ‘our care services are having difficulty keeping pace with escalating demand and the needs of many children in the care system are being inadequately met’. It reported in September 2006 that:

- children are living in transitional accommodation because of a lack of long-term care options
- children and young people are moving from emergency placement to emergency placement
- children are being placed in potentially risky situations, for example, with unassessed carers or being returned to their biological family because there are no other options
- too many children are living in one foster care household
- there is burnout and a loss of foster carers
- children are being accommodated in unsuitable accommodation.

In May 2007, the government stated that ‘an immediate injection of funds will be provided to help transition children and young people in these placements into stable and quality care options’. In November 2007, the department advised the Inquiry that at the end of October 2007 there were 47 children and young people placed in serviced apartments, bed and breakfast accommodation and motels (at an average weekly cost of $5000 a child) and 29 children living in houses leased from Housing SA (at an average weekly cost of $3800 a child); those children were being cared for by contracted paid carers. The average annual cost of such emergency accommodation per child ($259,000) is 15 times more expensive than the average cost per child of foster care, relative/kin care or financially assisted adoption ($17,400 for each type of care).

No person would suggest such arrangements are suitable for a child. The department acknowledged in May 2007
that ‘it is a highly unsatisfactory situation, both for the children and for those trying to meet these children’s care needs’.  

Indeed, two of the participants in the CREATE Foundation response to the Keeping them safe – in our care: draft for consultation, had each spent more than six months in a motel. The recommendation by participants was that ‘Young people in care should never have to stay in a motel’. The Inquiry’s Young People Advisory Group stated that there is never enough permanent housing or beds in emergency accommodation.

One issue is the shortage of foster carers. In May 2007, the department submitted to the Inquiry that there ‘are currently insufficient foster placements available’ so that the primary focus of the selection process becomes one of placement availability rather than suitability. The manager of the department’s office for Foster Care Relations, Stephanie Kiley, told the Inquiry that the department had a long history of not valuing and respecting foster carers highly enough. The office, which has the task of brokering goodwill and creating better relationships with foster carers, is trying to have their voices heard and find practical solutions to issues. The Foster Carers’ Forum arranged by the Inquiry in May 2006 showed that foster carers want to be consulted. Approximately 250 attended the forum, most of whom were carers. A letter sent by Ms Kiley to the department’s foster carers following the forum received 100 responses from carers saying they wanted to contribute to the change process.

The Inquiry received eight submissions on a shortage of foster carers in response to its Issues paper. The Careworkers Coalition submitted that Anglicare placement officers report a ‘chronic’ shortage. The YWCA submitted that carers feel pressured to accept children when social workers say that there are ‘no other options’; placement is according to availability not compatibility; and a system already stretched will be more likely to accept a lower standard of care. Suggestions made to the Inquiry to overcome the shortage included increasing foster carer payments; reversing poor treatment of carers by departmental workers; making foster care more professional, rather than a part-time enterprise; and conducting research to inform recruitment and retention programs.

During the past 10 years, senior lecturer in psychology at the University of Adelaide, Associate Professor Paul Delfabbro, has been commissioned by the department to participate in research on various aspects of the foster care system. In a recent report, he outlined various reasons for difficulties in recruiting foster carers, including the increasing involvement of women in the workforce, the ageing population, cost of living increases, a reduced interest in volunteering and frequent negative media coverage of reported cases of child abuse in statutory care. In giving evidence to the Inquiry, Associate Professor Delfabbro said that ‘there’s no question that in the last few years the numbers of foster carers are dropping off’. He said there are many reasons for this, including older carers becoming discontented with their role and not wanting to take on too many more children; and, with the cost of living rising rapidly, payments not covering expenses.

The department advised the Inquiry that foster carers are paid a subsidy ranging from $93.80 a week ($4895 a year) for children aged up to four years to $160.65 a week ($8380 a year) for young persons aged 15 to 17 years. It was acknowledged that the rates of subsidy have not kept pace with rising costs of caring for children, which has
resulted in a disproportionate share of the cost placed on foster carers, many of whom are unable to absorb the additional expense. It was stated that ‘the levels of remuneration should reflect the actual costs of caring for a child or young person’. It was acknowledged that ‘South Australia’s subsidy to foster carers is the lowest of any Australian jurisdiction’ and that ‘Families SA is currently developing a model of funding for foster carers’. Nine submissions in response to the Inquiry’s Issues paper said that the level of financial support was inadequate. In Keeping them safe – in our care: implementation194 (May 2007), the government stated that ‘as an immediate measure’, the rates were to increase by five per cent from 1 July 2007 ‘while we finalise new improvements to carer payments’. On 7 January 2008, the Minister announced an average 21 per cent increase in carer payments, effective from 31 January 2008.

Another factor identified by Associate Professor Delfabbro as being important to recruitment strategies was to ‘allow people to adopt a variant of roles in the system’. He considered that:

Greater advantage should be taken of people’s desire to become involved in short-term foster care, for example, via offering respite, mirror family and child-care opportunities to assist existing carers.

This was also the view of Professor Scott, who told the Inquiry:

There is so much we could do to support the placements that have a risk of breaking down, and particularly where there’s been that duration of a placement ... it’s shoring up those foster parents to be the closest to kin that this child will ever have. It becomes a very, very vital priority.

The Inquiry received six submissions that were generally supportive of residential care196 as an option for children and young people who do not want to live in a family care setting or whose needs are better suited to a different type of care. The department stated that:

While foster care does afford the most appropriate care for the vast majority of children and young people under the guardianship of the Minister; there will always be a group of children and young people with high and complex needs where traditional family-based foster care is not the most appropriate type of care to meet their individual needs.197

The department referred to Families SA research, in which Associate Professor Delfabbro found there was a need for residential care. The government reported receiving ‘mixed views’ about residential care in the responses to action eight, Residential and leaving care, in its Keeping them safe – in our care: consultation responses. Some people said there should be placements in a ‘family home’ setting where possible because residential care lacks continuity of carers; others felt that some children and young people do not benefit from placement in foster care; still others believed there was a need for therapeutic care models in residential care and a need to ensure more home-like environments.198

In regard to staffing levels in residential care facilities, the department submitted that its ‘experience in this area indicates that homes should be limited to three residents plus one emergency’.199 The Guardian for Children and Young People (GCYP) submitted that an acceptable standard was two adults with a maximum of five children and young people, less if they had a serious intellectual disability, or behavioural or mental health problems.200 In a progress report provided to the Inquiry in November 2007, the GCYP advised that this is supported in principle by the department, which said that it will be considered in long-term planning as immediate implementation would result in a loss of 16–22 placements in residential care. She said, however, that Community Residential Care facilities are being asked to accommodate more children (up to 12). As part of the work of the GCYP, its senior advocate visits residential and secure care facilities as often as possible. In her evidence the GCYP said:

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194 DFC, Keeping them safe – in our care: implementation, p. 7.
195 DFC, Evaluation of the South Australian foster carer recruitment services.
197 Families SA written response to this Inquiry, p. 102.
199 Families SA written response to this Inquiry, p. 104.
200 GCYP submission, p. 20.
[the senior advocate] does a bit of one-on-one with young people, particularly if she’s there in the residential care units because she can be there for three hours and so she will spend a bit more time with them.

She said that there has been a ‘great’ response from the children and young people; ‘they’ve really enjoyed it, particularly as they are starved of one-on-one attention, so they certainly appreciate that when they can get it’.

The recommendations in the CREATE Foundation’s response to Keeping them safe – in our care: draft for consultation included making residential care ‘more like a home’ and organising ‘less people living in a unit’.

RECOMMENDATION 16

That adequate resources are directed towards:

- ensuring that no child or young person ever needs to be placed in emergency accommodation such as serviced apartments, bed and breakfast accommodation, hotels and motels
- placing children and young people according to suitability of placement rather than availability
- the recruitment and retention of foster carers including providing adequate support (such as respite care) and ongoing consultation
- accommodating a maximum of three children in residential care facilities.

Training of carers

I … told [my foster mother about the abuse] … She said I mustn’t tell [my foster father] because I’d be sent back … She said no-one would believe me and in fact I don’t think she believed me either.

Evidence from PIC placed in State care in the mid 1940s, when newborn

The Inquiry considers that all carers, like departmental social workers, should receive training in regard to child sexual abuse.

Section 43A of the Family and Community Services Act 1972 provides that the chief executive of the department must ensure that training courses are available to approved foster parents together with ongoing support and guidance. Associate Professor Delfabbro found, in his recent research, that ‘the availability of training is likely to influence both the recruitment and retention of foster carers’. He referred to the view of The Fostering Network in the UK, that if applicants know that training is available, both during assessment and once they are registered, they may be more likely to persist with the recruitment process. He also referred to international studies that have shown that foster carers are interested in receiving training.

The Inquiry received 11 submissions on the issue of training carers in response to its Issues paper and all identified a need for improvement.

The Careworkers Coalition submitted that Anglicare’s training is a four-day course over four weeks. While attendance at this course is compulsory for prospective carers, it was submitted that carers do not attend all the seminars. The Careworkers Coalition submitted that it had anecdotal evidence that training, particularly for foster carers, was ‘patchy’ and some had not received any training in the prevention and recognition of child sexual abuse. It said that new care workers were supposed to undertake a four-day training course, but some were registered as carers despite not doing the course. Many who did not do the course were still registered as carers. The coalition believed that training in protective behaviour for foster carers should be included.

Children in Crisis Inc. submitted that present and past foster carers, relative carers and children in care should be involved in the training of carers:

The current voluntary-based system is one that continues to rely on carers who only have a very
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short orientation training program to prepare them for their role. Once they are registered as foster carers, there is no compulsory, competency based in-service training to ensure that all carers are adequately trained and skilled to meet the physical, emotional and psychological needs of the child while working with other professionals to achieve case plan goals.

It appears there is generally an ad hoc approach to in-service training which sees topical information presented for carers who may be interested in attending. It is not compulsory for foster carers to attend training sessions, and even if they do, the training is not accredited to ensure competencies have been attained.

Child entering the care system may indeed find a loving and nurturing family home, but due to lack of appropriate training and support, chances are they will not always find what they also equally need—skilled, competent and well-supported carers.

Families SA submitted:

It is clear that foster carers require substantially more education regarding the effects of abuse and neglect, and the effect that disrupted and disturbed attachment relationships can have on children.

Relationships Australia (SA) submitted that ‘foster carers require training and support to understand trauma and its potential behavioural manifestations and be able to respond appropriately’. In 2005 it opened a new training centre, the Australian Institute of Social Relations (AISR), which has received federal funding to become the first specialist training centre to provide training to community services and health sectors on issues such as domestic violence, sexual abuse, youth work, community development and social health. It has provided nationally recognised training to youth workers in several communities across the APY Lands. It was also involved in developing and delivering customised training for foster carers in the Remand Intensive Neighbourhood Care (RINC) program. Further, Relationship Australia’s Respond SA service provided statewide Aboriginal youth worker training about childhood sexual assault in Port Augusta, Ceduna, Murray Bridge and the APY Lands; and to Department for Correctional Services staff.

In 2006 the government acknowledged that there are children and young people with complex needs who can have challenging behaviours and the level of support, training, and payment of carers needed to reflect this. In Keeping them safe – in our care: consultation responses, carers indicated that they needed training and many people agreed with the proposal of establishing categories of carers around the needs of children and young people, with competency-based training, accreditation and remuneration. The government indicated that it would fund increased training for carers as one of its immediate actions.

Submissions from foster carers to the Inquiry also revealed a concern about the lack of specialised training provided in relation to the needs of the children and the problems they suffer; one suggested that ‘professional development’ should be compulsory at least twice a year. One PIC who works as a professional in the field told the Inquiry that:

While it’s stipulated within documentation that carers need to continue to attend foster care training, most of the carers will identify that they haven’t done any training in the last 12 month period, and I would advocate that I think that a carer’s registration needs to be conditioned on the proof that they actually have attended training.

The Inquiry considers it is critical for carers to attend compulsory training in regard to child sexual abuse. The training should be regularly updated and completed by carers every three years. Completion of an initial training course and updated training every three years should be part of a system of registration/accreditation of carers.

206 Relationships Australia (SA) submission, p. 25.
207 Remand Intensive Neighbourhood Care (RINC) is an alternative care program for children and young people who enter the criminal justice system. It is administered by Families SA. The young people are placed with selected foster carers, who have received specialist training.
208 DFC, Keeping them safe – in our care: draft for consultation, Action 6, p. 29.
209 ibid., Action 7, p. 33.
210 DFC, Keeping them safe – in our care: implementation, p. 7.
RECOMMENDATION 17

That Families SA and relevant stakeholders develop relevant training programs about child sexual abuse for all carers of children and young people in care (foster, relative/kin and residential carers).

That the programs be developed in consultation with current and former children and young people in care, and professionals working in the area of child sexual abuse.

The particular training programs must address aspects of child sexual abuse, including:

- what constitutes child sexual abuse
- that it is a crime and a breach of human rights
- its prevalence in family and other contexts
- statistics on different perpetrator groups
- the tactics that perpetrators use to secure silence
- the abuse of power inherent in child sexual abuse
- that perpetrators are solely responsible for the abuse
- that children, by definition, are incapable of giving informed consent to sexual abuse
- that children should be able to tell trusted adults about any abuse to which they are subjected
- what others can do if they suspect that a child is at risk (for example, reporting to police or Families SA)
- that child sexual abuse is a community issue requiring vigilance and appropriate responses
- understanding the dynamics involved in disclosure (for example, a child disclosing has usually identified some quality in the confidant that they can trust—people who have been abused are often very attuned to ‘reading’ people’s likely responses)
- understanding sexual abuse of children and young people in care with disabilities and the difficulties of disclosure
- identifying and understanding cultural issues relating to supporting disclosures by Aboriginal children and young people in care
- listening to children and young people
- empowering children and young people
- understanding needs beyond mandatory reporting protocols and requirements (that is, the needs of the person or child who has been subjected to child sexual abuse)
- caring for a child or young person who has been sexually abused, taking into account the need for a therapeutic response and understanding their vulnerabilities
- protective behaviours for carers.  
- the role of the Guardian for Children and Young People generally and specifically as an advocate for a child in care who has been sexually abused
- the role of the Health and Community Services Complaints Commissioner as an independent investigator.

The training program should be mandatory and accredited. There should be a system of registration/accreditation of carers with registration being contingent on completion of this training; and the completion of updated training programs on this topic every three years.

Caring for children and young people with disabilities

Nobody told us she had sexual problems. Nobody told us she was depressed. Nobody told us she couldn’t use a knife or fork. Nobody told us she couldn’t cross the road … They didn’t even know her background. We never ever had a case plan. To this day, we’ve never had a case plan or anything.

Evidence from foster parents of a child with a disability

The need for stable care placements with carers specially trained in matters regarding sexual abuse of children and young people with disabilities is paramount in regard to protecting this particularly vulnerable group.
Reasons for this increased vulnerability include reduced cognitive and emotional judgment, reduced communications skills, lack of education about appropriate sexual behaviour and a reliance on others for intensive personal care.211

The Intellectual Disability Services Council (IDSC) submitted to the Inquiry that there are acute difficulties finding appropriate care placements for children with disabilities. It said that as a result such a ‘struggling service system contributes to ongoing difficulties for children in care who are subjected to inappropriate, unsafe, unsupported and/or multiple placements in which there is not the opportunity for rehabilitation or healing’.212 It considered that foster care is the preferred choice in the provision of alternative care, however, ‘there is a serious shortage of people willing to provide foster care, particularly for children with disabilities’.213 The IDSC submitted that while community residential settings may work well for some young people with intellectual disability, they are ‘particularly vulnerable in this system’ because it is possible for residents to leave the unit. IDSC told the Inquiry it was aware of several young people who regularly visited places associated with prostitution and substances abuse, stating that they are ‘at high risk of developing relationships with adults likely to perpetrate further abuse, and are at risk of finding themselves in dangerous and potentially life-threatening situations without an understanding of the risks they are taking’.214 The IDSC referred to the need for more intensive intervention and that while the idea of secure care is undesirable, there ‘needs to be serious discussion about the reality of the current system and the risks involved’ with ‘open debate about secure care’.215

In regard to the training of carers, Professor Briggs highlighted that although caregivers are told about the vulnerabilities of children with disabilities, the extent of sexual abuse has not been appreciated. Associate Professor Hayes stated that caregivers may not receive adequate training in behaviour management and so may not be able to assess potential indicators of abuse, or may attribute any behavioural changes to alterations to the routine of care. Attempts at disclosure may occur in forms that are not recognisable as a disclosure to an untrained caregiver, such as altered behaviour patterns.

To inform parents and carers about protecting children with disabilities from abuse, in 2005 Families SA’s Office for Disability and Client Services (ODACS) developed a resource booklet216 about child abuse and strategies for protecting children. The booklet also provides a ‘checklist’ of items that parents and carers should consider when choosing a service provider who will have contact with a child. While the booklet has been a useful resource, Families SA said ‘further work is required to raise awareness’ of the issue.

The Child and Youth Special Service in Disability SA runs an alternative care disability support program in partnership with foster families, carers and service providers. Part of the program is the provision of ‘education, information and training for foster families on factors contributing to challenging behaviour, and support to carry out specific intervention strategies’ in relation to caring for children with disabilities, ‘as very difficult child behaviour, stressful family issues, lack of support or knowledge about the child’s disability can significantly affect the coping abilities of foster families’. It does not specifically address child sexual abuse.217

Families SA submitted that the lack of specific training for carers in the area of disabilities ‘continues to be raised as a major service gap which impacts on all systems and particularly the children and young people’.218
Caring for Aboriginal children and young people

The Aboriginal children that we have today that are going through the system—I call them the lost generation. We’ve already had the stolen gen., but the ones that are going through the system now—we still have a great deal of problems with children that are still placed in non-Aboriginal placement, because we don’t have enough Aboriginal foster care so that they maintain that cultural connection.

Evidence from former South Australian child protection worker

As with all children, finding a suitable and stable placement for Aboriginal children and young people placed in care is crucial to prevent the risk of sexual abuse and to provide an environment in which they feel able to disclose the occurrence of any sexual abuse so that an immediate therapeutic response can occur. Because of the mistakes of past government policy in regard to taking Aboriginal children and young people into care in the first place, there are now real challenges to ‘getting it right’.

During the past 20 years, the Aboriginal child placement principle (ACPP) has been an important policy in Australia. The ACPP evolved in the late 1970s in response to the continued high numbers of Aboriginal children entering non-Aboriginal care. It was inspired by the Indian Child Welfare Act 1978 (US), which was designed to ensure that Native American children living on reservations were placed with their extended families or tribal groups as a first option. It is based on the premise that Aboriginal children are better off cared for in their Aboriginal families and communities; that being in close contact with family and kin can be important for the sense of identity, and as a source of learning and support, of Aboriginal children and young people.

In asserting a right to raise their own children in culturally appropriate ways, Aboriginal people are claiming no more than what most other Australians already take for granted. The [Aboriginal child placement] principle is also an important acknowledgement by the government that previous policies directed at Aboriginal children have caused suffering to Aboriginal people.

In 2003, a South Australian review of out-of-home care for Aboriginal children and young people stated that:

In South Australia, legislation requires that the ACPP be observed in relation to the placement of any Aboriginal child in alternative care. The principle is that an Aboriginal child should be placed in the following order of priority:

(a) with a member of the child’s family, as determined by reference to Aboriginal culture.

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219 See discussion in this chapter, ‘Prevention through early intervention: Aboriginal children and young people’.
223 DHS, Review of Aboriginal children in non-Aboriginal care, p. 3.
224 Children’s Protection Act 1990, s. 4(8); Children’s Protection Regulations 2006.
225 Children’s Protection Regulations 2006, r. 4.
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(b) with a member of the child’s community who has a relationship of responsibility for the child, as determined by reference to Aboriginal traditional practice or custom

(c) with a member of the child’s community, as determined by reference to Aboriginal traditional practice or custom

(d) a person with the same Aboriginal cultural background as the child

(e) a non-Aboriginal person who is able to ensure that the child maintains significant contact with the child’s family (as determined by reference to Aboriginal culture), the child’s community or communities, and the child’s culture.

The ACPP, however, is subject to the need to protect children from harm. As the Secretariat of National Aboriginal and Islander Child Care Inc (SNAICC) policy paper on out-of-home care for Aboriginal and Torres Strait Islander children and young people226 states:

> At the outset, it is important to clearly state that keeping children free from physical and psychological harm is paramount—equally as important for Aboriginal and Torres Strait Islander children as it is for other children. This paper focuses in large part on the need to maintain an Aboriginal or Torres Strait Islander child’s involvement with their family and community. This involvement, however, should never be seen as more important than the child’s safety. Maintaining connections to family and community is not a justification for leaving a child at risk of harm or making a placement that puts them at risk of harm.227

In South Australia, application of the ACPP is subject to the fundamental right of a child to be safe from harm.228

At 30 June 2006, 77 per cent of the 359 Aboriginal children and young people in care in South Australia were placed according to the ACPP. Of the 359, 33 per cent were living with relatives/kin (as compared with 24 per cent for non-Indigenous children), and 38.4 per cent were living with other indigenous carers. There were 7.8 per cent living with other relatives/kin (as compared with three per cent for non-Indigenous children) as a result of providing for complex needs or keeping siblings together.229

Respondents to the Keeping them safe – in our care: draft for consultation indicated that the ACPP must be adhered to, to ‘get it right’ for Aboriginal children.230 A member of the Inquiry’s Aboriginal Advisory Committee stated why it is so important:

> It is going to take years to enable Aboriginal people to find their way, learn about themselves, go in the right direction and meet up with people they should be meeting with. Culture is passed on through the way you are held, the body contact. It’s a whole mental involvement. You have to live the life totally and show them the bushes and the plants. It is difficult to transfer. You have to tell the stories and say what they mean. You have to start with languages. All the kids have to be proficient at the language first and get used to the terms and then start doing the different subjects like burials and dance and song.

However, some members of the Aboriginal Advisory Committee expressed concerns about a dogmatic approach to the ACPP. One said:

> The Aboriginal child placement principle should not be mandatory. It should include the phrase ‘an appropriate place’. A non-Aboriginal woman cared for two young Aboriginal people. She had a close connection with Aboriginal culture. The Aboriginal child placement principle tore her apart.
The Layton report also revealed concerns that inflexible application of the ACPP was increasing the risk of re-abuse and taking precedence over the needs of the child. A departmental employee echoed that statement, telling the Inquiry that while the principle worked well most of the time, placements sometimes became politicised and application of the principle could take precedence over the child’s interests and wishes. The employee gave an example of a five-year-old girl (whose parents and grandparent carer were dead), saying that after failed attempts to fulfil the ACPP, the girl was placed in the care of her grandmother’s friend, who was not Aboriginal. The girl ‘settled … and formed an attachment to her’. However, eventually, another relative interstate was found and despite the girl being ‘very clear’ that she did not want to go, the matter went to court and she was placed interstate. When advised of the decision, the girl sobbed and said she did not understand why she was not listened to. The last time the employee heard about the girl, she was being ‘handed around the family’ interstate. The employee said:

We have to grapple with what does it mean in terms of an Aboriginal child placement principle when children are forming attachments to people that others deem they don’t want them to be attached to because they’re not culturally appropriate, they’re not the right outcome we want. We get into a process where, particularly with it being reaffirmed even more strongly in the legislation now, that children continue to be disrupted out of placements and are unable to form any secure bond with anybody until they’re put in the right place.

In response to the Inquiry’s Issues paper, the Youth Court submitted that the ACPP provides helpful guidance but also can be driven by an ideological agenda that may not meet the needs of the child or family, particularly when the child has a mixed heritage. A non-Aboriginal relative may not be viewed as satisfactory despite the wishes of the child, parents or other family. There has been pressure exerted to move a child from a satisfactory ongoing placement with a white relative to a placement with a less known Aboriginal family member. The department submitted that the ACPP provides scope for the placement of Aboriginal children in the care of non-Aboriginal carers and families.

One member of the Aboriginal Advisory Committee referred to the lack of available care placements, saying that ‘while it’s a good principle, it’s not being implemented in practice because there aren’t any Aboriginal foster families left and none can be recruited. This is a national problem.’ Indeed, the 2003 out-of-home care review in South Australia said that Aboriginal child placement agencies are faced with the task of trying to recruit carers from among the most disadvantaged families in the population. It observed that with Aboriginal people making up two per cent of the population and Aboriginal children 24 per cent of children in out-of-home care, ‘even without accounting for very high mortality and morbidity rates, it is obvious that there is not the same pool of prospective carers on which to draw’. In *Keeping them safe – in our care: draft for consultation*, the government stated that given the numbers of Aboriginal children in care, it ‘continues to be difficult to recruit sufficient Aboriginal carers and this is a significant challenge in meeting our obligations under the Aboriginal child placement principle’. It stated that it would work actively to increase the number of Aboriginal kinship or relative carers, and provide support, resources and appropriate training. In its submission to the Inquiry, the department submitted that Aboriginal alternative care agencies are contracted by Families SA to recruit, support and train Aboriginal foster carers. It submitted that improved partnerships between Families SA and those agencies would enable ‘more appropriate and culturally respectful work with Aboriginal families and carers’.
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Other members of the Aboriginal Advisory Committee expressed concerns about the safety of children in some Aboriginal placements. One member said that the relative care program is not working well...

… because there is no authority in the home and that the majority of those children who are running around the streets in gangs are from families where there is no father figure, no discipline.

Other members were concerned about the neglect of children in some foster families:

Some children are left alone by some Aboriginal foster carers including in Intensive Neighbourhood Care placements. The carers are not supervised and no-one asks the children if they are satisfied with the placement. Evaluation of families needs to be more thorough and should continue with regular reviews. There is also a need for greater vigilance of some foster carers who may use allowances for drug abuse.

Submissions referred to in the Keeping them safe – in our care: consultation responses indicated that assessment and registration processes for relative, community and kinship carers should be streamlined.240 In its submission to the Inquiry, the department advised that the assessment process has been identified through several reviews and consultations as too intrusive, disrespectful and offensive to Aboriginal people and, as a result, a Kinship and community care assessment manual was being drafted.241

Given what has been described by the government as the over-representation of Aboriginal children and young people in care242, the issues raised about the application of the ACPP and the difficulties in finding suitable placements for Aboriginal children and young people, the Inquiry believes that the Office of the Guardian for Children and Young People requires specialist and additional resources in regard to the individual and systemic advocacy for Aboriginal children and young people in care.243

RECOMMENDATION 19

That there be a specialist position created in the Office of the Guardian for Children and Young People to assist in carrying out the guardian’s functions pursuant to section 52C Children’s Protection Act 1993 in relation to Aboriginal children and young people under the guardianship or in the custody of the Minister.

Responding to a disclosure by a child in State care of sexual abuse

… from my own personal experience, if someone had listened to me way back then, I wouldn’t have had the horrific journey that I went through; the fact that nobody listened.

Evidence from PIC placed in State care in the early 1960s, when aged five

When a child or young person discloses that he or she has been sexually abused, it is vital that the response to that disclosure is appropriate. Some PICs who gave evidence to the Inquiry said that they did tell someone about the sexual abuse when they were children in State care. They described a systemic culture in which children in care were either expected to ‘cop their lumps’ or were not believed. One woman described how ingrained that system was:

Even on the way in here [to the Inquiry] I say, ‘What if they don’t believe me and I’m going to go home and I’m going to feel the worse that I’ve felt’.

Some PICs gave evidence that, after disclosing, they were told that action would be taken. But they said they were never told what, if any, action was taken and the allegations were not discussed again. One PIC who alleged sexual abuse at Glandore Boys Home told the Inquiry that a staff member responded to his disclosure by saying:

… he would do something about it because he’d had other complaints but [the alleged perpetrator]
would stay there sometimes for three, six months or whatever, then all of a sudden he would disappear and I couldn’t ever understand because three to six months later he would come back, and everybody’s fear would just come back again because they knew what was going to happen. We could never understand why they kept bringing him back.

Another PIC said that after experiencing abuse in several placements with no action taken in response to any of his disclosures, he ‘just shut up about it. And it was getting to the stage where I was just thinking it must be okay, must be all right.’

Many PICs reported responses that they were lying, confused, or mistaken. One woman who disclosed abuse in the family home to her departmental worker remembered him telling her she was fantasising. In response, she said, ‘I just clammed up, shut up, and didn’t say it again … after a while you sort of give up telling people’. A man who reported sexual abuse by his father while on a visit out of the orphanage in which he lived recalled that when he disclosed to a nun on his return he got ‘a backhander across the back of the head and told not be blasphemous’.

Some PICs told the Inquiry that they suspected they were not believed because they had committed offences. One PIC said that his departmental worker’s response to his disclosure of sexual abuse was to tell him that he was an habitual troublemaker and liar: ‘I said, “Please get me out of here”. He said, “You are lying again.” ’ The witness said, ‘Why didn’t [the departmental worker] believe me? … I told officers what happened to me. They didn’t believe me.’

Some witnesses said that family members actively promoted the idea that they were untruthful. One PIC reported that her parent made statements such as ‘Whatever [the PIC] says, don’t worry about it because you know what? She lies about stuff.’

Responding to notifications of child sexual abuse

There was no independent person at any place I was at which was any of the homes; there was no independent person who I could go to to ask for help or to listen to me, so therefore I was stuck with the problem of either going to ask a senior officer or complain to a senior officer which, as I’ve stated in my file, the time I did that I was either ignored, I was told I was a liar; or told I was a troublemaker.

PIC placed in State care in the mid 1960s, aged 12.

The department may become aware of an allegation of sexual abuse against a child or young person either directly from the child or young person, or indirectly as a result of a mandatory notification to the department by a third person.

In South Australia, certain people must notify the department if they reasonably suspect that a child has been or is being abused or neglected.244 This includes sexual abuse.245 The reports are made to the child abuse report line (CARL) or, if the sexual abuse is suspected in relation to an Aboriginal child or family, then the report may instead be made to Yaltiya Tirramangkotti (staffed by Aboriginal workers).

The chief executive of the department is required to assess or investigate the circumstances of the child if he/she reasonably suspects that the child is at risk.246 This power can be delegated.247

CARL or Yaltiya Tirramangkotti assess the notifications and rate them according to a tier system. Tier one is an emergency response to ‘children in immediate or imminent danger’; two is a priority response to ‘children at high risk’; and three is a non-intrusive, collaborative response to ‘children in need but low risk’.

Tier one reports are immediately electronically transferred to the department’s district centres for urgent investigation; tier two are transferred the same day and are assessed for urgency; and tier three are transferred before the start of the next working day. There are two crisis care teams which operate outside normal hours.

244 Children’s Protection Act 1993, Part IV, Division 1.
245 ibid., s. 6.
246 ibid., s. 19.
247 The power to delegate such responsibilities is set out in section 57 of the Children’s Protection Act 1993, section 8 of the Family and Community Services Act 1972, and section 17 of The Public Sector Management Act 1995.
The department advised that of more than 16,000 notifications of child abuse and neglect in 2006–07, 3385 were of suspected sexual abuse.248

Investigating notifications of sexual abuse of children and young people in care

It should have been so easy to see the signs. I mean, when you see kids drawing stuff like that—just that would be enough to send a beep off in my head and go, ‘There’s something not right here. I best dig further.’

PIC placed in State care in the 1970s, aged eight.

The department’s Special Investigations Unit (SIU) was established in 2003–04 to … ensure the timely, independent assessment and investigation of allegations of harm or abuse by a carer, staff member or volunteer towards a child or young person in the care of the Minister.249

SIU is staffed by a manager, four investigations officers and one administrative officer. Manager Steven Edgington gave evidence to the Inquiry in 2005, when the unit’s guidelines were in draft form. The approved guidelines, Department for Families and Communities, Special Investigations Unit, Philosophy and Practice Guidelines 2007, were provided to the Inquiry.

For the purposes of SIU, a child or young person in the care of the Minister is:

- under a voluntary custody agreement250
- under an investigation and assessment order251
- under a care and protection order252 (includes children waiting for the finalisation of adoption orders)
- accommodated in a community residential care or secure care facility
- involved in a Families SA program or service
- in an approved and registered foster care placement paid for by DFC, or
- on a temporary protection visa and on community detention placed in an approved DFC care arrangement.

SIU may receive referrals directly from a person making an allegation, or from CARL or Yaita Tiramangkotti. It will then determine whether the allegation is a matter that warrants a ‘special investigation’.253 If so, the matter will be managed by SIU. It is stated that ‘any matter that warrants a police investigation will constitute a special investigation’.254 However, allegations of sexual abuse where the alleged perpetrator is not a staff member, carer or volunteer but is another child or a third party are not dealt with by SIU but at district office level.255 SIU also does not handle historical matters where the victim of the alleged abuse is over the age of 18.256

The SIU guidelines state that:

If the allegations constitute a possible criminal offence, the matter must be referred to SAPOL [SA Police] for their immediate assessment, or within 24 hours … concerns that should be referred to the police include: all allegations of sexual abuse …257

In cases where SAPOL is involved in any investigation, the SIU investigation must be made in direct consultation to ensure the integrity of evidence is maintained.258

The guidelines state that, as part of a special investigation, a strategy discussion is convened ‘as soon as possible to

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249 DFC, Special Investigations Unit (SIU), Philosophy & practice guidelines 2007, p. 2.
250 Children’s Protection Act 1993, s. 9.
251 ibid., ss. 20–1.
252 ibid., ss. 37–8.
253 DFC SIU, Guidelines, p. 7.
254 ibid., p. 7.
255 SA Police must be contacted in relation to all allegations of sexual assault and there must be liaison with the police before intervening. DFC, Child protection manual, vol. 1, p. 177.
256 DFC SIU, Guidelines, p. 27.
257 ibid., p. 9.
258 ibid.
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coordinate a multi-agency approach. The strategy discussion includes the SIU investigation team, the Families SA district centre manager and the manager of the alternative care service provider. It may also include SA Police and other people. The strategy discussion is recorded on the SIU report form, a copy of which is provided to all participants.

The department advised that the number of notifications of suspected sexual abuse of children in the care of the Minister concerning carers, staff or volunteers in the past three years have been 19 (15 carers, four staff) in 2006–07; 15 (11 carers, three staff; one volunteer) in 2005–06; and 26 (22 carers, four staff) in 2004–05.

The SIU guidelines do not set out specific practices and procedures relating to sexual abuse; the Inquiry considers that it is important that they do so. It should be clear that those notifications must be referred to the police; that no investigation by SIU occurs before that referral; and that once the matter becomes a police investigation, any subsequent action by SIU is not to be taken without the prior written notification to, and then approval by, SA Police. This would reduce the potential for prejudice to a police investigation or possible prosecution for sexual abuse that exists if there are two investigations running, even if one of them (SIU) is not investigating the alleged crime. As the investigator of the criminal allegations, SA Police must always be aware of any action SIU proposes, to ensure that no such prejudice occurs. In its submission to the Inquiry, SA Police stated that:

In some instances if there is a common aim, SAPOL and SIU work in partnership to ensure that the investigation is conducted appropriately and evidence relating to the sexual assaults is presented for prosecution. 260

The Inquiry considers that if such is to occur, there is a need for specific guidelines agreed between SA Police and SIU regulating that investigation. This should include the police directing the investigation and all such directions being recorded in writing.

One further matter raised in the Inquiry’s Issues paper concerned the potential for conflict of interest by SIU given that the investigations involve Families SA staff or carers.

The department advised that:

There is no potential for conflict of interest … the unit was specifically established so that it is independent of Families SA, and reports directly to the chief executive of the Department for Families and Communities. The role and function, and the processes adopted by the unit, ensure there is independence, objectivity and fairness for all parties, that all information is sought, considered and assessed. This includes obtaining information from victims, witnesses and alleged perpetrators, and all documents held by Families SA, as well as any alternate care providers. 261

Three other submissions to the Inquiry saw a potential for conflict of interest. The Careworkers Coalition submitted that SIU does not have the built-in checks and balances of a statutory body and that after three years of operation, it was not clear if SIU had completed an approved policies and procedures manual. Another submission, from The Premier’s Council for Women, suggested a separate unit overseen by an independent commissioner for children. The Inquiry agrees there is potential for a conflict of interest and considers that the Guardian for Children and Young People should be part of any investigation from its beginning. The GCYP’s role would be to monitor and represent the best interests of the child. This is considered consistent with the Inquiry’s recommendation that the GCYP act as an independent advocate for any child or young person in care who makes an allegation of sexual abuse. 262

259 Ibid.
262 See this chapter, ‘Responding to a disclosure by a child in State care of sexual abuse: Individual advocacy’. 
RECOMMENDATION 20

That the practice guidelines of the Special Investigations Unit (SIU) be amended to include specific guidelines concerning notifications and investigations of alleged sexual abuse of children and young people in care.

In regard to notifications, it is recommended that the guidelines include requirements for mandatory notification of sexual abuse allegations by SIU to South Australia Police and the Guardian for Children and Young People immediately or within 24 hours, depending on the urgency of the circumstances.

In regard to SIU investigations, it is recommended that the guidelines include requirements for:

- a strategy discussion between SIU and SA Police before the start of any SIU investigation, with the GCYP given prior notification of the discussion and invited to attend
- a written record signed by SIU and SA Police of the strategy discussion, outlining any actions to be taken by each, with a copy provided to the GCYP within 24 hours
- SIU to only take action in accordance with what was agreed in writing at the strategy discussion
- SIU to take no action that would prejudice a police investigation or potential prosecution. In particular, the SIU must not speak to the child, alleged perpetrator, potential witnesses or other potential complainants without seeking, and then gaining, approval in writing from SA Police
- the GCYP to be kept informed by SIU and SA Police of the progress and outcome of the investigation. Both SIU and SA Police to provide the GCYP with information concerning the investigation on request and to respond within 24 hours to any request by the GCYP for information regarding the investigation.

The need for a therapeutic response

It must be realised by those who have not suffered abuse that it is extremely difficult for victims of abuse to firstly face the prospect of making a formal complaint, and secondly to then come forward and articulate that abuse to others. Many victims live every day with the feelings of the shame and humiliation that was perpetrated against them. Respect and empathy is imperative in dealing with the victims.

Evidence from PIC placed in State care in the early 1970s, aged seven

Many of the PICs who said they disclosed allegations of sexual abuse as children, told the Inquiry that the response was far from therapeutic. Even if the response was positive in the sense that they were listened to and believed, they were rarely offered any counselling or therapy. Evidence and submissions to the Inquiry were unanimous in support for children and young people to receive appropriate counselling and therapy after a disclosure of sexual abuse.

Relationships Australia (SA) submitted that:

While child sexual abuse is destructive and can have ramifications that continue into adulthood, adults and children can and do move on from these experiences and can be assisted to do so. Just as the effects of abuse can be exacerbated by negative circumstances or events, they can also be assisted by positive relationships and appropriate therapeutic or other responses.

The Victim Support Service Inc. submitted that:

Access to counselling and therapy for a child goes without saying. Where a child requires therapy it should be available at the time of need. The treatment should be from a qualified therapist who is skilled in working with the issues arising out of sexual assault and in working with children.

263 Relationships Australia (SA) submission, p. 11.
264 Victim Support Service Inc. submission, Mar. 2007.
An individual submission said that the therapy should be provided by the same service that does the assessment. The Premier’s Council for Women submitted that support and treatment services are essential, including counselling for the child to be provided by trained and accredited child sexual assault professionals ‘since this work requires specialist skills’. Relationships Australia (SA) submitted to the Inquiry that

> When child sexual abuse has been disclosed we strongly support that the needs of the child should be the overarching priority. The child’s needs for safety and wellbeing extend beyond legal and assessment responses and should include mental health and counselling services that are consistent and available in an ongoing way. People delivering such services need particular skills, including the ability to listen to, notice and act upon the priorities, preferences and needs of the child.

David Tully, team leader, Streetlink, UnitingCare Wesley, Adelaide, gave evidence in support of a therapeutic response:

> I fundamentally believe unless certain interventions occur in certain ways, which revolve around a whole range of major issues, but mostly that if a child is blaming themselves for what’s occurred, that person is going to have extended issues through their life.

Evidence to the Inquiry not only identified the need for a therapeutic response to children in care who disclose sexual abuse, but also indicated that the existing assessment and therapeutic service provided by Child Protection Services and Child and Adolescent Mental Health Services (CAMHS) for children and young people must be reviewed and its resources significantly increased. In the Keeping them safe and Rapid response reform agenda, reference is made to the provision of therapeutic services to children in care, but not specifically to those who disclose sexual abuse.

Strategies 2 and 3.1–3.2 of the Rapid response reform agenda deal with ‘psychological developmental assessments’ and ‘therapeutic services, psychological’. Strategy 2 recommends an initial psychological and development assessment for all children and young people when they are placed in State care. Strategies 3.1–3.2 are aimed at prioritising a ‘more assertive response to the therapeutic needs of children and young people under the guardianship of the Minister’ and health regions providing therapeutic services where there are psychological, emotional or behavioural disturbances.

In Rapid response progress report 2007, Health Services reported that in partnership with Families SA, a set of Health Care Standards for Children and Young People under the guardianship of the Minister have been developed. In 2007 Health Services, in partnership with Families SA, released Health standards for children and young people under the guardianship of the Minister, which are to establish an agreed code of practice in relation to various matters including ‘developing priority access to health services for children and young people under the guardianship of the Minister including time frames’. Standard 2 provides that Health Services will make an appointment within two to three weeks (in a non-crisis situation) of receiving a referral from Families SA for a psychological assessment, and that the assessment will be reviewed annually. Standard 3 provides that in relation to outpatient therapeutic services, if the child or young person is not a ‘priority one (urgent)’ (appointment within four to six weeks) then they will be automatically be put at the top of a ‘priority two’ (appointment within 12 weeks) and allocated an appointment based on clinical need.

Counselling and therapeutic services for children and young people are currently provided by Child Protection Services, based at the Women’s and Children’s Hospital (CPS WCH) and Flinders Medical Centre (CPS FMC), and Child and Adolescent Mental Health Services (CAMHS).
CPS WCH, which serves the central and northern metropolitan region and northern country areas of South Australia, assesses and treats children from birth to 18 years and their families where there are suspicions of child abuse or neglect. Its services include:

- telephone consultation to discuss child protection matters and how to obtain appropriate services
- forensic medical/psychosocial/psychological assessment to develop an understanding of a child's situation by gathering information, forming opinions and making recommendations with regard to abuse, safety and needs of the child and family/carers
- therapy for children and family members where abuse has been established and there is evidence of resulting harm, which needs to be resolved to restore and enhance health.

It also undertakes research into abuse and neglect and provides training and education for health professionals.

CPS FMC, which serves the southern metropolitan and regional areas, provides assessments and longer-term interventions of children from birth to 18 years when there are concerns about sexual, physical and/or emotional abuse and neglect. Assessment involves talking to the child and his/her parents/carers. A medical examination is offered to every child. CPS FMC works with Families SA and, when appropriate, with the police. It also has expertise in longer-term interventions in the areas of child abuse and neglect, and working with children who are sexualised, with high-risk infants and their parents, and with parents who neglect and harm their children.

As part of its services, CAMHS provides confidential counselling for children and young people up to the age of 18 years and their families. Northern CAMHS is a division of Mental Health, Women’s & Children’s Hospital, and Southern CAMHS is a community service of Flinders Medical Centre. Each has its own regional services.

Yarrow Place Rape and Sexual Assault Service is the main public health agency responding to adult rape and sexual assault in South Australia. It provides specialist services to any person who has been raped or sexually assaulted and who was, at the time, 16 years or older. Its services include counselling and group sessions, medical, training, advocacy and resource development. Staff include a youth sexual assault counsellor outreach to the Shopfront Youth Health and Information Service and two Aboriginal sexual assault workers: one for youth and one for adults.

Dr Terence Donald, director of CPS WCH, and Karen Fitzgerald, director of CPS FMC, gave evidence to the Inquiry. Both were asked about the resources available for the provision of therapeutic services to children. Dr Donald referred to $2.6 million in recurring funding as a result of Keeping them safe. The money was used to create therapy positions at CPS WCH, CPS FMC, CAMHS and at Yarrow Place. However, he said that even with this funding,

… the majority of children who had been abused and harmed by abuse were not seen in any therapeutic context at all unless Families SA took some initiative with say CAMHS or something similar, and a lot of those kids were not getting any treatment. I mean, a lot of them aren’t now … we haven’t even reached 30 per cent treatment level across the State for children who have been abused, which I think is a disaster.

Dr Donald said that CPS WCH made a decision to focus on children and young people under guardianship. He said that the program was now full and that all participants were in foster placements. ‘Most of these kids will be managed long-term. We will still be seeing them, probably a year or two down the track. Maybe even longer.’ He said that the therapy requires ‘an incredible amount of extra input’.

When asked about possible reform, Dr Donald said that ‘there’s never been any proper look at our capacity to provide service’ given that the service is based in the Department of Health but also relates to police and
community services. He told the Inquiry that ‘double the staff’ in terms of psychologists and social workers would ‘make a significant difference … would increase our therapy provision very significantly’ as ‘we’d probably be able to see all the kids that we actually assess plus significantly more from Families SA who aren’t getting treated’. In trying to nominate an initial ‘reasonable goal’, Dr Donald said there needs to be funding to ensure that 60 per cent of children who have been abused receive therapy.

CPS FMC’s Ms Fitzgerald stated that it was also necessary to have a better service for country regions. Dr Donald said that the CPS WCH service to Port Augusta had to be stopped because of a lack of resources. He considered that Whyalla, Port Augusta and Port Pirie could be covered by the use of hospital rooms, saying that ‘in fact, the number of referrals that come from the country are not massive. We only get about 150 a year. So you can manage most of those relatively easily. It’s a tenable thing’. He said that there should also be a triage system in the country to assist in making better decisions about which children should come to Adelaide.

The Victim Support Service Inc. submitted that ‘it would be appropriate’ if both CPS services ‘were able to offer a comprehensive service to children’. The department submitted that Families SA social workers currently make referrals to appropriate services but that

… generally, therapeutic services for children are limited and not always readily available when required. Provision of additional services/resources, as well as financial support to ensure carer involvement in such services, would ensure more responsive treatment to children.271

On 20 November 2007, a director working in Families SA told the Inquiry that the CAMHS services are ‘so overstretched’ that the department has to

… outsource to private therapists in the community, so already that is additional money that we’re

spending because there’s a gap in the services. It’s really about two things: increasing capacity of those sorts of service and also in resourcing them and focusing on our client group.

In evidence to the Inquiry, the director of the Yarrow Place Rape and Sexual Assault Service, Vanessa Swan, said the service offered various forms of counselling to meet the needs of people presenting in different situations. If the sexual assault has occurred in the past 72 hours, counsellors respond within two hours: it is crisis oriented in that ‘it’s very much about people’s safety, their immediate affirming of their experience … making them feel safe and comfortable’, Ms Swan said. She indicated that the service does offer long-term counselling but ‘there’s more work to be done than we can possibly do’. For example, Ms Swan said that if a person over the age of 16 was sexually assaulted up to a year ago, then the wait for the first counselling appointment may be eight to 12 weeks, ‘and the chances of us being able to see you for very long are less’. However she said that because of some additional funding received under Keeping them safe, Yarrow Place did some counselling for 12–16 year olds; however it did not have the capacity to lower that age group at the moment. She said that Yarrow Place staff were ‘quite comfortable with middle adolescents and even probably 14s and above’ but ‘once we go below that, our staff feel that it’s a different body of knowledge’. She said that adolescence ‘is not well-serviced because I think we tend to have adult services and child services and people stretch each way to cover adolescents’.

The evidence to the Inquiry establishes that the existing provision of therapeutic services to children and young people by CPS, CAMHS and Yarrow Place is both highly professional and well regarded. However, it also shows there is a need for a review to examine how many children and young people the services are able to respond to, identify structures that need to be put in place to increase the level of response with the appropriate expertise, and estimate the resources required to achieve those goals.

270 Victim Support Service Inc submission, Mar. 2007.
271 Families SA written response to this Inquiry, pp. 118–9.
There is no doubt that significant resources would need to be allocated to achieve an appropriate level of response. The Inquiry believes it would make sense to encompass all children and young people in any such review of service provision, rather than only those in care.

**RECOMMENDATION 21**

That there be a review of therapeutic services to children and young people provided by Child Protection Services, Child and Adolescent Mental Health Services (CAMHS) and Yarrow Place Rape and Sexual Assault Service.

The review should include the:

- services’ ability to provide counselling and therapeutic services to children and young people in care
- structures required to increase the number of children and young people to whom counselling and therapeutic services can be provided, in both metropolitan and regional areas
- resources required to achieve an appropriate level of response, that is, the provision of counselling and therapeutic services to at least 60 per cent of children and young people who have been abused. Child Protection Services and CAMHS should receive a significant allocation of resources to increase their ability to provide such a level of response.

If a child or young person in care discloses sexual abuse, it is important that they are made safe and have a suitable and stable placement,272 and that their carers are trained to provide an appropriate, caring response273 and a safe and caring environment.

Dr Donald from CPS WCH told the Inquiry:

> One of the difficulties … (is) often the foster parents have no idea of what to expect; what’s happened to the child. It just blows them when they come [into a foster home] and they start doing things, particularly sexual things to other kids or their pets or toys. So trying to get some resources to provide, not just support, but actual therapy for the foster parents has been a big challenge.

Some of them will respond to just simply explanations, but some of them need actual therapeutic—it’s an intervention approach, otherwise the relationship can be set awry immediately, and they … instead of trying to understand why this kid has suddenly become like he is, they’d become punitive, which then escalates the whole thing. Then you end up with children running away … (or) they can’t cope, so they change placements. What we’re trying to do is consolidate … the relationship between the foster child and the foster parents.

Ms Swan from Yarrow Place expressed a similar view in relation to intrafamilial abuse, which applies equally to carers of children and young people in care. She told the Inquiry that the

... role or significance of the non-abusive parent … is really crucial … and I think that somehow catching some time in that crisis to support the non-abusive parent around what their response is and what their role is would be really critical as well, because I think that the immediate reaction at times can be that the non-abusive parent just does not want to know this information. It is very traumatising for them.

In its submission to the Inquiry, Children in Crisis Inc. stated that it must be recognised that the counsellor provides

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272 See this chapter, ‘Promoting disclosure by children in State care of sexual abuse: The importance of suitable and stable placements’.

273 See this chapter, ‘Promoting disclosure by children in State care of sexual abuse: Training of carers’.
limited assistance on a regular basis, whereas the foster carer is in a position to observe the child daily, provide important information for the therapist, and manage the child's behaviours. It submitted that the foster carer is the key person who can help with the treatment of the child and assist all relevant parties to understand the child's feelings, problems and needs. This is why foster carers need to have specialised training and be acknowledged as professionals in their own right.

In *Rapid response*, recommendation 3.1.2 states that health regions will provide therapeutic services to children, young people and foster carers where there are psychological, emotional or behavioural disturbances, and ongoing support to assist foster carers to provide effective and responsive parenting to children whose behaviours reflect attachment disturbances and issues of loss and grief. The recommendation does not make specific reference to a therapeutic response to disclosure by a child or young person of sexual abuse while in care. The Inquiry believes support in this area should be available to the relevant carers.

**RECOMMENDATION 22**

That therapeutic support is made available for the relevant carers when a child or young person in care makes a disclosure of sexual abuse.

Submissions made to the Inquiry referred to the need for carers to be appropriately informed about a child or young person in care making a disclosure of sexual abuse. Children in Crisis Inc. submitted that many children ‘are suffering and not receiving the help they need due to some agencies’ reluctance to impart such information to foster carers’.274 The Careworkers Coalition submitted that foster carers should be given as much information as possible about the child’s circumstances and needs. It said that because the carer is accountable, ‘nothing should be held back’. If it was, the coalition submitted that the carer may be unable to provide adequate support and would be vulnerable to allegations of inappropriate care. The department submitted that foster carers should be informed about the disclosure of the child and the features of any assessment relevant to the care of the child; ‘this is essential if the child is to be afforded appropriate, responsive care’.275

The government has developed the *Information sharing and client privacy statement* in relation to children and young people under the guardianship of the Minister, as part of its *Rapid response* reform agenda.276 It concerns the provision of information about a child or young person under guardianship by government and non-government agencies to the Minister and by the Minister/Families SA to other government agencies and people (for example, people with responsibility for day-to-day care, such as foster carers). The statement on information sharing is ‘to enable the improvement of continuity and quality of care and service’ for children and young people while at the same time protecting privacy. It states that ‘the views of the child (if she/he is able to form and express them) will generally be sought when disclosure of their personal information is contemplated’. For example, in the Foster Carers Charter released by the Department in September 2005, it is stated that foster carers have the right to ‘have as much information as you need to meet the individual needs of the child in your care’. It stated that it provides ‘the broad framework for information sharing and client privacy’ but that ‘specific procedural and protocol documents will be developed to provide operational guidance for staff and individuals in the wide range of contexts in which information sharing occurs’.

**Individual advocacy**

I never forgot nothing because I knew one day—through all what I went through—that one day I would get a voice out there, out in the world way,
you know, because virtually, when I got brought up in the homes and taken away at six, it was virtually—I didn’t know—the world was shut out to me.

