Case Study 30

The Response of Turana, Winlaton and Baltara and the Victoria Police and the Department of Health and Human Services Victoria (and its relevant predecessors)

Submissions of BDF

Introduction

1. The Thirtieth Case Study of the Royal Commission considered the response of Turana, Winlaton and Baltara and the Victoria Police and the Department of Health and Human Services Victoria (and its relevant predecessors).

2. BDF gave evidence of her experiences whilst in the care of Winlaton as a Ward of the State. Additionally, she spoke of her interaction with members of the Victoria Police at various times.

3. BDF’s evidence is recorded in her statement to the Royal Commission. Additionally, she gave viva voce evidence. BDF was not cross examined by any party. BDF has read the submissions of Counsel assisting the Royal Commission dated 2 October 2015: (“the submissions of Counsel assisting”). BDF does not contest the submissions of Counsel assisting, nor does she contest the summary of available findings contained therein.

4. These submissions rely heavily upon, and adopt the summaries of, the evidence described in the submissions of Counsel assisting. BDF wishes to supplement such submissions by pointing to additional evidence, comment upon available findings of particular relevance to BDF, and to offer some reflection upon her experience and hopes for the future.

5. Additional Evidence to that referred to in the Submissions of Counsel Assisting, (“the submissions”):

(a) In respect to paragraph 365 of the submissions, Line 2, respectfully, to read, “occasions”.

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1 Exhibit 30 - 0022, Statement of BDF, STAT.0616.001.001_M_R.
2 Transcript of BDF, C9350:45 to C9353:40 (Day C090).
(b) In respect to paragraph 367 of the submissions, respectfully, Line 1, to read "presented".

(c) In respect of paragraph 373 of the submissions, page 68, footnote 595, line references respectfully to include 11-21.

(d) In respect of paragraph 453, footnote 696, line references, respectfully, to include 11-18.

(e) In respect of paragraph 517, footnote 775, line references respectfully to include 11-34.

6. **Available Findings of Particular Relevance to BDF:**

   BDF respectfully submits that her experience as a Ward of the State generally and more specifically whilst at Winlaton, evidences a fundamental failure to provide the level of care expected. This failure occurred at both a departmental level and also throughout her time at Winlaton.

   BDF desires to refer to and adopt, all of the suggested available findings, and in particular the following:

**Re: WINLATON**

**F15 Available finding on overcrowding and supervision of residents at Winlaton**

   The interaction of children admitted to Winlaton as Wards of the State with children committed to Winlaton for criminal offences, and the placement of younger children with older children at Winlaton, increased the risk of child to child sexual abuse.

**F17 Available finding on punishment of residents at Winlaton**

   The punishment administered at Winlaton, and the methods of control used by some staff members, were cruel, dehumanising and degrading. This had the effect of discouraging residents from disclosing sexual abuse because they thought they would not be believed.

**F19 Between 1980 and 1987, the policies and procedures for responding to 'sexual assault' at Winlaton:**

   (a) did not consider an incident of 'sexual assault' to be a 'major offence', but rather viewed it as a 'serious incident' that did not require the complaint to be reported to the Principal Youth Officer, Deputy Superintendent or the Superintendent.
F20 Available finding on training to recognise and respond to allegations of child sexual abuse at Winlaton

During the period Marilyn Minister was at Winlaton (1974-1991) the Department failed to provide adequate training for staff members to recognise the risk of child sexual abuse and respond to complaints of child sexual abuse. The absence of this training undermined the capacity of staff members at Winlaton to deal effectively with complaints of sexual abuse.

F20 Available findings on barriers to reporting at Winlaton

During the period that Winlaton was in operation, some residents did not report child sexual abuse to anyone at the time it was occurring because they thought they would not be believed, or would be punished.

F23 During the period that Marilyn Minister was employed at Winlaton (1974-1991), the internal communication, management and reporting procedures in place at Winlaton were not effective at ensuring that the Superintendent was aware of reports of child sexual abuse.

F24 Available finding on the supervision of residents at Winlaton

The supervision of child residents by the staff of Winlaton was inadequate as a result of:

(a) insufficient number of staff;
(b) overcrowding;
(c) lack of training, and
(d) the physical environment of the institution.

F29 Available finding on the use of triad therapy in response to child sexual abuse at Winlaton

Triad therapy was an inappropriate forum for receiving and responding to reports of child sexual abuse because:

(a) it was conducted in a group environment;
(b) it was overseen by inexperienced and poorly trained staff;
(c) it was not directed to child sexual abuse; and
it required the child to take responsibility or accept blame for the sexual abuse of which they were the victim.

F30  Available finding on the oversight and protection of the Superintendent at Winlaton
During the period that Dr. Eileen Slack was Superintendent of Winlaton (from the late 1970s to 1991) she did not ensure that there was adequate supervision, management and oversight of staff in place to protect residents from child sexual abuse.

Re: THE DEPARTMENT
F54  Available finding on the provision of policies and procedures by the Department
During the 1960s to early 1990s, the Department did not have policies, procedures or practices for:
(a) receiving and responding to complaints of child sexual abuse, and
(b) ensuring that complaints of child sexual abuse by residents of State run youth training or reception centres were reported to the Director of the Department and/or the Victoria Police.

F55  Available finding on recruitment, training and resourcing offered by the Department
During the 1960s to 1980s, the training of staff at youth training and reception centres did not equip them to recognise the risk of child sexual abuse and to deal effectively with complaints of child sexual abuse.

F57  Available findings on the responsibility of the Department
The Department had a responsibility to protect vulnerable children who were admitted or committed to the care of the Department from sexual abuse.

F58  During the 1960s to early 1990s, the Department failed to protect a number of residents of youth training and reception centres who were under the care of the Department from sexual abuse.
Mr. Timothy Seccull of Counsel
Dr. Vivian Waller, Instructing Solicitor of Waller Legal
30 October 2015