ROYAL COMMISSION INTO INSTITUTIONAL RESPONSES
TO CHILD SEXUAL ABUSE
AT MELBOURNE

COMMONWEALTH OF AUSTRALIA

Royal Commissions Act 1902 (Cth)

PUBLIC INQUIRY INTO

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 COUNSEL ASSISTING THE ROYAL COMMISSION

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Introduction

About the public hearing

1. The 30th public hearing of the Royal Commission was held in Melbourne from 17 August 2015 to 28 August 2015.

2. The scope and purpose of the public hearing was to inquire into the following matters:

   a. The experiences of former child residents at Turana Youth Training Centre (Turana), Winlaton Youth Training Centre (Winlaton) and Baltara Reception Centre (Baltara) between the 1960s and early 1990s.

   b. The responses of Turana, Winlaton and Baltara and their staff members to child sexual abuse of former child residents of Turana, Winlaton and Baltara between the 1960s and early 1990s.

   c. The past and current policies and procedures of the:

      i. Victoria Police; and

      ii. Department of Health and Human Services Victoria (and its relevant predecessors) (the Department)

      in relation to children and young people in youth training, reception and youth justice centres in the State of Victoria.

   d. Any related matters.

3. During the public hearing, 11 former residents of Turana, Winlaton and Baltara gave evidence of the physical and sexual abuse they suffered while they were placed at Turana, Winlaton and Baltara between the 1960s and early 1990s.

4. The Royal Commission heard evidence from various institutional witnesses including a former Superintendent of Turana, a former Youth Officer of Turana, a former psychologist of the Parkville Psychiatric Unit, former Superintendents and a Deputy Superintendent of Winlaton, a former Youth Officer of Baltara, former social workers from the Department and a former psychologist from the Children’s Court Clinic.

5. Evidence was also heard from the current Assistant Commissioner of the Victoria Police, Chief Information Officer and the Secretary of the Department.

6. The Royal Commission also heard expert evidence from an academic in juvenile crime, justice and corrections.
What this case study considers

7. This case study explored in detail, the experiences of 11 former residents who suffered physical, emotional and sexual abuse while placed at Turana, Winlaton or Baltara. The principal focus of the hearing was to bear witness to their experiences.

8. This case study also examined the responses of Turana, Winlaton and Baltara and their staff members in responding to allegations of child sexual abuse of former residents, and also the response of the Victoria Police and the Department to these allegations. In examining the response of these institutions, the past policies and procedures were also examined.

9. This case study also explored the current policies and procedures of the State of Victoria in relation to children and young people in youth justice centres today.
Part 1  The history of child welfare and youth justice in the State of Victoria

1.1 1864 – 1954

10. From 1864, legislation in Victoria defined situations in which a child could be removed from parental care, and provided for the establishment of institutions for ‘neglected’ children and convicted juvenile offenders.1

11. Before 1954, although the State of Victoria had power under the legislation to establish and run institutions for the care of children, all but one such institution were run by charitable and religious organisations.2

12. The Children’s Court, which was established in 1906,3 had exclusive jurisdiction to hear and determine both criminal charges against juveniles, and applications with regard to neglected children.4 Both groups of children were known as ‘wards of the department’, a term that was introduced in 1887.5

1.2 Legislative changes from 1954

13. In 1954, the introduction of the Children’s Welfare Act 1954 (Vic) (1954 Act) placed the responsibility and administration for ‘neglected children’ and ‘convicted juveniles’ with one government body, that being the Children’s Welfare Department.6

14. The Children’s Welfare Department underwent a number of name changes over the years following legislative reforms that passed responsibility for child welfare and youth justice to new or renamed Departments. During the period examined in the public hearing, it was also known as the Social Welfare Branch,7 the Social Welfare Department,8 the Department of Community Welfare Services,9 and the Department of Community Services10 (collectively known as the Department).

15. From 1954, the Victorian government began to take responsibility for direct service provision in child welfare, along with the development and enforcement of standards

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3 Children’s Court Act 1906 (Vic).

4 Children’s Court Act 1906 (Vic) s 12.

5 Juvenile Offenders’ Act 1887 (Vic); Neglected and Criminal Children’s Act 1887 (Vic).


7 Social Welfare Act 1960 (Vic) s 3.

8 Social Welfare Act 1970 (Vic) s 5.


for the provision of services by the non-government sector.\textsuperscript{11} Between the 1950s and the early 1990s, there were over 30 institutions run by the State of Victoria to care for children and young people,\textsuperscript{12} including children and young people of indigenous background who had a relatively high rate of admission to State care.\textsuperscript{13}

16. By the 1960s, the State of Victoria had power to establish the following types of institutions:

a. Reception centres, for the short term accommodation and maintenance of children or young persons admitted to the care of the Department, taken to or placed in these centres under legislation, or in respect of whom protection applications were made.\textsuperscript{14}

b. Remand centres, for the detention of young persons awaiting trial or sentence, or transit to or from a youth training centre, children’s home or children’s reception centre.\textsuperscript{15}

c. Youth training centres, for the care and welfare of young persons committed to detention pursuant to legislation, or young persons admitted to the care of the Department who in the opinion of the Director-General were in need of special supervision, social adjustment or training.\textsuperscript{16}

d. Children’s homes, for the care and welfare of children or young persons admitted to the care of the Department.\textsuperscript{17}

17. The main institutions established by the State of Victoria during this time, included:

a. Turana;

b. Baltara;

c. Winlaton;


\textsuperscript{15} Social Welfare Act 1960 (Vic) s 9(1)(c); Social Welfare Act 1970 (Vic) s 92(a).

\textsuperscript{16} Social Welfare Act 1960 (Vic) s 9(1)(c); Social Welfare Act 1970 (Vic) s 92(b).

\textsuperscript{17} Children’s Welfare Act 1954 (Vic) s 12(b).
d. Allambie Reception Centre;

e. Pirra Girls’ Home; and

f. Hillside Boys Home.

18. Between 1954 and 1970, the Director of the Department became the guardian of children and young people who were deemed to be in need of care and protection, as well as juvenile offenders.\(^{18}\) From 1970, the Director of the Department was the guardian of children who were deemed to be in need of care and protection,\(^{19}\) but only had legal custody over children who were committed as juvenile offenders.\(^{20}\)

19. The 1954 Act replaced the term ‘neglected child’ with the term ‘child in need of care and protection’. Children could be deemed in need of care and protection for reasons such as being ‘exposed to moral danger’ or if deemed ‘likely to lapse into a career of vice or crime’.\(^{21}\)

20. Professor Allan Borowski gave evidence at this public hearing that between 1954 and the early 1970s, a number of factors were responsible for the high levels of institutionalisation of children.

21. Firstly, Professor Borowski stated that the legislative definition of when a child could be deemed to be ‘neglected’ or ‘in need of care and protection’ was extremely broad. This reflected societal concern that children who were neglected by their parents were at risk of falling into a life of crime.\(^{22}\) He said that the inclusion of ‘status offences’ such as being ‘exposed to moral danger’ or ‘likely to lapse into a career of vice or crime’ blurred the distinction between juvenile offenders and ‘neglected’ children, and were easily substantiated.\(^{23}\)

22. Secondly, Professor Borowski stated that the informal processes of the Children’s Court resulted in inconsistent decision-making, inadequate attention to due process and an almost total lack of legal representation for defendants.\(^{24}\) Further, the legislation provided very few options for children found to be in need of care and protection, besides admission to the care of the Department and institutionalisation.\(^{25}\)

23. In relation to juvenile offenders, the Children’s Court Act 1956 (Vic) (which was later renamed the Children’s Court Act 1958 (Vic)), introduced a number of sentencing options for young persons convicted of a criminal offence, including detention in a government institution.\(^{26}\)

\(^{18}\) Children’s Welfare Act 1954 (Vic) s 21(1); Children’s Welfare Act 1958 (Vic) s 21(1).

\(^{19}\) Social Welfare Act 1970 (Vic) ss 36-37.

\(^{20}\) Social Welfare Act 1970 (Vic) s 95.

\(^{21}\) Children’s Welfare Act 1954 (Vic) s 16.

\(^{22}\) Transcript of A Borowski, C9563:47-C9564:12 (Day C092).

\(^{23}\) Exhibit 30-0029, Report prepared by Allan Borowski, EXP.004.001.0001_M_R at 0004_M_R.

\(^{24}\) Exhibit 30-0029, Report prepared by A Borowski, EXP.0004.001.0001_M_R at 0004_M_R.

\(^{25}\) Exhibit 30-0029, Report prepared by A Borowski, EXP.0004.001.0001_M_R at 0004_M_R.

\(^{26}\) Children’s Court Act 1956 (Vic) s 28(1); Children’s Court Act 1958 (Vic) s 28(1).
24. Juvenile offenders under the age of 15 could not be sentenced to detention, but could be committed to the care of the Department for up to two years. 27 Juvenile offenders aged 15 and above could be sentenced to detention for up to two years. 28

25. The Children’s Court Act 1956 (Vic) also established a Children’s Court Clinic to provide physical, psychiatric and psychological assessments of children found to have committed an offence or to be in need of care and protection. 29

26. From the 1960s, the Department began to employ social workers to work with children in care and their families. 30 This was said to have reflected the growing knowledge about child development and the benefits of children retaining contact with their families. 31

27. From the 1960s onwards, there was also an express recognition of the importance of training for social welfare staff in the legislation. 32

28. Between 1954 and the early 1970s, the separation of children and young people deemed in need of care and protection from juvenile offenders was not always clear. Children in need of care and protection could be committed to a youth training centre if found to be in need of ‘special supervision, social adjustment and training’, 33 despite not having committed an offence.

29. Similarly, a juvenile offender found to be in need of care and protection could be admitted rather than committed to the care of the Department. 34 The legislation also allowed for wards of the State to be returned to the care of the Department if convicted of an offence. 35

1.3 Process of de-institutionalisation

30. During the 1970s and 1980s, there was a significant decline in the number of State wards. The introduction of welfare payments for single parents by the Commonwealth Government and the end of the practice of parents placing children voluntarily into children’s homes contributed to the decline. 36

27 Children’s Court Act 1956 (Vic) s 28(1)(f)(i); Children’s Court Act 1958 (Vic) s 28(1)(f)(i).
28 Children’s Court Act 1956 (Vic) s 28(1)(f)(ii); Children’s Court Act 1958 (Vic) s 28(1)(f)(ii).
29 Children’s Court Act 1956 (Vic) s 44; Children’s Court Act 1958 (Vic) s 44.
30 Exhibit 30-0029, Report prepared by A Borowski, EXP.004.001.0001_M_R at 0002_M_R.
33 Children’s Welfare Act 1954 (Vic) s 12(c)(ii); Social Welfare Act 1960 (Vic) s 56(g)(ii); Social Welfare Act 1970 (Vic) s 40(c).
34 Children’s Court Act 1956 (Vic) s 28(1)(h); Children’s Court Act 1958 (Vic) s 28(1)(h); Children’s Court Act 1973 (Vic) s 26(1)(g).
35 Children’s Court Act 1956 (Vic) s 30; Children’s Court Act 1958 (Vic) s 30; Children’s Court Act 1973 (Vic) s 28.
36 Parliament of Australia, Submission by the Government of Victoria to the Senate Inquiry into Children in Institutional Care, July 2003
31. Professor Borowski told the Royal Commission that the decline also reflected a broader shift in thinking around youthful misbehaviour and the deficiencies of institutionalisation. 

32. A Committee of Enquiry into Child Care Services was conducted in 1975-1976. The report of the Committee, referred to as the ‘Norgard Report’, noted that the system of child welfare in Victoria was largely the same as it had been under the 1864 Act.

33. The Norgard Report recommended a number of changes to the system, including making admission to care a last resort. The Community Welfare Service Act 1978 (Vic) was passed, shifting the focus from admission to care based on the behaviour of a child to:

[Intervention where there was maltreatment of a child by a guardian, such as ill-treatment, abandonment, inability or unwillingness to exercise supervision, or the absence of a guardian due to death or incapacitation, and removed grounds based on the child’s behaviour.]

34. A comprehensive review of the Victorian child welfare system was undertaken from 1982 to 1984 by a committee chaired by Dr Terry Carney, with the report and recommendations published in 1984. This review formed the basis for the current structure of children and family welfare services in Victoria and the legislation governing this system.

35. In response to recommendations of the committee, the Children’s Court (Amendment) Act 1986 (Vic) established separate divisions in the Children’s Court of Victoria (a Criminal Division and a Family Division) to create a complete separation of hearings in regard to criminal and child protection matters.

1.4 1989 – 2005

36. The Children and Young Persons Act 1989 (Vic) (1989 Act) was implemented in stages between 1989 and 1992. The 1989 Act provided for separate services for children and

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37 Transcript of A Borowski, C9571:6–24 (Day C092).
41 Exhibit 30-0006, DHS.3001.009.0522.
43 Children's Court (Amendment) Act 1986 (Vic) s 5.
young people on protective orders and youth offenders in custody. It also introduced a range of new sentencing dispositions for children accused of criminal offences.\textsuperscript{44}

37. The process of de-institutionalisation during the 1970s, 1980s and early 1990s saw the closure of institutions, such as Turana, Winlaton and Baltara. Allambie was the last large state run residential institution to close in the 1990s.\textsuperscript{45}

38. The broader process of de-institutionalisation also saw the remaining children’s homes and psychiatric institutions closed.\textsuperscript{46} Youth training centres were also gradually scaled down, closed and redeveloped.\textsuperscript{47}

39. The \textit{Children and Young Persons (Further Amendment) Act 1993} (Vic) introduced mandatory reporting of suspected serious physical or sexual abuse of children for certain professional groups.\textsuperscript{48}

40. It has been estimated by the State of Victoria that between 1949 and 2003, there were nearly 48,000 children who became wards or were placed on custody or guardianship orders.\textsuperscript{49}

1.5 Current law

41. The introduction of the \textit{Children Youth and Families Act 2005} (Vic) (\textbf{2005 Act}) marks the latest major legislative change regarding child protection and juvenile offending in Victoria. The 2005 Act promotes a therapeutic approach to child protection and management, and overtly recognises the rights of the child.\textsuperscript{50}

42. Like the 1989 Act, the 2005 Act recognises the distinction between children and young people in need of care and protection, and juvenile offenders.\textsuperscript{51} This separation is reflected in the facilities provided by the State of Victoria.

\begin{footnotesize}
\begin{itemize}
\item[44] \textcite{Children and Young Persons Act 1989} (Vic) s 137; Transcript of A Borowski, C9570:32-37 (Day C092).
\item[48] \textcite{Children and Young Persons (Further Amendment) Act 1993} (Vic) s 4.
\item[51] \textcite{Children Youth and Families Act 2005} (Vic) Chapter 4 – 5.
\end{itemize}
\end{footnotesize}
43. Home based care, including foster and kinship arrangements, and smaller residential services are used for children in need of care and protection.\textsuperscript{52}

44. Children and young people involved in the criminal justice system are supervised by the Department, and youth justice centres have been established to provide facilities for these children and young people.\textsuperscript{53}

45. The youth justice legislative framework is set out at Part 5 of the 2005 Act, which provides that the State of Victoria may establish corrective services, including:

   a. Remand centres for the detention of children awaiting a court hearing;
   
   b. Youth residential centres, which provide special direction, support, educational opportunities and supervision; and
   
   c. Youth justice centres.\textsuperscript{54}

46. The 2005 Act also sets out the sentencing options available for juvenile offenders, which include youth justice residential centre orders and youth justice centre orders.\textsuperscript{55}

\textsuperscript{52} Exhibit 24-0001, \textit{VIC.0007.001.0001} at 0010.
\textsuperscript{54} \textit{Children, Youth and Families Act 2005} (Vic) s 478.
\textsuperscript{55} \textit{Children, Youth and Families Act 2005} (Vic) Pt 5.3.
Part 2  Turana Youth Training Centre

2.1  The institutional profile of Turana

47.  In 1880, the Victorian Government opened an observation, treatment and classification centre for children called the Royal Park Receiving Depot for Girls and Boys in Parkville (‘Royal Park Depot’).56

48.  In 1955, the Royal Park Depot was renamed the Turana Youth Training and Remand Centre.57 Following the name change, Turana began operating as a reception centre, children’s home and juvenile school predominantly for adolescent boys.58

49.  During the historical period examined in this public hearing Turana operated as:

a.  an assessment and classification centre;

b.  a residential facility for wards of the State aged 14-17 years that couldn’t be accommodated elsewhere;

c.  a reception centre for children admitted to the care of the Department;

d.  a remand centre for boys aged 10 to 16 charged with an offence or awaiting the hearing of a Protection Application or similar; and

e.  a youth training centre for boys aged 15 to 21 years that had been sentenced to a youth training facilities.59

50.  Until 1956, the Royal Park Depot was the only state run institution for children directly managed by the Department.60 Turana was the only reception centre for children committed to state care until 1961, when the Allambie Reception Centre became the main reception facility.61

51.  Over the period it was in operation Turana comprised various sections. Each section served a different purpose or catered to a different group of residents, and in some


60 Exhibit 30-0046, Second statement of P Philip, STAT.0626.002.0001 at [21].

cases how a section was used changed over time.62 By 1957, Turana had 14 sections with capacity for 265 children and young people.63

52. During the historical period examined, the sections of Turana included the following:

a. The Gables and Sunnyside were open sections designed to get boys ready to return to the community. Each of these sections housed between 15 and 20 boys.64

b. Quamby and Coolibah were medium security sections that accommodated both wards and trainees that required closer supervision. Each of these sections housed approximately 30 boys.65

c. Poplar House was a maximum security section that catered for boys who were emotionally unstable or presented a serious risk to themselves or the community. It housed approximately 28 boys.66

53. By the mid-1970s, the Department noted in its Annual Report that the boys coming into Turana presented as security risks, more so than they did in the past and that the physical conditions at the centre had deteriorated to the point that they were ‘inadequate’ for dealing with boys who presented such risks.67

54. In 1992-1993, a redevelopment project took place at the Turana site.68 In 1993, the Melbourne Youth Justice Centre opened on the site of Turana.69

2.2 The experience of former residents of Turana

55. Five former residents gave evidence that they were sexually abused at Turana by staff members and/or by other residents. The Royal Commission heard that officers at Turana were known colloquially among the residents as ‘screws’.

56. The former residents told the Royal Commission of the physical, emotional and sexual abuse they suffered while they were placed at Turana. The Royal Commission heard evidence of common experiences among residents including: a lack of supervision and oversight at Turana, which facilitated abuse by other residents and allowed staff members to sexually abuse some residents; absconding from Turana to escape the abuse and avoid further abuse; a culture of not being able to report abuse for fear of

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62 Exhibit 30-0046, Second statement of P Philip, STAT.0626.002.0001 at [22].
64 Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [17(a)]; Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [11]; Exhibit 30-0011, DHS.3040.0003.0001.
65 Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [17(b)]; Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [11]; Exhibit 30-0011, DHS.3040.0003.0001.
66 Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [17(c)]; Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [11]; Exhibit 30-0011, DHS.3040.0003.0001.
being further victimised and punished; and the use of degrading and humiliating punishment as a method of command and control and to ensure the silence of residents.

The evidence of Norman Latham

57. Norman Latham was born in Coburg, Victoria in 1946. When he was growing up, his father was violent towards him and his mother and physically abused him.

58. In 1962, at the age of 15, Mr Latham was sleeping under the pier in Port Melbourne after running away from home, when he was woken by a man who told him that he was a police officer.

59. Mr Latham said in evidence that the man took him back to his car, locked the door and drove him to an area that was dark, where he was sexually assaulted. Mr Latham stated that the man told him to ‘shut up or else. No one is going to hear you here anyway.’ At that time, a car pulled up and a uniformed police officer arrested the man and took Mr Latham to the police station, where he was interviewed.

60. Mr Latham told the Royal Commission that he was sent to the reception section of Turana, pending the hearing of a care and protection application in the Children’s Court. When he appeared before the Children’s Court, Mr Latham was made a ward of the State and was charged with being ‘likely to lapse into a career of vice and crime’. He was transferred from the reception section of Turana to the main area across the road, and was taken to Quamby, the medium security section of Turana.

61. Mr Latham said that he was taken to Quamby by a screw named Eric Horne who took him to the office of another screw named Douglas Wilkie. Mr Latham said that he saw Mr Wilkie and Mr Horne as the most senior screws in Quamby as they ordered other screws around.

62. Mr Latham told the Royal Commission that Mr Wilkie told him:

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

63. Mr Latham gave evidence that within the first few days of being in Quamby, Mr Horne also said to him:

Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [6].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [7].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [9].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [19].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [21]-[23].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [25]-[26].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [28].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [29].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [31].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [32].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [34].
Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [35].
You belong to us. If you act up, we’ll send you to Poplar House.\(^{80}\)

64. The Royal Commission heard that Poplar House, the maximum security area of Turana, was repeatedly used as a threat to Mr Latham to control his life and daily routine.\(^{81}\)

65. Mr Latham gave evidence that during his time at Turana, he was raped nine times by Mr Wilkie and ten times by Mr Horne.\(^{82}\) Mr Wilkie was represented at the public hearing, and denied the allegations of sexual abuse made against him. Mr Horne was deceased at the time of the public hearing.

66. Mr Latham gave evidence that on each occasion he was raped by Mr Wilkie, he was taken to the infirmary, which was a closed room with no windows and was located adjacent to Mr Wilkie’s office.\(^{83}\) Mr Latham said the room could only be accessed through Mr Wilkie’s office and another door, which were both locked during the sexual abuse.\(^{84}\)

67. Mr Latham said that on each occasion, Mr Wilkie put him on the bench before proceeding to rape him and on each occasion, Mr Wilkie told him ‘you’re a ward of the State. We are the State’.\(^{85}\) He threatened to send him to Poplar House if he reported the rapes, saying

Don’t forget what I told you about Poplar House. All I have to do is sign papers.\(^{86}\)

68. Mr Latham told the Royal Commission that after the fifth rape he absconded from Turana, but was picked up by police who never asked him why he absconded, but returned him back to Turana where he was raped repeatedly by Mr Wilkie.\(^{87}\)

69. Mr Latham gave evidence that after the seventh rape, he again absconded from Turana and was again picked up by police, but on this occasion, he was interviewed by a detective. The detective told him that he had ‘better things to do than rounding up absconders from Turana’ and Mr Latham responded by telling the detective

Well if you stop the mongrels Wilkie and Horne from raping us inside, we wouldn’t have to abscond.\(^{88}\)

70. Mr Latham gave evidence that the detective was the first person he told about the rapes, and the detective’s response was to physically abuse Mr Latham by hitting him
across the face with a Bakelite telephone.\textsuperscript{89} Mr Latham was returned to Turana and subjected to further rapes by Mr Wilkie.\textsuperscript{90}

71. Mr Latham also told the Royal Commission that he was raped by Mr Horne ten times; each rape also having occurred in the infirmary.\textsuperscript{91} He said that the first time he was raped by Mr Horne was a few weeks after he was first raped by Mr Wilkie.\textsuperscript{92} He gave evidence that he felt scared, did not feel safe and felt trapped.\textsuperscript{93}

72. Mr Latham said that he felt Mr Wilkie and Mr Horne were ‘tag teaming me and raped me whenever they felt like it’. He said he became paranoid and stressed and didn’t know which one would call for him.\textsuperscript{94}

73. Mr Latham said that he never reported the rapes by Mr Wilkie and Mr Horne to anyone at Turana because he was scared that they had the power to take him to Poplar House and he felt that anything he reported would get back to them.\textsuperscript{95}

74. Mr Latham said that in 2009, he reported the sexual abuse to the police.\textsuperscript{96} In 2013, Mr Wilkie was charged with offences relating to the sexual abuse of Mr Latham while he was a resident at Turana.\textsuperscript{97} The Royal Commission was told that committal proceedings were heard over three days (29 July 2013 and 26 and 27 August 2013), after which Mr Wilkie was committed for trial.\textsuperscript{98}

75. In 2014, the proceedings against Mr Wilkie were discontinued by the Victorian Director of Public Prosecutions (DPP) four days before the trial was to commence.\textsuperscript{99}

76. The decision of the DPP to discontinue the proceedings against Mr Wilkie was not pursued in this public hearing.

77. The Royal Commission heard from Mr Latham about the impact the sexual abuse had on him. He gave evidence that when he left Turana, he started drinking to wipe the memory of abuse out of his mind.\textsuperscript{100} He said the sexual abuse gave him nightmares and flashbacks and he had attempted to take his life to end the nightmares.\textsuperscript{101}

78. Mr Latham also told the Royal Commission that being made a ward of the State deprived him of the opportunity of interacting with his siblings.\textsuperscript{102} He said that he has

\textsuperscript{89} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [65].
\textsuperscript{90} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [68].
\textsuperscript{91} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [75]-[76].
\textsuperscript{92} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [76].
\textsuperscript{93} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [80].
\textsuperscript{94} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [81].
\textsuperscript{95} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [89]-[90].
\textsuperscript{96} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [103].
\textsuperscript{97} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [105].
\textsuperscript{98} Exhibit 30-0008, OPP.3023.006.0005\_R; Exhibit 30-0008, OPP.3023.006.0059\_R; Exhibit 30-0008, OPP.3023.006.0145\_R.
\textsuperscript{99} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [107].
\textsuperscript{100} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [94].
\textsuperscript{101} Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001\_R at [98]-[99].
\textsuperscript{102} Exhibit 30-0045, Further statement of N Latham, STAT.0611.002.0001\_R at [4].
fears of being vulnerable and helpless as he ages and particularly if he is placed in aged care.  

The evidence of Joseph Marijancevic

79. Joseph Marijancevic was eight years old in 1958, when he and his brother migrated to Australia from the former Yugoslavia. Mr Marijancevic gave evidence that growing up in Australia was difficult as his father was violent and physically abusive when drunk.

80. Mr Marijancevic gave evidence that in July 1961 he ran away from home because of his father’s physical abuse. He said that his father was charged and gaoled for the assault and a few days later he was taken to the Children’s Court where he was admitted to the care of the Department for being ‘ill-treated’.

81. Mr Marijancevic gave evidence that he was initially placed in the Billabong section of Turana before being transferred to Menzies Boys Home (Menzies), a non-state run institution. He said that at Menzies, he was sexually abused by an older boy who came into his bed late at night. He said he was traumatised and ashamed by the abuse and did not report the abuse to any screws for fear of being disbelieved and because the screws actively discouraged boys from ‘telling tales’.

82. The Royal Commission heard that Mr Marijancevic absconded to avoid being abused and was picked up by police who never asked him why he ran away. He said he was charged with escape and taken back to Menzies where he was further abused.

83. Mr Marijancevic said that in 1965, when he was 15 years old, he was placed back at Turana after absconding from Menzies and Gordon Boys Home, another non-state run institution, and for committing offences of breaking into shops and stealing. He was placed in Blue Gables, a section of Turana which he recalled lacked any supervision at night, before being transferred to Quamby.

84. Mr Marijancevic gave evidence that he absconded from Quamby a number of times and as punishment for running away, was sent to Poplar House, the maximum security section of Turana. He said that at Poplar House, boys were locked up in individual

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103 Exhibit 30-0045, Further statement of N Latham, STAT.0611.002.0001_R at [7].
104 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [6]; [9].
106 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [15];[17].
107 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [18];[19].
108 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [27];[28].
109 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [29]; [30];[31].
110 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [34].
111 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [32];[33].
112 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [44];[52].
113 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [54];[56].
114 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [59].
cells and occasionally, the screws opened the cells to let certain boys out to do chores.115

85. Mr Marijancevic told the Royal Commission that at Poplar House, he was sexually abused on two occasions by two screws when he was 15 years old.116

86. Mr Marijancevic stated that on the first occasion, he was cleaning the stairs with a toothbrush as punishment and was supervised by a screw named Michael Monaghan. He stated that Mr Monaghan indicated with his finger to follow him into a broom closet, which was next to the stairs,117 and said that ‘once you were in there, you were out of sight from others and couldn't be heard’.118

87. Mr Marijancevic told the Royal Commission that Mr Monaghan ‘king hit [him] right between the eyes and the punch knocked [him] out’.119 He stated that when he woke up, he was face down on a bench or table in the broom closet and was raped by Mr Monaghan.120 He was then taken to an isolation cell and called a ‘dirty little pig’.121 The Royal Commission made a number of enquiries to locate Mr Monaghan for this public hearing, but received confirmation that he died in 2011.

88. The Royal Commission heard evidence that Mr Marijancevic was visited by the Superintendent of Turana, Ian Cox when he was in the isolation cell. The Royal Commission made a number of enquiries to locate Mr Cox for the public hearing and enquiries confirmed that he died in 2008.

89. The Royal Commission heard that Mr Marijancevic told Mr Cox that ‘the screw hit me and hurt me’.122 He said that Mr Cox did not attempt to establish what had happened despite his clear physical injuries. Instead, Mr Marijancevic said that he was kept in the isolation cell overnight and was told he would be let out the next morning.123

90. Mr Marijancevic said that he was not taken to the nurse or the medical clinic for treatment of his injuries, nor did Mr Cox follow up with him.124 He also said that he never reported the abuse to anyone at Turana or social workers of the Department.125

91. Mr Marijancevic told the Royal Commission that after this incident he absconded from Turana multiple times because he was scared of being punished further and assaulted.126 He said that on one occasion when he absconded, he told a police officer

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115 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [61].
116 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [62]; [70]; [83].
117 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [63]; [64].
118 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [66].
119 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [67].
120 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [68].
121 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [70].
122 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [73].
123 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [74]; [75].
124 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [75]; [76].
125 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [76].
126 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [77]; [78].
that he ‘ran away because they hurt me’, but the police officer physically abused Mr Marijancevic and sent him back to Turana.127

92. Mr Marijancevic gave evidence that he was sexually abused by another screw at Poplar House. He said that at the time, he was polishing the floors when he was called into the office of the screw on duty.128 The screw offered Mr Marijancevic a piece of cake and soft drink and told him jokes.129 Mr Marijancevic told the Royal Commission that the screw told him to sit on his knee, where the screw proceeded to sexually abuse him.130

93. Mr Marijancevic said that the screw said to him ‘it’s important not to say anything or you’ll get in trouble. You won’t get to see your brother again if you tell’.131 Mr Marijancevic told the Royal Commission that he never reported the abuse because he was scared of being punished and humiliated further. He said that

[!]In the past, all the people I reported to who held positions of authority didn’t believe me, nothing would change this time.132

94. Mr Marijancevic gave evidence to the Royal Commission that the sexual abuse, separation and isolation he experienced at Turana was traumatic.133 He said that he was diagnosed with anxiety and depression and had suicidal thoughts, and started ‘seeing relief in death’.134

95. Mr Marijancevic told the Royal Commission that the biggest obstacle he faced was that no-one would believe him.135 He said he still finds the disclosure of the abuse difficult and he is still terrified, fearful and distressed ‘because of the deep sense of humiliation’.136

The evidence of BDB

96. BDB was born in Carlton, Victoria in 1951 and is now 64 years old.137 A couple of days after birth, BDB was sent to Hartnett House, an institution run by the Melbourne City Mission,138 and was made a ward of the State in 1952.139

97. BDB lived in Hartnett House until 1962, when BDB was 11 years old.140 BDB was transferred from Hartnett House to a foster family in June 1962, before being

127 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [79]–[80].
128 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [84].
129 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [86].
130 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [87].
131 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [89].
132 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [91].
133 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [93].
134 Transcript of J Marijancevic, C8908:7-11 (Day C087).
135 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [99].
136 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [100].
137 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [5]–[6].
138 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [7].
139 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [10]–[11].
140 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [12].
transferred to the Billabong section of Turana in May 1963. A month later, BDB was transferred from Turana to Gordon Boys Home, where BDB resided until November 1965.

98. BDB said that in November 1965, at the age of 14, BDB absconded from Gordon Boys Home and stole a truck. BDB was caught by police and was returned to Turana, ultimately residing in the section known as Classification B.

99. BDB told the Royal Commission that the dormitory accommodation of Classification B housed approximately 20 boys, and comprised a single door to the room with a small peephole. Boys were locked in the dorm at night and BDB said that no staff members ever came into the room to check on the boys at night.

100. The Royal Commission heard evidence that in Classification B, BDB was repeatedly sexually assaulted by an older and larger boy who slept in the same dormitory. One night, BDB banged on the door of the dorm room and yelled to go to the toilet to avoid the nightly visit from this boy.

101. The Royal Commission heard evidence that BDB was escorted out of the room by an officer named ‘Mr Jones’ who took BDB to the staff tea room and said ‘you just sit with me. We’ll wait for him to go to sleep’.

102. The Royal Commission was told by BDB that ‘Mr Jones’ then exposed his genitals and asked BDB to touch them. BDB told the Royal Commission that the abuse by the older boy and ‘Mr Jones’ was not reported because there was a culture at Turana that ‘lagging’ on someone would result in a beating.

103. Despite a number of attempts to identify and locate ‘Mr Jones’, the Royal Commission was unable to confirm his identity or whereabouts prior to the public hearing.

104. When asked whether any information about staffing arrangements within Classification B was given to BDB, BDB told the Royal Commission that:

We were just sort of sent – you know, people could come along and say, "Well, we’re transferring you to B class now", and off you would go. And you’d talk to the other boys and they’d tell you, you know, what the rules were, what the latest thing was. The first question they ask you, "What are you in for?"

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141 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [24]; [27].
142 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [32]; [39].
143 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [36]-[38].
144 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [42].
145 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [43].
146 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [44]-[45].
147 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [46].
148 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [47].
149 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [48].
150 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [50].
151 Transcript of BDB, C8924:37-45 (Day C087).
105. When also asked whether BDB was told of anyone to whom BDB could address any grievances to, BDB said:

   The staff there were sort of more like supervisors and security, rather than helping you do anything. Like, you didn’t feel as though you could talk to them. You called them “sir” and then, when they weren’t around, everyone called them “screws”...  

106. The Royal Commission heard evidence that BDB absconded from Turana and committed an offence. The police picked BDB up and returned BDB to Turana, where BDB was placed in the Quamby section of the institution. BDB gave evidence that shortly after placement in Quamby, BDB went to see the doctor because of pain around the stomach and anus. The doctor told BDB to bend over for the examination, which was degrading, painful and rough, and said:

   It’s your own fault. You should stop fucking the other boys.

107. BDB said that a few weeks later, a boy kicked BDB in the testicles, which became swollen. BDB said that staff arranged a doctor’s appointment, but the doctor refused to examine BDB and instead said that BDB needed a jockstrap. BDB gave evidence that these encounters resulted in BDB’s avoidance of doctors for several years.

108. The Royal Commission heard that in May 1966, BDB was released from Turana aged 15 years old. BDB said that during this time, a man named Mr Stover, from the Department, visited approximately once a month and arranged for a pastor to see BDB. On one occasion, the pastor took BDB to his car and forced BDB to perform fellatio.

109. BDB told the Royal Commission that this was not reported to Mr Stover as BDB felt that Mr Stover had the power to send BDB back to Turana.

110. BDB gave evidence that although she was raised as a boy, from a very young age she realised that she was female and by the time she was in Turana, she was very aware that she should be growing up as a girl. That caused difficulties for BDB, because she had all the issues with day to day living and the power structure in Turana, and in

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152 Transcript of BDB, C8925:6-12 (Day C087).
153 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [52]–[53].
154 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [55].
155 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [57]–[58].
156 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [58].
157 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [59].
158 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [60].
159 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [63].
160 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [72].
161 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [72].
162 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [73].
163 Transcript of BDB, C8920:21-43 (Day C087).
addition she felt very different to the boys. BDB said that there was no one she could talk to about what she was experiencing.

111. BDB gave evidence about the impact that the sexual abuse had on her life. She said that after being released from care, she did not know how to live in a normal society and ‘experienced a lot of shame over being a State ward’. She did not know how to get on with others at work and lacked social skills. BDB told the Royal Commission that on leaving Turana, she was illiterate and had acquired no vocational skills.

112. BDB told the Royal Commission that she has difficulty trusting people, particularly those in positions of power and for most of her life, she has hated and had a low opinion of herself. For a period of time, she thought seriously about how she could end her life and she spent three or four months figuring out how she could do that without hurting her children. BDB said that life had been good since she met her supportive husband, and that she felt privileged to know what it’s like to have someone to love.

113. When asked whether the care received at Turana was best practice for the time, BDB told the Royal Commission that

I’d like to call it very similar to warehousing. We were looked after much the same way as you would look after car parts or old TV sets or something like that. We had no one to talk to. People weren’t interested whether we did well at school; in fact, if we attended school.

The evidence of Robert Cummings

114. Robert Cummings was born in Albury in 1954 and is 60 years old. At home, when he was growing up and throughout most of his early teenage years, Mr Cummings stated that he was physically abused by his father and stepmother. He said that at times, he was locked in his room, starved and kept separate from the family.

115. Mr Cummings gave evidence that in July 1970, at the age of 15, he ran away from home because of the abuse and slept at the local sports pavilion, where he was eventually picked up by the police and taken to the Children’s Court. He stated that

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164 Transcript of BDB, C8920:45-C8921:10 (Day C087).
165 Transcript of BDB, C8921:12-16 (Day C087).
166 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [81].
167 Transcript of BDB, C8928:20-21 (Day C087).
168 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [86].
169 Transcript of BDB, C8921:26-29 (Day C087).
170 Transcript of BDB, C8922:5-12 (Day C087).
171 Transcript of BDB, C8932:4-12 (Day C087).
172 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [5]-[6].
173 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [7].
174 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [9].
175 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [11]-[13].
to the best of his recollection, the police never asked him why he ran away from home.176

116. Mr Cummings said in evidence that on 6 August 1970, a care and protection application was heard in the Children’s Court, where an order was made admitting him to the care of the Department for the reason that he had been ‘living under conditions likely to lapse into a career of vice and crime’.177 He spent a short time at Turana, awaiting classification for long term care, before being transferred to Harrison House, a Methodist based institution.178

117. Mr Cummings told the Royal Commission that he spent approximately six to seven weeks at Harrison House, during which he was physically and sexually abused by the house manager.179 He gave evidence that the physical abuse consisted of being hit in the stomach with a clenched fist while being forced to stand at the end of a corridor for a long time.180

118. Mr Cummings told the Royal Commission that within the first weekend at Harrison House, he was sexually abused by the manager in the living room. He said that the manager forced him to fondle his genitals and give him oral sex.181 Mr Cummings was then told to put on items of female clothing and was forced to turn around to face the pool table, where he was pushed down onto the table and anally raped.182

119. Mr Cummings gave evidence that the sexual abuse by the manager became a daily occurrence.183 He said he did not report the abuse to anyone for fear of punishment,184 and also because he felt there was no one he could speak to, as he had no contact with anyone at the Department.185

120. Mr Cummings told the Royal Commission that documents recorded by the Department at the time of the abuse state that he stole women’s clothing and wore makeup and jewels.186 He said that the record was not true and the real situation was that the manager of Harrison House was sexually abusing him.187

121. Mr Cummings stated that, while he was still under the care of the Department, he ran away from Harrison House and lived on the streets for about two months.188 He said

176 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [15].
177 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [23].
178 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [25]-[27].
179 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [30].
180 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [31].
181 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [35]-[36].
182 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [39]-[40].
183 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [42].
184 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [41].
185 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [47].
186 Exhibit 30-0004, Annexure RCJ-6, DHS.3002.083.0028; Exhibit 30-0004, Annexure RCJ-7, DHS.3002.082.0023.
187 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [50].
188 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [52]-[54].
that while living on the streets, he stole bread and milk to survive and accepted approaches from men for sexual favours in exchange for food or accommodation.\(^{189}\)

122. The Royal Commission heard that Mr Cummings was eventually caught shoplifting by police, who didn’t ask him where he was living or why he was shoplifting.\(^{190}\) He said that police simply picked him up, charged him with larceny and then took him to Turana for a second time.\(^{191}\)

123. Mr Cummings said that when he was taken back to Turana, he was sent to Quamby, a secure section of Turana that housed about 50 or 60 boys in cells, with two boys to a cell.\(^{192}\) He said that upon arrival at Quamby, he was not told what the rules were or to whom he could speak to if he had any problems. He said he was not introduced to the Superintendent, and recalls one ‘screw’ on patrol at night and three ‘screws’ on patrol during the day.\(^{193}\)

124. Mr Cummings told the Royal Commission that at Quamby, he was physically abused by other residents within the first few days, when he was forced to line up in the corridor as punishment for absconding.\(^{194}\) He said that the screws saw him being hit by other residents, but did nothing to prevent the abuse.\(^{195}\) Mr Cummings gave evidence that when he disclosed the physical abuse to the screw in charge, along with the abuse he suffered at Harrison House, he was told to ‘get back in the line’.\(^{196}\)

125. The Royal Commission heard evidence that Mr Cummings was also sexually abused by other residents during his time at Quamby.\(^{197}\) He said that the first incident occurred within the first week of his arrival when an older boy in his cell attempted to force him into oral sex. Mr Cummings told the Royal Commission that he reported this and again reported the abuse at Harrison House to the screw in charge, whose response was

> It’s only happening because of your homosexuality... This is your fault. You need to be cured.\(^{198}\)

126. The Royal Commission heard that Mr Cummings was then taken by two screws to a doctor at Royal Park Hospital. He said that the doctor told him

> You’re here because you’re homosexual and we’re going to cure that with electric shock treatment.\(^{199}\)

\(^{189}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [55]; [58].

\(^{190}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [59]-[60].

\(^{191}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [61].

\(^{192}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [64]-[66].

\(^{193}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [67].

\(^{194}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [68]-[69].

\(^{195}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [69].

\(^{196}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [71].

\(^{197}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [73]-[75].

\(^{198}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [76].

\(^{199}\) Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [80].
127. The Royal Commission heard evidence that the form of treatment used was aversion therapy, otherwise known as electric aversion therapy. Mr Cummings said that he had about 12 sessions of aversion therapy treatment over the course of two months.

128. Mr Cummings said that the treatment involved sitting on a chair with electrode wires attached to his ankle. A screen was placed in front of the chair which played a slide show consisting of half-naked women and full frontal naked men. He said that when a picture of a naked man appeared on the screen, he was given an electric shock, describing it as ‘a really massive jolt of sharp pain’.

129. Mr Cummings stated that at times when he wasn’t ready, he was thrown off the chair when he was given an electric shock. He gave evidence that there were times ‘the burn marks on my ankles [were] weeping, and therefore they had to use the other ankle’.

130. Documents obtained from the Department indicate that Mr Cummings initially asked for a referral for the treatment and that he was prepared to continue the treatment. Mr Cummings gave evidence that in fact, at no time did he agree or provide his express consent to the treatment. He told the Royal Commission that

[T]o say a 15 year old is going to voluntarily go to a psychiatric hospital, put electrodes on their leg and be shocked, is just ludicrous...

131. Mr Cummings stated that when the other residents at Turana found out about the treatment, he became a target and was labelled a ‘bum boy’. He said that he was repeatedly sexually abused by the other residents, including being raped in the toilet and in a storeroom by a group of four or five boys.