Evidence from PIC placed in State care in the 1950s, when less than six months old

In their evidence to this Inquiry, adults who were sexually abused as children in State care consistently said they would like to have had a person in authority to whom they could have taken their concerns and who would represent their interests and intervene on their behalf with the Minister and the department.

The Inquiry considers that a child in State care should have such an advocate from the time he or she has makes an allegation of sexual abuse until the completion of the criminal justice process. The role of an advocate would be to monitor the response of the State to that allegation, including the child’s placement; organisation of therapy for the child; the response of the police in investigating the matter; the response of the Director of Public Prosecutions (DPP) in proceeding with the matter and providing witness assistance; and the response of the courts in progressing the matter.

One of the legislative functions of the Office of the Guardian for Children and Young People is to act as an advocate for the interests of children under the guardianship or in the custody of the Minister. In the GCYP annual report for 2006–07, Guardian Ms Simmons stated that the emphasis and intention in the legislation is on systemic advocacy and change.\(^{277}\) She advised, however, that the GCYP had been, in specific circumstances, advocating on behalf of individual children or young people. During 2006–07, the GCYP responded to 103 requests for assistance with individual children and young people, and intervened on behalf of 34. The sources of referrals and major issues of the 34 cases\(^{278}\) were:

### Source of referrals

- Families SA social workers: 9
- Self referrals: 6
- Foster carers: 5
- Educators in schools: 5
- Parents/guardians: 1
- Disability SA: 1
- Youth Court: 1
- **TOTAL**: 28

The source of referral for six cases was not stated.

### Major issues

- Education: 9
- Families SA decision-making: 8
- Inappropriate placement: 5
- Reunification practice or decisions: 3
- Allegations of abuse in care: 2
- Lack of contact with social worker: 2
- Mediation between Families SA and foster carers: 2
- Accommodation for young person with a disability: 1
- Transition planning for young person post 17 years: 1
- Advocacy: 1
- **TOTAL**: 34

In her evidence to the Inquiry, Ms Simmons said individual advocacy was not intended to be part of the role of the GCYP. However it had started to provide individual advocacy in ‘limited circumstances’, which was ‘fully supported by the Minister’, because there was ‘no other service to provide it’. She said that ‘then it expanded and now I’ve accepted and believe that it is a really important role of the office to do some individual advocacy work’. She said that the GCYP has acted as an advocate for the

\(^{277}\) GCYP annual report 2006–7, p. 10.

\(^{278}\) ibid., p. 11.
child in situations such as gaining access to birth family or siblings; Families SA not being able to get access to disability services or having a different view from the Department of Education and Children’s Services (DECS) about the type of class that the child might need to be in; psychologists having a different view about case decisions; DECS not being satisfied with a decision made by Families SA which means that a child has to change school; or Disability SA disagreeing with a decision by Families SA or the Education Department about the child. Ms Simmons described the role of the GCYP in this area of individual advocacy as being ‘a problem solver’, but that in doing so ‘we are partisan on the part of the child and that is our role and we will therefore take our action on that basis’. There is no doubt that the areas of advocacy, investigation and complaints overlap. Ms Simmons said the GCYP is not an investigative or formal complaints body. It advocates for the child, the Special Investigations Unit (SIU) investigates and the Health and Community Services Complaints Commissioner (HCSCC) is responsible for formal complaints. Ms Simmons said that three years ago, when the three organisations were new, there was a lot of concern that suddenly there was a large number of bodies that are all potentially looking at the same issue and people were saying, ‘Well, where is the difference in your roles?’ She said she believes the roles are clearer now to the extent that people understand the GCYP does not handle formal complaints. She says there is a close working relationship between her office, the SIU and the HCSCC in that each refers the relevant aspect of the problem to the other.

Ms Simmons said the GCYP could take on a role as advocate for a child who had disclosed sexual abuse under the guardianship or in the custody of the Minister. However, she said that her office would not provide ‘a support role’ in the sense of counselling; rather the role would be to make sure that the child received the counselling elsewhere, to make all other necessary referrals and to follow the child through the matter. She also said there should be discretion in the extent of the GCYP’s involvement in each case, given that some children may already have an advocate, whereas others may not and may need more involvement. In all cases, however, the GCYP could ‘monitor a matter to make sure that those things are in place for the child as the matter proceeds’.

RECOMMENDATION 23
That the Children’s Protection Act 1993 be amended to add a function to the Guardian for Children and Young People, namely to act as an advocate for a child or young person in State care who has made a disclosure of sexual abuse.
That in accordance with section 52B of the Act, the GCYP is provided with sufficient staff and resources to accomplish this function.

In order to undertake the role of individual advocate, the GCYP must be notified when a child or young person in care makes an allegation of sexual abuse. It is not intended to make it mandatory to notify the GCYP of third party allegations unless and until the child or young person makes the allegation. However, it is intended that it be mandatory for the SIU to notify the GCYP once the SIU has received such a third party notification to investigate.

RECOMMENDATION 24
That it be mandatory for the chief executive of the Department for Families and Communities or Commissioner of Police to notify the Guardian for Children and Young People when a child or young person under the guardianship or in the custody of the Minister makes an allegation of sexual abuse. (Also refer Recommendation 20.)
The Inquiry believes that the methods of record keeping need to be improved in regard to children in State care who have alleged sexual abuse (see chapter 6). During the course of the Inquiry, it was not possible to make an inquiry on the department’s computer system (JIS) to locate all children who had allegedly been abused while in State care. Given the recommended role of the GCYP as an individual advocate for such children, the department must ensure that appropriate records are maintained and are easily accessible. Families SA is currently developing a new case management system called C3MS (Connection client and case management system). The Inquiry recommends the system include a separate menu for allegations of sexual abuse of a child in State care, which would collate all the names. A separate field in relation to each child in care would record any information about allegations of sexual abuse, including when that information had been forwarded to the GCYP.

**RECOMMENDATION 25**

That Families SA’s new C3MS (Connection client and case management system) include a separate menu for allegations of sexual abuse of a child in State care, which would collate the names of all such children.

That the system include a separate field in relation to each child in State care, which is dedicated to recording any information about allegations of sexual abuse, including when that information had been forwarded to the Guardian for Children and Young People.

**Independent individual advocacy**

The Inquiry: Did you ever tell welfare about it?

PIC: No, I never had any confidence in welfare, you know. I didn’t believe anything would happen, because, you know, welfare put me in homes.

Evidence from PIC placed in State care in the late 1960s, aged seven

The Guardian for Children and Young People, Ms Simmons, gave evidence to the Inquiry that she did not feel at all constrained in the performance of her functions. The office describes itself as ‘an independent government agency’. Nevertheless, as a result of the evidence given by current and former children and young people in State care, the Inquiry considers it is important that the GCYP’s independence is formalised in the *Children’s Protection Act 1993*. As one child welfare expert told the Inquiry, ‘we do have to have some independent advocacy for children that’s professional, that’s dedicated and that’s fearless because, without that, I think the advocate becomes as powerless as the child’.

The word ‘guardian’ is confusing and does not lend itself to the GCYP office being regarded as independent. The Minister is the legal guardian of children and young people placed in State care; he stands *in loco parentis* to children under the guardianship or in the custody of the Minister. Unlike in NSW, it is not the role of the GCYP in South Australia to exercise the parental responsibilities of the Minister as legal guardian so the office’s title should not be open to confusion with the Minister.

**RECOMMENDATION 26**

That consideration is given to changing the name of the Guardian for Children and Young People to avoid confusion with the role of the Minister as legal guardian of children and young people placed in State care.

The GCYP is appointed by the South Australian Governor for a set term up to a maximum of five years and may be removed by the Governor for reasons set out in section 52A(5) of the *Children’s Protection Act 1993* as follows:

(a) breach of, or non-compliance with, a condition of appointment, or

(b) failure to disclose a personal or pecuniary interest of which the Guardian is aware that may conflict with the Guardian’s duties of office, or

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280 Children and Young People (Care and Protection) Act 1998 (NSW), s. 181(1)(a).
281 *Children’s Protection Act 1993*, Part 7A, s. 52A(4)(e).
(c) neglect of duty, or
(d) mental or physical incapacity to carry out duties of office satisfactorily, or
(e) dishonourable conduct, or
(f) any other reason considered sufficient by the Minister.

On its face, section 52A(5)(f) gives broad, unqualified power for removal from office and does not sit well with the idea of an independent GCYP. Comparison can be made to other positions established by legislation in South Australia. The same power is given to the Minister/Governor in relation to members of the Council for the Care of Children283 and the Child Death and Serious Injury Review Committee.284 There is no such power in regard to the:

- Director of Public Prosecutions, whose appointment may be terminated by the Governor for limited and defined reasons.285
- Health and Community Services Complaints Commissioner286, who may be removed by the Governor for limited and defined reasons including becoming, ‘in the opinion of the Governor, mentally or physically incapable of carrying out satisfactorily the duties of office’. The Governor may also remove the Commissioner from office on the presentation of an address from both houses of parliament seeking the removal.
- Employee Ombudsman287, who may be removed by the Governor for defined and limited reasons including mental or physical incapacity; and after presentation of an address from both houses of parliament.

RECOMMENDATION 27

That section 52A of the Children’s Protection Act 1993 is amended to delete section 52A(5)(f), powers of removal of the Guardian for Children and Young People, and replace it with provisions similar to the powers of removal relating to the Health and Community Services Complaints Commissioner and Employee Ombudsman.

Subsections 52A(6), (7) and (8) of the Children’s Protection Act 1993 state that the GCYP is to be subject to the Minister’s direction:

6 Subject to subsection (7), the GCYP is to be subject to the Minister’s direction.

7 The Guardian is not, however, subject to directions –
   (a) preventing or restricting the Guardian from carrying out inquiries and investigations that the Guardian considers necessary for the proper performance of statutory functions, or
   (b) preventing or restricting the Guardian from communicating with any body or person, or
   (c) as to the nature or content of advice, reports or recommendations given or made in the performance of statutory functions.

8 Any direction given to the Guardian by the Minister must be in writing.

The GCYP’s independence from the Minister and the department is not expressly asserted in the Act. Such expression is clear for the Health and Community Services Complaints Commissioner288 and Employee Ombudsman.289 In order to fulfil the function in section 52C(1)(f) (investigating and reporting to the Minister on matters referred to the Guardian by the Minister), it is evident that there must be some direction from the Minister; albeit restricted to the performance of that specific function.
RECOMMENDATION 28
That the Children’s Protection Act 1993 be amended to expressly refer to the independence of the Guardian of Children and Young People; that the GCYP must represent the interests of children and young people under the guardianship or in the custody of the Minister; and that the Minister cannot control how the GCYP is to exercise the GCYP’s statutory functions and powers—subject to section 52C(1)(f).

One of the GCYP’s functions is to advise the Minister on the quality of care being provided to children under the guardianship or under the custody of the Minister and whether their needs are being met. Under the Children’s Protection Act 1993, the GCYP must report to the Minister as requested by the Minister pursuant to section 52C(1)(f) and also produce an annual report; copies of all reports must be laid before both houses of parliament.

The GCYP may, however, consider some matters require a special report to the Minister, which should also be laid before both houses of parliament. There is currently no provision for this in the Children’s Protection Act 1993.

RECOMMENDATION 29
That the Children’s Protection Act 1993 is amended to allow the Guardian for Children and Young People to prepare a special report to the Minister on any matter arising from the exercise of the GCYP’s functions under the Act. The amendment should require the Minister to table the special report in parliament within six sitting days of receipt.

It should be expressly stated in the Act that the Minister may not direct the Guardian to change the contents of the report.

Under the Children’s Protection Act 1993, a government or non-government organisation must provide information relevant to the performance of the GCYP’s functions if requested by the GCYP. However, this does not apply to people who are not part of an organisation. Also, there is no penalty for non-compliance with the GCYP’s request for information; nor is it an offence to persuade or attempt to persuade another by threat or intimidation not to provide that information or to generally obstruct the GCYP.

RECOMMENDATION 30
That the Children’s Protection Act 1993 is amended to provide the Guardian for Children and Young People with powers to obtain information from any person in connection with the GCYP’s functions under the Act. This power should be coupled with a penalty for failure to comply. It should also be an offence for a person to persuade or attempt to persuade another by threat or intimidation not to provide information.

There should be general provision making it an offence to obstruct the GCYP.

It is recommended that the amendment be modelled on similar provisions to those of section 47(2)–(6) and sections 78–81 of the Health and Community Services Complaints Act 2004.

Complaints by current and former children and young people in care

As an ex-State ward who was abused ... which basically instantly gave me no choice but to run away from that danger. No matter what got in my way or what was in my way, I still ran away. There was nowhere to actually give my complaint. There was no tribunal that had any judicial powers to investigate my complaint properly that operated

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290 Children’s Protection Act 1993, s. 52C(1)(d).
291 ibid., ss. 52C(3) and (4).
separate and independent and run away from under the direction and control of the Minister.

Evidence from PIC placed in State care in the mid 1960s, aged eight months

The Layton report\(^{292}\) recommended that a special unit be created to investigate complaints and grievances in relation to services concerning children and young people.

The Health and Community Services Complaints Commissioner was established by the Health and Community Services Complaints Act 2004 (HCSC Act), which came into operation on 3 October 2005. Leena Sudano, who was appointed the HCSC Commissioner, gave evidence to the Inquiry in 2007.

As its name implies, one of the main purposes of the HCSC Act is to provide for the making and resolution of complaints against health or community service providers. However, what might not be evident from the name is that the HCSC Commissioner has jurisdiction to receive, assess and resolve complaints in regard to child protection services, which fall under the Act’s definition of ‘community service’. This means:

*a service for the care or protection of any child who has been abused or neglected, or allegedly abused or neglected, and includes any service that relates to the notification of any case of child abuse or neglect (or alleged child abuse or neglect), or the investigation of a case where a child may be in need of care or protection, or any subsequent action taken by a service provider arising from any such investigation.*\(^{293}\)

This broad definition enables the HCSC Commissioner to investigate complaints concerning the many services associated with child protection, care and sexual abuse, including actions of the department and non-government agencies, hospital and medical services, counsellors and related services.\(^{294}\)

The HCSC Commissioner has numerous other functions under the Act\(^{295}\), including reviewing and making systemic recommendations; providing education and advice about service rights and responsibilities; and assisting service providers in their complaints procedures.

The Commissioner’s main aim is “to improve the safety and quality of child protection services”.\(^{296}\)

The grounds on which a complaint relating to child protection services may be made are appropriately numerous and broad, and most relate to the issue of reasonableness or otherwise of the service provided.\(^{297}\)

The Commissioner may resolve individual complaints by:

- conciliation\(^{298}\)
- investigation (including the power to search documents and examine witnesses) resulting in the provision of a report to any person the Commissioner thinks fit\(^{299}\) and/or the service of a notice on the service provider requiring action within 28 days. The service provider has a right of appeal to the Administrative and Disciplinary Division of the District Court
- referral to a registration authority, which must investigate the complaint and report back to the Commissioner, or
- referral to another person or body.\(^{300}\)

Ms Sudano told the Inquiry that:

*Having complaints and grievance mechanisms widely available and accessible to these very vulnerable people and their advocates, having a reparations process that is restorative, and having*
4.1 State response to sexual abuse of children in State care

In the first 12 months, the Commissioner received 93 complaints, of which 73 per cent came from family members. All but one complaint involved services provided by Families SA.305

The Inquiry supports the continued existence of the HCSC Commissioner as a separate and independent investigative body in relation to child protection services, and the GCYP as the advocate for children under the guardianship, or in the custody, of the Minister. A Green Paper titled A Children’s Commission for NSW, released by the NSW Office of Children and Young People in 1997, rightly observed:

While an advocate promotes the needs and interests of the group it represents, the impartiality of a complaints handler must be beyond doubt. For a complaint to be properly handled, the agency must be completely impartial and know the potential strengths of any argument from both the complainant and the agency. Locating the two functions within the same body could compromise the performance of one or both of the important advocacy and complaints handling function.306

In recommending the establishment of the GCYP and the child protection jurisdiction of the HCSC Commissioner, the Layton report identified the need for their independence and clear delineation of functions:

The clear message is that it is vital in developing a structure to ensure independence, avoid conflict and clearly articulate the functions of each body to eliminate overlap and confusion. Further, it is also important to provide an efficient process with minimum bureaucracy suitable to the circumstances of South Australia …307

Under the HCSC Act, the HCSC Commissioner must operate independently and is not subject to Ministerial control in the exercise of statutory functions and powers.308

Further, the HCSC Commissioner can only be suspended

...
or removed from office by the Governor on presentation of an address by both houses of parliament or if the Governor considers that the HCSC Commissioner has become mentally or physically incapable of satisfactorily performing the duties of office.

The HCSC Commissioner also has appropriate coercive powers with respect to production of documents, examination of witnesses, search and seizure to assist in inquiries, and to conduct self-initiated investigations. In addition and importantly, the HCSC Act creates offences in relation to reprisals and intimidation of complainants, and obstruction of the HCSC Commissioner and others in the performance of functions and powers under the Act.

The Inquiry notes that the HCSC Act does not permit children or young people under the age of 16 to make complaints directly to the HCSC Commissioner. Instead, the complaint must be from ‘a parent or guardian’. The HCSC Commissioner’s website advises that children and young people in care aged 16 years old can complain themselves; if they are under 16 they can ‘ask someone you trust to contact us on your behalf’ or ‘the Guardian for Children and Young People can help you’. The GCYP gave evidence to the Inquiry that the HCSC Commissioner has used the GCYP to advocate for children by interviewing and hearing what the child has to say in a particular complaint. The GCYP reported that this arrangement is working well. The HCSC Commissioner reported in her annual report of 2006–07 that: ‘The Guardian can complain to HCSC Commissioner on behalf of a child in the care of the Minister’.

The Inquiry acknowledges the sound working relationship between the Guardian and HCSC Commissioner in the matter of child representation in the complaints process. However, it considers there should be no age restriction on complainants. The provision in the HCSC Act seems contrary to the important recognition in the government’s reform agenda of empowering children and young people. It also puts the onus on a child or young person in care to find an older person they trust. Further it may also be the case that the child or young person wants to complain about the GCYP.

**RECOMMENDATION 31**

That the *Health and Community Services Complaints Act 2004* be amended to allow all children and young people to make a complaint directly to the Health and Community Services Complaints Commissioner.

The Inquiry is also concerned that the title of the HCSC Commissioner does not identify the HCSC Commissioner as an investigative body of child protection complaints, particularly to children and young people. Ms Sudano told the Inquiry that ‘the level of complaints … didn’t ever materialise as a major part of the day-to-day work’.

The Inquiry considers that in order to raise awareness of the child protection jurisdiction, the HCSC Commissioner should be permitted to adopt a second title.

**RECOMMENDATION 32**

That the child protection function of the Health and Community Services Complaints Commissioner be promoted by permitting the Commissioner to adopt an additional title as ‘Child Protection Complaints Commissioner’. This should be enacted in the *Health and Community Services Complaints Act 2004*.

That within a reasonable time after the delivery of the Inquiry’s report to the Governor, there be a public awareness campaign concerning the role of the HCSC Commissioner to receive complaints from people (including current and former children and young people in State care) about child protection service providers.

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326 CHILDREN IN STATE CARE COMMISSION OF INQUIRY
In its Issues paper, the Inquiry sought views on the establishment of a differently constituted, independent commission to receive evidence and information from people who were sexually abused while in care. The Inquiry received eight submissions in response: three recognised an ongoing need for such a commission and five did not consider this to be the most productive use of resources, but indicated a preference for extending existing services and/or the powers of existing bodies.

One of the Inquiry’s terms of reference was to consider the State’s response to the matters that gave rise to allegations of sexual abuse of a child in State care. Evidence was received from PICs complaining about the manner in which the department and other organisations responded to their allegations. The Inquiry considers that the HCSC has the potential to fulfil this function to some degree.

Complaints to the HCSC Commissioner about child care and protection service providers (including Families SA) must be made within two years from the day on which the complainant first had notice of the circumstances giving rise to the complaint. The Inquiry did not have such a time limit.

However, the HCSC Commissioner has the discretion to extend this two-year limit after taking into account whether a proper investigation should still be possible; the complaint is still amenable to resolution; and it would be in the public interest. In deciding whether to extend the time, the Commissioner may also take into account any other matter considered relevant. In regard to the discretion being exercised in relation to historical allegations of sexual abuse in care, the HCSC Commissioner is obliged to consider the generally accepted standards of the child care and protection service of the time. These standards have changed significantly since the government’s Keeping them safe reform agenda in 2004. As a result, historical complaints may not be appropriate for the systemic review considerations relevant to the HCSC Commissioner.

While it is a matter for the HCSC Commissioner’s discretion, it is evident that the HCSC Commissioner is not set up to completely replace the Inquiry in terms of continuing to hear and investigate historical complaints regarding child protection services and sexual abuse of children in State care. The significant resources that the State has expended in establishing and maintaining the Inquiry during the past three years for that purpose must be acknowledged. Importantly for the current and future children in care, the HCSC Commissioner is able to continue the Inquiry’s work by investigating complaints about more recent actions of child protection service providers. This will play a significant role in monitoring the implementation of Keeping them safe. As HCSC Commissioner Sudano said:

*The advantage … of my jurisdiction is that to the extent that any individual matter is pointing to systemic failures, I have the capacity to make systemic recommendations and, indeed, in this area of my child protection jurisdiction I’ve already started doing that fairly swiftly.*

The Inquiry believes the HCSC Act, which is due for review in October 2008, should contain a specific provision stating that a relevant consideration for extending the two-year time limit in the child protection jurisdiction is where the complaint arises from circumstances dating back to May 2004 (when Keeping them safe was launched). This could be a matter to be considered relevant by the Commissioner pursuant to section 27(2) of the HCSC Act.

**RECOMMENDATION 33**

That an amendment to the *Health and Community Services Complaints Act 2004* provides that a relevant consideration for extending the two-year limit in the child protection jurisdiction is that the complaint arises from circumstances since the launch of the *Keeping them safe* reform agenda in May 2004.
Chapter 4 State response

The criminal justice system

Police response

When I got [to the police station] I remember he went—they took him somewhere and took me in another room. I remember sitting there. They came in and said: ‘What’s your story?’ I said: ‘Well, my foster father is having sex with me’. I remember clearly them saying: ‘Yes, he told us that you tell lies and that you were going to say this story’. That’s all I remember. I don’t know what else was said but that’s all I remember: that, you know, ‘You’re a liar and he told us this’.

Evidence from PIC placed in State care in the 1960s, aged four

A police investigation will take place if a child or young person in State care discloses to an authority that they have been sexually abused. Such an investigation usually involves taking a statement from the child or young person (either a video recorded interview—usually done by Child Protection Services in the case of young children—or written statement), possibly a medical examination, taking statements from other potential witnesses and an interview with the alleged perpetrator.

In its submission to the Inquiry, South Australia Police advised that since 1995 it has received about 2200 reports relating to sexual offences with about 33 per cent of the alleged victims being children.312 It does not keep a record of the number of children who were in State care. It acknowledged past criticism levelled at the police practices concerning investigation of sexual assault including paternalistic, insensitive and unsympathetic male attitudes; blaming the victim; unresponsiveness; and lack of information given to victims by police about processes and victims’ rights.313 However, it submitted that ‘the police role and attitude in respect of investigating child sexual abuse and sexual assault in general has been the subject of some discussion in recent years’314 and that considerable progress had been made through ‘the enactment of major structural and organisational change’.315

After a 2003 review, the Commissioner of Police approved the establishment of the Sexual Crime Investigation Branch (SCIB) to investigate and manage all sexual assaults. The branch, which became operational in October 2004, has a particular focus on managing high-risk offenders outside intrafamilial situations. It investigates tier two (more serious) offences and the police local service areas investigate tier one (less serious) offences with oversight by SCIB.

The police Child and Family Investigations Units, which are based in six metropolitan local service areas, investigate intrafamilial child abuse. They have a working relationship with SCIB, as well as Families SA and other support agencies.

SCIB contains the:

- Child Exploitation Investigation Section (CEIS), which investigates persistent, systematic or predatory sexual abuse and exploitation of children, including suspected paedophile activities; organised child prostitution; serious sexual offences against children; and people who use their professional or voluntary involvement in child care, support, welfare, sport or other bodies for child exploitation or their own prurient interests.

- Paedophile Task Force (PTF), which investigates allegations of historical and systematic child sexual abuse in the Anglican Church in South Australia and other organisations; pre-1982 offences reported as a result of legislative change; and referrals from this Inquiry.

- Australian National Child Offender Register (ANCOR), which requires sexual offenders to keep the Commissioner of Police informed of their whereabouts and other personal details.316

- Victim Management Section (VMS), which is considered by the South Australia Police to be expert in interviewing victims of sexual offences. The section is regularly asked to interview intellectually disabled or mentally impaired victims of sexual assault over the age of seven.

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312 South Australia Police submission, 30 Mar. 2007, p. 7.
313 ibid., p. 7.
314 ibid.
315 ibid., p. 8.
316 See this chapter, ‘Child safe environments: National screening’.
SA Police submitted that:

The introduction of SCIB has provided the catalyst for change in SAPOL workplace practices and organisational culture which ensures that a victim of sexual assault will receive excellent, professional and consistent service from all members of SAPOL.\footnote{317}

It submitted that SCIB represents a significant step toward ensuring ‘a cultural shift’ in SA Police by raising the status of sexual offence investigations. For example, SCIB is responsible for contributing to continuous training and identifying any training gaps across SA Police.

SA Police submitted that its training in general sexual assault included the mandated notifiers’ course; a nationally accredited Certificate IV in child abuse investigation and interagency code of practice; a workshop on interviewing sexual assault victims conducted by SCIB to female officers (completed by 246 officers in metropolitan and country areas); and enrolment of VMS staff in Deakin University’s advanced practice in forensic interviewing of children.

Proceeding to trial

\begin{quote}
It’s almost like I’m carrying a backpack which was half full and every time something comes up in a delay it’s putting another pebble in the backpack and makes it heavier.
\end{quote}

\begin{quote}
Adult witness who was a victim of child sexual abuse
\end{quote}

During an investigation, the police may seek the advice of the DPP about whether charges should be laid. As a result, a solicitor or prosecutor from the DPP’s office may speak to the child. If a decision is made to prosecute, charges are laid and filed in the Magistrates Court. Some sexual offences\footnote{318} are dealt with in the Magistrates Court, either by a guilty plea or a trial, but most are dealt with in the District Court. Some are heard in the Supreme Court. In regard to those matters, the Magistrates Court conducts the committal proceedings, which involve the accused entering a plea, the filing of statements by the prosecution and the magistrate determining whether there is a case to answer.

If the accused pleads not guilty and the magistrate finds there is a case to answer, the matter is committed to the District Court.

Once in the District Court, the matter is listed for an arraignment hearing, at which the accused is required to enter a plea. If the accused pleads not guilty, the matter is then listed for directions hearings to discuss various matters including the use of closed-circuit television (CCTV) facilities, disclosure of material by the DPP, funding and legal representation of the accused, and setting a trial date.

The trial prosecutor speaks to the child before the trial and generally calls him/her as first witness. Today it is usual for a ‘court companion’ to accompany the child, sitting with him/her during the evidence. As well, children now usually give evidence by CCTV from another room, rather than entering the courtroom itself.

Unfortunately, the process from investigation to trial completion now takes many years. The Inquiry heard of a trial being listed for the second time in 2007 but not being reached the second time because of insufficient courts or judges; the complainant was 17 and had postponed her final year of school in order to ‘get through the criminal justice system’. She found out the matter was not going to be reached the day before it was due to start.

The Inquiry also received a submission from Mothers Against Child Sexual Abuse (MACSA) stating that:

\begin{quote}
… quite clearly the investigation and prosecution of child sex offences needs to be fast-tracked. A 2–3 year delay to reach trial is wholly unacceptable given that 2–3 years is a large proportion of a victim’s life. Delays clearly disadvantage children. Their families can’t move on. Delays also help defence lawyers to suggest to juries that the evidence of child witnesses is unreliable e.g. by asking questions about minute detail that is unrelated to the offences e.g. what colour was the offender’s shirt … In understanding that some of our cases have taken up to six years to get to court,
\end{quote}

\footnote{317} South Australia Police submission, p. 14.
\footnote{318} Summary offences and some minor indictable offences are dealt with in the Magistrates Court.
Chapter 4 State response

this is an extremely damaging position to take with huge repercussions on the emotional and mental state of child and mother, siblings and in turn damaging these relationships.310

The recognition of the particular problems caused by delay in the prosecution of allegations of child sexual abuse is not new. In 1986, the South Australian Government Task Force on Child Sexual Abuse reported delays of up to a year as normal and two years as not uncommon.320 The task force reported the detrimental effect on children as witnesses caused by delay:

Delays are likely to increase the ambivalence a child may feel about giving evidence. Feelings of guilt and fear of rejection by often hostile family members are likely to increase over time. It is also extremely difficult to engage a child in constructive therapy while a case remains unresolved.

The task force recommended the enactment of legislation to ensure that all courts charged with responsibility for dealing with criminal proceedings in which children are the alleged victims shall use their best endeavours to ensure a minimum of delay, with the child’s welfare being an important consideration in the listing of cases. It also recommended guidelines requiring the matter to be finalised (from the filing of a charge in the Magistrates Court to the trial) within six months and that the Attorney-General monitor the listing of child sexual abuse cases and present a report at regular intervals to the State Child Protection Council.

The Layton report also considered the delays in court proceedings involving children.321 It received submissions about the adverse impact that a delay of nine to 12 months can have on the prosecution of child sexual abuse allegations, including on the quality of the child’s evidence and his/her emotional wellbeing.

The University of Sydney’s Associate Professor Hayes gave evidence to the Inquiry about the deleterious effects of current delays in the criminal justice system on child victims of sexual abuse:

... the child two-and-a-half years later is a different child, and particularly if the child has had therapy. I mean, ironically what’s started off to help the child is probably also going to change the child’s evidence in an unknown way, and also at a period of time they’ve talked about what happened with an unknown number of people, and even though police can say to parents or carers scrupulously, do not talk about their experience, it’s just not going to happen.

In 2006, the government released a discussion paper on issues concerning rape and sexual assault,322 which raised the delay in the hearing of trials involving children as alleged victims of sexual abuse. The paper set out initiatives in other Australian jurisdictions, including a legislative three-month limit on the completion of a matter once it has been committed for trial323, a pilot program for a specialist child assault jurisdiction324 and a specialist list for allegations of child sexual assault in the Magistrates Court.325 After the government had received submissions in response to that topic in the paper, the Statutes Amendment (Evidence and Procedure) Bill 2007 was presented in parliament to insert section 50B into the District Court Act 1991 as follows:

Trials of sexual offences involving children to be given priority –

(1) The court will give the necessary directions to ensure that a trial of a sexual offence where the victim of the offence is a child is given priority over any less urgent criminal trial and is dealt with as expeditiously as the proper administration of justice allows.

321 Layton, ch. 16.
323 Sexual Offences (Evidence and Procedure) Act 1983 (NT) in Attorney-General’s Department, Review of South Australian rape and sexual assault law, Discussion paper.
(2) In this section sexual offence means –

(a) rape, or

(b) indecent assault, or

(c) any offence involving unlawful sexual intercourse or an act of gross indecency, or

(d) incest, or

(e) any offence involving sexual exploitation or abuse of a child, or exploitation of a child as an object of prurient interest, or

(f) any attempt to commit, or assault with intent to commit, any of the offences referred to in a preceding paragraph.

The difficulty will be in determining what is a ‘less urgent trial’ because of a general backlog of criminal cases in the District Court. In 2006, a District Court judge prepared an extensive report about various court-related matters, including delay, which was forwarded to the Attorney-General in June 2006. The backlog of court matters has risen dramatically from 70 at 30 June 2001 to more than 1800 at 30 April 2006, and has the potential to grow by 200 a year. The burden on the courts is considerable and increasing.

In late 2006 the Attorney-General established a Criminal Justice Ministerial Task Force, chaired by the Solicitor-General, Chris Kourakis QC. The task force ‘has a clear and simple mandate: to identify and implement practical measures to address backlogs in the criminal justice system’.326 It includes legal practitioners, members of the judiciary, government entities including the Legal Services Commission, South Australia Police and the State and Commonwealth DPP offices, as well as advocacy groups such as the Aboriginal Legal Rights Movement and the Commissioner for Victims’ Rights. This year the task force will ‘continue to work closely with the Justice Portfolio in developing a number of system measures to improve efficiencies, especially in the District and Supreme Courts’.327

326 Department of Justice annual report 2006–07, p. 5.
327 ibid., p. 5.

RECOMMENDATION 34

That the Criminal Justice Ministerial Task Force gives special consideration to the backlog of cases of sexual abuse involving child complainants and developing measures to prioritise the listing of those trials.

RECOMMENDATION 35

That the Criminal Justice Ministerial Task Force, or another committee specially established for the purpose, develop appropriate guidelines to ensure that trials involving child complainants of sexual abuse are fast-tracked.

Children and young people with disabilities

… for years, you know, I’ve been called a liar. … do you know what I mean? Because at the end I said that [the sexual abuse] didn’t happen …

Evidence from PIC with an intellectual disability, placed in State care in the 1970s, when aged four

The Inquiry heard evidence that children with a disability are generally disadvantaged in the criminal justice system, but face additional obstacles in the way their complaints are received and acted on when they are victims of sexual abuse. They reportedly have pressure placed on them not to proceed with their allegations; and when they don’t, it is left to Disability SA to support them as best it can.

The University of Sydney’s Associate Professor Hayes gave evidence to the Inquiry about her research in intellectual disability during the past 20 years. Much of her work focuses on the rights of people with intellectual disability, including those who have contact with the criminal justice system as victims or offenders.

She has argued that the police and judiciary’s lack of knowledge of people with intellectual disabilities is in itself a form of discrimination, which marginalises this group in the criminal justice system and leads to secondary victimisation by the criminal justice system itself.
She said:

Police and public prosecutors are not always making decisions about pursuing the case on the basis of the evidence, but rather on the basis of the IQ of the victim ... The time has come to face squarely these discriminating attitudes on the part of police, prosecutors, defence lawyers and the judiciary. Many of us have listened for years to polite suggestions that there needs to be more training for criminal justice personnel. Nothing has been done ... Our society does not evaluate the merits of a case on the basis of the gender, age or race of the victim, and yet there is no public outcry when a person’s intellectual disability is the primary factor in deciding whether to proceed with a prosecution. Most judges would not allow a defence lawyer to imply that the case against his or her client was nonsensical because the victim was ugly, or old, or black—and yet the assumption that no ‘normal’ person would want to have sex with a person with a disability can be openly canvassed in court. When did the personal characteristics of the victim become part of the defence?328

In 1990 a project was set up in South Africa to assist victims with learning disabilities in sexual assault cases. Victims were prepared for court, and psychologists advised investigating officers and prosecutors and provided expert testimony in court. Almost all of the cases involved allegations of rape. The conviction rate was 28 per cent, which was almost identical to the best conviction rates for sexual assault cases among the general population.329 Dickman and Roux, who reviewed the South African project in 2005, argued that the assessment of a person’s competence as a witness depends as much on the supportive facilities in court as it does on the abilities of the complainant. For example, it may be useful to have evidence given from another room using a camera, with a trained intermediary relaying questions to the victim.

In her research in NSW,330 Associate Professor Moira Carmody, Social Justice Social Change Research Centre, University of Western Sydney, stated that where a victim with intellectual disability does report abuse, the police interview is likely to be stressful, making it difficult for the victim to accurately relay what has happened. Police interviewers are usually not appropriately trained in communicating with people with intellectual disabilities. If a victim has difficulty in understanding conceptual terms or has memory problems, they will probably appear to be an unreliable witness.331 To minimise the likelihood of this happening the interview should be taken as soon as possible after the incident.

The Inquiry heard evidence about a South Australian police operation in 2002 where the alleged victims were children with disabilities at a private church school. Parents of those children were concerned that a man [X] had not been prosecuted for sexual offences committed against children from that school. After locating [X] in Queensland in 1998, police had made a decision not to extradite him back to South Australia for two main reasons. First, it was stated that the alleged victims were intellectually disabled and therefore ‘unreliable’ witnesses. Second, it was decided it would not be cost effective to extradite him. However the decision was reviewed in 2002 and [X] was extradited to South Australia to face charges relating to three boys who were intellectually disabled.

The police task force worked closely with the education office of the church that operated the school, Child Protection Services at Flinders Medical Centre (CPS FMC), and the Intellectual Disability Services Council (IDSC). CPS and psychologists determined the intellectual functioning of relevant witnesses and alleged victims and advised the police accordingly. If an interview was appropriate it was to be undertaken by the CPS FMC’s director, Ms Fitzgerald. Many of the witnesses or alleged victims, who had been children when the alleged offences occurred, were by then adults. Interviews of some of them were not possible because of their disability. One complainant who had an

331 ibid., p. 233.
intellectual disability told the police of sexual abuse against himself, which was supported by photographs of himself and another boy naked as well as a videotape showing the sexual abuse of a boy. The complainant was able to identify himself in the photographs and say that [X] and another man were present when they were taken. [X] was charged with multiple counts of sexual offences involving the complainant and two other children. The matter was listed for trial and the complainant went to court on the first day, prepared to give evidence. [X] pleaded guilty on the first day of trial and was sentenced to 10 years’ jail.

The police did a post-operational assessment and concluded that the initial decision not to extradite [X] was flawed. First, it was stated police had demonstrated prejudice and bias by assuming that people with an intellectual disability would make poor witnesses. Second, there was a mistake made in the information and assessment of the nature and seriousness of the charges against [X].

A matter of significance about this police operation is the manner in which the detectives approached this task once the decision to extradite was made. Experts, including workers at IDSC, worked closely with police to develop the necessary communication skills and supports for the prosecution to proceed. One detective in particular was highly commended by IDSC for his work with the complainant who was to give evidence at the trial.

In evidence to the Inquiry, Associate Professor Hayes said it is vital for police to receive training in communicating with people with intellectual disabilities. Furthermore, she said, every allegation should be followed up; it should not be the case manager’s decision whether or not the police or some other independent investigator should be involved.

Associate Professor Hayes said that children giving evidence in court should be allowed to narrate their story as far as possible: ‘Uninterrupted narration is likely to be the most accurate form of evidence’. She said research in which she was involved had shown that children who give evidence about a traumatic event are highly accurate when they narrate. However, the accuracy diminished the more they were interrupted and the more leading questions they were asked.

Families SA supported the concept of training for investigators and prosecutors concerning allegations of sexual abuse of children with disabilities. In addition, Families SA submitted that specialist training regarding the special needs of children with disabilities should be provided to the judiciary and prosecutors, and that solicitors representing children should be required to have that training.

4.1 State response to sexual abuse of children in State care

RECOMMENDATION 36
That specialist training is undertaken by police, prosecutors, defence counsel and the judiciary in regard to working in the criminal justice system with (child) victims of sexual abuse who have a disability.

Alternatives to proceeding to trial

Evidence from adult victim of child sexual abuse

The Inquiry received 15 submissions in response to its Issues paper on the topic of restorative justice as an alternative to the criminal justice system in cases of intrafamilial abuse.333 A few submissions expressed significant reservations about the concept of restorative justice for child sexual abuse matters, however most were in favour of having this alternative approach available.

Since 1997, the Centre for Restorative Justice (CRJ) in South Australia has been advocating for a different

332 Families SA submission, p. 113.
approach to the criminal justice system. The centre was ‘derived from significant community feeling at the time that different approaches to justice were needed to ensure that the current system did not continue to generate damage and harm’. A division of the Offenders Aid and Rehabilitation Services SA Inc. (OARS), the centre describes itself as a ‘venture with key collaborators from the victims movement with beliefs and ideals that hope to bring a balanced approach with respect to the rights and needs of victims. A strategic partner is Victim Support Services’. CRJ chief executive officer Leigh Garrett gave evidence to the Inquiry several times. The CISC Inquiry Commissioner was the inaugural chair of the CRJ. The CRJ focuses on four areas, including:

- action research and information dissemination on restorative approaches to justice
- innovative program development and implementation using restorative approaches to justice
- training and professional development programs for justice officials and administrators; educational policy makers and teachers; police and correctional services; and businesses that want to provide a different framework for employee relations and conflict resolution in their organisations
- accreditation, evaluation and audit service from a restorative perspective.

The CRJ defined restorative justice as:

A process that advocates that the people most effective at finding a solution to a problem are the people who are most directly affected by the problem, creating opportunities for those involved in a conflict to work together to understand, clarify, resolve the situation and work together towards repairing the harm caused.  

Restorative justice is another model of justice in which the primary victim is the person who was violated, not the State. The role of the offender is changed from a passive participant to one required to understand the consequences of their behaviour, and accepting responsibility both for these consequences and for taking action to repair the harm. This takes place within a community context, so that the process involves all the parties with a stake in the offence to come together to resolve collectively how to deal with the offence In evidence, Mr Garrett said restorative justice formed the basis of justice in Western Europe until the 12th century and was the norm in non-western cultures in New Zealand, South Africa and North America until colonial times. He said there are about 300 restorative programs in North America and more than 500 in Europe; Norway has a national mediation policy; Austria, the Netherlands and the United Kingdom have incorporated restorative justice into legislation; and it forms the basis of the juvenile system in Belgium.

The CRJ has recently worked with DECS schools to implement a restorative practices framework that approaches behaviour management in a different way. It began as a pilot project in 13 schools at the beginning of 2007 and in its first nine months there were positive signs that there had been a reduction in bullying, suspensions and exclusions. However, ‘most importantly, victims of bad behaviour and bullying are indicating their support for the process’ and some teachers have observed that ‘restorative approaches make it easier for some children to report matters of poor behaviour by others, because they believe that the process of resolving it restoratively is more likely to stop the poor behaviour’. The CRJ advised the Inquiry that it is now working with more than 40 other schools across the State to implement a similar framework. The CRJ submitted that:

**Whilst there appears to have been little research that we could find about this, one could surmise that the development of a culture that encourages the reporting and restorative resolution of poor behaviour, may have as a corollary, the possibility of**

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335 ibid.
337 Conditional cautions, Part 3, Criminal Justice Act 2003 (UK); see also <www.cps.gov.uk/publications> setting out the Code of Practice.
338 Centre for Restorative Justice SA submission, p. 3.
encouraging reporting of external matters of abuse and neglect to the school.339

It also advised that there are several overseas programs that use restorative approaches to assist in the prevention and reduction of harm associated with sexual misbehaviour and offending. In the Netherlands, the Centre for Restorative Action operates a family group conferencing process that is essentially restorative, to assist with the prevention of, and recovery from, sexual abuse of children in families.

The CRJ also referred the Inquiry to a 2001 paper by Professor Kathleen Daly, Professor of Criminology and Criminal Justice, Griffith University, Brisbane,340 in which there is discussion about retribution forming part of the restorative process. She stated that ‘restorative justice must ultimately be concerned first with vindicating the harms suffered by victims (via retribution and reparation) and then, second, with rehabilitating offenders’.

In its submission to the Inquiry, Victim Support Service Inc. stated that ‘there is a clear need for a greater recognition that restorative justice can become a significant track within the criminal legal system that supports the goals of victims’.341 It stated that the process could only proceed with the victim’s agreement and that the alleged offender must admit guilt.

The department, however, made an extensively researched submission to the Inquiry explaining its ‘significant reservations’ about using restorative justice in cases of intrafamilial sexual abuse of children.342 These included the possibility that the process may amount to secondary victimisation (including the issue of how a child can consent to such a process); power imbalances between victims and offenders; how ‘the best interests of the child’ may not be the same as the best interests of the family or offender; and that it may not overcome a victim’s resistance to report sexual abuse. The department also said that international literature during the past 10 years needed to be carefully analysed to ensure that restorative justice would serve the best interests of a child.

Relationships Australia (SA) submitted that the child should not be pressured into a restorative justice process. It said the dynamics involved in intrafamilial child sexual abuse, ongoing perpetrator tactics and ‘the acute sensitivity of children … to further pressure and coercion’ should be acknowledged.343 Relationships Australia said, however, that if an offender admits guilt then the offender should be dealt with in the criminal justice system because it was ‘imperative that child sexual abuse is not decriminalised’.344 Nevertheless, it supported ‘a cautious and well researched approach to the adoption of a restorative justice model in this area’.345 In relation to adult survivors of child sexual abuse, it submitted:

Professional practice experience with adult survivors of childhood sexual abuse and research within Relationships Australia (SA), gives rise to some caution about the concept of restorative justice in relation to child sexual abuse. Nevertheless, we do support this issue as an initiative which warrants further research and discussion.346

The Premier’s Council for Women submitted that any decision to follow a restorative justice process must be made on a case-by-case basis, with an independent professional assessment of the victim’s circumstances by a qualified child sexual assault expert.347 The council said it was important to recognise the continued existence of unequal power dynamics. It submitted that:

With clear guidelines, a restorative justice process could be useful in some cases, some of the time, and it should be one of the options open to those

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339 ibid.
341 Victim Support Service Inc submission, Mar. 2007, p. 3.
342 Families SA written response to this Inquiry, pp. 29–40.
343 Relationships Australia (SA) submission, p. 33.
344 ibid.
345 ibid., p. 34.
346 ibid., p. 33.
347 Premier’s Council for Women submission, p. 5.
who have been subjected to [child sexual abuse]. However, it should not be the only option, or necessarily the preferred option.

Other submissions referred to concerns about the power imbalance between the child and the perpetrator; potential manipulation of the process by offenders; the need for the perpetrator to admit guilt and successfully complete treatment; whether it would reduce or increase trauma for the victim; and the risk of trivialising the offence.

The Inquiry heard evidence that the Sexual Offenders Treatment and Assessment Programme (SOTAP) operates what it calls a pseudo-diversionary program, which covers situations where the child does not want the perpetrator to be charged with an offence or go to jail, but it has been agreed that the offender needs treatment for the offending to stop. The benefit, said director Dr Andrea Louis, is that the ‘whole family is alerted and educated’. To ensure the victim’s safety, during treatment the offender can be separated from the family and not allowed any unsupervised access. SOTAP said 10 per cent of its clients are doing this program. Dr Louis acknowledged that such a program should be available to ‘people who genuinely want to … change, rather than that little minority who want to use it as a way to get back into the family’.

South Australia is the only State that has a conferencing process for young people who have committed sexual offences.\(^{348}\) The Inquiry heard evidence from professionals at Mary Street about the program’s involvement with family conferences in the Youth Court. In relation to certain offences, rather than laying charges in court, a police officer may notify a Youth Justice Co-ordinator at the Youth Court of the offence so that a family conference can be convened involving the alleged young offender, his or her guardians or relatives and the alleged victim, although the alleged victim is not required to attend.\(^{349}\) The offence can be dealt with by way of caution or other remedies without going to court. If, however, the young offender breaches any undertakings, the police officer can lay the charge in court. Also, in relation to most charges laid in the Youth Court, the court may refer the charges to be dealt with by way of a family conference rather than sentence by the court.\(^{350}\) Mary Street can attend the conference, which may be delayed if the young person agrees to participate in the Mary Street adolescent sexual assault prevention program for 12 months. There may also be agreement that after completion of the program there will be a meeting or another process that involves restitution. The young person may return to court if they do not comply with the agreement. Mary Street’s Alan Jenkins said that it does not work for every young person. Rob Hall, a manager from Mary Street, told the Inquiry that experience has shown it is important that the child victim not attend the conference, but is represented by someone who has their best interests at heart. Mr Jenkins also said that there is a need to ensure that demands are not made of the victim:

> I think, too, we’re drawing a distinction between restitution and apology, and what is done in the name of apology can often be quite abusive in itself, whereas I see restitution requires a capacity to be able to understand something about what you’ve done and the effect on others, and then you can deliver something, you can connect in something that doesn’t require something more of the person you’ve hurt, like: ‘I’ve said I’m sorry. Now forgive me,’ and there’s a demand to give something more.

Although he had initial reservations about the conference process, Mr Jenkins said that he had now been ‘won over’ as a result of the difference from working with young offenders who have been through the traditional court system:

> … I look at the process of the conference where, one, he doesn’t have a lawyer—you know, there’s no lawyers part of that process, so he’s required to speak for himself, to be interviewed in that process about what he did and about what he thinks about it. He’s required to listen to, say, the family of the child that’s been assaulted, talk about what this has
meant for them. He’s required to participate in a process of looking at what would be a fair and respectful outcome of this, and there’s a sense of engagement I suppose, and a sense of commitment, and a sense of realisation that begins. Now, it begins there. It’s not enough; there’s a lot more that needs to happen. But I suppose the precedent or the foundation that it tends to set, I’ve felt, has been much more helpful both in terms of the young person facing what he’s done and in terms of the impact on others.

The Inquiry considers that a model for restorative justice should be developed by a panel of appropriately qualified people, including representatives from OARS SA, the Victim Support Service Inc., Yarrow Place, Child Protection Services, Mary Street, SOTAP, Aboriginal people nominated by the Council of Elders, the Office of the DPP, the Legal Services Commission, the Law Society, the Courts Administration Authority, SA Police and the judiciary.

RECOMMENDATION 37
That a panel of appropriately qualified people be formed to consider and establish a model for restorative justice in regard to complaints of child sexual abuse made by victims.

Adult disclosures of sexual abuse when a child in State care
During the three years 2004–07, the Inquiry received evidence from adults disclosing that they were sexually abused when they were children in State care. The alleged abuse dated back to the 1940s. The evidence included personal information about the long-term effects of child sexual abuse in care; the difficulties of disclosing child sexual abuse as an adult; and the motivations for disclosing to the Inquiry.

Long-term effects of child sexual abuse in care
The evidence received from adults about the long-term effects of child sexual abuse in care reinforces Relationship Australia’s submission to the Inquiry, which referred to research literature being

… unequivocal in asserting that a significant proportion of people who are subjected to child sexual abuse will, as a result, experience short- or long-term social, emotional and psychological problems of a serious and disruptive nature.

Those problems included a reduced capacity for trust, intimacy and sexuality; symptoms of post-traumatic stress disorder; high rates of depressive symptoms, anxiety disorders, substance abuse, somatic and eating disorders and self-harm, including suicide; reduced ability to parent and difficulty seeking help.351

One witness said: ‘Some people are stronger and can get through stuff, some aren’t, and no-one knows the degree of damage that it’s done because we’re all individuals’. Another said: ‘I put on a good front. I think the psychological scars are always there in your background. A lot of things will remind you.’

Some witnesses said they found their own ways to cope: ‘I’ve done my bit of crying, mate. It’s over and done with. Now I’ll just get on with my life.’ A large number of people said that sporting or leisure pursuits helped them interact socially. Some finished their education. Some had undertaken private courses of counselling, joined community groups and sought professional support services to ease the trauma of sexual abuse. Some people had become youth workers and participated in programs to assist children who had been sexually abused.

Most witnesses linked their difficulties in adult life to their abuse in State care. One male witness said:

They [the State] were given one of the most important jobs to do as far as I can see, and that
was to raise children into teenagers and then from teenagers into men, and a lot of that wasn’t done and it wasn’t provided.

Another said:

When you’ve had nobody to really guide you through life as a child … you don’t know—you’re out there by yourself and you have to learn by yourself.

The effects of abuse were both subtle and far-reaching. The Inquiry heard from many people who absconded as a result of abuse, or who were transferred among placements after being abused. As a result, many witnesses said they lacked basic numeracy and literacy skills. Asked whether he could read, one man said: ‘I still can’t, even today’. The evidence supports research that shows poor literacy and numeracy are secondary effects of institutionalisation.352

A significant number of witnesses said they were unable to express themselves as a result of being sexually abused. One woman said: ‘You lived in fear and you got very good at hiding feelings … Now I find it difficult to express emotion.’ Lack of trust was a major issue. Another adult said: ‘I’ve never trusted anyone in my life—never, ever. Not even my wife.’ Emotional intimacy was another area affected by abuse. A woman told the Inquiry she believed, ‘if you get close to people you just get hurt, so I try to keep my distance’. One man described his

… fear of getting close. Fear of intimacy, fear of abuse, fear of abandonment. It’s easier to be a loner and not have to deal with any of that, than to possibly deal with the pain.

The Inquiry heard from many people who experienced confusion and uncertainty in adult sexual relationships, including about their sexual orientation. Others expressed a belief that their adult sexual relationships failed because the childhood abuse had resulted in distorted ideas of appropriate sexual activity. Some people became very highly sexualised, believing they had been taught to see sex as love. Others rejected sexual intimacy. One woman said: ‘I’ve felt very dirty down there all my life’. Another: ‘I don’t like being touched. I don’t like any intimacy at all.’ From a man:

I find it difficult to talk to women and I find it difficult to talk—like, when it comes to the relations side of things I find it extremely difficult for me to trust a woman.

A woman said:

I don’t want anyone to touch me in a sexual way. I even find it hard to let people give me a hug. I don’t know why they want to give me a hug and I am always suspicious of people’s reasons.

Feelings of shame and low self-worth remained strong for many who gave evidence. As one witness said:

Once you give up on yourself … you turn yourself into a doormat and everyone will treat you so … If that’s all you know, you find comfort in abuse and it takes a lot to break free of that.