132. Mr Cummings gave evidence that as part of the aversion therapy, he was required to record the number of sexual acts he had with boys on a sheet provided to him by the doctor. Mr Cummings said he disclosed the abuse on the sheet and told the doctor he was being abused. He said that in response, the doctor said ‘well, we will need to up your dosage of electricity’. He stated that from that point on, he decided not to disclose the abuse as he felt he was being punished and was not being believed.

133. Mr Cummings said that towards the end of the treatment, he started receiving electric shocks when pictures of half-naked women were shown on the screen. He was told

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200 Transcript of T Verberne, C8974:31-34 (Day C087).
201 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [106].
202 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [88].
203 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [89].
204 Transcript of R Cummings, C8956:41-45 (Day C087).
205 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [83].
206 Transcript of R Cummings, C8955:14-21 (Day C087).
207 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [94].
208 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [95]-[96].
209 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [98]-[99].
210 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [101].
that this was to ensure he wasn’t ‘fixated’ on women.\textsuperscript{211} He said that he felt he was getting punished further and he attempted suicide twice.\textsuperscript{212}

134. Mr Cummings told the Royal Commission that towards the end of his time at Turana, he was called into the office of the screw who told him he would be transferred back to Harrison House.\textsuperscript{213} Mr Cummings said that he ‘felt that the screws either didn’t listen to what I said before or they didn’t care’.\textsuperscript{214} He was eventually transferred to Molloy House and was discharged from wardship when he turned 18 in November 1972.\textsuperscript{215}

135. Mr Cummings gave evidence about the short term and long term impact of the physical and sexual abuse he experienced at Turana. He said that when he was in his early twenties, he was an angry and violent man and developed a hatred for homosexuals,\textsuperscript{216} caused by the aversion therapy sessions. He said that at present, in spite of the tremendous support of his wife, he still suffers from related issues, including an inability to connect with adults, poor intimacy abilities,\textsuperscript{217} and nightmares.\textsuperscript{218}

The evidence of BDA

136. BDA was born in Dandenong, Victoria in 1977.\textsuperscript{219} When BDA was about seven years old, his stepfather began to brutally beat him, sometimes using belts and kettle cords to hit him across his body. BDA’s mother was also physically abusive.\textsuperscript{220}

137. In October 1987, when he was 9 years old, BDA attempted to commit suicide in the playground at school as a result of the ongoing physical abuse by his stepfather.\textsuperscript{221} BDA was placed in respite care with another family, and was admitted to the care of the Department in November 1987, for “being exposed”.\textsuperscript{222}

138. After a brief period in foster care, BDA was admitted to Baltara on 24 February 1988.\textsuperscript{223} He left Baltara on 15 June 1988.\textsuperscript{224} BDA gave evidence that he was sexually abuse by other residents at Baltara. The experience of BDA at Baltara is set out in Part 4.2 below.

\textsuperscript{211} Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [109].
\textsuperscript{212} Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [110]-[111].
\textsuperscript{213} Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [116].
\textsuperscript{214} Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [117].
\textsuperscript{215} Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [118]-[122].
\textsuperscript{216} Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [127]-[128].
\textsuperscript{217} Transcript of R Cummings, C8956:22-33 (Day C087).
\textsuperscript{218} Transcript of R Cummings, C8957:18-24 (Day C087).
\textsuperscript{219} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [6].
\textsuperscript{220} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [7]-[10].
\textsuperscript{221} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [15]-[18].
\textsuperscript{222} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [19]-[20].
\textsuperscript{223} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [21]-[24].
\textsuperscript{224} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [49].
139. Between June 1988 and 1992, while BDA was still under the care of the Department, he spent time living on the streets, and was placed at a number of institutions, including Minton, Yallum, Medium Term Unit, Interim Placement Unit and Tally Ho Boys Home.\textsuperscript{225}

140. BDA gave evidence that he was physically or sexually abused at most, if not all of these institutions.\textsuperscript{226} While living on the streets, BDA said that he was physically and sexually abused by other homeless men, and committed crimes such as stealing to survive.\textsuperscript{227}

141. BDA gave evidence that on a couple of occasions he reported that he had been abused to Department staff, but was made to feel as though it was his responsibility to keep himself safe.\textsuperscript{228}

142. Between June 1988 and 1992, BDA was picked up by police many times and returned home. BDA gave evidence that the police rarely asked him why he had run away, and didn’t seem to care about him. In evidence before the Royal Commission, Assistant Commissioner Fontana was asked about this response to BDA by Victoria Police, and described it as ‘really disappointing’.\textsuperscript{229}

143. BDA does not remember anyone from the Department asking him why he was running away.\textsuperscript{230} He stated that during this time, he didn’t know to whom he could speak to at the Department, because the counsellors and social workers kept changing.\textsuperscript{231}

144. On 7 September 1993, when he was 15 years old, BDA was caught for stealing and committed to Turana.\textsuperscript{232}

145. BDA spent about two years at Turana. He told the Royal Commission that during this time he absconded many times, and was always picked up by police and returned.\textsuperscript{233}

146. BDA gave evidence that when he first arrived at Turana, he was told who he could see if he had any problems.\textsuperscript{234} However he soon became aware that some of the officers were friends with some of the residents, and would pass on information to them. BDA said that this made him feel like he couldn’t trust or report anything to the staff.\textsuperscript{235}

147. BDA told the Royal Commission that while he was at Turana, he was physically abused by the other boys, and was also sexually abused many times by at least two residents who he shared a room with. He said that the other residents would jump into his bed

\textsuperscript{225} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R [50]-[51], [62].
\textsuperscript{226} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [63]-[69].
\textsuperscript{227} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [55]-[60].
\textsuperscript{228} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [65]-[72].
\textsuperscript{229} Transcript of S Fontana, C9836:12-24 (Day C994).
\textsuperscript{230} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [54].
\textsuperscript{231} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [60].
\textsuperscript{232} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [73].
\textsuperscript{233} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [74]-[75].
\textsuperscript{234} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [76].
\textsuperscript{235} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [76]-[77].
at night and masturbate him, or force him to masturbate them. BDA stated that he never felt protected at Turana, and thought that if he did not do what he was told, he would be further abused.

148. BDA did not recall reporting the abuse to anyone at Turana. However, documents produced to Royal Commission include handwritten notes dated October 1993, that record that BDA was ‘getting sick of getting hidings from other kids’ and was ‘still getting the ‘odd knock’ from other trainees’. A note dated 22 October 1993 records that BDA ‘would like to stay in slot today because he feels safer there.’ BDA told the Royal Commission that the ‘slot’ was solitary confinement in an empty cell, and that it was ordinarily used to discipline boys.

149. A health referral form dated 12 October 1993 states that BDA was ‘assaulted by several boys on several occasions’ and a referral was made to the ‘MAPPS program’. BDA did not recall what MAPPS was, or being taken to a doctor. BDA remembered participating in a small group program run by a male youth worker, in which children were supposed to talk about any issues they had at Turana. He said that he didn’t feel comfortable talking about the abuse because some of the boys that had abused him were in the group.

150. BDA did not recall being separated from the boys that abused him and he remembered being physically and sexually abused until he left Turana sometime in 1994. BDA did not report the further abuse because he felt that staff made him out to be the instigator and not the victim, and they didn’t believe him.

151. BDA gave evidence about the impact the sexual abuse has had on him. He said that he has experienced drug and alcohol abuse. Social acceptance is a continuing issue for him, and he has been anxious and depressed as a result of the abuse he suffered. This has made it difficult for him to find and keep a job. BDA is a single father, and said that the abuse has made him a hypersensitive and overly cautious parent.

BDA said that more recently, with counselling and support, he has gained confidence and feels more optimistic, and wants to have a better life for himself and for his daughter.

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236 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [78]-[79].
237 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [80].
238 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [82]-[83]; Annexure BDA-12, DHS.3002.091.0026_E_R at 0027_E_R.
239 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [84]; Annexure BDA-12, DHS.3002.091.0026_E_R at 0028_E_R.
240 Exhibit 30-0036, Annexure BDA-12, DHS.3002.091.0026_E_R at 0027_E_R.
241 Transcript of BDA, C9723:43-C9724:12 (Day C093).
242 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [85]; Annexure BDA-13, DHS.3002.092.0199_R.
243 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [85].
244 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [86].
245 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [87]; [89].
246 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [88].
247 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [108].
248 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [112]-[113].
249 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [115].
250 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [113]; [116].
Available findings on the experience of former residents of Turana

F1 During the period that Turana was in operation, some residents did not report child sexual abuse to anyone at the time it was occurring because:

a) they feared being punished;

b) they did not know who they could report sexual abuse to; or

c) they did not think they would be believed.

F2 During the period that Turana was in operation, some residents who did report sexual or physical abuse to a staff member were not believed, or were punished for reporting the physical or sexual abuse.

2.3 The operation of Turana

Staff hierarchy at Turana

152. Turana was run by a Superintendent, who was the most senior person responsible for the day to day running of the institution. The Superintendent was supported by a Deputy Superintendent, Principal Youth Officer, Chief Youth Officers, Senior Youth Officers, Night Senior Officer and Youth Officers.252 At times, the Superintendent was supported by an Assistant Superintendent.253

153. Ashley Cadd, a former Youth Officer at Turana between 1968 and 1990, said that the structure of Turana was very hierarchical and had a strict authoritarian culture. He said that ultimately it came down to the Senior Youth Officer that was running the section and what the Senior wanted the Youth Officers to do.253

154. David Green, a former Assistant Superintendent at Turana in 1965, and former Superintendent between April 1968 and mid-1970, agreed that the staffing at Turana had a very hierarchical structure.254 He agreed that the only people who had direct a relationship with residents, particularly when the institution was overcrowded or turnover was high, were Youth Officers.255

155. Mr Green did not disagree with the proposition that, whether the needs of residents were met, depended heavily on the empathy and personality of the Chief Youth Officers and the youth officers he encountered.256 He said that ‘the Superintendent depended upon [the] chain of command … and the critical link between the

251 Exhibit 30-0011, DHS.3004.003.0001 at 0005.
252 Transcript of A D Green, C9056:36-41: (Day C088).
253 Transcript of A Cadd, C9011:46 –C9012:1-9 (Day C088).
254 Transcript of A D Green, C9056:31-34 (Day C088).
255 Transcript of A D Green, C9056:36-41; C9057:8-35 (Day C088).
256 Transcript of A D Green, C9058: 6-29 (Day C088).
Superintendent and the sections and the day-to-day operation of the sections ... were the Chief Youth Officers.'

156. Mr Cadd stated that during the late 1960s to 1970s at Turana, there were approximately 120 base grade Youth Officers and about 12 to 13 Senior Youth Officers who ran the different sections at Turana. He said that there were about four Chief Youth Officers, a Principal Youth Officer and a Deputy Superintendent and Superintendent.

157. According to Mr Cadd, each section of Turana was staffed by a Senior Youth Officer and between two to seven rostered Youth Officers. Each section was also staffed by a Night Youth Officer and a Night Senior Officer.

Recruitment of staff at Turana

158. Mr Green gave evidence that the Principal Youth Officer and the Chief Youth Officers were critical in the recruitment of staff, and as Superintendent, he did not know the background of all of the officers employed. He said that some of the officers recruited were ‘more naturally skilled or had some training’, or were ‘more capable... than others’.

159. Mr Cadd gave evidence that from about 1968 to 1978, the Department recruited staff who were not equipped for the job and retained some staff who were only interested in having an easy day, ‘to keep the section exactly as it was supposed to be and not make any innovations’.

160. Mr Cadd told the Royal Commission that some of the staff members recruited at Turana were big men; ex-army and ex-policeman, which may have created an overwhelming environment for vulnerable children. Mr Cadd recalled Mr Horne, a Chief Youth Officer, as a ‘very imposing man, a very stern man, and you always had the feeling that, if you didn’t do what you were told, then you were going to get it’.

Training and qualifications of staff at Turana

161. Mr Green told the Royal Commission that when he was appointed Assistant Superintendent of Turana in 1965, he did not have any specific qualifications relating to childcare. He stated that he had completed an undergraduate degree in Arts and

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257 Transcript of A D Green, C9056:43-C9057:6 (Day C088).
259 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [28].
260 Transcript of A D Green, C9058:36-C9059:9 (Day C088).
261 Transcript of A D Green, C9056:7-13 (Day C088).
262 Transcript of A Cadd, C9011:11:26 (Day C088).
263 Transcript of A Cadd, C9014:40-C9015:7 (Day C088).
264 Transcript of A Cadd, C9019:12-29 (Day C088).
265 Transcript of A D Green, C9053:23-27 (Day C088).
Social Work, postgraduate study in social work, and had worked for a couple of years as a youth parole officer.266

162. Mr Green said that when he took on the role of superintendent in his late 20s, he was not fully equipped to manage the large staff of Turana. Prior to this role, he had some training in administration, but not in management.267

163. Mr Green gave evidence that in 1961, pursuant to legislative change, a training division was established which provided courses to childcare officers, youth officers and prison officers.268 He said that he occasionally lectured or participated in discussions, but did not attend any of those courses himself.269

164. Mr Cadd told the Royal Commission that prior to his employment at Turana, he received no formal training in the children or youth field.270 He said that none of the ex-army or ex-police youth officers appeared to have had any training in youth management.271

165. Mr Cadd stated that when he commenced employment at Turana, he was required to attend a training course in Hawthorne provided by the Department. The training course covered topics such as behaviour modification, group therapy, the structure of the Department and the Courts, and the rights of appeal for residents placed under care.272

### Available finding on the training of staff at Turana

F3 During the period that David Green and Ashley Cadd were employed at Turana (1965-1990), the Department:

a) did not provide adequate training or ensure that staff at Turana were trained in supervising and caring for residents; and

b) did not provide adequate training or ensure that the Superintendent of Turana was trained in the management and oversight of a large institution.

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266 Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001; Transcript of A D Green, C9053:29-44 (Day C088).
267 Transcript of A D Green, C9067:29-C9068:5 (Day C088).
268 Transcript of A D Green, C9056:15-24 (Day C088).
269 Transcript of A D Green, C9056:26-29 (Day C088).
270 Transcript of A Cadd, C9009:29-32 (Day C088).
272 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [41].
Placement and overcrowding of residents at Turana

166. The Royal Commission heard evidence from former residents that sections of Turana were overcrowded. BDB said that Classification B housed about 20 boys of all different ages. Mr Cummings said that Quamby had about 50 or 60 boys.

167. Mr Green gave evidence that the residents at Turana were admitted or committed for a variety of different reasons, and although there was an effort made to keep residents of different legal statuses separate, that effort was not always successful. Mr Green attributed this to three factors:

a. there were limited options for secure accommodation, so that on occasion when a boy admitted to the care of the Department had to be held securely, he was placed with boys that had been sentenced for criminal offences;

b. attempts were made to keep residents between 14 and 17 years of age separate from residents between 17 and 21 years of age, which sometimes meant that wards and juvenile offenders were placed together; and

c. overcrowding sometimes meant that the appropriate section for a resident to be placed in was full or over-full, and so he had to be placed somewhere else.

168. Mr Green told the Royal Commission that overcrowding affected the whole institution, and that Turana was overcrowded in some places most of the year. He said that to alleviate overcrowding, residents were transferred between units according to the demands of the institution population, and the nature of the boys involved.

169. Mr Cadd said that at times, sections of Turana held boys over their intended capacity. He said that Quamby normally should have housed 20 to 22 residents, but at times, held over 40, with the maximum he could recall being 47.

170. Mr Cadd gave evidence that when Turana was overcrowded, residents were placed in sections that they would not normally be classified into, because there was no room. He said that the increase in the number of residents did not lead to an increase in the number of youth officers allocated.

Available finding on the placement of residents at Turana

F4 During the 1960s, 1970s and 1980s the placement of children admitted to Turana as wards of the State in sections with children committed to Turana for criminal offences, and the placement of younger children in sections with older children at Turana, increased the risk of child to child sexual abuse.

273 Transcript of A D Green, C9054:28-47 (Day C088).
274 Transcript of A D Green, C9055:2-21 (Day C088).
275 Transcript of A D Green, C9055:23-31 (Day C088).
276 Transcript of A D Green, C9078:20-43 (Day C088).
277 Transcript of A Cadd, C9030:9-11 (Day C088).
278 Transcript of A Cadd, C9042:31-37 (Day C088).
The Turana Manual

171. The Royal Commission was provided with some documents comprising the policies of Turana. Both Mr Cadd and Mr Green identified a Manual of Instructions for Turana (Turana Manual) as containing policies that applied during their tenure at Turana.

172. Details of the specific policies contained in the Turana Manual which were examined in this public hearing are set out in the relevant sections below.

Supervision of residents at Turana

173. The Royal Commission heard evidence from former residents in relation to the supervision of children at Turana.

174. BDB said that in Classification B, there was a single door to a dormitory room that housed 20 boys, with the only visibility in the room being a small peephole. BDB did not recall any staff member ever entering the room to check on the boys at night.

Mr Cummings said that areas in Turana, such as the storeroom were near the night staff offices, but no screws were around when he was raped by four or five boys in the storeroom.

175. The Turana Manual set out the procedures for night shift officers, including among other things, the inspection of bedrooms, the support of the Night Senior, reports and spot checks.

176. Mr Green gave evidence that as Superintendent, he relied on Youth Officers or Senior Youth Officers to provide night-time supervision. He said that he was aware that there were problems with providing supervision at night, and that having only 10 or 11 officers on duty at night meant that the situation was ‘precarious’. He said that lack of staff was an ‘acute problem’, and gave the example of a medical emergency arising at night and a staff member having to accompany a boy to the hospital, thereby depleting the staff on duty for the night.

177. When questioned as to whether the night time supervision was ‘hopelessly inadequate’, Mr Cadd gave evidence that ‘hopelessly’ is not a strong enough word, and that he would describe it as ‘horrific’.

178. Mr Green gave evidence that he was ‘constantly discussing’ the issue of staffing of Turana and the capacity to manage demand during the 1960s with the Deputy Director of the Youth Welfare Division. He said that the Department response to these reports was a matter of budget processes, and that his understanding was that as

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279 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [43].
280 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [96].
281 Exhibit 30-0011, DHS.3004.003.0001 at 0061-0062.
282 Transcript of A D Green, C9059:16-18 (Day C088).
283 Transcript of A D Green, C9059:20-42 (Day C088).
284 Transcript of A D Green, C9061:13-21 (Day C088).
285 Transcript of A Cadd, C9033:47-C9034:9 (Day C088).
286 Transcript of A D Green, C9059:44-C9060:6 (Day C088).
Superintendent he had to manage the running of the institution, and the safety of the boys and staff of the institution, within the resources allocated by the Department on an annual basis.\[^{287}\]

179. Mr Cadd said that Youth Officers had direct supervision of the residents.\[^{288}\] He gave evidence that in all sections of Turana, including Quamby and Poplar House, there was one Youth Officer on supervision at night. He said that boys were all in bed by 9.00pm and that the instructions were that staff members were not to turn on bedroom lights to check on boys, but that checks were to occur every half hour.\[^{289}\]

180. Mr Cadd told the Royal Commission that at times it was impossible to supervise boys at Quamby when it was overrun. He said that on occasions there were four or five boys in a room designed for two, and the only checks that could be made were through an observation slit that did not provide a full view.\[^{290}\]

181. The number of residents in each section, according to Mr Cadd, made it difficult to know the residents and sections were under resourced to look after the residents.\[^{291}\]

### Available findings on the supervision of residents at Turana

**F5** Supervision of residents at Turana at night was inadequate. Specifically:

- a) there were insufficient numbers of night duty officers to supervise residents; and
- b) the physical environment made it impossible for staff to monitor each and every resident.

**F6** Overcrowding was a serious problem at Turana between 1968 and 1990. Overcrowding hindered the provision of adequate supervision, and meant that residents were placed in sections based on the availability of beds as opposed to their compatibility, suitability and safety.

### Absconding from Turana

182. The Royal Commission heard evidence that a number of former residents absconded from the institution because of abuse and to avoid further abuse. Mr Latham said that he ran away following repeated rapes by Mr Wilkie and Mr Horne. He said that he was picked up by police, who did not ask him why he ran away and was returned to Turana.\[^{292}\]

\[^{287}\] Transcript of A D Green, C9060:17-C9061:28 (Day C088).
\[^{288}\] Transcript of A Cadd, C9010:46-C9011:3 (Day C088).
\[^{290}\] Transcript of A Cadd, C9016:28-39 (Day C088).
\[^{291}\] Transcript of A Cadd, C9029:43-C9030:30 (Day C088).
\[^{292}\] Exhibit 30-0001, Statement of N Latham, STAT.0611.001.0001_R at [63]-[67].
183. Similarly, Mr Marijancevic stated that he absconded from Turana many times to escape the abuse. He was returned without being asked why, but instead was labelled as being ‘disturbed’ and ‘unstable’.293

184. The Turana Manual contains procedures regarding residents absconding from Turana. It states:

**Procedures:** Notify Chief Youth Officer and the Principal Youth Officer.

Notify Admitting Officer, who will contact Royal Park Police.

At night, contact the Night Senior who will contact Royal Park Police.

...Many of the boys are unstable for many reasons and as pressures develop in them, or their section, or in their relationships, they resort to absconding. Each officer is expected to show some insight into these problems and, through this, to help reduce absconding...

At all times each officer must know the number of boys in his care, their whereabouts and what they are doing. This entails considerable application to duty by an officer, but is one of his most important tasks.

Negligence in these matters is extremely serious and in all report writing related to absconding, officers are required to supply full and precise details...

These reports are to be made by the Youth Officer before his shift finishes. Reports will be forwarded to the Superintendent by the Principal Youth Officer as soon as possible on the same day.294

185. Mr Cadd stated that contrary to the Turana Manual, it was up to the Chief Youth Officer to report absconding to the Principal Youth Officer if it was considered necessary. The Principal Youth Officer similarly had the discretion to report absconding to the Superintendent. Mr Cadd stated that there was very little by way of policies in place to guide staff in finding out the reasons why a boy absconded. He stated that in practice, boys who were returned from absconding were placed in remand until a decision was made by the Chief Youth Officer or Principal Youth Officer as to where the boy should be placed.295

186. Mr Cadd stated that unless the boy volunteered the reasons why he absconded, there was no obligation on the Senior Youth Officer to find out why he had done so.296

187. Mr Cadd told the Royal Commission that when he worked in the admitting office and a police officer returned a resident who had absconded, no police officer ever told him

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293 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R at [82].
294 Exhibit 30-0011, DHS.3004.003.0001 at 0032.
295 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [45(b)].
296 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [45(b)].
that the resident had absconded because of abuse. He said that it was often transit police who picked the resident up and returned him to Turana.\textsuperscript{297}

188. Mr Cadd gave evidence that ‘there was very little interaction between police and the admitting staff’.\textsuperscript{298}

**Available finding on absconding from Turana**

\textbf{F7} Some residents absconded from Turana as a result of child sexual abuse or to avoid further incidents of child sexual abuse. Staff at Turana did not recognise this, and were not trained to deal with residents who had absconded because of child sexual abuse.

**Punishment of residents at Turana**

189. The Turana Manual set out procedures for discipline and correction and states that:

\[
[I]t \text{ is obligatory for all officers to see that punishment and negative correction of any kind is minimised... threats of action and statements of action which are not allowed in the Regulations, must never be made to any boy by any officer.}\textsuperscript{299}
\]

190. The Turana Manual also states that:

Isolation is only to be used as a punishment of last resort. It must only be used as directed by the Superintendent, Deputy Superintendent, Principal Youth Officer or Chief Youth Officer.\textsuperscript{300}

191. Yet the Royal Commission heard evidence from a number of former residents that punishment was inflicted at Turana in the form of degrading and humiliating chores, and that threats of punishment were made frequently by staff members.

192. Mr Marijancevic told the Royal Commission that he was made to clean stairs with a toothbrush as punishment and was left in an isolation cell overnight after being sexually abused.\textsuperscript{301} Mr Cummings said that when he returned after absconding he was made to line up in a corridor where he was exposed to physical abuse by other residents and he recalled having to polish steel buckets with steel wool.\textsuperscript{302} Mr Latham gave evidence that he was threatened with being sent to Poplar House if he did not follow directions from screws.

\textsuperscript{297} Transcript of A Cadd, C9050:12-28 (Day C088).
\textsuperscript{298} Transcript of A Cadd, C9050:12-28 (Day C088).
\textsuperscript{299} Exhibit 30-0011, DHS.3004.003.0001 at 0094.
\textsuperscript{300} Exhibit 30-0011, DHS.3004.003.0001 at 0095.
\textsuperscript{301} Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001\_R at [62], [70].
\textsuperscript{302} Transcript of R Cummings, C8961:15-23 (Day C087); Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001\_R\_M at [68]-[70].
193. Mr Cadd said that staff at Turana controlled boys through punishment. He agreed that some staff members punished residents by making them do menial tasks.\(^{303}\)

194. Mr Cadd told the Royal Commission that he witnessed youth officers assigning duties to boys which he agreed were humiliating and degrading, and that this was a technique used to abuse the residents. He said that some boys were forced to polish floors with two tissues on their hands and knees, because they were awake after the lights had been turned out.\(^{304}\)

195. Mr Green gave evidence that he recalled certain punishments relating to cleaning, including the use of mops and cloths.\(^{305}\)

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**Available finding on punishment of residents at Turana**

F8 The punishment administered at Turana by some staff members was cruel, humiliating and degrading. The forms of punishment inflicted by some staff members:

a) were designed to keep residents occupied and compliant;

b) were an informal mechanism of command and control; and

c) had the effect of discouraging residents from disclosing sexual abuse because they thought they would not be believed.

These forms of punishment were a feature of the culture of the institution; they were not mandated by formal policies or procedures.

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**Culture of Turana**

196. Mr Green gave evidence that when he commenced at Turana in 1965, he learnt that the method of looking after the residents involved a fair amount of authoritarian control and command.\(^{306}\)

197. Mr Cadd said that when he arrived at Turana, the focus was on the control, not the welfare of the residents.\(^{307}\) He perceived that Turana had a culture of covering up incidents in relation to the welfare of residents. He said that this was because reports made about residents never went anywhere and just disappeared. He told the Royal Commission that some reports were inaccurate and misleading.\(^{308}\)

198. A number of former residents told the Royal Commission that they received no education while resident at Turana.

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\(^{303}\) Transcript of A Cadd, C9032:41-C9033:5 (Day C088).

\(^{304}\) Transcript of A Cadd, C9015:9-34 (Day C088).

\(^{305}\) Transcript of A Cadd, C9081:10-31 (Day C088).

\(^{306}\) Transcript of D Green, C9054:14-18 (Day C088).

\(^{307}\) Transcript of A Cadd, C9032:41-46 (Day C088).

\(^{308}\) Transcript of A Cadd, C9033:29-45 (Day C088).
199. Mr Green gave evidence that ‘one of the significant failings of the institution was that the provision of meaningful education, training and work opportunities [was] limited’. Mr Green agreed that overcrowding exacerbated this problem, and said that it was particularly difficult to implement programs for residents in secure sections.

200. According to Mr Green another major shortcoming was the absence of adequate mental health services for boys with complex needs. He said that he instructed officers to stop using certain forms of punishment as they were demeaning, belittling and humiliating, and aggravated the problems that arose from the attitude residents had towards themselves and their experiences. He said that he relied on the Chief Youth Officers to implement this instruction.

201. Mr Cadd agreed with the evidence of Mr Green that there was a lack of suitable work programs and training and a shortage of school teachers. He agreed that there were insufficient opportunities for residents to engage in dignified work, proper schooling or trade programs. He said that the programs were there in theory and that trade instructors often did not engage with the residents.

2.4 Response to reports of child sexual abuse at Turana

202. The Royal Commission made a number of enquiries to identify and locate institutional witnesses who were directly involved in the response to allegations of child sexual abuse during the time period examined. A number of the institutional witnesses could not be identified or located, or were deceased at the time of the public hearing.

203. Some institutional witnesses involved in the experience of Robert Cummings were located, and contact was made by the Royal Commission to obtain evidence from these witnesses.

204. Dr Douglas Hibbs, the Psychiatric Medical Officer at Turana Psychiatric Clinic, who referred Mr Cummings to the Parkville Psychiatric Unit (PPU), was requested to provide a statement to the Royal Commission. Dr Hibbs resides in New Zealand and did not make himself amenable to the Royal Commission or this public hearing.

205. Dr Graham Mellsop, the Psychiatric Registrar at the PPU who assessed Mr Cummings, was put on notice of the matters concerning Mr Cummings prior to the public hearing. Dr Mellsop resides in New Zealand and did not contact the Royal Commission for this public hearing.

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309 Transcript of A D Green, C9055:33-44 (Day C088).
310 Transcript of A D Green, C9055:23-44 (Day C088).
311 Transcript of A D Green, C9071:47-C9072:5 (Day C088).
312 Transcript of A D Green, C9081:37-C9082:1 (Day C088).
313 Transcript of A D Green, C9082:3-15 (Day C088).
314 Transcript of A Cadd, C9029:22-41 (Day C088).
206. The Royal Commission did hear from Thomas Verberne, a Psychologist at the PPU, who administered the aversion therapy treatment to Mr Cummings. The evidence he gave the Royal Commission is set out below.

**Response to reports of child sexual abuse by Robert Cummings**

207. The Royal Commission heard evidence that Mr Verberne was employed as a Psychologist at the PPU shortly after it opened in about 1965. He stated that his role involved carrying out psychological assessments of patients referred to him through government work.

208. When asked whether he had an independent recollection of Mr Cummings, Mr Verberne said that he did not remember Mr Cummings or any child being referred to him from Turana, although ‘he can’t swear that it didn’t happen’.

209. A document obtained by the Royal Commission, being a letter dated 17 March 1971 from Dr Mellisop to Dr Hibbs regarding Mr Cummings, was shown to Mr Verberne during the public hearing. Mr Verberne told the Royal Commission that behaviour therapy was something he started at PPU and that the form of behaviour therapy referred to in the letter was known as aversion therapy.

210. Mr Verberne told the Royal Commission that aversion therapy:

> [i]s a form of psychological treatment in which the patient is exposed to a stimulus while simultaneously being subjected to some form of discomfort. This conditioning is intended to cause the patient to associate the stimulus with unpleasant sensations in order to stop the specific behaviour.

211. Mr Verberne said that aversion therapy was used to treat people who had ‘homosexual impulses’. He estimated that at the PPU, approximately 10 to 15 people were introduced to aversion therapy treatment, with some proceeding with the treatment, but none of whom were children.

212. Mr Verberne said that the treatment administered on Mr Cummings was a combination of two treatments – electric aversion therapy and systematic desensitisation. He gave evidence that the electric aversion therapy involved showing a patient photographs of naked or semi-naked men, after which they would or would not receive an electric shock. The aim was to associate a naked or semi-naked man...

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315 Transcript of T Verberne, C8966:24-29 (Day C087).
316 Exhibit 30-0005, Statement of T Verberne, STAT.0619.002.0001_R at [2]; Transcript of T Verberne, C8967:15-18 (Day C087).
317 Transcript of T Verberne, C8968:18-38 (Day C087).
318 Exhibit 30-0006, DHS.3002.082.0011.
319 Transcript of T Verberne, C8973:35-C8974:34 (Day C087).
320 Transcript of T Verberne C8974:45-C8975:8 (Day C087).
321 Transcript of T Verberne, C8975:47-8976:11 (Day C087).
322 Transcript of T Verberne, C8975:47-C8976:16 (Day C087).
323 Transcript of T Verberne, C8976:41-43 (Day C087).
324 Transcript of T Verberne, C8980:34-37 (Day C087).
with pain. He said that systematic de-sensitisation involved showing pictures of women in which the patient would not receive an electric shock.

213. Mr Verberne said that the administration of electricity was set at a particular level and the voltage could not be turned up if it was deemed to not be having any effect. When asked whether it could be turned down, he said that he didn’t think it could be, but was unsure as to how the electricity was supplied.

214. As indicated above, Mr Cummings told the Royal Commission that the electric shocks felt like a ‘really massive jolt of sharp pain’. Mr Verberne told the Royal Commission that the pain of the shock was ‘comparable with if you have a rubber band around your wrist and you flick it’. He accepted, however, that the way in which people experience pain is different.

215. Mr Verberne told the Royal Commission that Mr Cummings was referred to PPU by Dr Hibbs. He said that he did not discuss the appropriateness of the referral with Mr Cummings, because ‘the discussion had taken place between the patient and the psychiatrist who referred the patient’.

216. Documents obtained by the Royal Commission show that prior to Dr Hibbs’ involvement, the initial referral was made by David Green, the then Supervisor of Classification and Treatment. A letter from Mr Green to Dr Grigor, the Consultant Psychiatrist at Turana states:

Robert’s behavior has been somewhat bizarre at the Hostel but the indications of sexual disturbance had not become evident until fairly recently.

217. Mr Green accepted that it should have been in his mind that there was a possible explanation for Mr Cummings’ behaviour that did not involve him having volunteered that he had homosexual behaviours. He said that his level of appreciation of the possibility of sexual abuse in the 1970s was not as great as it should have been at the time and that ‘our thinking and systems at the time did not alert us to the possibility that the young man... was in fact a victim of an adult or abuse, rather than as I have described in the letter’.

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325 Transcript of T Verberne, C8981:24-43 (Day C087).
326 Transcript of T Verberne, C8982:7-15 (Day C087).
327 Transcript of T Verberne, C8982:33-43 (Day C087).
328 Transcript of T Verberne, C8997:42-C8998:2 (Day C087).
329 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [89].
330 Transcript of T Verberne, C8983:38-43 (Day C087).
331 Transcript of T Verberne, C8984: 15-20 (Day C087).
332 Transcript of T Verberne, C9001:5-7 (Day C087).
333 Transcript of T Verberne, C8987:21-27 (Day C087).
334 Exhibit 30-0004, Annexure RJC-7, DHS.3002.082.0023_R.
335 Exhibit 30-0004, Annexure RJC-7, DHS.3002.082.0023_R.
336 Transcript of T Verberne, C9074:22-29 (Day C087).
337 Transcript of T Verberne, C9074:42-C9075:9 (Day C087).
218. Mr Green said that he was regretful that he ‘was not more rigorous in thinking through these processes where the circumstances might have suggested that an entirely different construction could be placed’ on it.\textsuperscript{338} He said that in making the referral to Dr Grigor, he relied upon experts to guide his decision making process.\textsuperscript{339}

219. Mr Verberne said that when he was based at the PPU, he was not asked to provide treatment or counselling to a child who had been sexually abused,\textsuperscript{340} and said that at the time, it did not occur to him that some children might be subjected to child sexual abuse.\textsuperscript{341}

220. In relation to children at Turana, Mr Verberne gave evidence that he did not know or suspect that any children at Turana were being sexually abused.\textsuperscript{342} He said that he had not received any reports of sexual abuse and never asked whether anyone he was treating had been sexually abused.\textsuperscript{343} Mr Verberne told the Royal Commission that it was not his practice to systemically ask people whether they were ever sexually abused,\textsuperscript{344} but thought that in hindsight, this would have been relevant in a clinic situation.\textsuperscript{345}

221. A letter dated 10 May 1968 from Alan Stoller to Mr Verberne was shown to Mr Verberne during the public hearing.\textsuperscript{346} The letter states:

> In reply to your letter of 3rd May, I cannot see that there is any risk involved in the use of electrical stimulation for behavioural therapy, other than gross negligence.
> In regards to negligence, this is a matter which has to be treated legally on its merits and no legal protection can be afforded by the government in such cases...
> The medical practitioner in charge of the case should ensure that the patient is fully aware of what is being undertaken and in the case of a minor, the guardian or nearest relative should be consulted...\textsuperscript{347}

222. When shown the letter, Mr Verberne said that he wished he had really taken that in at the time.\textsuperscript{348} He was questioned about whether a guardian was responsible for consenting to a child receiving aversion therapy, and he said that the guardian of children who were wards of the State, was the State.\textsuperscript{349} He said that in the case of Mr Cummings, this was the Director at Turana.\textsuperscript{350} He assumed that if there was a referral

\textsuperscript{338} Transcript of T Verberne, C9075:11-21 (Day C087).
\textsuperscript{339} Transcript of T Verberne, C9088:20-23 (Day C087).
\textsuperscript{340} Transcript of T Verberne, C8972:28-33 (Day C087).
\textsuperscript{341} Transcript of T Verberne, C8973:3-15 (Day C087).
\textsuperscript{342} Transcript of T Verberne, C8986:3-9 (Day C087).
\textsuperscript{343} Transcript of T Verberne, C8993:18-25 (Day C087).
\textsuperscript{344} Transcript of T Verberne, C8993:45-C8994:7 (Day C087).
\textsuperscript{345} Transcript of T Verberne, C8993:27-29 (Day C087).
\textsuperscript{346} Exhibit 30-0006, DHS.3009.042.0187.
\textsuperscript{347} Exhibit 30-0006, DHS.3009.042.0187.
\textsuperscript{348} Transcript of T Verberne, C8979:6-13 (Day C087).
\textsuperscript{349} Transcript of T Verberne, C8980:12-22 (Day C087).
\textsuperscript{350} Transcript of T Verberne, C8989:28-33 (Day C087).
from Turana, it was implicitly understood that appropriate legal approvals had been given.\textsuperscript{351}

223. Mr Verberne said that the nature of the aversion therapy treatment was such that it would have been entered into voluntarily by the patient and he ‘couldn’t see how you could do it involuntarily’.\textsuperscript{352} He said that if the patient ‘indicated in any way that they didn’t want this treatment, that was that, it would be the end of it’.\textsuperscript{353}

224. Mr Verberne accepted that a child who is sexually abused is often very powerless and that in those circumstances, may submit to the demands of powerful adults, which does not mean that they do so voluntarily.\textsuperscript{354}

### Available findings on the response to reports of child sexual abuse by Robert Cummings

**F9** The response of staff to the sexual abuse of Robert Cummings in 1971 was to conclude that he was a homosexual, and to administer aversion therapy at the Royal Park Hospital to “cure” him of his homosexuality. Ultimately this response discouraged Robert Cummings from making further disclosures of sexual abuse, despite such abuse occurring. This response caused Robert Cummings considerable trauma.

**F10** In administering aversion therapy to Robert Cummings, Thomas Verberne did not adequately consider:

a) the possibility that Robert Cummings could have been the victim of child sexual abuse;

b) the vulnerability of Robert Cummings as a ward of the State; and

c) how these circumstances could affect whether Robert Cummings’ submission to treatment was truly voluntary.

### Response to reports of child sexual abuse at Turana

225. As indicated above, a number of enquiries were made by the Royal Commission to locate the whereabouts of Ian Cox (the former Superintendent at Turana during the 1960s) for the public hearing. These enquiries confirmed that Mr Cox died in 2008.

226. In the absence of evidence from Mr Cox, the Royal Commission heard from Mr Cadd and Mr Green who gave general evidence as to the response of Turana to the sexual abuse of the survivors.

227. Mr Cadd told the Royal Commission that he observed a culture at Turana where residents would not feel comfortable reporting abuse for fear of being labelled a ‘lagger’ or ‘dobber’ or for fear of making the situation worse. He said that older and

\textsuperscript{351} Transcript of T Verberne, C8980:24-28 (Day C087).

\textsuperscript{352} Transcript of T Verberne, C8996:26-34 (Day C087).

\textsuperscript{353} Transcript of T Verberne, C8991:41-47 (Day C087).

\textsuperscript{354} Transcript of T Verberne, C9002:18-27 (Day C087).
bigger residents would intimidate other boys and feminine nicknames would be attached to anyone who reported abuse.  

Mr Green agreed that boys rarely reported or provided all the detail of physical or sexual assaults for fear of being further victimised, intimidated and targeted by other boys. He stated that:

I have memories of having a really strong sense that a boy was not telling me what actually happened because he did not think that I could protect him if he had.

When asked what he did to combat this culture of non-disclosure, Mr Green described an informal response of attempting to talk to the boy, or asking the Chief or Senior to keep an eye on him. Mr Green said that if the boy had not lodged a complaint, he did not institute the complaint process.

In his experience during his first decade at Turana, Mr Cadd said that he was not aware of any instances of sexual abuse, with the exception of a couple of cases involving residents, including an incident where a resident was raped with a toothbrush. He said in this instance, the police were called and the perpetrator was charged. He did not become aware of any allegations of staff sexually interfering with residents.

Mr Cadd said that at Quamby and Classification B, there were opportunities for some residents to assault other residents. As discussed above, he said that in Quamby, there were times when there were four or five boys in a room designed for two, who could only be observed through an observation slit. He also said that in Classification B, the intake of new residents and the number of residents in each dorm (sometimes 16 or 17 residents), also created opportunities for abuse. He gave evidence that officers were not allowed to open the door to the dorms as it was considered a breach of security.

Mr Cadd told the Royal Commission that in the 1960s and 1970s, the Superintendent and Deputy Superintendent had very little contact with the residents, and only a few visited the residents. He said that most residents didn’t know who the Superintendent was, and a lot of the residents would have been terrified to complain to a Superintendent, as the Superintendent was often used as a threat to the residents.

Mr Green gave evidence that during his time as Superintendent he tried to interact with the boys, and that boys did report problems to him while he was doing his
rounds. He said that on a few occasions, boys spoke to him about being physically assaulted by other boys. He said that he discussed this with the boy, and then reported it to the Senior or Chief and asked that the matter be investigated and action be taken. He said that he had an expectation that the boy would be respectfully listened to, that an incident report would be made and that some decisions would be made with respect to the event.

234. Mr Green gave evidence that he was aware that there was a risk that residents could be sexually assaulted by each other or by officers. He said that this was particularly the case as many of the residents had experienced significant problems within their family prior to being placed in Turana, and were going through puberty.

235. Mr Green told the Commission that his ‘level of appreciation of the possibility of sexual abuse in 1970 was not as great as it is now or should have been at the time’.

236. Mr Green said that his concerns about the lack of supervision of night included concerns that residents might engage in inappropriate sexualised behaviours. He gave evidence that a lack of alternative arrangements meant that staff had no option but to lock boys in dormitories to sleep, despite the known risk of child-to-child sexual abuse. Mr Green said that he took no measures to safeguard children from being sexually abused by staff on duty at night, in this regard he had to trust the integrity of the officers.

Policies and procedures for reporting and responding to child sexual abuse at Turana

237. As set out above, the Royal Commission was provided with the Turana Manual. Mr Cadd stated that the Turana Manual remained in place until the mid-1980s when it was revised with an updated manual.

238. Mr Cadd stated that the Turana Manual did not contain any specific policy or procedure in handling or responding to complaints of child sexual abuse. He said that there was a section that required written reports on ‘unnatural acts’ between residents, but the policy did not specifically refer to an ‘unnatural act’ committed by an officer towards a resident.

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365 Transcript of A D Green, C9057:8-11; C9057:37-40 (Day C088).
366 Transcript of A D Green, C9057:42-45 (Day C088).
367 Transcript of A D Green, C9057:47-C9058:4 (Day C088).
368 Transcript of A D Green, C9058:6-23 (Day C088).
369 Transcript of A D Green, C9061:30-C9062:1 (Day C088).
370 Transcript of A D Green, C9062:3-37 (Day C088).
371 Transcript of A D Green, C9074:31-40 (Day C088).
372 Transcript of A D Green, C9062:39-44 (Day C088).
373 Transcript of A D Green, C9062:46-C9063:11 (Day C088).
374 Transcript of A D Green, C9063:13-19 (Day C088).
375 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [43].
376 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [46].
377 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [47]-[48].
378 Transcript of A D Green, C9024:4-18 (Day C088).
239. The section of the Turana Manual entitled ‘Reports and Report Writing’ states:

All officers will be requested to write reports to Senior Officers about incidents which have occurred while on duty...

Reports will be written automatically on incidents such as –

- Aggressive behavior by a group of trainees or one trainee towards officers.
- Unnatural acts committed or reported to have been committed by trainees on other trainees...
- Absconding or attempts to abscond.
- Peculiar behavior problems of particular trainees.
- Any incident which is of unusual nature.

Reports must be written prior to the completion of the shift and left accessible for the Senior Officer on duty in the division...\(^\text{379}\)

240. Mr Cadd stated that this section of the Turana Manual did not tell officers how to deal with or respond to reports of incidents, other than to write a report.\(^\text{380}\) Mr Cadd said that no training was provided to interpret the Turana Manual or how to apply it.\(^\text{381}\)

241. Mr Green stated that the Turana Manual was ‘not comprehensive’, and ‘lacked guidelines for proactive problem solving (particularly in the area of sexual abuse)’.\(^\text{382}\)

242. He agreed that there was no change to the Turana Manual in terms of dealing with child sexual abuse between 1970 and 1981,\(^\text{383}\) and said:

[T]he Turana Manual was built on a 1950s set of procedures which largely related to ... to care of stores and laundry and linen and lock up ... [rather than] the well-being of, or the enhancement of the support, training and lives of the inmates ...\(^\text{384}\)

243. Mr Cadd stated that when the Turana Manual was revised in the mid-1980s, there was still no specific policy or procedure for handling or responding to incidents of child sexual abuse.\(^\text{385}\) Mr Cadd said that the revised manual removed the reference to ‘unnatural acts’ and focused more on physical incidents, rather than sexual abuse.\(^\text{386}\)

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\(^{379}\) Exhibit 30-0011, DHS.3004.003.0001 at 0073.
\(^{380}\) Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [49].
\(^{381}\) Transcript of A Cadd, C9049:6-9 (Day C088).
\(^{382}\) Exhibit 30-0013, Statement of D Green, STAT.0637.001.0001_R at [59].
\(^{383}\) Transcript of A D Green, C9071:5-14 (Day C088).
\(^{384}\) Transcript of A D Green, C9071:5-14 (Day C088).
\(^{385}\) Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [53]; [60].
\(^{386}\) Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [59]-[60].
244. As set out above, Mr Cadd stated that when he first started at Turana, he attended a training course provided by the Department in Hawthorn, which taught different ways of looking after residents, but that training did not provide any instruction in dealing with or handling complaints of child sexual abuse or what to do if disclosures of sexual abuse were made.\(^{387}\) He told the Royal Commission that the course was what he would call a ‘Mickey Mouse course’; a trivial course.\(^{388}\)

245. Mr Cadd told the Royal Commission that in the mid-1980s, the Department ran courses for youth work, which he described as an ‘extended Mickey Mouse course’.\(^{389}\)

**Available findings on policies and procedures for reporting and responding to child sexual abuse at Turana**

F11 During the period that Turana was in operation, there were no formal policies or procedures for:

- a) receiving or responding to complaints of child sexual abuse, and
- b) reporting complaints of child sexual abuse to the Director of the Department and/or the Victoria Police.

F12 During the period that Ashely Cadd was employed at Turana (1968-1990), there was little or no training offered to staff members at Turana in understanding child sexual abuse or responding to complaints of child sexual abuse. The absence of this training undermined the capacity of staff members at Turana to deal effectively with complaints of sexual abuse.

**The reporting of incidents at Turana in practice**

246. Mr Cadd stated that the escalation and reporting of incidents remained with the Chief Youth Officer and Principal Youth Officer. Information could be withheld by Chief Youth Officers and the Principal Youth Officer from the Superintendent. Mr Cadd stated that complaints could be made by Youth Officers concerning incidents involving a boy, but these complaints could get lost in the bureaucracy and depended on the Chief Youth Officer and the Principal Youth Officer.\(^{390}\)

247. Mr Cadd told the Royal Commission that the reporting structure at Turana was referred to as a ‘sieve system’. He said that ‘in as much as the youth officer who would be reporting an incident would write the incident report, talk to the senior about it; the senior would only pass on what he felt to the chief, and the chief may in turn close the matter off and not proceed anywhere else’.\(^{391}\)

\(^{387}\) Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [40]-[42].

\(^{388}\) Transcript of A Cadd, C9012:11-32 (Day C088).

\(^{389}\) Transcript of A Cadd, C9040:36-C9041:13 (Day C088).

\(^{390}\) Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [64 (a)] – [64 (b)].

\(^{391}\) Transcript of A Cadd, C9010:25-35 (Day C088).
248. Mr Cadd said that a complaint could be made to look worse than it was, or made to look trivial.\textsuperscript{392} He agreed that in order for a complaint to get to the Superintendent, the Chief Youth Officer would be the conduit and could ‘snuff anything out’.\textsuperscript{393}

249. In the absence of an express policy, Mr Cadd gave evidence that he developed a general practice for responding to incidents of abuse, including physical and sexual abuse. This process was:

a. Complainant reported abuse or incident to the Youth Officer.

b. Youth Officer recorded the abuse or incident in the Report Book and reported to the Senior Youth Officer.

c. Senior Youth Officer and Youth Officer discussed the incident with the complainant.

d. If there was a foundation for the complaint, the incident was reported to the Chief Youth Officer.

e. Chief Youth Officer considered the incident and reported any matters to the Principal Youth Officer.

f. Principal Youth Officer considered the incident and reported any matters to the Superintendent.\textsuperscript{394}

250. Mr Cadd gave evidence that in the mid-1980s, his general policy was amended to include incidents being reported to the police (upon consultation with the Principal Youth Officer and Superintendent) and the complainant being taken to a psychiatrist for assessment.\textsuperscript{395}

251. Mr Green gave evidence that he did not receive any reports about child sexual abuse perpetrated by an officer.\textsuperscript{396} He said that he was informed of reports of sexual abuse of a resident by another resident.\textsuperscript{397} Mr Green said that he was informed of incidents of child to child sexual abuse either via night reports, incident reports or a direct report from the Senior or Chief on duty, or via a direct complaint from a resident during his movement around the institution.\textsuperscript{398}

252. Mr Green told the Royal Commission that in some instances the perpetrator of child to child sexual abuse was identified.\textsuperscript{399} He said that there were a range of strategies for

\textsuperscript{392} Transcript of A Cadd, C9036:14-24 (Day C088).
\textsuperscript{393} Transcript of A Cadd, C9037:3-5 (Day C088).
\textsuperscript{394} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [50]–[52].
\textsuperscript{395} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [53]–[54].
\textsuperscript{396} Transcript of A D Green, C9061:30-C9062:1 (Day C088); C9064:12-16 (Day C088).
\textsuperscript{397} Transcript of A D Green, C9064:18-20 (Day C088).
\textsuperscript{398} Transcript of A D Green, C9064:22-37 (Day C088).
\textsuperscript{399} Transcript of A D Green, C9079:42-C9076:1 (Day C088).
dealing with perpetrators, including referral to the police, transfer within the Institution, the imposition of penalties, counselling and referral to a psychiatrist.400

253. Mr Green said that he could not recall a referral to police with respect to an alleged perpetrator of sexual abuse.401

254. Mr Green gave evidence that as Superintendent he had an expectation that if a report of child to child sexual abuse was made, section staff, generally the Chief or Senior, would contact the medical officer and make other arrangements to look after the welfare of the child.402

255. Mr Green said that he was horrified and surprised by the evidence before the Royal Commission that when children reported sexual abuse, nothing was done to ensure their welfare or protect them from the abuse.403

Available finding on the reporting of incidents at Turana in practice

F13 The hierarchical staffing structure in place at Turana from 1968 (when Ashely Cadd commenced employment) to the mid-1980s prevented reports of child sexual abuse from being escalated to senior management, In practice:

a) Chief Youth Officers were relied upon to respond to complaints of child sexual abuse; and

b) reports of child sexual abuse made by residents to youth officers were rarely brought to the attention of executive staff.

Reporting to the Department and the Victoria Police by staff at Turana

256. Mr Cadd stated that the Department had very little interaction and oversight over the residents at Turana. He did not recall seeing any representatives of the Department at Turana interact with any of the residents, nor did he recall being involved in any meetings with the Department about the welfare of boys in the section he was allocated to.404

257. As set out above, Mr Cadd stated that although there were no formal policies or procedures in place at Turana to handle or respond to allegations of child sexual abuse, he developed his own policy to respond to incidents of abuse. In the mid-1980s, this policy included a report to the police.405

400 Transcript of A D Green, C9080:3-11; C9080:17-25 (Day C088).
401 Transcript of A D Green, C9080:13-15 (Day C088).
402 Transcript of A D Green, C9064:39-C9065:15 (Day C088).
403 Transcript of A D Green, C9065:21-47 (Day C088).
404 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [39].
405 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [53].
258. Mr Cadd stated that incidents were only reported to the police upon consultation with the Principal Youth Officer and the Superintendent, who were responsible for making decisions to contact the police.\textsuperscript{406}

259. Mr Green said that in dealing with instances of abuse amongst residents, Turana had a range of options or strategies, the most significant being a referral to the police, although he could not recall whether such a referral was made.\textsuperscript{407}

260. There was no evidence before the Royal Commission as to whether the Department had a policy requiring that staff at Turana report any allegations of child sexual assault to the Department or to Victoria Police.

\textbf{Available finding on reporting to the Department and the Victoria Police by staff at Turana}

F14 During the period that Turana was in operation, the Department provided little or no oversight of the institution. The responsibility for the day to day operations of Turana, including responding to complaints of child sexual abuse, was delegated to the executive staff members of Turana.

\textsuperscript{406} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001\_R at [54].
\textsuperscript{407} Transcript of A D Green, C9080:3-15 (Day C088).
Part 3  Winlaton Youth Training Centre

3.1  Winlaton Institutional Profile

279. Winlaton first commenced operation in August 1956.\textsuperscript{408} It was established to reduce overcrowding at the female remand section of the Royal Park Depot.\textsuperscript{409}

280. Winlaton was the only statutory institution in Victoria for young women aged between 14 and 21 years, although some girls younger than 14 were admitted to Winlaton because they were deemed to present a severe management problem or persistently ran away from non-secure facilities.\textsuperscript{410}

281. Winlaton operated as a youth training centre, a classification and assessment facility, a remand centre and a reception centre.\textsuperscript{411}

282. Winlaton provided single-room accommodation for up to 45 girls in three sections or cottages.\textsuperscript{412} The sections were designed to segregate girls in their various stages of training and also to avoid mixing newly admitted girls with girls who had almost completed periods of training.\textsuperscript{413}

   a. Goonyah was a maximum security section that catered for older and sentenced girls. Girls awaiting appearance in court also resided at Goonyah.\textsuperscript{414} Goonyah is described as the punishment section for Winlaton.\textsuperscript{415}

   b. Karingal was an open, medium security section for girls that were deemed to have continued behavioural problems or that had unsuccessful community placements.\textsuperscript{416}

   c. Warrina was also an open, medium security section that was divided into two sections. Newly admitted girls awaiting classification were placed in the east end. Classified girls awaiting further placement resided in the west end.\textsuperscript{417}


\textsuperscript{409} Exhibit 30-0006, DHS.3004.011.0367 at 0468.


\textsuperscript{412} Exhibit 30-0006, DHS.3004.011.0367 at 0468.


\textsuperscript{414} Exhibit 30-0011, DHS.3004.001.0010 at 0008-35.

\textsuperscript{415} Exhibit 30-0011, DHS.3106.005.0006 at 0011.

\textsuperscript{416} Exhibit 30-0011, DHS.3004.001.0010 at 0033.

\textsuperscript{417} Exhibit 30-0011, DHS.3004.001.0010 at 0031.
283. In 1959, two additional sections were established by the Department on the same property:

   a. Winbirra, a remand centre that allowed for the segregation of girls who had not yet been admitted to the Care of the Department from admitted girls,\(^{418}\) and

   b. Leawarra, a hostel that was mainly used as a halfway house for those girls who were employed but still required some supervised care.\(^{419}\)

284. Winlaton was run by a Superintendent assisted by two Deputy Superintendents. A Principal Youth Officer reported to the Deputy Superintendents and Superintendent. Below the Principal Youth Officer were three Chief Youth Officers, who were in turn assisted by Senior Youth Officers, Second-in-charge and Youth Officers.\(^{420}\)

285. In September 1991, Winlaton was renamed the Nunawading Youth Residential Service and became a mixed-gender facility.\(^{421}\)

286. In 1993, lower than expected numbers of both male and female clients at the Nunawading Youth Residential Service led to a decision to relocate the centre to the former Baltara site. That site then became known as the Parkville Youth Residential Centre.\(^{422}\)

3.2 The experience of former residents of Winlaton

287. Five former residents of Winlaton gave evidence to the Royal Commission of their experiences of sexual abuse at Winlaton. The Royal Commission also heard evidence from another former resident in relation to the response of Winlaton and the Department to reports of her being raped.

288. Each of the former residents of Winlaton told the Royal Commission of the physical, emotional and sexual abuse they suffered while they were placed at Winlaton. The Royal Commission heard evidence of common experiences among residents including: a lack of supervision and oversight, which facilitated abuse by other residents and allowed staff, referred to by some girls as ‘screws’ access to residents; a culture of not being able to report abuse for fear of being further victimised and punished; a culture of not being believed; and the use of lock up cells as punishment.

The evidence of BDC

289. BDC was born in Wagga, NSW in 1949 and is 66 years old.\(^{423}\)

\(^{419}\) Exhibit 30-0006, DHS.3004.011.0367 at 0468
\(^{420}\) Exhibit 30-0011, DHS.3004.001.0010 at 0027.
\(^{421}\) Exhibit 30-0006, DHS.3004.011.0367 at 0435.
\(^{422}\) Exhibit 30-0006, DHS.3004.011.0367 at 0435.
\(^{423}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [7].
290. When BDC was around five years old, her mother placed her in St Saviour’s Home in Goulbourn because she was unable to look after her.\textsuperscript{424} She was transferred to the Church of England Children’s Home in Brighton, Melbourne in February 1958, when she was nine years old, and was there until April 1963.\textsuperscript{425}

291. In April 1963, BDC was taken to Allambie Children’s Home (\textit{Allambie}),\textsuperscript{426} before being admitted to the care of the Department on 7 May 1963, for being deemed ‘likely to lapse into a life of vice and crime’.\textsuperscript{427}

292. On 12 May 1963, BDC was transferred from Allambie to Pirra Girls Home.\textsuperscript{428} BDC said that she immediately ran away because she was scared of the other girls and she was picked up by police the next day for shoplifting. She was admitted to Winbirra Remand Centre the following day.\textsuperscript{429}

293. On 14 May 1963, BDC appeared before the Children’s Court and was returned to the care of the Department.\textsuperscript{430} She stated that Miss Summersett (then Assistant Superintendent of Winlaton) came to collect her from Winbirra and physically abused her and two other girls, before driving them to Winlaton.\textsuperscript{431}

294. BDC stated that she was taken to the Goonyah section of Winlaton, where the first thing she witnessed was staff members physically abusing another resident.\textsuperscript{432} BDC stated that she was immediately locked in a cell for 48 hours and was given a uniform, but there was no induction process given.\textsuperscript{433}

295. BDC stated that during the day, she was given a single pair of underwear, which she was required to leave outside her room at night.\textsuperscript{434} She recalled that when she began menstruating she was given a single pad, which she had to show to female staff once used, in order to get a fresh pad.\textsuperscript{435}

296. BDC also stated that she was in and out of Goonyah for two years, between May 1963 and May 1965. She told the Royal Commission that all the other girls in the Goonyah section were older than her, and she was scared of them.\textsuperscript{436} She said that as soon as she arrived, three of the older girls started teasing and physically abusing her.\textsuperscript{437}

\textsuperscript{424} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [8].
\textsuperscript{425} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [9]-[12].
\textsuperscript{426} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [18].
\textsuperscript{427} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [20].
\textsuperscript{428} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [21].
\textsuperscript{429} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [23].
\textsuperscript{430} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [26].
\textsuperscript{431} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [27]-[28].
\textsuperscript{432} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [29].
\textsuperscript{433} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [30].
\textsuperscript{434} Transcript of BDC, C9106:21-34 (Day C088).
\textsuperscript{435} Transcript of BDC, C9107:38-C9108:10 (Day C088).
\textsuperscript{436} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [32].
\textsuperscript{437} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [38].
297. BDC said that during the day, girls that had not been assigned chores were locked in a room (the Day Room), which was separated from the staff room by a window.

298. The Royal Commission heard that on one occasion in the Day Room, the three older girls started teasing her. She said that when she got up and moved towards the door, two of them grabbed her and pushed her to the floor in a corner. BDC said that the two girls held her down while the third girl inserted her fingers into BDC’s vagina. She said that she was too scared to scream, that the other girls in the room didn’t do anything to help, and that she didn’t think that the staff could see or hear what was happening through the window because it happened in a corner.

299. BDC said that she was not sexually abused again by the girls at Winlaton, but she later witnessed a similar attack in the Day Room. She said that it was part of the culture in Goonyah for girls to abuse each other like this.

300. BDC told the Royal Commission that while she was at Winlaton, a counsellor or social worker visited her every month or six weeks, but she didn’t listen to what BDC had to say. BDC does not recall whether she reported the sexual abuse, but said that she didn’t know what to say or how to say it.

301. BDC gave evidence that she ran away from Winlaton many times because she was scared of the other girls and the staff. She said that each time she escaped, she was picked up by police, charged and returned to the care of the Department. She said that the police never asked her why she absconded.

302. BDC said that at Winlaton she was locked in her cell for 48 hours, made to stand in the quadrangle, and physically abused by Miss Summersett for things like swearing, fighting or trying to escape.

303. BDC said that on one occasion, she and another girl tried to escape but were caught by Miss Summersett. BDC said that she was dragged back to Goonyah by police officers, who watched as Miss Summersett hit her across the face and made her strip. BDC said she was then locked in her cell for several weeks, until she intentionally overdosed on pills and had to be taken to hospital.

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438 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [34].
439 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [35].
440 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [39].
441 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [39]-[40].
442 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [44].
443 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [46]-[47].
444 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [37].
445 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [43].
446 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [48].
447 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [50].
448 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [36].
449 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [58]-[59].
450 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [60]-[64].
304. BDC told the Royal Commission that on two of the occasions she escaped from Winlaton, she was taken by police to Fairlea Prison, where she spent a couple of weeks.\(^{451}\) She did not know why she was placed at an adult prison when she was only 14 or 15 years old, and she was frightened of the adult prisoners.\(^{452}\) BDC said that she was not sexually or physically abused at Fairlea, but started self-harming the second time she was placed there.\(^{453}\)

305. BDC stated that when she was first received into Winlaton, and each time she was returned to Winlaton after an absence, she was forced to undergo a ‘medical examination’ administered by a doctor from a venereal diseases (VD) clinic in Fitzroy.\(^{454}\) BDC recalled that she was locked in a room and made to put her legs up in stirrups. She said that the doctor then ‘fiddled around’ with her vagina.\(^{455}\)

306. BDC said that she was never told the purpose of the examination, and she never provided her permission.\(^{456}\) She said that during the examinations she felt very awkward and uncomfortable, and that one time the examination lasted 35 minutes.\(^{457}\)

307. BDC also told the Royal Commission that whenever she returned to Winlaton after a visit or appointment, she was strip searched by female staff members. She said that she was made to stand in a line with other girls, and that sometimes staff told her to stand with her legs apart and jump, or placed a mirror between her legs to check for contraband.\(^{458}\)

308. In December 1966, BDC was discharged from the care of the Department.\(^{459}\)

309. The Royal Commission heard that in November 2012, BDC received compensation from the State of Victoria in relation to being transferred to Fairlea Prison.\(^{460}\) She said that she received a verbal apology from the State of Victoria, but would have preferred a written apology.\(^{461}\) She said that she found the civil litigation process daunting and scary, and didn’t feel like she had any control over it.\(^{462}\)

310. BDC told the Royal Commission about the impact that the child sexual abuse has had on her life. She said that she suffered from alcohol and drug abuse,\(^{463}\) suffers anxiety and depression, and has previously suffered breakdowns and panic attacks.\(^{464}\) BDC

\(^{451}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [65]-[67], [70]-[71].
\(^{452}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [69].
\(^{453}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [74].
\(^{454}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [51]-[52]; Transcript of BDC, C9106:42-C9107:1 (Day C088).
\(^{455}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [53]-[54].
\(^{456}\) Transcript of BDC, C9107:18-29 (Day C088).
\(^{457}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [54]-[55].
\(^{458}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [57].
\(^{459}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [78].
\(^{460}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [82].
\(^{461}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [83]-[84].
\(^{462}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [84].
\(^{463}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [87].
\(^{464}\) Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [86].
gave evidence that she is extremely protective of her five children, and worries that she is an inadequate mother, or doesn’t give them enough attention.\textsuperscript{465} She said that she still feels uncomfortable going to the doctor, and finds it hard to trust authorities such as the police.\textsuperscript{466}

The evidence of Gabrielle Short

311. The Royal Commission heard evidence from Gabrielle Short, who is currently 59 years of age.\textsuperscript{467} Ms Short said that when she was growing up, her father was violent towards her mother and herself.\textsuperscript{468}

312. Ms Short gave evidence that by May 1970, she stayed at various government and non-government homes, including St Joseph’s Home, St Joseph’s Babies Home,\textsuperscript{469} Nazareth Girls Home,\textsuperscript{470} Pirra Girls Home, Allambie and St Aiden’s.\textsuperscript{471}

313. In May 1970, Ms Short absconded from St Aiden’s and was picked up by the police.\textsuperscript{472} She was transferred to the Winbirra section of Winlaton at the age of 14.\textsuperscript{473}

314. Ms Short stated that upon arrival at Winbirra, she was forced to undergo a full body strip search by two Winlaton staff. She told the Royal Commission that she initially refused to undergo the strip search because she was taught by the nuns at the Nazareth House that it was a sin to expose parts of the body. She said that the staff told her that if she didn’t cooperate, the night watchman would be called to do it for her. The night watchmen were used as a threat to anyone who didn’t want to cooperate.\textsuperscript{474}

315. Ms Short told the Royal Commission that during the strip search, she stood there naked while the staff members identified marks on her body and made notes on a clipboard. She said there was no physical contact by the staff members.\textsuperscript{475}

316. After the strip search, Ms Short said that she was given a nightie and told to shower in front of a staff member who watched her the whole time.\textsuperscript{476} She said she was taken to a cell and locked there for 48 hours without being told why or how long she would be there and she later understood that this was the standard procedure for children who

\textsuperscript{465} Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [90].
\textsuperscript{466} Transcript of BDC, C9108.21-34 (Day C088).
\textsuperscript{467} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [1].
\textsuperscript{468} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [2].
\textsuperscript{469} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [3]-[4].
\textsuperscript{470} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [5].
\textsuperscript{471} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [10]-[11].
\textsuperscript{472} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [15].
\textsuperscript{473} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [16].
\textsuperscript{474} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [18].
\textsuperscript{475} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [19].
\textsuperscript{476} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [20]-[21].
had absconded.\textsuperscript{477} Ms Short said that despite being new to Winlaton, she was not given any induction regarding who she could speak to if she needed help.\textsuperscript{478}

317. Ms Short stated that on a subsequent occasion, she was forced to strip naked and jump up and down for a few seconds in front of an officer who watched to see if anything fell out of her vagina.\textsuperscript{479} She told the Royal Commission that the officer placed her fingers inside Ms Short’s vagina to check if anything was hidden up there.\textsuperscript{480} She described this officer as a ‘very tall and strong woman and was very authoritative’, and was frightened to say anything.\textsuperscript{481}

318. Ms Short said that after a few days at Winlaton, she was taken to the Fitzroy Clinic for an internal medical examination.\textsuperscript{482} She said that she had heard from other residents at Winlaton what that involved, and begged staff members not to let her go as she was a virgin.\textsuperscript{483} She said that despite this, she was taken to the clinic where a doctor, who was nicknamed ‘Dr Finger’, inserted a cold instrument into her vagina.\textsuperscript{484} She said that when she returned to Winlaton, her underwear was covered in blood and she felt sick in the stomach and burst out crying.\textsuperscript{485}

319. Ms Short told the Royal Commission that she was again sent to the clinic ten days later, for another internal examination for venereal disease.\textsuperscript{486} She said that despite the results being negative for venereal disease, she received no apology. She said she felt as though she was not being heard and had no one to go to.\textsuperscript{487}

320. Ms Short gave evidence that after three to four months at Warrina, she was transferred to the Karingal section of Winlaton,\textsuperscript{488} where she witnessed a lot of gang rape and physical abuse among the residents.\textsuperscript{489}

321. She told the Royal Commission that residents engaged in frequent physical fights with each other at Leawarra. She recalled one occasion, when she intervened and attacked some of the residents who tried to insert the neck of a broken beer bottle into the vagina of another resident.\textsuperscript{490} Ms Short said that when Winlaton staff tried to intervene she remained silent. She said:

\textsuperscript{477} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [21]-[22].
\textsuperscript{478} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [20].
\textsuperscript{479} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [37].
\textsuperscript{480} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [38].
\textsuperscript{481} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [39].
\textsuperscript{482} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [30].
\textsuperscript{483} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [24].
\textsuperscript{484} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [25].
\textsuperscript{485} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [27].
\textsuperscript{486} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [28].
\textsuperscript{487} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [32].
\textsuperscript{488} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [34].
\textsuperscript{489} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [39].
\textsuperscript{490} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [40]-[46].
No one was punished because no one had said anything. You just didn’t dob people in; you would get a bashing up or, worse, be raped. It was all about surviving in those institutions.\textsuperscript{491}

322. Ms Short told the Royal Commission that she did not report the abuse she suffered or witnessed because every time she tried to complain it fell on deaf ears.\textsuperscript{492} She told the Royal Commission that when staff members at Winlaton saw what was going on, they took no steps to protect her or any other residents being abused.\textsuperscript{493}

323. The Royal Commission heard evidence that the physical, sexual and psychological abuse suffered at Winlaton had a great impact on Ms Short.\textsuperscript{494} She said that she had several relationship and marriage breakups.\textsuperscript{495} She said that she clams up when asked about her family history and bottles everything inside.\textsuperscript{496}

324. As a result of the internal examination she suffered as a child, Ms Short said that she has not had a pap smear for 20 years. She gave evidence that she would ‘rather risk dying from cancer than to have to go through another one of those procedures and the memories it brings with it’.\textsuperscript{497} Ms Short said that to this day, she has not been able to properly adapt to life on the outside of the institutions and does not think she ever will, although she stated that she is stronger now than she has ever been.\textsuperscript{498}

The evidence of BHE

325. BHE was born in Melbourne, Victoria in 1956 and is now 59 years old.\textsuperscript{499} She gave evidence that when she was growing up, her father was strict and physically abusive.\textsuperscript{500}

326. She told the Royal Commission that in mid-1971, she was beaten by her father for waking him up when she was using crutches to go to the toilet. The next day, BHE’s mother told her to leave home, despite her pleas to stay as she had nowhere to go.\textsuperscript{501} She said that she spent several weeks living on the streets, at friends’ houses and sleeping in the toilet on one occasion.\textsuperscript{502}

\textsuperscript{491} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [54].
\textsuperscript{492} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [55].
\textsuperscript{493} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [56].
\textsuperscript{494} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [57].
\textsuperscript{495} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [58]-[62].
\textsuperscript{496} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [64].
\textsuperscript{497} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [67].
\textsuperscript{498} Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [69] and [71].
\textsuperscript{499} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [5]-[6].
\textsuperscript{500} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [7].
\textsuperscript{501} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [10].
\textsuperscript{502} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [11].
327. On 26 June 1971, BHE was charged by police for ‘being exposed to moral danger’ as she was found wandering around Geelong with three boys. She was taken to the Winbirra Remand Centre at Winlaton.503

328. BHE gave evidence that upon arriving at Winlaton, she was immediately strip searched. She stated that she stood over a mirror naked with her legs open and arms out while an officer felt her all over. The officers checked BHE between her legs, bottom, arms and breast and inside her mouth to see if she had any cigarettes or drugs on her.504

329. BHE stated that all the girls at Winlaton were strip searched every Sunday after the visiting hours.505 She said that at first, only female officers performed these searches, but later on, male staff also performed these searches.506 BHE recalled that Florence Baxter was the officer-in-charge of one of the sections at Winlaton, and conducted a strip search of her on one occasion.507 She told the Royal Commission that the strip search made her feel terrified, embarrassed, humiliated and degraded.508

330. BHE told the Royal Commission that Winbirra was extremely scary.509 She said that it housed girls aged 15 to 18, with some having committed serious crimes such as murder.510 BHE was locked in a cell with another girl and the staff checked on them through a small window in the door of the cell.511 She said that she was not told what to do if she had any problems or issues.512

331. The Royal Commission heard that from 15 November 1971 to February 1977, BHE absconded from Winlaton numerous times and was charged with various offences. She said that during her time at Winlaton, she was placed at Winbirra, Goonyah, Karrinjal, Warrina and Leawarra.513

332. BHE told the Royal Commission that within the first few months of arriving at Winlaton, she was sexually abused by her allocated social worker, Ross McIntyre.514 She stated that Mr McIntyre placed BHE up against the wall of an office where he kissed her. She gave evidence that he fondled her breasts under her jumper but on top of her bra.515 Mr McIntyre was represented at the public hearing and denied the allegations of sexual abuse made against him.516

503 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [12].
504 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [13].
505 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [14].
506 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [15].
507 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [16].
508 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [13].
509 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [18].
510 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [19].
511 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [18].
512 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [17].
513 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [27]-[28].
514 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [30] and [33].
515 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [33].
516 Transcript of BHE, C9117:43-C9118:S (Day C088).
333. BHE gave evidence that she felt confused and violated by the abuse.  

334. The Royal Commission also heard that BHE was sexually abused by other residents on a number of occasions. BHE said that on one occasion, she was abused by two girls. She said she was too scared to report the abuse for fear of being labelled a ‘lagger’ and beaten. She recalled that on one occasion where she ‘lagged’, she had a blanket placed over her head and was beaten by other residents.

335. BHE gave evidence that she was also abused by one girl in Goonyah, almost every day for a couple of months. She stated that the abuse stopped when the girl was released from Winlaton. She stated that she never reported the abuse, for fear of not being believed or being beaten for ‘lagging’.

336. BHE said that there were only three staff supervising the residents during the day, but half the time they were not supervising the residents as they were in their office.

337. BHE gave evidence that at Winlaton, she participated in triad group meetings. She recalled that it involved people standing in a triangle, talking about their problems. BHE said that she found triad therapy helpful in the beginning but later found it confusing. She did not feel that it was an environment where people could talk about sexual abuse openly.

338. BHE told the Royal Commission that she absconded on many occasions because she hated Winlaton and hated being abused. She said that every time she was sent back to Winlaton, she had to undergo a VD check, which involved being sent to a clinic and made to sit on a table with her feet in stirrups. She stated that the doctor inserted a cold, hard duck-bill shaped object in her vagina which caused her pain. She said she was never told why she had to undergo these checks.

339. BHE said that in July 1976, when she was 17 years old, she was placed in the remand section at Fairlea Prison for two nights for absconding from Winlaton. She recalled Ms Baxter telling her that this was ‘to teach her a lesson’. BHE said that she was abused...
by other women inmates at Fairlea Prison and that the prison officer did nothing to prevent the abuse even though she screamed for help and was visible to the officer.\footnote{531}

340. BHE told the Royal Commission that what happened to her at Winlaton ruined her life.\footnote{532} To this day, BHE can’t bend her leg properly because she didn’t get proper medical treatment at Winlaton.\footnote{533} She was on anti-depressants for a long time and had suicidal thoughts.\footnote{534} She said that at times she hated herself more than her father and some of the Superintendents at Winlaton.\footnote{535} BHE told the Royal Commission that because of the medical checks and abuse at Winlaton, she found it hard to trust people.\footnote{536}

The evidence of Karen Hodkinson

341. Karen Hodkinson was born in Healesville, Victoria in 1960 and is currently 55 years old.\footnote{537} Her parents separated when she was about nine years old.\footnote{538}

342. Ms Hodkinson states that in 1974, when she was 14 years old, while living with her aunt, she became depressed because her aunt blamed her for her parents’ separation. She said she attempted to kill herself and was admitted to the Healesville Base Hospital for an overdose of valium.\footnote{539}

343. In March 1974, Ms Hodkinson was made a ward of the State by order of the Children’s Court and was taken to Winlaton, where she spent the six months.\footnote{540} Ms Hodkinson said that when she appeared before the Children’s Court, she did not have a legal or personal representative that could speak on her behalf nor was any explanation given to her about the Court’s order.\footnote{541}

344. The Royal Commission heard evidence that on arrival at Winlaton, Ms Hodkinson was introduced to Ms Baxter.\footnote{542} She said that she was sent to Goonyah, which she understood housed girls who were dangerous and violent.\footnote{543}

345. Ms Hodkinson gave evidence that within two weeks at Winlaton, she was taken to a VD clinic in Fitzroy where she was made to sit on a chair with her legs in stirrups. She said she was examined internally by a staff member,\footnote{544} and she recalled that there

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\footnote{531} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [55]-[56].

\footnote{532} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [59].

\footnote{533} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [62].

\footnote{534} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [60].

\footnote{535} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [61].

\footnote{536} Transcript of BHE, C9117:17-27 (Day C088).

\footnote{537} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [5]-[6].

\footnote{538} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [7].

\footnote{539} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [15]-[17].

\footnote{540} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [18]-[20].

\footnote{541} Transcript of K Hodkinson, C9133:8-34 (Day C088).

\footnote{542} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [21].

\footnote{543} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [23].

\footnote{544} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [24].
were four people holding her down while the examination occurred.\textsuperscript{545} She told the Royal Commission that she was screaming that she was a virgin.

346. Ms Hodkinson also gave evidence that her sexual history was taken at Winlaton before the examination was forced on her,\textsuperscript{546} but no one explained what the examination entailed, nor did she give her permission for the examination to take place.\textsuperscript{547}

347. Ms Hodkinson told the Royal Commission that there was poor sanitary care at Winlaton. She said that when she wanted to get a new pad, she had to put the dirty one in a brown paper bag to show the staff member.\textsuperscript{548}

348. Ms Hodkinson stated that in about April 1974, a month after her time at Goonyah, she was transferred to Karingal, where she shared a room with another girl.\textsuperscript{549} The room was locked at night and had a big metal door with a small window for observation.\textsuperscript{550}

349. The Royal Commission heard evidence that at Karingal, Ms Hodkinson was sexually abused by her allocated social worker from the Department, Paul Yew. She saw Mr Yew once a week at an interview room in head office.\textsuperscript{551} She gave evidence that during her first meeting with Mr Yew, he gave her chocolates and brought her pen and paper to ‘break the ice’.\textsuperscript{552} On other occasions, Mr Yew took Ms Hodkinson out of Winlaton on day leave. At first she thought he was a really nice, caring person.\textsuperscript{553}

350. Ms Hodkinson stated that not long after one weekend leave with Mr Yew, he sexually abused her. She stated that he put his hand on her leg when they were in the office and told her that he could make things easy for her if she was nice to him. She said that Mr Yew kissed her and put his hand up her dress and touched her on the outside of her underwear.\textsuperscript{554}

351. Ms Hodkinson told the Royal Commission that when Mr Yew left, Ms Baxter asked her what was wrong and Ms Hodkinson disclosed she had been sexually abused by Mr Yew. She said that in response, Ms Baxter slapped her across the face and said:

   How dare you make up such dirty lies about one of my staff members. You are nothing but a dirty little lying bitch. Girls like you are why we have places like this, because you need to be taught to tell the truth.\textsuperscript{555}

352. Ms Hodkinson stated that she was sent to Goonyah for disclosing the abuse and recalled that Goonyah was horrid. She said she was locked up for a few days and was

\textsuperscript{545} Transcript of K Hodkinson, C9134:37-41 (Day C088).
\textsuperscript{546} Transcript of K Hodkinson, C9134:5-10 (Day C088).
\textsuperscript{547} Transcript of K Hodkinson, C9134:24-29 (Day C088).
\textsuperscript{548} Transcript of K Hodkinson, C9135:5-20 (Day C089).
\textsuperscript{549} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [25]-[26].
\textsuperscript{550} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [27].
\textsuperscript{551} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [35].
\textsuperscript{552} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [36].
\textsuperscript{553} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [37]-[38].
\textsuperscript{554} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [40].
\textsuperscript{555} Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [42].
only given a blanket in a room with no bed. Ms Hodkinson said she tried to disclose the abuse to Ms Baxter again, but Ms Baxter said that if she continued to lie she would be sent back to Goonyah.

353. The Royal Commission heard evidence that Mr Yew continued to touch Ms Hodkinson once a week, and about two weeks after the first incident of abuse, he raped her. She recalled being raped by Mr Yew on three occasions and the abuse continuing for three months. Ms Hodkinson stated that he told her that the other girls did it for him as well. The Royal Commission made a number of enquiries to locate Mr Yew for the public hearing, but were unable to confirm his whereabouts.

354. Ms Hodkinson told the Royal Commission that she never reported the further abuse, as she feared punishment from Ms Baxter and feared she would be sent back to Goonyah. She eventually left Winlaton on 11 November 1974.

355. On 19 October 1976, Ms Hodkinson was discharged from the care of the Department. She said:

I still never reported my abuse to the authorities. I didn’t know who to go to and I didn’t think that anyone would believe me if I did.

356. As a result of the abuse, Ms Hodkinson gave evidence that she cannot form loving relationships with men and distrust them. She told the Royal Commission that she suffered depression and frequently had nightmares.

The evidence of BDF

357. BDF was born in Victoria in 1972 and is currently 42 years old. Her parents separated when she was one year old and she spent a number of years being transferred from one parent to another.

358. On 5 February 1986, when BDF was 13 years old, her mother took her to Melbourne’s Children’s Court, because she did not want her anymore.

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556 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [43].
557 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [44].
558 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [45]-[46].
559 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [47].
560 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [51].
561 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [54].
562 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [49].
563 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [55].
564 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [56] and [58].
565 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [5] and [6].
566 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [7].
567 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [11]-[12].
359. From February 1986 to March 1986, BDF was sent to Yallum, a hostel in Dandenong for adolescents in State care. BDF told the Royal Commission that at Yallum, she was sexually abused by two boys aged about 16 and 17.

360. BDF said that she spent time living in various different arrangements between March 1986 and January 1987. This included living back at home with her father, living in a private board arrangement with a man called BFE, being placed on remand in Winbirra at Winlaton for a week, and being placed with a carer at the Waverley Emergency Adolescent Care (WEAC) for six weeks.

361. In January 1987, BDF became a ward of the State at the age of 14. BDF continued to stay with her carer from WEAC before she absconded and was taken straight to a cell at Winlaton.

362. Between January and April 1987, BDF spent time in the Winbirra, Leawarra and Karingal sections of Winlaton, and spent around four months at Winlaton in total.

363. BDF told the Royal Commission that during her time at Winlaton, no workers from the Department came to visit her. She did not recall receiving an induction upon her arrival and had to work out where to go on her own. She stated that during this time, she started getting her period but did not know who to see about sanitary care.

364. BDF said that she had to shower at Winlaton with doors open and was supervised when she used a razor. If she wanted to go to the toilet at night, she had to be taken by a male guard with a dog who would watch her while she went to the toilet.

365. BDF told the Royal Commission that at Winlaton, she was abused by older girls on a number of occasion. BDF stated that one girl jumped in her bed at night and sexually abused her, which involved fondling and penetration. BDF said she was also forced to perform oral sex on the older girl.

366. BDF gave evidence that Winlaton held ‘movie nights’ approximately once a week. Girls from the Goonyah section also attended and sat at the front row of the hall. She said that when the lights were turned off during the movie, she was physically taken

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568 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [15].
569 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [15].
570 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [15]-[23]; Annexure BDF-3, DHS.3002.031.0451_E; Annexure BDF-4, DHS.3002.031.0425_E at 0425_E; Annexure BDF-5, DHS.3002.031.0448; Annexure BDF-6, DHS.3002.031.0213_E.
571 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [24]-[25].
572 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [27].
573 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [28]-[29].
574 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [30].
575 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [31].
576 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [32].
577 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [34].
578 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [35]-[36].
579 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [38]-[39].
367. BDF said there were staff members presented in the hall during movie nights and should have seen her being taken to the front row by older girls.581

368. BDF gave evidence that she was also sexually abused by some of the older girls in the yard of Winlaton. On one occasion, the older girls pushed her against the wall of the swimming pool building and held her shoulder down while one girl penetrated her vagina with her fingers and another stood watching.582 BDF told the Royal Commission that she cannot recall if there were staff present in the yard at the time.583

369. BDF said that in around May 1987, when she was 15, a staff member approached her and told her she had to leave as it was ‘against the law’ to keep her there.584 She was transferred to another institution before she absconded again and lived on the streets with other teenagers who were also wards of the State.585

370. When BDF was living on the streets, she began stealing cars for a group of older men to survive but was caught by the police on a few occasions.586 BDF gave evidence that she was taught by these older men to buy police beer and cigarettes to avoid being charged.587 She said that on one occasion, she was forced to perform oral sex on a police officer in return for not being charged.588

371. BDF told the Royal Commission that every week she attended the Department’s office to pick up her ward cheque from her case worker. She said that her case worker sexually abused her on four occasions by touching her breasts and making her rub his penis before giving her the ward cheque.589 She reported the abuse to another Department worker, and said that after this disclosure, she did not see the case worker again.590 She did not report the abuse to the police as she lacked trust in them.591

372. In November 1990, when BDF turned 18, her wardship expired.592

373. BDF told the Royal Commission that she never reported her sexual abuse to anyone at Winlaton because of fear.593 She said that there was a culture within Winlaton that people who were labelled as ‘dobbers’ or ‘laggers’ would be punished further by other

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580 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [40].
581 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [44].
582 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [45].
583 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [46].
584 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [47].
585 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [50].
586 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [52].
587 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [53].
588 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [50].
589 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [49].
590 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [71].
591 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [72].
592 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [69].
593 Transcript of BDF, C9351:19-26 (Day C090).
residents.\textsuperscript{594} She said that this culture was also reinforced by the adult supervisors working in Winlaton at the time.\textsuperscript{595}

374. BDF also said that she was led to believe that the abuse was just part and parcel of living at Winlaton and it was just what happened.\textsuperscript{596}

375. BDF gave evidence that the abuse had an ongoing impact in her life.\textsuperscript{597} As a result of the abuse, BDF developed an alcohol addiction and had attended rehabilitation.\textsuperscript{598} She was denied access to her family, in particular her father and her aunt, who BDF later realised wanted to care for her but couldn’t locate her.\textsuperscript{599} She formed no relationship with her father and although she reconnected with her father in her adult life, he passed away shortly after that.\textsuperscript{600}

376. BDF said that the abuse made it difficult for her to be touched and she has been unable to hold down a relationship.\textsuperscript{601} The abuse also affected her relationship with her children and her ability to care for them.\textsuperscript{602} She is currently attending counselling and receiving therapeutic support.\textsuperscript{603}

### 3.3 Operation of Winlaton

377. The Royal Commission heard evidence from a Deputy Superintendent and two former Superintendents of Winlaton, in relation to the operation of Winlaton between the period 1974 and 1992. The three witnesses were:

- a. Marilyn Minister, former Assistant Superintendent and Deputy Superintendent of Winlaton between the period 1974 and 1992;

- b. Lloyd Owen, former Superintendent of Winlaton between the period 1974 and 1978; and


### Staff hierarchy at Winlaton

378. Winlaton was run by a Superintendent, who was the most senior person responsible for the day to day operation of the institution. In the 1970s, the Superintendent was supported by two Deputy Superintendents – one for Programs and another for

\textsuperscript{594} Transcript of BDF, C9351:28-42 (Day C090).
\textsuperscript{595} Transcript of BDF, C9351:33-38 (Day C090).
\textsuperscript{596} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [70].
\textsuperscript{597} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [73].
\textsuperscript{598} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [75].
\textsuperscript{599} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [74].
\textsuperscript{600} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [74].
\textsuperscript{601} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [76]-[77].
\textsuperscript{602} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [78].
\textsuperscript{603} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [82].
Classification and Case Planning; a Principal Youth Officer, Chief Youth Officers, Senior Youth Officers, Night Senior Officer and Youth Officers. At times, the Superintendent was supported by an Assistant Superintendent.