Another said: ‘You always had that in the back of your mind. I think instability … —or insecurity, should I say—they follow you on for many years’. Acknowledging abuse, one witness said: ‘doesn’t take away the fact that it’s happened to you. It’s there, and the shame still exists. That goes with you.’

A large number of people who gave evidence to the Inquiry described experiencing depression and unhappiness as adults. A male witness said: ‘For 30 years I have had nightmares that have woken me in the dead of night … I would become irrational and depressed and all those around me would suffer’. A woman said: ‘I can’t say I’ve ever felt happy. I don’t know what a normal life is like.’ A man said:

I still suffer the nightmares. I still suffer the sweats and believe me it kills you; it hurts you; it knocks you out. I mean, I just want to, I don’t know, forget about it all, but you can’t.

Many have used drugs and alcohol to cope with their emotions:

I drank a lot. I must have drank a heck of a lot because what it did was just block everything out for me and I was quite happy that way.

Another said:

I had a great life. I met a woman, settled down, had four kids … until all this stuff [the Inquiry] hit the papers and it brought back too many memories and I hit the booze.

The Inquiry also took evidence from people who self-harmed to cope with their emotions.

Witnesses expressed their difficulty in building close ties with children and grandchildren. Many said that sexual abuse as children in State care had affected their parenting as they did not have a stable upbringing to use as a reference. Some struggled to express affection, such as the woman who said: ‘What’s happened to me has affected my family … Because I wasn’t taught how to love, to care, I didn’t do that with my kids.’ On becoming parents and grandparents, witnesses told the Inquiry they often became over-protective toward children in their families. One woman told the Inquiry: ‘I always tell [my adult children] to keep to themselves and I explain that there are lots of nasty people in the world who want to hurt them’. Some described a fear of emotional and physical contact with their children. One man avoided ‘being too close to or touching my children’ for fear of becoming an abuser. He said:

I think … if I grew up with like a family structure … or knew how to actually give love out properly … I am sure I would have done a better job.

Inclinations felt by some toward sexualised interaction with their own children caused significant distress.

**The difficulty of disclosure by adults of child sexual abuse in care**

Disclosure for adults is an extremely difficult, complex and painful process that does not begin or end with a single disclosure … commonly, the abuse has been surrounded by silence, anxiety, confusion, fear and shame.

Submission from Relationships Australia (SA)

This sentiment was reflected in the evidence to the Inquiry which, for many adults, was the first time they had spoken about their sexual abuse. They gave evidence about not ever telling anyone and the mixed emotions involved in disclosing.

A woman said she ‘had never sat down and spoken at length about any of this to anyone’. A man: ‘I’ve wanted to, all my life, I’ve wanted to tell’. Reasons for suppressing disclosures of past abuse varied. Some witnesses described a long process of accepting what had happened before they could make any disclosure: ‘You spend all your life making yourself forget things’. Many found it difficult to speak out after experiencing repression as children. One witness described the feeling: ‘You get told so many times not to say anything, and someone suddenly says, “I want to hear what you’ve got to say”’. Others said of the Inquiry: ‘I thought that perhaps for the first time in my life somebody would be willing to hear my pain’ and ‘I’m just still overwhelmed that all of this is happening’.

Many experienced relief at being able to disclose: ‘Thank you for listening to my story … I’ve never really told anybody about it.’ Another said:

Thank Christ I’ve got that out of my system, you know. I’ve had good friends over the years, I’ve had good wives and good partners, and I told them nothing.

Many of the adults expressed how difficult it was to disclose to the Inquiry. A successful businessman said he was ‘totally frightened’ before giving evidence: ‘The butterflies were building up in my stomach. I nearly was going to pick up that phone and say, “Forget it”.’ Many broke down during their evidence. Often, witnesses apologised when overwhelming emotions halted their evidence. Some were still so traumatised they were unable to give evidence after making initial contact with the Inquiry.
Motivations for disclosing to the Inquiry

I think it’s good that it’s told so that it doesn’t happen to other people.

PIC placed in State care in the 1980s, when aged seven.

Relationships Australia stated in its submission that ‘for adults, the decision to disclose is not necessarily linked to the desire to report or have any formal action taken’. This was confirmed by the experience of the Inquiry. Some people asked for their allegations to be forwarded to the police at the time of their hearing; some needed time to think about it; and others did not want their information forwarded.

For some, the experience of approaching the Inquiry was affirming. Coming forward as one of many hundred people helped one woman in ‘knowing that it’s not just me’. Giving evidence provided some witnesses with a measure of personal comfort: ‘I feel very empowered by coming here and doing this’. For another:

The experience [of giving evidence] has finally helped me realise I am not drowning in a sea of despair but treading water in a lake of sadness. That is okay, I can now float around a little then swim to shore and step on to firm ground when I am ready.

Others expressed a hope rather than a certainty that coming forward would be therapeutic: ‘I’ve had days where I just want to give it all away. And I just hope that this [coming to the Inquiry] will end it.’

People gave evidence for others’ benefit as well as their own. One young woman said she hoped her evidence would help police apprehend alleged current abusers ‘before they do it to another person’. A man said: ‘This is why I am sitting here today, so it doesn’t happen [to children in the current system]’. An older man said: ‘I’d like that nothing like this happens to any other kids, for a start, because I’ve got grandchildren’.

Witnesses also spoke of wanting to alert the community to the prevalence of sexual abuse of children in State care. One man said, ‘I was thinking, well, if I don’t come forward and no-one else comes forward, no-one’s going to know what really went on’. One witness, who experienced sustained physical abuse at the hands of a carer who also locked her in a cupboard, saw the Inquiry as a voice for other ‘frightened little girls hiding in cupboards’. By coming forward, some witnesses hoped to give comfort to others: ‘Maybe my story might help someone else that had a lot worse things happen to them, and help them out’. Many witnesses said their motivation was to seek redress on behalf of former State children who had died:

Someone has to speak up, someone has to represent—I go back again to the people that aren’t here to represent themselves because it wasn’t fair on them, you know?

Acknowledgment / apology

Someone to say … ‘Look, I’m sorry it didn’t turn out the way that it should have turned out’. I suppose having an understanding why it bloody went down the way that it did, yes. Someone to say also, ‘Look, sorry we fucked it up’. I think it’s only now as I’m a lot older that I do look back and I know the pain, the suffering and the struggles that I’ve gone through, and that still persists.

Evidence from PIC placed in State care in the 1960s, aged six

Many people who gave evidence to the Inquiry expressed a desire that the State Government acknowledge that children placed in State care were sexually abused. One man said: ‘It’s really up to I guess whoever is in power today … but a sense of recognition of what happened would be helpful’.

Others sought an apology for varying reasons. Many
wanted an alleged perpetrator to apologise. Some believed that the State should apologise as they were abused by people employed by the State Government, in institutions operated by the State Government, or in private placements funded by the State Government. Witnesses said: ‘The homes back then and the people that run them should be held responsible for what happened’; ‘I want a public apology. I want the government to take some responsibility’; and

... the government ... could apologise. Not just have it in a book like they’ve got, ‘Sorry to the poor lost generation’, but they would apologise to people that went through this. They were treated worse than a dog. Worse than a dog.

Some saw an apology as necessary to their healing: ‘I’ve been hurt and that apology, a genuine apology, is extremely important to me, because it would help relieve some of the grief that sits there to this day’. Another witness said, simply: ‘I would just like someone to say, “Sorry”’.

In response to the recommendations of the Forde Inquiry, the Queensland Government issued a statement of apology in 1999 to people abused in government and private institutions during childhood. The apology read, in part: ‘we sincerely apologise to all those people who suffered in any way’.354

The Commonwealth Forgotten Australians report recommended that

... all State Governments and Churches and agencies, that have not already done so, issue formal statements acknowledging their role in the administration of institutional care arrangements; and apologising for the physical, psychological and social harm caused to the children, and the hurt and distress suffered by the children at the hands of those who were in charge of them, particularly the children who were victims of abuse and assault.

The Commonwealth Government’s response was that this ‘is a matter for State and Territory Governments, churches and agencies to consider’.

The Premier of Tasmania placed a formal apology on the parliamentary record in May 2005, part of which reads:

The Tasmanian Government acknowledges and accepts that many children in the care of the State were abused by those who were meant to care for them, by those who were charged with providing them with a safe and secure home life. We apologise to the victims, and we express our deep regret at the hurt and distress caused.355

In June 2005, the Premier of New South Wales apologised to children in the State Government’s care who experienced abuse:

The Government of New South Wales apologises for any physical, psychological and social harm caused to the children, and any hurt and distress experienced by them while in the care of the State. We make this apology in the hope that it may help the process of healing. The New South Wales Government is strongly committed to supporting families to reduce the need for children to be in care. Where children and young people are placed in care, the Government will assist with the services available to them. We hope that this apology will be accepted in the spirit in which it is made and that the New South Wales Government, our community partners and the community at large can continue to work together to build a better and safer place in which our children can live, grow and flourish. We know we need to listen to these people and work with them to make this a reality. I thank the House for the opportunity to make this important and much overdue statement. I hope this apology, along with the other measures that I have outlined today, will help bring healing and help to those young Australians who, at a vulnerable time in their lives, were let down by the system.356

The Victorian Government issued an apology in August 2006, in response to the Forgotten Australians report:

The State, the churches and community agencies...
cared for thousands of children over the years. For those who were abused and neglected, the message we wish to give to them is that we acknowledge their pain and hurt. We are also committed to working together with survivors of abuse and neglect in care and to promote the healing process. We take the opportunity provided by the release of this report to express our deep regret and apologise sincerely to all of those who as children suffered abuse and neglect whilst in care, and to those who did not receive the consistent, loving care that every child needs and deserves.357

The Western Australian Premier gave ‘an unreserved apology’ to all children who were abused in State care as part of his announcement of a $114 million compensation package in December 2007.358 He stated:

Acknowledgement and apology are often of great importance to child abuse victims because many may not have been believed by friends, family or authorities in the past.359

The Inquiry received four submissions in response to its Issues paper on the topic of whether the State Government should formally acknowledge that children in State care were sexually abused. The submissions were from a government agency, non-government agency, former young person in State care and a professional person working in a related policy area. All said there should be an acknowledgement that children were sexually abused in State care; one stated that an acknowledgment should make it clear that not all children in care were sexually abused.

**RECOMMENDATION 38**

That the South Australian Government makes a formal acknowledgment and apology to those people who were sexually abused as children in State care.

After the Inquiry: listening to adult survivors of child sexual abuse in care

... just listening and believing and hearing what somebody is saying is crucial and important.

Evidence from Relationships Australia (SA)

Evidence to the Inquiry showed how difficult it is for adults to make disclosures of child sexual abuse. There is no doubt that the decision to disclose after years of silence can take time and sometimes will never be made. Also, the decision to disclose as an adult after having been disbelieved as a child has its own difficult challenges. Some witnesses said they waited months or years after the Inquiry was established in 2004 before they had enough confidence in themselves—and the Inquiry—to make their disclosure. Some witnesses said it was important that the Inquiry was independent of government and its agencies, such as the department and police. Some were willing to make statements to police after being involved in the Inquiry.

As discussed earlier in this report, in its Issues paper the Inquiry sought views on the continuation of a differently constituted commission independent of government and its agencies to receive evidence and information from people who were sexually abused while in care. Of the eight submissions received on this topic, three recognised an ongoing need for such a commission and five did not consider this to be the most productive use of resources, preferring the extension of existing services and/or the powers of existing bodies.360

It has to be acknowledged that the Inquiry was extended from its original six-month time and resourced and conducted hearings for three years. Despite the extension, evidence from the PICs suggests there are other people who were sexually abused in State care, but who could not, or chose not to, disclose. After the Inquiry ended the hearings phase, a small number of people came forward wanting to speak about their experiences of sexual abuse. It is impossible to estimate how many more people may want to disclose.


360 See this chapter, “Responding to a disclosure by a child in State care of sexual abuse: Complaints by current and former children and young people in care”.

442 CHILDREN IN STATE CARE COMMISSION OF INQUIRY
4.1 State response to sexual abuse of children in State care

Existing organisations relevant to adults who were sexually abused as children

When I joined CLAN, I received a lot of newletters … there were a lot of things that reminded me of my own experience. There were a lot of stories that were way worse than mine as well, which was quite shocking and hard to deal with as well, but it made a difference to just know that you weren’t alone.

PIC placed in State care in 1960s, aged three

Care Leavers of Australia Network (CLAN), which was established in 2000, is a national self-help support and advocacy group for people aged over 25 years who lived in orphanages, children’s homes, other institutions and foster care. CLAN started with 38 members and now has more than 800 in Australia, New Zealand, Canada, the United States and Ireland. Its objectives are to:

- provide a national network through which care leavers can communicate with each other and share their experiences
- raise public consciousness of past institutional care practices and the effects of institutional care
- lobby governments to provide acknowledgment and support for former State wards and children who lived in homes
- provide, wherever possible, advocacy for people who have left care.

CLAN assists members to obtain their departmental files or information about the institution where they spent their childhood. It also publishes a bi-monthly newsletter and holds social gatherings. The CLAN library contains videos and more than 600 books on issues related to institutional care and its effects, as well as some histories of individuals and orphanages. CLAN also promotes awareness of issues facing people who have left care, through activities such as lobbying. Leonie Sheedy and Dr Joanna Penglase, who founded CLAN, still primarily run the organisation.

CLAN has not received funding from the Commonwealth Government. It has received modest non-recurrent grants from the governments of NSW, Victoria and the ACT. In 2003 the South Australian Government contributed $5000 and since then has provided $15,000 a year in recurrent funding. Anglicare also has provided donations. CLAN uses some of this funding to employ Ms Sheedy and Dr Penglase part-time. It has also funded a website and has ongoing general running costs, such as administration, printing of newsletters and maintaining the library. CLAN does not have a representative in South Australia, but it can be reached on a free contact number (1800 008 774).

Advocates for Survival of Child Abuse (ASCA) is a national not-for-profit organisation for anyone who feels they have suffered ‘sexual, physical, emotional or spiritual abuse’. It welcomes survivors of childhood abuse as well as their partners and family members, professionals working in the field and the public. Its services include a free Information Support Line (1300 657 380), a Supportive Listening Network (where survivors can contact other survivors), support group meetings network, social events, online support group, monthly newsletter, therapists’ database and two main types of programs: ‘Breaking free’ and ‘Towards healthier relationships’.

ASCA representatives gave evidence to the Inquiry that it has almost 1000 members, about 800 of whom confidentially receive the newsletter. The Sydney-based organisation relies on volunteers to provide many of its services, with some volunteer positions requiring special training. ASCA’s South Australian branch holds a monthly meeting with a guest speaker, such as a psychiatrist or a therapist. Its main work is in providing healing programs and support, including bringing survivors together and facilitating group support. ASCA relies on donations and fundraising activities. An adult victim of child sexual abuse told the Inquiry that:

The ASCA meetings were the start of a very important part of my healing, because I was amongst my peers … just talking with my peers and knowing that there were others who knew what I was talking about was extraordinarily important because I had had a lifetime of feeling alone.
Ongoing services for adults who were sexually abused as children in care

This is an opportunity for people to finally state [the sexual abuse], and that is part of dealing with it, and I think if people are still caught up in that, then they need the ability to be able to access services so that they can deal with the past traumas. It’s hard, though, to do that because it reminds you then constantly that there was something that went down and that you were vulnerable, and that it brings up a whole lot of emotional stuff again.

Evidence from PIC placed in State care in the 1960s, aged six

Adults who were victims of child sexual abuse while in State care require access to an extensive range of different support services. The Inquiry created a full-time position for a witness support manager in June 2005 and many witnesses used this service, for a variety of reasons. Some needed practical help, such as securing safe and stable housing, financial aid and disability support. Others sought assistance to obtain copies of historical records through the Freedom of Information Act 1991 to understand the terminology used in records, lodge police statements, understand the Inquiry process, or gain information on pursuing compensation or police investigations. Others wanted to access treatment services for drug and alcohol addictions. The Inquiry also provided referrals and support to many people for mental illnesses and psychological disorders, such as post-traumatic stress disorder, anxiety, depression and suicidal inclinations. A significant number of people asked for referrals and assistance with dysfunction in their adult relationships, which included domestic violence, sexual intimacy, parenting skills, family relationships, conflict resolution and emotional connections with family and friends.

The witness support manager did not provide ongoing crisis counselling; the Inquiry believed it was important that external professionals, who could establish ongoing therapeutic relationships, undertook this role. The witness support manager ensured that the referral agencies were qualified to deliver the required services.

In June 2007 the department introduced Post Care Services (free call 1800 188 118) as part of its Keeping them safe and Rapid response reform agenda in response to the Layton report. The service’s five staff provide information, advocacy, referral and support services to adults who have been in care. This may involve helping them to strengthen contacts or reconnect with their family and their community; obtain their personal records; and access a wide range of community services and programs.

To be eligible for Post Care Services, a person must be 18 and have experienced for six months or more in South Australia:

- foster care
- State institutional care
- church-based institutional care
- government approved, funded and/or licensed institutional care, or
- alternative care and were under a care and protection order or secure custody order.

Post Care Services has established a consumer reference group, consisting of staff and seven people who have been in care, which aims to provide feedback on the development of the program and its services. It has also established a working party to discuss the development of an appropriate memorial for people who have been in care, funded by an $18,300 Commonwealth grant.

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361 In particular, Layton, recommendation 69.
363 Ibid.
366 Ibid. As a result of the 2004 Senate Community Affairs References Committee Inquiry into children in institutional care, Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children, the Commonwealth Government allocated funds to each State to help erect a suitable monument/memorial to those who were formerly children in State care.
Families SA told the Inquiry\textsuperscript{367} that Post Care Services does not provide therapeutic counselling. However, if its clients are referred to a psychologist by their doctor, Post Care Services will pay for the gap if the psychologist’s charge is over the Medicare rebate amount. If there is no doctor referral, then Post Care Services approves funding for counselling on an individual basis. It also refers people to a range of non-government services for counselling, including those operated by Centacare Catholic Family Services, UnitingCare Wesley, Southern Junction Community Services, Yarrow Place and Victim Support Service.

**A free specialist service for adults who were sexually abused in care**

I think I’ve been carrying it for too long … I felt that they should be obligated to help me get my feet back on the ground, so to speak, and that be with the help of counselling.

PIC placed in State care in the 1960s, aged less than one year

In June 2004, the government established Respond SA, anticipating that the service would provide support for people who gave evidence to the Inquiry. The service, run by Relationships Australia (SA), was available to all adult survivors of child sexual abuse; not limited by the Inquiry’s terms of reference to those adults who had been sexually abused in State care. The service stopped in December 2007, when the government withdrew its funding. It was a free, non-government and not-for-profit service for people aged 16 and over who had experienced childhood sexual abuse. It operated a telephone helpline, face-to-face counselling, workforce development, research and advocacy.

Respond SA received referrals from several government agencies as well as 172 referrals from the Inquiry. From July 2004 to June 2007\textsuperscript{368}, the helpline received 3149 calls (72 per cent from women; 28 per cent from men) of which 75 per cent were from survivors of childhood sexual abuse. It provided 4924 counselling sessions to 1242 clients, and had 65 people on a waiting list. It made 188 reports of childhood sexual abuse to the police Sexual Crime Investigation Branch. It conducted 51 training workshops involving 849 participants, provided policy advice to the department, participated in regular meetings at the Inquiry, developed resources (a website, pamphlets, posters, booklets and information sheets) and contributed to community education (presentations to community groups, training and education to service providers and a newsletter).

Relationships Australia (SA) submitted to the Inquiry that because Respond SA was funded on the basis of short-term contracts, there were significant constraints on the service in relation to assuring clients and other agencies of ongoing support services and training, limitations in developing service partnerships to reach certain groups, and difficulties in staff recruitment and retention.

The Inquiry does not believe Post Care Services offers the same service as Respond SA because it:

- is not a specialist service dedicated to the provision of support to adult survivors of child sexual abuse
- does not provide free counselling
- considers the provision of funding for counselling on an individual basis
- refers adults to various organisations that are already overstretched in their capacity to provide counselling.

For example, the Victim Support Service submitted to the Inquiry that ‘there has been a growing, rather than declining, trend in the need for services’\textsuperscript{369}. It stated that ‘prior to the Government establishing the Inquiry we were receiving many hundreds of enquiries for counselling from adults who had experienced child sexual abuse. We were unable to respond to most of these people’\textsuperscript{370}.  

\textsuperscript{367} Families SA executive director, letter, 21 Dec. 2007.
\textsuperscript{368} Statistical information from <www.respondsa.org.au>.
\textsuperscript{369} Victim Support Service Inc, submission, 30 March 2007, p. 1.
\textsuperscript{370} Ibid., p. 10.
In contrast, Respond SA provided free counselling services at five Relationship Australia (SA) offices in the city and suburbs, as well as outreach locations at an additional seven sites (including four community health services and three remand centres/prisons). Counselling was predominantly provided by Respond SA staff, with a small number of clients referred to a suitably qualified private practitioner registered with Respond SA.371

There is a strong case for a specialist service for adult victims of child sexual abuse. A wide range of general services is available to these adult victims372, including in generic settings such as community and women's health centres and those targeting particular populations or issues such as homeless youth, victim support services, drug and alcohol services, and domestic violence services. There are also some specifically funded services for adults that have focused on issues relating to childhood sexual abuse, such as UnitingCare Wesley’s Streetlink service.

In its submission to the Inquiry, Relationships Australia (SA) referred to various publications and studies373 to support its statement that:

There is considerable evidence to indicate that specialist responses to adult survivors of childhood sexual abuse are likely to be far more effective than generalist services that are established to respond to a whole range of psychosocial or mental health issues.374

Information from Respond SA clients revealed inappropriate responses from professionals not specially trained in responding to adult victims of sexual abuse and a preference for a designated service, primarily because they did not have to “struggle to negotiate how to raise, explain or discuss child sexual abuse” and felt “confident and safe” with the specially trained staff.375 The submission from Relationships Australia (SA) also referred to “an overwhelming call from researchers and practitioners in the field for generalist and therapeutic professionals to increase their capacity to respond to adult survivors of childhood sexual abuse”.376 It stated that specialist services could potentially be more involved in capacity building in generalist services.

As a PIC told the Inquiry: “You can't just go anywhere and talk to somebody ... It's not like a doctor, when you can go with a cold and he'll know what you've got”.

Other evidence to the Inquiry supported ongoing funding for a service such as Respond SA. Victim Support Service “strongly supported” the continuation of such a service “to provide a focused treatment service for adults who have experienced sexual abuse whether this is in State care or from other sources”.377

In December 2007 the Western Australian Government announced that people who experienced abuse while in State care would have “access to a range of free, ongoing counselling and support services”.378

In relation to the provision of an ongoing service to adult survivors of child sexual abuse, the Inquiry does not consider that a distinction needs to be made between those who were in care or not. However, the Inquiry only has the terms of reference to make a recommendation concerning adult survivors of child sexual abuse in care.

371 Relationships Australia (SA) submission, p. 4.
372 ibid., p. 29.
374 Relationships Australia (SA) submission, p. 22.
375 ibid., p. 24
376 ibid., p. 22
377 Victim Support Service Inc. submission, p. 7.
4.1 State response to sexual abuse of children in State care

The choice of a service provider for such an ongoing service is a matter for the government. However, given the circumstances in which sexual abuse of children in State care has occurred, the Inquiry believes it is important that such a service is provided by an organisation that is independent of government and church affiliation, and has never provided institutional or foster care.

RECOMMENDATION 39
That the South Australian Government funds a free specialist service to adult victims of child sexual abuse (while in State care) as was provided by Respond SA.
That the service is provided by an organisation that is independent of government and church affiliation, and has never provided institutional or foster care. That the organisation employs practitioners specially trained in the therapeutic response to adult victims of child sexual abuse.

Redress schemes and other services
I have spent the last eight years working with former residents to determine what they wanted from the Forde Inquiry recommendations, and for the majority of people the ex gratia payments are meaningful and show that the government has accepted some level of responsibility ... Even though applying for the payments will bring up a lot of emotion it will give a sense of closure for many people.

Evidence from Karyn Walsh, coordinator of the Queensland-based Esther Centre, a support service for former residents and victims of abuse established under the Forde Inquiry recommendations
The Inquiry was not a ‘compensation’ Inquiry: people did not come forward for monetary gain and the issue of compensation was not investigated on behalf of any PICs.

The Forgotten Australians (2004) report recommended that the Commonwealth Government establish and manage a national reparation fund for victims of abuse in institutions and out-of-home care settings. In not supporting the recommendation, the government said although it ‘deeply regrets the pain and suffering experienced by children in institutional care’, it was of the ‘view that all reparations for victims rests with those who managed or funded the institutions, namely State and Territory government, charitable organisations and churches’.

Before the release of Forgotten Australians, both the Tasmanian and Queensland governments had held an inquiry into the abuse of children in care and established mechanisms for ex gratia payments and/or the provision of services. In Tasmania the ombudsman was asked by the Minister for Health and Human Services in July 2003 to conduct an independent review of claims by adults who suffered abuse while children in State care (this was phase one of the review). The ombudsman’s report to parliament in November 2004 recommended that the government receive claims; the recommendation was accepted and phase two began. The total number of claimants from both phases was 878, with 670 accepted as eligible. The government appointed a Queen’s Counsel to independently assess the claims and make decisions in respect of individual ex gratia payments, which were capped at $60,000.

The Queensland Government established a $1 million Forde Foundation Trust Fund for victims in 2000. It is administered by an independent board of trustees, which assists people who experienced abuse as children in State care to gain access to services and therapeutic care. In 2001, the government provided a further $1 million to the fund, which also received contributions from church organisations and individuals. The Forde Foundation was not established to pay compensation. Eligible people can apply for assistance for services relating to education, health and family reunion.

379 Forgotten Australians, see <parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fjournals%2F2004-08-30%2F0002%22>
The Queensland Government recently established a $100 million redress scheme to compensate people who came within the terms of reference of the Forde Inquiry. Eligible people are those who experienced institutional abuse or neglect as defined in those terms of reference, had been released from care and had turned 18 years on or before 31 December 1999. Applications must be received by 30 June 2008. People may apply for a ‘level one’ payment of $7000 if they establish eligibility; or a ‘level two’ payment of up to $33,000 for those wanting to establish harm or loss of opportunity according to set criteria. The level two payments will be assessed on a case-by-case basis by a panel of experts. Applicants who accept payments are required to sign a deed of release preventing them from making any further legal claims on the State. The redress scheme is not open to people who were placed in foster care in Queensland. The Queensland Government also contributes funding to three organisations that provide services for former residents of institutions.383

In December 2007 the Western Australian Government announced a $114 million program called Redress WA, which will be available to people who are over 18 years of age and who experienced abuse in foster homes, institutions or non-government care before March 2006. Applications to Redress WA open on 1 May 2008 and must be lodged by 30 April 2009. Applicants claiming abuse or neglect will be eligible for payments on a sliding scale. Where it can be demonstrated there is a reasonable likelihood that abuse occurred, the maximum payout is $10,000. Applicants claiming physical or psychological suffering as a result of past abuse may be eligible for payments of up to $80,000, based on the severity and impact of the abuse. This is assessed based on information provided by applicants and information on historical departmental records. Legal advice for applicants on the conditions of accepting redress payments will be made available, as will counselling and support services.

In a media release in December 2007, Senator Andrew Murray (Australian Democrats) urged the State governments of South Australia, Victoria and New South Wales to set up similar redress schemes. He also urged the new Rudd Government to take up the recommendation from the Forgotten Australians report and establish a national reparations fund. South Australia does not have a reparations payment scheme. In 2003, the government established the Dame Roma Mitchell Trust Fund for Children and Young People, which awards grants to eligible children and young people who are, or have been, in State care or long-term family care supported by the department. The trust was established in response to research indicating that young people who have been in State care generally have poorer education, health, employment and socio-economic outcomes than their peers. Funds totalling $1.7 million have been made available, to be distributed over 10 years. Grants of $1000 up to $10,000 assist eligible persons in the areas of education, personal development, business and the transition to independent living. The trust has three funding rounds a year and applicants must be 29 years or younger on the closing date of the funding round. The trust’s board assesses each application and presents its recommendation to the Public Trustee, which determines funding applications.384 Each year, the demand for assistance has been greater than the funds available.

In its Issues paper, the Inquiry sought submissions on the provision of services and benefits for people who had been sexually abused as children in State care, and the need for a national approach to such provision.385 The six submissions (three from individuals and three from organisations) received on this topic were all in favour of a national approach, with one submission preferring a scheme for services and benefits such as the Veterans’ Affairs scheme over a lump sum payment. Families SA submitted that to provide such a service would require

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383 These are: the Aftercare Resource Centre, which provides direct and brokered counselling services, assists with record searches, family reunification and therapeutic services; the Esther Centre (centre for addressing abuse in human services and faith communities), which supports people who have experienced sexual, physical, emotional and spiritual abuse; and the Historical Abuse Network, an informal network of people who experienced abuse when they were residents in church or government institutions.

384 The board consist of 12 representatives, including a nominee of the chief executive of the department, the SA Council of Social Services, the SA Foster Care Association Inc., Aboriginal children and young people, and two people up to the age of 30 years who are, or have been, subject to a guardianship order or in long-term placement. A nominee of the Minister is appointed to chair the board of the Trust Fund. The Minister appoints the board but otherwise it is independent from government direction in making funding recommendations.

4.1 State response to sexual abuse of children in State care

Commonwealth funding and administration to ensure consistency between the States. Three submissions (one from Families SA and two from individuals) said that a national approach modelled on the existing structure and operation of the Department of Veterans’ Affairs would also serve those adults who live outside the State in which they were abused as children.

The Inquiry believes a task force should be established in South Australia to examine the redress schemes in three other states, to receive submissions from individuals and relevant organisations on the issues of redress and the provision of services, and to investigate with the Rudd Government the possibilities of national involvement.

**RECOMMENDATION 40**

That a task force be established in South Australia to closely examine the redress schemes established in Tasmania, Queensland and Western Australia for victims of child sexual abuse; to receive submissions from individuals and relevant organisations on the issue of redress and the provision of services, and to investigate the possibilities of a national approach to the provision of services.

Investigation and prosecution of alleged perpetrators

You say you’re going to talk about help that we need. I think that closure is a pretty good one. I know that this Inquiry is helping but the delays with [the prosecution of the offender] … that’s pretty hard because it’s constant that something comes up.

Evidence from adult victim of child sexual abuse

The Inquiry has referred the allegations of 170 people, some against multiple perpetrators, to the Paedophile Task Force (PTF). From those referrals, at October 2007, the PTF had documented 433 alleged perpetrators, of whom 315 are identifiable, 74 are unnamed/unable to be identified and 44 had died. Four of the alleged perpetrators have been arrested, 13 have been reported and 61 have been filed. These figures clearly raise the issue of delay in a criminal justice system already struggling with a backlog of cases, resources and priorities. In regard to priorities, a member of the SA Police told the Inquiry:

Now, whether that's an attitudinal approach to the way we deal with them [historical allegations of child sexual abuse] the criminal justice system, including investigators, DPP courts and everybody, I just wonder if we need something ... to put a greater degree of urgency on the historical [cases] ... because we know that the longer they go on the greater the propensity is they fall over and other things happen, but it seems to me, whether it's an attitudinal thing or a systemic issue, whereby once it's labeled ‘historical’ the degree of urgency drops off considerably.

In its submission, SA Police addressed the question of additional resources to manage the ‘extensive disclosures’ to the Inquiry. The PTF consists of 14 sworn police officers and 10 non-sworn staff. It informed the Inquiry that many of the referrals involve considerable research, retrieval of public records and statement taking, and initially do not require the exercise of police authority. It submitted that consideration could be given to establishing a special investigation unit (made up of suitably qualified retired police officers) to conduct preliminary investigations that do not require the exercise of police authority, for example, accessing public records and interviewing victims/witnesses. The proposed unit could be modelled on similar government investigation areas where suspected criminal matters are referred to the police for finalisation.

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386 If an alleged perpetrator is ‘reported’, then charges have been recommended and the file has been sent to the Office of the DPP, which adjudicates the matter and decides whether charges will be laid in court.

387 If the matter has been ‘filed’, then the matter has been allocated to an investigator and investigated, as a result of which either the complainant has chosen not to proceed with charges for personal reasons; the complainant is now deceased; the complainant is unable to particularise the offences and there is insufficient evidence to proceed; or the identity of the person of interest cannot be sufficiently established.
The proposed investigation unit would only conduct preliminary investigations, however if this led to a suspicion that a criminal offence may have been committed, the matter would be referred to SA Police for report/arrest of the suspect. The matter may also be referred to police to conduct further investigations requiring police powers, such as the execution of search warrants.

**RECOMMENDATION 41**

That the Paedophile Task Force, the Office of the Director of Public Prosecutions, the Legal Services Commission and the courts be allocated sufficient resources to investigate, prosecute, defend and conduct trials concerning the allegations of child sexual abuse arising from this Inquiry.
## 4.2 Children in State care who run away

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The Inquiry heard evidence from PICs that it has been common for children in State care to abscond from placements. The reasons they gave for running away were varied.

Some PICs said they absconded because they were being sexually abused. A PIC who said he ran away after being sexually abused during his first week at Glandore Children’s Home told the Inquiry: ‘It scared the living hell out of me and I thought, “if this is all I’ve got here, I might as well not stay”’. Another PIC said he was taken from Lochiel Park Boys Training Centre by staff on several occasions to a private residence, where he was photographed naked and indecently assaulted. He remembered that after he reported the abuse, which happened ‘half a dozen times at least I know of … I just got sick of it and that’s when I absconded from Lochiel Park’.

Some ran away because of both sexual abuse and physical cruelty. One PIC, who alleged he was sexually and physically abused at Glandore Boys Home, said:

I’d run away in the first place because I was sick and tired of the sexual abuse and the hidings and, believe me, it happened every day … the abuse just kept on going on and on … It just seemed like everybody was either bashing you or sexually abusing you in those days.

Some absconded because of the physically cruel regime. One man recalled ‘a big mass break-out’ from Glandore that involved ‘a big dispute, I think, between the big kids and [the superintendent] about the treatment and the canings that we were getting from him’.

Others ran away just because they wanted to go home. One woman who absconded from foster care as a young girl said:

It was really hard, you know? … I was 10. It was confusing. I just wanted to be in a spot that I knew, not uncomfortable with but with somebody I could call mum and dad.

While it is a tragedy that a child or young person should ever feel the need to run away from a placement for any reason, the Inquiry also heard evidence about the exploitation of some runaway children while they were on the streets, performing sexual favours in return for food, money, alcohol, drugs and gifts. On the evidence given to the Inquiry, there is no doubt that such exploitation has been extensive in Adelaide since the 1970s, involving paedophile parties where men exploit young boys and, occasionally, girls. Despite a number of police operations since the 1980s to investigate and arrest the perpetrators, this exploitation continues to thrive. Even worse, evidence to the Inquiry indicates that the tactics of these paedophiles who target such vulnerable children are so well developed that some children in State care abscond from their placements to go to the perpetrators. One man told the Inquiry he absconded from several placements and stayed with alleged perpetrators. There was one man with whom he stayed who he said sexually abused him:

A lot of times I’d be on the streets, on the run or something like that, and I’d end up at [the alleged perpetrator’s] place, you know, at night time, nowhere else to go.

After hearing extensive evidence about this problem, the Inquiry considers that a therapeutic secure care facility must be available as a last resort to care for these vulnerable young people who have become victims of such sexual exploitation; and that a specialist police operation should be set up to target the paedophiles who prey on them.
Sexual exploitation

Since 1987, the State has been aware of the sexual exploitation of children, including children in State care, by paedophiles operating around Adelaide. Further evidence has been given to the Inquiry about the extent of the exploitation and the fact that it continues today.

The known problem

You have to actually assume our kids will be a magnet because of their victimology … their easy vulnerability and because the system is not always a good carer.

Evidence about children in State care from departmental manager

In March 1987, a street worker employed by the Service to Youth Council addressed a meeting of the Hindley Street Youth Project, during which he asserted that child prostitution and paedophilia were common among children who frequented Hindley Street and adjacent areas. The Sunday Mail newspaper reported on 17 May 1987 that about 150 teenagers were working as child prostitutes in South Australia and that it was a ‘flourishing industry’ operating from the streets and escort agencies; that it involved death threats against a city street worker trying to expose the problem; that some teenagers were given air fares as part of an interstate vice racket; and that ‘very heavy duty’ people were in control. A Liberal Party member who spoke to children aged about 13 and 14 in Hindley Street was quoted in the newspaper as saying that their experiences were

… much uglier than I expected … [the] fierceness of their remarks, their bitterness and their low self-esteem was far more intense than I imagined or than I had encountered before.

Following this publicity the Minister for Community Welfare received a report from the Acting Commissioner of Police in May 1987, stating that child prostitution did exist but describing as ‘ridiculous’ the estimate that 150 children were involved. Despite this, in April 1987 the police had set up an operation (‘operation D’) to ‘collect, collate and analyse material relating to paedophiles in South Australia for the purpose of identifying the extent of crimes against young persons and to identify offenders’. The operation involved the investigation of both intrafamilial and extrafamilial child abuse. In regard to extrafamilial abuse, the operation found that the offenders ‘seek gratification through pornography, child prostitution, sexual abuse of “street kids” or “runaways”, or abuse of children entrusted to their care’. It found that child prostitution was occurring at street level (involving children being given shelter, food or money for sexual favours) and in the trade (mainly through escort agencies). The operation received 23 reports of street kids being sexually assaulted by adults or subjected to procurement as prostitutes. Some children were victims of violence, including through the use of firearms. There were arrests over the production and distribution of child pornography.

In August 1987, the department reported to the Minister for Health and Welfare that child prostitution was occurring in and around Hindley Street but its extent was uncertain; the children were engaged in prostitution for accommodation, food, drugs or affection.

Evidence to the Inquiry concerning this period established that there was child prostitution at both street and trade levels (involving specific escort agencies in North Adelaide, the western suburbs and Unley). In particular, the Inquiry received evidence from five men who had worked in the escort agencies as children; three of them were in State care. One of the three told the Inquiry that at the time of the 1987 newspaper report child prostitution was occurring in Hindley Street. He said some street children met clients and were approached by paedophiles when begging.

By the end of 1988, another police report, Child Prostitution, was prepared as part of the ongoing work of operation D. Police were aware of children as young as eight to 10 working as prostitutes, confirming an earlier
police report that ‘there is no doubt that some children who are “runaways” engage in prostitution or become victims to adults seeking sexual encounters with children’. Known conduct involving girls and boys between nine and 16 included prostitution; ‘peep’ shows; supply of children as escorts; sexual exploitation of children at private functions; harbouring of missing children; using children to produce pornography at studios; involvement of a few taxi drivers to procure girls as prostitutes for men; sexual exploitation of girls used by men as photographic models; and the use of girls over many months in a brothel. Information received was that most boys worked alone but some solicited in small groups. The usual price for sexual favours was $10 but ‘novices would accept a Coke and a hamburger’. Experienced children charged up to $35. The report concluded:

There is no doubt that child prostitution is, and has been, occurring in South Australia. The demand is Statewide but the prostitutes are particularly active throughout the metropolitan area. Intelligence indicates a substantial involvement by adults for the purpose of financial gain. It is not unreasonable to assume a child prostitute could earn on average $400 a week; nor is it unreasonable to assume there are 50 active child prostitutes in this State. This indicates that child prostitution in South Australia has a potential annual turnover of more than $1,000,000.

Towards the end of 1989, police working in operation D were over-stretched and could not record information about every alleged paedophile in the State, so they decided to concentrate on ‘high-value intelligence’.

During the early 1990s, a police operation based in the Elizabeth area (‘operation K’) reported mainly on intrafamilial child sexual abuse, but also identified some cases of extrapamilial abuse. It was originally intended to last six months but was extended to two years. It was an important police operation in that it provided considerable outreach to children (posters were placed at schools and teachers were asked to pass on the message to children that sexual abuse ‘is not your fault; you are not to blame and you are not going to get into trouble’) and involved the police focusing on the impact of sexual abuse on children (requiring detectives to be suitable and, according to evidence to the Inquiry, rejecting the idea that a detective ‘is capable of investigating any crime’; and developing special personnel and procedures for interviewing child victims). During the two years of the operation about 600 people were investigated for offences involving child sexual abuse. The Inquiry heard evidence alleging that a high-ranking police officer wanted to close down the operation to protect an alleged perpetrator. The Inquiry investigated this allegation because one of the alleged victims of the alleged perpetrator was a child in State care. However, the allegation could not be substantiated.

During the early 1990s, some intelligence was gathered incidentally about the sexual exploitation of children on the streets during two police operations that were set up to target other criminal activity. Police detected child prostitution in Veale Gardens and the inner-city area; some of the children were living at residential care facilities and other homes run by the department. Police suspected brothels and escort agencies were using child prostitutes but were unable to obtain evidence to prosecute the operators. Evidence to the Inquiry established the widespread use of children, particularly boys, as prostitutes for men in some of the escort agencies during this time.

Also in the early 1990s, another police operation (‘operation DE’) was set up to target a small number of suspected paedophiles after a member of the public gave police photographs and videotapes. As a result, four men were arrested for child sex offences. Two of the 36 children identified as possible victims were children in State care. Two of the men were convicted and imprisoned. During the operation, police uncovered links between the men and paedophiles overseas.
In the same period, a national operation (‘operation E’) involving all Australian police forces gathered intelligence about paedophilia and the sexual exploitation of children. It found there were networks operating in Australia and some had connections overseas. It considered that:

Most children involved in child prostitution are trapped by the need to survive, having been cast into their situations by abuse, neglect, abandonment, or poverty. Most find a means of financial and emotional support in prostitution and pornography. They perceive a distorted feeling of being wanted and a sense of importance which, in the absence of true and sincere emotion, is a temporary degree of satisfaction.

In the mid 1990s, SA Police established a special operation, (‘operation TE’) to target the exploitation of boys by men in certain areas, including Veale Gardens. Five boys who were in State care came to the attention of police because of the many times they were found in the relevant areas and their association with suspected paedophiles. The boys were placed at residential care facilities and frequently absconded. However, when asked, they or the alleged perpetrators denied involvement in child prostitution.

By this time, workers in the department had become more informed and, therefore, concerned about the sexual exploitation of children in State care who were running away from residential care facilities. Staff began to meet to discuss the problem, including the difficulty of charging and convicting known perpetrators, the unlikelihood of catching a child in the act of prostitution and children’s perceived unreliability as witnesses. One employee told the Inquiry that at the time staff—often at meetings including police—explored ‘the whole ideology of paedophilia’ and realised that ‘our kids will be prey, will be targets’. She said that in hindsight the dangers were self-evident, but not appreciated, until they accessed literature from the United States, where authorities were becoming more widely aware of the need to protect children from paedophiles. In early 1996 the department established a task group to formulate systems, strategies and practical advice for residential care services and district centres ‘to assist with working with young clients who are at risk of, or involved with, paedophile activities’. The task group estimated that about 30 to 40 young people in State care, mainly boys, were involved with paedophiles to some degree. These young people were described as:

- being mostly under the guardianship of the Minister
- streetwise
- having an extensive history of physical, emotional and sexual abuse
- displaying a physical demeanour of vulnerability
- needing and wanting money that the government cannot provide
- being good at keeping secrets—having been taught from an early age (as young as two)
- lacking confidence in adults because their parents have mostly rejected them, and due to this rejection believing that the welfare system, operated by adults, has failed them by not making their parents accept them
- often having a borderline IQ or, due to the abuse they have experienced, having emotionally delayed personalities
- having experienced severe loss and grief, including loss of their childhood due to abuse, loss of their parents due to removal, and loss of many foster placements due to the high tendency of placement breakdown, to name a few examples
- mostly displaying extreme behaviour problems—such as self-mutilation, low self-esteem, destructive acts, constant absconding and offending—that make it difficult for caregivers to provide adequate care.

Standards of practice had been established for staff working with these ‘extremely damaged and vulnerable young people’. The task group described these procedures as...
The Inquiry received extensive evidence from four senior staff members of the department and a child psychiatrist who worked extensively with children in State care over many years. All were deeply concerned about runaway children and their sexual exploitation by paedophiles. One worker said: ‘People not only knew about it but knew that there was a tendency for paedophiles to gravitate into the neighbourhood of residential units because there’s easy pickings’.

One facility from which boys were known to be absconding was Lochiel Park Boys Training Centre. As one staff member recalled:

[They] would disappear for two or three days at a time. They would come back looking like a lost, bedraggled dog, dirty, filthy, hungry … sometimes with cigarettes, sometimes with new shoes.

Sometimes the boys would be away for days, prostituting themselves for cigarettes, drugs and alcohol. It was not uncommon at times for up to five Lochiel Park children to go missing in a day. There was an opinion among staff that some of the paedophile activity was very highly organised and a relatively large number of people would take the children, harbour them and obstruct department staff trying to find them: ‘We were usually at a loss’. The evidence revealed that eventually the paedophiles became so bold that they contacted Lochiel Park, demanding that certain boys be allowed out. Staff started to patrol the Veale Gardens area when the boys ran off; many times they found them and brought them back. But the staff were fighting against the tide. The incentives for the boys to run away outmatched the measures the department could use to detain them. A staff member said:

Sometimes they disappeared into men’s homes, who would harbour them for three, four, five days at a time and then let them go. That’s when they would come back with decent clothing … they were basically prostituting for cigarettes, drugs, maybe some alcohol and a good time.

The witness said one of the boys left Lochiel Park and moved into the house of a paedophile, who

… looked after him better than we looked after him. He stopped offending, he got off the streets … this bloke sent him to school … stuck by him through thick and thin. [The boy] would run away, he’d bring him back. [The boy] would burn his house down; he’d build a new one. [The boy] would kill this man’s cat; he’d buy another. I couldn’t believe it. [The boy] one day walked into the unit and he was a young man … you had a known sexual offender actually do more with this kid than the department could. It was just all bizarre.

This was not an isolated case. The Inquiry was told that on several occasions staff attempted to detain the children by securing the units, but the department disapproved. There was concern that the boys could contract sexually transmitted diseases, which occurred in some cases. It was recorded in documents pertaining to Lochiel Park that sometimes experienced boys took other, more naive residents with them and introduced them to ‘unlawful and inappropriate sexual behaviour’. Clarence Park Assessment Unit logbooks record contact between one resident and a paedophile, that this resident engaged in ‘inappropriate sexual behaviour’ and was a habitual absconder.1

The problem faced by professionals trying to provide therapeutic care to these children was also raised in evidence:

He was a little boy—and he had been missing for four days. She found him, brought him to an

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1 SRSA GRS 6638/1/66 Clarence Park Assessment Unit Observation Log.
appointment and he fell asleep and we couldn’t rouse him, he was so tired. Back to the cottage; two days later, running again. He had a severe attachment disorder so he couldn’t attach to the cottage or to anyone else, but he attached to someone if they gave him goodies … we would often see these boys coming back from running away and we would think, you know, ‘They’ve been at risk. They’ve been on the streets. They haven’t eaten or anything and they’re better groomed than when they left, with gifts and all sorts of things.’ And from a child’s perspective there’s a huge reward running away and once that process starts, undoing it without containing them is impossible. You can do all the talking, protective behaviours, interventions and all of those things fail. They’re too superficial. Because every time they run and there’s reinforcement, be it a dollar or a new pair of sneakers or a skateboard, you have lost whatever therapy you have done leading up to that.

In February 1995, police began another operation (‘operation T’) to target the main homosexual beats in the City of Adelaide, particularly Veale Gardens, and a beat in Unley Park. It sought to build a rapport with the gay community, which was concerned about the sexual exploitation of children. Police were aware that some boys who absconded from residential care facilities were picked up by paedophiles in Veale Gardens and were being asked by those paedophiles to bring other children. Police tried to gather information for prosecution but did not witness the sexual abuse and were unable to obtain statements from the boys for court purposes. One police officer involved in the operation had regular contact with the manager of Lochiel Park concerning runaways and had discussions with these boys. He informed the manager of the contents of one of the documents seized from a well-known paedophile, indicating the best places to infiltrate to get children—one was named as the department. A staff member told the Inquiry this indicated that:

We’re really in trouble here. So they have our guardianship children, we’re prime targets for a whole range of reasons, including they were already victims of sexual abuse and so easily manipulated, they were always on the streets, they were always down Hindley Street. So they were easy targets.

When the operation started, police had a list of about 270 suspected paedophiles in South Australia. When it ended in 1998 the list had doubled. Various officers who worked in the operation told the Inquiry it was successful in many respects; it provided good intelligence and led to the arrest and successful prosecution of men charged with the sexual abuse of children.

A senior police officer [J] who had worked on the operation from the start was removed at short notice in November 1996. A witness who was not a police officer suggested to the Inquiry that at the time there was an influential person in either the SA Police or parliament who had a history of paedophilia and was getting nervous:

It came from the Commissioner down. The pin was pulled pretty quickly. They had 24 hours to vacate. We did have suspicions about people in high places that were in some way connected to the paedophile stuff.

Another witness suggested that the operation was closed down by police officer [T] in 1996 to protect a person in high office in government. However, the Inquiry found the operation did not cease until late 1998 and was not closed down by [T].

There is no evidence to support the suggestion that operation T was closed down to protect a person holding high public office or any other person. None of the police officers working in the operation gave any support to the suggestion and the evidence at the Inquiry indicates the contrary.

However, a departmental staff member told the Inquiry that when the operation did cease there were concerns about lack of action over children in State care who were being...
sexually exploited. The staff member said the intelligence was passed on to the department’s chief executive and most of it to the Minister. She recalled a meeting at Parliament House with both sides of politics and the department’s then manager of community residential care. When asked whether anything had changed since that meeting, she said,

No. The NCA [National Crime Authority] got the intelligence, the Minister got the intelligence, the Minister got Crown Law, the Minister got everything. Parliament got it. This was the state of play, so how high do you have to take it?

The extent of this sexual exploitation over the past four decades was made clear to the Inquiry, not only by police and departmental staff but also by adults who were once child victims of exploitation. Adults who had been children in State care told the Inquiry about their experiences of sexual exploitation. They confirmed the success of perpetrator tactics. One PIC said: ‘If I needed $20 or $40 I’d just go to his house, you know, and there was no question or doubt about it. He gave it to me.’ This PIC said the arrangement was ‘sex when he wanted it’.

The PICs spoke about the activity of paedophiles in Veale Gardens and other haunts around the city. One PIC told the Inquiry he ran away from his community residential care unit and frequented Veale Gardens ‘to have sex for money’. Another said: ‘I’d go down to Veale Gardens to try and make some money down there’ after absconding from a community unit. Several boys in State care said they went to Veale Gardens ‘because it’s a very, very easy place to make money’, or ‘it was easy escape. If you didn’t have money you’d get money.’ Another PIC said that when he ran away he ‘was running away from everyone and everything … I knew I was going to have sex and I would be paid and I’d get whatever I wanted, you know: marijuana, alcohol, you know.’

The PICs described the methods by which boys would solicit, or be approached, for sex at Veale Gardens and other beats. One said: ‘The people that fraternised these places are a very close-knit community’ so for boys ‘it was very easy to find out where these locations were’. One PIC described the network: ‘You’d go down the Torrens there, down the beat or … over by the parklands there in South Terrace occasionally … So you had a circuit where you would go.’ One PIC alleged that at Veale Gardens ‘there was judges, there was magistrates, there was police … they all go down there, absolutely’. The PICs told the Inquiry that men would not identify themselves: ‘You don’t really get names … not even nicknames; you just know faces’. One witness said the men referred to the young people as ‘chickens’.

The PICs gave evidence about paedophile parties, usually attended by men who sought sexual favours from young boys and occasionally from girls. At some parties, one witness recalled: ‘All we’d have to do is bring them drinks, make sure their glasses were always full, empty the ashtrays and just generally be standing around’. At other parties, children were given food, alcohol, drugs and sometimes money in return for sexual favours. One PIC told the Inquiry:

Everybody would just party. You could name your drug; it was there. You could name whatever you wanted to drink; it was there. The younger you were the more you were encouraged to drink.

Many of the men at the parties were referred to as ‘suits’, indicating they were well-dressed and had money. The parties occurred regularly over the years; according to some witnesses there was a party nearly every week.

The evidence reveals that the parties were held in homes in metropolitan suburbs including North Adelaide, Unley, Unley Park, Parkside, Magill and St Peters, and in the City of Adelaide. Some witnesses could not name the suburbs. The PICs confirmed the evidence of departmental staff that paedophiles recruited boys from some homes run by the department. There was also recruitment by word of mouth among the children. Also, they were recruited from city and
inner-suburban hotels and city streets. Men would frequent city hotels, nightclubs and other places of entertainment and ‘pick up … young people and pass them on’ to men for sex, said one witness. Another witness recalled: ‘You’d get picked up by a bloke in [the city] … and we’d go to [suburb], or it would be one of three or four places we’d go.’ One PIC told the Inquiry that after he was picked up and driven to various homes, the driver would ‘go in and let them know what we were like … then we’d go in and do the deed’. Usually these boys stayed at parties overnight. Several told the Inquiry they were drugged at parties. According to one witness:

I mean, they used to like us to bring our friends, but only after they were screened. And they wouldn’t initiate the sex; they’d want us to initiate the sex with them, and then we’d all be bombed out and then God knows what happened, really … You knew that something had gone on, you know, no matter how bombed out, but the whole point was you’d actually get really bombed out … to be able to do everything, I suppose, and to not let it affect [you].