379. Ms Minister gave evidence that there was a chain of command at Winlaton. She said that Youth Officers would report to the Chief Youth Officer and the Principal Youth Officer. Ms Minister said that Chief Youth Officers were seen as fairly senior in the management structure and could deal with all kinds of matters, including matters of serious misbehaviour.

380. The effect of this structure on receiving and responding to reports of child sexual abuse at Winlaton is discussed in further detail below.

Overcrowding and supervision of residents at Winlaton

381. The Royal Commission heard evidence that many former residents shared rooms with other residents and some sections of Winlaton house between 15 to 18 residents.

382. Dr Owen stated that it was not ideal for residents to share rooms. He gave evidence that on at least one occasion, there were mattresses in the recreation room at remand because of the overcrowding.

383. Dr Slack said that there were periods of overcrowding at Winlaton, and during this time, she kept asking for additional staff. She said that officers were careful when placing residents in shared rooms if the institution ran out of rooms.

384. Dr Slack told the Royal Commission that she requested more staff as she ‘absolutely’ saw supervision of residents during the day and night as a problem at the institution.

385. Dr Owen stated that supervision at Winlaton was fairly close but residents did share rooms and were often allowed to do things on trust. He said that resourcing was a factor that affected the provision of care and welfare to the residents. He told the Royal Commission that there were about 80 to 100 staff in five sections and the institution housed between 80 to 120 residents at any one time.

It sounds like a lot of staff working across five sections, but if you appreciate that it takes more than four staff to cover one position on the ground 24 hours a day, 7 days a week, 365 days a year, then the number – the best I could squeeze out of that number in a unit was two on duty during the daylight hours, three on duty in

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604 Transcript of M Minister, C9461:43 – C9462:6 (Day C091).
605 Transcript of M Minister, C9417:42-C9418:3 (Day C091).
606 Exhibit 30-0030, Statement of L Owen, STAT.0652.002.0001_R at [64].
608 Transcript of E Slack, C9620:7-11 (Day C093).
609 Exhibit 30-0030, Statement of L Owen, STAT.0652.002.0001_R at [56].
610 Exhibit 30-0030, Statement of L Owen, STAT.0652.002.0001_R at [20].
611 Exhibit 30-0030, Statement of L Owen, STAT.0652.002.0001_R at [62].
the evenings, and one on duty overnight in each unit. For a group of anything up to 15 girls, that wasn’t a lot of people, in my view.\textsuperscript{612}

386. Dr Slack told the Royal Commission that the lack of adequate staffing contributed to the failure of the institution to provide adequate supervision to the residents of Winlaton.\textsuperscript{613} She said that she was constantly drawing the lack of adequate staffing to the attention of the Department, but her requests were not heard or met in any way.\textsuperscript{614}

387. The relationship between lack of supervision and child sexual abuse at Winlaton is discussed in further detail below.

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

F15 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.

**Policies and procedures at Winlaton**

388. The Royal Commission was provided with some documents comprising the policies and procedures of Winlaton during the relevant period. A document entitled ‘Manual of Instructions for Winlaton Youth Training Centre’ (\textit{Winlaton Manual}), with a date of ‘August 1974, Revised 1980’,\textsuperscript{615} and a revised Winlaton Manual entitled ‘Winlaton Manual of Guidelines/Procedures, 1987 ed.’ (\textit{Revised Winlaton Manual}) provided a broad range of policies and procedures for the operation of Winlaton.\textsuperscript{616}

389. Details of the specific policies contained in the Winlaton Manual and the Revised Winlaton Manual that were examined in this public hearing are set out in the relevant sections below.

**Absconding from Winlaton**

390. The Royal Commission heard evidence that some former residents absconded from the institution because of physical and sexual abuse they experienced and to avoid further abuse.

\textsuperscript{612} Transcript of L Owen, C9525:24-42 (Day C092).
\textsuperscript{613} Transcript of E Slack, C9656:33-35 (Day C093).
\textsuperscript{614} Transcript of E Slack, C9656:37-C9657:2 (Day C093).
\textsuperscript{615} Exhibit 30-0011, DHS.3004.001.0078.
\textsuperscript{616} Exhibit 30-0011, DHS.3127.002.0019.
391. BDC told the Royal Commission that she ran away from Winlaton many times because she was scared of the other girls and the staff. 617 She said that each time she escaped she was picked up by police, but was never asked why she absconded.618

392. BHE told the Royal Commission that she absconded on many occasions because she hated Winlaton and hated being abused.619

393. Dr Slack gave evidence that she saw absconding as an issue when she first arrived at Winlaton.620 The 1980 edition of the Winlaton Manual states:

Officers should constantly bear in mind that trainees are unstable for different reasons, and as pressures develop in them, or in the Section, or in their relationships, they might resort to absconding. Each officer is expected to show some insight into these problems, and through this, to help reduce absconding.

Vigilant, unobtrusive supervision is required at all times and officers should always be quite clear in their own minds as to how many girls are in their particular care – the number, their whereabouts, and what they are doing...

A full and active programme along with good supervision will always give support to the trainee who is restless.621

394. The Winlaton Manual contains procedures to guide staff dealing with absconders, and the procedure for preparing absconding reports.622

395. The Winlaton Manual also includes a section entitled ‘Punishment for Absconders’ which states:

There is no automatic punishment for returned absconders. All are to be managed on an individual basis having regard to individual pressures, circumstances, plans and progress within the Institution. Discussion will occur at the Classification and Review meeting. In which Section a trainee is housed on return from an absconding is at the discretion of the Superintendent. It is expected that a policy of individualised decision making will require some interpretation to trainees. Staff should therefore show some concern for interpreting the basis of decision making to trainees, particularly the absconder involved.623

396. A similar policy appears in the Revised Winlaton Manual of 1987.624

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617 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [48].
618 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [50].
619 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [47].
620 Exhibit 30-0034, Annexure D of the Statement of E Slack, STAT.0630.001.0039.
621 Exhibit 30-0011, DHS.3004.001.0078 at 0120.
622 Exhibit 30-0011, DHS.3004.001.0078 at 0121.
623 Exhibit 30-0011, DHS.3004.001.0078 at 0122.
624 Exhibit 30-0011, DHS.3127.002.0019 at 0101-0107.
397. Assistant Commissioner Fontana told the Royal Commission that police would have had general conversations with residents, but some residents would not divulge the reasons for absconding. He accepted that there may have been an attitude at the time which meant that police did not enquire as to the reasons why residents abscond.625

**Available finding on absconding from Winlaton**

F16 Some residents absconded from Winlaton as a result of child sexual abuse or to avoid further incidents of child sexual abuse. Staff at Winlaton were not trained to investigate the risk that some residents absconded because of child sexual abuse.

**Culture of Winlaton**

398. Ms Minister gave evidence that when she arrived in Winlaton in 1974, the institution was ‘wild and woolly’ and one where ‘general mayhem’ occurred. She said that her general recollection was that Winlaton was an ‘out of control’ place, with a lack of structure and treatment programs.626

399. Ms Minister said that residents acted out, displayed a lot of aggression and there was very little respect between the children and staff members.627 She said that the aggression was occurring because of a number of factors, including poor management and lack of quality staff.628 Ms Minister said that some staff members, such as Ms Baxter, were of the ‘old school’ and used authoritarian techniques in dealing with residents.629

400. The Royal Commission heard evidence that some residents were physically abused by staff members. Ms Hodkinson gave evidence that she was slapped across the face by Ms Baxter. BDC said that she was physically assaulted by Miss Summersett. Ms Short stated that she was frightened of an officer who she described as a ‘very tall and strong woman [who] was very authoritative’.

401. Dr Owen told the Royal Commission that rather than being a supportive environment for residents, Winlaton was an environment that was ‘containing, controlling and putting things on hold until [the residents] grew up and hopefully grew out of it, or found some other way of coping’.630 He said:

> [T]he way in which things were delivered down the system, they were the people who were often given up on or not given access or excluded, rather than staying with them and their issues, which is often very, very difficult in order to see them through to the degree that we need to see them through.631

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625 Transcript of S Fontana, C9835:17-C9836:10 (Day C094).
626 Transcript of M Minister, C9390:11-21 (Day C091).
627 Transcript of M Minister, C9390:23-33 (Day C091).
628 Transcript of M Minister, C9413:40-C9414:1 (Day C092).
629 Transcript of E Slack, C9422:18-25 (Day C092).
630 Transcript of L Owen, C9526:25-C9527:1 (Day C092).
631 Transcript of L Owen, C9526:25-36 (Day C092).
402. Some former residents of Winlaton told the Royal Commission that the nature of control and authority extended to different aspects of their care and wellbeing. Ms Hodkinson, for example, said that before she could ask for a new sanitary pad, she had to put the used pad in a brown paper bag.

403. Dr Owen agreed that there certainly was an authoritarian element that was present at Winlaton. He said that ‘authoritarian’ described the actions of some of the staff at Winlaton.632

404. Dr Slack stated that when she commenced at Winlaton in 1976, it was an institution ‘beset by riots’, with ‘staff continuously reporting being physically assaulted by residents, and frequent physical assaults between residents’. She stated that ‘life among staff and residents went on amid fear, mistrust and intimidation’.633

405. Dr Slack gave evidence that shortly after she arrived at Winlaton, she wrote a memorandum to Dr Owen dated 16 December 1976 outlining the issues she thought needed attention, which included the need to reduce individual lock up, eliminate sexual assault, lower absconding and improve physical safety.634 Dr Slack said that she raised these issues, attended meetings and as Superintendent, developed several policies and guidelines which were implemented with the express purpose of ‘ensuring the well-being of the residents and staff of Winlaton’.635

406. Dr Owen told the Royal Commission that over the years he was at Winlaton, the authoritarian approach diminished quite substantially as a result of staff turnover, and as ‘the climate in the institution improved in terms of communication and some of the organisational structure’.636

Punishment of residents at Winlaton

407. The Royal Commission heard evidence from a number of former residents in relation to the punishment administered at Winlaton. A number of residents shared the experience that lock up facilities were used a means of punishment. Some residents recalled being locked up immediately after being placed at Winlaton.

408. Dr Owen told the Royal Commission that he was concerned about the use of lock up facilities as punishment for residents because he held the view that it was not a good solution for ‘anything other than dealing with an immediate crisis, but it was not uncommon for it to be seen as a response, a punitive response’.637

409. Ms Minister gave evidence that residents were locked up in cells at various times, ‘for their own protection... and for the protection of other people around them’. She said that residents could be sent to their bedroom or placed in a time out room that had no

632 Transcript of L Owen, C9492:43 - 9493:15 (Day C092).
633 Exhibit 30-0034, Statement of E Slack, STAT.0630.001.0001_R at [12].
634 Exhibit 30-0034, Annexure D of the Statement of E Slack, STAT.0630.001.0039.
635 Exhibit 30-0034, Statement of E Slack, STAT.0630.001.0001_R at [35].
636 Transcript of L Owen, C9494:19-29 (Day C092).
637 Transcript of L Owen, C9510:5-16 (Day C092).
furniture. According to Ms Minister, this was something that was done to ‘contain someone who was acting in a very violent manner and was likely to harm either themselves and/or other people’.638

410. Ms Minister told the Royal Commission that lock up was used ‘just long enough for the young person to settle down and not be a risk to themselves or other people’. She said that this was usually a matter of hours and not days, and she would have ‘taken issue with’ it, if she had become aware that they were held for days.639

411. Dr Slack gave evidence that she was not aware that residents were locked up in remand before being transferred to the general section of Winlaton.640 She accepted that it would be horrifying and destructive for a resident to come from the Children’s Court or the police and be placed in a lock up situation at Winbirra for a long period of time.641 Dr Slack accepted that when she first came to Winlaton, the punishment of lock up was being overused and was inappropriate.642

412. She said that the use of cells as punishment became infrequent during the period she was the Superintendent.643

413. Ms Minister said that right up until 1992, there was always a cell, or time out room, to lock up residents.644

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

F17 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.

### 3.4 Response to reports of child sexual abuse at Winlaton

**Introduction**

414. The Royal Commission made a number of enquiries to identify and locate institutional witnesses who were directly involved in the response to allegations of child sexual abuse during the time period examined. A number of the institutional witnesses who were identified could not be located or were deceased at the time of the public hearing.

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638 Transcript of M Minister, C9391:8-22 (Day C091)
639 Transcript of M Minister, C9391:30-42 (Day C091).
641 Transcript of E Slack, C9617:40-46 (Day C093).
642 Transcript of E Slack, C9616:20-25; C9617:5-11 (Day C093).
643 Transcript of E Slack, C9616:27-30 (Day C093).
644 Transcript of M Minister, C9391:24-28 (Day C091).
415. Some institutional witnesses involved in the experience of Katherine X were located and contact was made by the Royal Commission to obtain evidence from these witnesses. The evidence of these witnesses are set out below.

416. The Royal Commission heard evidence from Ms Minister, Dr Owen and Dr Slack regarding Winlaton’s response to child sexual abuse between the period 1974 and 1992.

417. The Royal Commission heard evidence from Dr Owen, that during his tenure as Superintendent of Winlaton between 1974 and 1978, there was not sufficient awareness of child sexual abuse. He said that in the 1970s, the ‘whole society was grappling with those issues, and the language of child sexual abuse did not appear until some time a little further down that track’.

418. Dr Slack told the Royal Commission that while she was at Winlaton, she was aware of the possibility of residents sexually abusing each other, but received no formal reports of child sexual abuse. She said that she was also aware of the possibility of staff members at Winlaton sexually abusing residents, but never received a report.

419. Ms Minister said that during her tenure at Winlaton from 1974 to 1992, it was possible that residents sexually abused other residents and she was sure that at the time it occurred to her as a possibility that this might have happened. She suggested that this was why rosters were set up to ensure there were sufficient staff on duty to provide supervision. Nevertheless, she gave evidence that staff never entered the rooms at night and that girls had to bang on the doors to get the attention of staff if they were in trouble. She said that if a girl was being sexually abused by her roommate it would have been a very difficult situation for that girl.

420. Ms Minister said that she did not know or turn her mind to the possibility of a staff member assaulting any of the children.

421. The Royal Commission heard evidence from Ms Minister that it was a fairly common occurrence for residents of Winlaton to have been abused by a family member. She said that she would estimate that hundreds of residents of Winlaton had been the victim of sexual abuse perpetrated by a family member, and that it was ‘not uncommon’ for residents to disclose this abuse to a staff member.

422. Dr Owen told the Royal Commission that Ms Minister’s evidence about the number of Winlaton residents that were the victim of child sexual abuse did not shock him given

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645 Transcript of L Owen, C9498:27-C9499:14 (Day C092).
646 Transcript of E Slack, C9602:46-C9603:14 (Day C093).
647 Transcript of E Slack, C9603:20-34 (Day C093).
648 Transcript of M Minister, C9415:41-C9416:9 (Day C091).
649 Transcript of M Minister, C9415:21-30 (C091).
650 Transcript of M Minister, C9422:3-10 (Day C091).
651 Transcript of M Minister C9393:25-28 (Day C091).
652 Transcript of M Minister, C9437:30-38 (Day C091).
653 Transcript of M Minister, C9437:30-C9438:18 (Day C091).
the number of girls that would have been admitted over her 15 years of employment.654 He said that during the four years he was at Winlaton, he was aware that some residents at Winlaton had been raped by a family member.655

423. By contrast, Dr Slack said during her time at Winlaton she was not aware that residents had been the victim of incest.656 She said that she would have expected Ms Minister, as her Deputy, to draw this to her attention because of the seriousness of the problem.657 She said that she was shocked to hear Ms Minister’s evidence that there were hundreds of girls at Winlaton who were the victim of incest,658 but that she accepted this evidence.659

424. The approach taken by Winlaton to residents who had been sexually abused by a family member is discussed in further detail at Part 3.6 below.

**Policies and procedures for responding to child sexual abuse at Winlaton**

425. As indicated above, the Royal Commission was provided with the Winlaton Manual and the Revised Winlaton Manual; policies that applied at least between the period 1980 and 1987.

426. Dr Owen gave evidence that the Winlaton Manual, which was originally printed in 1974, did not set out a policy for reporting instances of sexual abuse. He said that during the time he was at Winlaton, sexual abuse was not something that was clearly defined, nor was it on the top of his agenda,660 or at the forefront of his mind.661 He stated that his primary attention was on daily reports related to individual child behaviour, section reports and other administrative or functionary protocols.662

427. Dr Slack gave evidence that when she arrived at Winlaton in 1976, she was not made aware of any specific policies or procedures for the handling of serious incidents or complaints made by staff or residents.663

428. Dr Slack stated that she was involved in reviewing and updating the Winlaton Manual,664 but later said that she only looked at the Winlaton Manual at times and did not thoroughly read it. She said that it was ‘one of her failings’, not to have read the Winlaton Manual.665

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654 Transcript of M Minister, C9501:24-C9502:28 (Day C092).
655 Transcript of M Minister, C9502:30-34 (Day C092).
656 Transcript of E Slack, C9631:39-47 (Day C093).
657 Transcript of E Slack, C9632:2-10 (Day C093).
660 Transcript of L Owen, C9496:7-12 (Day C092).
661 Transcript of L Owen, C9497:31-35 (Day C092).
662 Exhibit 30-0030, Statement of L Owen, STAT.0652.002.0001_R at [24].
663 Exhibit 30-0034, Statement of E Slack, STAT.0630.001.0001_R at [33].
664 Exhibit 30-0034, Statement of E Slack, STAT.0630.001.0001_R at [38].
665 Transcript of E Slack, C9612:42-45 (Day C093).
429. Dr Slack gave evidence that when she was appointed Superintendent, she developed a guideline and procedure document setting out the process to be adopted in all cases of serious incidents or complaints. This was done, according to Dr Slack, with the aim of ensuring ‘wellbeing’ of residents and staff of Winlaton. She said that she introduced Grievance Hearings and Serious Incident Hearings referred to in the 1980 edition of the Winlaton Manual as a ‘method of handling individual escalating problems in the organisation’.666

430. The section of the Winlaton Manual entitled ‘Grievance Hearings’ states that the objective of grievance hearings is:

[T]o provide due process in a rational forum for examining the facts and stating the consequences for a major offence committed by a Winlaton trainee. Major offence to include 1) striking a staff, and 2) setting a fire.668

431. The steps of the grievance hearing in the Winlaton Manual are:

1. The involved staff person writes out a detailed Incident Report in the Correction Book on the section. Submits this book through normal channels to section Chief, who provides photostat copies of Incident Report to Superintendent and Deputy Superintendent.

2. Section Chief makes request for grievance hearing to Superintendent, informing Deputy Superintendent at same time.

3. Section Chief names involved parties in her/his request for hearing and Superintendent informs the following six (6) persons by written note, specifying the date, time and place of hearing: (1) Student (2) Student’s advocate (her Allocated Youth Officer) (3) Staff who was hit (or who witnessed fire) (4) Staff’s representative (staff’s Chief, Senior Youth Officer on section, or staff who witnessed the assault or fire) (5) Superintendent (6) Deputy Superintendent

4. Grievance hearing is held with this format: (a) Winlaton youth (Ward or sentenced) gives facts of incident. Is questioned by anyone present. (b) Winlaton staff (who was hit or witnessed setting of fire) gives facts of incident. Is questioned by anyone present. (c) Everyone given opportunity to say anything that pertains to incident. (d) When discussion is complete, Winlaton youth, assaulted staff (or person who witnessed setting of fire) and Deputy Superintendent leave hearing room, allowing Superintendent, staff’s representative and student’s Allocated Youth Officer to discuss the consequences for this student’s unacceptable action...

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666 Exhibit 30-0034, Statement of E Slack, STAT.0630.001.0001_R at [34]-[35].
667 Transcript of E Slack, C9640:5-21 (Day C093).
668 Exhibit 30-0011, DHS.3004.001.0078 at 0118.
9. Student’s advocate (her Allocated Youth Officer) has responsibility to see that decision and consequences about Winlaton trainee are carried out. AYO is to assist Superintendent in preparing court report if charges are pressed. Court report is to include written statement of trainee about incident.\textsuperscript{669}

432. The section of the Winlaton Manual entitled ‘Serious Incident Hearing’ states:

While the formal Grievance Hearing is reserved for the major incidents of 1) assault on staff by a girl, or 2) setting a fire, the Serious Incident Hearing can be set up to deal with serious incidents in which staff think that the behaviour of a trainee has endangered herself or others, or has damaged property. This would include incidents such as vicious fighting between girls, attempted drownings, sexual assault and premeditated or continuous vandalism.\textsuperscript{670}

433. The steps of the serious incident hearing in the Winlaton Manual are:

For assault of youth on youth or for other serious incidents, the Chief of the section is to be informed and is to collect written explanations of the details of the event from those involved... The Chief requests that the Senior of the section set the Serious Incident Hearing with each girl and her Allocated Youth Officer. These five (two girls and two AYOs or those Youth Officers designated the Senior, plus the Senior) meet. The matter is discussed thoroughly by these five, with consequences decided upon in the meeting and recommended to the Chief for approval. The AYO sees that all consequences are carried out.\textsuperscript{671}

434. When asked why it was that serious incident hearings, which involved a trainee being potentially sexually assaulted, was left to the management of the youth officers and not passed up the chain of command, Ms Minister told the Royal Commission:

[C]hief youth officers were seen as fairly senior in the management structure, and their job was to deal with all kinds of serious misbehaviour, so it would have been appropriate for staff at that level to run a serious incident hearing.\textsuperscript{672}

435. Ms Minister said that she expected complaints raised by residents to Youth Officers to be reported to her as Deputy Superintendent and that anybody could and was expected to raise any concerns they had.\textsuperscript{673}

436. When questioned as to why grievance hearings (for striking a staff or setting a fire) made provisions for a report to the police, and serious incident hearings (for sexual assault) made no provision for reporting to the police, Dr Slack said that the policy was

\textsuperscript{669} Exhibit 30-0011, DHS.3004.001.0078 at 0118.
\textsuperscript{670} Exhibit 30-0011, DHS.3004.001.0078 at 0119.
\textsuperscript{671} Exhibit 30-0011, DHS.3004.001.0078 at 0119.
\textsuperscript{672} Transcript of M Minister, C9417:42-C9418:3 (Day C091).
\textsuperscript{673} Transcript of M Minister, C9418:5-21 (Day C091).
written this way because ‘there was no information coming to [her] about sexual assault’. 674

437. Dr Slack agreed that the Winlaton Manual only contemplated sexual assault between residents, and she had never heard of sexual assault of residents by staff. 675 She accepted that the Winlaton Manual, as at 1980, reflected a lack of awareness of the possibility that staff members might sexually abuse residents. 676

438. Dr Slack gave evidence that she was involved in revising the 1987 edition of the Winlaton Manual to set out a procedure for dealing with sexual abuse. 677 She said that this was done because she thought ‘something was missing’ from the policies of the Winlaton Manual. 678


440. Ms Minister gave evidence that as at 1987, there was a clear recognition that sexual assaults within Winlaton were occurring or could have occurred. 682

441. Dr Slack told the Royal Commission that in developing the policies, she did not receive any instruction from the Department. 683

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**Available findings on policies and procedures for responding to child sexual abuse at Winlaton**

F18 Prior to 1980, there were no formal policies or procedures in place at Winlaton for:

a) receiving or responding to complaints of child sexual abuse, and

b) reporting complaints of child sexual abuse to the Director of the Department and/or the Victoria Police.

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

a) did not contemplate child sexual abuse perpetrated by staff members; and

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674 Transcript of E Slack, C9640:39-C9641:23 (Day C093); C9641:36-C9642:38 (Day C093).
675 Transcript of E Slack, C9642:40-44 (Day C093).
676 Transcript of E Slack, C9643:20-23 (Day C093).
677 Transcript of E Slack, C9643:25-36 (Day C093).
678 Transcript of E Slack, C9643:38-41 (Day C093).
679 Exhibit 30-0011, DHS.3127.002.0019 at 0143; Transcript of E Slack, C9644:3-16 (Day C093).
680 Exhibit 30-0011, DHS.3127.002.0019 at 0144-0146; Transcript of E Slack, C9645:3-29 (Day C093).
681 Exhibit 30-0011, DHS.3127.002.0019 at 0147-0149.
682 Transcript of M Minister, C9469:39-42 (Day C091).
683 Transcript of E Slack, C9644:3-21 (Day C093).
b) 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 Superintendents or the Superintendent.

Training to recognise and respond to allegations of child sexual abuse at Winlaton

442. Ms Minister gave evidence that during her 18 years at Winlaton, from 1974 to 1992, she recalled attending and participating in a training program relevant to dealing with perpetrators of sexual abuse. The program was run by an expert in the field and she said that she recalled this being a very difficult field with very few practitioners.  

443. Ms Minister said that the training was not offered by the Department, but was something organised internally at Winlaton. This was the only training she recalled attending.  

444. Prior to commencing employment at Winlaton, Ms Minister had six years’ experience working in youth and adult correction facilities in Canada. Despite her previous experience, she said that as a Deputy Superintendent at Winlaton, she was not adequately trained or guided by the Department in relation to the impacts of child sexual abuse pertaining to the residents that were in her care.  

445. Ms Minister said that during her tenure at Winlaton, the Department did not encourage or require her to increase her knowledge or professional development in relation to the area of child sexual abuse.  

446. When questioned on whether she considered this to be a failure of the Department and the system, Ms Minister said ‘yes, I would say so’.  

447. Dr Owen gave evidence that the institution did not do as much as was needed for the welfare of the residents. He attributed this to a number of factors including the state of expertise within the system at the time and resourcing. He told the Royal Commission that while the quality of staff was generally good at Winlaton, ‘there may have been some people who had some difficulties’. He said that this affected the extent to which the institution was able to ensure that they always had trained staff.  

448. Dr Slack accepted that the training offered at Winlaton was ‘remiss’.  

Available finding on training to recognise and respond to allegations of child sexual abuse at Winlaton

684 Transcript of M Minister, C9484:41-C9484:7 (Day C091).  
685 Transcript of M Minister, C9484:41-C9484:7 (Day C091).  
686 Transcript of M Minister, C9382:25-41 (Day C091).  
687 Transcript of M Minister, C9485:9-15 (Day C091).  
688 Transcript of M Minister, C9485:17-22 (Day C091).  
689 Transcript of M Minister, C9485:24-25 (Day C091).  
690 Exhibit 30-0030, Statement of L Owen, STAT.0652.002.0001_R at [20].  
691 Transcript of L Owen, C9525:44-C9526:6 (Day C092).  
692 Transcript of E Slack, C9656:42-C9657:2 (Day C093).
F20 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.

Barriers to reporting at Winlaton

449. The Royal Commission heard evidence that there were a number of barriers to reporting child sexual abuse at Winlaton. One such barrier was a pervading culture that residents who ‘lagged’ or ‘dobbed’ would be punished and abused further.

450. Dr Slack gave evidence that there was a culture of residents being subjected to further trouble or abuse if they were branded ‘laggers’ or ‘dobbers’. She accepted that in those circumstances, residents may have been too scared to report abuse.693

451. Dr Owen accepted that a culture where residents were discouraged to ‘lag’ or ‘dob’ was an endemic issue in almost every institution that he was involved in.694

452. Ms Minister accepted that in that culture, it was difficult for residents to speak out about any sexual abuse they were experiencing. She said that the main thing in place to protect residents from sexual abuse was supervision from staff, and she gave evidence that ‘in groups young people were encouraged to raise any issues that they had, any concerns that they had’.695

453. Contrary to the evidence given by Ms Minister, the Royal Commission heard evidence that residents weren’t reporting abuse for fear of not being believed by staff members. BDF told the Royal Commission that the officers reinforced the culture that ‘dobbers’ or ‘laggers’ would be punished further.696

454. Dr Owen gave evidence that it was possible that some staff members may have discouraged residents from reporting abuse.697 When asked to reflect on the evidence of Ms Hodkinson who said that she reported abuse by a staff member to Ms Baxter, but was told she was ‘nothing but a dirty little lying bitch’, Dr Owen said that was dreadful and he could not in any way condone that sort of behaviour. He said that it may have been part of Ms Baxter’s ‘frame of reference’ that staff were to be trusted more than residents and that it was possible this reflected an attitude at the time that residents were not to be believed.698

693 Transcript of E Slack, C9654:47-C9655:7 (Day C093).
694 Transcript of L Owen, C9512:41-45 (Day C092).
695 Transcript of M Minister, C9416:35-45 (Day C091).
696 Transcript of BDF, C9351:28-42 (Day C090).
697 Transcript of L Owen, C9512:47-C9513:9 (Day C092).
698 Transcript of L Owen, C9500:3-C9501:5 (Day C092).
455. He accepted that in that environment, some residents would never report being sexually abused by a staff member, knowing that was the reception they were going to receive.699

456. Ms Minister told the Royal Commission that there were staff members, like Ms Baxter, who were problematic and who displayed aggressive attitudes towards residents. In her view, this contributed to the aggression that residents felt and contributed to an environment where residents would not feel comfortable disclosing sexual abuse to staff members.700

457. Ms Minister said that the management team at Winlaton tried hard to create an open, caring culture, and that this was facilitated through:

[C]ase planning processes where [she] chaired meetings where [the residents’] progress, their assessments and progress were discussed, and [ensured] that every young person had a case plan and that things that were decided on were actually implemented, that no young [person] got ignored ... There were processes in place for ensuring that there was regular review of problems and progress of the young people throughout their stay.701

458. Ms Minister told the Royal Commission that the aim of the management team at Winlaton was to try to create an environment where the residents felt comfortable to reveal to staff members any sexual abuse they experienced.702

459. She said that having read the statements of former residents, ‘obviously things occurred there that were not very good and management wasn’t aware of at the time, so I would have to say that we weren’t totally successful’.703 She accepted that many of those residents got the opposite of safety and security when they were sexually abused at Winlaton.704

460. Another barrier identified at this public hearing was that incidents were not reported to the Superintendent because of the reporting structure and access to senior staff.

461. The Royal Commission heard evidence from Ms Minister, Dr Owen and Dr Slack that they each adopted different practices to build rapport with staff members and residents. Ms Minister said that she had lots of contact with the residents by having lunch with staff and residents and moving around the institution.705

699 Transcript of L Owen, C9501:18-22 (Day C092).
700 Transcript of M Minister, C9423:2-28 (Day C091).
701 Transcript of M Minister, C9410:32-C9411:3 (C091).
702 Transcript of M Minister, C9411:5-10 (C091).
703 Transcript of M Minister, C9411:12-16 (Day C091).
704 Transcript of M Minister, C9426:18-42 (Day C091).
705 Transcript of M Minister, C9389:1-8 (Day C091).
462. Dr Owen said that he had a significant degree of contact with the youth officers and held various meetings to ensure contact was facilitated. He said that he used to visit each of the sections reasonably often and read reports from the staff daily.\textsuperscript{706}

463. Dr Slack stated that she had a habit of moving throughout the facility daily, where she would meet and speak to the residents. She said that she attended daily informal lunches with residents and youth officers.\textsuperscript{707}

464. Ms Minister said that she expected reports of child sexual abuse to be communicated to her in her capacity as Deputy Superintendent.\textsuperscript{708} She gave evidence that any incidents that occurred at Winlaton would be recorded and noted on the resident’s file and that these incidents would be reported to the Chief Youth Officer and the Principal Youth Officer, and it would make its way up the chain of command.\textsuperscript{709}

465. Ms Minister told the Royal Commission that a ‘lot of incidents would probably be dealt with at the Chief Youth Officer or Principal level’.\textsuperscript{710} She accepted that if a particular Youth Officer was not going to report matters up the chain, then that Youth Officer had ultimate power over whether or not residents were protected.\textsuperscript{711}

466. Ms Minister accepted that in those circumstances, the systems that were in place at Winlaton were completely ineffective to ensure that residents were not subjected to sexual abuse.\textsuperscript{712} She accepted that by 1987, if there was any complaint consisting of sexual assault or sexual misconduct within Winlaton, the process still relied on the complaint making its way up to the Chief Youth Officer, who then had an obligation to report it directly to the Superintendent.\textsuperscript{713}

467. Dr Slack said that she was of the expectation that the Deputy Superintendent would have reported any sexual abuse to her. She said that any incident of child sexual abuse at Winlaton would have gone up the chain to the Deputy Superintendent.\textsuperscript{714}

468. Dr Slack accepted that there was no policy in place prior to 1987 for incidents of sexual abuse to be reported to her,\textsuperscript{715} and accepted that there was no policy or procedure that would ensure that she received that information.\textsuperscript{716}

\textit{Available findings on barriers to reporting at Winlaton}

\textsuperscript{706} Transcript of L Owen, C9508:39-C9509:6 (Day C092).
\textsuperscript{707} Exhibit 30-0034, Statement of E Slack, STAT.0630.001.0001_R at [21]; Transcript of E Slack, C9600:8-33 (Day C093).
\textsuperscript{708} Transcript of M Minister, C9425:26-30 (Day C091).
\textsuperscript{709} Transcript of M Minister, C9461:9-C9462:11 (Day C091).
\textsuperscript{710} Transcript of M Minister, C9462:23-26 (Day C091).
\textsuperscript{711} Transcript of M Minister, C9425:42-45 (Day C091).
\textsuperscript{712} Transcript of M Minister, C9425:26-40 (Day C091).
\textsuperscript{713} Transcript of M Minister, C9470:20-26 (Day C091).
\textsuperscript{714} Transcript of E Slack, C9702:4-17 (Day C093).
\textsuperscript{715} Transcript of E Slack, C9702:23-25(Day C093).
\textsuperscript{716} Transcript of E Slack, C9661:41-44 (Day C093).
F21. 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.

F22. During the period that Winlaton was in operation, some residents who did report sexual or physical abuse to a staff member were not believed, or were punished for reporting the physical or sexual abuse.

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.

Supervision of residents at Winlaton

469. The Royal Commission heard evidence that the sexual assault that occurred at Winlaton, often occurred as a result of a lack of supervision.

470. BHE told the Royal Commission that when she was being sexually abused by another resident in Goonyah, there were only three staff members supervising the residents during the day, and half the time, they were in their office.717

471. BDF said that when she was sexually abused during a movie night, there were staff members present in the hall who should have seen her being taken by older Goonyah girls, but did nothing.718 She also said that at night, she was sexually abused by an older girl in her dormitory on a number of occasions, and that when she needed to go to the toilet at night, she had to be taken by a male guard who watched her.719

472. Dr Slack accepted that the experiences of these former residents demonstrates that there was inadequate supervision of residents at Winlaton.720 She said that in relation to BDF, there was a fundamental failure of the institution to provide adequate supervision and prevent abuse from happening.721

473. Ms Minister said that during the 1970s and 1980s, Winlaton had a system in place for supervision of residents at night which involved locking the residents in their room. She said that there was one night staff on each unit for up to 15 residents, a Senior Youth Officer in a separate building, and a security guard roaming the grounds.722

474. Ms Minister gave evidence that if a resident needed the attention of a staff member, the resident would just knock on the door and call out; there was no distress or buzzer system available.723 She accepted that this system of supervision relied on residents

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717 Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [43].
718 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [44].
719 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [34].
720 Transcript of E Slack, C9654:37-45 (Day C093).
721 Transcript of E Slack, C9656:10-35 (Day C093).
722 Transcript of M Minister, C9414:29-44 (Day C091).
723 Transcript of M Minister, C9415:21-25 (Day C091)
pounding on doors to attract the attention of staff,\(^{724}\) and that this created a difficult situation for a resident who was being sexually abused by a roommate.\(^{725}\) She later stated that her view was that there was always sufficient staff on duty to provide supervision.\(^{726}\)

475. Dr Slack recalled that there were male guards employed to assist with security at night and moved around the sections to check for fire, smoke or intruders. They were not expected to have any supervisory role of the residents.\(^{727}\)

476. The Royal Commission also heard that in addition to a lack of supervision, some former residents were sexually abused in places that were not easily supervised by staff.

477. BDF said she was sexually abused by other residents in the yard, but she could not recall any staff members being present at the time. BDC gave evidence that when she was sexually abused by other residents in a corner of a room adjacent to the staff room, the abuse occurred outside the view of any staff member.

478. Ms Minister told the Royal Commission that the physical set up of the institution made it difficult to provide constant supervision on the part of the staff. She said that the ‘narrowness of the passages and the way in rooms were located, [meant that] young people could be out of the view of staff quite easily when they were on their units’.\(^{728}\)

479. She attributed the aggression among residents to a number of factors, and gave evidence as follows:

> I suppose overall it would have been many factors: poor management, probably the quality of staff, some of the staff, lack of proper procedures for handling misbehavior; I think the physical set-up of the institution didn’t – wasn’t conducive to the smooth running of the place.\(^{729}\)

480. Dr Owen agreed that the layout of Winlaton meant there were places hidden from staff where physical and sexual abuse could occur.\(^{730}\)

### Available finding on the supervision of residents at Winlaton

F24 The supervision of child residents by the staff of Winlaton was inadequate as a result of:

- a) insufficient number of staff,
- b) overcrowding,

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\(^{724}\) Transcript of M Minister, C9416:19-22 (Day C091).

\(^{725}\) Transcript of M Minister, C9416:24-27 (Day C091).

\(^{726}\) Transcript of M Minister, C9416:11-13 (Day C091).

\(^{727}\) Transcript of E Slack, C9620:13-30 (Day C093).

\(^{728}\) Transcript of M Minister, C9414:3-9 (Day C091).

\(^{729}\) Transcript of M Minister, C9413:40-C9414:1 (Day C091).

\(^{730}\) Transcript of L Owen, C9512:34-39 (Day C092).
c) lack of training and

d) the physical environment of the institution.

Programs at Winlaton

481. The Royal Commission heard evidence from Ms Minister and Dr Owen that residents who were known or were suspected to have been sexually abused prior to their accommodation at Winlaton were offered some form of assistance.

482. Ms Minister gave evidence that during her time at Winlaton, there was a policy in place to deal with trauma for those residents who were known or were suspected to have been sexually abused prior to Winlaton. She said that:

[Y]oung people that had serious problems around sexual abuse were referred to the Children’s Court Clinic for counselling from a psychologist or other clinician; that would be the usual – as well as the staff helping her to verbalise her feelings about what was happening in her life, and helping her in all sorts of other ways to increase her self-esteem and her self-confidence and her sense of self-worth, because that was very often a major effect of being a victim of sexual abuse.\(^7\)\(^3\)\(^1\)

483. When asked what sort of assistance was provided for residents who had been the victims of serious sexual abuse, Dr Owen told the Royal Commission that

The expectation would be that the professional staff at the institution were available to provide counselling, emotional support. We always had access to a consulting psychiatrist who was frequently in the institution. Where cases were picked up by any of the staff, or the social workers who were working with them, and of course that increasingly over that time included regional social workers who would be visiting families, coming in and seeing girls in the institution, then those issues would be referred to those professional staff for the social, emotional, psychological support.\(^7\)\(^3\)\(^2\)

484. A document entitled ‘Psychiatric/Psychological Referrals at Winlaton’ set out the policies and procedures for making such a referral.\(^7\)\(^3\)\(^3\) The referral of residents to the Children’s Court Clinic and its application to Katherine X, a former resident at Winlaton is discussed further below.

Strip searches at Winlaton

485. The Royal Commission heard evidence from a number of former residents that they were forced to strip naked when they were first placed at Winlaton, or when they were returned to Winlaton from absconding or weekend leave.

\(^7\)\(^3\)\(^1\) Transcript of M Minister, C9393:30-42 (Day C091).
\(^7\)\(^3\)\(^2\) Transcript of L Owen, C9502:42-C9503:12 (Day C092).
\(^7\)\(^3\)\(^3\) Exhibit 30-0011, DHS.3026.0004.0150 at 0150.
486. BDC told the Royal Commission that whenever she returned to Winlaton after a visit or appointment, she was strip searched by female staff members. She said that on some occasions, staff would tell her to stand with her legs apart and jump, or would put a mirror between her legs to check for contraband.734

487. Ms Short said that she was forced to strip naked and jump up and down in front of an officer who watched to see if anything fell out of her vagina. She said that the officer placed her fingers inside her vagina to check if anything was hidden up there.

488. BHE said strip searches were terrifying, embarrassing and degrading.

489. The Royal Commission was not provided with any policies in relation to strip searches, but in relation to searches, the 1980 edition of the Winlaton Manual and the Revised Winlaton Manual in 1987 states

On return from leave, the girl is to be searched before being allowed to return to her section.735

490. Dr Slack said that the issue of contraband was a problem for girls who had been on weekend leave.736 She was aware that residents were searched upon admission to Winlaton for the first time, but was not aware that residents were being strip searched.737 When shown the policy in the Winlaton Manual on searches, she said that she understood the search to have been a ‘very soft pat-down’ of the individual.738

491. Ms Minister said that searches of residents were held when residents had returned from the community or from leave, or were returned from absconding. She said the searches were done by female staff in the form of a ‘pat down search where no clothing was removed, or a strip-search, where all clothing was removed’.739

492. Neither the 1980 edition of the Winlaton Manual or the Revised Winlaton Manual in 1987 included any policy for the practice of strip-searches. Dr Slack accepted that this was an oversight.740

493. Ms Minister gave evidence that she considered that the searches were a breach of the residents’ privacy, and could be humiliating, degrading, intrusive and uncomfortable, but said searching was a necessity.741 Ms Slack gave evidence that strip searches were not appropriate in any circumstances.742

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734 Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [57].
735 Exhibit 30-0011, DHS.3004.001.0078 at 0105; Exhibit 30-0011, DHS.3127.002.0019 at 0079.
736 Transcript of E Slack, C9612:14-16 (Day C093).
737 Transcript of E Slack, C9613:29-35 (Day C093).
738 Transcript of E Slack, C9613:15-27 (Day C093).
739 Transcript of M Minister, C9404:25-37 (Day C091).
740 Transcript of E Slack, C9657:37-43 (Day C093).
741 Transcript of M Minister, C9405:40-44 (Day C091); Transcript of M Minister, C9408:46-C9409:11 (Day C091).
494. When asked whether she was ever present when a strip searches took place, Ms Minister said she was not.\textsuperscript{743} Dr Slack also told the Royal Commission that she did not attend any searches to see how they were being done.\textsuperscript{744}

495. Ms Minister agreed that part of her role as management was to ensure that policies were enforced correctly,\textsuperscript{745} but she never attended any of the strip searches.\textsuperscript{746} She said that the only way she knew that strip searches were being carried out appropriately was that no issues were raised by staff or residents.\textsuperscript{747}

496. Ms Minister gave evidence to the Royal Commission that:

a. she relied on individual staff members to conduct searches properly in the absence of any system of spot checks;

b. there was no audit process; and

c. she never made it her business to specifically seek out the residents and ask them how they experienced the search.\textsuperscript{748}

497. In those circumstances, Ms Minister accepted that individual youth officers who were conducting strip searches had a licence to do the search the way they wanted, and that if there was a youth officer who was inappropriate or abusive, the absence of a spot check or audit process would have facilitated an opportunity to abuse the residents.\textsuperscript{749}

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\textbf{Available findings on strip searches at Winlaton} \\
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F25 During the period that Winlaton was in operation, some residents were subjected to strip searches upon admission, return from leave and return from absconding. On some occasions these searches involved examination of residents’ vaginas. On some occasions male staff members, or male police members, were present during these searches. \\
F26 The strip searches that some residents of Winlaton were subjected to were degrading, humiliating and invasive. \\
F27 During the period that Winlaton was in operation, there were no formal procedures or policies regarding how strip searches at Winlaton were to be conducted, and no oversight by senior staff of strip searches. \\
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\textsuperscript{743} Transcript of M Minister, C9405:46-C9406:1 (Day C091).
\textsuperscript{744} Transcript of E Slack, C9657:33-35 (Day C093).
\textsuperscript{745} Transcript of M Minister, C9408:41-44 (Day C091).
\textsuperscript{746} Transcript of M Minister, C9405:46-C9406:1 (Day C091); Transcript of M Minister, C9409:13-14 (Day C091).
\textsuperscript{747} Transcript of M Minister, C9409:16-20 (Day C091).
\textsuperscript{748} Transcript of M Minister, C9409:22-33 (Day C091).
\textsuperscript{749} Transcript of M Minister, C9409:30-43 (Day C091).
Internal medical examinations at Winlaton

498. A number of former residents gave evidence that they were forced to undergo intrusive medical examinations, including checks for venereal diseases, despite having had no previous sexual activity.

499. BDC, Ms Short, BHE and Ms Hodkinson told the Royal Commission that while they were residents at Winlaton, they were subjected to intrusive medical examinations by a doctor (nicknamed 'Dr Finger'). Some residents recalled the examinations occurring in Winlaton; others recalled being taken to a clinic in Fitzroy.

500. Ms Short and Ms Hodkinson gave evidence that despite their pleas that they were both virgins, they were still forced to undergo the examination.


On admission to the Institution as a Ward of the State, Doctor will carry out a general medical examination. Details of this and any further medical examination will be recorded in the Medical File.

The Government Clinic attends each Wednesday morning for the treatment of Venereal Diseases. The Nursing Sister will arrange for appointments at the Clinic for appropriate trainees to be examined.750

502. Ms Minister told the Royal Commission that during her time at Winlaton, it was not mandatory for residents to be subjected to intrusive checks to determine if they had a venereal disease.751 She said that an assessment would have been done by the nurse to determine whether it was appropriate for the resident to undergo a medical check, and that the assessment could have been done at any time during a resident’s stay at Winlaton.752

503. Ms Minister said that during her time at Winlaton, she did not recall a practice of sending residents to a clinic, as she recalled sessional doctors attending Winlaton for medical checks, including venereal diseases.753

504. When shown the 1980 edition of the Winlaton Manual, a policy that was in operation during her time there, Ms Minister said that she was surprised the policy stated that the Government Clinic attended each Wednesday for the treatment of venereal diseases.754

505. Ms Minister said that in her mind, when she was in Winlaton in the 1970s, the residents had access to medical staff who were focused on the residents' needs and

750 Exhibit 30-0011, DHS.3004.001.0078 at 0129; Exhibit 30-0011, DHS.3127.002.0019 at 0117.
751 Transcript of M Minister, C9401:10-13 (C091).
752 Transcript of M Minister, C9401:26-C9402:3 (C091).
753 Transcript of M Minister, C9402:11-33 (Day C091).
754 Transcript of M Minister, C9403:18-C9404:1 (Day C091).
who were appropriate and sensitive to these needs. However, when asked whether she had heard of any residents who felt they had an intrusive medical examination, Ms Minister said that ‘there might have been comments made from time to time after they’d had an internal examination’.

506. Dr Slack told the Royal Commission that while walking around Winlaton, she was aware residents were complaining about invasive medical examinations, as she heard residents talk about medical examinations using words such as ‘they have [a fucking cunt] nerve’.

507. Ms Minister accepted that it was completely inappropriate for residents to be forced to undergo a venereal disease examination, saying that she would ‘consider it assault on the young person’.

Available finding on internal medical examinations at Winlaton

F28 In the 1960s and early 1970s, BDC, Ms Short, BHE and Ms Hodkinson were subjected to internal medical examinations by doctors that attended Winlaton, or at a venereal disease clinic in Fitzroy, Victoria. This was inappropriate because:

a) the examinations were intrusive and invasive;

b) the purpose of the examinations was not explained to the residents; and

c) the residents had not given consent to the examinations.

The use of triad therapy in response to child sexual abuse at Winlaton

508. A number of former residents gave evidence that they participated in a group program called ‘triad therapy’ while at Winlaton.

509. Triad therapy was introduced to Winlaton by Dr Slack.

510. The 1980 edition of the Winlaton Manual contains a three-page section on the policies and guidelines for triad therapy. It states:

Triad problem identification group meetings form an important part of the treatment program within Winlaton. It is based upon the theory that rehabilitation is produced in three-role social situations, called triads – (a) the person with the problem now; (b) the person who used to have the problem but now does not; (c) the people who have never had the problem or who had it so
long ago that it doesn’t matter – teachers, staff, volunteers, parents, friends, etc., who guide the get-together.\textsuperscript{759}

511. Dr Slack gave evidence that different forms of triad were used at Winlaton, including triad therapy in a group setting, which could involve around 15 residents, and ‘mini-triads’, which involved three persons, with one person in each of the roles.\textsuperscript{760}

512. The Winlaton Manual states that triad therapy was compulsory and occurred five days per week.\textsuperscript{761} Dr Slack told the Royal Commission that the goals of triad therapy, as set out in the Winlaton Manual, were:

1. To identify individual problems.
2. To work on alternatives to behaviour identified as a problem.
3. To overcome brooding about or keeping silent about problems.
4. To help each other when we have discovered ways to solve problems.
5. To help the individual to make it in his/her surroundings with a healthier, more responsible integration of the human self.\textsuperscript{762}

513. Dr Slack gave evidence that the group triad sessions commenced with a student moderator asking members to share with the group if they had helped another person or been helped by others in the last 24 hours.\textsuperscript{763} The student moderator then called for at least three group members to identify a problem they were experiencing, and a vote was taken to determine which resident’s problem would be dealt with in the group.\textsuperscript{764}

514. Dr Slack told the Royal Commission that she developed a problem list for triad, which was intended to give residents an indication of the types of problems they could discuss in triad. She said that the list was continually revised over time.\textsuperscript{765} A version of the problem list revised on 3 May 1982 was produced to the Royal Commission. The problems on this list include:

- Bitchy: starting arguments and taking bad moods out on someone else. Back stabbing.
- Overweight: always eating and putting on too much weight.
- Prostitution: sex for money.
- Sexual: thinking you are in love with someone of the same sex and it’s hassling your mind. Thinking you are in love with someone of the opposite sex and it means trouble.\textsuperscript{766}

\textsuperscript{759} Exhibit 30-0011, DHS.3004.001.0078 at 0084.
\textsuperscript{760} Transcript of E Slack, C9595:40-C9596:6 (Day C093).
\textsuperscript{761} Exhibit 30-0011, DHS.3004.001.0078 at 0084; Transcript of E Slack, C9623:9-15 (Day C093).
\textsuperscript{762} Exhibit 30-0011, DHS.3004.001.0078 at 0084; Transcript of E Slack, C9623:17-29 (Day C093).
\textsuperscript{763} Exhibit 30-0011, DHS.3004.001.0078 at 0084; Transcript of E Slack, C9623:36-44 (Day C093).
\textsuperscript{764} Transcript of E Slack, C9624:23-35 (Day C093).
\textsuperscript{765} Transcript of E Slack, C9630:5-13 (Day C093).
\textsuperscript{766} Exhibit 30-0029, TEN.0027.001.0001 at 0002.
515. Dr Slack told the Royal Commission that she received complaints about triad therapy from external bodies and from residents. Dr Slack said that residents called triad ‘a fucking waste of time’. She said she became aware of complaints that triad therapy was

...intrusive, people were being scapegoated, individuals were being forced to list their problems, people were pretending they had fewer problems than the reason why they were sent to the Winlaton area, and that it was a joke.

516. She said that ‘scapegoating’ referred to some group members placing attention on others instead of themselves. Dr Slack said that at the time she was concerned that triad therapy was being used to pick on some of the residents and realised the need to intensify the training provided to youth officers.

517. The Royal Commission heard evidence that some former residents felt that triad therapy ‘[assumed] everyone had some big problem’ and that ‘the bottom line was that, whatever had happened, was your fault’. BDF told the Royal Commission

I feel that those groups actually exposed me to more harm. One of the first things that you discuss is your reasons for being there, and I didn’t have a clue why I was there, so when I voiced that within that group, I was instantly attacked; I was labelled a liar, I was labelled as someone who was in denial, and that went on with my peers.

518. Dr Slack gave evidence that it was a part of the therapeutic understanding that the person with the problem being discussed would take responsibility for their problem. She said that ‘taking responsibility meant understanding what it was that started you into that path which led to many persons’ self-destruction.

519. Dr Owen agreed that triad therapy placed an expectation on residents to assume responsibility or acknowledge their own responsibility for their problems as a way of helping residents to deal with their problems.

520. Dr Slack gave evidence that she did not expect residents who were subject to sexual abuse to reveal the abuse in a triad setting. She said that she would have thought that residents would hesitate to discuss their sexual problems in such an

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767 Transcript of E Slack, C9626:38-43 (Day C093).
768 Transcript of E Slack, C9626:45-47 (Day C093).
769 Transcript of E Slack, C9626:10-16 (Day C093).
770 Transcript of E Slack, C9627:7-11 (Day C093).
771 Transcript of E Slack, C9627:13-23 (Day C093).
772 Transcript of E Slack, C9627:25-31 (Day C093).
773 Transcript of BHE, C9121:3-10 (Day C088).
774 Transcript of Winnie Girls documentary, C9376:7-14 (Day C091).
775 Transcript of E Slack, C9353:27-34 (Day C090).
776 Transcript of E Slack, C9598:18-30 (Day C093).
777 Transcript of L Owen, C9514:28-32 (Day C092).
778 Transcript of E Slack, C9629:47-C9630:3 (Day C093).
environment,\textsuperscript{779} and she anticipated that any such problems would first be raised with the youth officers.\textsuperscript{780}

521. Dr Slack acknowledged that the problem list included problems that were ‘sexual’,\textsuperscript{781} and that residents were encouraged to speak about problems which may have been deeply personal and emotionally conflicting.\textsuperscript{782} Dr Slack said that she could not recall any resident raising a sexual experience in group despite it being on the problem list.\textsuperscript{783}

522. Dr Slack said she never instructed staff not to discuss any problems, including sexual problems, in triad therapy, and that residents could choose whether or not to raise any problems that they had.\textsuperscript{784}

523. Dr Owen told the Royal Commission that it was ‘certainly questionable’ for residents who had been a victim of sexual abuse to be told to take responsibility for that abuse, and that this could have caused them to be traumatised.\textsuperscript{785} He said that ‘with hindsight, I can see that the issue with sexual abuse, as to where blame is attributed, is a critical factor’.\textsuperscript{786}

524. Dr Slack said that at the time she was at Winlaton, she was not aware that many of the residents who were participating in triad therapy had been victims of sexual abuse.\textsuperscript{787} She accepted that:

a. triad therapy in the way that it was set up in a large group therapy was specifically designed for a range of issues where the resident would take responsibility for their own behaviour;\textsuperscript{788}

b. staff were trained to expect the resident to take responsibility for their own behaviour, but not to ‘hammer them’ or make them feel guilty;\textsuperscript{789}

c. it was inappropriate to expect one type of training to staff to be appropriate for all different issues or problems that could have been raised by the residents;\textsuperscript{790}

\textsuperscript{779} Transcript of E Slack, C9631:4-10 (Day C093).
\textsuperscript{780} Transcript of E Slack, C9631:12-15 (Day C093); Transcript of E Slack, C9630:31-43 (Day C093).
\textsuperscript{781} Transcript of E Slack, C9631:17-29 (Day C093).
\textsuperscript{782} Transcript of E Slack, C9630:26-29 (Day C093).
\textsuperscript{783} Transcript of E Slack, C9631:31-37 (Day C093).
\textsuperscript{784} Transcript of E Slack, C9699:16-31 (Day C093).
\textsuperscript{785} Transcript of L Owen, C9514:43-C9515:4 (Day C092).
\textsuperscript{786} Transcript of L Owen, C9514:34-41 (Day C092).
\textsuperscript{787} Transcript of E Slack, C9637:43-47 (Day C093).
\textsuperscript{788} Transcript of E Slack, C9699:38-42 (Day C093).
\textsuperscript{789} Transcript of E Slack, C9699:44-47 (Day C093).
\textsuperscript{790} Transcript of E Slack, C9700:7-10 (Day C093).
d. it was problematic to introduce triad therapy in Winlaton where staff, including her in her capacity as Superintendent, did not understand the depth of the trauma that some residents had undergone;\(^{791}\) and

e. it had the effect of causing harm to some participants who suffered sexual abuse,\(^{792}\) and was traumatising for a number of survivors.\(^{793}\)

525. Dr Slack accepted that although triad therapy was well-intentioned,\(^{794}\) it was completely misguided.\(^{795}\)

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

F29 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
- d) it required the child to take responsibility or accept blame for the sexual abuse of which they were the victim.

**Acknowledgment by Dr Eileen Slack**

526. When reflecting on the evidence given by the former residents, Dr Slack said that she was shocked and devastated.\(^{796}\) She said that she recognised her ignorance as a failure of the institution itself and her own failure, as ‘the buck stops with [her]’.\(^{797}\)

527. Dr Slack apologised to the former residents of Winlaton, stating:

> On 4 August 2015, when advised that sexual abuse of residents had occurred during my time as superintendent of Winlaton, I was shocked and devastated. I had not at this stage been made aware of the details of such sexual abuse as experienced by the five young victims named in the Royal Commission’s correspondence to me. However, I accept that it occurred and have no excuse for my ignorance. My ignorance is inexcusable. Whilst my words and thoughts are inadequate, I want to sincerely apologise to each and every victim of this insidious and inhumane abuse. I feel unable, I feel unable to express my horror

\(^{791}\) Transcript of E Slack, C9701:9-14 (Day C093).

\(^{792}\) Transcript of E Slack, C9701:21-27 (Day C093).

\(^{793}\) Transcript of E Slack, C9701:47-C9702:2 (Day C093).

\(^{794}\) Transcript of E Slack, C9701:16-19 (Day C093).

\(^{795}\) Transcript of E Slack, C9638:2-26 (Day C093).

\(^{796}\) Exhibit 30-0034, Statement of E Slack, STAT.0630.001.0001_R at [61].

\(^{797}\) Transcript of E Slack, C9658:5-9 (Day C093).
and to express my deep shame that you experienced sexual assaults with me as your superintendent. As your superintendent, each and every one of you had the right to expect my protection.

I live now with the regret and guilt of having failed you and your loved ones. Despite my best efforts, it is now apparent that my ‘policies’ and communication procedures up and down Winlaton were woefully inadequate. I am deeply sorry for the pain my management inadequacies inflicted on you. I will forever remain acutely distressed, acutely distressed, in the knowledge of the pain and the trauma each of you endured while residents at Winlaton. 798

Available finding on the oversight and protection of the Superintendent at Winlaton

F30 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.

3.5 The experience of Katherine X

528. Katherine X was born in Victoria in 1964. 799 She told the Royal Commission that during her childhood, her father was violent, unpredictable and an alcoholic, and he was admitted as a certified patient at the Royal Park Psychiatric Hospital a number of times. 800 Her father was physically abusive towards her, her mother and her siblings, and her mother was also emotionally and verbally abusive to her. 801

529. In December 1971, Katherine X’s mother applied to voluntarily admit her and her three younger brothers to the care of the Department. 802 On 31 December 1971, Katherine X was admitted because she was deemed to have ‘[had] no visible means of support’. 803

530. Katherine X was briefly placed at Allambie, before being transferred to the Victorian Children’s Aid Society (Vic Kids) on 23 February 1972. 804 She said that she remained at Vic Kids for about four years, and that during this time she witnessed one of her younger brother’s death after drowning. 805

531. Katherine X gave evidence that on 24 August 1976, when she was 12 years old, she was returned to her mother’s care, but remained a ward of the State. 806 Katherine X

798 Exhibit 30-0034, Statement of E Slack, STAT.0630.001.0001_R at [61]-[62].
799 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R at [6].
800 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R at [9].
802 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R at [12].
803 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R at [13].
804 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R at [15]-[16].
805 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R at [17].
806 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R at [19].
said that her mother was living with her new boyfriend, BGF, and that her father had been involuntarily detained in a psychiatric unit.807

532. Katherine X told the Royal Commission that soon after she returned home, BGF attempted to rape her while her mother was out.808 She said that she told her mother what had happened, and her mother got very upset and confused, and didn’t believe her. She also told her grandfather, who reported it to the police,809 and two social workers from the Department named Jennifer Power and Carolyn Pearl.810 Katherine X said that BGF was charged for the assault, and he continued to live in the family home until he was convicted of attempted carnal knowledge and sentenced to three months in gaol.811

533. Katherine X told the Royal Commission that in late 1977, when she was 13 years old, her father returned to live with the family.812 She said that he was very affectionate towards her, and after a while began to cuddle, grope and kiss her.813 Katherine X said that one afternoon in 1977, her father told her to undress and lie down on the bed, and then raped her.814 She said that her father threatened to kill her if she told anyone about it, and that she didn’t think anyone would believe her anyway after the response to the attempted rape by BGF.815

534. Katherine X told the Royal Commission that her father raped her again about a month after this first incident.816 She said that over time, the abuse became more frequent and more aggressive, and that her father continuously raped, physically abused and threatened her, at times daily.817 During this time, Katherine X said that Ms Pearl visited the family home, but was unable to help.818

535. In 1979, when Katherine X was 14 years old, she began running away and self-harming.819 Between 15 February 1979 and 21 March 1979, she spent time at the House of the Gentle Bunyip and the Kildonan Teenage Unit (Kildonan).820 During this time, her social worker from the Department was Brian Fitzgerald.821 Contemporaneous documents record that Katherine X told Mr Fitzgerald and Ms Pearl that her father was sexually abusing her.822

807 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [20].
808 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [21].
809 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [22].
810 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [23].
811 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [24].
812 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [26].
813 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [28].
814 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [29].
815 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [30].
816 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [31].
817 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [32].
818 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [34].
819 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [35].
820 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [36]-[37], [40].
821 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [38].
822 Exhibit 30-0017, Annexure KX-4, DHS.3002.323.0146_E_R; Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [39].
536. Katherine X stated that in late March 1979, she ran away from Kildonan and was taken by police to Winlaton. She said that she told police that she was running away because her father was raping her. In response, she was told that she couldn’t make a formal statement unless she was with an adult.823

537. Katherine X said that she was placed in the Warrina section, and does not remember any induction process.824 She said that although she didn’t think it was fair that she was locked up when she hadn’t done anything wrong, she felt safe because she was away from her family.825

538. Katherine X said that everyone at Winlaton, including the staff and the other residents, seemed to know that her father was raping her,826 and soon after she arrived at Winlaton, staff began giving her regular contraceptive injections.827

539. Katherine X stated that at Winlaton she participated in a form of group behavioural therapy called Triad Therapy, which was overseen by Eileen Slack.828 She gave evidence that she thought Triad Therapy was ‘a waste of time’, and that she was not sure whether she had disclosed that her father had raped her during these sessions.829 She said that she was made to feel as if she was to blame for what was happening, and that triad therapy did not assist her to keep herself safe from her father.830

540. Katherine X recalled that while she was at Winlaton she told a number of her assigned youth workers that her father had raped her. She said that some of the youth workers believed her and were really supportive, but that others did not believe her, or made her feel as though she was to blame.831

541. Katherine X disclosed the sexual abuse by her father on ‘Personal Report Sheets’ that she was required to fill out before classification meetings.832 The Royal Commission was provided with a number of these ‘Personal Report Sheets’.833

542. Katherine X said that around this time she began meeting with Michael Groome from the Children’s Court Clinic, and that she told him that her father had raped her.834 Documents show that a Department employee attached to Winlaton, named Jennifer Lines, was also involved in the management of Katherine X.835

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823 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [41]-[42].
824 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [43].
825 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [44]-[45].
826 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [46].
827 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [47].
828 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [48].
829 Transcript of Katherine X, C9161:21-34; C9162:10-12 (Day C089).
830 Transcript of Katherine X, C9163:18-21; C9163:36-43 (Day C089).
832 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [53]-[54]; [57]-[58]; [60]-[61];
833 Exhibit 30-0017, Annexure KX-9, DHS.3002.323.0108_E, Annexure KX-11, DHS.3002.323.0124_E; Annexure KX-13, DHS.3002.323.0116_E, Annexure KX-14, DHS.3146.002.0306.
834 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [56].
835 Exhibit 30-0017, Annexure KX-8, DHS.3002.323.0107_E.
543. Katherine X gave evidence that she remembers her father visiting her at Winlaton once. She said that she was told about the visit 10 minutes before her father arrived. She said that during the visit, her father leaned towards her, squeezed her thigh hard and said words to the effect of ‘Keep your fucking moth shut’. She stated that there was a youth worker sitting nearby, but that they didn’t intervene during the visit. 836

544. Katherine X told the Royal Commission that while she was at Winlaton she was also allowed to go home to visit her mother, and that during these visits her father visited her mother’s house. 837

545. Katherine X said that she is aware that Dr Groome met with her mother and grandparents on 26 June 1979, where he told them about the sexual abuse. She said that she was not told that Dr Groome was going to do this, and she did not give her consent for her mother and grandparents to be told. 838 The Royal Commission heard that Katherine X was shown a letter that her mother wrote to her father a month after this meeting, which made her feel extremely hurt. 839

546. The Royal Commission heard evidence that in August 1979, Katherine X was transferred from Winlaton to Hillview Hostel (Hillview). She said that a couple of days after she was transferred she was informed that a letter had been sent to her father by Ms Lines and Dr Groome telling him that they knew about the sexual abuse. Katherine X said that when she found out about the letter she was appalled, and scared that her father would be angry or would reject her. 840 She said that she was also scared of what her father might do to her after he received the letter, and that when she told staff, they didn’t discuss with her how they could protect her from further abuse. 841 This letter is discussed further in Part 3.6 of these submissions.

547. Katherine X was at Hillview for just over one year. 842 She said that her father could visit her at Hillview whenever he wanted, and that she also visited him regularly. 843 She said that her father began raping her again almost immediately. 844 Katherine X said that staff at Hillview knew that her father had raped her, and may still be raping her, and they continued to administer the contraceptive Depo Provera. 845

548. In around December 1980, Katherine X moved back to her parent’s house. Her wardship was discharged on 1 December 1981. 846 She said that after she returned

836 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [64]-[68].
837 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [69]-[71].
838 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [74]-[76].
839 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [78]; Annexure KX-23, DHS.3002.323.0089_E.
840 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [84]-[89].
841 Transcript of Katherine X, C9161:6-19 (Day C089).
842 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [90].
843 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [91]-[92].
844 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [92].
845 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [93] – [96].
846 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [98]-[101].
home, her father began to rape her every day, and threatened her with violence if she refused.847

549. Katherine X told the Royal Commission that this emotional, physical and sexual abuse continued for the next 24 years, until 2005. She stated that during this time she suffered two miscarriages, and gave birth to four children fathered by her father. Her youngest child, a daughter, was born premature and died two and a half months after birth due to health complications. She said that two of her three sons still don’t know that their grandfather is also their father.848

550. Katherine X told the Royal Commission that in around 2001 or 2002, she disclosed the abuse to a counsellor who helped her to arrange a place to live away from her father. She said that the counsellor reported the matter to the Police SOCIT Unit, and a police woman and a Child Protection worker from the Department came to her house. Katherine X said that she found the police, judgmental and untrustworthy and she became aware that the police were considering charging her. As a result, she denied the abuse and the investigation ended.849

551. Katherine X told the Royal Commission that in June 2005, she made a statement to police for the purpose of applying for compensation from Victims of Crimes Victoria.850 She made further statements to police in 2008, for the abuse to be investigated.851

552. The Royal Commission heard that Katherine X’s father was arrested in February 2009, and charged in April 2009 with 83 separated charges of incest, indecent assault on a girl under 16, and common law assault.852 He ultimately pleaded guilty to 13 ‘rolled up’ charges (charges that represent a pattern of offending over a period of time), and was sentenced on 22 February 2010 to a term of imprisonment of 22 years and 5 months, with a non-parole period of 18 years.853

553. Katherine X told the Royal Commission that she prepared a Victim Impact Statement and watched the criminal proceedings via video link.854 She said that she found the adjournments and delays frustrating, and felt like she didn’t have a voice in the process.855 She said that the media were very intrusive, and that media coverage of the trial was how her eldest son found out that his grandfather is his father, which was extremely distressing for both her and her son.856

554. Katherine X told the Royal Commission that in 2010, she commenced civil proceedings against the State of Victoria, which settled in January 2011. Katherine X said that she

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847 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [102].
848 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [105]-[111].
849 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [114].
850 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [116].
851 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [119].
852 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [120]-[121].
853 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [122]-[123].
854 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [123].
855 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [124].
856 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [126].
became fed up with the whole process, and agreed to sign a deed of release in which the State of Victoria denied all liability. She said that she wanted and did not receive an apology or acknowledgment that the Department had failed to fulfil the duty of care that they owed to her as a ward, and once again felt like her voice wasn’t being heard.\textsuperscript{857} Katherine X gave evidence that she was annoyed that some of the documents produced to the Royal Commission were not available to her when she commenced and settled the civil proceedings.\textsuperscript{858}

555. The Royal Commission heard evidence about the impact the sexual abuse has had on Katherine X. She has been diagnosed with post-traumatic stress disorder, and has suffered with anxiety and depression.\textsuperscript{859} She said that she has been admitted to psychiatric hospitals around 20 times as a result of nervous breakdowns, and has attempted to commit suicide on a number of occasions.\textsuperscript{860} The sexual abuse meant that she had limited education and employment prospects, and that although she was gifted at languages, she never got the opportunity to pursue her goal of being an interpreter.\textsuperscript{861}

3.6 Response to reports of child sexual abuse by Katherine X

556. The Royal Commission heard evidence from six witnesses about the response of the Department and Winlaton staff to reports of child sexual abuse made by Katherine X. They were:

- a) Brian Fitzgerald,
- b) Jennifer Mitchell (nee Lines) (Ms Lines),
- c) Michael Groome,
- d) Marilyn Minister,
- e) Lloyd Owen, and
- f) Eileen Slack.

557. Assistant Commissioner Fontana also gave evidence about the response of Victoria Police to reports made by Katherine X, and about the lack of reporting to police by staff of Winlaton and the Department.

558. Mr Fitzgerald was employed by the Department in 1979 as a regional welfare officer and caseworker in the Inner Urban Metro Region. He told the Royal Commission that prior to accepting this role he was employed as a child care officer at Baltara,\textsuperscript{862} and

\textsuperscript{857} Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [135]-[139].
\textsuperscript{858} Transcript of Katherine X, C9166:3-14 (Day C089).
\textsuperscript{859} Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [140].
\textsuperscript{860} Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [141].
\textsuperscript{861} Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [144].
\textsuperscript{862} Transcript of B Fitzgerald, C9170:1-3 (Day C089).
had received no specific training in dealing with allegations of child sexual abuse.\footnote{Transcript of B Fitzgerald, C9173:24-27 (Day C089).} Mr Fitzgerald said that in this role he was supervised by a senior social worker, who allocated responsibility for particular children to him.\footnote{Transcript of B Fitzgerald, C9175:3-33 (Day C089).}

559. The documents produced to the Royal Commission suggest that Mr Fitzgerald was involved in the care of Katherine X from approximately February to June 1979, and that during this time Katherine X disclosed to him that her father had raped her.\footnote{Transcript of B Fitzgerald, C9180:15-33; C9182:24-38; C9196:14-16 (Day C089).} Mr Fitzgerald told the Royal Commission that he had no recollection of Katherine X independent of the documents,\footnote{Transcript of B Fitzgerald, C9178:37-42 (Day C089).} but that it was clear from the documents that he believed her reports of child sexual abuse at the time.\footnote{Transcript of B Fitzgerald, C9183:9-13 (Day C089).}

560. Ms Lines was employed between early 1979 and mid-1981 as a social worker within the Liaison and Referral Unit at Winlaton. This position was based at Winlaton, and involved liaising between regional case workers and Winlaton staff to provide support with case management.\footnote{Exhibit 30-0019, Statement of J Mitchell, STAT.0640.001.0001_R at [5]-[6]; Transcript of J Mitchell C9210:9-19 (Day C089).} Prior to accepting this role, Ms Lines had completed a Bachelor of Social Work and worked for the Department for two years, but had not received any training specific to reporting or responding to child sexual abuse.\footnote{Exhibit 30-0019, Statement of J Mitchell, STAT.0640.001.0001_R at [4]-[5]; [11]; Transcript of J Mitchell, C9209:33-38 (Day C089).} Ms Lines was 26 years old when she started working at Winlaton in 1979.\footnote{Transcript of J Mitchell, C9213:45-46 (Day C089).}

561. Ms Lines told the Royal Commission that she first became involved with the care of Katherine X soon after Katherine X was admitted to Winlaton, and she was aware of the allegations of child sexual abuse from this time.\footnote{Exhibit 30-0019, Statement of J Mitchell, STAT.0640.001.0001_R at [14]; [16].} Ms Lines said that she met with Katherine X on approximately a weekly basis while she was at Winlaton.\footnote{Exhibit 30-0019, Statement of J Mitchell, STAT.0640.001.0001_R at [14]; Transcript of J Mitchell, C9215:19-34 (Day C089).} Ms Lines told the Royal Commission that she remembered Katherine X, but could not remember specific events.\footnote{Exhibit 30-0019, Statement of JMitchell, STAT.0640.001.0001_R at [13].}

562. Between 1976 and 1986, Dr Groome was the senior psychiatric nurse at the Children’s Court Clinic, which provided psychiatric and psychological assessment and treatment to the residents of Winlaton and other youth training centres.\footnote{Exhibit 30-0020, Statement of M Groome, STAT.0628.001.0001_R at 0002_R.} Dr Groome gave evidence that as part of this role, he attended Winlaton weekly to consult with staff about the management of residents, and to carry out individual and group counselling or psychotherapy for residents referred by staff.\footnote{Exhibit 30-0020, Statement of M Groome, STAT.0628.001.0001_R at 0004_R-0005_R; Transcript of M Groome, C9251:28-38 (Day C090).}
563. Dr Groome said that prior to undertaking this role at the Children’s Court Clinic, he had completed a three year course in psychiatric nursing. He said that he had not received any specific training in dealing with children or adolescents.

564. A ‘Request for Psychological/ Psychiatric Assessment’ form produced to the Royal Commission suggests that Katherine X was first referred to Dr Groome in April 1979. Dr Groome told the Royal Commission that he has ‘memory issues’ as a result of suffering seizures in 2012, and that he has no recollection of Katherine X. He said that all of the evidence he gave was based on the documents produced to the Royal Commission and provided to him. He said that he is still practicing part time as a clinical psychologist.

565. Ms Minister was the Deputy Superintendent of Winlaton from 1975 to 1992. Minister told the Royal Commission that she had no memory of Katherine X but accepted that at the time she was aware of the sexual abuse perpetrated by Katherine X’s father, as a result of discussion at the weekly classification meetings, and the referral to the Children’s Court Clinic.

566. Dr Slack was the Superintendent of Winlaton while Katherine X was a resident there in 1979. She said that she did not recall Katherine X and the sexual abuse of Katherine X was never brought to her attention.

Response of Victoria Police to Katherine X in 1979

567. A document dated 5 April 1979 and signed by Mr Fitzgerald, includes information about Katherine X’s movements prior to being admitted to Winlaton. It states:

[Katherine X] absconded from [Kildonan] on Friday morning March 30, 1979 ... During the afternoon she telephoned the staff of [Kildonan] to tell them that she was with her father and that and she would return by 6.00pm. Later that evening a request for her to remain overnight was approved by [Kildonan] staff who then informed me at home of the situation. I expressed some concern about Katherine X being with her father as several days earlier she had refused to see [him]. According to [Katherine X], [he] had, in the past, taken advantage of her sexually and she was afraid he would do so again. The following day she phoned to say that she was in a Hotel with her father and was not going to return to

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876 Transcript of M Groome, C9250:15-17 (Day C090).
877 Transcript of M Groome, C9250:34-38 (Day C090).
878 Exhibit 30-0017, Annexure KX-10, DHS.3002.323.0276_E_R.
879 Transcript of M Groome, C9251:46-C9252:41 (Day C090); Exhibit 30-0021, EXH.030.021.0001_R; Exhibit 30-0021, EXH.030.021.0001_R.
880 Transcript of M Groome, C9259:38-C9260:16 (Day C090).
881 Transcript of M Groome, C9251:46-C9235:26; C9259:47-C9260:16; C9295:15-34 (Day C090).
882 Transcript of M Groome, C9253:5-7 (Day C090).
883 Transcript of M Minister, C9426:44-C9427:3 (Day C091).
884 Transcript of M Minister, C9427:1-20 (Day C091).
885 Transcript of E Slack, C9649:10-14 (Day C093).
886 Exhibit 30-0034, Statement of E Slack, STAT.0630.001.0001_R at [40].
887 Transcript of E Slack, C9653:27-45 (Day C093).
[Kildonan]. At this stage a request was made to the police to apprehend [Katherine X] who subsequently was admitted to Winlaton.888

568. When questioned about this document, Mr Fitzgerald did not recall contacting police, but said that it was certainly an action that he would have taken.889

569. Katherine X gave evidence that when she was picked up by police and taken to Winlaton, she told police that she was running away because her father was raping her. She said that in response, she was told that she couldn’t make a formal statement unless she was with an adult.890

570. Assistant Commissioner Fontana accepted that this was ‘extremely problematic’, and that he was disappointed that no action was taken at that stage by Victoria Police.891 He said that in 1979, the Victoria Police did have the ability to obtain an adult to provide support to victims making a statement, and policewomen specially trained to take statements and deal with young people.892 While giving evidence Assistant Commissioner Fontana said that a Standing Order produced to the Royal Commission demonstrates that Katherine X should have been interviewed by someone from the Sexual Offences Squad (which is discussed further below).893

Available finding on the response of Victoria Police to Katherine X in 1979

F31 Victoria Police did not properly investigate the allegation of child sexual abuse by Katherine X in 1979.

Administration of Depo Provera at Winlaton

571. Katherine X told the Royal Commission that soon after she arrived at Winlaton, staff began giving her regular contraceptive injections,894 and that these injections continued when she was transferred to Hillview.895


573. A Review Action Sheet dated 7 August 1979 states:

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888 Exhibit 30-0017, Annexure KX-5, DHS.3002.323.0144_E_R at 0144_E.
889 Transcript of B Fitzgerald, C9194:7-C9195:15 (Day C089).
890 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [41]-[42].
891 Transcript of S Fontana, C9859:13-36 (Day C094).
892 Transcript of S Fontana, C9859:38-C9860:7 (Day C094).
893 Transcript of S Fontana, C9877:38-C9878:32 (Day C094); Exhibit 30-0011, VPOL.3029.002.0279_E.
894 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.00001_R_M at [47].
895 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.00001_R_M at [96].
896 Exhibit 30-0017, Annexure KX-6, DHS.3002.326.0004.
VD Check Clear
Next Depot [sic] Provera due 8.1.80

574. A document entitled ‘Hillview Review’ and dated 4 January 1980 states:

[Katherine X] is due for another depo provera (contraceptive) injection. As she is keen to have another injection, despite no known sexual activity with boys, then continued contact with her father seems a real possibility.897

575. The Royal Commission heard evidence that Depo Provera, the contraceptive injection, was administered to residents of Winlaton as a contraceptive and was not approved for general use in Victoria until 1991.898

576. Dr Slack gave evidence that when she arrived at Winlaton in 1979, she became aware that some residents were being given Depo Provera as a contraceptive.899 Dr Owen said that Depo Provera was used as contraception, as the risk of pregnancy was an issue and a serious risk for residents.900 Ms Minister said that the introduction of Depo Provera was a decision made by the doctors.901

577. Ms Minister told the Royal Commission that the rationale for the use of Depo Provera was that many young women at Winlaton were sexually active and didn’t want to become pregnant, but forgot to take the pill. She said that the opportunity for residents to be sexually active occurred during weekend leave or on release.902

578. The Royal Commission was provided with a Departmental policy in relation to the use of Depo Provera entitled ‘Guardianship Services Manual’ dated 1984 (Guardianship Manual).903 Section 9.1.5(c) of the Guardianship Manual entitled ‘Use of Depo Provera’ states:

Depo Provera is classified as an experimental drug because its effects on the human body have been insufficiently tested and evaluate. It is imperative that the young person for whom it is prescribed understands this, together with the drug’s known advantages and possible disadvantages.

Before proceeding with the administration of Depo Provera the following are to be followed:

(i) Ensure that the young woman has explored all contraceptive alternatives.
(ii) The young woman should read and sign the Informed Consent for Depo Provera...
This may be difficult for some young women to understand so the worker must ensure that the girl comprehends what she is signing.

897 Exhibit 30-0017, Annexure KX-30, DHS.3002.323.0082_E_R at 0083_R.
898 Transcript of Winnie Girls documentary, C9374:24-29 (Day C091).
899 Transcript of E Slack, C9603:36-44 (Day C093).
900 Transcript of L Owen, C9518:19-33 (Day C092).
901 Transcript of M Minister, C9396:43-47 (Day C091).
902 Transcript of M Minister, C9397:2-11 (Day C091).
903 Exhibit 30-0011, DHS.3002.381.0008.
(iii) The parents’ consent should be sought... Under s199(2) the department has authority to override the parents’ wishes if this is in the young person’s interest... 904

579. When asked about the Guardianship Manual, Dr Slack told the Royal Commission that she was not aware of Winlaton receiving any policy from the Department concerning Depo Provera, and said that she was ‘not in the loop’ in any discussions with the Department about the use of Depo Provera. 905

580. Dr Slack stated that she opposed the use of Depo Provera and constantly voiced her objections to its administration to residents. 906 She gave evidence that her concerns were expressed in many forms, including a letter sent to the Director of Family and Adolescent Services, 907 and a letter to the Australian Health Department. 908

581. Dr Slack said that she did not feel she had any authority as Superintendent of Winlaton to stop the use of Depo Provera as it was an issue for the Health Department, who she said told her ‘in no uncertain terms that [she] was stepping outside [her] lines of authority’. 909

582. Ms Minister told the Royal Commission that the administration of Depo Provera on residents did not cause her concern despite it not being released for general use until 1991. She gave evidence that she was aware that Depo Provera was supposed to be restricted to research and development. 910 She said that Winlaton management and nursing and medical staff obtained advice from different experts and she had also read advice that it was appropriate to use on residents. 911

583. During the public hearing, the Royal Commission viewed a DVD entitled ‘Winnie Girls’ which contained interviews of a number of former residents at Winlaton on matters including Depo Provera. The DVD included a caption that read:

The injectable contraceptive Depo Provera was used in Winlaton from 1975 onwards. Depo Provera was released for general use in Victoria in 1991. Up until then it was approved for research and testing purposes only. 912

584. In the DVD, Ms Minister is recorded saying:

Well, it was seen to be the most appropriate form of contraception for those young women who wanted it. They had to want it. 913

904 Exhibit 30-0011, DHS.3002.381.0008 at 0181-0182.
905 Transcript of E Slack, C9608:4-C9609:13 (Day C093).
906 Exhibit 30-0034, Statement of Eileen Slack, STAT.0630.001.0001_R at [45].
907 Exhibit 30-0034, Annexure L to the Statement of Eileen Slack, STAT.0630.001.0067.
908 Transcript of E Slack, C9605:41-C9606:5 (Day C093).
909 Transcript of E Slack, C9609:23-31 (Day C093).
910 Transcript of M Minister, C9398:21-C9399:3 (Day C091).
911 Transcript of M Minister, C9398:41-C9399:3 (Day C091).
912 Exhibit 30-0024; Transcript of Winnie Girls documentary, C9374:24-29 (Day C091).
913 Exhibit 30-0024; Transcript of Winnie Girls documentary, C9375:13-16 (Day C091).
585. One former resident interviewed for the DVD said:

We were made to have it... Never had any choice.\(^{914}\)

586. Another former resident said:

Ward girls, the ward of state girls wouldn’t be allowed to have a weekend leave unless they had a shot of this Depo Provera.\(^{915}\)

587. When Ms Minister was questioned during the public hearing, after the DVD was played, about whether residents had a choice about what action to take in terms of contraception, she said that residents definitely had a choice.\(^{916}\) She said that there was an extensive consent form that was thoroughly discussed with the resident by medical staff, and that for residents under 16 years of age parental permission or the permission of the Director of the Department was obtained.\(^{917}\) Residents over 16 were capable of signing their own consent form.\(^{918}\)

588. Dr Owen said that the question of consent was a matter that concerned medical staff.\(^{919}\) He said that he had concerns that the issue of consent was not easy to resolve as it was ‘reasonably new on the agenda’.\(^{920}\) Although he said that for most matters, the Director of the Department delegated wardship decisions, including decisions about medical procedures, to the Superintendent.\(^{921}\)

589. An undated consent form for the administration of Depo Provera to Katherine X, signed by Katherine X’s mother, was produced to the Royal Commission.\(^{922}\) Dr Owen gave evidence that in his view, it would not be appropriate to rely on a consent form that was undated.\(^{923}\)

590. The Royal Commission heard evidence from Dr Groome that in 1979, he held the view that Katherine X was not having sexual relations other than the sexual abuse perpetrated by her father.\(^{924}\) Similarly, the Hillview Report noted that Katherine X had ‘no known sexual activity with boys’.