Some of the named perpetrators were prominent in the community and became known to the boys, although correct names were not used. Some perpetrators attended parties frequently. Different witnesses gave corroborating evidence identifying men who frequented beats and parties and had sex with children in State care. Several recalled names but refused to divulge them to the Inquiry out of fear. Although some of the parties occurred years ago and the sexually exploited children are now adults, various PICs would not provide statements to police for fear of repercussions. ‘I was just told never to ask anything,’ said one witness.

One PIC’s evidence demonstrated the vulnerability of children in State care to this sexual exploitation:

And it’s about trust as well, you know, because often enough they’d take you under the wing and— you know, a lot of these times it wasn’t a one-off thing, you know. You actually formed, in a strange way, relationships, I suppose … these men were, in many instances, the closest things to father figures a lot of us had, in many ways—you know, in that way, and of being loving and showing affection, as such, and giving you—and making you feel good at something, and worthwhile.

Evidence to the Inquiry indicates that the sexual exploitation of children in State care is still a serious problem. A police operation (‘operation C’) that started in 2005 and continued for 18 months was established as a result of a concern about particular children in State care absconding from residential care facilities and being sexually exploited at Veale Gardens or in hotel rooms. It focused on children who were recent absconders from such facilities and were being sexually exploited. Because this is recent intelligence, it is not in the public interest to publish further details. The Guardian for Children and Young People provided information from residential care staff that of the 55 young residents in community residential care facilities at June 2007, 16 (29 per cent) abscond frequently (more than five times in three months) and all are at high risk.²

² Office of the Guardian for Children and Young People (GCYP), Children missing from residential care, July 2007, p. 3.
A therapeutic response to young people who run away

There is no doubt that the response to children and young people in State care who run away from placements should be therapeutic and not punitive. The reason for the absconding must be ascertained and appropriate counselling and other services need to be provided. This may seem obvious, but the strength of the evidence to the Inquiry about past punishment of children in State care who ran away and its harmful effects on them cannot be underestimated.

Historical response to children in State care who abscond

Evidence to the Inquiry from PICs demonstrates that the response to a child in State care who absconded was punitive, with little, if any, effort made to find out why the child was running away. One witness who absconded from Brookway Park said he was not asked why he had run away; only that he was ‘thrown against a wall and thrown into a chair’. The Inquiry took evidence from a man who had absconded from several institutions. When asked whether he was questioned about why he absconded from placements he said: ‘No, never. They don’t ask you. They just say the police bring you back, hand you over, and that’s it. That’s it.’

Another man told the Inquiry that after absconding from Eden Park at Mt Barker and being apprehended while heading for Adelaide, he was returned to Eden Park, where ‘I got the living daylights punched out of me’ by senior staff ‘to teach me a lesson for running away’. Another PIC said he ran away from Eden Park because of sexual abuse there. He fled to his family home but his parent returned him to Eden Park, where he was placed ‘straight in the lock-up. I got belted ... six of [the] best across the hands’. The PIC said the senior staff member asked him why he had run away:

> I told him I was being abused, [the alleged perpetrator] was screwing me. I had to play with him and stuff like that, and he called me a liar. So that’s when I got the six. I was only going to get three, he said, but he’d make it an extra three because I lied.

For decades, such a practice of punishing children who absconded was entrenched in legislation and policy. From the time the State Children Act 1895 was enacted, children who ran away could be charged as being ‘uncontrollable’ or ‘incorrigible’ and detained in an institution, sent to a probationary school for up to three months, punished by whipping or released on probation. By 1903, absconding had become an offence punishable by ‘imprisonment’ in a reformatory school; children could be apprehended without warrant for absconding and punished, which included corporal punishment or confinement in a cell for up to 48 hours on a diet of bread and water. The State Children’s Council could direct that an absconding child be detained for one month beyond the existing period of detention. A similar regime continued under the Maintenance Act 1926-37 from the 1920s onwards under the supervision of the Children’s Welfare and Public Relief Board (CWPRB).

As to the problem of absconding, the Delinquent report commissioned by the government and published in September 1939 expressed disagreement with provisions of the Maintenance Act that made absconding an offence:

3 State Children Act 1895, s. 34.
4 State Children’s Further Amendment Act 1903, s. 11.
5 State Children Act 1895, s. 48.
6 ibid., regs 78–9. However, corporal punishment was to be ‘administered as seldom as possible’, and only resorted to when ‘absolutely necessary for discipline’ and not inflicted for first offences unless the offence was of ‘a grave nature’. In 1921, the regulations were amended so that girls could no longer be subject to corporal punishment, but could be placed on a diet of bread and water, given extra work or deprived of the usual cuttings. In 1921 several girls absconded from Redruth Reformatory School. The Council noted in its annual report for the year ending 30 June 1921 that it ‘had been criticised by many, that its attitude towards corporal punishment did not allow sufficiently stern measures to be adopted to maintain discipline’.
7 State Children Act 1895, rr. 80.
8 State Children Act 1895, s. 49.
10 Government of South Australia, Report of the committee appointed by the government to inquire into delinquent and other children in the care of the State, Sep. 1939, p. 15.
We cannot agree with the present section of the [Act], which reads, ‘Any State child guilty of an offence (i.e. of absconding) under this section shall be liable to imprisonmen in a reformatory school’, that a child placed under the care and control of the Children’s Welfare Board through no fault of his own may now be ‘imprisoned in a reformatory’ if he absconds from his foster parent or from an institution. All cases of absconding either from foster home or training school should, in the interests of the child, be investigated … and no child should be punished for running away without such an investigation.11

Despite these views, the same legislative provisions remained in force and children continued to be transferred to reformatory schools, including Vaughan House and The Pines for girls and the Magill Reformatory for boys.12 Even with general legislative changes to the care and protection system in the mid 1960s, including the abolition of the CWPRB, the provisions regarding the punitive response to absconding largely remained.13 Caring was still the accepted punishment for boys who absconded during the 1960s, as evidenced by entries in the Magill ‘punishment book’ for 1958–75. Eight strokes of the cane were still administered up to 1966. Regulations thereafter specified that no boy should receive corporal punishment except for that authorised by the director.14 Records indicate that in March 1969 the director authorised the reintroduction of caning in McNally Training Centre after a number of boys absconded from the facility earlier in the year.15

It was not until 1972 that absconding was no longer an offence.16 A child under the care and control of the Minister who absconded could be apprehended without warrant17 and placed in any home (including a secure facility)18 nominated by the director-general. Regulations specified that punishment of children in homes and centres should normally be the deprivation of privileges, but that no child was to receive corporal punishment; a child 12 years or older could be placed in a detention room for up to 48 hours, if this was in the best interests of the child or in the interests of other children in the home.19 A child who absconded also could be made the subject of a ‘safekeeping order’ and detained in secure facilities.20 These orders were most commonly made with respect to young girls. In the 1970s up to 70 girls were held at any one time in Vaughan House for behaviour including being in moral danger, promiscuity, refusing to obey directions and running way.21 The use of ‘safekeeping orders’ was gradually discontinued from 1983 after the release of a report22 and changes to the legislation.23 From the late 1980s to 1994 the same provisions continued regarding punishment for absconding and the placement of children in a detention room.24

11 ibid., p. 33.
12 SRSA GRG 29/6 file 21/1948, Transfers of wards of the department.
13 Maintenance Act 1926–1963 was renamed the Social Welfare Act 1926–1965 by the Maintenance Act Amendment Act 1965. This Act vested the general powers, functions and responsibilities in a Minister. The Department of Social Welfare was established and a director appointed.
15 SRSA GRG 29/6, file 105/69, Corporal punishment of absconders.
16 The Social Welfare Act 1926–1971 was repealed by the Community Welfare Act 1972. The Act established the Minister, then called the Minister of Community Welfare, the department known as the Department for Community Welfare, and the director-general of Community Welfare.
17 Community Welfare Act 1972, s. 72.
18 ibid., s. 6.
20 Community Welfare Act 1972, s. 44(1).
21 Department for Families and Communities (DFC), An overview of past and current practice: a brief history of State involvement in the care of children and young people in South Australia (Dr Susan Marsden, consultant historian), Sep. 2006, p. 49; Department for Community Welfare (DCW), Difficult adolescent girls and safekeeping, report prepared by E Crisp, DCW, 1983, pp. 5, 19.
22 Difficult adolescent girls found that a higher proportion of young girls were subject to such orders than boys and that the orders were being used in effect as a social control on what was perceived as sexually promiscuous behaviour; Families SA executive director letter, 3 Oct. 2006.
23 Community Welfare Amendment Act 1981, s. 6; Community Welfare Act, s. 32(1)(d) starting in May 1983 and provided that the director-general could only place the child in a training centre or any other home used for the detention of children charged with, or convicted of, offences … if of the opinion that the child’s behaviour was such that the child was likely to cause serious self-harm or injury to others, or to properly, and could not properly be controlled in any other manner, and then only for a period not exceeding seven days.
Current response to children in State care who abscond

Significant legislative amendments came into effect from 1 July 1994 and remain in force.25 There are no longer any legislative provisions that deal with absconding from a residential care facility.26 Children considered to be ‘at risk’ can no longer be placed in secure training centres in any circumstances for ‘safekeeping’ or otherwise.27 Regulations limit the treatment and types of discipline that can be inflicted on residents of training and residential centres generally.28

Children and young people who frequently run away from placements are now generally considered to be at high risk and to have complex needs. Witnesses at the Inquiry were of the view that an early and intensive therapeutic response was required for children and young people who run away, especially for those who run away and are sexually exploited on the streets.

The government’s Keeping them safe – in our care: draft for consultation recognises there are children in State care with complex needs who require more intensive therapeutic support.29 It promises to ‘develop and implement initiatives to expand the therapeutic component in other care services such as residential care’, including ‘more assistance for care teams to establish effective interventions’ and ‘intensively supported therapeutic foster care placements that are linked to 24-hour facility-based care’.

Evidence to the Inquiry establishes without question that there should be a range of placement options for each child and young person in State care. Each should be placed in the most suitable option available. The department’s current proposals—to provide and expand intensively supported foster care or family-based placements; to develop and implement initiatives to expand the therapeutic component in other care services, such as residential care; and to respond better to children with complex needs—must be adequately resourced, monitored and regularly evaluated to be effective. This response remains in its early phases.

Other responses: Victoria and the United Kingdom

The early stage of developing an appropriate response in South Australia contrasts with the State of Victoria and the United Kingdom, where well-developed systems and programs are in place. The Inquiry took evidence about the two models. The South Australian Council for the Care of Children concluded in its 2006–07 annual report that these models are a good starting point for reforming the system in this State.30

Victoria has a coordinated system to deal with children identified to be at high risk. It has a range of placement options, including rostered and 24-hour residential units, secure welfare, home-based care, specialised home-based care, one-to-one home-based care, lead tenant arrangements and individualised flexible care to cater for the individual needs of children with complex needs.

In 1996 the secretary of the Department of Human Services in Victoria (DHS) determined that each region

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25 The Community Welfare Act (Children) Amendment Act 1993, which came into effect on 1 July 1994 made significant amendments to the Community Welfare Act, which was renamed the Family and Community Services Act 1972. The Children’s Protection Act 1993 and the Young Offenders Act 1993 also started at this time. These Acts remain in force.

26 However, a youth subject to detention who escapes from a training centre or lawful custody, or who is otherwise unlawfully at large, is still guilty of an offence: Young Offenders Act 1993, s. 48.

27 Children’s Protection Act 1993, s. 51(1)(c).

28 Family and Community Services Act 1972 r. 7, 9, 13. Residents cannot be subjected to any of the following kinds of treatment: (a) any form of corporal punishment, that is to say, any action which inflicts, or is intended to inflict, physical pain or discomfort; (b) isolation from other residents, that is to say, being kept apart from the normal routine of the centre in a locked room; (c) any form of psychological pressure or emotional abuse intended to intimidate or humiliate; (d) deprivation of medical attention, basic food and drink, clothing or any other essential item; (e) deprivation of sleep; (f) unjustified deprivation of contact with persons outside the centre/facility; (g) any other treatment that is cruel, inhuman or degrading. However, residents of training centres over 12 years of age can be locked in a detention room where an employee believes on reasonable grounds that the resident is about to self harm, harm another or cause significant property damage; or that it is necessary to maintain order in or preserve the security of the centre.

29 DFC, Keeping them safe – in our care: draft for consultation, Action 6.

should establish a high-risk adolescent register to monitor the circumstances, needs and service requirements of young people who pose a high level of risk to themselves or the community. DHS also reviewed placement and support services for high-risk adolescents, which examined their characteristics, needs and necessary service requirements, identifying service gaps and developing appropriate management strategies. Out of this review came an initiative termed the High Risk Adolescent Service Quality Improvement Initiative, consisting of three key service components: intensive case management, brokerage funds and one-to-one home-based care. Children identified as being at high risk can be referred to an Intensive Case Management Service (ICMS) and are assigned an experienced case manager who prepares and implements an individual case plan. ICMS is delivered by professional staff working in a multi-disciplinary team that includes drug and alcohol workers, mental health workers and intensive case managers. The ICMS works in collaboration with several other agencies, including the Central After-Hours Child Protection Service, Central After-Hours Bail Service, Streetwork Outreach Service, Juvenile Justice, Placement and Support Services, Secure Welfare Services, Mental Health Services, Drug Treatment Services, and the Department of Education. Teams work with children to achieve stable accommodation; establish and maintain positive relationships; attend to their health matters; address mental health needs, including therapeutic approaches to past trauma; reduce drug use and promote understanding of the impact of drug use; minimise criminal behaviour; access suitable day programs, including education, work placements and employment; and participate in recreation and leisure activities. When the needs of a child at high risk are not met through mainstream services, brokerage funds may be provided to tailor a direct service response that meets an individual’s specific needs. Examples include specific educational or day programs, mentoring programs and personal or self-esteem development activities.

One-to-one home-based care is an intensive placement for high-risk adolescents aged 12 to 18. Each carer has been specifically recruited and trained to care for high-risk young people with multiple complex needs. One-to-one care differs from other forms of foster care in several ways. The level of remuneration paid to the carer is higher, a high level of support is provided to the carer and the young person, and the carer is included as an equal member of the care and case management team. Carers receive compulsory training and youth worker time is provided. This type of care is similar to what the department in this State proposes in its Keeping them safe – in our care: draft for consultation.

Berry Street is an independent child and family welfare organisation that provides ICMS to three regions in Victoria. In partnership with the Austin Hospital Child and Adolescent Mental Health Service (CAMHS), Latrobe University School of Social Work and Mindful, a child psychiatry training program of Melbourne University, it also runs the Take Two program. This program, which is funded by DHS, consists of a therapeutic service for children and young people at high risk in the child protection system. Children and young people are eligible for referral to Take Two if they have experienced severe abuse or neglect and have been judged to be demonstrating, or at risk of demonstrating, behavioural or emotional disturbance. Each child undergoes specialist assessment and, if necessary, treatment. Their family and others who care for them are also assessed. Treatment planning is collaborative between all parties and designed to assist the child as well as the adults who care for the child. Some children simply come in for assessment, while others are given treatment, which

31 Department of Human Services, Victoria, High risk adolescents service quality improvement initiative guidelines, Care and Protection Branch, DHS, 1998.
Chapter 4 State response

is ongoing and for as long as is required. Take Two also has a specialist team to work with Aboriginal children, who represent a disproportionately large number of children in need of this type of intensive care.

In the United Kingdom, children and young people with extreme behavioural and emotional issues, for which standard residential and foster care placements are not adequate, have the option of therapeutic residential care. This type of care is run by an organisation known as Childhood First, which has been operating for more than 35 years and provides intensive residential programs and specialist integrated care, education and treatment.

Centres are supported by a team of consultant psychotherapists, psychiatrists and other therapists as appropriate. The context in which they are placed is much like a family home, although there is 24-hour cover by key workers, and group sessions. Although the home is not a locked-up environment, the presence of key workers at all times lessens the likelihood of the child running away.

Should a child abscond there is a quick response; police are notified and the child is returned to the place of care immediately. The event is taken very seriously: key workers meet immediately with the child to discuss and discourage running away from care.

**Recommended response**

The Inquiry supports the early work and initiatives that are proposed by the department. However, there is an urgent need for a coordinated response to children in State care who are at high risk. In particular, there is a need to develop an intensive case management system and a therapeutic intervention program that identifies, assesses, assists and treats children with complex needs. This program should be run in conjunction with intensively supported foster care and residential care placements.

**RECOMMENDATION 42**

That the provision of therapeutic and other intensive services for children in State care who abscond as envisaged in *Keeping them safe – in our care*, action six: ‘Children with complex care needs’, be implemented and developed as a matter of urgency and be adequately resourced.

That a group of care workers with suitable training and experience for such intensive therapeutic services be established and assigned to work on a one-on-one basis with children in State care who have complex needs and frequently abscond from placements.

That a specialist team be engaged to examine the benefits of establishing a specific therapeutic intervention program in South Australia that identifies, assesses, assists and treats children at high risk, similar to those in place in Victoria and the United Kingdom.

**Therapeutic secure care**

The need for this type of facility as a last resort for children who frequently abscond and place themselves at high risk became evident during the Inquiry.

**Current initiatives**

The need for therapeutic safekeeping arrangements with secure short-term accommodation for young people in serious conditions of risk was recommended in the Layton report in 2003. It was observed that some young people are caught in a cycle of drug addiction, sexual abuse and prostitution. The need for “those persons to have access to a place where they can be taken to give them a chance to ‘dry out’ and assess their future lives with professional assistance” was acknowledged. The report notes that [while] ‘voluntariness’ is a desirable goal, the age of these young people, their addicted state and their state of physical and mental health dictates that some enforcement may initially be required to help them.

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33 Ibid., ch. 13
The report stressed that any use of safekeeping arrangements be strictly monitored and assessed to prevent ‘systems abuse’ and that they require the sanction of the Youth Court. The report suggested that agencies should

… have to demonstrate that they have made all attempts to put in place other more appropriate services before safekeeping arrangements are sought. These arrangements cannot be seen to be a dumping ground for difficult adolescents because the service system has failed to provide proper supports and assistance at early stages.34

In relation to children and young people with complex needs, it is stated in Keeping them safe – in our care: draft for consultation that the government ‘will explore innovative responses with our sector partners for children who engage in extreme risk-taking behaviours through persistent running away and who need some level of safekeeping’.35

The Keeping them safe – in our care: consultation responses reported ‘mixed views’ on the issues of runaways and safekeeping orders. It also said some people had expressed concern about secure safekeeping for children and young people who engage in extreme risk-taking behaviours through persistent running away because therapy for long-term issues is hard to provide in short-term stays within a secure care unit; and because of concern that young people out of control may be placed in secure care because of limited alternatives, rather than as a last resort.

In September 2005, the Inquiry gave a discussion paper, Recovery of State children and secure care, to the chief executive officer of the Department for Families and Communities, Sue Vardon, and the executive director of Families SA, Beth Dunning. One issue for discussion was the need for a short-term therapeutic secure care-based facility for children engaging in extreme risk-taking behaviours.

Ms Vardon responded by letter and enclosed a detailed response from the department. It was indicated that the department has considered such a model at different times. However, she said that currently ‘[there] is not a body of evidence that supports it as a constructive intervention in isolation but rather it possibly raises as many difficulties as it seeks to resolve’. Ms Vardon contends that ‘such children are best assisted by intensive and supportive intervention to the level required to break the cycle of their extreme risk-taking behaviour’ and that multiple service approaches are required with intense care management until the children re-establish themselves in a safer set of circumstances. She notes that the department is ‘working to identify a suite of services and system change required to provide stability and certainty for children who may be an ongoing risk as runaways’.

Ms Vardon supports the development of a raft of system responses, recognising that greater emphasis must be placed on early intervention and real support at earlier stages for children and young people wherever possible, to prevent and not merely treat problematic behaviours. She also contends that:

Once an adequate suite of prevention-focused therapeutic support and placement options is in place, we will be better positioned to consider any potential role that an intensive short-term mandated treatment model could play as a part of a continuum of responses.

The department expressed the view that ‘the subject of secure safekeeping requires more thought and debate’; further, that:

The use of this sort of intervention would need to be targeted at those children and young people for whom other interventions have not reduced significant and untenable levels of risk.

Their preferred option

… is to enhance and improve current systems, inter-agency accountability, service delivery models and multi-disciplinary approaches to address the complex needs of these people.

34 ibid.
35 Keeping them safe – in our care: draft for consultation, Action 6.
Interstate and overseas experience

Other States and Territories in Australia and overseas jurisdictions have adopted the theory or practice of a therapeutic secure care facility. Brief discussion follows in relation to the situation in the Australian Capital Territory, New South Wales, Victoria, New Zealand and the United Kingdom.

**Australian Capital Territory**

The Children and Young People Act 1999 (ACT) provides for therapeutic protection orders (TPO). Therapeutic protection is defined as care provided by the chief executive of the department for a child or young person who is confined to a place in a way that the chief executive considers appropriate to protect them from serious harm. The Children’s Court may make a TPO if satisfied that there are reasonable grounds for believing a child is in need of such care and protection. Unless the court otherwise orders, the TPO has the effect of a residence order in favour of the chief executive and a specific issues order that gives day-to-day responsibility for the care, welfare and development of the child or young person to the chief executive. Provisions relating to therapeutic protection have been expanded in proposed legislation in the form of the Children and Young Persons Bill 2007. However, the ACT still does not have a secure care facility. Consequently, no therapeutic protection orders have been made under the Act.

**New South Wales**

In New South Wales, provisions in the Children and Young Persons (Care and Protection) Act 1998 allow for compulsory assistance orders to be made in respect of a child or young person. At the time of writing this report these provisions were yet to be proclaimed. ‘Compulsory assistance’ is defined as

... a form of intensive care and support for the child or young person that is necessary to protect the child or young person from suicide or other life-threatening or serious self-destructive behaviour.

It includes a requirement that the children reside and remain at specified premises and be under 24-hour supervision. Before orders can be made, the court must be satisfied that:

- The children or young people will receive treatment, therapy or other services which will help them deal with the problems that have led them to be a danger to themselves.
- The program offered to them is likely to lead to significant improvement in their circumstances.
- The agency that will be required to provide intensive supervision of the child or young person has indicated to the court that it will, and is able to, allocate the necessary resources.

The order must be made by the Children’s Court and must not exceed three months. Interim compulsory intervention orders can be granted for up to 21 days.

**Victoria**

Victoria is the only Australian State running a therapeutic secure welfare facility, which it established in 1992. Under section 173 of the Children, Youth and Families Act 2005, if the department secretary is satisfied that there is a substantial and immediate risk of harm to a child who is in the custody or under the guardianship of the State, he or she can be placed in a secure welfare service for up to 21 days. This period can be extended in exceptional circumstances for a maximum of 21 days. Placement in the unit is considered to be a last resort, implemented only after other avenues have been exhausted or are not sufficient to secure the safety of the child.

In considering whether to place a child in secure care, the secretary is bound to:

- consider the best interests of the child
• ensure the physical, intellectual, emotional and spiritual
development of the child in the same way as a good
parent would
• consider the treatment needs of the child.44

Importantly, section 174(1)(c) provides that the secretary
must have regard to the fact that a child’s lack of adequate
accommodation is not in itself a sufficient reason for
placing him or her in a secure welfare service.

Victoria has a secure unit for boys and one for girls, each
accommodating 10 children. A specialist school co-located
in the residential setting is funded by the Education
Department. The facility is staffed by specially trained
residential care workers. There also is access to medical
staff, alcohol and drug treatment nurses and therapeutic
intervention through Take Two and CAMHS. The average
stay in the units is eight to nine days. Children and young
people begin therapy while in secure care and are
linked to other services so treatment can continue once the
child leaves.

If a child is placed in a secure welfare service, the secretary
must provide transitional or ‘step-down’ support for the
transfer to and integration into another suitable
placement.45

While evaluation is difficult, those working in Victoria
estimate that it is highly successful as a ‘circuit breaker’ for
children who have an imminent risk of suicide, or are at risk
of physical or mental injury or exploitation.

The Act also provides for children not subject to custody
and guardianship of the State to be placed in secure care
in certain circumstances if there is a substantial and
immediate risk of harm to the child.46

The manager of the Take Two program in Melbourne told
the Inquiry:

Even I, who was, when I first heard about it, terribly
critical of [secure welfare]—I’ve had so many kids

where, in the end, it was the only thing that was
ending a trajectory that was going to end very
badly, and I have been just so surprised over the
years—the number of kids who have come in and
said: ‘Please put me back in. Leave me for a few
days’; or, ‘I want to stay there for a bit longer’ …
Although people talk about confinement, it’s also
about containment and care, and it’s not as if they
are frog-marched through the corridors or to school
and everything. The intent of secure welfare is
therapeutic.

International jurisdictions

Many other countries, including New Zealand, the United
Kingdom, the United States (in various States) and
Sweden, have legislation that provides for the therapeutic
secure care of young people at risk.47

New Zealand child protection legislation has provisions that
enable children to be placed in therapeutic secure care. In
particular, section 368 of the Children, Young Persons, and
Their Families Act 1989 (NZ) allows for a child or young
person to be placed in secure care in a residence if, and
only if, such a placement is necessary to prevent the child
or young person from absconding from the residence in
circumstances where two of the following conditions
are satisfied:

• The individual has absconded in the previous six months.
• There is a real likelihood that he or she will abscond.
• The individual’s physical, mental or emotional wellbeing is
likely to be harmed if he or she absconds.
• To prevent the individual from behaving in a manner likely
to cause physical harm to himself, herself or any other
person.

44 Children Youth and Families Act 2005 (Vic), s. 174(1)(a),(b) and (d).
45 ibid., s. 175.
46 ibid., s. 242.
No child or young person can be kept for a continuous period of more than 72 hours or on more than three consecutive days unless a court grants approval under section 376 of the Act. The court can then extend the period for up to 14 days if satisfied that it is necessary on the basis of the criteria set out above.

In the United Kingdom, children and young people with such extreme behavioural and emotional issues that standard residential and foster care placements are not adequate, have the option of therapeutic residential care. It is only if that type of care fails that someone may be referred to a fully secure environment as a ‘last resort’ for his or her own safety. Dr Jenny Pearce, Professor of Young People and Public Policy at the University of Bedfordshire in the UK, told the Inquiry:

*My view is that it’s an absolute last resort for a terribly small minority, but that for those young people it is better to secure them and contain them than it is to allow them to wander around the streets and do further damage to themselves, because other people will damage them ...*

Section 25 of the Children Act 1989 (UK) allows children who are being looked after by a local authority to be placed in secure accommodation only where they have a history of absconding, are likely to abscond and, if they abscond, are likely to suffer significant harm; or, if they are kept in any other type of accommodation, are likely to injure themselves or other people. A child can be placed in secure care for up to 72 hours without the need for a court order. A court can order that a child satisfying the criteria set out above be kept in secure accommodation for up to three months, although this can be extended for a further six months at any one time.

Secure children’s homes are run by local authorities and overseen by the Department of Health and the Department for Education and Skills. They focus on the physical, emotional and behavioural needs of the young people they accommodate and provide intensive support programs tailored to their individual needs. To achieve this, they have a high ratio of staff to young people and are usually small facilities, ranging in size from six to 40 beds. These homes are generally used to accommodate offenders aged 12 to 14, girls up to 16, and boys aged 15 to 16 who are assessed as vulnerable.

The Secure Accommodation Network is a group of about 24 secure children’s homes run by local authorities. Staff include social workers, experienced teachers, doctors and other health professionals. The behavioural, emotional and mental health needs of young people are assessed and treated by a range of specialist services including psychiatrists, psychologists, substance abuse workers and people with expertise in areas such as sex offending. Staff also work closely with family and friends to enable and facilitate the rebuilding of broken relationships and to provide a support network for young people when they go home or move on to an alternative community placement.

**Evidence to the Inquiry**

In regard to the issue of children in State care who abscond and engage in risk-taking behaviour, the Inquiry held a public meeting in September 2005 and a meeting of departmental staff and non-government agencies involved with young people in October 2005. The Inquiry also heard evidence about this issue from witnesses who work, or have worked, in the field of child protection and from representatives of relevant organisations.

Many workers thought a secure care therapeutic facility was necessary ‘to break the cycle’. One said: ‘Sometimes people need to be protected from themselves for a period of time’.

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468 CHILDREN IN STATE CARE COMMISSION OF INQUIRY
While many viewed secure care as an option, they were concerned that it not be the only option. One worker said:

*I think that our response needs to be very flexible and offer a range of styles and options … [Secure care] will never ever meet the needs of all runaways, but it will meet the needs of some of them.*

Evidence was received from residential care workers about the one-to-one care in different units. They said young people who were runaways in real danger eventually stopped this behaviour because of one-to-one care. It is likely that there have been many cases where a close relationship was established between a carer and a child or young person on a one-on-one basis with positive results, without the need for secure care. Another former residential care worker expressed his dislike for secure care but disclosed having locked in a young teenage girl because her father and brother were abusing her.

Witnesses involved in treating children with behavioural issues indicated that a child’s treatment was disrupted by absconding, and in most cases treatment was more successful in cases where the child had committed an offence and as a consequence was detained in the Magill or Cavan training centres. This particularly applied to those with substance abuse problems. One specialist in the field said: ‘Running interrupts, amongst other things, it interrupts their therapy … for example, if they’re on medication and they’re gone two days, then that’s stuffed up.’ He added: ‘We often hoped that a child would get a lengthy sentence so we could treat them’. This specialist advocated a ‘long-term residential system for the treatment’.

There was evidence that an increasing number of young people were being detained or remanded in training centres, not as a result of the seriousness of any offence they had committed but because of mental health or substance abuse issues. There was no other appropriate place to send them for treatment. The location of treatment programs in the training centres makes a secure response seem more punitive than therapeutic.

Another specialist told the Inquiry:

*I’m not convinced that their offences are serious enough to warrant being in custody, but certainly they are in custody because of their mental health issues … I would suspect the courts struggle with knowing that there aren’t community options for those young people and so, in the best interest of young people, they will remand them for a period of time to help stabilise their health issues.*

Many people were concerned that any secure care facility may be used inappropriately; for example, by children being placed in such care simply because there was nowhere else:

*I know the fear is, if you have a facility of this type, then you will use it and you will place people there regardless of whether there is a need or not. I think it’s pretty clearly demonstrated that there is a need for some kind of facility.*

Advocates of a therapeutic secure care facility were clear that such a facility should be separate from juvenile training centres. Many referred to the past practice of placing children on safekeeping orders among children who had committed offences:

*… these people may be at significant risk but they should not be put in jail and contaminated with people who have committed, at times, quite serious offences and, more to the point, quite serious behaviour.*

Some people were concerned that the facility might become like the institutions of old or a detention centre:

*I would hate them to become large, big environments because then they become institutions. I have done some work at Magill and I wouldn’t want it to become like that.*

On the nature of such a facility, one worker suggested these children needed a safe place, an ‘asylum’. He pointed out that there is ‘an extraordinary fine line between asylum and detention, and how we actually go about that, I think, is going to be critical’. He added:

4.2 Children in State care who run away
They have to feel that it’s going to be a safe place for them, not just someone taking over their life again and locking them up, and that’s very hard to do. But if it can be done, then I think that it’s a fundamental shift in the right direction.

People were concerned that if a secure care facility was established then placement of children and young people there should be tightly controlled. Many saw the type of staff as critical to the success of any such proposal, and one commented:

It doesn’t matter how well you design a program, it doesn’t matter how well-meaning you are. Unless you’ve actually got the people at any one time who actually fit that bill, it will never work.

Another witness said:

You need to find very special people to be able to—not just ordinary institutional secure care staff … to have a secure physical environment, but … very special people that have got the training and the values and the motivation to give that person not just the security, but some warmth and some love and some caring, because they’re the sorts of things that are going to turn that kid around.

Advocates of secure care considered that the provision of some type of transitional or ongoing support to young people after they had left secure care was critical:

There should be an ability to have … a residential type program that can work in partnership with a family, and … there needs to be some skill development of perhaps the foster carers with a particular child, where they can get some—not only respite, but also some support and skills. So that even when kids go into that sort of secure care there is still a family that is there and available for them when they get to a certain point, that they obviously get along with. So I think it’s about doing a whole range of things at the same time.

Some witnesses who had absconded while in State care agreed with the need for and benefit of a therapeutic secure care facility:

… at the same time I think about it and I think, well, if somebody had stuck me in one of them, instead of letting me just do what I wanted to do, and said, ‘Right, this is it. You’re here, and the premises is locked at this point in time and if you’re not here, we’re going to go send coppers looking for you, and you’ll come back and you’re going to stay here and we’re going to sort this out and we’re going to get you help, and we’re going to do this and we’re going to do that and we’re going to do the other’, then all of a sudden my life would have been different.

At the Inquiry’s public meeting, differing views were expressed about secure care for children in danger. Some people, mainly parents, were strongly in favour and wanted runaway children to be placed in therapeutic secure care. One young woman told the meeting she had been prevented from absconding and had been placed in secure care for assistance. However, most people at the meeting were opposed to therapeutic secure care. Views expressed were that children should not be locked up for safekeeping and that secure care should be restricted to punishment for criminal behaviour; in the past there had been secure care for safekeeping, which was unfair and unjust. Much the same view in opposition to secure care was expressed at the meeting of departmental staff and non-government agencies involved with young people organised by the Inquiry.

To provide a response to Keeping them safe – in our care: draft for consultation, CREATE Foundation consulted with young people formerly and currently in State care. In relation to runaways and secure care the responses included:

- Talk to young people about why they run away.
- Have safe houses where young people can go when they run away; where they know they will get help.
• Restraint affects all young people in a unit—even those who are not being restrained.
• Bedroom doors should not be locked.
• Restraining should not be used except as a last resort.

The responses to CREATE included ‘No restraining in CRC [community residential care]’; ‘No detention’; and ‘Children run away if they get scared’. Twenty per cent of participants said that apart from foster care or relative care there should be ‘independent living with one-on-one support’.

The Guardian for Children and Young People said in evidence to the Inquiry:

It’s definitely time for a discussion. It’s definitely a time to consider the idea more seriously, to think about if we were to have it what is it that we would need to have in place to ensure that it was the safest facility that we could have, that protected the rights of the children and young people who entered there.

What needs to be done

The Inquiry recommends that urgent attention be given to the provision of appropriate services and care, including intensive therapeutic services to children who abscond from their placements. Secure care should be an option of last resort for children in serious danger. The government has known for several decades that children and young people in State care who run away from placements are at high risk of sexual exploitation. The high risk continues and secure care must be a last-resort option to protect and care for these children.

The establishment of therapeutic safekeeping arrangements with secure short-term accommodation for children at risk was a recommendation made in the Layton report in 2003. Experience in other jurisdictions suggests there is a proportion of children with complex needs who will benefit from a short-term therapeutic secure environment in addition to other therapeutic alternatives.

The Inquiry believes the secure therapeutic welfare systems used in other jurisdictions, particularly the Victorian system, should be examined and assessed with a view to establishing such a system in this State.

The facility should be a residence in metropolitan Adelaide near other intensive therapeutic services being envisaged as part of Keeping them safe – in our care. A full range of therapeutic services should be available at the residence and elsewhere as appropriate, and the staff must have suitable training and experience. The residence must be capable of being secured to prevent residents from absconding. The facility should be used only as a last resort and for a short period of up to 21 days.

Once a runaway child or young person in State care has been found, any decision to place him or her in secure care must be made by the executive director of the department. When making the decision, the executive director must have regard to the matters set out in section 174(1) of the Victorian legislation. If such a decision is made, the child may be placed in the secure care facility and the executive director must inform the Minister of the decision and placement within 24 hours. There must be judicial supervision of the secure care of any child in State care. The executive director must start proceedings in the Youth Court within 24 hours and seek orders and directions of the court as to the immediate future care of the child. The child must not continue to be kept in secure care without a court order. In giving directions and making orders about the child, the court must also have regard to matters set out in section 174(1) of the Victorian legislation. The role of the court is to ensure there is independent judicial supervision of the length of time the child is kept in secure care and the services and programs that are provided. The Guardian for Children and Young People must be notified of the secure care placement. The child, members of his or her family and any person who the court decides has a sufficient interest in the child may apply to the court for discharge or variation of the order.
RECOMMENDATION 43

That a secure care therapeutic facility to care for children exhibiting behaviour placing them at high risk be established as a last-resort placement.

That the Minister appoints a panel of suitably qualified persons to select and design the secure care therapeutic facility and determine the therapeutic services to be provided.

Locating children in State care who run away

The Inquiry heard evidence from police officers, residential care workers and the Guardian for Children and Young People (GCYP) that in the past timely responses in recovering children have been impeded by poor communication between police and the department, different interpretations of what constitutes a missing person, slow responses, and disagreement about responsibilities, as well as a general shortage of resources.\(^{55}\)

One police officer said:

*It does take up a lot of resources to basically play taxi for kids … some that just want to walk out and then ring up the workers and get a taxi back to the unit, and that does happen.*

He said, however, about the police: ‘I think the attitude that might have developed was a bit dismissive: “These kids again. They’re wasting our time”’. Some residential care workers said that when children ran away from a placement the staff who worked closely with them were often the most successful at locating them and persuading them to return: ‘Ninety-five per cent of the kids you will get back just by doing that and they will come back with you willingly’. However, they said they needed support from police because often in retrieving a child they put themselves at risk: ‘We don’t have the resources to go down and get them all the time’. It was felt that with more resources the agencies could work in collaboration and respond faster and more appropriately to runaway children and young people. The ratio of staff to young people in residential care units has also been of concern to the GCYP\(^{56}\) and is the subject of a recommendation in this report (see Chapter 4.1).

Operational response to missing children in State care

The police operation (operation C) undertaken over 18 months from April 2005 identified a need for a more coordinated and stronger operational response to the issue of children absconding from residential care facilities. A report by the GCYP in July 2007 acknowledges the work done by that police operation, but notes that at present the coordination of the response between the department and police when children and young people abscond varies from one region to another.\(^{57}\) The Inquiry heard evidence that Holden Hill police and the two units in that area were making progress toward setting out procedures for developing a missing persons protocol. The Inquiry endorses the recommendation of the GCYP that the protocol between police and the department for a rapid response to missing persons reports be implemented in all regions where residential care facilities are located (including transitional accommodation houses). The Inquiry also considers there should be contact officers in the SA Police local service areas where residential care facilities are housed and also to facilitate the flow of information about children who frequently abscond and are ‘at risk’ of sexual exploitation.

\(^{55}\) GCYP. *Children missing from residential care*, 2007, p. 4.

\(^{56}\) ibid.

\(^{57}\) ibid., p. 9.
### Record keeping

The Inquiry also heard evidence about the need to improve record keeping in relation to children in State care who frequently abscond (see chapter 6). The SA Police computer system (PIMS) does not record as a separate field the fact that a child or young person is in State care; nor does it record as a separate field the fact that a child is a frequent absconder. This means that information about the number of children in State care who are missing or considered to be frequent absconders is not readily available. The status of a child as being in State care should be on a separate menu, with a subset of that menu permitting an inquiry into all children who are ‘at risk’ from frequent absconding.

The Inquiry also believes SA Police local service areas and the Missing Persons Unit should keep specific files about children in State care who are considered to be ‘at risk’ due to frequent absconding. The files should contain information about each time a child absconds, including where he or she has been located. This would assist in finding the missing person and overcome the difficulties encountered by changes in personnel.

### Power to retrieve a child in State care

Once a child in State care has been located, a police officer or authorised departmental officer has the power to use reasonable force to remove him or her from a place when the officer believes on reasonable grounds that the child is in a situation of ‘serious danger’ and needs to be protected from harm or further harm.

The department told the Inquiry that this legislative provision has now strengthened the ability of the department and police to remove children from dangerous situations, is now actively invoked and may be used to return runaways home.

There is, however, a limitation on the use of the power: the officer must first believe that the child is in ‘serious danger’. What is ‘serious danger’ is open to interpretation and may not always be immediately apparent to the relevant officers. There should be a more general power to retrieve and recover children in State care who abscond from placements. The power should not be premised on the need for a belief on reasonable grounds of ‘serious danger’. An example is in Western Australia, where the officer must have a reasonable belief that there is ‘a risk to the wellbeing of the child’.

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58 Children’s Protection Act 1993, s. 15–6.
60 Children and Community Services Act 2004 (WA), s. 41(2).
Chapter 4 State response

46

This legislative amendment is recommended on the basis that the response to a child in State care who has run away and is then found must be therapeutic, not punitive.

RECOMMENDATION 46
That section 16 of the Children’s Protection Act 1993 be amended to provide for a more general power to recover children in State care by deleting the requirement of a reasonable belief as to ‘serious danger’ and inserting a lesser standard such as ‘a risk to the wellbeing of the child’.

Stopping the perpetrators

A range of criminal offences with severe penalties that relate to the sexual abuse and exploitation of children already exists. However, prosecutions of alleged offenders for such offences rely on children and young people disclosing the offence to the police and then giving evidence in court against the perpetrator. The Inquiry has heard evidence about the alleged victims’ unwillingness to do that for various reasons, including intimidation and fear or not wanting to lose the source of gifts such as money, cigarettes, drugs, alcohol, shelter or clothes. There was a concern and frustration expressed that young people were ‘continually sexually abused’ and the perpetrators were known; however, ‘they are not prosecuted, they are not even followed up closely’. It was observed that under the current system it is difficult to get a conviction because ‘a lot of our young people will protect the people who are abusing them’.

Proof of serious criminal offences of child sexual abuse and exploitation will almost always rely on the child being prepared to give evidence. However, the Inquiry heard evidence from people who would like the introduction of a legislative provision that made it an offence for an adult to harbour a child, but did not rely on evidence from the child. One departmental worker said:

I certainly would advocate for a system where the people who harbour these kids are the ones who actually get some consequence and not the children themselves, who really are the victims in these situations.

Another departmental worker said: ‘If we get some type of deterrence it would help at least persuade these people not to attempt to do so’. Another said the biggest issue was cutting off the places that absconders run to so workers can get them into a unit long enough to show them that ‘the place is a good place to be, and long enough to put things in place so that they can have a stable and normal life’. Witnesses were concerned that any action to remove the child occurred as quickly as possible and did not require cumbersome procedures.

Harbouring children in State care: current legislative provisions

All States in Australia have provisions that make harbouring or concealing and/or the unlawful removal of a child under guardianship an offence. South Australia’s legislative provisions that attempt to deal with the issue of the taking and harbouring of children are:

- Section 76 of the Family and Community Services Act 1972, which makes it an offence to unlawfully take a child from his or her placement, or to harbour or conceal a child. It is rarely used. Proof of the charge generally requires evidence from the child that he or she was ‘induced’ or provided with a ‘refuge’.
- A child who absconds from a residential care facility to obtain benefits for sexual favours and/or leaves to go to a

61 Children and Young People Act 1999 (ACT), ss. 389-390; Children and Young Persons (Care and Protection) Act 1998 (NSW), s. 229; Community Welfare Act 1983 (NT), s. 96; Children Protection Act 1999 (Qld); ss. 162, 164; Family and Community Services Act 1972 (SA), s. 76; Child, Youth and Families Act 2005 (Vic), ss. 495-6; Children, Young Persons and Their Families Act 1997 (Tas), ss. 95-6; Children and Community Services Act 2004 (WA), ss. 108-109.

62 Punishable by six months’ imprisonment or a $2000 fine.

63 Harbouring has a distinct meaning at common law and is said to require a positive act such as ‘the provision of shelter in the sense of providing a refuge’: Darch v. Weight (1984) 79 Cr App R 40.
4.2 Children in State care who run away

'refuge' is not likely to be willing to give evidence against the person who gave those benefits and/or provided that refuge.

- Section 80 of the *Criminal Law Consolidation Act 1935*, which makes it an offence to abduct a child under 16.54 However, it requires proof that the child was taken or enticed away by ‘force or fraud’; or that the child was harboured by someone who knows the child was taken or enticed away in those circumstances. A youth support worker who took a 15-year-old child under the guardianship of the Minister interstate was recently convicted of an offence against section 80(1a).65 Generally, however, it is not well suited to deal with the situation where a child in State care runs to the paedophile because proof of ‘force or fraud’ would require the child to both report and give evidence against the offender.

- Section 99 of the *Summary Procedure Act 1921*, which provides for a court to make a general restraint order against a person. However, it requires proof that a person has been behaving in an ‘intimidating or offensive manner’ on two or more separate occasions. Such proof in court would generally require the evidence of the child. Failure to comply with a restraining order is an offence punishable by imprisonment, although proof of non-compliance may require evidence from the child.

- Section 99A of the *Summary Procedure Act 1921*, which provides for the making of paedophile restraint orders. It does not rely on the evidence of the child or children, and the application can be made by a police officer. An order may be made restraining a person from loitering near children in any circumstances, or it can restrain the person from being near children at specified places or in specified circumstances. The court must first be satisfied that the person has been found loitering near children on at least two occasions and there is reason to think the person will do so again unless restrained. ‘Loitering near children’ means the person loiters, without reasonable excuse, at or in the vicinity of a school, public toilet or place at which children are regularly present; and children are present at the school, toilet or place at the time of the loitering.66 Again, its applicability to children in State care who run away and are sexually exploited is very limited.

- Section 38 of the *Children’s Protection Act 1993*, which permits the Youth Court to make an order that a person not have contact with a child. However, this applies only to someone who is a party to an application for a care and protection order relating to the child; usually a parent, guardian or custodian. It is evident that the current legislative provisions are not generally suited to addressing this particular issue and/or would require evidence from the child.

**Offences of acting contrary to a written direction**

It is considered that offences should be created regarding the harbouring of (or communicating with) a child in State care contrary to a written direction of the chief executive. Examples of offences based on acting contrary to direction from a chief executive include the following:

- In Western Australia a legislative provision permits the chief executive of the relevant department to direct a person not to communicate, or attempt to communicate, in any way with a child specified in the notice.67 If the person fails to comply with that direction, then an offence is committed, with a penalty of a fine of up to $6000.

- In South Australia, it is an offence if a person, having been forbidden to do so by the chief executive of the department, communicates in any manner with a child who is being detained or who lives in a training centre, a children’s residential facility established by the Minister or other specified facilities.68

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*54 Punishable by seven years’ imprisonment.*

*55 South Australia Police v Moore (unreported), 24 Sep. 2007.*

*56 Summary Procedure Act 1921, s. 99AA(4).*

*57 Children and Community Services Act 2004 (WA), s. 110.*

*58 Family and Community Services Act 1972 (SA), s. 77.*
The elements of the proposed offence of ‘harbouring a child in State care contrary to written direction’ should be that the person charged is providing accommodation for the child, was aware at that time that the child was in State care and knew that he or she had been previously directed in writing not to provide accommodation for the child. There should be a presumption, or deeming provision, in the legislation that upon proof that the person had been previously served with a written notice from the chief executive of the department or the Commissioner of Police, the offence is committed when the child is found with that person. The authorised officer (police or authorised departmental officer) recovering the child could serve the notice, contravention of which would form the basis of this offence. The punishment should be a fine or imprisonment, and the penalty should increase for subsequent offences.

A similar offence in relation to communicating with a child contrary to a written direction from the chief executive should also be created.

**RECOMMENDATION 47**

That the following offences be created:

1. Harbouring a child in State care contrary to written direction.
2. Communicating with a child in State care contrary to written direction.

The legislation should provide for a written notice to be served on a person with a presumption that, upon proof of prior service, the offence is committed if the child is found with that person.

**Police operations**

... to this day we cannot understand ... why there is still a Veale Gardens to go to? Why are these haunts and these beats still there to go to? If that was my backyard and my child was in that backyard, I would go down there and stop it. I beg of this community to be loud and to be heard about this.

The Inquiry has been impressed by the dedicated work of a number of police officers during the past 20 years in regard to the investigation of child sexual abuse generally. As a result of their actions, there was a change in culture towards these investigations and an immense amount of intelligence has been gathered, as well as cases being prosecuted successfully.

It is apparent to the Inquiry that beats such as Veale Gardens have not come under close police scrutiny since the end of a specific police operation about 10 years ago. It is known by the State that sexual exploitation of children, including children in State care, at Veale Gardens and other beats continues. The Inquiry asks—as did several witnesses—why this conduct is permitted to occur. Young people continue to be sexually exploited at these beats; they provide sexual favours in exchange for money, cigarettes, alcohol, drugs and other benefits. They are collected from those beats and taken elsewhere for sexual offences.

The Inquiry received evidence from police officers about their present approach to the policing of these beats. For operational reasons, that evidence will not be published. In summary, the view was that ‘we are sort of walking a fine line’. The officers did not want the police to be perceived in any way to be targeting or harassing members of the homosexual community who meet at those areas for legitimate purposes, and also expressed the view that with ‘a heavy-handed approach to the policing of the area, you just displace the occurrences to some other location’. A police witness posed the question about legitimate homosexual activity:
Is it not better to allow it to be in this area, which it’s been for many, many years and people feel a degree of safety when they go there because they build up networks of people and trust …

There must always be great reluctance to make recommendations about how police should undertake their work and what that work should be, particularly in an operational sense, but a known haunt for serious crimes involving children, including children in State care, should not be allowed to continue. It is recommended that another operation of the nature of the police operation (operation T) 10 years ago be undertaken and adequately resourced, with a view to detecting sexual crimes against children and young persons in State care at Veale Gardens and other city beats to reduce its prevalence. If it is conducted with the same approach and sensitivity as used in the previous operation, appropriate understandings between police and the homosexual community in those areas shall not be compromised.

RECOMMENDATION 48

That the South Australia Police undertake an operation in relation to Veale Gardens and other known beats to detect sexual crimes against children and young persons in State care, apprehend perpetrators and develop further police intelligence.
Chapter 5 Deaths of children in State care
5 Deaths of children in State care

Method of investigation

Determining the number of children who died in State care

Information sources

Generating a single list from the department

Omissions in department information

Determining the cause of death of children in State care

Deficiencies in departmental records

Coronial records

Office of Births, Deaths and Marriages

Deaths after release from State care

Deaths in State care

Deaths in institutional care

Deaths in foster care/other placements

Deaths of children who had absconded from State care

Deaths of children on probation to family

Other issues

Unmarked graves

Recommendations regarding deaths

Central database

Maintaining files

Funding for legal representation at coronial inquests
Chapter 5 Deaths of children in State care

The Inquiry received information about more than 900 people during its investigation of children who had died in State care. Information came from various sources, including members of the public and the government agencies: Families SA (the department), the offices of the State Coroner and Births, Deaths and Marriages, and State Records of South Australia.

The Inquiry’s term of reference relating to deaths of children in State care is set out in schedule 1 (1)(b) of the Commission of Inquiry (Children in State Care and Children on APY Lands) Act 2004 Commission of Inquiry Act. It is to inquire into any allegations of ‘criminal conduct that resulted in the death of a person who, at the time that the alleged conduct occurred, was a child in State care, (whether or not any such allegation was previously made or reported)’.

The Inquiry has interpreted the term of reference to include situations where criminal conduct perpetrated upon a child while in State care was the direct and immediate cause of the child’s death (for example, homicide, death caused by dangerous driving) and where it was a substantial cause of the child’s later death (for example, the child was sexually assaulted when in State care and later committed suicide because of that criminal conduct).

The Inquiry initially asked the department to provide the names of all children in State care who had died. These were provided across eight lists during the course of the Inquiry as the department did not have any mechanism by which it could produce a single consolidated list. Evidence was also taken from people about the deaths of children who they believed were in State care.

The Inquiry found the department had failed to properly record the deaths of children in State care over the past century. The lists provided by the department contained errors, overlaps and were not complete. Even when the fact of a death was recorded, in many cases there was no information about the cause or circumstances. This not only applies to the department’s administrative records but also the individual child’s files. Any information about the death on the child’s file was often from an unverified source. The files were only rarely kept open after the death to obtain official information (such as a post-mortem report or a police report) about the circumstances.

The inconsistency, error and minimal attention to recording and maintaining information about the death and the circumstances of the death of children in State care in departmental records supplied to the Inquiry is not solely historical. Nor is it confined to one type of record—errors and omissions were found in the State ward index cards (SWICs), on client files and on the current Client Information System (CIS).

As a result of the department’s inadequate recording, the Inquiry had to request many coronial files just to ascertain the cause of the death. In some cases these files were either not available—before 1 July 2005 the death of a State child was not reportable to the coroner—or could not be found. In some cases, the only information about the cause of death was the death certificate at the Births, Deaths and Marriages Registration Office (BDM). Sometimes the paucity of information (only a stated cause of death on the death certificate, for example, drug overdose) meant that the circumstances surrounding the death could not be determined.

The poor maintenance of departmental records demonstrates an indifference to how children in State care have died.

From its investigations of records, the Inquiry has identified the deaths of children in State care as a result of criminal conduct. It has also received allegations of criminal conduct resulting in deaths of children and investigated whether the children were in State care and whether the death was the result of criminal conduct.
Method of investigation

Determining the number of children who died in State care

Information sources

The Inquiry found the department had no centralised system for recording the names of children who had died in State care. In response to the Inquiry’s request for information, the department supplied eight lists of children in State care who had died. Some were drawn from specific sources such as SWICs and the Mortality Record Book, and others were generated for the Inquiry from various administrative records.

Other names were provided by people who gave evidence to the Inquiry and also sourced from non-departmental and other departmental records.

The number of people on the various lists is set out in Table 1. A discussion of each source of information follows.

<table>
<thead>
<tr>
<th>Source of information</th>
<th>Number of names of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Departmental:</strong></td>
<td></td>
</tr>
<tr>
<td>Minister for Families and</td>
<td>40</td>
</tr>
<tr>
<td>Communities</td>
<td></td>
</tr>
<tr>
<td>State ward index cards (SWICs)</td>
<td>339</td>
</tr>
<tr>
<td>Client Information System (CIS)</td>
<td>186</td>
</tr>
<tr>
<td>Mortality Record Book</td>
<td>159</td>
</tr>
<tr>
<td>Disability SA</td>
<td>41</td>
</tr>
<tr>
<td>Consignment list of GRS 11086/1</td>
<td>4</td>
</tr>
<tr>
<td>List of files sent to State  Coroner's Office 1995–2004</td>
<td>28</td>
</tr>
<tr>
<td>Families SA data warehouse</td>
<td>34</td>
</tr>
<tr>
<td><strong>Non-departmental:</strong></td>
<td></td>
</tr>
<tr>
<td>Evidence to the Inquiry</td>
<td>76</td>
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<tr>
<td>Inquiry research</td>
<td>16</td>
</tr>
<tr>
<td>State Records of South Australia</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>924</td>
</tr>
</tbody>
</table>

Table 1 Sources of information on deaths provided to the Inquiry

Minister for Families and Communities

A list of 40 names was prepared for the Minister for Families and Communities following the Layton report in 2003. These deaths occurred between 9 June 2002 and 26 December 2004.

State ward index cards

Following a manual search of the SWICs, the department gave the Inquiry a list of 339 names. The completeness of the list depended on the death being recorded on the SWIC (which was not always the case) and the accuracy of the manual search process.

Client Information System

The department’s computer system, CIS, yielded a list of 186 names of children who were recorded as having died, which was given to the Inquiry.

Mortality Record Book

The department’s Mortality Record Book is an administrative record that contains a handwritten list of 159 entries drawn into columns for name, age, date of death, where placed and cause of death. The entries span the years 1927–1974. The book does not record whether the children were in State care. The Inquiry asked the department about the book’s function, how information was compiled and who was responsible for its maintenance. The department could not provide this information.

Disability SA

Disability services are coordinated and funded through Disability SA, which is part of the Department for Families and Communities. The office provided the Inquiry with the names of 41 children who had died and who were receiving government disability services in supported residential care or similar facilities.

Consignment list of GRS 11086/1/P ‘Records of deceased people while in care’

The department provided a list of archived files relating to four people who had died while in the care of the Minister.

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1 Department of Human Services 2003, Our best investment: a State plan to protect and advance the interests of children, report prepared by Robyn Layton QC, DHS Adelaide.
5

Chapter 5 Deaths of children in State care

List of files sent to State Coroner’s Office 1995–2004
The department supplied a list of 28 names of people whose client files had been sent to the Coroner’s Office between 1995 and 2004. The list came from a departmental file marked ‘subpoenas’, but there was no other description of the list’s function. It was not clear which people had died, if any, or the number who had been in State care. The Inquiry’s investigations found that most of the people on the list were not dead, but their files had been transferred to assist coronial investigations into the deaths of other people known to the department.

Families SA data warehouse
The department provided a list of 34 people who had an involvement in secure care, community residential care, alternative care placements or were the subject of a care and protection order at 31 January 2005 and who had died.

Evidence to the Inquiry
The names of 76 children who had died were given to the Inquiry during evidence from more than 90 people. This information included allegations of criminal conduct resulting in the death of children thought by the witnesses to have been in State care. It included evidence from people about the death of a family member who had been in State care, but they were uncertain, due to separation, whether that family member died while in State care. Others gave evidence about deaths of people they had known while in State care or during their involvement with children in State care in a professional capacity. This included the names of 23 children from one source, who believed all were in State care. In many cases, people giving evidence were unable to provide information about the cause of death or whether the death was related to criminal conduct that occurred while the child was in State care. For these reasons investigations were conducted into whether the child was in State care, the cause of death and whether there was criminal conduct related to the child’s time in State care.

Inquiry research
The names of 16 children who had died were found by the Inquiry in the minutes of the State Children’s Council (SCC), indices of the City Coroner’s police reports held at State Records of South Australia, and logs and registers maintained at departmental secure care, residential care and other facilities.

State Records of South Australia
State Records of South Australia (SRSA) found the name of one deceased child in Families SA correspondence files.2

Generating a single list from the department
The department’s sources produced a total of 825 names. The earliest date of death from the sources of information was 1908. Given the disparity of sources and the paucity of information in many cases, the Inquiry undertook to verify the status of the person as a child in State care and each fact of the death. In this process the Inquiry’s investigations eliminated 404 cases as being outside the terms of reference, leaving 421 names of children in State care who had died. Reasons for the eliminations were:

- Names appearing on more than one list
- One person on the CIS list was not dead. The department had recorded the person as having died at the age of 17 in 1992; no cause of death was specified. The Inquiry found that three people had been recorded on CIS with the same date of birth and name, but the first name was spelt slightly differently in each case. Each ‘person’ was recorded as receiving different services from the department, but only one was recorded as having died. Among other investigations, the Inquiry sought records from the State Coroner and the police recording system, but none could be found. It was resolved that the record was in error and that the 1992 date was when the child had committed a property damage offence. CIS records have been amended.
• It is likely that one other child on the CIS list is not dead. The list includes two girls with the same name and date of death in 2000. It shows different dates of birth and a middle name for one girl only. After many inquiries, the Inquiry determined that the entries were for different girls. The State Coroner’s Office confirmed that the girl recorded as having a middle name died in 2000. The department could not confirm that the other girl is alive, however it seems likely she is, as there is no record of her death at the Office of Births, Deaths and Marriages (BDM).

• The Inquiry also found that one person on the CIS list who died was recorded twice under different surnames.

The Inquiry was able to ascertain, after investigation, that the CIS list contained names of children who had never been placed in State care, so were outside the Inquiry’s terms of reference and not investigated further. They included:

• Seven children had no contact with the department before they died. They had come to the department’s attention after death for various reasons, such as concerns arising post-mortem about possible child abuse and the welfare of living siblings.

• Forty-five children came to the attention of the department for direct financial assistance only. This may have been for food, accommodation or clothing while the child was alive or assistance to pay for the child’s funeral (the department has historically provided assistance for the burial of people with limited financial resources). The Inquiry often had to request departmental files to determine that the department’s involvement was either post-mortem or for direct financial assistance only.

• Seventy-two children had never been placed in State care as defined by the Inquiry’s terms of reference, but had come to the department’s attention during their lives because of child protection notifications made in relation to them or members of their families.

In the vast majority of these cases the Inquiry found it necessary to request files from the department and State Coroner’s Office to ascertain the child’s status and cause of death.

After investigation of records the status as children in State care remained unclear in 39 cases. However because the causes of death did not suggest any relevant criminal conduct, the cases were not further investigated.

Seven deaths occurred after 18 November 2004. Under the Commission of Inquiry Act, only deaths occurring before that date come within the jurisdiction of the Inquiry.

Table 2 shows the number of deceased children in State care.

<table>
<thead>
<tr>
<th>Source of information</th>
<th>Number of children in State care from source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minister for Families and Communities’ list</td>
<td>5³</td>
</tr>
<tr>
<td>State ward index cards</td>
<td>339</td>
</tr>
<tr>
<td>Client Information System (CIS)</td>
<td>45</td>
</tr>
<tr>
<td>Mortality Record Book</td>
<td>30⁴</td>
</tr>
<tr>
<td>Disability SA</td>
<td>1</td>
</tr>
<tr>
<td>Consignment list of GRS11086/1</td>
<td>1</td>
</tr>
<tr>
<td>Listing of files sent to State Coroner’s Office 1995–2004</td>
<td>0⁵</td>
</tr>
<tr>
<td>CYFS data warehouse</td>
<td>0⁶</td>
</tr>
<tr>
<td>Total</td>
<td>421</td>
</tr>
</tbody>
</table>

Table 2 Number of deceased children in State care from departmental sources after accounting for overlap

³ Five names on the Minister’s list were not on any of the lists provided by the department.
⁴ All 159 names in the Mortality Record Book were of children in State care, however 30 were not included in the SWIC list.
⁵ The names of deceased children in State care on this list were already on other lists provided by the department.
⁶ As per footnote 5.
Chapter 5 Deaths of children in State care

Omissions in department information

The Inquiry believes the list of 421 names of children who died in State care between 1908–2004 is not complete for various reasons.

The Mortality Record Book is a hardcover foolscap book containing handwritten entries concerning persons who died between 1927 and 1974. The Inquiry compared the number of names in the book to departmental annual reports7 that recorded deaths of State children. As the annual reports list the numbers of children who died in a particular year but not their names, it was not possible to confirm whether they were the same children named in the Mortality Record Book each year. In terms of numbers, however, there was a discrepancy between the Children’s Welfare and Public Relief Board (CWPRB) annual report for the year ending 30 June 1941, which listed the deaths of one girl and two boys, and the Mortality Record Book, which did not list any deaths for the same period. Also, six children who died in State care were listed on the department’s SWIC list for that year but not recorded in the Mortality Record Book. This includes the three deaths in the CWPRB annual report. From these comparisons alone, it is evident that the book was deficient by at least six deaths.

The SWIC list provided by the department was also deficient. The Inquiry is not critical of the departmental employees who performed the task of manually searching the SWICs for a recording of death at the Inquiry’s request. However, the difficulty of such a task and the inevitable inaccuracies that arose serve to highlight the historical failure of the State to centrally record the deaths of children under its guardianship, resulting in its inability today to produce a comprehensive list of these children.

At least 30 deaths were missed in the manual search of the SWICs. There were 30 deaths recorded in the Mortality Record Book that were not on the SWIC list. The Inquiry found that each of the 30 children in the Mortality Record Book did have a SWIC, which recorded their death.

There was no consistency in the practice of recording the death of children after they were released from State care. Sometimes a child’s death would be recorded on the SWIC whether or not the death occurred while they were in State care. For example, one male was released from State care in 1909 aged 18 and his death three years later is recorded on his SWIC. Another male was released from State care in 1913 aged 18 and his SWIC records that he died in 1918 when he was 22. Another male was released from State care in 1962 aged 18 and his SWIC records that he died in 1968, aged 24. However, the death of a female only four months after she turned 18 and was released from State care was not recorded on her SWIC.

The Inquiry also became aware from non-departmental sources of the deaths of two children while in State care, which had not been recorded on their SWICs. One child’s last entry on her SWIC was ‘released, term expired’ in August 1989, however she had died in 1987. Exactly the same notation was made for the other child as his last SWIC entry in 1985, but he had died the previous year.

The Inquiry also found that the department’s CIS list was not complete or consistent. Eight deaths discovered by the Inquiry from non-departmental sources were recorded on CIS, although they were not on the CIS list provided to the Inquiry.

Sometimes, but not consistently, the department would record the death of a child on CIS, whether or not the death had occurred while the child was in, or had left, State care. Further, the recording of the death on CIS was not always timely. For example, one boy died in State care in January 1994, but the death was not recorded on CIS until five months later, in June. One girl died in State care in 1994, but the death was not recorded on CIS until 1996.

The Inquiry became aware, through evidence and research, of the deaths of three State children that were not recorded on CIS. Two should have been recorded because they had died while they were in State care, one as a result of a homicide.

7 State Children’s Council (SCC) annual reports 1896–1926; Children’s Welfare and Public Relief Board (CWPRB) annual reports 1927–65; Department of Social Welfare (DSW) annual reports 1966–70; Director of Social Welfare and Aboriginal Affairs annual report 1971; Department for Community Welfare (DCW) annual reports 1972–75.
The Inquiry’s finding that the list of 421 names is not complete is clearly demonstrated by the fact that non-departmental sources provided 55 names of deceased State children that had not been advised by the department. Of the 55, 45 arose from evidence given to the Inquiry (13 of these children were in State care when they died), nine from the Inquiry’s research into other topics (three were in State care when they died) and one from State Records’ research. Therefore at least 16 children had died in State care but their deaths were not recorded by the department.

There were an additional three names provided by witnesses where the allegation was that the children had been in State care when they died. Those three names were not on the departmental lists, however, none of the deaths could be verified by the Inquiry’s investigations and therefore no criticism is made of the department for not recording these three deaths. In relation to one death, according to the person who gave evidence, the death was due to alcohol consumption. Departmental records show the child was placed in State care in 1981 aged nine and released on turning 18 in 1990. No records of him were found at the Coroner’s Office or BDM. The departmental file notes that he was believed to be living in Alice Springs when released from State care, which may explain the lack of records in South Australia.

In the other two cases, it was alleged by the witnesses that both children had died while in State care. In one case, it was not possible to determine that the child existed or died in the alleged circumstances. In the other case, a police investigation concluded that no such death occurred.

Adding the 58 names from non-departmental sources to those from the department gave the Inquiry a list of 479 children in State care whose deaths had to be further investigated in terms of any link between the death and criminal conduct that occurred during the child’s time in State care.

**Determining the cause of death of children in State care**

**Deficiencies in departmental records**

The department’s failure to properly record the cause of death of State children made it very difficult to determine, from departmental records, whether any deaths resulted from criminal conduct.

Of the 339 names recorded on the SWIC cards, 108 recorded only the fact of death, not the cause. The entry was commonly ‘released – died’. Where a cause of death was recorded, there was no indication of the source of the information.

The Mortality Record Book lists 159 deaths. A column is dedicated to the causes of death, which for 15 people were:

- Blank column (seven children)
- Entry simply ‘?’ (6)
- ‘Died’ – no details (1)
- ‘A spastic child’ (1)

For an additional seven children a cause of death was listed, but followed by a question mark.

The CIS list gave no cause of death for 17 of the 44 children in State care listed. Where causes of death were included, details were scant, for example:

- ‘Died in care, possibly accidental’
- ‘Cerebral palsy sufferer’
- ‘Health problems’
- ‘Natural causes’
- ‘Possible heroin overdose’
- ‘Died in house fire’

Of the nine names arising from the Inquiry’s research, the three names of children who had died in State care were found incidentally by the Inquiry in other departmental records. One child had died in custody, one had committed suicide and the Inquiry found an allegation in CIS that the other was murdered.
Chapter 5 Deaths of children in State care

There is rarely any indication of the information’s source or any record of later verification by the department where ‘possible’ causes had been recorded initially.

The Inquiry requested department client files on each of the dead children. Most files had no information about the circumstances of the death. In the minority that did, the quality of information varied, ranging from a newspaper clipping to a memo to the chief executive/Minister providing advice about the fact of the death, to a copy of a police report to the coroner following an investigation.

However, carers for children in State care were legally required to provide information to the department about children’s cause of death for only six years, from 1966–72. Otherwise, they were only required to notify the department of the fact of the child’s death. As a result of the lack of information from the department, the Inquiry had to request many files from the Coroner’s Office in order to ascertain a cause of death.

Coronial records

The Courts Administration Authority (CAA) is the controlling agency for coronial records in South Australia. Records from 2002 are held at the Coroner’s Office, while those before 2002 are controlled by CAA and stored in archives maintained by State Records of South Australia.

Coronial records for a reportable death may include a police report to the coroner, a burial order signed by the coroner (permitting burial when an inquest was deemed unnecessary or completed) and an inquest file (when an inquest was held).

SRSA provided information on references for coronial records for more than 500 names on the Inquiry’s list. The Coroner’s Office was consulted on additional cases and where further information was required. Coronial records were requested for 458 deaths, after the elimination of cases where the child had died after being released from State care and the cause of death available from departmental sources did not suggest criminal conduct linked to the period in care.

However the process of gaining coronial files was not straightforward. The historical records management system used at the Coroner’s Office has limitations, which make it difficult to locate references for records. A central database has been used since 1997, which was made consistent with the National Coroners Information System (NCIS) in 1999. A spreadsheet program is used to locate coronial records for deaths between 1966 and 1997. However, the spreadsheet does not record all the necessary information (e.g., date of death, inquest file reference) because it is based on various historical documents that may overlap in date range, span only a discrete period, cover only specific geographical areas and vary in administrative function.

The Coroner’s Office uses several, incomplete historical documents to locate references for matters before 1966. For example, the office only holds an index to records of inquests from 1931 (inquest files from 1877 to 1930 were destroyed during World War II) and to coronial reports from 1936 so it is difficult to determine whether the records existed before those dates. As a result, the Inquiry manually searched records at SRSA. Also, there was no index for archived burial orders between 1955 and 1971 (contained in 13 boxes at SRSA), which are stored according to the year in which they were signed by the coroner rather than the year in which the death occurred. In a manual search of the boxes, Inquiry staff found burial orders for 18. Two of these orders were the only coronial record of the deaths.

8 From 1966, if a State child died, the person who had immediate care of the child and the person in possession of the child’s body had to immediately notify the DCW director. Licensees of children’s homes and foster parents had to notify the director in writing within 24 hours of the child’s death, giving the name, date of death and cause of death ‘so far as known’; see Regulations 32, 70, 75 under the Social Welfare Act 1926–65. This was the first time the regulations stipulated that the notification include cause of death, however the provisions were revoked in 1972.

9 From 1996, if a State child died, the person who had immediate care of the child and the person in possession of the child’s body had to immediately notify the DCW director. Licensees of children’s homes and foster parents had to notify the director in writing within 24 hours of the child’s death, giving the name, date of death and cause of death ‘so far as known’; see Regulations 32, 70, 75 under the Social Welfare Act 1926–65. This was the first time the regulations stipulated that the notification include cause of death, however the provisions were revoked in 1972.
In some cases the Coroner’s Office was unable to find any reference for coronial records but Inquiry staff subsequently located references or records in the Index to Certificates of Burial 1933–1953, which is held at SRSA (despite finding the references using the index, the actual coronial records could not be located).

In several cases, coronial records obtained by the Inquiry indicated the existence of other coronial records for which the Coroner’s Office had no reference. For example, in the case of the 1970 death of a youth in State care in a motor vehicle accident, which involved the theft of the car, the burial order refers to the receipt of a police report to the coroner setting out the circumstances of the death, but the Coroner’s Office had no reference for this report and it could not be located.

There were several cases where the Coroner’s Office located a reference to coronial files, which could not be located, including:

- the death from criminal conduct of a 14-year old girl in State care in 1944. SRSA found a police report to the coroner that contained a notation concerning an inquest into the matter. The Coroner’s Office confirmed the existence of an inquest file, however the office could not find the file and had no record of it being archived.

- an alleged homicide in 1974. The Inquiry requested the police report to the coroner, however the Coroner’s Office said that its records showed it had requested the file from SRSA in 1985. The file had not been returned to SRSA, however the office was unable to find it and there is no evidence to suggest it was destroyed. The Inquiry later determined that the deceased was not in State care and the matter was not pursued.

- a 1982 death by criminal conduct of a youth who had been in State care. The Coroner’s Office found references for both coronial and inquest files. The office recorded that the coronial file was transferred to archives, however SRSA advised the Inquiry that the coronial file could not be located and there was no record the file had ever been transferred.

As a result of these difficulties, the Inquiry also searched records at BDM for information on State children’s causes of death.

**Office of Births, Deaths and Marriages**

BDM registers deaths from 1842 in a variety of formats including microfiche, microfilm and electronic database. In this report ‘death certificate’ denotes certificates of registered deaths taken from historical registers at the BDM or printouts of information from a database of registered deaths maintained by BDM since the early 1990s. With the assistance of BDM staff, the Inquiry located and retrieved 364 death certificates. Death certificates contain information that was generally not recorded in departmental records, notably a cause and location of death. For example, several children were found to have died at the Edwardstown Industrial School in the early 20th century, but this information was not on any of the children’s SWICs.

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10 SRSA G RG 1/92.
11 SRSA staff advised of gaps in the archival records from 1931–76.
Deaths after release from State care

Of the 479 children in State care whose deaths required further investigation, the Inquiry found that 85 had died after they were released from State care. In relation to one additional person, the Inquiry was not able to verify his death, however, available records suggest that if he has died, his death occurred after he was released from State care. The Inquiry therefore proceeded on the basis that 86 out of the 479 children who had been in State care died after they had been released from State care.

Suicides

Of the 86 children who died outside State care, 22 committed suicide. The Inquiry has not tried to make a definitive finding about the reason for suicide, but has sought to determine whether any criminal conduct occurred while the person was a child in State care and if this was linked to the suicide.

Three people committed suicide within a year of being released from State care. In two cases, family violence and allegations of sexual abuse precipitated the child’s placement in State care. Each child had extensive interaction with the department, which focused on addressing serial offending, substance abuse and expressions of suicidal thinking.

The third case involved a youth under a guardianship order that was made in 1993 and ran for two years, or until his 16th birthday. The department incorrectly calculated his age and released him on his 15th birthday. The two years expired early the following year and the youth hanged himself six months later. At the time he was living with family members in a private arrangement that was not organised by the department. The department wrote to the youth shortly after the premature expiration of the guardianship order, noting that the order had ended because the youth had turned 16 (which was not the case): “We believe you are now living with relatives at [name of town] and are well settled”. The youth hanged himself after an altercation with family members who had attempted to curb his drug use.

Five people committed suicide from one to five years after their release from State care. In one case, departmental files record a discussion between the departmental worker and a foster carer of a sexual abuse allegation, however no information could be found in the files to indicate whether the child made the allegation himself or whether it was investigated. Another child experienced sexual abuse, family instability, substance abuse and offending preceding the period in State care. Her extensive interaction with the department involved alternative and secure care. She was living interstate at the time of her death. Another suicide victim had experienced family violence as a child and was taken into foster care. The child absconded from foster care, became involved in substance abuse and spent time in secure care as a result of offending. One person committed suicide in an adult prison.

In another case, records suggest one factor (among many, including alcohol) in the youth’s suicide may have been something he had experienced or witnessed during a period in secure care. He committed suicide at the age of 19 in 1998, having first been placed at the Magill Training Centre for three months in 1993 for offending. In 1995 he was again sent to the centre for offending. Two statements from friends provided to the coroner said the youth told them he hated jail and never wanted to go back to it again. A former employer made a statement that the youth had said ‘some pretty bad things happened in prison’. Log books for the Magill Training Centre in 1993 indicate visits to the centre by two suspected perpetrators of child sexual abuse during that time, though not to the victim. The logs also indicate that the centre was full and there were standover tactics between inmates, bullying, theft and intimidation. The youth’s father said at his son’s inquest that his son’s...

... desire was not to get back into trouble with the law at all, but, realising that potentially that’s where he’s going to end up … he wasn’t going to have that, and decided to take things in his own hands, if I can use that expression. That’s just my thoughts on the matter.”

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12 Social worker, letter to client, departmental client file.
Six people committed suicide 5–10 years after their period in State care had ended. One had made allegations of familial sexual abuse while a child, before being placed in State care. There are no records of any sexual abuse while in State care. The child expressed suicidal ideas during the period in State care. In another case, the child came into State care because of familial physical abuse but no records of criminal conduct were found during the child’s time in State care. Again, the child’s time in care was marked by suicidal thoughts.

Five people committed suicide 10–15 years after they had been in State care. A friend of one of these people gave evidence to the Inquiry that the person’s extensive period in foster care and alternative care as a child was allegedly linked to the suicide. Departmental records showed a history of family violence and that the child’s period in care involved substance abuse and suicidal thinking. Two of these people had spent periods in secure care for offending and records show that both suicides occurred after significant alcohol use. In the other two cases the suicides seem to have been linked to relationship breakdowns.

The Inquiry received information on the suicide of one person about 15 years after release from State care. He had been in State care for a brief period on juvenile justice matters. Investigations revealed no evidence of criminal conduct while in State care.

Two people had committed suicide about 20 years after their period in State care had expired. One death appeared to have been linked to a relationship breakdown and the other was the result of an acute drug overdose. The latter death appeared to be directly linked to sexual abuse. The woman had taken court action against the State regarding sexual abuse. The court found that the sexual abuse occurred after she had been adopted, not while she was in State care, and that the State was not liable for its involvement in the adoption. The woman died eight days after the court delivered its judgment.

The names of five males alleged to have committed suicide were given to the Inquiry by the Special Investigations Unit of the department on the basis that at some stage, as youths, they had all been in the care of a youth worker who was the subject of sexual assault allegations by other youths. The Inquiry was to investigate whether there was any link between their contact with the youth worker and subsequent suicides. The Inquiry obtained the five men’s departmental and coronial files. The deaths occurred in 1994 (age 21), 1995 (age 20), 1998 (age 20), 2000 (age 23) and 2004 (age 33). The Inquiry determined that the 1995 death was not due to suicide but to an accident at a train station. In relation to the 2004 death, the Inquiry was unable to find any recorded contact between the deceased and the youth worker.

The Inquiry found that the remaining three deaths were the result of suicide and in each case there was contact between the youth and the youth worker. Concerning the 1994 death, the files record that contact was in 1989, however the youth worker was named as the person who collected the youth’s clothes from the police station after his death. In relation to the deaths in 1998 and 2000, the last recorded contact between the two youths and the youth worker was in 1993. There was no record of any allegation of sexual abuse made by the three youths against the youth worker. From the records, the Inquiry was unable to substantiate any link between the youth worker and the three youths who committed suicide.

Substance abuse

Seven people died outside State care from substance abuse, including one from sniffing petrol.

One Aboriginal male died from petrol sniffing one month after his release from State care. He had been placed in State care at the age of three weeks by court order and had several placements in foster care and departmental institutions. According to department files, he was assessed as severely emotionally disturbed at an early age, attributed in part to his placement in departmental care and
Chapter 5 Deaths of children in State care

fostering. The child’s case management involved debate about whether he should be placed with white foster parents or reunited with his mother, who had a history of alcohol abuse. The child was returned to his mother, but she then abandoned him. The department’s records indicate that the child first sniffed petrol at 14 and three times in the next two years the departmental reviews noted efforts to combat the sniffing. The department was unable to locate him when he was 17 even though he had been charged with attempting to steal petrol and ordered to reside where directed and be under departmental supervision. The department planned to release the child from guardianship once he was located, as he was deemed ‘an independent person of independent means’. He was not located before he died.

Homicides

Five people died as a result of homicide. Two were aged 18, two 17 and one 15. Four had previously been placed in foster or secure care and one child had been placed under the care and control of the Minister, his term expiring a year before his death.

One girl, 17, was murdered by a family member. She had been placed under the guardianship of the Minister for a month in 1987 and then spent some time in detention on remand for criminal offences. A month before her death in 1988, she had been placed on a court-ordered bond, which required her to be under the supervision of a departmental officer. She went to live with the family member who, one month later, murdered her. There is a recorded note that she had chosen to live with the family member against the advice of the departmental officer. She also previously alleged that the family member had raped her. Two days before her death, she advised the officer that she had found a new place to live and told the officer not to tell the family member. Her body was found near a railway line. The family member was convicted of her murder.

Deaths in State care

The Inquiry determined that 391 children died while in State care. It was unable to verify a further two deaths that allegedly occurred in institutions. In one case, it was not possible to determine that the child existed or died in the alleged circumstances. In the other case, the police investigation concluded that no such death occurred. Table 3 shows the number of children who died from each cause of death while in State care, including the two additional deaths that could not be verified.

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Number of children who died while in State care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural causes: infectious disease</td>
<td>128</td>
</tr>
<tr>
<td>Natural causes: medical condition</td>
<td>108</td>
</tr>
<tr>
<td>Accident</td>
<td>85</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>24</td>
</tr>
<tr>
<td>Undetermined</td>
<td>20(^{14})</td>
</tr>
<tr>
<td>Allegations of criminal conduct</td>
<td>15(^{15})</td>
</tr>
<tr>
<td>Suicide</td>
<td>11</td>
</tr>
<tr>
<td>Substance abuse including petrol</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>393</td>
</tr>
</tbody>
</table>

Table 3 Causes of death of children in State care

The Inquiry uses the term ‘medical condition’ to refer to deaths of children from congenital medical conditions or those arising during their lifetime, for example, heart disease, epilepsy, cancer, asthma and rickets. The records show that a death was categorised as due to a medical condition even when the main cause of death was an infectious disease, such as pneumonia, if the child suffered from a serious underlying medical condition that made the child more susceptible. This was to distinguish between otherwise healthy children who died purely as the result of

\(^{14}\) Includes the death where investigations were unable to determine whether the child existed or died in the circumstances alleged; see ‘Deaths in State care, Deaths in institutional care – undetermined’.

\(^{15}\) Includes the alleged death caused by criminal conduct in which a police investigation concluded that no such death occurred; see ‘Deaths in State care, Deaths in institutional care – allegations of criminal conduct’.

492 CHILDREN IN STATE CARE COMMISSION OF INQUIRY
an infectious disease. The predominant infectious diseases, particularly in historical cases between 1908 and 1930, were gastroenteritis, meningitis, pneumonia and tuberculosis.

The Inquiry placed 20 deaths in an ‘undetermined’ category to cover three circumstances:

- a coronial record of the cause of death as ‘undetermined’
- insufficient records to determine the circumstances of the death
- few records available and containing conflicting information that could not be resolved.

Deaths in institutional care

Medical conditions and infectious diseases

Of 171 children in State care who died while placed in institutions, 67 were caused by medical conditions, 67 from infectious disease and 21 from malnutrition, referred to in historical records as marasmus or asthenia. Sixteen of the malnutrition deaths occurred between 1908 and 1914.

Before the prescription of penicillin in the late 1930s, there was a high risk of infectious disease, particularly gastrointestinal illnesses, due to crowded, unsanitary housing. In South Australia the risk was exacerbated by a dry, hot climate. Dehydration during summer was common, as was contamination of milk and foodstuffs, which contributed to the spread of bacterial infections in babies and children.

The SCC reported on the issue of infant and child mortality. In 1911 the death of 11 State children, nine in institutions, moved the council to comment on the ‘dangers of institutional life for infants’. In addition to the need for hygiene and clean air, the council noted that infants in institutions lacked attention compared to those placed in homes. ‘Infants appear to be unable to live without love … no matter how good the nurse.’ The council noted that the statistics ‘display the facts’. At a council meeting in 1914 the secretary presented statistics on the death rate of ‘Supervised infants, which the Council did not think it wise to publish’.

At the Edwardstown Industrial School, 23 children died from infectious diseases or malnutrition from 1908–17, with death from infectious disease being prevalent from 1908–12. Many children passed through the school, some of whom were ill on admission. The SCC was aware of the risk of infectious disease due to crowding at the school. In its annual report for the year ending 30 June 1910, the council noted the difficulty in finding homes for young children and that a high number of babies in the school is ‘always prejudicial to the health of such children no matter how carefully they are managed’. In 1911, the council reported its concern that six infants had died at the school, all of whom were ill on admission. Its report for 1912 noted the ‘serious mortality’ among infants at the school and the council’s decision to request assistance from the children’s hospital in the care of children with non-notifiable illnesses. The ‘heavy death rate’ was attributed to the ‘influx of diseased and ailing infants’, who were placed in the same institution as the healthy. In addition, the council noted it was seeking out children in need of care and that the condition in which many infants were found made ‘their early decease almost a certainty’. In 1914 a minute notes that the council would ‘consider the isolation of infectious cases among the children at the Industrial School when the Council visits the School’. A special meeting on the subject was convened in November 1916, the minutes recording discussion of ‘the limited room in the IS, the number of children of all ages accommodated there, the
possibility of importing infectious diseases ... Its unsuitability for delicate children ... the open drains at the IS, the flies ... the risk of importing marasmus and gastroenteritis. Measures were taken to prevent infection, for example, in October 1917 the council resolved that ‘in view of the number of children in the IS and as a preventive to sickness a McKenzie Disinfecting Spray Pump be provided’. In January 1918 the council resolved that the school’s matron should submit regular reports on the numbers of infectious disease cases at the industrial school and that instruction in ‘new methods of disinfection’ be obtained.

It is a risk to make assumptions about the circumstances of a death simply from a description of the cause of death as infectious disease. For example, the Inquiry obtained records about the deaths of two girls through ‘infectious disease’. However records reveal that their deaths cannot be put down simply to overcrowding or lack of antibiotics.

In 1907, a nine-year-old girl was charged as having unfit guardianship and placed in State care by court order until she turned 18. The order was later changed to age 20. At 19, in December 1916, she was recorded as having died after one month of heart disease and 14 days of pneumonia.

Departmental records indicate that while she was in State care, the girl was repeatedly placed in service—out to homes as a domestic servant—despite a history of serious illness. Between September 1910 and her death in 1916, she was admitted to hospitals 12 times for ailments including rheumatic fever, measles, heart trouble, appendicitis and tonsillitis. The department received doctor’s advice in May 1911 that the ‘condition of girl’s health is serious’. Despite this the department transferred her among institutions and service placements in metropolitan and rural areas 13 times from June 1907 to April 1913. During a rural placement in March 1913, the local doctor advised the department that the girl should be transferred to Adelaide for effective medical care. She collapsed at the railway station and was admitted to a rural hospital. The doctor advised the State Children’s Council secretary that ‘on the face of it, it would appear that either her being sent to Adelaide was too long delayed, or she should have remained in [the boarding-out] home’. At another rural placement in November 1913, where the child worked as a maid, the female employer requested her removal as her illness limited her ability to work. The department’s secretary wrote, ‘I regret that you have had so much trouble in the matter, but it was quite unforeseen, as the doctor here had passed her as quite well before she went to [the placement]’. Again, a local doctor sent a telegram to the department recommending that the child ‘be removed as soon as possible suggest [a local] Hospital’. In October 1916 the girl was transferred to the Edwardstown Industrial School. The records indicate that she had been sent from the school in October to visit her aunt, collapsing on arrival at the State Children’s Department, where the two were to meet. Reference was also made to her expectorating blood in the weeks before her death. Correspondence from 1916 shows that the doctor attending the Industrial School ‘has never thought her fit to go to a situation’.

In November 1916, an anonymous card alleging ill-treatment of the girl by the acting matron of the Industrial School was sent to the secretary of the State Children’s Department. The card, written in what appears to be a child’s hand, stated that the acting matron’s treatment...
... ought to be seen into. I wish you would call at the hospital and [the girl] would explain. It’s a disgrace to any institution (sic) the poor girl was that frightened to tell the sister how ill she was because if she dropped dead at her feet she would kick her and tell her to get up it was all shame hope you will see into it.30

The acting matron denied the allegations and identified the girl as the likely author of the card, suggesting that she had been influenced to write it. She cited her excellent care and attention to the girl and argued that ‘every consideration’ had been given by the doctor visiting the Industrial School, including the prescription of 10 drops of Easton’s Syrup before each meal.31 She claimed to have no knowledge that the girl had expectorated blood. She denied that the girl could have been too frightened to speak with her and suggested that because the girl was

... mentally depressed, I really do not think [the girl] at all times realises what she says. … I have always been very fond of the children down here and it worries me very much to learn that I have had such a complaint laid against me in this way, which I cannot possibly understand.32

The records do not show whether the council took any further action.

Sixteen months after the girl’s death, however, the council received information that the same acting matron had slapped the faces of several children at the Industrial School. Under regulations in force since 1909, permission would have to be sought from the SCC secretary before inflicting any punishment on residents. The council took no action in response to the information about slapping. However, two further complaints were received about ill-treatment of residents, including physical abuse and stripping, by the acting matron. In July 1918 the council resolved that the acting matron should be suspended pending further enquiry. Evidence was taken from several children, which is contained in the departmental correspondence docket. The council requested that the acting matron resign and resolved that she was not to be transferred to any other State institution. She resigned in July 1918.

In 1939, a 14-year-old girl was placed in State care and committed to the Salvation Army Girls Home, Fullarton, after a court found that she was uncontrollable. Her SWIC records that she died from toxicemia in 1941, however records obtained by the Inquiry reveal that the girl’s death was not simply the result of an infectious disease. Her death was not recorded in the Mortality Record Book. The girl’s SWIC shows that she absconded from the home after 2½ months to live with her mother. Her mother was told by the department that she was in breach of section 185 of the Maintenance Act for harbouring absconders and the girl returned to the school four days later. She wrote to the secretary of the CWPRB about 10 months later, asking to go home to her mother rather than be placed out in a situation. The board advised that the application for release was ‘deferred for the present’.

The child wrote again three months later, asking when she could be released: ‘I have learnt all the work now ... I hope you say I can go home this month ... I have been here a year and six months and I haven’t run away for a long time’. The secretary wrote back, saying the board was not prepared to let her go home, but telling her to ‘keep learning as much as you can in regard to housework, cooking etc in order that something may be done for you at the earliest possible date’.

Two months later the child wrote again: ‘Please ... would you let me go home’. The secretary responded: ‘I am sorry that this request cannot be granted. I want you to try and learn all you can while in the Institution so that when an opportunity arises Matron will be able to give me a good

30 ibid.
31 Easton’s Syrup was a thick syrup containing phosphates of iron, quinine and strychnine administered orally as a nerve tonic.
32 SRSA GRG 27/1/41.
report and recommend you for placing out in a situation. I hope you will have a very happy Christmas. 33

The child died in hospital about three weeks later.

Departmental records include a report from the CWPRB’s secretary to its chief secretary after the death, which notes that in October 1940 the matron had called a doctor after she noticed that the child had a bad cough. The doctor advised that the child would recover in a few days. The cold did not improve so the matron gave the child ‘local remedies’, which included a herbal treatment called white pine. The doctor saw the child again in late November and a further 10 times during the next month. A report from the doctor after the death indicates that he thought the child seemed well on Christmas Eve, so he had decided he would only attend the institution if called. As he was not called, he assumed that the child’s condition was satisfactory.

According to a departmental report on the death, the child advised the matron six days before her death that she was not feeling well, suffering pain in her right side. Children from the school were to be taken to the beach that day. The matron wrote in her report that she took the child along to the beach, thinking it would do her good, taking rugs and aspirin to ‘make her more comfortable’. She did not take the child’s temperature beforehand as she thought it unnecessary. At the beach, the child’s mother approached the matron and asked to see her daughter. Her daughter cried upon seeing her mother and the matron told the mother that the doctor would see her child the next day. The mother left and returned with a police officer. The matron advised the police officer that the child was a ‘State ward’ and receiving the best possible care. The mother then returned with a doctor, who ordered the child be sent to hospital, where she was diagnosed with pneumonia and died six days later.

Correspondence from the hospital indicates that the child had an early pneumonia when she was admitted to hospital. 34 The post-mortem revealed evidence of tuberculosis in both lungs, with pyo-pneumothorax on the right side. Toxaemia from that condition caused the death. The doctor who had seen the child at the school reported to the board after her death that she may have had some ‘deep seated quiescent old lesion in the lung which lighted up suddenly and manifested itself on the morning’ at the beach.

A member of the public sent a letter of complaint to the department five months after the child died. The writer referred to the ‘callous treatment to a poor girl who had been a very sick girl’. She alleged that the child was ‘made to work right up to the time that she went to Hospital’, that she was ‘yelled and screamed at and threatened to be punished’, that she was being called ‘lazy in front of the other girls, would say that she went about as though she was half dying, the girl would say that she didn’t feel well enough to work’. She alleged that the child was made to scrub the floor of the dormitory when she had stayed in bed, made to eat her meals even though others were permitted to leave their food and then, a week or two before her death, was made to do ironing/laundry work. She alleged that before they left for the beach that morning, the child had a ‘very bad turn’, had to leave the breakfast table to vomit but was then ‘made’ to go on a picnic to the beach. The complainant stated that this was ‘a terrible affair’ that ‘should be brought before the Public’. The department responded to the effect that it was aware of the facts and that ‘suitable action has been taken’. 35 There is a record that the secretary of the CWPRB had seen the girl working at the institution eight days before she died. A few weeks after the child died, a board minute in relation to the death noted that a report to the chief secretary had been read to the board and a letter from the matron received, which talked about ‘precautions taken in connection with bed-clothes’. The minute also noted that a report in relation to the use of thermometers in all institutions was received and ‘it was decided to discuss matters connected therewith at the next meeting of the Board’. No further records about the girl’s death were located.

33 SRSA GRG 29/121/66; SRSA GRG 29/123/78.
34 SRSA GRG 29/121/66.
35 SRSA GRG 29/123/78.
**Accidents**

Eight children died from accidents while in an institution, and all their departmental files contain some information about the circumstances.

The Inquiry found that two girls died at Seaforth Home in strikingly similar circumstances, although their deaths were 22 years apart. Each demonstrates a significantly different approach taken by the department following the deaths. The departmental records indicate little effort was made to determine the circumstances of the earlier death, however its records of the later accident contain statements of relevant witnesses.

In 1923 a court placed a seven-year-old girl in State care until the age of 18, for reason of unfit guardianship. She had Aboriginal heritage and was described on her SWIC as ‘half-caste’. She was placed with various foster carers in the community, once being removed because she was ‘unsuitable’. Her first time in Seaforth Home was because the subsidy to her foster parent of five years had expired. Over six months in 1929–30 she was returned to Seaforth Home from foster placements three times, the reasons given being ‘did not like girl being half-caste’ and ‘on account of color’. After living at Seaforth Home for a year, she died, aged 16. Her SWIC states the cause of death as ‘result of burning accident, heart failure following severe burns’.

Coronial records include statements from people who had been at Seaforth Home at the time of the girl’s death. One child witness stated that the girl was working in the laundry at Seaforth Home at 8am. She was seen to enter the laundry and stand near the copper, which was enclosed with bricks and contained a wood fire. The witness stated that the girl took hot water from the copper and stood next to it, washing her clothing. The witness next heard a scream and saw that the girl’s clothing, made of cotton and flannel, had caught fire. The child witness ran out and called ‘fire’. A nurse and others put out the flames with blankets. The records indicate that the girl had burns to her chest and arms. After a doctor saw her, she was transferred to Adelaide Hospital. Her condition deteriorated and she died three days later. In a statement, the home’s nurse said: ‘I have warned the inmates from time to time, including the deceased, about standing near the copper when washing clothes’.

The child’s departmental file included a report from the matron to the secretary of the board on the morning of the accident, stating that the girl was standing in front of the copper getting a bucket of hot water when her clothes caught on fire. The report stated that the girl ‘was not a laundry girl she had no right in the laundry’.

A report from the matron three days later said five staff members had been on duty, but did not say where they were at the time. The matron also said: ‘The copper is well built in and not at all dangerous to anyone working there unless of course they stand in front when a flame is likely to escape’. The next note is that the child died. The board did not conduct an investigation, and the questions of why the girl was in the laundry and whether the copper door had been opened were not answered.

In 1943 a five-year-old girl was placed in State care until the age of 18, the court finding that she was neglected and had unfit guardianship. She was committed to Seaforth Home and placed out with foster parents at least eight times in the next decade. She died at Seaforth Home in 1953 when she was 14; the cause of death on her SWIC and in the Mortality Record Book was ‘Toxaemia from burns’.

Coronial records contained statements from people at Seaforth Home on the day the girl died. The laundress’s statement said the child entered the laundry with some tea towels about 8.45am. She was told to put them in a basket by the door. The laundress then left to get some soap, leaving the child standing by the copper. She then heard screaming, but ignored it thinking that it was from girls playing. After hearing a girl yell her name, she then saw the
child, on fire, in the yard and another staff member smothered her in a blanket. The records indicate that the child was transferred to hospital and died 10 days later. The laundress said the door to the copper was shut when she left the laundry but open after the incident. There was paper missing from a bucket in the laundry.

The departmental file contained a certified copy of the registration of death (rarely seen by the Inquiry on departmental files). It also contained a report from the CWPRB chairman to its chief secretary, and statements from witnesses, including the girl’s sister, who stated that the girl resisted her help. It was assumed that the child had been standing near the copper, possibly to warm herself, when her clothes caught alight.

Four people who were once children in State care at Seaforth Home contacted or gave evidence to the Inquiry about the death of this child.

One person gave a statement to the Inquiry saying that she was 12 at the time of the girl’s death and described her as ‘being like a sister’. She said there was a sauna in the laundry and the copper fire was kept going day and night for the babies’ nappies and other clothes. She said the girls would often go in there to keep warm. She did not remember being specifically told they could not touch the copper fire, but she did not ever work in the laundry. She remembered playing chasey on the day the girl was burnt, running up the path into a forbidden area to hide. It was from there that she saw her friend screaming and

... switched off ... I felt guilt as I couldn’t do anything ... I know now that there was nothing I could have done as I couldn’t get through the cyclone fence. I didn’t talk to anyone about it as I was forbidden to be where I had witnessed the incident.

She said that she remains puzzled about why the girl opened the copper fire door, saying it did not make sense because the girls would warm themselves in the sauna. She said that until coming to the Inquiry she had never really talked about what she saw and her friend’s death. ‘This is really good for me.’

Another witness to the Inquiry also described the girl as one of her best friends. She said she was a service girl and that the schoolgirls mixed with the service girls in the laundry, where they dried the clothes. She saw the girl was very badly burnt that day.

Another witness who alleged she was sexually abused during her placement at Seaforth Home said she remembered seeing the girl’s sister trying to help her, but the girl wouldn’t let her. The witness stated: ‘She wanted out, it was more or less a suicide’. She said she was told as a child that the girl had poured cleaning fluid over herself and set herself alight because she couldn’t stand living there any longer.

Another witness said about Seaforth Home:

Well, there wasn’t a day that went by that somebody wasn’t crying for their mother or crying because they’d gotten punished or crying for something ... There was just crying all the time.

She said she remembered seeing what happened to the girl from her window next to her bed. As a child, she said, she was angry with the girl for dying because ‘death was one way of escaping’.

Other records received by the Inquiry stated that four boys allegedly died as a result of drowning while placed at various institutions. Departmental files on two of the deaths did not contain any information about the circumstances. However, the Inquiry was able to determine the circumstances of all four deaths from coronial records.

In 1961 an 11-year-old boy was placed in State care after a court found he was neglected and had unfit guardianship. His SWIC recorded his death at 15 as ‘released – died’. The Mortality Record Book noted the cause of death as ‘drowned’. At the time of his death, he was placed at Struan Farm School, Naracoorte, and had been there for five months. Departmental files obtained by the Inquiry contained no details about the circumstances of his death.
According to statements on his coronial file, the boy was given permission in the afternoon to go to the pools at Mosquito Creek, which were about 160 metres from the school. Three other boys were there when he arrived. One of the boys stated that he last saw him swinging from a rope suspended from a tree over the pool. Another boy said he slipped on the bank and fell on his back. No inquest was held.

A man who gave evidence to the Inquiry was in State care at Struan Farm when the boy died. He said the boy had been abused; he had ‘all these whip marks on his back’. He could not give any detail about who may have abused the boy or when it occurred.

A three-year-old boy was placed in State care in 1950 after a court found he was neglected. His SWIC stated he was eventually transferred to Minda Home, Brighton, to have ‘psychiatric treatment’, and stayed there for seven years. He died aged 14 on an outing for Minda children to Gorge Park.

The departmental files contained insufficient information about the circumstances of the death. The file contained a note that ‘the Chairman reported that [name of boy], aged 14 years 6 months, had died by drowning at the Torrens Gorge on [date] 1961. Noted with regret’. Four days later, the CWPRB secretary wrote to the boy’s parents advising them of the death, stating that it occurred as the result of a ‘drowning accident’ and extending the board’s condolences. A letter on file (in response to a letter from the parents requesting assistance with funeral expenses) stated that the department was unable to assist.

Coronial records indicate that a group of about 40, with two Minda Home staff supervising them, went to the park. The children ate a large lunch and then went for a swim in the river approximately 45 minutes later. The boy jumped into the river and was seen to go under, surface with his arms in the air and then submerge again. Neither of the two staff supervisors could swim and had to go for help. Two bystanders entered the river but the child’s body was not located until after police arrived. The post-mortem findings revealed that the boy’s lungs were congested and had excess fluid – ‘his stomach was distended by an enormous meal’. A letter was sent from the State Coroner’s Office to the secretary of Minda Home commenting on the inadequate supervision due to the child’s mental disability and questioning the wisdom of letting children swim soon after a large meal. However, it said, ‘an inquest would probably do more harm than good’. A letter in response disputed the comments, stating that having one attendant in charge of 12 boys was adequate and that the boy did not go swimming for at least 30 minutes after eating and ‘in all probability the time was considerably in excess of that period’.

Departmental records relating to the following two deaths by drowning did contain information about the circumstances of the deaths.

An 11-year-old boy was placed in care in 1948 after a court found he was neglected and had unfit guardianship. He was eventually placed at Kumanka Boys Hostel and, according to his SWIC, had been there for about six months before his death in 1951.

Departmental and coronial records show that the superintendent gave six boys permission to go swimming in the Torrens River near the weir one evening. They swam for about one hour before the boy who had been put in charge left the group to go into the city. According to the statements of the remaining boys, they heard a cry for help. One boy went into the water, as did some men who were nearby, but the missing boy could not be located. His body was found the next day.

An inquest was held. The post-mortem revealed the boy did not die from drowning, but from ‘vagal shock’. The pathologist said this was caused by the sudden immersion of a person with distended stomach (but there was no suggestion of a recent meal) and an enlarged thymus, 100 per cent larger than it should be for the boy’s age. There were spots on the lungs indicating asphyxia, but the cause
could not be found and there were no blockages in the airways. The pathologist suggested the boy might have inhaled some water in trying to surface, which shut off the airway, and then fought against the spasm and lost consciousness. The pathologist believed this would occur in heavy drinkers or smokers. (While the boy was known to smoke, he was only 14.) The death was ruled a ‘misadventure’.

Vagal inhibition is cardiac arrest brought on by the impact of cold water on the larynx. It is an atypical but not uncommon form of drowning. Contributing factors include entering the water feet-first and duck-diving. Loss of consciousness is instantaneous and death occurs within minutes.

The departmental files show that the superintendent conducted his own investigation, which included interviewing the boys. He stated that the boy in charge ‘did not do the job I gave him’. The CWPRB decided to forward a letter of sympathy and expression of confidence in his work to the superintendent.

A 16 year-old boy drowned at the Salvation Army Boys Home, Eden Park, at Mount Barker in 1930. He was placed in State care aged 12, after committing larceny. An Education Department psychologist assessed him as having a mental age of six or seven. He was transferred to Eden Park in 1928 after a placement in service.

Coronial records showed that the child drowned in a watering hole on school property. A group of nine children went swimming, accompanied by an attendant. While the children were undressing, the boy jumped into a 2.4-metre stock-watering hole next to the bathing hole. This was off-limits to the children. He surfaced, but disappeared again and could not be recovered. One of the boys told police that he had asked the boy whether he could swim. He had replied that he could not, but ‘I will have a try’. The coroner deemed an inquest unnecessary.

According to departmental records, the attendant reported that the boy ‘did not cry out or give any alarm’. The CWPRB secretary reported that: ‘The next thing they knew was the lad crying for help’. The school superintendent’s report to the CWPRB stated that the youth jumped into the water ‘while the officer was temporarily engaged otherwise’. The board secretary reported that the child jumped ‘while the attention of the attendant was on the other boys’. The board’s chairman reported that the child jumped ‘directly [the assistant’s] back was turned’. Each report presents a different account of the events. The attendant’s statement to the police made no mention of having left the group unattended. After reviewing the events, the chairman wrote: ‘I am satisfied that every effort was made to rescue [the youth] and that he deliberately disobeyed orders in entering the Water-hole’. The report concluded that ‘no blame is attachable to the staff’.

There was sufficient information on departmental files to determine the circumstances of the death of a boy who died in an unusual accident at the Boys Reformatory, Magill. The boy, 16, was placed in State care by order of a court for offences of breaking, entering and stealing in 1928. He was placed on probation to his father but later the police brought him to Adelaide and he was sent to the reformatory in early 1929. He died two months later, the cause of death stated on his SWIC as ‘injuries, gored by a bull’. One department file contained a copy of the police report, which was forwarded to the department by the Inquirer of Police. The boy was sent to the bull yard by the superintendent to keep watch at the gate while another boy repaired the enclosure. They were told not to go into the pen or feed the bull. According to witness statements, the boy left the gate to speak to another boy at the far side of the enclosure, both having their backs to the enclosure. The bull charged and pinned the boy. No inquest was held.

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36 The vagus nerves are cranial nerves that supply internal organs with autonomic sensory and motor fibres.
37 SRSA GRG 27/1/62 file __/1925, police report to the coroner.
A coronial inquest found that the death of a 14-year-old youth in custody at the McNally Training Centre in 1975 was an accident rather than suicide. His SWIC records ‘released – died’. In 1972, when he was 11, the boy was placed in State care until he turned 18 for breaking, entering and stealing. He was placed in Windana Remand Home and Brookway Park but re-offended on the two occasions when he was on probation living with relatives. He absconded from subsequent placements at Kali Hostel, Windana and Brookway Park.