591. Ms Minister said that the administration of a contraceptive in the circumstances of Katherine X’s case was a medical decision that ‘had nothing to do with [her]’.\(^{925}\) She said that in line with the policy that parental approval or Departmental approval was required to administer Depo Provera to a resident under 16 years of age, if Katherine

\(^{914}\) Exhibit 30-0024; Transcript of Winnie Girls documentary, C9375:3-18 (Day C091).

\(^{915}\) Exhibit 30-0024; Transcript of Winnie Girls documentary, C9375:5-8 (Day C091).

\(^{916}\) Transcript of M Minister, C9397:34-36 (Day C091).

\(^{917}\) Transcript of M Minister, C9399:31-C9340:8 (Day C091).

\(^{918}\) Transcript of M Minister, C9400:3-4 (Day C091).

\(^{919}\) Transcript of L Owen, C9519:5-11 (Day C092).

\(^{920}\) Transcript of L Owen, C9519:20-25 (Day C092).

\(^{921}\) Transcript of L Owen, C9554:30-C9555:7 (Day C092).

\(^{922}\) Exhibit 30-0032, DHS.3002.326.0008_R.

\(^{923}\) Transcript of L Owen, C9553:21-30 (Day C092).

\(^{924}\) Transcript of M Groome, C9290:44-47 (Day C090).

\(^{925}\) Transcript of M Minister, C9480:14-19 (Day C091).
X’s parent was not deemed suitable to give permission, then a signed permission slip should have been obtained from the Director of the Department.926

592. Dr Slack said that she may have made enquiries as to why Depo Provera was being administered to residents, but she said that she was never told that it was because there was incest within the family.927

593. Dr Slack accepted that it was a wholly inappropriate institutional response to place a child thought to be at ongoing risk of sexual abuse perpetrated by her father on a contraceptive to ensure that she was not getting pregnant, and yet not report that abuse to police.928

Available findings on the administration of Depo Provera at Winlaton

F32 From the late 1970s, Depo Provera was administered by medical staff of Winlaton to residents as a contraceptive in circumstances where:

a) it was not approved for general use as a contraceptive in Australia; and

b) it was unclear whether consent had been properly obtained for administration.

F33 Depo Provera continued to be administered to residents of Winlaton until 1991, despite objections to the practice being made repeatedly by then Superintendent, Dr Eileen Slack.

F34 The response by medical staff at Winlaton, after Katherine X had disclosed that she had been sexually abused by her father in 1979, was to administer Depo Provera. The only consent obtained was an undated consent form signed by Katherine X’s mother.

Reporting of disclosures of child sexual abuse by Katherine X to Victoria Police

594. The documents clearly show that when Katherine X arrived at Winlaton, and during her time there, staff of Winlaton and the Department were aware that she had reported being sexually abused by her father.929

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926 Transcript of M Minister, C9481:3-41 (Day C091).
927 Transcript of E Slack, C9698:26-35 (Day C093).
928 Transcript of E Slack, C9698:47-9699:6 (Day C093).
929 Exhibit 30-0017, Annexure KX-5, DHS.3002.323.0144_E_R; Annexure KX-6, DHS.3002.326.0004; Annexure KX-7, DHS.3002.323.0111_E_R; Annexure KX-8, DHS.3002.323.0107_E_R; Annexure KX-9, DHS.3002.323.0108_E_R; Annexure KX-10, DHS.3002.323.0276_E_R; Annexure KX-11, DHS.3002.323.0124_E_R; Annexure KX-18, DHS.3002.323.0287_E_R; Annexure KX-19, DHS.3002.323.0274_E_R; Annexure KX-20, DHS.3002.323.0253_E_R; Annexure KX-21, DHS.3002.323.0254_E_R.
595. Mr Fitzgerald, Ms Lines, Dr Groome, Ms Minister and Dr Slack all gave evidence that the matter should have been reported to police, but no report was made.\(^{930}\) The Royal Commission heard evidence from each of these witnesses as to the reasons why a report was not made to police by staff of Winlaton or the Department in 1979.

596. Mr Fitzgerald attributed his failure to notify the police to his inexperience.\(^{931}\) He said he would have discussed the case of Katherine X with his supervisor or other senior staff to get direction about what to do with the information he had.\(^{932}\) He gave evidence that there was an expectation that disclosures of alleged sexual abuse would be reported to police, although there was no formal procedure for doing so.\(^{933}\)

597. Ms Lines stated that she did not report the child sexual abuse of Katherine X to police because she was ‘concerned to preserve the relationship of Winlaton staff with [Katherine X] so that [they] could support and assist her in her separation from her father’.\(^{934}\) Ms Lines also said that she was concerned about how the consequences of reporting to the police would affect Katherine X.\(^{935}\) She said that she doesn’t recall whether there was any discussion about reporting to the police.\(^{936}\)

598. Dr Groome told the Royal Commission that when he reviewed the contemporaneous documents regarding Katherine X, he was ‘puzzled’ that she had been through various services but no-one had reported the situation.\(^{937}\) When asked why he didn’t report the matter to police, he responded:

> Because this had already been widely known within [the Department], that this young lady was in this situation, and I would have thought something would have been done about it before then.\(^{938}\)

599. Dr Groome was unable to recall whether he ever checked whether the matter had been referred to the police.\(^{939}\)

600. Dr Groome told the Royal Commission that he encouraged Katherine X to report the abuse to police, but that when she told him that she didn’t want to, he respected that request.\(^{940}\) He accepted that the documents do not show that he spoke with Katherine X about going to the police, or that he was thinking that the matter ought to have been

\(^{930}\) Transcript of B Fitzgerald, C9184:22-25; C9177:1-17 (Day C089); Exhibit 30-0019, Statement of J Mitchell, STAT.0640.001.0001_R at [24]; Transcript of M Groome, C9276:26-35; C9278:5-19; C9292:11-23 (Day C090); Transcript of M Minister: C9439:23-36 (Day C091); Transcript of E Slack, C9652:20-37; C9653:27-34 (Day C093).

\(^{931}\) Transcript of B Fitzgerald, C9184:22-33 (Day C089).

\(^{932}\) Transcript of B Fitzgerald, C9184:22-33 (Day C089); Exhibit 30-0018, Statement of B Fitzgerald, STAT.0621.001.0001_R at [12].

\(^{933}\) Exhibit 30-0018, Statement of B Fitzgerald, STAT.0621.001.0001_R at [8]-[9]; Transcript of B Fitzgerald, C9177:1-17 (Day C089)

\(^{934}\) Exhibit 30-0019, Statement of J Mitchell, STAT.0640.001.0001 at [24].

\(^{935}\) Transcript of J Mitchell, C9228:7-22(Day C089).

\(^{936}\) Transcript of J Mitchell, C9226:25-28 (Day C089).

\(^{937}\) Transcript of M Groome, C9258:47-9259:9 (Day C090).

\(^{938}\) Transcript of M Groome, C9262:35-40 (Day C090).

\(^{939}\) Transcript of M Groome, C9262:42-45 (Day C090).

\(^{940}\) Transcript of M Groome, C9270:41-C9271:27 (Day C090).
reported to the police.\textsuperscript{941} He accepted that because there was no clear policy in place about when matters should be reported to police, the child was made responsible for this decision, and that was totally inappropriate.\textsuperscript{942}

601. Ms Minister told the Royal Commission that in 1979, she did not consider that she had a legal obligation to report the matter to police because it was ‘not thought of in those terms’.\textsuperscript{943} She said that:

   In retrospect, we probably should have gone to the police but ... back in the 1970s incest cases were generally dealt with as family dysfunctional matters and the focus really was on trying to improve the dynamics in the family as well as keeping the victim safe, rather than as treating the incest as a criminal offence.\textsuperscript{944}

602. Dr Slack told the Royal Commission that, as Superintendent, she was not aware of the sexual abuse perpetrated against Katherine X by her father.\textsuperscript{945} She said that if she had known, she would have reported it to police.\textsuperscript{946}

603. Assistant Commissioner Fontana said that he found it surprising that no report was made to police by Winlaton or Department staff in 1979, and that it should have been reported and investigated.\textsuperscript{947} He said that he was not aware of an attitude among Victoria Police of treating incest as a family matter rather than a criminal offence, or of reluctance to investigate these kinds of offences.\textsuperscript{948} He said that if a report was made, it would have been followed up.\textsuperscript{949}

### Available finding on the reporting of disclosures of child sexual abuse by Katherine X to Victoria Police

F35 In 1979, Michael Groome, Jennifer Lines and Brian Fitzgerald did not report the disclosures of child sexual abuse made by Katherine X to the Victoria Police.

### Katherine X’s participation in triad therapy

604. The Royal Commission heard evidence from Katherine X, that she participated in Triad Therapy, but was not sure whether she had disclosed that her father was raping her during these sessions.

605. A document entitled ‘First Term Review’ and dated 6 April 1979 states

\textsuperscript{941} Transcript of M Groome, C9295:41-C9296:23 (Day C090).
\textsuperscript{942} Transcript of M Groome, C9283:21-45 (Day C090).
\textsuperscript{943} Transcript of M Minister, C9480:40-43 (Day C091).
\textsuperscript{944} Transcript of M Groome, C9452:21-31 (Day C091).
\textsuperscript{945} Transcript of E Slack, C9649:27-C9650:2 (Day C093).
\textsuperscript{946} Transcript of E Slack, C9652:20-37; C9653:27-38 (Day C093).
\textsuperscript{947} Transcript of S Fontana, C9841:35-43 (Day C094).
\textsuperscript{948} Transcript of S Fontana, C9842:46-C9843:15 (Day C094).
\textsuperscript{949} Transcript of S Fontana, C9842:28-44 (Day C094).
There has been some question of whether he [sic] father was interfering with her sexually – [Katherine X] says this was the reason for the arguments at home, that there was competition between [Katherine X] and her mother. It is felt that triad therapy will help [Katherine X] once she stops blaming everyone else for her problems instead of facing up to her own feelings. At the moment she is not saying much in the therapy meetings but is exhibiting a lot of anger.  

606. Ms Minister told the Royal Commission that this statement was inappropriate, and inconsistent with Winlaton’s attempts to reinforce to Katherine X that her father was at fault.  

607. A Transfer Summary completed by Brigid Beirne around the time Katherine X left Winlaton states:  

[Katherine X] next spent some time in Winlaton and although she absconded on occasion the experience had some positive results. She attempted to work through some of her problems in Triad Therapy and identified her confused, ambivalent sexual relationship with her father as the main problem area.  

608. The Royal Commission heard and was provided with evidence that Katherine X completed a number of Personal Report Sheets while she was in Winlaton. On these Personal Report Sheets, Katherine X disclosed the child sexual abuse perpetrated by her father under the section entitled:

State what you think: My most serious problem(s) which I am working on in groups is/ are (please explain)  

609. Ms Minister accepted that the fact Katherine X mentioned the sexual abuse in that section of the Personal Report Sheet suggested that she was revealing the sexual abuse in group therapy. Dr Slack did not accept that suggestion.  

610. Dr Slack told the Royal Commission that she would not have expected Katherine X to feel comfortable talking about the sexual abuse perpetrated by her father in the triad group program because it was too complex and sensitive. She accepted that the Winnie Girls documentary demonstrated that she (Dr Slack) participated in a mini-triad meeting with a girl in very similar circumstances to Katherine X but distinguished between this and the larger triad groups of eight to ten people.

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950 Exhibit 30-0017, Annexure KX-7, DHS.3002.323.0111_E_R.
951 Transcript of M Minister, C9476:16-25 (Day C091).
952 Exhibit 30-0017, Annexure KX-9, DHS.3002.323.0045_E_R.
953 Exhibit 30-0017, Annexure KX-11, DHS.3002.323.0108_E_R; Exhibit 30-0017, Annexure KX-11, Annexure KX-13, DHS.3002.323.0116_E_R; Exhibit 30-0017, Annexure KX-14, DHS.3146.002.0306; Exhibit 30-0017, Annexure KX-22, DHS.3146.002.306_R.
954 Transcript of M Minister, C9446:10-13 (Day C091).
955 Transcript of E Slack, C9672:8-37; C9674:16-29 (Day C093).
956 Transcript of E Slack, C9667:7-74; C9667:1-10; C9699:8-22 (Day C093).
957 Transcript of E Slack, C9667:20-23 (Day C093).
958 Transcript of E Slack, C9667:25-32 (Day C093).
611. When asked whether she thought it was appropriate that a 14 or 15 year old girl discussed the incestuous relationship she had with her father in group therapy, Ms Minister replied:

    Yes, I think that was one of the purposes of groups, was sharing problems between the girls. 969

612. Ms Minister later said that ‘[triad therapy] was an avenue provided for girls to talk about their problems with each other and a group leader in a controlled group setting’. 960

613. Ms Minister said that if this issue was raised in triad therapy, there would also be another resident who had had an incestuous relationship with their father or other family member, and a group leader present. 961 Ms Minister said that there was no expectation that Katherine X would discuss the sexual abuse perpetrated by her father, and that ‘nobody was forced to discuss any particular thing in groups.’ 962

**Visits to Winlaton by Katherine X’s father**

614. Katherine X told the Royal Commission that her father visited and threatened her while she was at Winlaton. She stated that she still considered the day that her father visited her in Winlaton as ‘one of the greatest betrayals of [her] life’. 963

615. Katherine X stated that while she was at Winlaton, her feelings about her father were extremely complicated, and that although she was scared of him and wanted the rapes to stop, she also wanted to see him and craved his affection. 964

616. Documents produced to the Royal Commission suggest that Katherine X’s father visited her in Winlaton twice; in May and June 1979. Handwritten notes of Dr Groome dated 30 May 1979 record:

    Dad came to visit her on Sunday and section staff were struck by the sensuousness of their relationship – not at all like mother and father [sic] 965

617. A Review Action sheet dated 6 June 1979 records:


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959 Transcript of M Minister, C9446:15-20 (Day C091).
960 Transcript of M Minister, C9447:14-20 (Day C091).
961 Transcript of M Minister, C9446:30-43 (Day C091).
962 Transcript of M Minister, C9445:33-42 (Day C091).
963 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [68].
964 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [51].
965 Exhibit 30-0017, Annexure KX-18, DHS.3002.323.0287_E_R.
If he comes again, J Lines will see him alone as he saw M Groome as a rival. ... [Katherine X] regressed after father’s visit.966

618. A memorandum from Ms Minister to Dr Groome dated 13 June 1979 states:

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

Perhaps you would like to arrange to see him then also967

619. A Progress Report of Winlaton Psychiatric Services dated 14 June 1978 states:

[Katherine X] was visited by father today at his request. She feared this when she was told of it an hour before his due arrival time.

She agrees that it is a good idea for me to see her father and discuss their relationship, although, of course, she remains ambivalent about it.

I will contact [Katherine X's father] within the next 24 hours to arrange a time suitable to us both for me to see him.

I will discuss my interview with [her father] with [Katherine X] next Wednesday.968

620. Dr Owen gave evidence that when he left Winlaton in 1978, there was no written policy to the effect that if a resident was being victimised by a family member, that family member should not be allowed to visit.969

621. Dr Slack agreed that there was no written policy that specified that a child who was the victim of incest could not be visited by the perpetrator of the abuse, but that that was a matter of common-sense.970

622. Ms Minister said that there was a ‘vetting’ of visitors, and that Winlaton youth officers would seek the advice of regional workers that were more familiar with the young person’s family situation.971 She said that she would have thought that Dr Groome would have been consulted about whether Katherine X’s father should come to visit Winlaton, but it was possible that he wasn’t.972 She said that she thinks that she would have deferred to Dr Groome’s opinion in relation to whether or not Katherine X’s father should visit.973

623. Dr Groome initially said that he discouraged the visit of 14 June 1979. He later said that there was a ‘general flavour’ in the documents that he was discouraging contact with

966 Exhibit 30-0017, Annexure KX-17, DHS.3002.323.0104_E_R.
967 Exhibit 30-0017, Annexure KX-15, DHS.3002.323.0275_E_R.
968 Exhibit 30-0017, Annexure KX-16, DHS.3002.323.0245_E_R.
969 Transcript of L Owen, C9504:29-41 (Day C092).
970 Transcript of E Slack, C9651:9-21 (Day C093).
971 Transcript of M Minister, C9387:41-9388:3 (Day C091).
972 Transcript of M Minister, C9448:37-46 (Day C091); C9449:38-C9450:19 (Day C091).
973 Transcript of M Minister, C9448:42-C9449:5 (Day C091).
the father.\textsuperscript{974} Dr Groome told the Royal Commission that he found the lack of supervision, and the whole decision-making process ‘quite disturbing’.\textsuperscript{975} He said that he was now quite angry that permission was granted for Katherine X’s father to visit her in Winlaton on 13 June 1979 despite the previous visit being completely inappropriate.\textsuperscript{976}

624. Ms Lines accepted that she would have been informed if a visit was going to occur, and never tried to stop it taking place.\textsuperscript{977} She stated that she ‘took the view that [Katherine X]’s contact with her father at Winlaton was unhelpful’ and she ‘did not encourage or condone it’.\textsuperscript{978}

625. Mr Fitzgerald said that he would have hoped that he would have been consulted about whether or not Katherine X could meet with her father, but that it appeared that Dr Groome was making a lot of decisions in relation to contact and leave for Katherine X within Winlaton.\textsuperscript{979} He said that he would have strongly questioned whether it was appropriate for Katherine X to have contact with her father, but he didn’t recall actually doing so.\textsuperscript{980}

626. Mr Fitzgerald and Dr Groome accepted that the father’s visit to Katherine X at Winlaton put her in serious danger.\textsuperscript{981}

627. Dr Slack said that if she had been aware of Katherine X’s situation, she would have ordered that her father not be allowed to visit.\textsuperscript{982} She accepted that permitting Katherine X’s father to visit her was a gross breach of the duty Winlaton staff had to protect Katherine X.\textsuperscript{983}

628. Ms Minister told the Royal Commission that she made a mistake by granting permission for Katherine X’s father to visit her in Winlaton.\textsuperscript{984} She accepted that for Katherine X to be subjected to such a visit was, in the circumstances, in itself a form of sexual abuse.\textsuperscript{985}

629. Ms Minister said that she thinks she made the decision thinking that Katherine X ‘would be safe because the visit would be closely supervised by staff and therefore nothing untoward could happen during the visit.’\textsuperscript{986} She could not explain why

\textsuperscript{974} Transcript of M Groome, C9300:1-37 (Day C090).
\textsuperscript{975} Transcript of M Groome, C9273:21-40 (Day C090).
\textsuperscript{976} Transcript of M Groome, C9273:8-25; C9267:28-32 (Day C090).
\textsuperscript{977} Transcript of J Mitchell, C9219:19-32 (Day C089).
\textsuperscript{978} Exhibit 30-0019, Statement of J Mitchell, STAT.0640.001.0001_R at [22].
\textsuperscript{979} Transcript of B Fitzgerald, C9187:3-9 (Day C089).
\textsuperscript{980} Transcript of B Fitzgerald, C9187:15-39 (Day C089).
\textsuperscript{981} Transcript of B Fitzgerald, C9188:13-19 (Day C089); Transcript of M Groome, C9273:21-40 (Day C090).
\textsuperscript{982} Transcript of E Slack, C9650:14-29; C9689:14-24 (Day C093).
\textsuperscript{983} Transcript of E Slack, C9651:23-33 (Day C093).
\textsuperscript{984} Transcript of M Minister, C9428:47-C9429:8 (Day C091).
\textsuperscript{985} Transcript of M Minister, C9441:45-C9442:10 (Day C091).
\textsuperscript{986} Transcript of M Minister, C9429:41-C9430:10 (Day C091).
permission was granted for a second visit in circumstances where the previous visit a week earlier was observed to be inappropriate.987

630. Ms Minister said that she would only have given permission if Katherine X had indicated to staff that she wanted to see her father, but she accepted that it was a mistake to let Katherine X decide whether to see her father or not.988 She accepted that permitting visits from Katherine X’s father sent mixed messages about whether Katherine X should have contact with her father or not.989

631. Mr Fitzgerald also gave evidence that the documents suggest that it was left to Katherine X to decide whether or not she would see her father, rather than putting in place firm boundaries to ensure Katherine X’s father didn’t have access to her.990

### Available finding on visits to Winlaton by Katherine X’s father

F36 In 1979, Marilyn Minister permitted Katherine X’s father to visit Katherine X at Winlaton in circumstances where she was aware that Katherine X had been sexually abused by her father. This decision exposed Katherine X to a serious risk of further harm.

### Weekend and day leave from Winlaton by Katherine X

632. Katherine X told the Royal Commission that while she was at Winlaton, she was allowed to go home to visit her mother. Katherine X was released on weekend and day leave to her mother’s house from Winlaton.991 She said that during this time, her father visited her at her mother’s house.992

633. The Winlaton Manual includes a section entitled ‘Regarding Leave for Trainees’ that states:

> It is the policy at Winlaton to allow and encourage trainees to have leave from the Institution in order to provide opportunities for them to: (a) build better relationships with their families and home environment...993

634. Dr Owen said that when he left Winlaton in 1978, there was no written policy about not releasing a resident on leave if an alleged perpetrator would have access to them, but that it was ‘a matter of common-sense’.994

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987 Transcript of M Minister, C9436:22-43 (Day C091).
988 Transcript of M Minister, C9429:19-23; C9430:26-30 (Day C091).
989 Transcript of M Minister, C9482:16-21 (Day C091).
990 Transcript of B Fitzgerald, C9185:27-31 (Day C089).
991 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [69]-[70]; Annexure KX-13, DHS.3002.323.0116_E_R; Annexure KX-14, DHS.3146.002.0306_R; Annexure KX-17, DHS.3002.323.0104_E_R.
992 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [71]; Annexure KX-13, DHS.3002.323.0116_E_R; Annexure KX-14, DHS.3146.002.0306_R
993 Exhibit 30-0011, DHS.3004.001.0078 at 0102.
994 Transcript of L Owen, C9522:6-16 (Day C092).
635. Ms Minister told the Royal Commission that weekend leave would be discussed at weekly classification meetings and that various people, including in some cases the psychologist, would have input into the decision.\textsuperscript{995} She accepted that as Deputy Superintendent it was ultimately her responsibility to make a decision about whether a resident could go on weekend leave.\textsuperscript{996}

636. Ms Minister said that there would have been a ‘general expectation’ that somebody would do a risk assessment prior to the visit, and that this would have been discussed and recorded at the classification meetings.\textsuperscript{997} She said that she believes that Dr Groome would have been involved in deciding whether it was appropriate for weekend leave to be permitted.\textsuperscript{998}

637. Dr Slack told the Royal Commission that she did not know of any risk assessment process in place with regard to home visits, and that this was a ‘major oversight’.\textsuperscript{999}

638. A Progress Report of the Winlaton Psychiatric Service dated 14 June 1979, completed by Dr Groome states:

   [Katherine X] should have weekend leave if mother requests it.\textsuperscript{1000}

639. Handwritten notes of Dr Groome dated 20 June 1979 record:

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

   He had asked her to run away to NSW, she managed to refuse.\textsuperscript{1001}

640. Ms Minister accepted that the documents suggest that Katherine X was sexually abused by her father while on weekend leave from Winlaton, and that staff knew about this.\textsuperscript{1002}

641. Ms Minister said that Katherine X:

   … would never have been allowed to go on weekend leave to any place where we thought the father would be. So when she had weekend leave to her mother … it would have been on the basis that the mother and the father lived in separate places, and that the mother wouldn’t allow the father to have access to her.\textsuperscript{1003}

642. Dr Groome said that at the time of completing the Progress Report dated 14 June 1979 recommending leave, he believed that Katherine X’s parents were living in separate

\textsuperscript{995} Transcript of M Minister C9386:45-C9387:10 (Day C091).
\textsuperscript{996} Transcript of M Minister, C9387:12-14 (Day C091).
\textsuperscript{997} Transcript of M Minister, C9428:24-45 (Day C091).
\textsuperscript{998} Transcript of M Minister, C9438:39-42 (Day C091).
\textsuperscript{999} Transcript of E Slack, C9653:20-25 (Day C093).
\textsuperscript{1000} Exhibit 30-0017, Annexure XX-16, DHS.3002.323.0245_E_R.
\textsuperscript{1001} Exhibit 30-0017, Annexure XX-19, DHS.3002.323.0274_E_R; Statement of Katherine X, STAT.0615.001.0001_R_M at [72].
\textsuperscript{1002} Transcript of M Minister, C9442:12-16 (Day C091).
\textsuperscript{1003} Transcript of M Minister, C9428:14-22 (Day C091).
places and that there was ‘an understanding, or whatever, that going to her mother would be a safe situation, or a relatively safe situation’.\textsuperscript{1004} There is nothing in the documents produced to the Royal Commission that demonstrates that Dr Groome held this belief in 1979.

643. Dr Groome said that he didn’t know whether anybody checked that Katherine X would be safe while on leave, or who would have been responsible for checking this.\textsuperscript{1005} He said that he thinks he would have met with or spoken to Katherine X’s mother, but that he ‘can’t sort of really see what actual practical supervision there would have been’ while Katherine X was on leave.\textsuperscript{1006} He said that it was his intention that Katherine X be kept away from her father.\textsuperscript{1007}

644. Dr Slack said that if she had been aware of Katherine X’s situation, she would not have allowed for Katherine X to be released on a home visit to her mother.\textsuperscript{1008} She said that she would have expected a report to be made to police after staff became aware of the predatory behaviour of Katherine X’s father during weekend leave.\textsuperscript{1009}

**Available finding on Katherine X being released on weekend and day leave from Winlaton**

F37 In 1979, staff of Winlaton and the Department released Katherine X on weekend and day leave without taking any action to minimise the risk that her father would continue to sexually abuse her. This exposed Katherine X to a serious risk of further harm.

**Interaction between Department staff and Katherine X’s father and family**

645. The Royal Commission was provided with evidence that Dr Groome met with Katherine X’s mother and grandparents on 26 June 1979, and told Katherine X about this meeting the following day.

646. Dr Groome’s handwritten notes of 26 June 1979 state:

Visit to clinic of Mo, GM and GF

... After a long discussion re [Katherine X]’s life and their hedging around her and her father I asked Mo if she was aware of [Katherine X father] making sexual advances towards [Katherine X], Mo said she had suspected it. She didn’t show any dramatic, perceptible upset re this.

I told them I was available to contact if they wanted to

\textsuperscript{1004} Transcript of M Groome, C9274:18-31 (Day C090).
\textsuperscript{1005} Transcript of M Groome, C9274:33-40 (Day C090).
\textsuperscript{1006} Transcript of M Groome, C9274:42-C9275:7 (Day C090).
\textsuperscript{1007} Transcript of M Groome, C9275:9-17 (Day C090).
\textsuperscript{1008} Transcript of E Slack, C9682:10-15 (Day C093).
\textsuperscript{1009} Transcript of E Slack, C9652:20-37; C9653:27-37 (Day C093).
They appreciated this and felt a lot happier and clearer about where things were going.\textsuperscript{1010}

647. Dr Groome’s handwritten notes of 27 June 1979 state:

[Katherine X] at Winlaton

Told her re yesterday’s interview and included that I had discussed [Katherine X] and Fa’s sexual rel.

She hit the roof and said it just goes to prove some people can’t be trusted etc

I pointed out that I merely brought out into the open what it seems people have been whispering to each other about anyway. She calmed down and expressed fear of what Fa will do to her. …

These fears seem pretty reality based, in that she says it is impossible to know how he will react from day to day, he is so unpredictable

She also feared that GM might talk Mo into taking legal action against Fa

... I said I’d phone and tell Mo it was imperative to [Katherine X’s] emotional health that no legal action be taken and also to ask Mo to come and visit. I did this while [Katherine X] was present. Mo assured she would do this and understood the effect it would be having on [Katherine X].\textsuperscript{1011}

648. On 26 July 1979, Katherine X’s mother wrote to her father. The letter stated:

Please don’t tear this up before you read this. Would there be any chance of my seeing you. At the moment there are things which you should know about. I would like to help [Katherine X] in any way I can.

Did you know [Katherine X] has implicated you. I know you don’t want anything to do with me. But I feel it is to your own benefit that in future you contact me. Please ring up Dad as he feels you should know about certain things that I can’t put in a letter. Please come and see my [sic] any day or night after the weekend or ring me at Dad’s this week end.\textsuperscript{1012}

649. Dr Groome said that he has no recollection of these events, but his notes of the interactions he had with Katherine X’s mother and grandparents may have been inadequate.\textsuperscript{1013}
Letter to Katherine X’s father

650. The Royal Commission heard evidence that after Katherine X was transferred from Winlaton to Hillview, a letter was sent to her father. At this time, staff of Winlaton and the Department knew that

a. Katherine X had reported being sexually abused by her father;

b. Katherine X’s father had made ‘sexual advances’ while she was on weekend leave from Winlaton;

c. Katherine X’s mother had been made aware of the sexual abuse and had not shown any ‘perceptible upset’; and

d. Katherine X’s father was a violent man with a history of mental illness.

651. A Review Action Sheet produced to the Royal Commission dated 7 August 1979 states

J Lines to send letter to father explaining that staff at Winlaton and elsewhere are aware of his relationship with [Katherine X].

652. The letter was dated 9 August 1979. It included the names of Jennifer Lines and Michael Groome at the foot of the letter, but was only signed by Ms Lines. The letter stated:

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

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

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1014 Exhibit 30-0017, Annexure KX-26, DHS.3146.002.0291_R.
example of the growing up that [Katherine X] has done whilst at Winlaton, and I guess we all hope that you see this letter in the same light.  

653. A file note of Brigid Beirne, a social worker, includes the following entry

9.8.79: [Katherine X] very anxious re her fathers [sic] reaction on getting the letter sent from Winlaton yesterday telling him that staff know of the incestuous relationship. She is scared of his anger and rejection of her. Says she doesn’t want him hurt. Wants to ring him. ... She agrees it might be better to write to her father rather than ring him. ...

654. Ms Beirne also completed a Transfer Summary around this time, which states:

... [Katherine X] agreed to the relationship with her father being discussed with him and a sensitive letter was written to him from Winlaton. He did not respond to this letter and in interview with Michael Groom [sic] – psychologist denied the whole ...

655. Katherine X told the Royal Commission that by sending the letter, Dr Groome and Ms Lines abused her trust and put her in danger.

656. Ms Lines said that she did not recall whether Dr Groome or anyone else was involved in the writing of the letter. Dr Groome said that he could not remember whether he was involved in writing the letter. Ms Minister told the Royal Commission that she thinks that she would have been involved in the decision to send the letter, but would not have read the letter prior to it being sent.

657. Katherine X gave evidence that contrary to what the letter stated, she had not asked for the letter to be sent.

658. Ms Lines stated that although she cannot now recall Katherine X asking her to write the letter, she would not have done so if she had not believed that she had permission. Ms Lines accepted that the decision to send the letter was a joint decision made by staff at a meeting on or before 7 August 1979, and that it wasn’t Katherine X’s idea to send the letter. She said that it was possible that Katherine X felt pressure to give permission for the letter to be sent.

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1015 Exhibit 30-0017, Annexure KK-27, DHS.3002.323.0249_E_R.
1016 Exhibit 30-0017, Annexure KK-28, DHS.3002.323.0088_E_R.
1017 Exhibit 30-0017, Annexure KK-29, DHS.3002.323.0045_E_R.
1018 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [86]-[87].
1019 Transcript of J Mitchell, C9239:4-17 (Day C089).
1020 Transcript of M Groome, C9288:29-35; C9313:13-35 (Day C090).
1021 Transcript of M Minister, C9440:23-35 (Day C091).
1022 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0015_R_M at [86]-[87].
1023 Exhibit 30-0019, Statement of J Mitchell, STAT.0640.001.0001_R at [25].
1024 Transcript of J Mitchell, C9223:4-7; C9238:1-9 (Day C089).
659. In relation to the purpose and appropriateness of the letter, Ms Lines said that the letter ‘could have been worded better’\textsuperscript{1026} She said that the letter was written in a conciliatory way because she was aware that it could aggravate Katherine X’s father, and she was trying to protect Katherine X from any consequences or repercussions.\textsuperscript{1027} She was also trying to encapsulate the ambivalence that Katherine X had towards her father.\textsuperscript{1028} In wording the letter as she did, Ms Lines said that she was trying to acknowledge that each of them cared for each other,\textsuperscript{1029} and she wanted to reflect that Katherine X did not want her father to feel bad.\textsuperscript{1030}

660. Ms Lines gave evidence that the letter reflected her inexperience, and a lack of understanding of the gravity of the situation.\textsuperscript{1031}

661. Dr Groome said that ‘it was an awkward situation’ and that the letter ‘could have been worded quite differently ... in terms of probably being more confrontative [sic].’\textsuperscript{1032} He told the Royal Commission that he thought that the letter was worded the way that it was to convey to Katherine X’s father that they knew about the sexual abuse in the least threatening way, to avoid him becoming defensive.\textsuperscript{1033}

662. Dr Groome accepted that, based on the documents, he knew at the time the letter was sent that Katherine X’s father may become angry or aggressive in response.\textsuperscript{1034}

663. Ms Minister said that her understanding is that the letter was ‘a last ditch effort to make the father aware that everyone else was aware of his sexual abuse to try to change his behaviour towards his daughter.’\textsuperscript{1035} She agreed that it was an inadequate and inappropriate strategy to stop the abuse.\textsuperscript{1036}

664. Dr Slack told the Royal Commission that in her view the letter was ‘totally inappropriate’ and ‘absolutely awful’.\textsuperscript{1037}

**Available findings on the letter to Katherine X’s father**

F38 A letter, dated 9 August 1979 and signed by Jennifer Lines, was sent on behalf of Jennifer Lines and Michael Groome to Katherine X’s father. This letter was an inappropriate response to the disclosures of child sexual abuse made by Katherine X because:

a) it alerted Katherine X’s father to the disclosure of the abuse; and

\textsuperscript{1026} Transcript of J Mitchell, C9224:32-34 (Day C089).
\textsuperscript{1027} Transcript of J Mitchell, C9234:35-38; C9239:39-C9240:10 (Day C089).
\textsuperscript{1028} Transcript of J Mitchell, C9225:9-21 (Day C089).
\textsuperscript{1029} Transcript of J Mitchell, C9225:33-41 (Day C089).
\textsuperscript{1030} Transcript of J Mitchell, C9226:4-16 (Day C089).
\textsuperscript{1031} Transcript of J Mitchell, C9246:12-19 (Day C089).
\textsuperscript{1032} Transcript of M Groome, C9288:41-C9289:9 (Day C090).
\textsuperscript{1033} Transcript of M Groome, C9317:4-13 (Day C090).
\textsuperscript{1034} Transcript of M Groome, C9318:11-14 (Day C090).
\textsuperscript{1035} Transcript of M Minister, C9440:37-44 (Day C091).
\textsuperscript{1036} Transcript of M Minister, C9441:10-16 (Day C091).
\textsuperscript{1037} Transcript of E Slack, C9652:39-C9653:14 (Day C093).
b) it was sent without Katherine X’s consent.

The letter dated 9 August and signed by Jennifer Lines was sent in circumstances where Katherine X had just been transferred to a less secure institution, and no safeguards had been put in place to prevent her father having further access to her. As such, it exposed Katherine X to a serious risk of further harm.

Transfer of Katherine X to Hillview Hostel and beyond

665. Katherine X gave evidence that after she was transferred from Winlaton to Hillview in August 1979, her father began raping her again almost immediately.1038

666. A Progress Report of the Winlaton Psychiatric Service completed by Dr Groome and dated 1 August 1979 states:

[Katherine X] seems to have come to terms with her feelings about her father and expresses the need to keep away from him.

... I am planning on following her up for a period if/when she moves to Hillview.1039

667. Mr Fitzgerald completed a Hostels Referral Form for Katherine X just prior to his departure as caseworker in the Inner Urban Metro Region.1040 The form included the following comments

Young person’s relationship with family

[Katherine X]’s relationship with her father is complexed [sic]. She claims that her father has an emotional hold over her and has taken advantage of her sexually in recent years ... Placement with her father would appear impossible in the foreseeable future as, it is felt, such a situation would be too destructive for [Katherine X]. Current contact with her father is conducted in the controlled environment of Winlaton. Placement with her mother is not a possibility at this stage but may be considered for future case planning.

Reason for hostel referral

It is felt that [Katherine X] still requires the support of a hostel situation because of the existing father/daughter relationship difficulties.1041

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1038 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [92].
1039 Exhibit 30-0017, Annexure X2-KX, DHS.3002.326.0017_R.
1041 Exhibit 30-0017, Annexure X2-KX, DHS.3002.323.0068_E_R.
668. Mr Fitzgerald accepted that the form focused on the relationship between Katherine X and her father, rather than the child sexual abuse.\textsuperscript{1042} He agreed that this form should have been better articulated,\textsuperscript{1043} and that it doesn’t adequately reflect the harm that Katherine X’s father posed to her.\textsuperscript{1044}

669. A Transfer Summary completed by Ms Beirne states:

\begin{quote}
... Weekend leave with father has occurred and although it is suspected that the sexual relationship continued for some time [Katherine X] seems to have separated to some extent and is unlikely to allow this to happen easily any more.\textsuperscript{1045}
\end{quote}

670. Dr Groome told the Royal Commission that the matters recorded in the Transfer Summary indicate that the strategy of helping Katherine X to separate herself from her father was starting to be successful.\textsuperscript{1046}

671. Subsequent to Katherine X’s departure from Winlaton, Mr Fitzgerald said that it appeared from the documents that there was a total absence of proper follow up when she was transferred from Winlaton and beyond.\textsuperscript{1047}

672. Ms Lines said that that she expected, and there was a general expectation in 1979, that Katherine X would continue to receive follow up care while she remained a ward of the State, and that this would have been the responsibility of her regional worker, and the staff of the institution she was subsequently placed in.\textsuperscript{1048}

673. Dr Groome told the Royal Commission that he thought that the staff in the group home she was transferred to, and the Regional Community Welfare Service, were responsible for supervising Katherine X once she left Winlaton.\textsuperscript{1049} He said that the documents demonstrate that he continued to see Katherine X after she was transferred to Hillview.\textsuperscript{1050} He later accepted that there are no documents to suggest that he had contact with Katherine X after the letter was sent on 9 August 1979.\textsuperscript{1051}

674. Ms Minister said staff at Winlaton, herself included, had no further involvement in Katherine X’s care when she moved out of Winlaton.\textsuperscript{1052} She said that staff from Hillview were made aware of Katherine X’s situation by the referral form.\textsuperscript{1053}

\textsuperscript{1042} Exhibit 30-0017, Annexure KX-24, DHS.3002.323.0068_E_R; Transcript of B Fitzgerald, C9206:19-23 (Day C089).
\textsuperscript{1043} Transcript of B Fitzgerald, C9206:44-C9027:6 (Day C089).
\textsuperscript{1044} Transcript of B Fitzgerald, C9207:8-13 (Day C089).
\textsuperscript{1045} Exhibit 30-0017, Annexure KX-29, DHS.3002.323.0045_E_R.
\textsuperscript{1046} Transcript of M Groome, C9336:40-C9337:6 (Day C090).
\textsuperscript{1047} Transcript of B Fitzgerald, C9193:33-39 (Day C089).
\textsuperscript{1048} Transcript of J Mitchell, C9229:43-C9280:18 (Day C089).
\textsuperscript{1049} Transcript of M Groome, C9285:10-15 (Day C090).
\textsuperscript{1050} Transcript of M Groome, C9285:34-C9286:11 (Day C090).
\textsuperscript{1051} Transcript of M Groome, C9320:29-C9321:8 (Date C090).
\textsuperscript{1052} Transcript of M Minister, C9443:18-27 (Day C091).
\textsuperscript{1053} Transcript of M Minister, C9443:29-33 (Day C091).
Approach of Winlaton and Department staff to incest

675. Ms Minister, Dr Owen and Dr Slack gave evidence about the general approach taken by the institution to incest during the historical period examined.

676. The Royal Commission also heard evidence from Mr Fitzgerald, Ms Lines and Dr Groome about their approach to incest, in the context of their response to the reports made by Katherine X.

677. Mr Fitzgerald gave evidence that in 1979, he took allegations of incest very seriously, and that his attitude was that it was illegal and should not have occurred. He was unable to recall whether he would have viewed Katherine X's disclosures as a rape, as currently understood.  

678. During the course of giving oral evidence, Ms Lines was at first unsure whether she knew that incest was a crime in 1979, but later agreed that she had known that it was. Ms Lines did not agree that the response to the disclosures made by Katherine X reflected a view that incest was treated less seriously as rape by a stranger.

679. Ms Lines agreed that she considered incest to be both criminal behaviour and the product of a dysfunctional family, and that she had dealt with the situation of Katherine X as family dysfunction rather than criminal offending.

680. Dr Groome told the Royal Commission that in 1979, he was aware that incest was a crime, and did not view it as any less serious than a rape perpetrated by someone unrelated to the victim. He said that in 1979, there was a general view in the community that children who were the victims of incest were provocateurs, or somehow responsible, but that he and his colleagues didn't share that view.

681. Dr Groome told the Royal Commission that within psychiatric services from the late 1960s into the 1980s, there was an emphasis on family therapy rather than reporting intra-familial perpetrators to police. He said:

[T]here was [an] attempt to try and work with the family, no matter how... broken it was. There was a belief that somehow you could try and work with the family system to try and correct it.