The coronial inquest found that the boy was placed alone in a cabin at McNally at 5.10pm in an area known as ‘the Block’. Inside the cabin was a foam rubber mattress with vinyl covering and blankets. A call button had been removed from the cell three years earlier as the boys had continually broken it. At 5.35pm, a residential care worker wanted to place four other boys in the cabins. He noticed that the peep-hole of the boy’s cabin was black. When the door was opened, smoke and soot billowed out. The Coroner’s Court found that the fire probably started from a match or cigarette, although none was found. The coroner found the boy could have had matches and criticised the fact that he was not searched before being placed in the cabin. It would have taken a couple of minutes for the boy to be overcome by the toxic fumes. Also, even if he had thumped on the door, it was considered unlikely that it would have been heard, as the nearest staff member was 60 metres away. The coroner commended the subsequent actions of the supervisor in ensuring fireproof mattresses, self-opening/closing doors, specific instructions about searching boys beforehand, a larger window in the wall of each cabin for surveillance and an alarm system in each cabin.

Five people gave evidence to the Inquiry about the death of the boy. Two stated there was a rumour that a match had been slipped into the cell and it smouldered, the fumes killing the boy while he was asleep. One person stated that he was in the Block at the time and that there was banging coming from a cell for about an hour but he could not understand why nobody was answering. He said the other boys joined in when they could smell smoke. He said nobody came for a couple of hours. A staff member at the time gave evidence that there had been a few fires in rooms because the boys

... discovered that if you get a bit of foam out of a mattress and light it, that it makes a terrific pall of black smoke, which was great fun in a dormitory, but this kid did it in a small room with no decent ventilation.

Suicides

Two children committed suicide while placed in institutions. The inquiry found that in one case the department failed to record anything about the circumstances of the death. In the other it was praised by the coroner for conducting an internal investigation.

In 1918 a one-year-old girl was placed in State care until the age of 18, a court finding she was destitute. During her life she had various placements in subsidy homes and with foster parents, several times being found to be ‘unsuitable’. She spent long periods at Seaforth Home, where she committed suicide at the age of 19 in 1937.

The CWPRB extended her care order twice, until she was 20, considering it ‘in her best interests’. A letter written to her by the board in March 1936 advising of the second extension stated:

You know you have not been as good as you might have been, and I hope for your own sake you will make your mind up to do better when you are again placed out.

The only information about the circumstances of her death on the departmental files was ‘Died 17.1.37 … Cause of Death?’ then a pencilled note ‘Picric Acid Poisoning’. The file noted that about a month before her death, the latest

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foster parents said they were going to return the girl because she is ‘so moody and will not do as she is told, will do things her way’. The Inquiry obtained the circumstances of the death from coronial records, in particular a police report to the coroner and an inquest file. According to the records, the girl was caught trying to abscond from Seaforth Home to visit her grandmother. The staff took her clothes from her and she became hysterical. After a few hours, a doctor was called and prescribed morphia. The next day she was observed wandering around, hysterical. The following day she told a child at the home: ‘I have taken poison and I am serious about it. Don’t tell anyone.’ The child told a nurse who then spoke to the girl, who confirmed she had taken picric acid, which was kept on a shelf in the unlocked surgery. The matron contacted a doctor who gave instructions for treatment, which were followed. However, the girl’s condition deteriorated that evening and she was found dead by the matron. In finding that the girl died from the self-administration of picric acid, the coroner noted that ‘no blame whatsoever is attachable to the Matron, nurses or other Officers of the Home’. The secretary of the CWPRB told the inquest that Seaforth

... is used as an industrial school for neglected destitute and some uncontrollable girls, and boys under 6 years of age. It is not a disciplinary home. It is not for convicted children or incorrigible children. A small percentage of girls are difficult. Some girls are difficult. It is merely used as a depot in the process of the boarding out system.

In relation to the girl he stated:

We regarded her as of rather low mentality. She was backward in schooling and somewhat unsatisfactory in the different homes she was in. She was morose and melancholy. She had been in various positions and was usually sent back from those positions. She did not keep positions long. There is a grandmother living in the suburbs but no record of father and mother.

In complete contrast, the department conducted a thorough investigation of a youth’s suicide at Cavan in 1994. The youth, who had turned 18 one week before his death, was in secure care serving a Youth Court sentence for an offence committed while he was a juvenile. His involvement with the department, which started when he was 12, spanned periods in community residential care, secure care and Intensive Neighbourhood Care, along with various adolescent support programs. His first serious offence occurred when he was 13. He lived on the streets for a brief period when he was 14 and was reportedly in contact with a known paedophile. A coronial inquest found that he had an extensive history of substance abuse and had attempted suicide twice, in 1990 and 1993. While in secure care he made statements to family members indicating a desire to commit suicide. After the death, the department conducted an internal review. The coroner commented the

... professional and dispassionate way in which this investigation was conducted, and for the fact that the department has taken such an open and self-critical approach to these events in an attempt to avoid a similar tragedy in the future.

Allegations of criminal conduct

Three witnesses to the Inquiry made allegations that the deaths of three children at institutions were the result of criminal conduct. The Inquiry could not substantiate the allegations.

One witness gave evidence about a child alleged to have been murdered at St Stanislaus House at Royal Park in the 1960s. The witness gave evidence that when he was about 10 or 11, a nun elbowed a boy who was standing in front of him in a line. He said that the force of the blow knocked the boy to the ground and that he did not get up. The boy’s eyes were open but glazed. The witness never saw the boy again. He said that another nun told him later that night that the boy had been taken by a foster family. He said that the boy had previously been the victim of this nun’s physical abuse.

39 SRS GRG 29/123/183
40 ibid.
41 Children in State Care Commission of Inquiry, Interim report, p. 109
The witness had reported the allegations to police in 2003, which started an investigation. The allegations were also raised in State Parliament. The alleged perpetrator died more than 20 years ago. The police narrowed the time frame down to the six months between December 1968 and May 1969. The police obtained a book of boarders from the Professional Standards Office of the Catholic Church, which contained the names of 105 boys who were at the home during the relevant time. The book was forensically tested and found to be an authentic record. After extensive and exhaustive enquiries, the police were able to account for all 105 children. The police spoke to 15 males who had been present at the home, none of whom recalled an incident as described by the witness. The police took a statement from the only surviving nun, who was alleged to have told the witness that the boy had been taken into foster care. The nun had no recollection of such an incident as described by the witness. The allegations were found not to be substantiated.

In 1986, aged 14, a girl was placed in State care until the age of 18 after a court found she was in need of care. According to her SWIC, she spent the following 14 months in foster care and a shelter. During the next few months she was charged with assault and hindering police, and spent some time in the South Australian Youth Remand and Assessment Centre (SAYRAC). Her SWIC records that she spent about seven months in 1987–88 at Glenside Hospital and was then placed at various regional admission units. A witness at the Inquiry alleged that the girl was the victim of homicide in 1988.

Department files contained several memoranda to the Minister following the death of the girl. They note that she was placed on several 21-day detention orders at Glenside Hospital in the year before her death. She had significant drug and alcohol issues, on one occasion taking an overdose. After the second detention order, she stayed at Glenside Hospital voluntarily and then had several short-term placements before going to live at St Stephens youth shelter. At 16, she spent six weeks living with a boy at his parents’ home. She became pregnant and returned to live at St Stephens. After a violent episode, she was detained at Glenside, but was staying there voluntarily at the time of her death.

The coronial records contained several witness statements arising from a police investigation into the death, but an inquest was not held. On the day she died, the girl had left Glenside Hospital in the morning and was due to return at 4pm. About 5.40pm, witnesses heard screams coming from a park and saw a girl engulfed in flames. One man tried to smother the flames with his jacket while his wife ran to call an ambulance. Another man came with a heavier jacket, which they used to try to put out the flames. The first man's wife then returned with a blanket and they were able to extinguish the flames.

One of the men then spoke to the girl, who said: ‘Help me’. He asked who did it. She said: ‘I did it to myself to get out of this world’. He asked her why she had done it. She replied: ‘I haven’t got anybody. I’ve never hurt anybody’. She said: ‘Help me, do I have to stay here forever?’

Another witness overheard her say: ‘I don’t want to stay in this world’.

Police and ambulance officers arrived and she was transferred to the Royal Adelaide Hospital, where she died the next day. About 20 metres from where she had been lying in the park, police found a lighter, methylated spirits and a black cloth bag. One of the witnesses, who lived nearby, said he did not see anyone else when he first heard the screams and saw the girl in flames from his window. No suicide note was found at the scene. The cause of death was: ‘1. suppurative bronchitis and intravascular coagulation complicating 2. shock due to burns’. The body was found to have 92 per cent burns, with no other external signs of recent trauma. The girl was about six months pregnant, the foetus dying soon after the burning incident.

Two people gave evidence to the Inquiry about the girl’s death. One person stated that she knew the girl had set fire to herself, that she was pregnant and that she had been...
sexually abused. The other stated that she believed the girl was murdered and not burnt because when she saw her after her death, she had bruises to her face but no burns. She also referred to a suicide note at the hospital, which she believed was not in the girl’s handwriting.

The Inquiry was unable to find any support for the allegation that the girl died as a result of criminal conduct and that she was not burnt. There was no reason to doubt the post-mortem report, which was written by a highly regarded pathologist in South Australia. A copy of the note referred to by the witness was obtained. It is not evident that it can be categorised as a suicide note. Rather, it appears to be a note written by the girl about several things. Initially she writes about thinking that she was being followed and thinking that it was the Holy Ghost, but later suggests she was thinking about death.

A 16-year-old boy was placed in detention in 1988 for an offence of break, enter and stealing, according to his SWIC. He had spent significant periods in detention for similar criminal offending since 1985. He died in 1988 at the South Australian Youth Training Centre (SAYTC) when he was 17, after almost 3½ months in detention.

A witness gave evidence to the Inquiry regarding his own abuse while in care. He also said he had been in custody when an Aboriginal youth died in an institution. He alleged that to break up a fight between the youth and another inmate, a staff member rendered the youth unconscious by holding him in a headlock while suspending him in the air. He said he then saw staff strip the unconscious youth and drag him to an isolation cell, where he was locked inside.

The Inquiry referred the matter for police investigation. The police spoke to the witness the next day. He then returned to the Inquiry and retracted what he had said regarding staff involvement in the youth’s death, stating that he had confused the incident with another. He said the police had let him look at the statement he made at the time as well as other documents and that he was definitely wrong. Police investigations revealed that the witness had not been present when the fight erupted, nor had the workers he said were involved. Police concluded that the youth had committed suicide, no third party was involved and there were no suspicious circumstances.

The Inquiry obtained the youth’s files from the department and the coroner. An inquest, conducted in 1988, found that the youth had been playing soccer in the SAYTC gym in the hours before his death. A fight erupted between him and another inmate, which was broken up by staff, one of whom escorted the youth to his cell. About 30 minutes later, when a worker and another inmate went to the cell to deliver dinner, he was found hanging from an air-conditioning grille by a torn sheet. The coroner found that the youth committed suicide by hanging himself and died from asphyxia. He ruled that there was no criminal conduct and no suspicious circumstances surrounding his death.

He said he was concerned about the length of time the youth was left alone. As a result, SAYTC surveillance frequency increased and a new monitoring system and ventilator grille were installed.

In 2006, another witness gave evidence to the Inquiry about the death. His recall of events differed slightly from the police and coronial findings but still suggested that the youth committed suicide and that no third party was involved in the death. He stated that he and another inmate were in the gym when the fight started and he saw the youth being escorted out after the fight. He said that he saw the youth being held around the neck by someone with his feet still touching the ground. He next saw the youth about 10 minutes later, standing in his cell and tearing up the bed sheets. He did not advise staff as he thought the youth was simply destroying the sheets in anger. He said no staff went to the cell until dinner was served, about one hour later.

42 ibid., p. 108.
**Undetermined causes**

The cause of death could not be determined in three cases.

One girl, aged 15, came under a care and protection order against her will in December 1995. She had given birth a month earlier. She died in January 1996 at St Joseph’s Refuge, Fullarton. The Coroner’s Court found that the cause of death was undetermined. The inquest heard several expert opinions. Toxic shock syndrome was considered unlikely but could not be discounted. Another possibility was an asthma attack. The cause most favoured was an epileptic fit. There were no injuries or markings on her body to indicate the involvement of another person.

In 1958 an eight-year-old girl was placed on remand at Seaforth Home on a charge of being neglected and illegitimate. After six weeks, the charge was withdrawn and a note on her SWIC recorded ‘child certified and admitted to Mental Hospital Parkside’. Her departmental file indicated confusion about her status as a State child. A note on the file in 1963 from a social worker stated that the girl was ready for placing out and that from ‘reading the file of her mother suggests that [the girl] is a State Ward or she has a brother or sister who is’. Another note stated that she is ‘Not a State Ward’ and that the child was placed in the hospital through the department, who sent the mother papers to sign. No such papers were on the file. Correspondence about who should place the child followed. A former worker at the hospital who gave evidence to the Inquiry thought the child was a State child. It is not possible to finally determine her status as a State child.

The files show the girl spent most of her life in Parkside or Hillcrest hospitals. She absconded in 1962 when she was 12 and was sexually assaulted; the perpetrator was convicted and sentenced to three years’ jail. Records leading up to her death in May 1968 indicate that she was very aggressive and was often locked up as a result. Recorded incidents include ‘threatening to break glass and injure herself; ripped sheet and wrapped it around throat’ and ‘acutely disturbed because she did not receive immediate attention from the nurse’.

The Inquiry obtained information about the circumstances of the death from the coronial records. At Hillcrest Hospital she was placed in a secluded room after burning a mattress in her room. In the afternoon she wanted to talk to one of the nurses and when he refused she verbally abused him. He returned half an hour later and saw her sitting on the floor in her room with her back to the door. He returned five minutes later and when he touched her, she fell over. There was a piece of her nightdress tied in a slipknot around her neck. She died five days later in hospital.

The Hillcrest patient file referred to the girl being admitted unconscious to the Royal Adelaide Hospital with a rope around her neck. She regained consciousness but could not move her body. This was defined as further cerebral damage due to strangulation. The final diagnosis on the RAH notes was ‘Strangulation, Epilepsy, Severe Behaviour Problem’. The post-mortem report had the cause of death as ‘cerebral oedema arising from long-standing effects of meningitis’. The coroner’s burial order agreed with the post-mortem, deeming an inquest unnecessary ‘because the death was natural’.

To add to the unsatisfactory and conflicting nature of the records, a witness to the Inquiry said she thought the girl had hanged herself because of some inappropriate attention from a worker at Hillcrest.

A witness to the Inquiry gave evidence about the death of a child at Vaughan House, Enfield. On her first day at Vaughan House in 1972, aged 11, she went to the shower block and ‘saw a girl that had hung herself, and she was about 15, and it was like, a sheet’. She said the girl was a ‚white girl‘. She said that when she told the staff, ‘they just said, “Off you go” ... no-one pulled me aside and comforted me and explained to me’. Records obtained by the Inquiry, however, stated that the witness first arrived at Vaughan House in January 1975. The matter was referred to the police. As part of the police investigation, a former staff member was spoken to and denied there had been any such hanging or any deaths at Vaughan House. The police investigation is continuing.
Deaths in foster care/other placements

One hundred and twenty-four children died while in foster care or apprenticed.

Thirty-one children died from medical conditions, some of whom had been born with significant disabilities, reducing life expectancy.

Infectious diseases

The Inquiry found that 51 children died from infectious diseases, although sometimes the only information on the cause of death was on the death certificate, not from department or coronial files.

For example, a one-month-old baby was committed to Seaforth Home until she turned 18, after a court found she was neglected. She died 13 months later, in 1971, at her third foster placement. Her SWIC recorded that she ‘died’ but says nothing about a cause of death. The Mortality Record Book has a question mark in the cause of death column. Both the department and Coroner’s Office advised the Inquiry they had no files relating to the child. Her death certificate lists the cause as gastroenteritis of three weeks’ duration.

The Inquiry found that the circumstances surrounding the death of one child in foster care exemplified the danger of assuming death by ‘infectious disease’ to be clear-cut.

A six-year-old child was placed in State care in 1905 after a court found she was ‘illegitimate’ and her mother was unable to maintain her. She died in a foster placement, aged 16, in 1916, her SWIC recording ‘died, consumption’. Her death certificate stated the cause of death as ‘tuberculosis of lungs’.

Departmental files contained several letters concerning the child’s death. A letter from a departmental inspector of foster placements to the secretary of the State Children’s Department, written while the girl was in hospital, stated that she was in service with her last foster parent for eight months and had a bad cough most of that time. She was visited by a departmental inspector once in that period. The inspector ordered a mustard poultice and said if the cold was not better soon she was to be taken to a doctor.

Her cold worsened but she was not taken to a doctor until four months later. Records show she was buying remedies out of her minimal wages. The inspector noted:

_The Matron [Adelaide Hospital] said she cannot understand how she had any strength to work at all & it appears as if through ignorance and thoughtlessness this poor child, who has always been a weakling, has been grossly neglected & suffered greatly..._

Following that visit, there was a letter from the secretary of the State Children’s Council to the foster parent stating that she had neglected the child and that it was disgraceful that the child paid for the elixirs. A letter in response from the foster parent denied neglect, stating she paid for the remedies and cared for the child. After the death, there was another letter from the secretary to the foster parent, advising that the girl had died and so ‘it is useless to prolong any correspondence with regard to the past’.

Accidents

Twenty-five children died as a result of accidents while placed in foster care or apprenticed.

The discretionary nature of the department’s record-keeping of the circumstances of children’s deaths is illustrated by the death of a 17-year-old youth in 1967. The boy was placed in State care in 1951 at the age of two, after being found by a court to be neglected and under unfit guardianship. His SWIC stated ‘released – died’ and the Mortality Record Book listed ‘result of fall from a roof’. The coronial records stated that there were no suspicious circumstances, but did not record any of the circumstances. The circumstances of death were not found in a departmental file relating to the deceased boy, but in a report titled ‘Workmen’s Compensation for Foster Parents’43. A report to the director of Social Welfare advised that the boy had fallen from a roof of a house while working for a plumber. Another letter stated that he fell from a scaffold while working for a building contractor.

Records obtained by the Inquiry in relation to another accidental death demonstrate the department’s

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43 SRSA GRS 6629/1/6, file 83/1967. Workmen’s compensation for foster parents.
acceptance of an employer’s word as to the circumstances, despite later allegations putting that word into doubt.

In 1912, a 14-year-old boy was placed in State care after a court found he was uncontrollable. He was then sent to Snowtown to be a farmer’s labourer. His SWIC recorded ‘died – tetanus’.

Departmental records revealed that the hospital, not the employer, advised the department of his admittance and death. The SCC secretary wrote to the employer asking:

When the accident happened, and why it was not reported to me, what was the character of the boy’s injuries, and what was done to help the lad while he was sick, how the injuries were treated, whether a doctor was in attendance or not, and if not, why not? 44

The employer responded that no doubt the secretary had seen the results of the coronial inquiry. The secretary replied:

Your letter ... does not give the particulars necessary ... you mention the enquiry. I have seen nothing of it nor have I heard anything. Will you please send me a copy of the newspaper in which it appeared – if it was so published. Will you please also answer the questions I put to you in my letter.

The employer wrote back to show ‘how quick [the child] was taken’. According to the employer, the child had been thrown from a horse and cut his face. His employer cleaned the wound but did not send for a doctor. The next day, the child could not close his mouth, but apparently refused to see a doctor. Soon, he reported feeling better and his wound healed. After complaining of pain and stiffness a week later, the boy was taken to the doctor and admitted to hospital, where he died. The employer noted: ‘We did not report the fall because it seemed not very bad at the time’. He stated that hospital staff had advised him that the secretary had already wired for an inquiry to be held. ‘However, I was told afterwards that there was no enquiry or inquest’ as a doctor certified the cause of death.

He claimed to have asked hospital staff to contact the secretary: ‘It was not any neglect or carelessness that it was not reported’. The secretary thanked the employer for the report and said: ‘The boy’s death would appear from it to have been quite accidental’.

The department’s records also contained an anonymous note received after the death. It read:

In view of the circumstances surrounding the death of a State boy named [child’s name] and in view of the fact that he did not receive medical attention till 12 days after meeting with a nasty accident don’t you think people like [employer’s name] should be debarred from having State children under their control.

There was no departmental response on file.

Despite the employer’s failure to obtain medical attention for the boy and his subsequent death, the SCC continued to place children on the farm. The Inquiry obtained other files that indicated there were subsequent problems with the employer and no action was taken by the SCC. In 1913, a girl wrote to the SCC, asking to leave the farm: ‘They think because you are a state child they [can] say just what they like’. The employer complained about another girl in 1914. Of one girl who asked twice to be removed, the employer wrote in 1916: ‘I do not take any notice of her sulk fits now I have got so used to them’. The employer complained about another girl in 1917. In 1918, when asked why another child had absconded from his farm, he said: ‘I am not sorry she left, as she would not be a bit of use on a farm’. In 1925, the employer sent another child back, saying he was ‘too lazy, a real failure’ and ‘I told him he ought to be ashamed of himself’.

In relation to a child’s death in 2004, the department decided an internal review was not needed. A boy aged 19 months was fatally injured while his parents, foster carer and departmental staff were meeting to review his case. The boy came to the department’s attention in 2003 before he was a month old, due to parental neglect. After several child protection notifications, the child’s parents authorised...
Chapter 5 Deaths of children in State care

his placement in short-term foster care. On the day of his death, a day before the agreement expired, a meeting was held at a local health centre to determine his care. The foster carer removed the boy from the meeting as he was being noisy and took him to a neighbour’s house, before returning to the meeting. The neighbour left the child unsupervised for a short time in the yard and later backed over him with a utility. The neighbour drove him to the same health centre at which his care meeting was being held for treatment. The child died later of head injuries. The coroner found that the death was accidental, but commented on the department’s delay in finding suitable care for the boy and the neighbour’s negligence, noting that the neighbour’s own children had been the subject of neglect notifications. From the records, it is evident that the carer had not planned for the child’s care during the meeting and his placement with the neighbour was a spur of the moment decision. The departmental supervisor at the meeting said he saw the boy being removed but did not know where he had been taken until the carer’s return. While the boy was still receiving medical attention at the health centre, the departmental workers who had been present at the centre left to return to their office. The boy died two hours later. The department deemed the death a ‘tragic accident’ that did not warrant internal review.

A former departmental worker alerted the Inquiry to another death in foster care. The coronial file notes that a 20-month-old boy was found face-down in a swimming pool at his foster parents’ home. His foster father told police that the boy had gone outside to play and he checked up on him after 30 minutes. The foster parents retrieved the body and attempted resuscitation, but the boy was pronounced dead in hospital. His autopsy summarised the cause of death as ‘apparently victim of fresh water drowning’. 45

The foster parents’ file indicated that the child had been placed in several foster care placements as his mother had been unable to manage his care—the last two placements were to the home where he drowned. A report by the boys’ social worker indicates that the child’s parent was ‘extremely angry’ about the accident and was considering taking up the issue. The report concluded: ‘There is no question of negligence on the part of the foster parents (both were home at the time)’. The report does not refer to whether the child was left unattended for 30 minutes and, if so, why. It contains a discrepancy about how the child gained access to the pool. There is no record of interview between the department and the foster parents about the accident.

Suicides

Three children committed suicide while in foster placements. The departmental records contained information about the circumstances of the deaths. In one case of an 11-year-old boy, the recorded cause of death as intentional suicide rather than accident, however, was questioned by the department.

A nine-year-old boy was placed in State care in 1912 due to unfit guardianship and spent two months in the Edwardstown Industrial School. During the next 4½ years he was placed in four separate foster homes. His SWIC recorded ‘died from gunshot wound’. Coroner’s records stated that an inquest found he had died from ‘a bullet fired from a rifle self inflicted while temporarily insane’. The boy was 15 and had been in the foster placement for one year. He shot himself in his bedroom, using a rifle kept in the house for shooting rabbits. The coroner’s report noted that a letter in the boy’s handwriting was found, which stated: ‘I have tried to do my best but I can’t there is more than one liar in this world’. The departmental files also contained information on the death. A letter from the chief prosecuting officer to the SCC secretary stated that the officer had spoken to the foster parents and

... from the Constable and others I am convinced this boy had an exceedingly good home ... I have formed the opinion that this boy had made up his mind to leave the home, probably to abscond. I do not think the note he left was written on the morning of his decease. And some incident upsetting the

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45 SRSA GRG 1/44, police report to the coroner on this file.
He in a moment of moodiness, to which he seemed subject, took the gun and shot himself.

In 1972 a one-year-old boy was placed in State care until the age of 18. He was placed in Seaforth Home and later with foster parents. At nine, the child exhibited concerning behaviour, including arson and theft. The department arranged for a psychiatric assessment, which showed the child had above-average intelligence but was emotionally immature. The records suggested a strong maternal attachment, yet only intermittent contact between the boy and his mother. His mother committed suicide when he was 10. When the boy turned 11 he was placed with maternal relatives in Western Australia with a view to moving there permanently. He died in that home when he was 11. The department’s files recorded correspondence between the South Australian and WA departments for community welfare about the death. A WA department worker advised that the child had been playing in the family home and had been found in the bathroom by his aunt with a belt around his neck. His feet were on the floor and he was considered to have accidentally hanged himself. The post-mortem revealed the cause of death to be inhalation of gastric contents. Correspondence from the WA departmental worker stated that the coronal inquest found that the child died of ‘asphyxiation caused by the inhalation of gastric contents as a result of hanging himself with the intention of taking his own life’. The SA department expressed surprise at the inquest finding and requested a basis for it. In further correspondence, the WA worker noted that general surprise was expressed at the finding, including from the police. There were no coroner’s documents on the file, only correspondence referring to the coronial process. The WA worker reported that the child had never shown any tendency to self-harm and had not appeared upset. The SA department closed the file after the foster parents said they did not want to pursue the matter.

The inquiry’s research into other general sexual abuse matters, rather than the department’s lists, brought to light the suicide of a 17-year-old girl who was in State care at the time of her death and who was the victim of criminal conduct during her time in care. The child came to the department’s attention in 1989, at the age of 15, after disclosure of parental sexual abuse of her sister. Departmental workers assessed the girl’s safety and consulted her school counsellor, who stated that the child appeared well-adjusted. The records do not show the girl was interviewed. The file was closed as there appeared to be no evidence of abuse other than to the sibling. The following year, at 16, the child disclosed that she had also been sexually abused since she was eight. The offender was subsequently charged, convicted and jailed. The child was initially placed under a temporary guardianship order, then placed under the guardianship of the Minister until the age of 18. The department’s case management addressed the child’s multiple suicide attempts, drug use, family breakdown and habitual absconding from placements and programs. The girl spent several periods living on the streets. She was raped in August 1990 after absconding from a psychiatric counselling program. Departmental staff liaised with the hospital and police. She was raped again in April 1991, after she absconded from a care placement. Information about the department’s role here was missing as the child’s files were partially destroyed by fire. At the time of her suicide, she was living in a friend’s home and had plans to obtain her own housing with the department’s assistance. The child shot herself at this home in an apparent suicide pact, and died in hospital.

Departmental files showed that before the death, the girl’s mother had threatened to sue the department, claiming it had separated the family and caused her daughter to live on the streets and use drugs. The files noted that the child acknowledged the considerable efforts of her many caseworkers to provide accommodation, support and counselling. After the death, the girl’s social workers reported her case history to the department’s chief
executive. The files also contained a copy of the registration of death, a level of documentation rarely seen on client files.

**Malnutrition**

Three children died from malnutrition while in foster care. Two died between 1908–15 and the third as recently as 1973, when he was two years old.

The boy who died in 1973 had been placed in State care at birth in 1970, after a court finding that he was ‘neglected’. His SWIC recorded ‘released – died’, however the Mortality Record Book contained no information other than his name.

Department and Coroner’s Office files showed that the department received a phone call from the foster mother saying ‘we’ve got problems’ a week before the child died, however the department was unable to visit. Four days later the foster mother was admitted to hospital after taking an overdose. The next day, a worker from the department went to the home and saw that the boy looked unwell—‘his face had an extreme pallor and his eyes appeared sunken with dark circles’. The worker considered taking the child away but did not in case this was interpreted by the foster mother as a ‘lack of confidence in her ability’.

The next day, the worker went to the foster house and was informed that the child had died. A post-mortem revealed that the boy was very thin, extremely dehydrated and covered in small bruises. He had been with the foster parents for four months. A doctor gave an opinion after the death that the foster parents were not fit parents. From information provided to the Inquiry by the police, it seems there were no criminal charges laid against the foster parents.

The Inquiry obtained the department’s files relating to the foster parents. About five years after the death, there was a record of a meeting held to discuss whether the foster parents should be reapproved to take other children.

Central Mission Child Care Services, a private foster care provider, recommended to the department that they be approved. A departmental check showed no previous record and they were approved. However, it appeared that the death of the child later came to the department’s attention. A letter on the foster parents’ file reads:

...some months later ... the old file was discovered and the circumstances surrounding [the foster mother’s] admission to Glenside 4 years ago came to light. At this time a retarded child was in ... [their] care and he unfortunately died from dehydration; had this been known at the time of their reapplication, Department for Community Welfare would not under any circumstances have given approval. The current situation is that ... [they] are fostering 4 children ... and we are very satisfied with the quality of care.

**Undetermined causes**

Nine children died in foster care where a cause of death could not be determined because of lack of records or conflicting information from records.

One of the record discrepancies related to the death of a girl who was placed in State care aged one and died aged 12, in 1909. Her SWIC and the 1909 annual report of the SCC listed asthma as the cause of death. However, the microfilm print of her death certificate lists the cause of death as ‘nephritis, coma’. (Nephritis is acute kidney inflammation). Her departmental files contained no information about her death. The Inquiry was advised that a coronial file could not be located.

A boy placed in State care in 1914, when he was almost one, died at the age of two from gastroenteritis and meningitis, according to his SWIC. However his death certificate listed general tuberculosis. There were no files available from the Coroner’s Office or the department.

A 15-month-old girl was placed in State care in 1920, a court finding her illegitimate, and died in foster care eight months later. Her SWIC recorded her death as ‘from effect of swallowing caustic soda’ and her death certificate as due to collapse after the accidental drinking of caustic
soda. As there was no information on the death in departmental files and the Coroner’s Office could not locate any records about the death, the Inquiry could not assess the circumstances of the poisoning, including whether there was any criminal conduct.

There is no record of the circumstances of the ‘accidental’ death of a 17-year-old boy in State care in 1922. He had been placed in State care at the age of 10 for truancy and absconded several times from his many placements during the next seven years. His SWIC recorded his death as ‘perforation of bowels – result of accident’ and the death certificate as ‘laceration of small intestine, 2 days duration, peritonitis’. His departmental files contained no information about the circumstances of his death and the Coroner’s Office was unable to locate a file reference for the death.

A five-year-old girl placed in State care in 1914, after a court found she was destitute, died in 1923 of pulmonary tuberculosis – secondary cause exhaustion, according to her SWIC. The State Coroner’s Office was unable to find any file reference.

A nine-year-old boy died in State care in 1924, his SWIC listing the cause of death as gastroenteritis. He had been placed in State care when three months old, a court finding him destitute. His death certificate listed the causes of death as otitis media (infection of the middle ear) and chronic mastoiditis, both of some years’ duration, and a cerebral abscess of nine days’ duration. The inconsistency could not be investigated as the child’s departmental files contained no information about his death and the Coroner’s Office could not locate any records.

A one-month-old girl placed in State care died when almost two years old in 1925. Her SWIC listed uraemia (accumulation in the blood of toxins normally excreted from the body) and chronic nephritis (acute kidney inflammation). It also listed ‘paralysis of the brain’, but these words are struck through. The death certificate listed ‘cerebral tumour 3 days duration?, paralysis’.

Correspondence on the departmental files included a letter from the foster parent advising the department of the death, citing the cause as paralysis of the brain. The department noted that this was not the case and requested further information by writing a letter to an undertaker. The undertaker replied that he was unable to communicate the cause of death as the treating doctor had left Jamestown and advised the department to contact BDM. This letter is not from the undertaker who actually performed the funeral and the records do not clarify why this undertaker was writing the letter. There was a note added to the undertaker’s letter listing chronic nephritis uraemia ‘vide Registrar General of Births Deaths etc’. It is not possible to determine how the child died from the confusion in the records.

No record of the circumstances of a baby boy’s suffocation in 1951 could be found. The baby had been placed in State care by order of a court when he was one month old and died four months later. His SWIC recorded ‘released died, suffocation’ and his department files noted that he died and included correspondence regarding payment of his burial account. No file reference could be found at the State Coroner’s Office. His death certificate stated ‘suffocation’. The CWPRB minutes noted that the child died of suffocation while in the care of foster parents, however that there were no suspicious circumstances and an inquest was not held. The minutes noted that the board received reports relating to the matter, but these could not be located.46

Another baby died aged six months while in foster care. He had been placed in State care from birth in 2000. A coronial inquest could not determine the cause of death, however noted that it was consistent with sudden infant death syndrome (SIDS), with no evidence of any third-party involvement.

46 SRSA GRG 29/124/19, CWPRB minutes (minute 1668), 1958-60.
Allegations of criminal conduct

The Inquiry received evidence of possible criminal conduct in relation to the deaths of two children while in foster care.

The Inquiry received an allegation of possible criminal conduct resulting in the death of a baby who was placed in foster care in 2004. The girl was born in 2003. It was a traumatic birth for both mother and baby. The mother told the Inquiry that her baby had some possible seizures after the birth. About seven months after the birth the mother asked the department to care for her baby while she moved into a new home and regained her health. By voluntary agreement with the mother, the department placed the baby in foster care. One foster parent became ill and the baby was moved to another foster placement, where she died eight days later.

On the morning of her baby’s death, the mother had made several phone calls to the department, complaining that she was not receiving enough information about her daughter. She was told that the manager would make inquiries and respond to her. The manager did not return her call. The baby died less than three hours later. Both police and departmental employees went to the foster parents’ home. Despite this, the maternal grandmother was not advised of the death until nine hours later. The mother was advised the next morning.

The Inquiry received evidence from the mother about her ongoing efforts to obtain information about the circumstances of her baby’s death. She gave evidence that a departmental employee turned up at her house and said her baby had died, that she had just gone to sleep. She said that the police stated it was a tragic accident, however the following day she received information that her baby was found wrapped and lying face-down in a cot. She considered that this did not make sense—the baby could not roll if she was wrapped. She then received information that the baby had been put on a pillow and had a bottle propped in her mouth while the foster parent folded up the washing.

The post-mortem found that the baby died from the combined effects of asphyxia and inhalation of gastric contents. The baby was unable to free herself once she had vomited when in a face-down position. The pathologist reported information received that the baby was found 2½ hours after being left by the carer face-down in a U-shaped pillow, which appeared wet, and there was an empty bottle in the cot.

The mother told the Inquiry about her relentless efforts to have a coronial inquiry into the death of her baby. An inquest started in late 2006, almost 2½ years after the death. The mother also told the Inquiry about needing to have legal representation at the inquest and the distress involved in the potential costs.

The foster parents’ file was requested and received from the department. The file contained forms approving the registration of the parents as foster carers over a number of years. The Inquiry became aware that two other foster children made complaints in relation to the foster parents two years before the death of the baby, however there was no information on the file about those complaints. There was an approval form for their registration postdating those complaints. Similarly, there was another approval form for the registration of the foster parents that postdated the death of the baby. There was no information on the foster parents’ file about the death of the baby.

It was at this stage that the coroner decided an inquest would be held into the baby’s death. The coroner delivered his findings in September 2007. He found that the baby died as a result of the combined effects of asphyxia and inhalation of gastric contents. He also found that the baby’s previous possible history of seizures was minor and did not play a role in her tragic death, but rather “the most likely situation was that the U-shaped pillow restricted her ability to breathe freely once she had wriggled into a position in which her face was obstructed by the pillow itself”. He found that there was no formal training available to foster carers for the care of children under the age of two and the
recent introduction of such training ‘is an implicit acknowledgement of a deficiency in the system as it existed prior to [the baby’s] death’ and that ‘had such training been available for [this foster carer], it is possible that she may not have placed [the baby] in a cot with a U-shaped pillow [which] … may have prevented what was, in all probability, an avoidable death’. In the course of his decision, the coroner noted evidence from Families SA that it had no central computerised record keeping system that would enable the agency to keep track of complaints made against foster carers, but said that had been addressed since 2004.

The Inquiry received evidence about a girl who committed suicide in 2002. It was suggested to the Inquiry that her allegations of sexual abuse by her foster father were connected to her death. In 1993, at the age of eight, she was placed under the guardianship of the Minister until she was 18 years old. In July 2001, she complained to the police that her foster father had sexually abused her. She had been living in that foster placement since December 1998. She gave a statement to the police that he had regularly sexually abused her since she began living at the home. Six charges of unlawful sexual intercourse were laid in the Magistrates Court in May 2002. The girl died on 9 June 2002 after taking an overdose of Panadol. 48

Seven people gave evidence to the Inquiry about the girl’s death, three of whom came specifically to speak on that topic. In particular, one witness told the Inquiry that she believed the girl had fabricated the sexual allegations and that she had been pressured by the department and the Office of the Director of Public Prosecutions (DPP) to proceed. The Inquiry obtained files from the department and the DPP relating to the girl. There was no suggestion in the files that the department or the DPP had pressured her. To the contrary, they contained notes of conversations with her, in which she was recorded as saying that her family and people she called family were putting pressure on her to withdraw the charges. The files contained two letters from family members stating that she was a liar and that she would not see one of them again if she proceeded.

In January 2008, the coroner delivered his findings following an inquest into the girl’s death. He found that the girl died ‘as a result of raised intracranial pressure due to hepatic encephalopathy related cerebral oedema’. The coroner found that the girl made allegations of sexual abuse perpetrated by her foster father and that it was not the function of his inquest to determine the truth of those allegations. He received evidence from some witnesses that the girl was subjected to pressure by the department, the SA Police and the DPP officers to proceed with the charges, which those witnesses said were false. The coroner found that no pressure was brought to bear upon the girl by the departmental workers, the police or the DPP officers and that

... no criticism should be directed at any of the [departmental] workers … for failing to predict that [the girl] might have a suicidal intent. In my opinion, [the girl] obtained a considerable amount of support from all of the workers involved.

He observed that ‘there is no doubt however that she felt immense pressure from family members and others to withdraw the allegations’. He decided that the girl felt a great deal of pressure in relation to her allegations and ‘it appears that she was ultimately unable to cope with this pressure and sought release by taking an overdose of paracetamol’.

Deaths of children who had absconded from State care

Twenty-one children died after absconding from their placements. The SWICs recorded the fact that they had run away. However, the Inquiry generally found that there was little, if any, information on departmental files concerning the circumstances of their deaths. It was often necessary to obtain coronial records to find the information.
Chapter 5 Deaths of children in State care

Accidents

Eleven children absconded and then died as a result of accidents. The Inquiry found that several children died when they ran away from their placements, stole cars and crashed them.

In 1968, a 16-year-old boy absconded from McNally Training Centre with another boy. According to his SWIC he was ‘released – died’. The Mortality Record Book recorded ‘asphyxia’. The department was unable to locate any files to provide information about how he died.49

The Inquiry obtained information about the circumstances of the death from coronial records. The two boys stole a car and rolled it in the Adelaide Hills. They both survived the crash, however the 16-year-old complained to the other boy about his health for the next few days. The two boys were eventually located by police four days later but did not advise them about the boy’s ill-health. On return to Adelaide under police escort, the boy fell to the floor, convulsing. A doctor was called but the boy died. His cause of death was asphyxia occurring during an epileptic fit, probably sustained as a result of the accident.

In 1970 a 16-year-old boy absconded from Brookway Park one month after being placed there by court order due to a criminal offence of break, enter and larceny. His SWIC recorded ‘released – died’ and the Mortality Record Book recorded ‘road accident’. The department was unable to locate any files relating to the boy.

The only coronial reference was to a burial order, which the Inquiry found after a manual search. It listed the cause of death as cerebral injuries sustained in a traffic accident. A memorandum attached to the burial order recorded that the boy ran away with another boy and stole a car on the same day. The other boy was driving the car when it crashed into a monument. The driver survived.

In 1971 a 17-year-old boy absconded from McNally Training Centre after two months. At 15 he had been placed in State care for criminal offences until he turned 18. He was then permitted to live with his parents but he committed further offences and, at 16, was sent to McNally for illegal use of a motor vehicle. There is no cause of death on his SWIC, but the Mortality Record Book listed ‘car accident’. The department could not locate any relevant files.

The Inquiry obtained the circumstances of his death from coronial records. On the evening of his 17th birthday, the boy absconded and lost control of a stolen car, colliding with a brick fence. The boy was taken to hospital, where he was found to have 0.14 per cent alcohol in his blood, and died soon after his arrival. His three passengers were arrested and charged with illegal use of a motor vehicle.

In 1993 a 16-year-old boy in State care had left his placement and was living on the streets. Two years earlier a court had placed him in State care after several unsuccessful placements arising from his being ‘unmanageable’ at home and in trouble with the police. The departmental files obtained by the Inquiry contained concerns from workers about his involvement in crime and ‘being on the fringe of the Adelaide street culture’. About three months before his death, community residential care workers raised concerns that he ‘still might be associating with known paedophiles’. The boy had been living on the streets for approximately three weeks before his death, having left community residential care.

The coronial records contained detailed circumstances of his death. The boy moved out of a hostel several weeks before his death and had been living on the streets. He was friendly with a group of youths who stole cars to ‘engage in hot pursuit, as a form of exciting recreation’.

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49 The department advised the Inquiry that from 1970–85, it allowed the destruction of up to 95 per cent of client files, with only 5 per cent retained as ‘samples’. The department did not record what material was archived at SRSA. Therefore the department was unable to advise whether, in this case, there were no departmental files or whether they had been destroyed.
On the night of his death, he was driving a stolen car at high speed, at one stage being involved in a police chase. He went through red lights, hit a median strip and then slid sideways into a tree. The coroner found that his driving was reckless and that the police actions did not contribute to the way the boy drove the car.

Two people gave evidence to the Inquiry about the boy’s death. One confirmed that the boy had been living on the streets before his death.

In 1953 a 13-year-old boy absconded from the Glandore (formerly Edwardstown) Industrial School after three weeks. He had been placed in State care about 10 years earlier due to unfit guardianship and neglect, and had been in various foster placements since. His father applied for his release when he was 11, but was declined. His SWIC and the Mortality Record Book recorded the cause of death as ‘motor vehicle accident’. The State Coroner’s Office had no record of a file on the death.

The departmental file contained a copy of the death certificate, as well as a memorandum stating that the boy absconded with another boy who was on remand on the evening of 1 October 1953 ‘and who was undoubtedly the ringleader’. The memo stated that:

*Information from the Police shows that [the other boy] was driving. He will not be charged in relation to the death … but will be charged with the "illegal use of a Motor Vehicle". It seems unlikely that there will be an inquest, and [the other boy’s] only injury was a broken thumb.*

Other children died as a result of other types of accidents. Again there was generally little, if any, information on departmental client files concerning the nature of the accidents. The first two examples are exceptions.

In 1921 a two-year-old boy was placed in State care until the age of 18 for being illegitimate. When he was 14, he absconded twice from subsidy placements and, at 15, from the Edwardstown Industrial School. He died 11 months later in Victoria in 1936. His SWIC recorded ‘died’ and the Mortality Record Book ‘sudden – poison’. No coronial files were held in South Australia because the death occurred interstate.

The Inquiry obtained department files relating to the boy. One file contained a report on absconding from the superintendent of the industrial school, which said the boy absconded in February 1935. The police were notified and a warrant issued. Eleven months later, the department received information from the police regarding an unnamed person dying from poisoning in Mildura. According to an informant, the person had given himself a different name but stated that he had come from an Adelaide orphanage. He told the informant that he had twice previously escaped from the orphanage and that he had no intention of returning to SA until he turned 18. Fingerprints taken from the deceased matched those of someone with a different name again. A photo was then sent to the department, which identified the boy. It appears he had used at least two false names after he had absconded. A newspaper article on the file refers to the circumstances of the death. The boy had been camping on the River Murray with two other youths. He wandered onto an island and what happened next was not known, but later the boy came running from trees and collapsed, saying, ‘I am dying’. He died ‘in agony almost immediately at [the boys’] feet’. The article said that a swiftly acting poison caused the boy’s death. The file contained no official documents following up the circumstances of the boy’s death.

A 15-year-old boy absconded in 1939 from the Boys Reformatory, Magill, and the department discovered from a funeral notice in the newspaper that he had died. According to his SWIC, he had been placed in State care at 12 after committing an offence of unlawful possession. He absconded from the reformatory after 15 months and was then placed with his mother. However, three months later he was charged with breaking, entering and stealing and sent back to the reformatory. He absconded after five weeks but was returned on the same day. After six months, he absconded again and a warrant was issued for his arrest. The department did not know where he was for almost three months.
Both his SWIC and the Mortality Record Book recorded drowning as the cause of death. The files showed the department found out about the death from the funeral notice. The secretary then wrote to police asking for confirmation of identity and the circumstances of the death. A police report to the coroner stated that the boy had been staying with his brother for a few weeks and was found dead in a tank, having gone swimming after dinner. His cause of death was given as drowning, there were no signs of violence on his body and an inquest was deemed not necessary.

A youth, aged 18, drowned after running away with another boy from the Northfield Mental Hospital in 1964. He had been placed in State care at 14 until he turned 18 after a court found him to be neglected and under unfit guardianship. The order was extended to the age of 19. Both his SWIC and the Mortality Record Book recorded his cause of death as accidental drowning. There was no information in the departmental files about the circumstances of death. The Inquiry obtained the information from the coroner’s file, which stated that the boy went swimming with the other runaway in the River Torrens the day after they absconded, and he drowned.

The department was unable to locate any files relating to a 15-year-old girl who had been placed in State care in 1969 on a larceny charge. Her SWIC stated that she was placed with her mother, but absconded in February 1971. It is not clear from the SWIC whether she returned home before her death three months later. Her SWIC registered her death two months after it occurred as simply ‘released – died’. There was no record of her death in the Mortality Record Book.

Coronial records showed she died as a pillion passenger on a motorbike that collided head-on with a car. She was 17. The driver of the motorbike provided a statement to police but his whereabouts were unknown at the time of the inquest.

A 13-year-old boy was charged with larceny in 1956 and placed in State care until he turned 18. His SWIC recorded that he was placed in Kumanka in 1956–57 and repeatedly absconded over a four-month period. He was found in Victoria and placed in the Boys Reformatory, Magill. He spent some time in hospital (reason not recorded) and had a few holidays with his mother. During this time there was a note on his SWIC: ‘to be seen by the psychologist as soon as possible’. He was sent back to Kumanka but absconded again. He was then placed in foster care, absconded and was sent to the Boys Reformatory. He was on holiday with his mother when he absconded for the last time. He died 12 days later, aged 17, in Broken Hill. The SWIC recorded his death as ‘died’ and the Mortality Record Book as a ‘shooting accident’.

Because the boy died interstate, there were no coronial records in South Australia. The only information about the circumstances of his death was in a newspaper clipping on a departmental file. It stated that the boy was on a shooting trip with two friends in Broken Hill. He climbed a tree and his rifle accidentally fired, shooting a bullet into his head. His friends found him hanging by the foot from a fork of the tree. He died in hospital. There was no other information about his death in the department’s file. There was no correspondence to the police or the coroner to verify the circumstances of the death.

Suicides

Two children committed suicide after absconding from their placements.

The department had no information about the death of a 16-year-old girl who absconded with another girl from Vaughan House in 1952. Her death was recorded as ‘suicide’ on her SWIC, but was not listed in the Mortality Record Book. The departmental file recorded that the girl had absconded and contained a note to the parents advising them of that fact. Curiously, the file recorded that...
she was ‘released’ a day after she absconded and two days before her death. There was no information about what efforts, if any, were made to find the girl after she absconded.

Information about her death was obtained from coronial records. Three days after absconding the girl died as a result of jumping from a building on North Terrace. Witnesses saw her alone on top of the building, then she put her arms out and jumped. On the roof she left a note addressed to the police, but the records did not include any information about its contents. Information was provided to the coroner that the police became aware of the girl in 1951, when she reported that a boy had indecently assaulted her. She believed she was pregnant and took pills hoping to abort the pregnancy. Her father then reported her as missing to the police. When found, she was too afraid to go home and was placed in the Bridge Women’s Rescue Home run by the Salvation Army. She returned to her parents after eight days but ran away on several occasions over the next year. On one occasion she could not be found for six weeks. In 1952 she was charged with theft and remanded in custody to Vaughan House, where she spent 12 days before absconding on the day she was due to appear in court on the theft charges.

An Aboriginal boy was placed under the guardianship of the Northern Territory Minister in 1986; an order that was later transferred to South Australia. He had been in various placements, including foster care, with relatives and then in Aboriginal supported accommodation hostels. Two months before his death he was recorded as a priority to be referred to a psychologist for urgent assessment due to depression and expressions of suicidal thoughts and mood swings. However, he then went missing a couple of times. About three weeks before his death, he contacted the Queensland Youth & Community Services Department for help with accommodation; the department then informed its South Australian counterpart, which reported him missing. He was found dead at a train station in Queensland, after hanging himself. He was 17.

The circumstances of his death were contained in a memorandum to the chief executive on his departmental funeral file. There was no record of any complaint by the boy that he had been sexually abused, however there were records of complaints by others against the boy as an alleged perpetrator of sexual abuse.

Undetermined causes

The deaths of two children who absconded from State care could not be determined.

An 17-year-old girl was placed in State care in 1987 until she was 18, after a court found she was in need of care. At the time of her death she was placed in a cottage home. She had made sexual abuse allegations against her father and was due to give evidence in court in August 1988, however her body was found at the bottom of a cliff one month earlier. Coronial records showed debate as to whether it was suicide or an accident. Records from the cottage home indicate a history of depression.51

A 13-year-old boy was committed to the control and custody of the CWPRB until the age of 18 for committing larceny in February 1941. The child was placed on probation to his mother in Adelaide and held jobs on various stations in remote South Australia during 1941 and 1942. He was returned to his mother in August 1942 after being convicted of an offence. In February 1943 the child left Adelaide to travel to what would be his last position, as a station stockman in South Australia’s north.

In April 1943 the boy argued with the station manager over his duties as camp cook on a muster, then left the mustering camp on foot without any provisions; the station manager stated he had no intention of following the child. The camp broke that day and relocated. In May 1943 Oodnadatta police made enquiries with the station manager about the child’s whereabouts. According to the coroner’s file, the station manager advised police that the boy had left in a ‘fury’ and surmised that he had made his way to Adelaide. In December 1943, the station manager alerted the Oodnadatta police that a stockman had seen human remains in the area. The station manager did not investigate.

51 Catholic Archdiocese of Adelaide, Professional Standards Office Records Service, casenotes, —/—/198-.
An inquest into the death was conducted in Adelaide and Oodnadatta in late 1944 and early 1945. The coroner ruled the cause of death as unknown due to the time that had elapsed between the death in April 1943 and the body being found in December 1943, although there was no evidence to suggest direct criminal conduct or violence. Evidence suggested the child had returned to the area of the mustering camp the next day, possibly expecting to be collected. The inquest heard the station manager made no effort to inform the police that the child had left his station. The coroner found the station manager guilty of ‘reprehensible indifference’ to the boy’s fate, as ‘no search of any kind was made by those at the camp as to the subsequent safety or whereabouts of the deceased’. The child was at real risk of becoming lost and dying, given his limited knowledge of the bush, a fact known to the station manager, who sent no trackers after the child. The coroner found that the child was in a ‘petulant state’ when he left the camp. The coroner concluded that the station manager should have ‘protected him from the possible consequence of his ignorance and his youthful petulance’. The coroner found no evidence to suggest that an indictable offence had been committed.

The CWPRB secretary’s evidence noted that the child was on probation in the custody of his mother, in effect that ‘he was free and his mother had control of him subject to our general Dept. approval regarding employment guidance and general conduct’. The secretary recounted the child’s positions of employment and his last departure from Adelaide. He concluded: ‘Apart from what we heard from him through his mother, that is the last time we heard of him alive’.

The secretary’s evidence revealed omissions in the department’s records of the child’s location and employment. Departmental files suggested he was required to notify the department on leaving each placement and that it was the practice for station managers to issue weekly reports, but no reports were on file. In May 1943, one month after the boy had walked from the muster camp, the department wrote to him to say that it expected a monthly letter from him. The departmental file did not contain a report on the death nor any record of an investigation of the department’s involvement with the child. The file contained an April 1944 news article pertaining to the possible exhumation of the body for a coronial inquest and news articles on the station manager’s trial for mistreatment of Aboriginal station hands.