682. Although Ms Minister was aware that there were hundreds of residents of Winlaton who had been the victim of sexual abuse perpetrated by a family member, she said

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1054 Transcript of B Fitzgerald, C9185:33-C9186:9 (Day C089).
1056 Transcript of J Mitchell, C9232:7-22 (Day C089).
1058 Transcript of J Mitchell, C9232:34-C9233:10 (Day C089).
1059 Transcript of M Groome, C9262:22-33 (Day C090).
1060 Transcript of M Groome, C9264:34-47 (Day C090).
1061 Transcript of M Groome, C9276:41-C9277:6 (Day C090).
1062 Transcript of M Groome, C9289:28-35 (Day C090).
that she did not report any of these cases to police.1063 She recalled one occasion where a regional case worker reported sexual abuse of a resident of Winlaton perpetrated by her father.1064

683. Ms Minister said that:

[It]n general, incest cases at that time, in the 1970s and 1980s, were generally dealt with more as a family problem rather than dealt with as a criminal issue, because the focus was more on providing therapeutic interventions to the dysfunctional families, rather than treating it as a criminal offence; that was the general climate at the time, the general thinking, the general focus.1065

684. She later said that:

[T]he focus was on trying to engage the family in a therapeutic sense of intervention to try to change the damaging dynamics that we knew were going on in that family.1066

685. Ms Minister agreed that such an approach necessarily enmeshed the child, rather than identifying him or her as the victim of criminal behavior.1067 Ms Minister said that this approach of working with the family rather than reporting the behavior as a criminal offence continued throughout the period she was in Winlaton.1068

686. Dr Owen said that when he was at Winlaton between 1974 and 1978 incest ‘was seen more as a moral issue … than a criminal issue.’1069

687. Dr Owen said that between 1974 and 1978, there was no expectation that Winlaton staff would report allegations of incest to police because there was a general sense that ‘the police were reluctant to get involved in some of those family-related issues’.1070 He could not recall any instance where such a case was referred to police.1071

688. He suggested that between 1974 and 1978, the Department did not necessarily consider it to be a serious matter that needed to be reported.1072

689. Although Dr Slack said she was not aware that a significant number of residents of Winlaton had been victims of incest, she acknowledged that she knew at least one resident who had been the subject of sexual abuse by her father.1073 The Winnie Girls

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1063 Transcript of M Minister, C9483:3-17 (Day C091).
1064 Transcript of M Minister, C9483:19-24 (Day C091).
1065 Transcript of M Minister, C9432:7-16 (Day C091).
1066 Transcript of M Minister, C9483:26-33 (Day C091).
1067 Transcript of M Minister, C9483:26-44 (Day C091).
1068 Transcript of M Minister, C9484:15-22 (Day C091).
1069 Transcript of L Owen, C9521:12-20 (Day C092).
1070 Transcript of L Owen, C9503:14-41 (Day C092).
1071 Transcript of L Owen, C9504:43-C9505:3 (Day C092).
1072 Transcript of L Owen, C9505:45-C9506:9 (Day C092).
documentary included audio of a conversation between Slack and a resident that had been the victim of sexual abuse perpetrated by her father. The audio includes the following exchanges between Slack and the resident:

DR SLACK: And I know that she has had in the past a problem of having sex with her father. What was the first idea that you had that maybe this wasn't something that you should be doing?

UNKNOWN FEMALE 2: Well, I didn't really know, until I was 13, what he was doing.1074

... 

DR SLACK: Yeah. Did you ever resist him at all and say, 'I don't want it' even when he was next to you physically?

UNKNOWN FEMALE 2: Well I - I couldn't 'cos he'd just get in and get on top of me and that was it.

DR SLACK: Yeah. How did you feel?

UNKNOWN FEMALE 2: Um, I felt guilty about it.

DR SLACK: For what reason? Do you think that maybe you had sexually attracted him by something you had done or said or?

UNKNOWN FEMALE 2: I don't know.1075

690. Dr Slack told the Royal Commission that this conversation occurred during a mini-triad session.1076 She said that the language she used in talking to this resident was ‘terrible’, ‘insensitive’ and ‘inappropriate’.1077 She said that it ‘[pointed] a finger at the child’,1078 and would have been embarrassing for them.1079 She said that she ‘was making a terrible mistake’, and was now horrified by her ‘inappropriate behavior’.1080 She was unsure whether this interaction reflected a view that she had of incest being less serious than rape by a stranger, or in some way the fault of the child, but said that she didn’t recall other people at Winlaton expressing such views.1081

691. Dr Slack said that she was relieved to hear that other parts of the Winnie DVD suggest that a report was made to police in this case.1082
692. Dr Slack told the Royal Commission that she never had an attitude of trivialising sexual abuse or incest.\textsuperscript{1083}

**Systems, processes and procedures for making decisions about the management, care and protection of Katherine X**

693. In 1979, there were no formal polices or procedures in place at Winlaton to receive or respond to complaints of child sexual abuse, or to report complaints of child sexual abuse to the Victoria Police. In the case of Katherine X, it was not clear who was responsible for making decisions about the management, care and protection of residents.

694. In the absence of formal systems, processes and procedures, a number of witnesses gave evidence about the informal processes adopted by Winlaton and the Department, to make decisions about Katherine X on matters concerning:

   a. reporting complaints of child sexual abuse to Victoria Police;
   b. permitting Katherine X’s father to visit her in Winlaton; and
   c. releasing Katherine X on day or weekend leave.

695. Mr Fitzgerald told the Royal Commission that there was a team of people responsible for making decisions about Katherine X’s care in 1979. He said that staff at Winlaton took on a primary decision making role when a child was admitted, and that he kept in contact with them by visiting or by telephone.\textsuperscript{1084}

696. Dr Groome stated that in his role with the Children’s Court Clinic, he could consult and make recommendations, but had no power to make decisions about the management of young people under the care of the Department.\textsuperscript{1085} He said that he attended case meetings,\textsuperscript{1086} and accepted that as somebody giving expert psychiatric or psychological advice, he had a significant role in the joint decision making process.\textsuperscript{1087} He said that his recommendations were not always acted upon, but accepted that they were given some weight in the decision making process.\textsuperscript{1088}

697. Ms Lines gave evidence that she contributed to case planning meetings, along with section staff and Winlaton management. She said that she thinks that youth worker Terry Best and Deputy Superintendent Ms Minister also attended case planning meetings in relation to Katherine X.\textsuperscript{1089}

698. Ms Lines said that decisions were made by institutional staff, but she had input and was involved in discussions, and was responsible for feeding that information back to
the regional worker.\textsuperscript{1090} She agreed that decisions regarding residents were made within a ‘team environment’.\textsuperscript{1091}

699. Ms Lines described the role of Ms Minister as being the ‘ultimate overseer’.\textsuperscript{1092} She said that each girl had an allocated youth officer, but that the Senior Youth Officer, the Deputy Superintendent or the Superintendent was ultimately responsible for decision making.\textsuperscript{1093}

700. A document dated 1979 entitled ‘Winlaton Youth Training Centre, Nunawading, Victoria, 3131’ states that in relation to Classification and Review:

Each week there is a Classification and Review Meeting. During these meetings, individual teenagers are discussed in detail with regard to personal problems, placement or treatment options, potential development, needs, etc.

Youth officers and other staff contribute information which is compiled and discussed until some decision is reached. The young woman submits her own written statement about her wishes for herself and says if she wishes to join the meeting. Time permitting, she is called into the meeting. There is usually a joint decision made in each case with the Chairman of Classification having the last word...\textsuperscript{1094}

701. Ms Minister gave evidence that as the Deputy Superintendent, she was responsible for case planning, which included discussing assessment of new admissions and the development of plans for their management within the institution and their future plans. She said that she chaired the weekly case planning meetings, which she attended every single week.\textsuperscript{1095}

702. She acknowledged that as the Chair, she ultimately had the decision regarding residents on matters such as placement, weekend leave, transfers and visits.\textsuperscript{1096}

703. Although the overall decision making regarding the management and case planning of Katherine X rested with Ms Minister as Deputy Superintendent, she gave evidence that it wasn’t a decision made by her alone but was a team decision of all the workers involved in the case.\textsuperscript{1097}

704. Dr Groome said:

I can’t say overall who would have had the final say, because it often seems from reading these papers that sometimes it was the senior youth officer, sometimes it was the superintendent or deputy superintendent, sometimes it was me,

\textsuperscript{1090} Transcript of J Mitchell, C9211:11-18 (Day C089).
\textsuperscript{1091} Transcript of J Mitchell, C9212:44-47 (Day C089).
\textsuperscript{1092} Transcript of J Mitchell, C9212:5-13 (Day C089).
\textsuperscript{1093} Transcript of J Mitchell, C9216:17-28 (Day C089).
\textsuperscript{1094} Exhibit 30-0011, DHS.3128.003.0012 at 0017.
\textsuperscript{1095} Transcript of M Minister, C9383:39-C9384:11 (Day C091).
\textsuperscript{1096} Transcript of M Minister, C9386:35-C9387:35 (Day C091).
\textsuperscript{1097} Transcript of M Minister, C9387:21-24 (Day C091).
sometimes it was just a general consensus in a meeting. There just doesn't seem to have been any clear chain of command, from what I can see.\textsuperscript{1098}

705. Dr Groome agreed that this was problematic.\textsuperscript{1099}

706. Mr Fitzgerald, Dr Groome and Ms Lines gave evidence that prior to becoming involved with Katherine X, they had received no training specific to reporting or responding to child sexual abuse.\textsuperscript{1100}

707. Mr Fitzgerald said that he was ‘very inexperienced and not qualified’.\textsuperscript{1101} He said that he did not recall any particular policy about reporting accounts of sexual abuse to a senior social worker.\textsuperscript{1102} He said he would have discussed the case of Katherine X with his supervisor or other senior staff to get direction about what to do.\textsuperscript{1103}

708. Ms Lines gave evidence that in her position at the Liaison and Referral Unit she was unsure who her supervisor was.\textsuperscript{1104} Ms Lines said that her relationship with staff in head office was more managerial than supervisory, and that within Winlaton she would have discussed any issues in relation to the girls with the Deputy Superintendent.\textsuperscript{1105}

709. Dr Groome stated that his role at the Children’s Court Clinic was ‘autonomous’ and that there was ‘minimal supervision’, but that he could and did consult with a more experienced colleague or the Psychiatric Superintendent.\textsuperscript{1106} He said that this was an informal process that occurred when there was time available, and that he did not think any notes were taken of these consultations.\textsuperscript{1107} Although he did not have any specific memory of Katherine X, Dr Groome said that he would have discussed this case because it was so serious.\textsuperscript{1108}

710. Dr Groome said that, although he had no specific recollection, he thought that he would have taken issues to the Superintendent if they were not being appropriately dealt with by the Deputy Superintendent.\textsuperscript{1109} He said that he recalled having several conversations with Dr Slack while at Winlaton.\textsuperscript{1110}

\textsuperscript{1098} Transcript of M Groome, C9268:5-13 (Day C090).
\textsuperscript{1099} Transcript of M Groome, C9268:15-16 (Day C090).
\textsuperscript{1100} Transcript of B Fitzgerald, C9173:28-31 (Day C089); Exhibit 30-0019, Statement of J Mitchell, STAT.0640.001.0001_R at [4]-[5]; [11]; Transcript of J Mitchell, C9213:8-13 (Day C089); Transcript of M Groome, C9250:34-44 (Day C090).
\textsuperscript{1101} Transcript of B Fitzgerald, C9190:31-39 (Day C089).
\textsuperscript{1102} Transcript of B Fitzgerald, C9185:43-C9185.4 (Day C089).
\textsuperscript{1103} Transcript of B Fitzgerald, C9184:27-C9185.4 (Day C089); Exhibit 30-0018, Statement of B Fitzgerald, STAT.0621.001.0001_R at [12].
\textsuperscript{1104} Transcript of J Mitchell, C9211:20-34; C9227:39-44; C9240:35-43 (Day C089).
\textsuperscript{1105} Transcript of J Mitchell, C9227:39-44; C9240:15-23 (Day C089).
\textsuperscript{1106} Transcript of M Groome, C9253:41-C9254:1; C9255:18-32; C9322.29-33 (Day C090).
\textsuperscript{1107} Transcript of M Groome, C9261.33-C9262.44 (Day C090).
\textsuperscript{1108} Transcript of M Groome, C9262.6-10 (Day C090).
\textsuperscript{1109} Transcript of M Groome, C9329.8-11 (Day C090).
\textsuperscript{1110} Transcript of M Groome, C9329.13-21 (Day C090).
711. Ms Minister said that if, as Deputy Superintendent she became aware of a serious case such as that of Katherine X, she would ‘not necessarily’ bring it to the attention of the Superintendent, as ‘the Superintendent didn’t normally get involved in ... case planning issues.’

712. Dr Slack told the Royal Commission that she was not aware of the sexual abuse perpetrated against Katherine X by her father. She said that she would have expected her Deputy Superintendent, Ms Minister, to inform her about this situation, and accepted that this was an oversight in the hierarchy of complaint reporting. She said that they ought to have raised it with her, and that she ought to have asked. She accepted that there was no policy or procedure to ensure that she would receive this type of information.

713. Dr Slack accepted that if the case had been brought to her attention, she would have maintained complete and utter oversight and control over every aspect of her treatment and any decisions made in respect of her.

714. The lack of clear policies on accountability and oversight, and the reliance on inadequately trained staff members to make decisions regarding the management, care and protection of Katherine X contributed to:

   a. no report being made to the Victoria Police by Winlaton or Department staff;

   b. Katherine X’s father being permitted to visit her at Winlaton; and

   c. Katherine X being released on day and weekend leave at Winlaton.

### Available findings on the systems, processes and procedures for making decisions about the management, care and protection of Katherine X

**F40** The lack of policies and procedures for dealing with reports of child sexual abuse at Winlaton in 1979 meant that in relation to Katherine X:

   a) it was not clear who was ultimately responsible for making key decisions; and

   b) responding to reports of child sexual abuse fell to inexperienced, junior staff members.

**F41** The lack of policies and procedures for dealing with reports of child sexual abuse at Winlaton in 1979 meant that staff did not take clear and decisive action for the care and protection of Katherine X, which made her feel confused and helpless.

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1111 Transcript of M Minister, C9471:12-21 (Day C091).
1112 Transcript of E Slack, C9649:47-C9650:2 (Day C093).
1113 Transcript of E Slack, C9650:4-12 (Day C093).
1114 Transcript of E Slack, C9653:47-C9654:2 (Day C093).
1116 Transcript of E Slack, C9661:41-44 (Day C093).
1117 Transcript of E Slack, C9688:29-C9689:10 (Day C093).
Response of Victoria Police to Katherine X in 2002-2009

715. Katherine X gave evidence that her interaction with police in 2002 was distressing, and that she ultimately denied the abuse because she was worried that the Police would charge her. She said that she found the police judgmental and untrustworthy.1118

716. Assistant Commissioner Fontana said that he found the response of Victoria Police to the reports made by Katherine X in 2002 ‘disappointing’.1119 He agreed that it was completely inappropriate for Katherine X to have been treated as some form of criminal herself, when in fact she had been the victim of years and years of sexual abuse by her father.1120 He accepted that the response of Victoria Police had the effect of re-traumatising Katherine X.1121

717. Assistant Commissioner Fontana said that prior to the Law Reform Commission review in 2004 there were occasions where Victoria Police did not believe what was being told to them, and grilled victims of these serious crimes.1122 He gave evidence that the review resulted in a significant change in attitudes in terms of how Victoria Police approach investigations and provide support for victims.1123 He said that, particularly prior to 2004, the reception received by victims of child sexual abuse from Victoria Police depended on the attitude of the individual member.1124

718. Assistant Commissioner Fontana said that he was pleased that Katherine X’s interaction with police in 2009 was far more positive, and he commended her for her courage to continue on despite the ‘knock-back’ that she’d had from police, years earlier.1125

Available finding on the response of Victoria Police to Katherine X in 2002-2009

F42 Victoria Police did not properly investigate the allegation of child sexual abuse made by Katherine X in 2002.

1118 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [114].
1119 Transcript of S Fontana, C9846:1-15 (Day C094).
1120 Transcript of S Fontana, C9846:17-26 (Day C094).
1121 Transcript of S Fontana, C9846:39-C98474 (Day C094).
1122 Transcript of S Fontana, C9846:17-26 (Day C094).
1123 Transcript of S Fontana, C9846:32-37 (Day C094).
1124 Transcript of S Fontana, C9847:6-16 (Day C094).
1125 Transcript of S Fontana, C9847:26-45 (Day C094).
Part 4  Baltara Reception Centre

4.1  Baltara Institutional Profile

742.  The Baltara Reception Centre commenced operation in October 1968 in the former ‘Parkside’ section of Turana.\(^\text{1126}\)

743.  Baltara was a remand centre designed for boys aged 10-15 years old.\(^\text{1127}\) It also acted as a reception centre for early adolescent male wards awaiting placement in children’s homes.\(^\text{1128}\)

744.  Initially, Baltara comprised four sections that each accommodated about 20 to 25 boys. A fifth section was added during 1969/1970.\(^\text{1129}\)

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

a.  Kinta was designed to accommodate up to 20 ‘older, tougher, rougher’ boys, including sexual perpetrators;\(^\text{1130}\)

b.  Mawarra, which was in the same building as Kinta, was designed to accommodate a mixed group of up to 20 boys;\(^\text{1131}\)

c.  Warrawong, the only high-security section, was designed to hold up to 20 habitual absconders and serious offenders;\(^\text{1132}\)

d.  Akora was designed to house up to 20 boys that were less mature, or had physical or mental disabilities;\(^\text{1133}\) and

e.  The Oaks was a house offsite that was designed to house up to five boys convicted or with a strong pattern of sex offending.\(^\text{1134}\)

743.  In Kinta, Mawarra, Akora and Warrawong, the boys slept in shared bedrooms, most of which were designed to accommodate three boys.\(^\text{1135}\)

\(^{1126}\) Find and Connect, Baltara Reception Centre (1968 – c. 1992)
\(^{1127}\) Exhibit 30-0006, DHS.3004.011.0367 at 0386.
\(^{1128}\) Exhibit 30-0029, Report of A Borowski, EXP.0004.001.0001_M_R at 0005_M_R.
\(^{1129}\) Social Welfare Department, Annual Report Year Ended June 30, 1969
\(^{1130}\) Exhibit 30-0006, DHS.3004.011.0367 at 0386.
\(^{1131}\) Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [19]-[20].
\(^{1132}\) Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [21].
\(^{1133}\) Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [23].
\(^{1134}\) Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [22].
\(^{1135}\) Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [24].
744. From 1985, Baltara was also a youth training centre.1136 In 1991, residents from Baltara were moved into residential and reception units in the community.1137

4.2 The experience of BDA at Baltara

745. The Royal Commission heard evidence from one former resident of Baltara, BDA.

746. The evidence BDA gave about his admission to the care of the Department, and his experiences after leaving Baltara, including his placement at Turana, is set out in Part 2.2 of these submissions.

747. BDA was admitted to Baltara on 24 February 1988, when he was 10 years old.1138 He spent almost four months at Baltara.1139

748. BDA gave evidence that when he arrived at Baltara he was scared and overwhelmed. He was given a tour, and may have been told what the rules were, but found it difficult to absorb all of the information because of other boys running around and making noise.1140 He did not recall being told to whom he could report incidents.1141

749. BDA was placed in ‘Akora’, an open section, in a dormitory with about eight to ten other boys who looked like they were between 12 and 16 years of age.1142 BDA gave evidence that on his first night in Akora, he was sexually abused by other residents who he believes he shared the dormitory with.1143

750. BDA gave evidence that the other residents approached his bed holding their penises in their hands. He said that BFN, one of the other residents, forced BDA to perform oral sex on him. BDA said that the other residents held him down by the shoulders, and threatened that they would hurt or tattoo him if he did not do what they said, or if he told anyone.1144

751. BDA gave evidence that the abuse was interrupted when the other residents heard an officer walking along the corridor outside the dormitory. He said that the boys returned to their beds, but after the officer had passed they continued their attempts to sexually abuse BDA.1145 BDA said that officers patrolled the hallways at night, and the office for night staff was down the hallway, far from his dormitory.1146

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1136 Exhibit 30-0029, Report of A Borowski, EXP.004.001.0001_M_R at 0005_M_R.
1137 Exhibit 30-0006, DHS.3004.011.0367 at 0386 – 0387.
1138 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [24]; Exhibit 30-0036, Annexure BDA-4, DHS.3002.089.0043_R.
1139 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [27].
1140 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [28].
1141 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [29].
1142 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [30]-[31].
1143 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [32]-[35].
1144 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [32]-[35].
1145 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [35].
1146 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [37].
752. The night officer didn’t check on BDA’s dormitory that night, and BDA didn’t make any noise to get the attention of an officer because he was scared that the other boys would hurt him.1147

753. BDA gave evidence that he does not recall reporting this incident of abuse to anyone, including his allocated counsellor or social workers, because he was scared of the other boys.1148 He stated that he also does not recall any other incidents of sexual abuse at Baltara. 1149

754. The Royal Commission identified a handwritten report, dated 1 June 1988, prepared by a Child Care Officer in Akora, which records a disclosure from BDA about the sexual approach BFN made towards him at night when they were sharing the same bedroom.1150 The document also records that another boy reported that BDA had been approached by BFN on two previous nights, and that BDA had told him that he had sexual relations with another boy in a different dorm.1151 Furthermore, the document notes that the dormitories where the abuse occurred were positioned so that residents could hear the approaching footsteps of staff, giving them time to return to their own beds.1152

755. BDA also gave evidence about games that were played by other residents of Baltara which were sexual and degrading in nature.1153

756. BDA left Baltara on 15 June 1988, and went back to live with his mother.1154 He said that he spent time at other institutions, including Turana, where he experienced further sexual abuse.

4.3 Operation of Baltara

Staff hierarchy at Baltara

757. Baltara was initially under the overall control of the Superintendent of Turana. It had its own Officer-in-Charge, who was the Deputy Superintendent at Turana.1155

758. Grant Holland, a staff member at Baltara from 1983 until the early 1980s, gave evidence that while he worked at Baltara, the most senior position was that of the Manager, who oversaw the entire institution. Supporting the Manager was a team of...
administrative staff, including deputy managers, senior admitting officers and Senior Youth and Child Care Officers (Senior YACCOs). The Principal YACCO was the most senior of the Senior YACCOs. The Manager, Principal YACCO, Senior YACCOs and other administrative staff were known as the ‘executive team’.

Each section was overseen by a Senior YACCO, who, together with Youth and Child Care Officers (YACCOs), was responsible for the day to day supervision and care of the boys.

Each YACCO also acted as the “assignment officer” for up to six of the residents. Assignment officers were required to have detailed knowledge of the background and issues of the residents assigned to them.

**Recruitment of staff at Baltara**

The Royal Commission heard evidence from two witnesses about their experience prior to being employed at Baltara.

Mr Fitzgerald gave evidence about his employment as a Child Care Officer (CCO) at Baltara between 1970 and 1978. When Mr Fitzgerald was first employed at Baltara he had no relevant experience or specific qualifications regarding working with children.

When Mr Holland was first employed as a YACCO at Baltara in 1983 his only employment experience was as a clerk at the Children’s Court. He had no experience or qualifications in managing children with problem behaviours.

Mr Holland gave evidence about a staff member recruited by the Department from the United States of America who was later found to have criminal convictions for sexual offences against children in the USA, and for firearms offences in Australia. Mr Holland stated that although he and other staff almost immediately raised concerns about the appropriateness of the interactions between this staff member and residents at Baltara, it was not until a police check was done many months later that the staff member was removed. During his time at Baltara the staff member had direct and unsupervised access to residents while on night shift.

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1156 Transcript of G Holland, C9732:40-C9733:6 (Day C093).
1157 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [12], [14].
1158 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [15].
1159 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [16].
1160 Transcript of B Fitzgerald, C9170:5-35 (Day C089).
1161 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [5]; Transcript of G Holland, C9761:26-39 (Day C094).
1162 Transcript of G Holland, C9761:26-39 (Day C094).
1163 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [40].
1164 Transcript of G Holland, C9744:45-C9747:27 (Day C093).
Training of staff at Baltara

765. Mr Fitzgerald gave evidence that he received no training of any significance when he commenced at Baltara in 1970.1165

766. In 1977, Mr Fitzgerald completed a Certificate of Child Care through the Institute of Social Welfare. This was a three month course delivered by the Department about basic human development and working with children with behavioural issues.1166

767. Mr Fitzgerald did not recall receiving any training specific to dealing with allegations of child sexual abuse.1167

768. Mr Holland gave evidence that when he was first employed as a child care officer by the Department in the early 1980s he received no training.1168 After a probationary period at Baltara of about one year, he completed a basic training course in child development that took a couple of months.1169

769. A number of years after starting at Baltara, Mr Holland was promoted to the position of Senior YACCO, and completed an advanced course on child development.1170

770. Mr Holland stated that during one of the training courses he attended the issue of sexual abuse was raised in such a way that many participants became upset, and the session couldn’t proceed.1171 On another occasion there was some discussion of how to deal with allegations of sexual abuse of children, but ‘it was not advanced’, it was ‘[probably not] clinically accurate at the time’ and it was not thorough.1172

771. Mr Holland told the Royal Commission that the training provided to him at Baltara in relation to responding to complaints of child sexual abuse was ‘deficient’.1173 He stated that when he commenced employment at Baltara he didn’t feel in any way properly equipped to deal with the at times extreme situations he found himself in.1174

772. Dr Varughese Pradeep Philip, the current Secretary of the Department, accepted that between the mid-1980s and early 1990s the Department did not provide adequate training to child care officers at Baltara to enable them to assess and respond to the risk of child sexual abuse.1175

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1165 Transcript of B Fitzgerald, C9171:34-37 (Day C089).
1166 Exhibit 30-0018, Statement of B Fitzgerald, STAT.0621.001.0001_R at [5]; Transcript of B Fitzgerald, C9173:11-26 (Day C089).
1167 Exhibit 30-0018, Statement of B Fitzgerald, STAT.0621.001.0001_R at [6]; Transcript of B Fitzgerald, C9173:28-31 (Day C089).
1168 Transcript of G Holland, C9728:19-23(Day C093).
1169 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [8]; Transcript of G Holland, C9728:25-43 (Day C093).
1170 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [8].
1171 Transcript of G Holland, C9728:45-C9729:14 (Day C093).
1172 Transcript of G Holland, C9729:28-40 (Day C093); C9765:33-C9766:8 (Day C094).
1173 Transcript of G Holland, C9730:39-45 (Day C093).
1174 Transcript of G Holland, C9739:1-17 (Day C093).
1175 Transcript of V Philip C9939:10-14 (Day C095).
Available finding on the training of staff at Baltara

F43 During the period 1970 to the early 1990s, the training offered to staff members at Baltara regarding child sexual abuse and responding to complaints of child sexual abuse was inadequate. The absence of this training undermined the capacity of staff members at Baltara to deal effectively with complaints of sexual abuse.

Placement of residents at Baltara

773. Mr Holland gave evidence that decisions about where residents should be placed were made at weekly classification meetings. These meetings were attended by the Senior YACCOs, the relevant assignment officer, and other members of the executive team.1176

774. Mr Holland gave evidence that although Baltara was designed to cater for boys between 10 and 14 years of age, from time to time younger boys aged eight or nine, and boys over 14, were admitted to Baltara because behavioural issues or mental or physical disabilities meant they could not be accommodated at Allambie or Turana.1177 Mr Holland told the Royal Commission that when an older boy was admitted, he could be placed to sleep in the same room as children who were much younger than him.1178

775. Mr Holland also gave evidence that it was common for Baltara to be overcrowded, particularly in the early to mid-1980s, and also over the Christmas holiday period. This resulted in newly admitted boys being placed wherever there was a bed available, or even on a mattress on the floor of a bedroom.1179

776. Mr Holland told the Royal Commission that when Baltara was overcrowded, boys admitted as wards were placed in sections with boys on remand for criminal offences.1180 He said that it was not always possible to appropriately place residents who had offended or were the victims of sexual abuse,1181 nor could it be ensured that every child with a mental or physical disability was placed in Akora.1182 Mr Holland said that in reality there were vulnerable children in every unit.1183

777. Mr Holland’s evidence is consistent with BDA’s account of being placed in a room in Akora with boys much older than him.1184

Available findings on the placement of residents at Baltara

1176 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [29].
1178 Transcript of G Holland, C9731:15-30 (Day C093).
1179 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [26]-[27]; Transcript of G Holland, C9736:26-43 (Day C093).
1180 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [27].
1181 Transcript of G Holland, C9734:26-45; C9737:23-30 (Day C093).
1182 Transcript of G Holland, C9735:27-C9736:1 (Day C093).
1184 Transcript of G Holland, C9763:4-14 (Day C094).
F44 During the period that Grant Holland was employed at Baltara (1983 to the early 1990s), overcrowding was a serious problem. Overcrowding hindered the provision of adequate supervision, and meant that residents were placed in sections based on the availability of beds as opposed to their compatibility, suitability and safety.

F45 The placement of children admitted to Baltara as wards of the State in sections with children committed to Baltara for criminal offences, and the placement of younger children in sections with older children at Baltara increased the risk of child to child sexual abuse.

Supervision of residents at Baltara

778. Mr Holland stated that during the day most sections of Baltara were staffed by a Senior YACCO and up to three YACCOs, all of whom worked 12.5 hour shifts. It was not unusual for a YACCO to be required to take a boy to an external appointment, or to attend to an incident or injury, or for the Senior YACCO to spend significant periods of time at head office. This meant that just one or two YACCOs were responsible for supervision of up to 20 boys for a number of hours.

779. Mr Holland stated that between 8:30pm and 10:30pm there were only two YACCOs on duty per section, and that between 10:30pm and 6:00am one YACCO was on duty per section. During this ‘night shift’ a Senior YACCO also moved between all five sections, to check on the YACCOs, but provided minimal direct supervision of residents.

780. Mr Holland said that the YACCO responsible for night shift was required to complete administrative work in the office. The office was near the boys bedrooms, but only had a view of the bedrooms directly adjacent. The YACCO was responsible for performing regular checks of the boys’ bedrooms during the night.

781. Mr Holland told the Royal Commission that in his view, the night-time supervision of boys at Baltara during the 1980s and early 1990s was inadequate, and left boys vulnerable to physical or sexual abuse.

782. When asked to reflect on BDA’s account of being abused by other residents at night, Mr Holland agreed that there was insufficient staff to provide proper supervision for the boys. He also stated that the structure or layout of the institution made it impossible to adequately provide effective and full supervision. He agreed that the layout of bedrooms along a hallway meant that residents could hear when officers...
were approaching, thereby allowing them to avoid being caught for sexual offending.1192

783. On behalf of the Department, Dr Philip accepted that between the mid-1980s and early 1990s there was inadequate supervision of the residents of Baltara.1193

**Available finding on the supervision of residents at Baltara**

F46 Supervision of residents at Baltara between the mid-1980s and early 1990s was inadequate, particularly at night. Specifically:

a) there were insufficient numbers of night duty officers to supervise residents, which meant that individual staff members were left alone with residents; and

b) the physical environment made it impossible for staff to monitor each and every resident.

**Culture of Baltara**

784. Mr Holland told the Royal Commission that Baltara was a scary and intimidating place.1194

785. Mr Holland gave evidence that physical assaults between residents occurred daily.1195 He also witnessed many serious incidents of self-harming and attempted suicide during his time at Baltara.1196

786. Mr Holland stated that when he started at Baltara he experienced what he described as the “old school” system of brutal care.1197 He gave evidence that he witnessed staff members physically abuse, or threaten to physically abuse residents on a number of occasions throughout the period he worked there.1198 Mr Holland stated that solitary confinement was used as a form of punishment.1199

787. Mr Holland also gave evidence that staff often failed to follow-up on issues or complaints raised by residents, whether minor (such as concerns about pocket money) or more serious (for example complaints of physical assault by staff). Mr Holland told the Royal Commission that this failure, coupled with the use of physical aggression by staff to control behaviour, resulted in a lack of trust between residents and staff.

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1192 Transcript of G Holland, C9764:37-C9765:6 (Day C094).
1193 Transcript of V Philip, C9938:45-C9939:8 (Day C093).
1195 Transcript of G Holland, C9758:24-39 (Day C094).
1196 Transcript of G Holland, C9753:25-C9754:9 (Day C093).
1197 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [57].
1198 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [42]; Transcript of G Holland, C9754:15-45 (Day C093).
1199 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [43].
Children who were already vulnerable were made to feel that no-one would listen to them, and that they had no-one to turn to and nowhere to go.1200

4.4 Response to reports of child sexual abuse at Baltara

788. The Royal Commission requested a statement from Robert Urquhart, the child care officer who prepared a handwritten report of the abuse of BDA. Mr Urquhart was not called to give evidence at this public hearing.

789. Mr Holland gave general evidence that during the time he worked at Baltara, he observed or was notified of incidents of sexual and physical abuse between residents on a weekly basis.1201 Mr Holland told the Royal Commission that between 1983 and the early 1990s staff members at Baltara were definitely aware of the problem of sexual abuse between residents.1202

790. Mr Holland also stated that he observed or was notified of allegations of physical and sexual abuse perpetrated against residents by staff of Baltara.1203

791. Mr Holland told the Royal Commission that it was ‘very hard to get admissions’ of child sexual abuse from residents.1204 He attributed this to residents feeling powerless, and because even if they did report, nothing would be done.

792. Mr Holland also said that residents would have chosen not to report because they feared further sexual or physical abuse, and did not feel protected by staff.1205

Available finding on the response to reports of child sexual abuse at Baltara

F47 During the period that Grant Holland was employed at Baltara (1983 to the early 1990s), some residents did not report child sexual abuse to anyone at the time it was occurring because:

a) they did not believe that staff could protect them from further victimisation, abuse or reprisals;

b) they did not think that staff would believe them; and

c) they did not think that staff would act on the report.

1200 Transcript of G Holland, C9757:32-C9758:9 (Day C094).
1201 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [36].
1202 Transcript of G Holland, C9734:19-45 (Day C093).
1203 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [37].
1204 Transcript of G Holland, C9741:29-47 (Day C093).
1205 Transcript of G Holland, C9758:11-39 (Day C093).
Policies and procedures for reporting and responding to child sexual abuse at Baltara

793. The Royal Commission was provided with two undated documents comprising some of the policies of Baltara from the mid-1980s to 1990. The first document concerned the section of Baltara called ‘Akora’, and set out the aims and objectives, criteria for placement and programs available for the section.\textsuperscript{1206} The second document was entitled ‘Introduction to “Baltara”’, and is a pamphlet providing an overview of the institution, including institution aims and objectives, procedures for assessment and placement of residents, and responsibilities and procedures for staff.\textsuperscript{1207}

794. Dr Philip gave evidence that the Department was unable to locate any policies in relation to receiving and responding to allegations of sexual abuse specific to Baltara.\textsuperscript{1208} He said that a Manual of Instructions appears to have been created for Baltara, but a copy of this document could not be located for this public hearing. Dr Philip also stated that the policies and procedures of Turana may have been used by staff at Baltara.\textsuperscript{1209}

795. Mr Holland gave evidence that while he was employed at Baltara from 1983 to the early 1990s he was not aware of a training manual that set out the steps to follow if a child complained of child sexual abuse, or any policy specifically concerned with child sexual abuse.\textsuperscript{1210}

796. Mr Holland told the Royal Commission that between 1983 and the early 1990s complaints of child sexual abuse were dealt with under the general system of incident reports.\textsuperscript{1211} Mr Holland estimated that at least five incident reports were completed per day for minor to very serious incidents.\textsuperscript{1212}

797. Mr Holland did not recall receiving any specific training about how incident reports should be completed when there was a complaint of child sexual abuse, although general training was provided from time to time by the Department, for instance when the structure or format of the incident reports changed.\textsuperscript{1213}

798. Mr Holland said that if a YACCO received a complaint or witnessed an incident, they were required to complete an incident report.\textsuperscript{1214} Incidents were classified as follows:

a. Category 1: incidents that may have the potential to attract some media attention, or involved death, serious injury or possible criminal charges

b. Category 2: serious incidents that may not attract media attention

\textsuperscript{1206} Exhibit 30-0011, DHS.3076.002.0015.
\textsuperscript{1207} Exhibit 30-0011, DHS.3076.006.0005.
\textsuperscript{1208} Exhibit 30-0046, Second statement of V Philip at [49].
\textsuperscript{1209} Exhibit 30-0046, Second statement of V Philip at [49]-[50].
\textsuperscript{1210} Transcript of G Holland, C9730:47-C9731:4 (Day C093); C9733:35-47 (Day C093).
\textsuperscript{1211} Transcript of G Holland, C9733:35-47 (Day C093).
\textsuperscript{1212} Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [56].
\textsuperscript{1213} Transcript of G Holland, C9734:2-17 (Day C093).
\textsuperscript{1214} Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [45].
c. Category 3: minor incidents, for example a boy falling over and banging his knee.\(^{1215}\)

799. Mr Holland also stated that although there was no specific policy, procedure or direction about how to classify reports of child sexual abuse, he believed that all YACCOs understood that incidents of child sexual abuse should be reported as a Category 1 or 2.\(^{1216}\) The lack of evidence, or an express admission by the alleged victim could result in an incident of child sexual abuse being reported as or later downgraded to a Category 2 incident.\(^{1217}\)

800. Once completed, the YACCO submitted the incident report to their Senior YACCO, who made comments on the report and submitted it to the executive team.\(^{1218}\)

### Available finding on policies and procedures for reporting and responding to child sexual abuse at Baltara

F48 During the period that Baltara was in operation, there were no policies or procedures specifically for:

a) receiving and responding to complaints of child sexual abuse, and

b) reporting complaints of child sexual abuse to the Director of the Department and/or the Victoria Police.

### Reporting of incidents at Baltara in practice

801. Mr Holland stated that:

It was not uncommon for a Senior YACCO to instruct a YACCO not to submit an incident report, or for them to advise the YACCO that they had submitted the report to the executive team only to later find out that they had not in fact done so. There were other occasions that I am aware of when YACCOs were pressured by supervisors to water down an incident report to make the incident seem less "serious" or a report was returned and the category had been downgraded. Allegations of child sexual abuse were sometimes watered down and described as sexual experimentation. I was asked to do this on numerous occasions. I also had many staff confide to me that they were upset that they had been asked to change their reports by their supervisors to exclude serious issues so that there would not be the "hassle" of an investigation.\(^{1219}\)

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\(^{1215}\) Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [46].

\(^{1216}\) Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [47].

\(^{1217}\) Transcript of G Holland, C9747:37-C9748:11 (Day C093).

\(^{1218}\) Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [48].

\(^{1219}\) Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [50]; See also Transcript of G Holland, C9749:13-44 (Day C093).
802. Mr Holland said that complaints would also be downgraded because incident reports were seen to reflect badly on, and had career consequences, for the Senior YACCO responsible for the section.1220

803. Mr Holland told the Royal Commission that YACCOs were discouraged from deviating from the above procedure, or from the chain of command.1221

804. He stated that staff that were seen to be ‘rocking the boat’ by not adhering to the reporting hierarchy, or repeatedly raising an issue, were ostracised, transferred between units, allocated less desirable shifts, not promoted, or pressured to leave.1222

805. Mr Holland gave evidence that there was no co-ordinated or systematic response to incident reports. On some occasions, the resident would be moved to a different section; sometimes there was no response.1223 Mr Holland said that the fragmented approach adopted meant that systemic problems were not resolved, and reports of sexual abuse were not responded to appropriately.1224

806. Mr Holland gave evidence that while he was employed at Baltara he reported concerns about the interaction between a staff member and a resident of Baltara to his supervisor on at least three occasions. On one occasion, he was initially chastised and ignored, but later vindicated.1225 On another occasion, nothing was done in response to the report and Holland was moved to another section.1226

807. Mr Holland stated that the lack of professional counselling or de-briefing for staff meant that staff became desensitised and this ‘led to a systemic failure to respond to incidents of concern in any meaningful way in order, so as to prevent similar incidents from occurring in the future’.1227

Available finding on the reporting of incidents at Baltara in practice

F49 During the period that Grant Holland was employed at Baltara (1983 to the early 1990s), the hierarchical staffing structure, and the culture amongst staff, prevented reports of child sexual abuse being escalated to management.

1220 Transcript of G Holland, C9750:7-16 (Day C093).
1221 Transcript of G Holland, C9758:41-C9759:19 (Day C094).
1222 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [57]; Transcript of G Holland, C9744:21-39 (Day C093); C9750:35-C9751:17 (Day C093).
1224 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [56]; Transcript of G Holland C9748:30-39 (Day C093).
1225 Transcript of G Holland, C9744:45-C9747:1 (Day C093).
1226 Transcript of G Holland, C9744:10-19 (Day C093).
1227 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [44].
Reporting to the Department and Victoria Police by staff at Baltara

808. Mr Holland told the Royal Commission that between 1983 and the early 1990s there was no opportunity for YACCOs to directly contact the Department to raise any concerns or incidents, including incidents of child sexual abuse. He said that any contact with the Department had to be channeled through the Baltara executive.1228 If a staff member ignored this procedure they risked losing their job.1229

809. Mr Holland gave evidence that some YACCOs at Baltara made verbal and written complaints to the Department about boys that appeared to have been forgotten,1230 but YACCOs got in trouble for contacting the Department directly in this way.1231

810. Mr Holland told the Royal Commission that YACCOs were not allowed to contact the police to report an incident; this was a matter for the executive team once the incident report had been completed.1232 During his time at Baltara, Mr Holland was never asked to report an incident of child sexual abuse to Victoria Police.1233

811. Mr Holland said that he had some second-hand knowledge of police attending Baltara in response to complaints of child to child sexual abuse, but that this happened very rarely.1234

812. Mr Holland gave evidence that on some occasions the police were contacted, but he did not recall any further action being taken.1235

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1228 Transcript of G Holland, C9752:29-42 (Day C093).
1229 Transcript of G Holland, C9753:8-17 (Day C093).
1230 Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [52]-[54].
1231 Transcript of G Holland, C9752:14-27 (Day C093); Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [52]-[54].
1232 Transcript of G Holland, C9743:17-33 (Day C093).
1233 Transcript of G Holland, C9744:1-3 (Day C093).
1234 Transcript of G Holland, C9743:17-46 (Day C093).
Part 5  Response of Victoria Police

813. The Royal Commission heard evidence from the Assistant Commissioner of Victoria Police, Stephen Fontana. Assistant Commissioner Fontana gave evidence about the historical and contemporary systems, policies and procedures employed by Victoria Police to respond to reports of child sexual abuse in general, and reports of child sexual abuse concerning residents of Victorian state run youth training and reception centres.

5.1 Historical response of Victoria Police

Historical views on child sexual abuse

814. Assistant Commissioner Fontana stated that historically the investigation of an allegation of child sexual assault was treated in the same manner as any other crime, and necessarily focused on the victim’s behaviour before, during and after the commission of the alleged offence, and their ability to recall and describe events.\(^1\)

815. He told the Royal Commission that prior to a report prepared by the Victorian Law Reform Commission entitled ‘Sexual Offences: Law and Procedure Final Report’ (2004 VLRC Report) there was ‘a lot of disbelief’ about child sexual abuse within Victoria Police.\(^2\)

816. Assistant Commissioner Fontana said that the need for corroboration, and the strict requirements and procedures concerning the assessment of witnesses and the preparation of briefs of evidence contributed to this culture of disbelief, and created a disincentive to reporting.\(^3\)

817. He accepted that there was a lack of recognition by police that behaviours like indecent exposure could in fact be harmful both in and of themselves, and as the beginning of much more serious behaviour.\(^4\)

818. As mentioned briefly under Part 3.6, Assistant Commissioner Fontana was asked about the historical views of Victoria Police to incest.