**Allegations of criminal conduct**

The Inquiry found that three children died, and another two allegedly died, as a result of criminal conduct while they were on the run from their placements.

Evidence was received from four people about the death of a boy aged 14 and a 15-year-old girl from Victoria in 1990. The Inquiry found that the boy was a child in State care at the time of his death, but the girl was not. The Inquiry was told the two children were found near the Victorian border and that they had been murdered. The witnesses said the two used to hang around Hindley and Bank streets in Adelaide’s CBD and were considered to be street kids. One of the witnesses, a friend of the murdered boy, told the Inquiry about the effect that the deaths had on the street kids at the time and that many of them wanted to attend the funeral:

> It was actually almost like a state funeral type thing. Lots and lots of street kids went there … the police provided buses for us to go down there, because they were worried that we were all going to steal cars to get there.

The South Australian police confirmed the homicide of the two children at Kaniva in October 1990. The deaths were registered with the Coroner’s Office in Melbourne. The murders remain unsolved.

The boy had come to the department’s attention through the criminal justice system a year before his death. He was placed on bail under the supervision of the department but was remanded to the South Australian Youth Remand and

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52 SRSA GRG 29/123/190. The coronial file contained a letter from the child to his mother dated 31 Mar. 1943.
Assessment Centre (SAYRAC) after breaching his curfew and residence conditions. The department attempted several placements but he absconded from all of them and was returned by the courts to SAYRAC. He was then placed on a bond, which he breached by absconding from the Gilles Plains Unit. He was arrested and remanded to SAYTC. Records showed that he told staff he wanted to live on the streets. Five weeks before his death he received a suspended sentence with a bond to be under the supervision of the department. However, he did not live where directed, did not attend supervision appointments and was admitted to the Queen Elizabeth Hospital with a suspected drug overdose. The department recommended to the court that his bond be revoked and the court issued a warrant for his arrest. His body was found the next day.

Two girls, aged 12 and 14, were separately placed in State care in the 1970s for criminal offending. The girls spent time together at Vaughan House. The 14-year-old had various placements but stayed in only a few. She continued to contact Vaughan House, wanting to live there. However, departmental reports showed that she would not benefit from Vaughan House and she was released to live with her brother, then mother, then boarded in a flat. A departmental report when she was 16 stated that:

... every effort made by officers has failed and have suggested to [the girl] that she should contact me rather than me chasing after her. Want her to accept some responsibility for her own behaviour, manage her own affairs which may assist her to become more independent and self reliant.

Departmental records of the girls’ placements in their last months alive are deficient. The second last entry on the older girl’s SWIC recorded that she absconded from Allambi Girls Hostel in August 1975. The last entry, in 1976, was ‘released – died’. The child’s departmental file contains an internal memo from a community welfare worker to the District Office Enfield dated three months after she died. It stated the girl ‘was killed in a road accident at Barmera ... she had been living in community placement most recently with family of [the other girl] (also killed) since absconding from Allambi in October, 1975’. There was no other information about the circumstances of the child’s death.

Coronial records showed that the girls were both killed in February 1976 as pedestrians, while working as fruit pickers in the Riverland. Police records stated that the driver was convicted of causing their deaths by dangerous driving and sentenced to 18 months’ jail.

At the age of 14 in 1991, a girl was placed under the guardianship of the Minister until she turned 18 due to allegations of sexual abuse in the family home. She had previously alleged she had been raped by a stranger when she was four and raped by her mother’s friend when she was about 11. The Inquiry became aware of her death as a result of research on other matters when reading logbooks at the SAYTC. After becoming aware of her death, the Inquiry found a record on the CIS:

Case closed – 6/3/96. Child died Dec 1994. Notifier stated that [girl] was murdered 4 years ago (notifier stated that not sure if this is correct but it is well known that [girl] did die 4 years ago.

The departmental files contained a minute from the chief executive officer advising the Minister on the day of the girl’s death that police had found her body and that the circumstances of her death were yet to be ascertained. A further minute summarised the girl’s history in State care. After being placed in State care, she was placed in several Intensive Neighbourhood Care and foster family placements but absconded from them all. She was then briefly reunited with her mother, but began offending and
living on the streets in 1992. In the two years before her death she spent most of her time in secure care due to criminal offending. The minute stated: ‘The Department does not automatically undertake a formal enquiry of such incidents (unlike a death in custody or death of a baby) unless there are some issues which clearly need to be reviewed’. The final note on the file, from the case worker in 1996, indicates that the worker was in contact with ‘the Port Adelaide police for about 4 months after the girl’s death to see if they have finalised their investigations but nothing definite was forthcoming’. The file was closed three weeks later. It contained no information about the circumstances of her death.

Coronial records noted the girl’s body was found in 1994 at the Semaphore Esplanade. The post-mortem report stated that her wrists indicated healing wounds, consistent with self-inflicted about three weeks earlier. A recent injection site was noted. Her blood contained morphine as well as flunitrazepam. The latter is the active constituent of Rohypnol tablets. The level of flunitrazepam was potentially toxic. In relation to the level of morphine, its significance depends on how long she lived after taking the drug and other circumstances of death. Her lungs showed bronchitis and extensive early patchy bronchopneumonia. The coroner recorded the cause of death as ‘bronchopneumonia complicating flunitrazepam and intravenous heroin’.

Another girl who was with the dead girl gave a statement to the police. She stated that she and the girl went to a house at Mansfield Park the day before and were supplied with a cap of heroin, which they both injected. They were then supplied with three ‘rollies’ each. The witness fell asleep, waking the next morning to find four men in the house, as it was hot in the house. Police inquiries revealed that the girl did not use heroin until her conditional release from Magill Training Centre on 20 October 1994. It appeared as though the witness had introduced her to the drug, administering it about three times before her death. On her own admission the witness was charged with administering heroin and was convicted in 1995 in the Children’s Court, with no penalty. It is not known how the dead girl came to be in the car park at Semaphore beach. The occupants of the Mansfield Park house left after the girl’s death. When the police went to the girl’s home they found a letter from the department dated 17 November 1994 advising her that they had information that she had breached her conditional release from the Magill Training Centre by injuring her wrists, non-attendance at meetings and the use of drugs and alcohol. They found another departmental letter requesting that she appear before the training centre board. They also found a note written by the girl talking of her unrequited feelings for someone (‘a sad love story’) and of suicide because ‘my life … goes nowhere’. The note also mentioned that ‘if the butane in his lungs kills him’ then she would introduce herself to heroin and that she felt like overdosing on some. The police report said there would be another report once they had made further inquiries. There was no additional report on the file.

In 1985 a 12-year-old girl was placed in State care until the age of 18 due to neglect, physical abuse and sexual abuse by family members. Departmental records showed that during the next three years she was in and out of SAYRAC and absconded constantly from placements, spending periods of time on the streets. About six weeks before her death, she was charged with breaking, entering and theft of items, and assaulting and resisting police. One week before her death in December 1988, she was given bail, to be under the department’s supervision.

The girl’s SWIC recorded ‘released – died’. The departmental files in relation to her death contained a closing summary to the effect that the girl was in an Intensive Neighbourhood Care (INC) scheme home, broke house rules and stole from the family. She then left the home and her whereabouts were unknown. She died in hospital after inhaling fumes from correction fluid in Hindley Street.

The coronial records set out the circumstances and cause of her death as ‘anoxic epileptic fit following anoxia and cardiac arrhythmia in consequence of sniffing [brand name] correction fluid (containing trichloroethane)’. She and
another girl slept in the car park by the Academy Cinema for her final two nights. They smoked cannabis together. On the day of her death, the girl was seen by the other girl, intoxicated and inhaling from a bottle of correction fluid. She was then seen to collapse on Hindley Street and died later in hospital.

Three people gave evidence to the Inquiry about her life and death.

One witness believed that the girl was murdered. She said that she and the girl and another were ‘prostitutes together’.

Another witness said the girl had been chronically sexually abused. She said that over the years the girl had been in and out of SAYRAC, where a worker had sexually abused her. She said the girl was pregnant at some stage. She thought she had been given an injection in Hindley Street and kicked in the head when she died. (The post-mortem report on the coroner’s file stated that there was no pregnancy and no evidence of physical abuse at the time of her death).

Another witness gave evidence that a taxi driver raped the girl and that she was the victim of sustained sexual abuse at home.

The Inquiry was unable to find any evidence to substantiate the claim that the girl was murdered.

Deaths of children on probation to family

Seventy-seven children died while under departmental supervision and having been placed on probation to their parents. The majority, 41, died as a result of accidents and, of those, 25 involved motor vehicles. Nine children died from medical conditions and 10 from infectious diseases.

Accidents

In many of the accident cases, information about the circumstances of the deaths could not be obtained from the department because its records could not be found. For example:

An 11-year-old boy placed in State care in 1966 due to a larceny charge died 10 months later while on probation to reside with his mother. His SWIC stated that he was ‘released – died’. There was no record of his death in the Mortality Record Book and the department was unable to locate any relevant files. The coronial records contained the details of his death: he died at home after he was electrocuted while handling Christmas lights.

In 1955 a two-year-old boy was placed in State care until the age of 18, after a court found that he was destitute. He died aged four, having spent most of his time in State care on probation to his mother. His SWIC recorded ‘either burns or prior asphyxiation’ and the Mortality Record Book listed ‘misadventure – either burns or prior asphyxiation’. The department was unable to locate any files relating to the child.

The coronial records contained various statements about the circumstances of the death, including that the child died under a tank stand outside a house. There was speculation that somehow he had got hold of a box of matches and lit a fire under the stand, ‘although there is not evidence to support same’. There was no report from the pathologist on the file.

Suicides

Three children committed suicide while on probation to their parents. The deaths occurred in 1944, 1963 and 1991.

A 17-year-old youth was placed in State care in mid 1944 after being charged with unlawful use of a motor vehicle. He was placed on probation to his parents immediately after his committal on an 18-month order. The youth had arranged employment as a labourer in regional South Australia, but about three weeks after he started, his employer found him bleeding from a bullet wound to the chest. The 17-year-old had shot himself after a failed love affair. He had written ‘sorry’ in the dirt nearby. The youth died from haemorrhaging from the wound.

The youth’s SWIC notes that the insurance company, which was acting in relation to the stolen motor vehicle, alerted the department to the death. It also notes that the information about the coroner’s finding on the file came from the region’s newspaper. The Inquiry received no files from the department so could not verify the manner in which the department recorded the death beyond the
Chapter 5 Deaths of children in State care

SWIC. The coroner told the Inquiry that no records could be found. The Inquiry’s staff found a reference to a coronial record at SRSA and advised the Coroner’s Office, however this record could not be located. All information on the youth’s death came from a mortuary book maintained by the regional police station, which was located at SRSA.

A 18-year-old woman committed suicide in 1963, while placed in the care of her husband. She had been remanded to Vaughan House on a charge of break, enter and steal. She was charged and committed to the custody and control of the CWPRB until 1965. The young woman was initially placed with her mother but returned to Vaughan House briefly; her SWIC noted at the time, ‘needs discipline’. Two months before her death, the young woman was released to her husband. She had a history of depression and violent behaviour, which had worsened in the month before her death. While she and her husband were travelling, she ingested almost a bottle of barbiturates without his knowledge. She was pronounced dead on arrival at an Adelaide hospital. Her SWIC read, ‘released – died (suicide)’. The Inquiry received no departmental files for her.

The Inquiry discovered the death of a boy in 1991 incidentally, in the course of researching secure care facility logbooks. He had first come to the department’s attention in 1981, aged five, due to parental neglect. He was placed in State care in 1982, until the age of 16.

The child was placed initially in emergency foster care, then a departmental cottage home. Departmental records showed he had become depressed, aggressive and insecure after removal from the family home when he was six. From 1983, the boy resided intermittently with his family, who remained unstable and transient, and in various alternative care placements, generally refusing to attend or absconding to return to his family. He attended seven primary schools and rarely attended high school. He was drinking, abusing drugs and offending repeatedly from the age of 11.

In 1989 allegations of familial sexual abuse of the child were raised, however a departmental investigation found no evidence. The same year, the boy made allegations of sexual abuse by an adult involved in his case management. After initial police enquiries, the child said he did not want to pursue the matter.

The boy committed suicide in late 1991, aged 15. At the time he was on conditional release from detention to reside with his parents, was participating in departmental programs and was considered stable. His welfare worker last spoke with him 12 days before his death.

The departmental files contained no records about the circumstances of the death. The child’s welfare worker was alerted to the death by police, who had allegedly received a report from a departmental worker. The welfare worker verified the death through a newspaper. The departmental file recorded the cause of death as shooting, while the coronial file had death by hanging; the client file was never corrected to accurately record the death as death by hanging. CIS had three different listings under two surnames for the child, none of which noted that he had died.

Undetermined causes

The Inquiry has been unable to determine the circumstances of the deaths of six children who died while placed on probation to their parents.

A 13-year-old placed in State care in 1966 as a result of a criminal offence was given permission to join the Navy just over three years later. His SWIC recorded that in 1971, at 17, he was ‘released – died’. The cause of death in the Mortality Record Book was ‘fell under train’. There is no record of how this happened. The department or State Coroner could not provide the Inquiry with any files.

A mother placed her 13-year-old daughter in St Vincent de Paul Orphanage, Goodwood, in 1949, after the girl had twice run away from home. She also absconded from the orphanage and was then placed in State care until 18 years of age, charged as ‘destitute’ as her parents were not constantly in Adelaide. The girl’s mother had a fractious relationship with the department and expressed a desire to take her daughter interstate.

53 SRSA GRG 1/92/1.
54 SRSA, GRG 5/235/2/1, Renmark Police Station mortuary book.
thus reducing the department’s involvement with her. The girl was placed in foster care but then ‘reballed against the authority and advice of her mother’ and absconded to Melbourne. She was located and returned to South Australia on probation to her mother. Both mother and daughter had contact with a departmental probation officer for a short period, however they failed to maintain contact. The girl was reported as a ‘missing friend’ by the department and died interstate about six months later, aged 15. The only information about her death on the departmental file was an article from The Advertiser in 1950 reporting that she had fallen from the balcony of a Brisbane hotel, where she had been staying with her mother. A note on the file stated that ‘until the paragraph appeared in The Advertiser today, this Department had no definite idea of the whereabouts of either the mother or daughter’. The department wrote to the Commissioner of Police to confirm the child’s identity. Nothing in the records indicated that the department sought to discover the cause or circumstances of her death. Her SWIC noted ‘released – died’ and ‘Girl and mother staying at [name of hotel] when killed’. The Mortality Record Book gave the cause of death as ‘result of fall from balcony’.

A two-year-old girl was placed in State care in 1960 until 18 years of age, after a court found her to be neglected and under unfit guardianship. She was placed on probation to her mother six months later. She died when she was 14. Her SWIC recorded ‘released – died’ and the Mortality Record Book, ‘Fell from the Gap, NSW’. There was no information about the circumstances of her death on the departmental files.

In 1968 a 15-year-old boy was placed in State care until he turned 18 after committing larceny, and was then placed with his parents. He died in 1970. His SWIC recorded ‘released – died’ and the Mortality Record Book, ‘died’. The only information found was a burial order stating ‘multiple injuries received in a motor vehicle accident’.

In 1972 a 17-year-old boy was placed in State care—on probation to his father—for 18 months as a result of committing a criminal offence. He died 14 months later. His SWIC recorded ‘released – died’ and the Mortality Record Book ‘motor accident’. The department and the Coroner’s Office were unable to provide the Inquiry with any files. The Inquiry infers but cannot confirm that the death occurred interstate.

In 1969 a 16-year-old boy was placed under the care of the Minister for two years after committing a criminal offence. He was placed on probation to his parents and died one year later. The cause of death is ‘drowned’ in his SWIC and the Mortality Record Book. The only reference from the Coroner’s Office was for a burial order, which contained no information about the circumstances of the death. The boy’s departmental files contained the following entries:

9/1/71 Report in Advertiser this date that [name] missing, believed drowned near Lock 5, River Murray, Renmark area.
10/1/71 Report in Sunday Mail that [name] body recovered from the River Murray, dead.
11/1/71 Home Visit. Offered condolences and any assistance to family.

There was no information about the circumstances. The file was closed the day after the body was found.

Petrol sniffing

Two Aboriginal boys died from petrol sniffing while they were on probation to their parents.

One boy was placed in State care in 1974 at the age of seven, after a court found him neglected. His SWIC recorded that during the next 10 years he was regularly moved between foster care and his mother’s care. Three months before his death he was charged with larceny, spent a few weeks in SAYRAC and was then released on bail to live with his mother. He was 17. His
bond and supervision file from the department contained a copy of the forensic and autopsy reports, which attributed cause of death to petroleum hydrocarbons in the lungs and liver consistent with inhalation of petrol.

The boy's SWIC did not record his death and noted on 10 January 1985, 2½ months after he had died, 'released term expired'. His name was not on any of the lists provided to the Inquiry by the department. The Inquiry learnt of his death from a member of the public.

The second boy was placed in State care in 1973 at the age of 13, a court finding he was in need of care and control. Departmental files showed he had been involved in minor offending and petrol sniffing. He was placed at Windana Remand Home and then at Amata, an Aboriginal community. He continued offending and was then placed in State care until the age of 18. In 1975 he spent two months at McNally Training Centre. A report on his departmental file raised concerns about the secure care of Aboriginal youths. It noted a ‘very thin, undernourished, confused, petrified, full-blood Aboriginal boy, coming from an environment and cultural setting completely alien to European living’. The boy did not speak English. The report writer stated that he disagreed with the District Court's decision to place the boy at McNally. He was released and went to Amata. He died 14 months later in the Northern Territory, where he was living with a relative. A letter on the departmental file stated:

> It is believed that he died as a result of petrol inhalation. This latter is a problem which is affecting quite a number of the teenage Aboriginal youths within that general area.

A report on the file said the boy’s uncle found him slumped over in a car, his head in a billycan.

**Allegations of criminal conduct**

Five children died as a result of criminal conduct while on probation to their parents. A 16-year-old girl died as a result of an infection as a result of an abortion in 1944. When she was 13 she was charged as uncontrollable and placed in State care. Her father had died and her mother remarried. She was placed at Barton Vale Home for Girls on 25 August 1941 for a year and then placed on probation with her mother.

Her SWIC recorded ‘released – deceased. Conduct good’. The Mortality Record Book recorded ‘abortion’.

According to the coronial files, the girl told her friend she had ‘slipped’ and they discussed getting her ‘fixed up’. He told her about a woman, Florence Tucker, who performed abortions. The girl’s mother borrowed £10 from a money lender. After visiting Tucker, the girl returned home. She told her mother she had been syringed with soapy water and had been given a telephone number to call if she had complications. When the girl complained of abdominal pain, her mother called the number, reaching a nurse, who said she was unable to help. A doctor was called and admitted the girl to hospital. The girl provided a statement to police but died soon after. The inquest found that Tucker brought about the death of the girl by mechanical interference. She was committed for trial on a charge of manslaughter and was also committed to stand trial for the unlawful abortion of another woman (who survived). The Courts Administration Authority was unable to locate any records on the charge of manslaughter. However, Tucker was found guilty of the second charge and sentenced to three years’ jail with hard labour.

The department’s supervision file for the girl indicated that her probation officer had no knowledge of the events leading to her death. The girl’s employer told the officer about the death and he then visited the family home. The officer’s report to the secretary of the CWPRB did not include any information about the circumstances leading to the death or details of supervision, apart from noting that the most recent visit to the girl’s home had been about one month before her death. After that visit he recorded that the girl ‘has been very satisfactory since her release. She
seems to have left all her uncontrollable traits behind her.’ It concludes that the girl ‘was a very good girl on probation, her manner was always most pleasant, and she spoke freely about what she was doing’. The file also contained an extract from the death registration listing ‘abortion’ as the cause of death, a note from the probation officer that ‘this girl died in the Royal Adelaide Hospital’ and a newspaper clipping about the death, which stated that the police took ‘dying depositions from the girl, who died three hours later’.

Six months before her death, the department’s visitation report had noted: ‘She has become acquainted with a young man, who has taken her to pictures and dances’.

It appears that while the girl was at Barton Vale in 1941–42 she was medically examined by a doctor at the police medical room. The departmental file recorded this examination and noted: ‘vagina: admits two fingers easily. Hymen: healed hymen tags. Slight mucous discharge. Intercourse could have taken place on a number of occasions’. It is not known why the girl was examined in this way and at that time.

A 13-year-old boy was placed in State care for breaking and entering and died in 1967, aged 17, one year before his release from care. He was visited by the department in 1964 and 1965 while on probation and living with his father in Mount Gambier. There were no departmental files other than his SWIC, which recorded ‘released – died’. The Mortality Record Book noted his cause of death as ‘result of street fight’.

Courts Administration Authority files recorded that a 17-year-old youth pleaded guilty to manslaughter in 1967, part-way through a trial in the Supreme Court. He was fined $100, with a four-month prison term if he defaulted, on the basis that he

... engaged in unlawful violence in the form of a fight with this young man, which has had the quite unintended and extremely unfortunate result of this boy losing his life.

The judge told the defendant:

_I do not think you can blame yourself for any worse crime than indulgence in a fight that you ought to have kept out of. It was a piece of villainously bad luck that this fight should have had the fatal result that it did._

In 1967 a three-year-old girl was charged as neglected and placed under the care of the Minister until she turned 18. She was released on probation to her mother in 1970 when she was six. She died six weeks later. Her SWIC recorded ‘released – died’ and the Mortality Record Book ‘murdered (drowned)’. The department was unable to provide any files relating to the girl.

The Coroner’s Office file stated that a 16-year-old youth was charged with her murder. The girl’s body was found in the River Torrens near her home. She was last seen by her mother in the backyard of her home.

Courts Administration Authority files showed that the youth was originally charged with her murder and pleaded not guilty. The charge was then replaced with manslaughter, to which he pleaded guilty. The court ordered that he be placed under the control of the Minister of Social Welfare until he turned 18, when he would be sentenced to 12 months’ prison – suspended if he entered into a three-year good behaviour bond and undertook medical and psychiatric treatment. The files showed he had been placed in State care in 1968 at the age of 13, having committed larceny. According to his SWIC, he was placed under the care of the Minister until the age of 18. He was immediately released on probation to his parents. Three months later he was placed in Windana Remand Home, then Brockway Park and later Lochiel Park Boys Training Centre, when he committed a further offence of malicious damage. He absconded from Lochiel Park several times and was also released to stay with his parents a few times. During the next year he was charged with further offences: disorderly behaviour, illegal use of a motor vehicle and unlawful use of a bicycle. He was released on probation to his parents in September 1969, seven months before he killed the girl.
Chapter 5 Deaths of children in State care

The court files showed a work placement had been arranged for the youth on his release to his parents but this lasted only 1½ days. He was assessed for vocational training at St Margaret’s Rehabilitation Centre for four weeks in April 1970 but was found unsuitable for training. The youth told the police that he took the girl, who lived nearby, to the shop on his bike on the day she died. She wanted another ride on his bike, but he said no and she began to call him names. She followed him down to the river. He got angry and pushed her into the river ‘to teach her a lesson’ and hurt her for calling him bad names. He held her down in the water and then got a piece of corrugated iron in an attempt to hide her body.

In a report obtained for sentencing purposes on the court files, the youth said he suddenly got very angry and felt that it could happen again if someone called him bad names. He said that he did not like Lochiel Park because ‘one man kept hitting them all the time’ and that is why he ran away. A doctor diagnosed the youth as ‘multiple minimal handicap’.

After he was sentenced, in March 1971, he was placed in the McNally Training Centre but, according to his SWIC, absconded three times during the next two years before being released in 1973. For more than a decade from the early 1980s, he committed larceny, a grossly indecent act in public, and breaking into a building and felony.

In 1963 a baby boy was placed in State care until the age of 18 after a court found him ‘neglected and under unfit guardianship’. His SWIC stated that he was put on probation into his mother’s care on the same day. About 14 months later, the two-year-old boy, his younger sister and their mother were found dead at their home.

The boy’s SWIC recorded ‘released – died, killed by mother’ and the Mortality Record Book recorded ‘gassed by mother (who suicided)’. The department was unable to locate any files relating to the boy.

The coroner’s file showed that the mother killed herself and her two children by coal gas poisoning, using the stove jets and oven. She left a note to her eldest child (then in foster care) that was scathing of the department: ‘...I could not save you from the claws of murderous Welfare now they killed me and your little sister and brother’.

In 1959, a 13-year-old boy was placed in State care until the age of 18 after committing larceny. He was placed at Struan Farm School just before he turned 15 and died about six weeks later, while on a holiday with his parents. Coroner’s records stated that he and three youths stole a car in Adelaide. The 15-year-old driver misjudged a turn and the car ran off the road, killing the boy. The driver was convicted and sentenced to the reformatory until he turned 18. His SWIC and the Mortality Record Book recorded his death as due to a road accident.

Other issues

Unmarked graves

Two people gave evidence to the Inquiry about the graves of their relatives – a brother and sister. Both witnesses said they believed the children were in State care and both had wanted to put headstones on the graves but had been stopped. One of the witnesses said he thought there were at least 100 unmarked graves at a particular cemetery and the question needs to be asked, “Which ones are related to institutional care or issues gone wrong?” He said that the graves can also be put into strangers’ names, for example, the name of the funeral parlour. He said he would not stop until he got headstones for the two children. The other witness said she was told:

... that there are a fair few of FAYS [Family and Youth Services] graves, that there’s—no documents handed over to the cemeteries. They’re just kind of, like, told to dig the hole and that’s it, that’s all they do.

She said she would love to take over the graves of the two relatives, ‘but the thing is, we’re going to lose those graves because we don’t own them’.

The Inquiry requested all departmental files referring to the two children.
The girl's file contained some information about the boy's death. He died when he was eight years old and had never been in State care. His grandmother paid for his funeral over 12 months, in which time the grave site lease was in the funeral director's name. Once it was paid, in 1999, the lease was transferred to the grandmother's name. The child was not buried by the department. The Inquiry concludes that if there is no headstone on the grave, the grandmother has chosen not to have one.

The files showed the girl died when she was 17. When she was three, her grandmother had been granted custody and received a guardianship allowance. She was placed in State care for brief periods. The file recorded a meeting between family members and the department following her death, at which it was decided that the mother would claim the body and arrange the funeral and the father would supply the headstone. The department paid for the funeral but the grave site lease was in the mother's name. The Inquiry concludes from the documents and the witnesses' evidence that this is also a family, not a government, issue: the father did not supply a headstone as agreed and the mother has subsequently chosen not to install one.

In relation to the issue of unmarked graves, the Inquiry received information from the department that the department's Funeral Assistance Program, which started in 1988[58], funds funerals for children in State care and families eligible to receive financial assistance. A funeral director is contracted to provide the funerals statewide and the procedures are the same regardless of whether the child was in State care or not.

Before 1 May 2006, the lease for the burial plot of financially assisted funerals was in the department's name unless the child was under five, in which case the lease was in the family's name. The family could buy leases at any time for the original price paid by the department. The department did not pay for headstones and required permission if a person wanted to erect a headstone on a department plot. If the cost of the headstone was less than a certain amount, permission was automatic. But if the headstone cost more, the department required the family to purchase the plot lease. The program was changed in May 2006 to provide financial assistance for headstones.

The department advised that it recorded the names and place of burial of all children who received funeral assistance, regardless of whether the grave had a headstone.

The Cemeteries Association of South Australia, which was formed in July 1978, advised that all cemeteries and crematoria are legally required to keep burial records, all state-funded funerals are contracted to a funeral director and the department buys burial sites from cemeteries.

In relation to unmarked graves, the association said that ‘large numbers’ of babies, children and adults were buried in common ground, known as pauper sites, until the 1970s. This occurred at West Terrace Cemetery and, to a lesser extent, Dudley Park, Cheltenham and various country cemeteries. Records at West Terrace generally provided the name, last known address, age, date of burial and location of the grave, with some omissions. The government funded burials for people who had no estate or identity, or whose family could not afford to pay, as well as for children in State care. The records did not note whether a deceased person was a State child. The custom was for a State-contracted funeral director to conduct a burial in the common ground, with no grant or licence issued over the grave. Therefore the Inquiry found that the issue of unmarked graves raised by the two witnesses was not particular to the burial of State children.

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[58] Between 1985–88 the department provided financial assistance for burials; between 1970–85 the department was responsible for ‘all burials in South Australia of persons with insufficient resources’ and during the 1960s the department arranged destitute burials. See DCW annual report 1976, p. 17.
Recommendations regarding deaths

Two committees relating to the deaths of children in South Australia were established as a result of recommendations made in the 2003 Layton report. They are the Child Death and Serious Injury Review (CDSIRC) and Adverse Events (AEC) committees.

The CDSIRC was established by Part 7C of the Children’s Protection Act 1993 on 1 February 2006. It has a wide focus in that it may review the death or serious injury of any child resident in the State at the time. It consists of up to 20 members—appointed by the Governor of South Australia—who must meet at least five times a year. It is subject to direction of, and resourced by, the Minister of Families and Communities. It must report to the Minister, who is to table its reports in Parliament.

The committee’s main functions are to review cases in which children die or suffer serious injury and identify legislative or administrative ways of preventing similar cases; and to make, and monitor the implementation of, recommendations for avoiding preventable child death or serious injury.

The Children’s Protection Act sets out criteria to decide whether a review should be held. For example, a review should be held if the child was, at the time of death or serious injury, under the guardianship, or in the custody, of the Minister or was in custody or detention or in the care of a government agency.

The review should be done by examination of coronial and other relevant records and reports, however the committee may engage an expert to assist. The committee can ask to be provided with documents or supplied with other written information. Information provided to the committee is confidential, unless it relates to possible criminal offences, risk of abuse or neglect, or matters relevant to a coronial inquiry, in which case it must be referred to the relevant authority.

The committee is to maintain a confidential database of child deaths and serious injuries and their circumstances and causes.

The committee met 10 times in the year 2005–06, having been operating under Cabinet Directions since April 2005. Its main tasks included the collection and analysis of deaths, the development of a database for storing information, analysis of information about the causes and circumstances of deaths, and recommendations to the Minister.

The committee completed reviews of the deaths of two people who had been in contact with the department. One was the possible suicide of a child aged 10–14 and the other a youth aged 15–17 from a fatal medical condition. The committee also considered the ways in which the Adverse Events Committee could improve its review of the services that Families SA provided to children and families.

The AEC was established in July 2004 and operates in the Department of Families and Communities, reporting to the chief executive. It has a narrower focus than the CDSIRC. Its purpose is to conduct internal reviews of deaths and serious injuries of children and young people who have been, or are currently involved with, the department. This includes deaths of children under the custody or guardianship of the Minister. The primary focus of the reviews is “quality improvement” with the ultimate purpose being “to identify and ameliorate system issues that may assist in the reduction of adverse events”. By the end of 2004, the committee had determined its procedures, including that the executive director of the department be provided with an internal memo about an adverse event and that the committee meet within 14 days of being notified by the executive director. The committee would then decide whether there is to be a case review (conducted by a social worker) or the establishment of an inquiry panel.
Between July and December 2004, 23 referrals were made to the committee, of which 14, including 10 deaths, were assessed as requiring review. Of these, four were conducted by inquiry panel and six by case file review. All of the children had current or previous contact with Families SA, including three guardianship and two youth justice orders.63

Central database

Neither the Child Death and Serious Injury Review nor Adverse Events committees has a specific provision for a database of the deaths of children in State care. However, there is a basic need for the department to establish and maintain such a database.

There was a significant amendment to the Coroner’s Act 2003 from 1 July 2005, requiring—for the first time—that the coroner be informed of the death of a child in the custody or under the guardianship of the Minister.64 The State Coroner must hold an inquest into the death if he considers it necessary or desirable or if he is directed by the Attorney-General. Even if an inquest is not held, the coroner must make a finding on the cause of death.

Following the amendment to the Coroner’s Act the department distributed an internal circular informing staff of reporting requirements concerning child deaths. However, it did not address the issue of the central recording of deaths in a database.

In Rapid Response progress report 2007, Families SA said it was undertaking ‘a major service and practice reform through its new case management (C3MS – Connection Client and Case Management System) system’. The Inquiry recommends that as part of that reform, the department ensures that the deaths of children in State care are centrally recorded.

RECOMMENDATION 49

That the Department for Families and Communities creates a central database of children who die while in State care as part of its new C3MS.

The database should contain:

- the child’s name and date of birth
- when the child was placed in the custody or under the guardianship of the Minister; or the details of the voluntary agreement
- the child’s last place of care
- the name of the child’s last carers
- the date of death
- the cause of death (as initially advised to the department)
- the circumstances of the death (as initially advised to the department)
- the source of initial advice about the cause and circumstances of death
- confirmation that the death was reported to the State Coroner and when
- if an inquest was not held, the cause of death as found by the coroner and when that finding was made
- if an inquest was held, the cause of death as found by the Coroner’s Court and when that finding was made
- if an inquest was not held because of a criminal prosecution, the name of the investigating police officer and the outcome of the criminal prosecution.

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63 DFC, Adverse Events Committee, Progress report No. 1, p. 6.
64 Coroners Act 2003, s 28.
Maintaining files

If the child died in State care, the Inquiry recommends that this information is also kept in a physical file relating to the child, whether in the child’s client file or a separate file created for this purpose. The file should contain any correspondence related to obtaining information concerning the child’s death, including copies of any coroner’s or court findings. The Inquiry recommends that when a child dies in State care, the case not be ‘closed’ until the Minister, as guardian or custodian, has properly informed himself/herself about the child’s death and made sure the death has been properly investigated.

RECOMMENDATION 50

That where a child dies in State care, the Department for Families and Communities maintains a physical file, which contains:

- information about when the child died and in what circumstances, including reference in the file to where the information has come from
- information from the State Coroner as to whether an inquest is to be held
- the coroner’s finding as to cause of death
- a copy of the coroner’s reasons in the event that a coronial inquest is held.

Funding for legal representation at coronial inquests

Depending on the circumstances of a death, the coroner may decide to hold an inquest. This includes a death of a child in State care. A person who, in the opinion of the court, has a sufficient interest in the subject or result of the proceedings may appear as a party in the court and have legal representation. It is foreseeable that the department’s interests in the proceedings may not always be the same as the interests of the birth parents in any such proceedings. There could be a potential conflict of interest. The Inquiry heard evidence from the mother of a baby who died in State care about how she persevered for almost two years for an inquest to be held into the death of her baby and the ongoing stress of legal expenses when she finally succeeded. The department had its own legal representation and the issues surrounding the death were such that the department’s interests did not reflect the mother’s interests. Unlike in civil proceedings, there is no provision for a person to be reimbursed for legal expenses in regard to legal representation at a coronial inquiry. Given that the death of a child in State care is now reportable, the Inquiry recommends that the State Government financially assists a family member of the dead child with legal representation, if requested, at an inquest.

RECOMMENDATION 51

That the South Australian Government provides financial assistance to a family member of any child who dies in State care to enable that family member to be legally represented at a coronial inquest into that child’s death.
Chapter 6 Keeping adequate records
# Keeping adequate records

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Chapter 6 Keeping adequate records

One of the purposes of the Inquiry as set out in the Commission of Inquiry (Children in State Care and Children on the APY Lands) Act 2004, Schedule 1 Clause 2(2)(c) is to ‘determine and report on whether appropriate and adequate records were kept … have been destroyed or otherwise disposed of’ in relation to the allegations of child sexual abuse in State care and of criminal conduct resulting in the death of a child while in State care.

In presenting the allegations of sexual abuse of children in State care in chapter three and the deaths of children in State care in chapter five, the Inquiry has identified what relevant records, if any, were available on each person.

The Inquiry found that records received in response to requests were sometimes inadequate due to poor file management practices and minimal documentation. Sometimes the Inquiry was advised that no records could be found; possibly a result of the authorised destruction of records by the department during the 1970s and 1980s. Thus it was not possible for the Inquiry to properly determine whether some people were in State care. Even for those in State care, important information about this period in their lives was often missing.

The Inquiry: requesting, viewing and storing records

As part of its investigations, the Inquiry made 5880 requests for records from government and non-government organisations and individuals to:

- determine whether a person who alleged sexual abuse was in State care at the relevant time and the State’s response to any disclosure of sexual abuse that may have been made
- determine whether a child who died was in State care at the time and whether the circumstances of that death were recorded
- obtain historical information about places of care for children in State care.

Table 1 shows the number of records requests made by the Inquiry to categories of agencies/organisations.

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<tr>
<th>Agency / organisation</th>
<th>No. of requests</th>
<th>Percentage of total</th>
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<tr>
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Table 1: Number of records requests to categories of agencies/organisations

Table 2 shows the number of records requests made by the Inquiry to each agency/organisation.

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<td>The department(^1)</td>
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<td>The Catholic Archdiocese of Adelaide Professional Standards Office</td>
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<td>Aboriginal Affairs and Reconciliation Division(^2)</td>
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<td>Youth Court</td>
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<td>Total</td>
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Table 2: number of records requests made by the Inquiry to each agency/organisation.

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\(^1\) Department for Families and Communities.

\(^2\) Situated in the Department of the Premier and Cabinet.

\(^3\) Includes organisations such as the Umeewarra Aboriginal Mission, United Aborigines Mission and Anglicare SA.
As the impact of the requests on agencies varied, so too did their response time.

About 33,300 records were received and housed by the Inquiry in response to the requests. Of these, 24,915 came from government agencies and 8385 from private organisations and witnesses who came forward to the Inquiry. Records storage required 275 metres of shelving in a fireproof area. The Inquiry had to expand its premises twice to cater for the volume of files.

The Inquiry was aware that it must keep records in good order and in the same order, use them only for the purposes of the Inquiry’s investigations, and return them when requested or at the end of the Inquiry. The Inquiry was also aware of its obligation not to lose or abuse records, endanger their security or integrity, and show or distribute them to a third party.

The Inquiry also reviewed some files at other premises, including Minda Inc., State Records of South Australia (SRSA), the Office of Births, Deaths & Marriages, the Coroner’s Court, the department’s Adoption and Family Information Services, the department’s Adoption and Family Information Services, the department’s library and the United Aborigines Mission archives in Melbourne, which consisted of thousands of individual pieces of correspondence. The Anglican Archbishop of Adelaide, Jeffrey Driver, gave the Inquiry access to all the church’s records, which are stored at the Anglican Archives in North Adelaide. The Inquiry also provided funding and resources to assist the Coroner’s Court to answer records requests.

The Inquiry requested and received sign-off from relevant government agencies for 1267 records requests concerning allegations within the terms of reference. Most of the sign-offs were from the department, South Australia Police and the Aboriginal Affairs and Reconciliation Division. The sign-off was a formal letter from the agency stating that a thorough search had been done in relation to the request, that any necessary searches had been done for other documents or evidentiary material in response to that request, and setting out the results of those searches. There were three possible outcomes. These were that a search was conducted and

- produced results—all searches were listed, files found were listed and then provided to the Inquiry
- no evidentiary material was located—all searches were listed, it was stated that no records were found and the agency was required to explain why nothing was found
- files were found to have been destroyed—the agency was then required to provide details of the disposal schedule and authority under which the records were destroyed, as well as the date of destruction.

The Inquiry received 387 sign-offs from the department that no records were found after all relevant searches were made.

The Inquiry received evidence on records management from current and former departmental staff, and the department also provided a written response to the list of records issues in the Inquiry’s Issues paper. As well, three non-government organisations provided evidence about their records management systems.

SRSA also provided substantial assistance to the Inquiry. In addition to retrieving records in response to requests, it provided a chronological overview of the legislative context for archives and records management and information on government records management over time, and supplied the State Record Council’s Members handbook for background information. SRSA located historical reference materials and records used in research into the deaths of children in State care, often after government departments were not able to provide complete listings of their historical records. It also provided a written submission to the Inquiry’s Issues paper.

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4 State Records Act 1997, s. 13.
5 Evidence Act 1929, ss. 34C(1), 45A.
6 A records disposal schedule is a systematic listing of records, created by an organisation or agency, which plans the life of these records from the time of their creation to their disposal. It identifies business activities, classes of records (which result from each activity) and specifies retention periods and disposal action. It ensures that inactive records are disposed of efficiently and effectively in accordance with legislative, evidential, financial, social and historical requirements.
Chapter 6 Keeping adequate records

Adequate records

Until the current State Records Act 1997, there were no comprehensive legislative guidelines for agencies to manage records. In its submission SRSA described the previous Libraries Act 1982 as giving agencies little guidance on the management and disposal of records. SRSA had its origins in the Public Record Office of South Australia, which was established in 1985. In 1990, as part of a move to strengthen agency records management, the office was renamed State Records South Australia and made a commercial entity under the control of the State Services Department.


The current SRSA standards define adequate record keeping as:

- records are created
- records are captured
- records are disposed of systematically
- access to records is managed
- records can be found
- records can be relied upon
- the management of official records is planned
- records management training is provided to staff
- records management reporting mechanisms are implemented
- policies, procedures and practices exist for the management of official records.

The importance of keeping adequate childhood records

... having access to my file ... it does give you the opportunity to see some of your identity and to resolve some of the things that have happened that you just don’t know about because of being so young and not being informed about things, so that in itself was something that was quite valuable for me to do.

PIC placed in State care in 1960s, aged six

The Inquiry heard evidence from people whose childhood had been marked by sexual abuse about the benefits of having access to their departmental and other files. Some spoke about the trauma of discovering that records about their childhood were incomplete or non-existent. The Inquiry assisted some people to make requests for records under the Freedom of Information Act 1991 (FOI) and others had already been through this process. The department processed these applications confidentially and expeditiously, and provided individuals with copies of any available records, deleting third-party information.

One general witness told the Inquiry about the need for organisations to understand the emotions experienced by people asking for records about their childhood:

People don’t understand what they’re getting into by releasing a file. People front up at departments, and are challenged, ‘Why do you want this? It’s only terrible stuff written about you?’ You know, it’s so emotional to go and ask for your file. It’s about treating these people with respect. They have every right to know this information … and they really still hurt, children inside that adult body.

One woman who told the Inquiry she was sexually abused as a child spoke of the benefits of having access to her file:

It was helpful when I was resolving a lot of issues … so that I could piece together bits and pieces of fragments ... I don’t recall a lot of stuff, because I’ve shut it off.

Similarly, another woman said:

When I’ve been working through my files, I’ve been recalling things in my head that have happened … things are coming back to me that I had just obviously forgotten or blocked.

The Inquiry heard evidence from a government employee that a person making an FOI request of a government
agency will generally be given only those records that directly relate to the applicant. Relevant information may exist on another client file but not be passed on, and the applicant will not know that the information provided is incomplete. The witness noted the situation in the Northern Territory, where an agreement was made to disclose secondary party information to members of the stolen generations, and said he hoped this would set a precedent for other states and territories, including South Australia.

A person who was placed in State care in the 1940s told the Inquiry about the frustrations she felt when making an application for her own records but being unable to access all of them:

They’ve got a story on my life. I, I didn’t know my own life. So I got these papers and worked out from the dates how old I was. That is my life and I had no right to records. What a load of crap.

One woman who was placed in State care in the mid 1970s at the age of 13 was not only distressed that she received only a partial record of this time, but also angry at how she was portrayed in the file. She said:

I wasn’t even allowed to have my whole file, and in my file it’s got, ‘What a bad sexual behaviour, boys hang around’. Everything is so bad about me … because it’s not all the truth, it’s not the truth about me. That’s what I don’t understand.

Some people told the Inquiry that their files were incomplete because they were lost (‘When I tried to get my records through freedom of information years ago, they lost half my file’) or because no records were made. Some did not believe they had been given all of their file. One man who was placed in State care at the age of 11 in the early 1970s was searching for information to piece together his alleged abuse at Brookway Park. He said:

I arranged to have a look at my file and I saw my file in ’92, I think, and one section of my file is missing because it had all the details about Brookway Park in it and that file is missing.

A PIC who was placed in State care in the early 1960s when she was four told the Inquiry that she had accessed her file twice, but there was information missing the second time. The first time, in the 1990s:

... after reading my file and knowing what I knew—I wanted to at that time have someone accountable for what happened, which I at the time thought was not only [her foster parents], but also the Community Welfare.

However, at that time she did not have the money to seek legal assistance. She saw her file again more recently under an FOI request. She said: ‘When I had my file in the early ’90s there was a lot more to [it] than what’s here … they haven’t given me all of it’.

Some people described their frustration at finding that only a small portion of their file was available because the rest had been destroyed. A man who was placed in State care in the late 1970s when he was less than one year old and alleged he was abused in foster care said:

Well, I got a letter basically saying that my file has been destroyed. They no longer have my information available. I can’t get any of my file dating back to the time I was with the [foster family].

Another PIC placed in State care in the mid 1970s when she was six recalled: ‘I discovered when I first got my files under the freedom of information there was a note saying that half my files were destroyed’.

One person who lived in large congregate care in the 1950s told the Inquiry how he felt when there were no records to help him piece together his past:

I think the big thing for me is I know we’ve been let down … Why is there no records? Why have the authorities not been able to find this … She says that no records can be found. How can you close the door when the door’s left open, you know?

In 2007, the department established Post Care Services to, among other functions, facilitate access to the records of people who were in State care. The service arose from the government’s Keeping them safe child protection reform agenda in 2004 and, in particular, Rapid response: whole of government services, which focused on children in State care, the following year.

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Chapter 6 Keeping adequate records

Inadequate records

Departmental records

Various types of records were created during a child’s time in State care.

One of the oldest records kept by the department was the State ward index card (SWIC), a small card created when a child entered the department’s jurisdiction (discussed in chapter 1, ‘Assessing whether a witness was a child in State care’). The SWIC was used from around 1900 until the mid 1980s and was maintained in the department’s central records branch. In order to preserve the original SWICs, each card was scanned into the Adoption and Family Information Service’s image retrieval system software (AMS Imaging).

The Inquiry found that while some SWICs recorded comprehensive details, others contained no information other than the child’s name and the date of being placed in State care. Some did not even record the reason why the child was placed in State care. In relation to the AMS Imaging, the Inquiry found that some SWICs were missing or scanned incorrectly, or that names entered into the electronic search index were incorrectly spelt. It was common to find that a scanned SWIC for one child was inadvertently appended to the scanned card image relating to another child, but only the name of one child was in the searchable index.

For many years, information was not stored in a dedicated file for each State child, making it hard to trace information about a particular child.

The State Children’s Council (file group, GRG 827) and its successor, the Children’s Welfare and Public Relief Board (GRG 29) kept information on the abuse of children in general correspondence files, rather than in individual children’s files. Information was stored by the docket number and year, rather than by the child’s name. The Inquiry found that hundreds of pieces of correspondence relating to children in State care had been destroyed because of the department’s destruction of records in the 1970s and 1980s or could not be located.

Between the 1920s and 1960s, the department created ‘files relating to children under departmental supervision’ (GRG 29/108, GRG 29/123), which were series of correspondence docket files on varying topics created as the need arose. Multiple separate docket files might exist for a single child but docket files were registered according to the number and year created (for example, 1/1924). The name on the file may be that of a foster carer or parent, although the docket pertained to the child. The department told the Inquiry that many of these files have been destroyed.

From the 1960s to the 1980s, the department used a system where each child received a fixed ‘client’ number. Specific files were then created using a two-digit designation depending on the nature of each child’s involvement with the department. These files also may have included other files such as ‘Children under the care and control of the Minister’ (type 40), ‘Treatment and assessment’ (type 41), ‘Bond and treatment’ for young offenders (type 50), ‘Psychological services’ (type 55), ‘Family’ (type 90) and ‘Community residential care’ (type 93). The Inquiry heard evidence that records in a child’s file included initial court orders and subsequent orders, reports made by social workers and officers, medical information, details of private and foster home placements, and reimbursement and money paid to foster parents. If a child moved to a different district or home, the file would normally move with the child to the closest district office.

From the mid 1980s, one ‘contact file’ (type 85) superseded file types 40, 41, 50 and 90. One file could contain information on many people; for example, an adoption file might contain information on 10 unrelated people. From the mid 1990s, files relating to various areas of a child’s involvement with the department, such as placements in secure care or community residential care, became subfiles to type 85. In 2003 the establishment of the department’s Special Investigations Unit (SIU) to investigate allegations of abuse against foster carers, staff members and volunteers involving children under the guardianship of the Minister meant that the unit created and held investigation files separately from type 85 files.

8 Until the 1980s, the relevant system for the arrangement and storage of government records was the Government Record Group (GRG) system. It grouped series of records according to their creator or controlling agency. Record groups could consist of many series of records, but were always linked back to the government agency controlling those records. The record group material is now a closed system, and the information it contains is static.
From the 1970s to the 1990s, the department used a central index card system to better manage client files by recording client names with file numbers. This was part of standard procedure 9, which covered the creation, transfer and numbering of files. The records section created a central index card whenever a new file was opened. The card recorded the location of the file and whether or when it was sent to the archives. If a file was destroyed, however, the corresponding central index card was also destroyed. Summarised client information was contained on a master index card, which, under the department’s standard procedure 10, was not to be destroyed.

The Inquiry heard evidence from former departmental social workers that suggests record-keeping was often negligible. Records management was largely seen to be an administrative and financial function rather than part of the child’s case management. A child’s file was more likely to record formal information, such as court orders and details of boarding-out placements, and administrative details, such as the date of a departmental worker’s visit, than the aim of the worker’s visit and the outcomes sought.

Also, the standard of each file was dependent on the social worker who maintained it. The Inquiry heard that district offices and social workers often held ‘unofficial’ files on children or stored documents without following the prescribed filing system. Records on children in State care living in residential accommodation were often not transmitted to the central office. A witness told the Inquiry that when a district centre closed or relocated, staff were more likely to cull old and unused records than follow retention and disposal procedures.

In the mid 1980s, the electronic Justice Information System (JIS) was established across several government departments to collect, store and sort information for government agencies. SWICs were no longer needed. As part of JIS, the department introduced the Client Information System (CIS), to electronically record client information, better track files and list archived files. CIS was introduced in 1991 and became fully operational in 1993 (discussed in chapter 1, ‘Assessing whether a witness was a child in State care’). The Inquiry found there were several problems with the CIS, including that:

- Unlike an electronic document and records management system (EDRMS), which records all types of files created, the CIS only records client files
- Although some archived client files were recorded on JIS, the department could not then find the client files
- Some client information was incorrect and there was little cross-referencing between past and present information.

Institutions and secure care facilities

I think those people who ran those homes and treated us as children should be exposed. Because they would have disposed of those [records] quite happily because you wouldn’t want something like that [sexual abuse] to come back and bite you later, do you?

PIC placed in State care in 1960s, aged four

From the early 1900s, each institution maintained its own records and developed its own record-keeping requirements.

In the 1920s, the CWPRB issued rules for institutions caring for State children, which included some record-keeping guidelines, such as the requirement for written reports to be sent to the board noting all accidents involving children, children’s attendance at hospital and reports of staff misconduct or absence from duty.

In November 1942, the CWPRB abolished the need for institutions to make formal reports on State children. Instead, heads of institutions were to report on children by letter; the CWPRB could then request a formal report if necessary.

It continued to make suggestions to institutions about record-keeping. For example, the board secretary wrote to the matron of the Convent of the Good Shepherd (The Pines) in 1942 to suggest the keeping of an internal register with children’s names, ages, religion and dates of

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9 Department of Family and Community Services annual report 1990–91, p. 31.
11 ibid., vol. 13, CWPRB minutes 1940–42 (minute 823), 26 Nov. 1942.
admissions and departures.\textsuperscript{12} The secretary also suggested the keeping of a punishment book, ‘in which will be recorded immediately any punishments inflicted upon certain girls, showing date, name, punishment inflicted, reason for punishment, and any other particulars thought desirable’.\textsuperscript{13}

However, some homes and secure care facilities, such as Brookway Park, held only each child’s court order on file as it was deemed preferable that institution staff not know each child’s history and circumstances.

In May 1943, the CWPRB resolved that homes should only refer unusual or involved cases of ‘wards’ to it.\textsuperscript{14} The Inquiry heard evidence that each home completed a weekly report to the department’s records section, listing children’s arrivals, departures and abscondings.

In the mid 1970s, the Minister of Community Welfare became concerned with the retention of records on children in children’s homes that had been, or were intended to be, closed down. He wrote to the Residential Child Care Advisory Committee (RCCAC):

\begin{quote}
It is important that information pertaining to the child’s placement away from parents and personal details concerning the family be preserved in a way which will guarantee confidentiality. Such records should not be indiscriminately destroyed by the agency as they may contain pertinent information that may be required by the child in later years.\textsuperscript{15}
\end{quote}

As a result, the RCCAC wrote to Northcote Home, Morialta Protestant Children’s Home and the Salvation Army Boys Home, Kent Town, to ascertain their retention and storage procedures. Records from the Morialta home were found to be inadequately stored in cardboard cartons on an enclosed veranda in Hackney. The Salvation Army Social Services replied:

\begin{quote}
We have a ruling that no records (finished) are destroyed until a period of five years has elapsed, but personal records concerning the boys will be kept confidential in a locked cabinet.\textsuperscript{16}
\end{quote}

The RCCAC responded: ‘We are anxious that these and other personal records from your homes should be preserved until they are at least 60 years old’. It then sought advice from the Archives Department\textsuperscript{17} to develop and implement record preservation procedures. The department recommended the permanent preservation of records relating to individual children or their families, as well as certain administrative records, and suggested that access to records be strictly controlled for 60 years.\textsuperscript{18} The procedures adopted by the RCCAC included:

\begin{itemize}
\item preserving personal records until they are 60 years old
\item transferring records on children and their families and certain administrative records to the Department for Community Welfare and then to the Archives Department
\item requiring the written authority of the director-general of Community Welfare for personal records to be consulted
\item continuing access by welfare workers to homes’ records.\textsuperscript{19}
\end{itemize}

However, homes were responsible for storing their records and files. The Inquiry heard evidence to suggest that homes and secure care facilities improperly stored records and files, for example, in disused rooms. It heard that at the
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McNally Training Centre in the early 1980s, records were piled in the gymnasium in no order.

The Inquiry was also told about record-keeping in homes operated by the Salvation Army—homes in which some witnesses alleged they had been sexually abused. Files relating to children in State care placed in Salvation Army institutions were in general sent to the next institution when a child left the previous place of care. A senior ranking officer of the army told the Inquiry that, in the past, if a child was discharged from a Salvation Army institution, the general policy was to return his or her file to the department. However, the Inquiry determined that this did not always occur in practice. Management of Salvation Army institutions was gradually decentralised before the 1980s, with the officer in charge of each institution responsible for its management. Records were retained for seven years, after which there was no consistent standard for keeping and managing records—each home made its own decision.

During the past 20 years, the Salvation Army has become aware of the need for records management systems. It provided evidence that it has engaged an external consultant to develop recommendations on archiving and records management, as well as disposal schedules and periods of retention. This was being arranged in consultation with the Public Records Office of Victoria (PROV).

Remaining records of children in South Australian Salvation Army institutions, such as admission books, financial documents and individual client records, were sent to Salvation Army headquarters in Melbourne for archiving. Inquiry staff visited these headquarters but only two boxes of relevant records were located—most of the material contained financial records; no client files were discovered.

From the mid 1970s to the 1980s, social workers responsible for the case management of children placed in non-government homes maintained their own case files but were unaware of the homes’ record-keeping practices. A witness told the Inquiry that letters the department received from institutions or homes regarding children were filed appropriately in the children’s files, but otherwise there was no cross-correlation of records between the non-government homes and the department. The witness also said that records maintained by non-government homes relating to State children should have been sent to the department once a child had left their care, but this was not practised. Another witness said that in the late 1970s, the ‘assessment and treatment’ file was introduced so a file could be held in the home where the child was placed and then, once he or she was released from State care or the institution, the file was sent to headquarters for central storage.

Retention and destruction of files relating to children in State care

They have no records of me, and apparently no records of those people ever being foster parents.

PIC placed in State care in the 1990s

The department did not start to devote attention to record storage and retention until the 1970s. A witness told the Inquiry that a newly appointed systems and methods officer reviewed the department’s systems at that time.

As part of this, from the early 1970s to the mid 1980s, the department, with the agreement of the relevant State authorities—the Archives Department and Libraries Board—scheduled the retention and destruction of records. The destruction was authorised under the legal procedures in place at the time. During the late 1960s, due to the large number of records received by the Archives...
Department, disposal schedules were developed for government agencies and some agencies implemented record retention periods. Agencies could destroy records once they had been issued with a disposal schedule and the proposed retention time had elapsed.

Under standard procedure 10, after a minimum retention period of six years, 95 per cent of client files were destroyed, with a randomly selected five per cent retained at the Archives Department for research purposes. The client files included court orders, reports made by social workers and officers, medical records, records of reimbursement and monies to foster parents as well as records of placements. Other files destroyed under this procedure were types 40, 41, 50, 55, 90 and 93. The SWIC appears to be the only type of record that survived.

A former departmental witness told the Inquiry that ‘little importance’ was given to the future historical or personal value of retaining the files. He said that one of the reasons for the destruction of so many records was to avoid a storage charge at the government’s Netley storage facility and said that records were burnt, at either an Adelaide City Council or Dry Creek facility. He recalled in one year that up to 2000 files were destroyed in this way.

Another departmental witness recalled taking ‘a carload’ of files to Glandore Industrial School for burning in a 44-gallon drum.

The Libraries Board did not require the department to keep lists of what files were destroyed and a witness told the Inquiry that the department decided it was not necessary to keep such a list. The Inquiry also heard evidence that the department did not keep lists of what files were kept, but wrote names on the outside of the boxes retained for research. Today, under the SRSA’s adequate records management standard, comprehensive consignment lists must be completed for each archived box of records.

The Inquiry found that personnel files were also affected by the destruction and retention policy from the early 1970s to mid 1980s. Standard procedure 10 stated that confidential and personnel files relating to departmental staff could be disposed of six years after an employee left the department. As a result, the department was unable to provide many employees’ personnel files in response to the Inquiry’s requests. This hindered the Inquiry’s ability to obtain records to investigate allegations involving departmental staff, either as alleged perpetrators or as people to whom allegations may have been reported.

The department informed the Inquiry that many individual records were not available because of the mass destruction and poor tracking of files. When it could not find records, the department issued a statement as part of the sign-off process to the Inquiry:

In the period between 1970 and 1985, the department made policy decisions to allow for the destruction of up to 95 per cent of client files, with only 5 per cent being retained as ‘samples’. This practice has resulted in numerous client files being destroyed. However the department did not keep consignment lists of client files destroyed at the time. Therefore, the department cannot confirm if the client files requested by [the Inquiry] were destroyed under this policy or, indeed, whether they have been destroyed at all.

In 2002, the department introduced a record disposal schedule to retain all client files for 105 years, with Aboriginal and Torres Strait Islander files to be kept permanently. After 105 years, the State Records Council must still approve any destruction. This relates only to client (type 85) files: subfiles (such as psychological services, community work program, secure care and community residential care) have a 75-year retention period, even though they contain potentially valuable information. The department gave evidence to the Inquiry that it is currently drafting a new record disposal schedule, in which it will maintain the practice of retaining client subfiles for 75 years only. The State Records Council must approve this schedule.

Today the recommended retention period for employee files is 85 years after the employee’s date of birth. However,

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20 Exceptions were adoption files, which were to be retained for 20 years, after which a five per cent sample would be retained, and family files, which were to be stored for six years, after which 10 per cent would be retained permanently at the State Archives. It also stated that all Aboriginal files were to be kept permanently.

21 The schedule stated that files of surnames starting with ‘P’ are to be permanently retained as this letter covers a cross-section of nationalities.
some files such as payroll, allowances, or human resources management can be destroyed seven years after the last action or authority of delegation expires.

Recommendations regarding records

The Inquiry considers that because the aforementioned subfiles contain valuable information, they should be retained for 105 years.

**RECOMMENDATION 52**

That departmental client subfiles have a 105-year retention period.

Since 2002, when it released its two records management standards for government agencies and official records, further SRSA initiatives have included a 2003 proposal for an electronic document and records management system (EDRMS) to be implemented across agencies; the release in 2004 of an Across-government records management strategy that outlined six goals to be achieved from 2004 to 2010; and the development of an adequate records management standard for State and local government agencies. The latter requires the SRSA director to advise the Minister if any agency’s records management practices are inadequate. SRSA therefore audits agencies for compliance with the standard. In its submission to the Inquiry, SRSA advised that in 2006, only one of the 30 government agencies it audited complied with the standard.

In relation to electronic records, the Inquiry notes that in the government’s Rapid response progress report released in December 2007, the department stated that it is implementing a new case management system—C3MS (Connection client and case management system)—which aims to ‘provide electronic interfaces to service providers and other agencies to enable seamless referral and exchange of information’ and to ‘implement interfaces to electronic document and record management systems to provide secure control and auditing capability for all Families SA client information’. The department told the Inquiry that implementation would take four to five years.

The Inquiry considers that an EDRMS is critical to ensure the adequate keeping of all records created by the department in relation to children in State care and that it should be implemented with the C3MS.

**RECOMMENDATION 53**

That the Department for Families and Communities implement an appropriate electronic document and records management system (EDRMS), including file tracking, to appropriately manage paper and electronic records, including client and administration files. The EDRMS should interface with C3MS.

In mid 2003 the department appointed its first records manager. The role is responsible for locating and cataloguing department records, including those stored at SRSA and other places.

Arising out of the records request made by the Inquiry, the department advised that it needed to update the main client file series (GRG 856), which consists of about 33 unlisted consignments.

The Inquiry believes it is very important that the department knows what records it holds, to make access by government or people in care achievable.

**RECOMMENDATION 54**

That the Department for Families and Communities continues with the discovery and consignment listing of any records relating to children in State care held permanently at State Records of South Australia or at other temporary storage providers where the department is the agency responsible.
CHILDREN IN STATE CARE COMMISSION OF INQUIRY

Appendices
## Aboriginal advisory committee

### Objectives

The Inquiry established an Aboriginal Advisory Committee, which met for the first time on 21 February 2005 and adopted the following statement of purposes:

1. Ensure that a strong Aboriginal voice is heard by the Inquiry and reflected in its reports.
2. Advise as to the best way for the Inquiry to –
   2.1 make contact with Aboriginal people who are, or have been, children in State care and were sexually abused
   2.2 encourage Aboriginal witnesses to come forward
   2.3 protect the privacy and confidentiality of Aboriginal witnesses
   2.4 provide interpreters and, if necessary, companions or counsellors for Aboriginal witnesses.
3. Indicate the Aboriginal people who can best help make contacts in each Aboriginal community and region and explain how the Inquiry operates.
4. Inform the Commissioner and staff of all matters of Aboriginal culture, law and custom relevant to the work of the Inquiry, including –
   4.1 to whom Aboriginal women and men will, or may not, speak about sexual abuse of them and their children, or deaths of Aboriginal children while in State care
   4.2 whether it is desirable that an Aboriginal person with cultural authority should sit with the Commissioner and the Inquiry staff when disclosures of sexual abuse are being made
   4.3 the best place and environment for making disclosures
   4.4 the circumstances in which it is inappropriate for a disclosure or part of it to be recorded and, if so, what part
   4.5 how to gain an understanding of Aboriginal laws, legislation and social circumstances of Aboriginal people.
5. Inform the Inquiry of any special problems facing Aboriginal children and former children in State care in disclosing sexual abuse or deaths of children in State care, particularly when the alleged perpetrators of the abuse or criminal conduct leading to death were family members.
6. Inform the Inquiry of what outcomes Aboriginal people would like to see discussed in the Inquiry’s report.
7. Assist the Inquiry in locating records relating to Aboriginal people who were children in State care.
8. Direct the Inquiry to people, including Aboriginals, who may be able to provide information relevant to the Inquiry’s terms of reference.
9. Other matters of significance or importance.

The committee met 21 times over the course of the Inquiry. It consisted of up to 20 members.
Advisory committees to the Inquiry

### Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Mr Brian Butler</td>
<td>Aboriginal advocacy manager, Aged Rights Advocacy Service Inc., former ATSI commissioner and founder of the Aboriginal Child Care Agency.</td>
</tr>
<tr>
<td>Mr Stan Butler</td>
<td>Acting State coordinator, SA Aboriginal Partnership, Aboriginal Health Division, Department of Health.</td>
</tr>
<tr>
<td>Ms Amelia Campbell</td>
<td>Voluntary worker with homeless people.</td>
</tr>
<tr>
<td>Ms Kerry Colbung</td>
<td>Director, Department of Education, School &amp; Children’s Services, previously Social Inclusion Unit, Department of the Premier and Cabinet.</td>
</tr>
<tr>
<td>Ms Sharon Gollan</td>
<td>Lecturer, Unaipton School of Indigenous Studies, University of South Australia.</td>
</tr>
<tr>
<td>Dr Doreen Kartinyeri</td>
<td>Formerly SA Museum genealogist, and an eminent genealogist of the South Australian Aboriginal Community (died on 3 December 2007).</td>
</tr>
<tr>
<td>Mr Frank Lampard</td>
<td>Director, Aboriginal Prisoners and Offenders Support Services, Inc.</td>
</tr>
<tr>
<td>Ms April Lawrie-Smith</td>
<td>Executive director, Aboriginal Health Division, Department of Health.</td>
</tr>
<tr>
<td>Ms Sandy Miller</td>
<td>Former director, Strategic Policy and Planning, Aboriginal Health Division, Department of Health.</td>
</tr>
<tr>
<td>Mr Frank Nam</td>
<td>Manager, Kumangka Aboriginal Youth Service.</td>
</tr>
<tr>
<td>Ms Isabelle Norvill</td>
<td>Aboriginal elder; elder project officer, Aboriginal Drug and Alcohol Council (SA).</td>
</tr>
<tr>
<td>Mr Lewis O’Brien</td>
<td>Kaurna elder.</td>
</tr>
<tr>
<td>Mr Doug Rogers</td>
<td>Field officer, Aboriginal Legal Rights Movement Inc.</td>
</tr>
<tr>
<td>Mr Tauto Sansbury</td>
<td>Former ATSI commissioner; chairperson, Patpa Warra Yunti Regional Council.</td>
</tr>
<tr>
<td>Mr Major Sumner</td>
<td>Field officer, Aboriginal Sobriety Group, Nunkuwarrin Yunti.</td>
</tr>
<tr>
<td>Ms Sharon Williams</td>
<td>Director, Aboriginal Family Support Services.</td>
</tr>
<tr>
<td>Mr Andrew Wilson</td>
<td>Senior Aboriginal project officer, State Records of South Australia.</td>
</tr>
<tr>
<td>Ms Coral Wilson</td>
<td>Aboriginal elder; former Aboriginal liaison officer, Adelaide Remand Centre, Department for Correctional Services.</td>
</tr>
<tr>
<td>Ms Sharnaire Wilson</td>
<td>Field officer, Aboriginal Legal Rights Movement Inc.</td>
</tr>
<tr>
<td>Ms Barbara Wingard</td>
<td>Chairperson, Aboriginal Legal Rights Movement Inc.</td>
</tr>
</tbody>
</table>
Young People Advisory Group

Objectives

The objectives of the Young People Advisory Group were to:

1. Ensure that a strong voice of children and young people is heard by the Inquiry and reflected in its reports.

2. Advise the best way for the Inquiry to –
   2.1 contact people who are, or have been, children in State care and were sexually abused or who have knowledge about sexual abuse and deaths of other children in State care
   2.2 encourage young people to come forward
   2.3 establish procedures in the Inquiry that are appropriate for young people.

3. Indicate the people who can best help make contact with people who are, or have been, children in State care.

4. Inform the Commissioner and staff of matters of culture and attitudes of young people, particularly in the context of sexual abuse of children and its consequences.

5. Inform the Inquiry of the best place and environment for making disclosure of sexual abuse.

6. Inform the Inquiry of any special problems facing people who are, or have been, children in State care, including problems in making disclosures when the alleged perpetrators of sexual abuse or criminal conduct leading to death are family members.

7. Overcome a lack of trust and confidence in authority and adults experienced by many people who are, or have been, children in State care so as to facilitate the work of the Inquiry.

The group met nine times between August 2006 and June 2007. It consisted of up to 13 members: their names cannot be published for confidentiality reasons.
A sexual offence for the purpose of the Inquiry is defined in the Commission of Inquiry (Children in State Care and Children on the APY Lands) Act 2004 to mean a sexual offence within the meaning of section 4 of the Evidence Act 1936. That is:

(a) rape
(b) indecent assault
(c) any offence involving unlawful sexual intercourse or an act of gross indecency
(d) incest
(e) any offence involving sexual exploitation or abuse of a child, or exploitation of a child as an object of prurient interest
(f) any attempt to commit, or assault with intent to commit, any of the foregoing offences.

The legal names and penalties for those offences changed over the period covered by the allegations received by the Inquiry. The following is an analysis of those changes.

(a) Rape
At 18 November 2004, the offence of rape was defined in section 48 of the Criminal Law Consolidation Act 1935 (CLC Act). It involved the proof of three matters. First, an act of sexual intercourse. Second, that the act of sexual intercourse was without the consent of the child. Third, that the alleged offender knew the child did not consent or was recklessly indifferent to whether the child was consenting. This offence of rape has been in section 48 of the CLC Act since 1936. The penalty has always been life imprisonment.

(b) Indecent assault
At 18 November 2004, the offence of indecent assault was defined in section 56 of the CLC Act. An indecent assault involves the proof of an assault in circumstances of indecency. The offence has been set out in section 56 of the CLC Act since 1936 relating to females and in section 70(c) relating to males. A person who indecently assaulted any female could be imprisoned for up to five years for a first offence and up to seven years for any subsequent offence. A person who indecently assaulted a male could be imprisoned for up to seven years. In 1975, section 56 was amended to refer to a person who indecently assaulted any person. In 1982, the penalty was increased to eight years generally but up to 10 years where the victim was aged under 12.

Since 1936, the law has deemed that a child is not capable of consenting to an act of indecent assault. In other words, in proving an offence of indecent assault the question of whether the child consented is irrelevant.

(c) Any offence involving unlawful sexual intercourse or gross indecency
The offence of unlawful sexual intercourse has been set out in section 49 of the CLC Act since 9 December 1978. It is an offence to have sexual intercourse with any person under 17 years. The maximum penalty for the offence is life imprisonment if the child is under 12 and seven years if the child is 12 or older. The question of whether the child consented to the act of sexual intercourse is irrelevant. In 1976, the definition of sexual intercourse included anal intercourse and oral intercourse but it was expanded from 1 December 1985.

Similar offences, although differently named, have existed since 1936. The corresponding offences in earlier enactments in relation to girls were carnal knowledge and buggery; in relation to boys it was the offence of buggery. Maximum penalties ranged from seven years to life imprisonment, depending on the age of the child.

The offence of gross indecency has existed since 1936. Again, consent of the victim is no defence. For female victims the offence was set out in section 58 and for male

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1 This was repealed and replaced with s. 69(1)(b)(ii) relating to males between 1972 and 1975.
2 s. 5: ‘Sexual intercourse’ includes (a) the introduction of the penis of one person into the anus of another and (b) the introduction of the penis of one person into the mouth of another.
3 s. 5: ‘Sexual intercourse’ includes any activity (whether of a heterosexual or homosexual nature) consisting of or involving (a) penetration of the vagina or anus of a person by any part of the body of another person or by any object; (b) fellatio; or (c) cunnilingus. The word ‘vagina’ was replaced with ‘labia majora’ from 26 May 1994.
5 s. 69 from 2 Jan. 1936 – 8 Nov. 1972.
victims in section 71. On 2 October 1975, both female and male victims were covered by section 58. The penalties have a maximum of two to three years.

(d) Incest
The offence of incest has been set out in section 72 of the CLC Act since 1936. The maximum penalty has been seven years.

(e) Any offence involving sexual exploitation or abuse of a child, or exploitation of a child as an object of prurient interest
Offences involving sexual exploitation or abuse of a child would include:

(i) ‘Abduction of male or female person’9, relating to the abduction of a person with intent to marry or have sexual intercourse, with a maximum penalty of 14 years

(ii) ‘Procuring females to be prostitutes’ (amended in 1975 to include males)10 with a maximum penalty of seven years

(iii) ‘Procuring defilement of females by threats or fraud’11, with a maximum penalty of seven years

(iv) ‘Procuring sexual intercourse’12, relating to procuring a person to have sexual intercourse by threats, intimidation, false pretences, false representations or other fraudulent means, with a maximum penalty of seven years

(v) Commercial sexual services and related offences13, which include the use of children in commercial sexual services, with penalties up to life imprisonment, depending on the age of the child

(vi) ‘Indecent interference with children and females’14, with a maximum penalty of one year or a fine

(vii) ‘Persistent sexual abuse of a child’.15
Also, since 1 December 1983, section 58A of the CLC Act has made it an offence to incite or procure the commission by a child of an indecent act; or cause or induce a child to expose any part of his or her body with a view to gratifying prurient interest. The maximum penalty is two to three years.

(f) Any attempt to commit, or assault with intent to commit, any of those offences.
This would also include sections 69 or 70 of the CLC Act, which from 2 January 1936 to 1 October 197516, referred specifically to the offence of attempted buggery and assault with intent to commit buggery, with a maximum penalty of seven years.
The Inquiry heard evidence from 224 general or expert witnesses. The following list does not include people who gave evidence in confidence.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title / Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott, Ms Maureen</td>
<td>Indigenous family liaison officer, Family Court of Australia, Northern Territory.</td>
</tr>
<tr>
<td>Allen, Mr Phillip</td>
<td>Case management consultant, Indigenous Services, Families SA.</td>
</tr>
<tr>
<td>Anderson, Ms Elizabeth</td>
<td>Foster carer, Queensland, and former president, Foster Care Queensland (FCQ).</td>
</tr>
<tr>
<td>Bertram, Dr David</td>
<td>Psychiatrist.</td>
</tr>
<tr>
<td>Bonnar, Ms Margaret</td>
<td>Social worker, Port Youth Accommodation Program.</td>
</tr>
<tr>
<td>Breckenridge, Dr Jan</td>
<td>Director, Centre for Gender-Related Violence, School of Social Sciences and International Studies, University of New South Wales.</td>
</tr>
<tr>
<td>Briggs, AO, Emeritus Professor Freda</td>
<td>Child development researcher and lecturer in sociology, child protection and family studies, University of South Australia.</td>
</tr>
<tr>
<td>Burvill, Dr Michael</td>
<td>Manager, Rehabilitation Programs Branch, Department for Correctional Services.</td>
</tr>
<tr>
<td>Byrne, Ms Robyn</td>
<td>Manager, Independent Advocacy SA Inc.</td>
</tr>
<tr>
<td>Calvert, Ms Gillian</td>
<td>Former New South Wales Commissioner for Children and Young People.</td>
</tr>
<tr>
<td>Castell-McGregor, Ms Sally</td>
<td>Principal policy and planning officer, Aboriginal Health Division, Department of Health.</td>
</tr>
<tr>
<td>Copley, Mr Ivan</td>
<td>Indigenous engagement manager of South Australia, State Statistics Coordination Unit, Australian Bureau of Statistics.</td>
</tr>
<tr>
<td>Cossey, Mr Bill</td>
<td>Chair, Dame Roma Mitchell Trust Board.</td>
</tr>
<tr>
<td>Coultard, Ms Katie</td>
<td>Co-ordinator, Aboriginal Family Support Services.</td>
</tr>
<tr>
<td>Cox, Mr Ian</td>
<td>Former director-general, Department for Community Welfare.</td>
</tr>
<tr>
<td>Daniel, Professor Brigid</td>
<td>Professor of child care and protection, Faculty of Education in Social Work, University of Dundee, United Kingdom.</td>
</tr>
<tr>
<td>Davies, Ms Corelle</td>
<td>Director, Child Safety, and representative, Suspected Child Abuse and Neglect (SCAN) sub-committee, Department of Health, Queensland.</td>
</tr>
<tr>
<td>Davis, Mr Alf</td>
<td>Indigenous representative, Suspected Child Abuse and Neglect (SCAN) sub-committee, Aboriginal and Islander Health Council, Queensland.</td>
</tr>
<tr>
<td>De Poor, Ms Sinead</td>
<td>Community Health Nurse, Oodnadatta Community Health Centre.</td>
</tr>
<tr>
<td>Delfabbro, Professor Paul</td>
<td>Associate Professor, School of Psychology, University of Adelaide, North Terrace Campus.</td>
</tr>
</tbody>
</table>
### General and expert witnesses

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denholm, Mr Steven</td>
<td>Manager, transitional accommodation, guardianship and alternative care directorship, Families SA.</td>
</tr>
<tr>
<td>Djakovic, Ms Tanya</td>
<td>Records manager, Families SA.</td>
</tr>
<tr>
<td>Donald, Dr Terence</td>
<td>Director, Child Protection Services, Women's and Children's Hospital.</td>
</tr>
<tr>
<td>Dunlop, Mr William</td>
<td>Barrister and solicitor, Canada.</td>
</tr>
<tr>
<td>Durdin, Ms Chris</td>
<td>Women's health nurse, Primary Health Unit, Coober Pedy Health Services.</td>
</tr>
<tr>
<td>Edgington, Mr Steve</td>
<td>Manager, Special Investigation Unit, Department for Families and Communities.</td>
</tr>
<tr>
<td>Etherington, Ms Robyn</td>
<td>Forde policy officer, Child Safety Unit, Department of Communities, Queensland.</td>
</tr>
<tr>
<td>Fitzgerald, Ms Karen</td>
<td>Director, Child Protection Services, Flinders Medical Centre.</td>
</tr>
<tr>
<td>Fitzpatrick, Ms Colleen</td>
<td>Director, Lutheran Community Care.</td>
</tr>
<tr>
<td>Forde, AC, Ms Leneen</td>
<td>Commissioner, Forde Inquiry, Queensland.</td>
</tr>
<tr>
<td>Fraser, Ms Elizabeth</td>
<td>Commissioner, Commission for Children and Young People, and Child Guardian, Queensland.</td>
</tr>
<tr>
<td>Fry, Mr Geoff</td>
<td>Supervisor, Aberfoyle Park District Centre, Families SA.</td>
</tr>
<tr>
<td>Gallagher, Mr David</td>
<td>Care and protection co-ordinator, Courts Administration Authority, Youth Court of South Australia.</td>
</tr>
<tr>
<td>Gazard, Ms Elizabeth</td>
<td>Chief executive officer, Wyatt Benevolent Institution Inc.</td>
</tr>
<tr>
<td>Gordon, AM, Dr Sue</td>
<td>Magistrate, Children's Court of Western Australia; former Commissioner of Gordon Inquiry.</td>
</tr>
<tr>
<td>Hall, Mr Rob</td>
<td>Director, Nada Counselling, Consulting &amp; Training, and manager, Mary Street Adolescent Program.</td>
</tr>
<tr>
<td>Har nett, Ms Claire Louise</td>
<td>Housing manager, Department for Families and Communities.</td>
</tr>
<tr>
<td>Harvey, Ms Janine</td>
<td>Assistant director, Child and Student Wellbeing, Department of Education and Children's Services.</td>
</tr>
<tr>
<td>Hayes, Associate Professor Susan</td>
<td>Head, Centre for Behavioural Sciences, Department of Medicine, University of Sydney.</td>
</tr>
<tr>
<td>Holmes, Mr Garth</td>
<td>Manager, Port Youth Accommodation Service.</td>
</tr>
<tr>
<td>Horsnell, Ms Jan</td>
<td>Chief executive, Anglicare SA.</td>
</tr>
<tr>
<td>Jenkins, Mr Alan</td>
<td>Director, Nada Counselling, Consulting &amp; Training, and manager, Mary Street Adolescent Program.</td>
</tr>
<tr>
<td>Johnston, Mr Bruce</td>
<td>Manager, Enfield District Centre, Families SA.</td>
</tr>
<tr>
<td>Joy, Ms Maxine</td>
<td>Director, Nada Counselling, Consulting &amp; Training, and counsellor, Mary Street Adolescent Program.</td>
</tr>
</tbody>
</table>
### General and expert witnesses

<table>
<thead>
<tr>
<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Jureidini, Dr Jon</strong></td>
<td>Child psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital.</td>
</tr>
<tr>
<td><strong>Kartinyeri, Dr Doreen</strong></td>
<td>Aboriginal author, genealogy studies; 2007 NAIDOC Award for Person of the Year.</td>
</tr>
<tr>
<td><strong>Kaufman QC, The Hon Fred</strong></td>
<td>Legal practitioner, Canada.</td>
</tr>
<tr>
<td><strong>Keating, Mr Lee</strong></td>
<td>Former chief supervisor, Shelburne School for Boys, Nova Scotia, Canada.</td>
</tr>
<tr>
<td><strong>Kennedy, Mr Barry</strong></td>
<td>Director of programs, Salvation Army.</td>
</tr>
<tr>
<td><strong>Kennedy, Mr David</strong></td>
<td>Director, Centre for Crime Prevention and Control/Professor, Department of Anthropology, John Jay College of Criminal Justice, New York.</td>
</tr>
<tr>
<td><strong>Kent, Dr Julian</strong></td>
<td>Psychiatrist, clinical lecturer, Discipline of Psychiatry, University of Adelaide, and private practitioner.</td>
</tr>
<tr>
<td><strong>Kiley, Ms Stephanie</strong></td>
<td>Manager, Office of Foster Care Relations, Department for Families and Communities.</td>
</tr>
<tr>
<td><strong>King, Ms Elizabeth</strong></td>
<td>Care worker, Regency Park Community Unit.</td>
</tr>
<tr>
<td><strong>Knill, Mr Graham</strong></td>
<td>Former secretary, Residential Child Care Advisory Committee.</td>
</tr>
<tr>
<td><strong>Langton, Ms Denise</strong></td>
<td>Member, Grandparents for Grandchildren.</td>
</tr>
<tr>
<td><strong>Layton, Mr Ron</strong></td>
<td>Former departmental director, executive projects, Department for Community Welfare.</td>
</tr>
<tr>
<td><strong>Le Maistre, Mr Barry</strong></td>
<td>Former principal, Salvation Army Boys Home (Eden Park).</td>
</tr>
<tr>
<td><strong>Lemar, Dr Susan</strong></td>
<td>Associate lecturer, School of History and Politics, University of Adelaide.</td>
</tr>
<tr>
<td><strong>Lennon, Ms Kate</strong></td>
<td>Former chief executive officer, Department for Families and Communities.</td>
</tr>
<tr>
<td><strong>Little, Ms Hazel</strong></td>
<td>Vice-president, Foster Care Queensland (FCQ) and foster carer.</td>
</tr>
<tr>
<td><strong>Lloyd, Dr Jane</strong></td>
<td>Principal specialist, Australian Crime Commission on the National Indigenous Intelligence Task Force, Northern Territory.</td>
</tr>
<tr>
<td><strong>Louis, Dr Andrea</strong></td>
<td>Director, Sexual Offenders Treatment and Assessment Programme (SOTAP).</td>
</tr>
<tr>
<td><strong>Loveday, Mr Graham</strong></td>
<td>Manager, disability services, UnitingCare Wesley Adelaide.</td>
</tr>
<tr>
<td><strong>Lovell, Mr Lionel</strong></td>
<td>Supervisor, special projects, Families SA.</td>
</tr>
<tr>
<td><strong>Mackean, Ms Laney</strong></td>
<td>Manager, Southern Adelaide Health, Flinders Medical Centre.</td>
</tr>
<tr>
<td><strong>MacWilliams, Mr Alan</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Manuel, Mr Robert</strong></td>
<td>Mental health social worker, Lower North Health Service.</td>
</tr>
<tr>
<td><strong>March, Mr Allen</strong></td>
<td>Manager, South East District Centre, Families SA.</td>
</tr>
<tr>
<td><strong>Marsden, Ms Carol</strong></td>
<td>Executive director, PeakCare Queensland Inc.</td>
</tr>
<tr>
<td><strong>Marshall, Mr William</strong></td>
<td>Rockwood Psychological Services, Canada.</td>
</tr>
</tbody>
</table>
## General and expert witnesses

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>McCluskey, Ms Patricia</td>
<td>Manager, Take Two, Berry Street Victoria.</td>
</tr>
<tr>
<td>Meldrum, Mr David</td>
<td>Chief executive officer, Advanced Community Care Association of SA (ACCASA).</td>
</tr>
<tr>
<td>Miller, Mr Peter</td>
<td>Director, Peteus Pty Ltd.</td>
</tr>
<tr>
<td>Morgan, Ms Catherine</td>
<td>Principal co-ordinator, Aboriginal Program &amp; Service, Families SA.</td>
</tr>
<tr>
<td>Mulkerin, Ms Deidre</td>
<td>Director, Child Safety Services Division, Department of Child Safety, Queensland.</td>
</tr>
<tr>
<td>Murphy, Ms Annette</td>
<td>Acting manager, team support &amp; development unit, Department of Health, and representative, Suspected Child Abuse and Neglect (SCAN) sub-committee, Queensland.</td>
</tr>
<tr>
<td>Neill, Ms Kenise</td>
<td>Supervisor, Coober Pedy District Centre, Families SA.</td>
</tr>
<tr>
<td>Nelson QC, Ms Frances</td>
<td>Chair, Parole Board of South Australia.</td>
</tr>
<tr>
<td>Ngatokurua, Ms Lavene</td>
<td>Umeewarra–Davenport Aboriginal Community.</td>
</tr>
<tr>
<td>Nicolau, Ms Anne</td>
<td>Principal social worker, Families SA.</td>
</tr>
<tr>
<td>Nolan, Ms Christine</td>
<td>Director, Policy Practice and Development Branch, Department of Child Safety, Queensland.</td>
</tr>
<tr>
<td>North, Ms Marianne</td>
<td>Child and family counsellor, Offenders Aid and Rehabilitation Service of SA Inc. (OARS).</td>
</tr>
<tr>
<td>O’Brien, Dr Ken</td>
<td>Acting director and clinical director, Forensic Mental Health Service, South Australia.</td>
</tr>
<tr>
<td>O’Loughlin, Ms Carmel</td>
<td>Director, foster care relations, Department for Families and Communities.</td>
</tr>
<tr>
<td>Oudasi, Ms Lourdes</td>
<td>Manager, social health team, Ceduna Community Health Service.</td>
</tr>
<tr>
<td>Owens, Reverend Don</td>
<td></td>
</tr>
<tr>
<td>Pardoe-Matthews, Ms Vanessa</td>
<td>Mental health liaison worker, Port Pirie Regional Health Service Inc.</td>
</tr>
<tr>
<td>Peake, Mr Andrew</td>
<td>Social worker, Central Northern Health Service.</td>
</tr>
<tr>
<td>Pearce, Dr Jenny</td>
<td>Professor of Young People and Public Policy, Department of Applied Social Studies, University of Bedfordshire, United Kingdom.</td>
</tr>
<tr>
<td>Phippen, Ms Nora</td>
<td>Foster carer.</td>
</tr>
<tr>
<td>Procopis, Ms Gilli</td>
<td>Family resource worker, Coober Pedy Health Services.</td>
</tr>
<tr>
<td>Quinian, Ms Deidre</td>
<td>Project officer, Job Placement, Employment &amp; Training (JPET), Lutheran Community Care.</td>
</tr>
<tr>
<td>Rathman, Mr David</td>
<td>Executive director, Aboriginal Education and Employment Strategies, Department of Education and Children’s Services.</td>
</tr>
<tr>
<td>Reimers, Mr Everard</td>
<td>Former departmental worker.</td>
</tr>
</tbody>
</table>
General and expert witnesses

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Ricciotti, Ms Angela</td>
<td>Co-ordinator, Marni Wodli, Families SA.</td>
</tr>
<tr>
<td>Rigley, Major Graeme</td>
<td>Officer in charge, social program department, Salvation Army, Victoria.</td>
</tr>
<tr>
<td>Rigney, Mr David</td>
<td>Chief executive officer, Disability Advocacy Complaints Service, SA.</td>
</tr>
<tr>
<td>Ruthven, Mr Patrick</td>
<td>Program co-ordinator, Citizen Advocacy South Australia.</td>
</tr>
<tr>
<td>Schellen, Mr Kym</td>
<td>Bringing Them Home counsellor, Kalparrin Community Inc.</td>
</tr>
<tr>
<td>Schrapel, Mr Simon</td>
<td>Executive manager, family and community development, Anglicare SA.</td>
</tr>
<tr>
<td>Schulz, Ms Pamela</td>
<td>Former departmental worker.</td>
</tr>
<tr>
<td>Scott, Professor Dorothy</td>
<td>Director, Australian Centre for Child Protection, University of South Australia.</td>
</tr>
<tr>
<td>Sheedy, Ms Leonie</td>
<td>Co-founder, Care Leavers Australia Network (CLAN).</td>
</tr>
<tr>
<td>Simmons, Ms Pam</td>
<td>Guardian for Children and Young People, South Australia.</td>
</tr>
<tr>
<td>Skurray, Ms Pam</td>
<td>Former departmental worker.</td>
</tr>
<tr>
<td>Smith, Mr Brian</td>
<td>President, Foster Care Queensland.</td>
</tr>
<tr>
<td>Smith, Ms Tracey</td>
<td>PeakCare Queensland Inc.</td>
</tr>
<tr>
<td>Snail, Mr Ivor</td>
<td>Former superintendent, Kennion House.</td>
</tr>
<tr>
<td>Stewart, Dr Nigel</td>
<td>Senior paediatrician, Port Augusta Hospital.</td>
</tr>
<tr>
<td>Stonehouse, Ms Anne-Louise</td>
<td>Executive officer, Foster Care Queensland.</td>
</tr>
<tr>
<td>Stratton, Mr Mark</td>
<td>Manager, Coober Pedy District Centre, Families SA.</td>
</tr>
<tr>
<td>Swan, Ms Vanessa</td>
<td>Director, Yarrow Place, Rape and Sexual Assault Service.</td>
</tr>
<tr>
<td>Symons, Mr Victor</td>
<td>Former chief executive officer, Child and Youth Services.</td>
</tr>
<tr>
<td>Temple, Ms Rose</td>
<td>Anangu Youth Leadership project officer, Umoona Council, Coober Pedy.</td>
</tr>
<tr>
<td>Thomas, Ms Lisa</td>
<td>Principal adviser, Student Services Directorate, Queensland Department of Education, and representative, Suspected Child Abuse and Neglect (SCAN) sub-committee, Queensland.</td>
</tr>
<tr>
<td>Tucci, Dr Joe</td>
<td>Chief executive officer, Australian Childhood Foundation, Victoria.</td>
</tr>
<tr>
<td>Tully, Mr David</td>
<td>Counsellor, Childhood Sexual Abuse Counselling, UnitingCare Wesley, Adelaide.</td>
</tr>
<tr>
<td>Varano, Ms Lina</td>
<td>Social worker, Streetlink Youth Health Service.</td>
</tr>
<tr>
<td>Vucic, Ms Basia</td>
<td>Manager, CaFE Enfield Children’s Centre.</td>
</tr>
<tr>
<td>Walsh, Ms Karyn</td>
<td>Co-ordinator, Esther Centre, Queensland.</td>
</tr>
<tr>
<td>Walsh, Mr Martin</td>
<td>Psychologist, Walsh &amp; Associates.</td>
</tr>
<tr>
<td>Weightman, Mr John</td>
<td>Former departmental worker.</td>
</tr>
</tbody>
</table>
## General and expert witnesses

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weir, Mr Rob</td>
<td>Detective Inspector, Sexual Crime Investigation Unit, Queensland Police, and representative, Suspected Child Abuse and Neglect (SCAN) sub-committee, Queensland.</td>
</tr>
<tr>
<td>Weston, Ms Nina</td>
<td>President, Children In Crisis Inc.</td>
</tr>
<tr>
<td>Wilson, Mr Andrew</td>
<td>Senior project officer, Aboriginal Access Team, State Records of South Australia.</td>
</tr>
<tr>
<td>Wise, Mr Max</td>
<td>Assistant Commissioner, Commission for Children and Young People and Child Guardian, Queensland.</td>
</tr>
<tr>
<td>Woenne-Green, Ms Susan</td>
<td>Research manager, Aboriginal Legal Rights Movement.</td>
</tr>
<tr>
<td>Wyld, Ms Helen</td>
<td>Special project officer, Nunkuwarrin Yunti.</td>
</tr>
</tbody>
</table>
The Inquiry received 35 written submissions. The names of two people who provided submissions have not been published for confidentiality reasons.

### Name / organisation

- Association of Independent Schools SA
- Australian Association of Social Workers
- Australian Childhood Foundation
- Bosisto, Ms Dianne
- Briggs, Professor Freda
- Careworkers Coalition
- Catholic Archdiocese of Adelaide
- Children in Crisis Inc
- Cox, Mr Ian
- Department of Education and Children’s Services
- Department of Justice
- Families SA
- Health and Community Services Complaints Commission
- Intellectual Disability Services Council Inc (IDSC)
- Knill, Mr Graham
- McKenzie, Ms Linda
- Monash University
- Murray, Senator Andrew
- Offenders Aid and Rehabilitation Services of SA Inc. (OARS)
- Office of the Guardian for Children and Young People
- Phippen, Ms Nora
- Premier’s Council for Women
- Relationships Australia SA
- Secomb, Mr Chris
- Sisters of St Joseph - South Australia Province
- South Australia Police
- State Records of South Australia (SRSA)
- Stojadinovic, Ms Tanja
- Symons, Mr Vic
- Thomas, Ms Leah
- Victim Support Service Inc (SA)
- White, Mrs J
- Young Women’s Christian Association (YWCA) of Adelaide
The following list of agencies, organisations and individuals provided support services and assistance to people who were referred by the Inquiry.

**Counselling & support services**
- Respond SA
- UnitingCare Wesley Sexual Abuse Team
- Women’s Health State Wide
- Dulwich Centre
- Centacare Catholic Family Services including Centacare Port Lincoln, Salisbury, Mt Gambier, Whyalla and Port Augusta
- Relationships Australia (SA)
- Nada Counselling, Consulting & Training SA
- Sparks Resource Centre
- Margaret Tobin Centre
- Queen Elizabeth Hospital Mood Disorders Unit

**Interstate services**
- Queensland Aftercare & Resource Centre (Relationships Australia)
- Centres Against Sexual Assault (Victoria)
- Relationships Australia, Toowoomba, Queensland
- Men’s Line Australia (national phone counselling service)

**Community health centres**
- Metropolitan: Port Adelaide, The Parks, Southern Women’s, Northern Women’s, Dale St
- Port Pirie Community and Allied Health Service
- Murray Mallee Community Health Service
- Southern Yorke Peninsula Community Health Service
- South Eastern Community Health Service, Naracoorte

**Private practitioners in SA and interstate**
- Counsellors, social workers and psychologists
- Psychiatrists
- General practitioners

**Housing**
- Aboriginal Housing Authority
- SA Housing Trust
- Housing Advocacy of SA
- Tenancies Board

**Aboriginal support services**
- SA Link-Up
- Aboriginal Kinship Program
- Nunkwarrin Yunti
- Pika Wiya Health Service Inc. (Port Augusta)
- Nunga Minimis (women’s shelter)
- Muna Paendi

**Crisis services**
- Crisis Care
- Hindmarsh Centre Sobering Up Unit
- Lifeline
- Mental Health - ACIS (Assessment Crisis Intervention Service)
- Yarrow Place (Rape and Sexual Assault Service)

**Support groups**
- Care Leavers Australia Network (CLAN)
- Advocates for Survivors Of Child Abuse (ASCA)
- CREATE Foundation
- Victim Support Service Inc.
**Witness support services**

**Department for Correctional Services**
- Social workers
- Medical staff
- Sexual Behaviour Clinic, Rehabilitation Programs Branch
- Aboriginal liaison officers

**South Australia Police**
- Sexual Crime Investigations Branch – Sexual Assault Investigation Section and Paedophile Task Force
- Victim Management Section

**Department for Families and Communities**
- Families SA Customer Relations Unit
- Post Care Services

**Miscellaneous support agencies**
- Mary Street Adolescent Program
- Sexual Offenders Treatment and Assessment Programme (now called Owenia House)
- Legal Services Commission
- Franklin St Medical Practice
- Noarlunga Health Village
- Port Adelaide Strengthening Families Project
- Port Pirie Allied and Community Health Service
- SouthEastern Community Health Service
- Shine SA
Staff of the Inquiry

During the Inquiry, 57 staff were employed by way of temporary contracts with the South Australian Government, temporary employment through recruitment agencies, or as individual consultants to undertake the following positions:

<table>
<thead>
<tr>
<th>Position</th>
<th>No of employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project manager</td>
<td>1</td>
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<tr>
<td>Media liaison</td>
<td>1</td>
</tr>
<tr>
<td>Investigators</td>
<td>10</td>
</tr>
<tr>
<td>Legal support staff</td>
<td>9</td>
</tr>
<tr>
<td>Historians</td>
<td>3</td>
</tr>
<tr>
<td>Research analyst &amp; support staff</td>
<td>6</td>
</tr>
<tr>
<td>Researchers</td>
<td>9</td>
</tr>
<tr>
<td>Records &amp; information management staff</td>
<td>10</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>5</td>
</tr>
<tr>
<td>Editor</td>
<td>1</td>
</tr>
<tr>
<td>Witness support managers</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>57</strong></td>
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### The Department for Families and Communities and its predecessors

<table>
<thead>
<tr>
<th>Period</th>
<th>Department name</th>
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<tbody>
<tr>
<td>1886–1926</td>
<td>The State Children's Department; State Children's Council (SCC)</td>
</tr>
<tr>
<td>1927–65</td>
<td>Department for Children's Welfare and Public Relief; Children's Welfare and Public Relief Board (CWPRB)</td>
</tr>
<tr>
<td>1966–70</td>
<td>Department of Social Welfare (DSW)</td>
</tr>
<tr>
<td>1970–72</td>
<td>Department of Social Welfare and Aboriginal Affairs (DSWAA)</td>
</tr>
<tr>
<td>1972–90</td>
<td>Department for Community Welfare (DCW)</td>
</tr>
<tr>
<td>1990–98</td>
<td>Department of Family and Community Services (FACS)</td>
</tr>
<tr>
<td>1998–2003</td>
<td>Department of Human Services (DHS) with the division Family and Youth Services (FAYS)</td>
</tr>
<tr>
<td>2004–06</td>
<td>Department for Families and Communities (DFC) with the division Children, Youth and Family Services (CYFS)</td>
</tr>
<tr>
<td>2006–present</td>
<td>Department for Families and Communities (DFC) with the division Families SA</td>
</tr>
</tbody>
</table>

In relation to Aboriginal people, from 1911 the separate Aboriginals Department had responsibility for ‘controlling and promoting the welfare of the Aboriginals’. This became the Aboriginal Department in 1939, but the duty concerning the welfare of Aboriginals was transferred to the Aborigines Protection Board (APB). From 1963-70, the department became the Department of Aboriginal Affairs and the board became the Aboriginal Affairs Board, which had an advisory role to the Minister.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anglican Archives</td>
</tr>
<tr>
<td>AASW</td>
<td>Australian Association of Social Workers</td>
</tr>
<tr>
<td>ACC</td>
<td>Aboriginal Catholic Community</td>
</tr>
<tr>
<td>ACPP</td>
<td>Aboriginal child placement principle</td>
</tr>
<tr>
<td>AFSS</td>
<td>Aboriginal Family Support Services</td>
</tr>
<tr>
<td>AISSA</td>
<td>Association of Independent Schools SA</td>
</tr>
<tr>
<td>ANCOR</td>
<td>Australian National Child Offender Register</td>
</tr>
<tr>
<td>APB</td>
<td>Aborigines Protection Board (1934–63)</td>
</tr>
<tr>
<td>APY Lands</td>
<td>Arangu Pitjantjatjara Yankunytjatjara Lands</td>
</tr>
<tr>
<td>ASAP</td>
<td>Adolescent Sexual Abuse Prevention Program (Mary Street)</td>
</tr>
<tr>
<td>ASCA</td>
<td>Advocates for Survivors of Child Abuse</td>
</tr>
<tr>
<td>BDM</td>
<td>Births, Deaths and Marriages, Office of</td>
</tr>
<tr>
<td>CAA</td>
<td>Courts Administration Authority</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CARL</td>
<td>Child Abuse Report Line</td>
</tr>
<tr>
<td>CDSIRC</td>
<td>Child Death and Serious Injury Review Committee</td>
</tr>
<tr>
<td>CYWHS</td>
<td>Children, Youth and Women's Health Services</td>
</tr>
<tr>
<td>CHSA</td>
<td>Country Health SA</td>
</tr>
<tr>
<td>CIB</td>
<td>Children's Interest Bureau</td>
</tr>
<tr>
<td>CIS</td>
<td>Client Information System</td>
</tr>
<tr>
<td>CISC Inquiry</td>
<td>Children in State Care Commission of Inquiry</td>
</tr>
<tr>
<td>CLAN</td>
<td>Care Leavers Australia Network</td>
</tr>
<tr>
<td>CLC Act</td>
<td>Criminal Law Consolidation Act 1935</td>
</tr>
<tr>
<td>CNAHS</td>
<td>Central Northern Adelaide Health Services</td>
</tr>
<tr>
<td>CPS FMC</td>
<td>Child Protection Services Flinders Medical Centre</td>
</tr>
<tr>
<td>CPS WCH</td>
<td>Child Protection Services Women's and Children's Hospital</td>
</tr>
<tr>
<td>CRJ</td>
<td>Centre for Restorative Justice</td>
</tr>
<tr>
<td>CWPRB</td>
<td>Children's Welfare and Public Relief Board (1927–66)</td>
</tr>
<tr>
<td>CYFS</td>
<td>Children, Youth and Family Services (within DFC)</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>DAA</td>
<td>Department of Aboriginal Affairs (1963–70)</td>
</tr>
<tr>
<td>DCW</td>
<td>Department for Community Welfare (1972–90)</td>
</tr>
<tr>
<td>DECS</td>
<td>Department of Education and Children's Services</td>
</tr>
<tr>
<td>DFACS</td>
<td>Department of Family and Community Services (1990–98)</td>
</tr>
<tr>
<td>DFC</td>
<td>Department for Families and Communities (2004–present)</td>
</tr>
<tr>
<td>DFEEST</td>
<td>Department of Further Education, Employment, Science and Technology</td>
</tr>
<tr>
<td>DPP</td>
<td>Director of Public Prosecutions</td>
</tr>
<tr>
<td>DSW</td>
<td>Department of Social Welfare (1966–70)</td>
</tr>
<tr>
<td>DSWAA</td>
<td>Department of Social Welfare and Aboriginal Affairs (1970–72)</td>
</tr>
<tr>
<td>EASY</td>
<td>Emergency Accommodation Services for Youth scheme</td>
</tr>
<tr>
<td>EFC</td>
<td>Emergency Foster Care scheme</td>
</tr>
<tr>
<td>FAYS</td>
<td>Family and Youth Services (within DHS)</td>
</tr>
<tr>
<td>GCYP</td>
<td>Guardian for Children and Young People</td>
</tr>
<tr>
<td>HCSC</td>
<td>Health and Community Services Complaints</td>
</tr>
<tr>
<td>IAS</td>
<td>Intensive Adolescent Support scheme</td>
</tr>
<tr>
<td>IDSC</td>
<td>Intellectual Disability Services Council</td>
</tr>
<tr>
<td>IIB</td>
<td>Internal Investigations Branch</td>
</tr>
<tr>
<td>INC</td>
<td>Intensive Neighbourhood Care scheme</td>
</tr>
<tr>
<td>IPS</td>
<td>Intensive Personal Supervision scheme</td>
</tr>
<tr>
<td>JIS</td>
<td>Justice Information System</td>
</tr>
<tr>
<td>MAYFS</td>
<td>Metropolitan Aboriginal Youth and Family Services</td>
</tr>
<tr>
<td>OARS</td>
<td>Offenders Aid and Rehabilitation Services of SA Inc.</td>
</tr>
<tr>
<td>ODACS</td>
<td>Office for Disability and Client Services</td>
</tr>
<tr>
<td>PIC</td>
<td>Person in care</td>
</tr>
<tr>
<td>PROV</td>
<td>Public Records of Victoria</td>
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<tr>
<td>PTF</td>
<td>Paedophile Task Force</td>
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<td>RCCAC</td>
<td>Residential Child Care Advisory Committee</td>
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<td>RCCSAC</td>
<td>Residential Child Care Support and Advisory Committee</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>RGSN</td>
<td>Regional guardianship service networks</td>
</tr>
<tr>
<td>RINC</td>
<td>Remand Intensive Neighbourhood Care program</td>
</tr>
<tr>
<td>SAHS</td>
<td>Southern Adelaide Health Services</td>
</tr>
<tr>
<td>SAPOL</td>
<td>South Australia Police</td>
</tr>
<tr>
<td>SARC</td>
<td>Sexual Assault Referral Centre</td>
</tr>
<tr>
<td>SAYRAC</td>
<td>South Australian Youth Remand and Assessment Centre</td>
</tr>
<tr>
<td>SAYTC</td>
<td>South Australian Youth Training Centre</td>
</tr>
<tr>
<td>SCC</td>
<td>State Children’s Council (1886–1927)</td>
</tr>
<tr>
<td>SCIB</td>
<td>Sexual Crime Investigation Branch, South Australia Police</td>
</tr>
<tr>
<td>SIU</td>
<td>Special Investigations Unit, Department for Families and Communities</td>
</tr>
<tr>
<td>SMART</td>
<td>Strategies for managing abuse-related trauma</td>
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<tr>
<td>SNAICC</td>
<td>Secretariat of National Aboriginal and Islander Child Care</td>
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<td>SOTAP</td>
<td>Sexual Offenders Treatment and Assessment Programme</td>
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<tr>
<td>SRSA</td>
<td>State Records of South Australia</td>
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<tr>
<td>SWIC</td>
<td>State ward index card</td>
</tr>
<tr>
<td>UAM</td>
<td>United Aborigines Mission</td>
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<tr>
<td>VCA</td>
<td>Voluntary custody agreement</td>
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<tr>
<td>WCH</td>
<td>Women’s and Children’s Hospital</td>
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</tbody>
</table>