819. He told the Royal Commission that he was surprised that no report was made to police about Katherine X,\(^5\) or the many other cases of incest that Ms Minister said she became aware of as Deputy Superintendent.\(^6\)

820. He said that he was not aware of an attitude among Victoria Police of treating incest as a family matter rather than a criminal offence, or of reluctance to investigate these

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\(^{1}\) Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [19].

\(^{2}\) Transcript of S Fontana, C9830:11-33 (Day C094).

\(^{3}\) Transcript of S Fontana, C9829:37-C9830:33 (Day C094); Transcript of S Fontana, C9867:39-C9868:13 (Day C094).

\(^{4}\) Transcript of S Fontana, C9828:46-C9829:9 (Day C094).

\(^{5}\) Transcript of S Fontana, C9841:18-38 (Day C094).

\(^{6}\) Transcript of S Fontana, C9844:39-42 (Day C094).
kinds of offences.\footnote{1242} He acknowledged that victims of incest were often reluctant to report, and that incest is inherently difficult to prosecute, but said that this would not stop police from conducting an investigation.\footnote{1243}

821. Assistant Commissioner Fontana said that between the 1970s and 2015 there was a change in dealing with sex offences across the board, as a result of the reforms that had been introduced and continued to be introduced over that period.\footnote{1244} He gave evidence that over that period, there has been an increasing recognition of the ongoing and devastating harm experienced by victims of child sexual abuse, including intra-familial sexual abuse.\footnote{1245}

**Historical views on residents of youth training and reception centres**

822. Assistant Commissioner Fontana said that disbelief about reports of child sexual abuse was particularly pronounced when the complainant was a resident of a state run youth training or reception centre. He said that there was a view among some members that residents were ‘troublemakers’ or ‘juvenile delinquents’ who were not believable, and would not make credible or reliable witnesses.\footnote{1246} He said that this reflected a regrettable societal view of these children,\footnote{1247} and that this view attached to all residents, notwithstanding that many of them had been admitted because they needed care and support, not because they had committed an offence.\footnote{1248}

823. Assistant Commissioner Fontana was asked about a document concerning the sexual assault of Norman Latham by an unknown male in 1962. It is entitled ‘Details of previous court appearances or warnings by an officer’, and states:

Latham was found in the company of a [REDACTED] who had offered to drive the boy home but had taken him to a deserted track of the Boulevard Port Melbourne and Indecently Assaulted him. Latham was not perturbed about the assault at all when questioned.\footnote{1249}

824. Assistant Commissioner Fontana said that this document ‘highlights the lack of understanding that police had at the time in terms of the impact these types of offences can have on individuals, particularly young children’. He said that although the document acknowledges the assault, it ‘doesn’t really highlight the seriousness of the actual offence’, and ‘[comments] on the victim rather than the perpetrator’.\footnote{1250}

\footnote{1242} Transcript of S Fontana, C9841:45-C9842:26 (Day C094).
\footnote{1243} Transcript of S Fontana, C9843:17-27 (Day C094).
\footnote{1244} Transcript of S Fontana, C9845:13-20 (Day C094).
\footnote{1245} Transcript of S Fontana, C9845:22-26 (Day C094).
\footnote{1246} Transcript of S Fontana, C9830:35-C9831:18 (Day C094).
\footnote{1247} Transcript of S Fontana, C9831:20-22 (Day C094).
\footnote{1248} Transcript of S Fontana, C9834:13-32 (Day C094).
\footnote{1249} Exhibit 30-0001, Annexure NEL-1, DHS.3002.103.0052_E_R.
\footnote{1250} Transcript of S Fontana, C9829:11-21 (Day C094).
**Historical interaction between Victoria Police and residents**

825. During the public hearing, Assistant Commissioner Fontana was asked to comment on the evidence given by survivor witnesses about their interactions with Victoria Police when they were initially taken to a youth training or reception centre, or when they absconded.

826. Assistant Commissioner Fontana accepted that some of the interactions with police experienced by former residents were ‘negative, unhelpful and damaging for those children’.1251

827. He said that as a result of the views held by Victoria police, members would not ‘[drill] into the background of these children to find out what was actually going on in their lives’.1252

828. Assistant Commissioner Fontana was asked about the response of Victoria Police to Mr Latham’s report to a detective that ‘...if you stop the mongrels Wilkie and Horne from raping us inside [Turana], we wouldn’t have to abscond’. He said that the lack of follow-up enquiries and the treatment of Mr Latham, was ‘mind-boggling’, and made him ‘quite angry’. He said that unfortunately it goes back to the attitudes of the day.1253

829. When asked to reflect on the experiences of Mr Cummings and BDA, who both gave evidence that while living on the streets in the early 1970s and late 1980s (respectively) they were both picked up by police who made no enquiries as to their well-being. Assistant Commissioner Fontana again accepted that this reflected the attitude of police at the time,1254 and was ‘really disappointing’.1255

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**Available finding on the historical interaction between Victoria Police and residents**

F50 Between the 1960s and early 1990s, some members of the Victoria Police treated residents of youth training and reception centres as ‘juvenile delinquents’ or ‘trouble maker’s’, who were not to be believed, or who needed to be disciplined.

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**Historical policies, procedures and training of Victoria Police**

830. Assistant Commissioner Fontana gave evidence that during the historical period examined (1960 to 1993), there were localised arrangements between police stations and the youth training and reception centres.1256 He said that it was likely that stations developed their own standard operating procedures for responding to particular

1251 Transcript of S Fontana, C9826:34-37 (Day C094).
1252 Transcript of S Fontana, C9830:11-33 (Day C094).
1253 Transcript of S Fontana, C9832:39-44 (Day C094).
1254 Transcript of S Fontana, C9835:37-41 (Day C094).
1255 Transcript of S Fontana, C9836:12-24 (Day C094).
1256 Transcript of S Fontana, C9826:44-C9827:19 (Day C094); Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [18].
incidents in their specific area. Documents recording these localised arrangements could not be located by the Victoria Police.

831. The Royal Commission was provided with some documents from the Victoria Police that appeared to be historical manuals and police academy documents in relation to sexual offences. The documents appear to outline sexual offences at the time the documents were created and in some instances provide the evidence required to prove the sexual offence. A document entitled ‘Law and Procedure Publication Scheme Sex Offences’ with a date of ‘circa 1978’ crossed out, includes a section ‘Sexual Offences Squad’. This section states:

This is a recently formed squad comprising of detectives who are specially trained in taking initial complaints of women and children who have reported being the victims of serious sexual offences (excluding Indecent Exposure matters). Their duties and responsibilities can be found in the Manual...

They are briefly:

(a) Provide a 24 hour service in metropolitan districts to attend on request to the initial complaint as aforesaid;

(b) Interview, counsel and support such women and children, and where appropriate, female witnesses present during such offences;

(c) Assist as required during the investigation;

(d) Assist victims and witnesses during court hearings etc., and where practicable, the interviewing member shall provide such assistance;

(e) Liaise with police surgeons, and staff of sexual assault clinics, hospitals and other specialist support services assisting such victims;

(f) Maintain records of and provide advice about community trends in serious sexual offences and related matters including victim compensation.

Where a member of the squad is not available, a suitably qualified policewoman who is conveniently available should perform these duties.

It is of paramount concern that such women and children are treated as sensitively and professionally as possible, consistent with the police responsibilities to properly investigate crime and to ensure that the best evidence is presented to the court.

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1257 Transcript of S Fontana, C9827:29-39 (Day C094).
1258 Exhibit 20-0041, Statement of S Fontana, STAT.0623.001.0001 at [18]; Transcript of S Fontana, C9827:41-43 (Day C094).
1259 Exhibit 30-0011, VPOL.304.001.0011.
1260 Exhibit 30-0011, VPOL.3029.002.0805_E.
1261 Exhibit 30-0011, VPOL.3029.002.0279_E at 0295_E.
832. When asked to reflect on the evidence of Katherine X, who told the Royal Commission that she reported sexual abuse to the police in 1979, when this policy appeared to have applied, but was told she could not report the matter unless an adult was present, Assistant Commissioner Fontana said that this was ‘extremely problematic’, and that he was disappointed that no action was taken at that stage by Victoria Police. He said that in 1979, the Victoria Police did have the ability to locate an adult to provide support to victims making a statement, and policewomen were specially trained to take statements and deal with young people.

833. Assistant Commissioner Fontana stated that historically, police had ‘very little understanding of the complexities of sexual offending, sexual offenders and, in particular, victims and their experiences’. He said that police had insufficient appreciation of how a victim of sexual abuse might present, why they might delay reporting to police or others, and why they may suffer ‘broken recollections’.

834. Assistant Commissioner Fontana stated that:

> It is essential that investigators have an understanding of sexual offending. If investigators do not understand the dynamic of sexual offending then they will not be able to appreciate the experience of victims, the trauma caused by the offending and the way in which victims remember things associated with or as a result of that trauma.

835. Assistant Commissioner Fontana accepted the need for regular investment in police training about the complexities around children running away from home or out of home care, and the importance of developing relationships with children at risk.

836. In relation to policies regarding children who had absconded from youth training and reception centres, he gave evidence that there were historical policies for dealing with these children, but these policies simply set out when a child could be apprehended, charged and prosecuted. For example, during the 1980s, escapees could be apprehended and charged, but proceedings would not be commenced against a ward of the state without first consulting the Department. The policies did not include any procedure for enquiring into the reasons for a child absconding.

Available findings on historical policies, procedures and training of Victoria Police

F51 Prior to 2004, members of the Victoria Police were not adequately trained to recognise, understand or respond to child sexual abuse.

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1262 Transcript of S Fontana, C9859:20-C9860:4 (Day C094).
1263 Transcript of S Fontana, C9859:38-C9860:4 (Day C094).
1264 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [57].
1265 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [63].
1266 Transcript of S Fontana, C9835:17-C9836:10 (Day C094).
1267 Transcript of S Fontana, C9852:46-C9853:36 (Day C094).
1268 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [21]-[22].
Between the 1960s and early 1990s Victoria Police policies and procedures regarding residents who had absconded from youth training and reception centres did not recognise that residents may have absconded because of child sexual abuse, or require that members inquire into or investigate why residents had absconded.

**Sexual and physical abuse by Victoria Police**

837. A number of witnesses gave evidence that they were physically or sexually abused by members of the Victoria Police while they were residents of youth training or reception centres, or in the period soon after they left.

838. Mr Marijancevic told the Royal Commission that when he told police that he had absconded ‘because they hurt [him]’, he was physically abused and sent back to Turana. Assistant Commissioner Fontana said that this was ‘really disappointing’ and ‘very unfortunate’, and that the Victoria Police had never condoned that sort of behaviour.\(^\text{1269}\)

839. Assistant Commissioner Fontana accepted that during the 1960s, 1970s and 1980s, some members thought it was appropriate or necessary to use force and physical discipline with children admitted or committed to state run youth training or reception centres.\(^\text{1270}\)

840. BDF told the Royal Commission that on one occasion in 1987, she was forced to perform oral sex on a police officer to avoid being charged. Assistant Commissioner Fontana said that he was ‘outraged’ by this situation, and that if this happened today, the member involved would be charged with a criminal offence and subject to disciplinary action.\(^\text{1271}\)

841. Assistant Commissioner Fontana told the Royal Commission that this kind of behaviour indicated a lack of proper leadership and supervision.\(^\text{1272}\) He acknowledged that even today, from time to time, members display predatory behaviour or commit offences, and it is essential that the organisation remains vigilant about the risk of members abusing their power and privilege.\(^\text{1273}\) In this regard, he mentioned the Professional Standards Committee, which investigates internal and external allegations of misconduct, criminality or corruption by police, and implements proactive training programs about professional standards and the ethical health of the organisation.\(^\text{1274}\)

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\(^{1269}\) Transcript of S Fontana, C9831:24-C9832:2 (Day C094).
\(^{1270}\) Transcript of S Fontana, C9831:34-C9833:18 (Day C094).
\(^{1271}\) Transcript of S Fontana, C9839:34-C9840:7 (Day C094).
\(^{1272}\) Transcript of S Fontana, C9840:9-18 (Day C094).
\(^{1273}\) Transcript of S Fontana, C9840:24-44 (Day C094).
\(^{1274}\) Transcript of S Fontana, C9840:35-44 (Day C094); C9874:32-C9875:7 (Day C094).
Victoria Police involvement in strip searches

842. During the public hearing, Assistant Commissioner Fontana was also asked to reflect on the evidence of a former resident, BDC, who told the Royal Commission that she when she was strip searched at Winlaton after trying to abscond, police were present.

843. Assistant Commissioner Fontana said that he was surprised and disappointed to hear this evidence, and that as far as he knew it had always been the policy of the Victoria Police that if a female had to be searched, this was to be done by a police woman. He said that police were only involved in strip-searches at institutions if the institution didn’t have a female staff member present to conduct the search.1275

844. He accepted that were no written policies or procedures regarding strip-searches prior to 1980,1276 and told the Royal Commission that Victoria Police are now much more sensitive about conductive strip searches, relative to the past.1277

5.2 Contemporary practices of Victoria Police

Major reviews, reforms and developments

845. Assistant Commissioner Fontana told the Royal Commission that over his 40 years of experience as a member of the Victoria Police, he has observed some very significant shifts in both the culture and practice of policing in Victoria.1278

846. Assistant Commissioner Fontana said that since he joined the Victoria Police in 1975, he has observed or been involved in a number of key developments with regard to receiving and investigating reports of sexual offences, including:

a. In the 1960s, units specifically dedicated to taking statements from adult and child victims of sexual assault were established. These units have been known as Police Women’s Division, Community Policing Squads and Sexual Offences Squads.1279

b. In 1988-1989, the Rape Investigation and Evaluation Group was established to review the effectiveness of investigations conducted by Victoria Police into rape and other serious sexual offences. It identified serious deficiencies in the investigation of these offences, and recommended significant changes.1280

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1275 Transcript of S Fontana, C9838:24-C9839:5 (Day C094).
1276 Transcript of S Fontana, C9839:7-17 (Day C094).
1277 Transcript of S Fontana, C9839:19-23 (Day C094).
1278 Transcript of S Fontana, C9820:38-C9821:5 (Day C094).
1279 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [20].
1280 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [5]; Transcript of S Fontana, C9821:36-C9822:15 (Day C094).
c. In 1989, as a result of the findings of the Rape Investigation and Evaluation Group, the Rape Squad was established (now known as the Sexual Crimes Squad). \[1281\] Subsequent to that, the Child Exploitation Unit was established. \[1282\]

d. In 1991, the Spectrum Taskforce was established to investigate a number of child abduction and murders. This resulted in legislative change regarding possession of child pornography and stalking. \[1283\]

847. Assistant Commissioner Fontana told the Royal Commission that the 2004 VLRC Report was the catalyst for major structural, practical and cultural reforms. He said that this Report found that:

...the police response to sexual assault was undermined by a culture of disbelief, a deficit in the skills and knowledge of investigators and a lack of transparency in the process. \[1284\]

848. Assistant Commissioner Fontana said that in response to the recommendations in the 2004 Victorian Law Reform Commission Report:

a. Sexual Offence and Child Abuse Investigation Teams (SOCITs) were established to facilitate the specialist investigation of sexual offences and child abuse; \[1285\]

b. a new training program was implemented for SOCIT detectives; and

c. Multi-Disciplinary Centres were established to provide a collaborative, multi-agency response to victims of sexual assault and child abuse. \[1286\]

849. The Victorian Government has recently introduced three new criminal offences to further protect children from sexual abuse: grooming, failure to disclose, and failure to protect. \[1287\] Assistant Commissioner Fontana said that it is expected that these new offences will be widely used, \[1288\] and there are guidelines in place for members and others about how they will operate in practice. \[1289\] He told the Royal Commission that these new offences, coupled with the introduction of mandatory reporting in 1993, will make a significant difference to how reports of child sexual abuse are dealt with. \[1290\]

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\[1281\] Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [5].
\[1282\] Transcript of S Fontana, C9822:17-23 (Day C094).
\[1283\] Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [6].
\[1284\] Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [25].
\[1285\] Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [27.1]; [28]-[29].
\[1286\] Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [30]-[32].
\[1287\] Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [49]-[50].
\[1288\] Transcript of S Fontana, C9856:39-44 (Day C094).
\[1289\] Transcript of S Fontana, C9856:46-C9857:10 (Day C094).
\[1290\] Transcript of S Fontana, C9857:12-21 (Day C094).
850. Assistant Commissioner Fontana said that in his current role, he oversees both the Sexual Crimes Squad and the Child Exploitation Unit. The Child Exploitation Unit comprises:

a. the Sano Task Force, which was established to respond to the historical allegations of abuse made as a result of the Victorian Parliamentary Inquiry into the Handling of Child Abuse in Religious and Other Non-Government Organisations, and more recently, the Royal Commission.1291

b. the Astrea Task Force, and

c. the Joint Anti Child Exploitation Team, a partnership between the Astrea Task Force and the Australian Federal Police focused on investigating online child exploitation.1292

Contemporary interaction between Victoria Police, the Department and youth justice centres

851. Assistant Commissioner Fontana told the Royal Commission that Victoria Police continue to have the challenge of encouraging disclosures by children that have absconded from out of home care.

852. Assistant Commissioner Fontana said that in August 2013, ‘Task Force Cider House’ was established to investigate allegations of sexual abuse and sexual exploitation in out of home care.1293 He said that both historically and today, children are often reluctant to divulge why they are running away, and that time and resources are required to build rapport so that children will reveal to police or child protection workers what is happening in their lives. 1294

853. Assistant Commissioner Fontana said that in recent years, efforts have been made to improve communication between Victorian Police and youth justice centres to encourage reporting, and deal collaboratively with some of the issues concerning young people and their vulnerabilities.1295 This is provided for in the “Protecting Children” Protocol between Child Protection and Victoria Police, 2012 (the Protocol).1296 Assistant Commissioner Fontana stated:

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

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1291 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [33]-[36]; Transcript of S Fontana, C9825:8-13 (Day C094).
1292 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [10].
1293 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [37].
1294 Transcript of S Fontana, C9833:9-45; C9835:37-C9836:10; C9836:30-45; C9869:23-43; Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [37]-[48].
1295 Transcript of S Fontana, C9850:46-C9851:18 (Day C094).
1296 Exhibit 30-0011, VPOL.3027.003.0480.
Protocol articulates the statutory and non-statutory responsibilities of both [the Department] and Victoria Police and how they will interact with each other. The statutory responsibilities of Victoria Police in relation to child abuse are outlined in the Victorian Children, Youth and Families Act 2005 which provides that police are protective interveners and mandatory reporters.  

Response to reports child sexual abuse from youth justice centres by Victoria Police

854. Assistant Commissioner Fontana stated that criminal investigations linked to youth justice centres are dealt with by the relevant Victoria Police Command, as with any other investigation.  

855. Pursuant to the Protocol, the Department must contact police to report sexual assault within a youth justice centre. These reports are then dealt with by SOCITs. Where both the victim and the offender are residents of the youth justice centre, a joint investigation is undertaken pursuant to the Protocol. Assistant Commissioner Fontana said that the youth justice centre has a responsibility to ensure the safety of the suspect, the victim and other residents, and to this end information is shared between Victoria Police and the Department.  

856. Assistant Commissioner Fontana stated that children’s statements are taken via ‘Video and Audio Recorded Evidence’ (VARE) to obtain as much detail as possible about the abuse, and to limit the exposure of the young person to court proceedings in the future. This reflects a ‘whole-story’ approach to investigating sexual crimes, which looks at the entire relationship between an offender and a victim, and how it was crafted over time. Assistant Commissioner Fontana stated that this approach is designed to ensure that investigators

a. are open-minded;

b. are knowledgeable;

c. place importance on listening to victims and their stories;

d. understand the counterintuitive nature of victim behaviour;

e. understand the behaviour and motivations of offenders; and

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1297 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [55].
1298 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [51].
1299 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [76]-[77].
1300 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [52]-[53].
1301 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [78].
1302 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [80]-[82].
1303 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [56]; Transcript of S Fontana, C9870:20-31 (Day C094).
1304 Exhibit 30-0041, Statement of S Fontana, STAT.0623.001.0001 at [61].
857. Assistant Commissioner Fontana is confident that the current regime, including in relation to the reporting of sexual abuse, is sufficient to provide a safe environment for young people in youth justice detention centres.\textsuperscript{1306}

\textbf{Contemporary Victoria Police training}

858. Assistant Commissioner Fontana gave evidence about the four week training course undertaken by SOCIT members to address the complexities of investigating sexual offences.\textsuperscript{1307} This course includes a significant component on responding to, and investigating, child sexual and physical abuse, and covers (among other topics):

\begin{itemize}
  \item a. Child development, victimology and memory
  \item b. Interviewing children
  \item c. Counterintuitive victim behaviour
  \item d. Working with child Protection and
  \item e. Sexual exploitation of children in residential care.\textsuperscript{1308}
\end{itemize}

859. Assistant Commissioner Fontana told the Royal Commission that Victoria Police has also engaged with child protection agencies and key players in the judicial system to provide education about the impact of child sexual abuse.\textsuperscript{1309}

860. Assistant Commissioner Fontana said that there is ‘constant review and refreshing of the training, and trialling new models and rolling those modes out and exposing the broader membership to these type of issues and training.’\textsuperscript{1310}

\textbf{Contemporary practices of Victoria Police regarding absconding}

861. The Victoria Police provided contemporary policies and guidelines relating to absconding from a youth justice centre.\textsuperscript{1311} In those circumstances, the centre contacts the Victoria Police to file a missing person report. Police then return the absconder to a youth justice centre.\textsuperscript{1312} Assistant Commissioner Fontana said that some police districts have specific protocols with their local youth justice centre.\textsuperscript{1313}
862. Assistant Commissioner Fontana told the Royal Commission that he wasn’t sure today whether police would, as a matter of routine, ascertain from a child or young person why they had absconded. He said that

It’s something that we should be doing and we’re in the process of rolling that out, looking at absconders, people that go missing to find out exactly what’s going on in their life.\footnote{Transcript of S Fontana, C9876:31-39 (Day C094).}

863. He said that it was ‘not best practice’ to simply return a child that had run away from home or out of home care without asking why they had run away.\footnote{Transcript of S Fontana, C9874:6-21 (Day C094).}

### Available finding on contemporary practices of Victoria Police regarding absconding

F53 There is currently no formal requirement in Victoria Police policy or protocols that members inquire into or investigate why a child absconds from a youth detention centre.
Part 6  Response of Department of Health and Human Services (and its relevant predecessors)

864. At the public hearing, the Royal Commission heard from the current Secretary of the Department, Dr Philip, who gave evidence about the past and current policies and procedures of the Department (and its relevant predecessors), to respond to reports of child sexual abuse concerning residents of youth training, reception and justice centres.

865. Dr Philip provided three statements to the Royal Commission for the purpose of this public hearing:

a. statement dated 10 August 2015, amended on 26 August 2015 which contains an overview of the current policies and procedures in youth justice in the State of Victoria;

b. statement dated 10 August 2015 that addresses the past policies and procedures that applied to youth training and reception centres; and

c. statement dated 27 August 2015 that outlines changes introduced to youth justice in the State of Victoria since the evidence given by former residents of Turana, Winlaton and Baltara at the public hearing.

6.1 Historical response of the Department

866. A number of issues common across Turana, Winlaton and Baltara were canvassed at the public hearing, including the Department’s oversight of the institutions, policies and procedures of the Department, the provision of resources, and the role of social workers.

Oversight of institutions by the Department

867. The Royal Commission heard evidence from Mr Cadd that the Department had very little interaction and oversight of the residents at Turana. He said that the role of the Department was, principally to look after the residents. He said:

[T]hat was the role the Department never filled, that was the role that the Department was well aware of but made no attempt whatsoever to provide care and nurturing to young people that weren’t getting it at home, that were living on the street, that were in deplorable conditions; they may have been offenders, but they’re human beings starting on the journey of life.1316

868. Mr Cadd gave evidence that the Department was mainly concerned with the facilities and keeping maintenance costs low. He said that anyone visiting Turana from ‘head office’ was a ‘rare event’.1317

1316 Transcript of A Cadd, C9049:26-47 (Day C088).
1317 Transcript of A Cadd, C9027:21-37 (Day C088).
869. Mr Green, Superintendent at Turana, gave contrasting evidence, stating that the Director and Deputy Director of the Youth Welfare Division of the Department, regularly visited Turana and did so at short notice. He stated that the issues discussed with the Director concerned budget, building and facilities, as well as problems with residents.\footnote{1318}

870. Evidence before the Royal Commission suggests that the Department’s oversight of the institutions was minimal and did not extend to the provision of policies or procedures, proper recruitment and resourcing, proper training or appropriate numbers of social workers. The lack of oversight provided by the Department during the historical period examined is set out in further detail below.

**Provision of policies and procedures by the Department**

871. The Royal Commission heard evidence from institutional witnesses that the Department did not provide policies or procedures to assist in the operation of the institution.

872. Mr Cadd gave evidence that during his employment at Turana, the Department did not provide policies to assist staff members at Turana.\footnote{1319} He said that in relation to policies regarding child sexual abuse, no policies or procedures were provided as ‘the Department is a very polite society, we don’t talk about those things. We don’t mention, we don’t explain, we just ignore that it’s there’.\footnote{1320}

873. Mr Green gave evidence that when he commenced as Superintendent at Turana, he was aware that a Turana Manual was being developed and he thought that it could have been because of a lack of policies and procedures provided by the Department.\footnote{1321}

874. Dr Slack gave evidence that in developing the policies for Winlaton, she did not receive any instruction from the Department.\footnote{1322} She stated that when she arrived at Winlaton there was little or no policy for the handling of serious incidents.\footnote{1323} She said she developed a guideline and procedure document to be adopted in all cases of serious incidents and/or complaints that applied to Winlaton.\footnote{1324}

875. Dr Philip gave evidence about the historical policies in place during the 1960s to 1980s. He said that in the 1960s, there may have been policies of the Department, but he was unable to find any policies on matters such as reporting of complaints or absconding.\footnote{1325}

\footnotesize
\begin{itemize}
\item \footnote{1318} Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [40]-[41].
\item \footnote{1319} Exhibit 30-0012, Statement of A Cadd, STAT.0627.001.0001 at [64(h)].
\item \footnote{1320} Transcript of A Cadd, C9044:39-45 (Day C088).
\item \footnote{1321} Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [57].
\item \footnote{1322} Transcript of E Slack, C9644:3-21 (Day C093).
\item \footnote{1323} Exhibit 30-0034, Statement of Eileen Slack, STAT.0630.001.0001_R at [12].
\item \footnote{1324} Exhibit 30-0034, Statement of Eileen Slack, STAT.0630.001.0001_R at [34].
\item \footnote{1325} Transcript of V Philip, C9953:3-26 (Day C095).
\end{itemize}
876. Dr Philip said that in the 1970s, there were some policies in relation to incidents involving child to child incidents and hearings for incidents, but he acknowledged that these policies applied within an institution.\textsuperscript{1326} He stated that from his search of Departmental policies, there was no comprehensive Department policy for the reporting and responding to incidents.\textsuperscript{1327}

877. This position appeared to have changed when an incident reporting system was developed by the Department.\textsuperscript{1328} Dr Philip stated that the purpose of the incident reporting system was to provide for the efficient delivery of accurate and concise information on all major incidents to the appropriate Manager, Supervisor, Directors, Director-General and Minister.\textsuperscript{1329} The incident reporting policy required incidents of sexual and physical assaults by staff and residents against residents to be reported to the Superintendent who maintained primary responsibility for the action to be taken.\textsuperscript{1330}

<table>
<thead>
<tr>
<th>Available finding on the provision of policies and procedures by the Department</th>
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<tbody>
<tr>
<td>F54 During the 1960s to early 1990s, the Department did not have policies, procedures or practices for:</td>
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<tr>
<td>- receiving and responding to complaints of child sexual abuse, and</td>
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<tr>
<td>- 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.</td>
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Recruitment, training and resourcing offered by the Department

878. Mr Cadd told the Royal Commission that from about 1968 to 1978, the Department recruited staff who were not equipped for the job and retained staff who were only interested in having an easy day, ‘to keep the section exactly as it was supposed to be and not make any innovations’.\textsuperscript{1331}

879. Mr Green gave evidence that by the 1970s, when the Department became known as the Social Welfare Department, the Department introduced a policy to appoint professionals, rather than career officers who had risen through the ranks, to executive positions within institutions.\textsuperscript{1332}

880. Mr Green stated that this decision led to more focus on the diverse needs of children and young people in care or under sentence, and the development of systems that

\textsuperscript{1326} Transcript of V Philip, C9953:22-30 (Day C095).
\textsuperscript{1327} Exhibit 30-0046, Second statement of P Philip, STAT.0626.002.0001 at [56].
\textsuperscript{1328} Exhibit 30-0046, Second statement of P Philip, STAT.0626.002.0001 at [53]-[56].
\textsuperscript{1329} Exhibit 30-0046, Second statement of P Philip, STAT.0626.002.0001 at [54].
\textsuperscript{1330} Exhibit 30-0046, Second statement of P Philip, STAT.0626.002.0001 at [55].
\textsuperscript{1331} Transcript of A Cadd, C9011:11-26 (Day C088).
\textsuperscript{1332} Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [39].
addressed these needs. He gave evidence that there was commitment to improved communication and greater access to staff. He stated that as a result, procedural oversight through forms and administrative checks were reduced and replaced with supervision based on services and problem solving.\textsuperscript{1333}

881. By contrast, both Mr Fitzgerald and Mr Holland gave evidence that when they were employed as youth officers at Baltara, they had no relevant experience or qualifications in working with children. Mr Fitzgerald said that when he was first employed at Baltara, he had no previous experience working with children.\textsuperscript{1334} Mr Holland said that when he was employed at Baltara, his only employment experience was as a clerk at the Children’s Court.\textsuperscript{1335}

882. Mr Cadd said that when he commenced employment at Turana, he attended a training course provided by the Department, which he described as a ‘mickey mouse’ course; a ‘trivial’ course that did not provide any instruction in dealing with or handling complaints of child sexual abuse.\textsuperscript{1336}

883. Mr Fitzgerald gave evidence that when he commenced at Baltara in 1970, he received no on-the-job training of any significance.\textsuperscript{1337}

884. Ms Minister said that training was not offered by the Department during her time at Winlaton. The only training she recalled attending was an internal training program organised at Winlaton.\textsuperscript{1338} When asked whether she believed she was adequately trained or guided by the Department in relation to the impacts of child sexual abuse of the girls in her care, Ms Minister said ‘no’.\textsuperscript{1339}

885. Mr Holland gave evidence that when he started at Baltara in the early 1980s, he received no training,\textsuperscript{1340} and only attended a training course after a probationary period at Baltara of about one year.\textsuperscript{1341}

886. Mr Green told the Royal Commission that the issue of staffing of Turana and its capacity to manage the demand during the 1960s, was constantly discussed with the Deputy Director of the Youth Welfare Division of the Department.\textsuperscript{1342} He said that other Superintendents at other institutions were reporting to the Department of the pressures in their respective institution, but he was informed by the Department that there were budgetary issues. He said:

\textsuperscript{1333} Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [39].
\textsuperscript{1334} Transcript of B Fitzgerald, C9170:9-17 (Day C089).
\textsuperscript{1335} Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [5]; Transcript of G Holland, C9761:26-39 (Day C094).
\textsuperscript{1336} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [40]-[42]; Transcript of A Cadd, C9012:11-32 (Day C088).
\textsuperscript{1337} Transcript of B Fitzgerald, C9171:39-42 (Day C089).
\textsuperscript{1338} Transcript of M Minister C9484:41-C9485:7 (Day C091).
\textsuperscript{1339} Transcript of M Minister C9485:9-15 (Day C091).
\textsuperscript{1340} Transcript of G Holland, C9728:19-23 (Day C093).
\textsuperscript{1341} Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [8]; Transcript of G Holland, C9728:25-35 (Day C093).
\textsuperscript{1342} Transcript of A D Green, C9059:44-C9060:6 (Day C088).
The budget processes of the Department was the response, because altering our staffing, increasing our staffing, was a budget issue and there were budget processes, and submissions were made and priorities were given, and that was the decision for the division, the Department itself, and then it went to treasury and then eventually government would make decisions about priority...

There was a view in the Department that increasing the staffing and the capacity of Turana in particular was not the answer. What we had to do was stop boys coming in, not increase the facility, and priority was given to the development of alternatives to the institution.1343

887. Mr Green said that he made reports to the Department that the overcrowding problem meant that it was not possible to keep residents safe, but he may not have been as ‘urgent or strident enough about it’.1344 He said that the reality was that he had to wait on the budget process and the allocation priorities.1345

888. Dr Slack told the Royal Commission that the lack of adequate staffing at Winlaton contributed to the failure of the institution to provide supervision to the residents of Winlaton.1346 She said that she was constantly drawing the lack of adequate staffing to the attention of the Department, but her requests were not heard or met in any way.1347

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### Available finding on recruitment, training and resourcing offered by the Department

F55 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.

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### Reporting to the Department

889. Mr Green stated that there was no routine system or procedure for making reports (except annual reports) to the Department. He stated that in practice, verbal and written reports could be made to the Department and were often in the form of letters or phone calls, where necessary.1348 He stated that there were only limited times when he reported matters to the Department, which included matters of serious assaults involving staff or inmates, but could not recall whether these matters were reported to put the Department on notice, or seek the Department’s assistance.1349

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1342 Transcript of A D Green, C9060:17-37 (Day C088).
1344 Transcript of A D Green, C9060:39-47 (Day C088).
1345 Transcript of A D Green, C9060:39-C9061:11 (Day C088).
1346 Transcript of E Slack, C9656:33-35 (Day C093).
1347 Transcript of E Slack, C9656:37-C9657:2 (Day C093).
1348 Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [48].
1349 Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [49]-[50].
890. Mr Green stated that on some occasions, he discussed matters concerning aggressive behaviours of the residents and absconding, with the Director of the Department, to seek advice and keep the Director informed of issues.\textsuperscript{1350}

891. Mr Holland told the Royal Commission that between 1983 and the early 1990s, there was no opportunity for staff members to directly contact the Department to raise any concerns or incidents, including incidents of child sexual abuse. He said that any contact with the Department had to be channelled through the Baltara executive,\textsuperscript{1351} and if a staff member ignored this procedure they risked losing their job.\textsuperscript{1352}

892. Mr Holland gave evidence that some youth officers at Baltara made verbal and written complaints to the Department about boys,\textsuperscript{1353} but said that these youth officers got in trouble for contacting the Department directly in this way.\textsuperscript{1354}

893. Mr Holland gave evidence that during the period he was at Baltara, boys were admitted to Baltara without any information or paperwork from the Department as to the reasons for their admission.\textsuperscript{1355} He stated that this made it difficult for staff to make appropriate decisions regarding the placement of residents, and often resulted in boys being mixed with other boys that had committed serious crimes.\textsuperscript{1356} Mr Holland agreed with the proposition put to him that this was a failure of the Department, which made it difficult to keep children at Baltara safe.\textsuperscript{1357}

**Role of social workers of the Department**

894. A number of former residents told the Royal Commission that they didn’t report incidents of child sexual abuse to their social workers, because they didn’t know who their social worker was or because the social worker was more concerned with finding them a placement.

895. Mr Cadd told the Royal Commission that there were social workers employed by the Department who visited the residents at Turana. He stated that in his view, many of the social workers were unable to connect with the residents.\textsuperscript{1358}

896. Mr Cadd stated that in his experience, the divide between the social workers and boys at Turana was significant.\textsuperscript{1359} He said that:

> They come from a different social structure, whether people like it or not, the greater majority, and I mean the real greater majority of our kids come from

\textsuperscript{1350} Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001 at [42].
\textsuperscript{1351} Transcript of G Holland, C9752:29-42 (Day C093).
\textsuperscript{1352} Transcript of G Holland, C9753:8-17 (Day C093).
\textsuperscript{1353} Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [52]-[54].
\textsuperscript{1354} Transcript of G Holland, C9752:14-27 (Day C093).
\textsuperscript{1355} Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [28].
\textsuperscript{1356} Exhibit 30-0038, Statement of G Holland, STAT.0638.001.0001 at [28].
\textsuperscript{1357} Transcript of G Holland, C9740:23-26 (Day C093).
\textsuperscript{1358} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [33].
\textsuperscript{1359} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [33].
working class backgrounds, unemployed, terrible home lives et cetera, and the social workers usually come from a social strata well above them.\textsuperscript{1360}

897. Mr Cadd gave evidence that social workers only attended Turana during classification meetings and prepared reports and made recommendations for placement of the residents in another section at Turana or at another home or institution.\textsuperscript{1361} He gave evidence that these reports had the effect of changing residents’ lives,\textsuperscript{1362} and recalled that:

a. on some occasions, reports were simply reproduced for residents and did not contain a legitimate assessment of progress of the resident’s welfare and needs;\textsuperscript{1363}

b. on some occasions, reports were prepared for residents in the absence of the social worker seeing the resident for assessment;\textsuperscript{1364} and

c. on one occasion, two identical reports were prepared for two different residents, with the only change being, the name of the resident and the dates of the report.\textsuperscript{1365}

898. In contrast, Mr Green gave evidence that social workers were a ‘critical link between the Department and the trainee or wards and provided another important connection for them which was independent of Turana’.\textsuperscript{1366} He stated that social workers tried to keep regular contact with the residents, but heavy case loads usually meant the visits were limited.

899. Professor Borowski provided expert evidence to the Royal Commission and he agreed that case loads for social workers were extremely high and there was ‘gross under-resourcing’ during the early to mid-1970s.\textsuperscript{1367}

900. Mr Fitzgerald told the Royal Commission of his experience as an employee of the Department:

I think it’s a high pressure position and therefore you have a high turnover so it’s not always easy to get who you would always regard as the best possible staff in these positions. In 1979 I think positions were created, like the welfare officer, to actually fill a position – to fill those positions.\textsuperscript{1368}

901. This position did not appear to change during the 1980s. BDA gave evidence of his experience with social workers in the late 1980s, stating ‘if children are able to just tell

\textsuperscript{1360} Transcript of A Cadd, C9022:22-35 (Day C088).

\textsuperscript{1361} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [34].

\textsuperscript{1362} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [35].

\textsuperscript{1363} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [36].

\textsuperscript{1364} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [37].

\textsuperscript{1365} Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [38].

\textsuperscript{1366} Exhibit 30-0013, Statement of D Green, STAT.0627.001.0001_R at [45].

\textsuperscript{1367} Transcript of A Borowski, C9566:9-34 (Day C092)

\textsuperscript{1368} Transcript of B Fitzgerald, C9199:15-28 (Day C089).
their allocated worker what they know the worker wants to hear, the worker is not doing their job’.\textsuperscript{1369} He spoke of the need for social workers and other allocated workers from the Department to really engage with the children in the institution and not just focus on if or when the child will return home.\textsuperscript{1370}

902. Mr Holland gave evidence that between 1983 and the early 1990s, social workers from the Department visited residents at Baltara infrequently and sporadically. He stated that sometimes a resident was not visited by a social worker for up to a year at a time. This meant that both the resident and staff at Baltara did not know what the plan was for the resident’s ongoing care.\textsuperscript{1371}

903. Mr Holland stated that during the period he worked at Baltara, some youth officers wrote many letters of complaints and made phone calls to the Department regarding residents who appeared to have been ‘forgotten’ by the Department.\textsuperscript{1372}

### Available finding on the role of social workers of the Department

F56 The employment of social workers by the Department from the 1960s did not prevent, or facilitate the reporting of, child sexual abuse because:

- a) some residents didn’t know who their allocated social worker was;
- b) some residents were not visited by their allocated social worker;
- c) some residents were only visited by their social worker infrequently; and
- d) some social workers didn’t foster a relationship or environment in which residents felt comfortable reporting child sexual abuse.

### Acknowledgement of responsibility of the Department

904. Dr Philip accepted propositions put to him during the public hearing that there were a number of failures of the Department (and its relevant predecessors) in protecting children from sexual abuse. He told the Royal Commission that:

- a. as a general proposition, the Department could have done more to take into account the impact of child sexual abuse on wards in their case work;\textsuperscript{1373}
- b. the system of placing children who were wards of the State with children who had behavioural problems or committed crimes, put vulnerable children at risk;\textsuperscript{1374}

\textsuperscript{1369} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [117].
\textsuperscript{1370} Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [117].
\textsuperscript{1371} Exhibit 30-0038: Statement of G Holland, STAT.0638.001.0001 at [52];[53].
\textsuperscript{1372} Exhibit 30-0038: Statement of G Holland, STAT.0638.001.0001 at [54].
\textsuperscript{1373} Transcript of V Philip, C9926:12-29 (Day C095).
\textsuperscript{1374} Transcript of V Philip, C9938:27-37 (Day C095).
c. institutions set low expectations for the children in their care;\textsuperscript{1375}

d. there were serious deficiencies in the selection of employees at Turana,\textsuperscript{1376} and the training of employees at Turana\textsuperscript{1377} and Baltara;\textsuperscript{1378} and

e. at Baltara in the late 1980s, there was inadequate supervision due to understaffing.\textsuperscript{1379}

905. In addition, Dr Philip accepted propositions put to him during the public hearing that the Department failed to provide care to specific former residents that gave evidence at the public hearing.\textsuperscript{1380} He said that institutions such as Turana focused on containment.\textsuperscript{1381}

906. During the public hearing, he addressed the former residents and said:

To Norman Latham, to Joseph Marijancevic, to BDB, Robert Cummings, BDC, BHE, Karen Hodkinson, BGD, Gabrielle Short, BDF and BDA, I want you to know that I have heard your stories. I have spent time in the gallery every day of this hearing and I have watched many hours in evidence online.

To BDD, William Clarke and BHU, I will read your stories about your experiences in these state-run centres. Thank you to you all, thank you for your bravery and for your stories.

Before I address topics raised by the Royal Commission I wish to acknowledge on behalf of the State of Victoria the abuse that children experienced in institutions that are the subject of this hearing.

Hearing the evidence that has been relayed to this Commission over the past fortnight, there is no one who would not be deeply shocked, saddened and appalled by the experiences that witnesses have lived through. These experiences are abhorrent and should never have occurred.

As a father, I am shaken to the core that children and young people were forced to endure such horrific experiences. And, Your Honour, I cannot shake from my mind seeing Mr Marijancevic pass to the Commissioners and general counsel a photograph of himself and his three brothers and his comments, ‘Your Honour, you have the narrative of an old man hurtling towards death. The human being that suffered was a child’, and he goes on to say, pointing to the picture, ‘That’s the person that suffered, I’m the person that carried it’.

As a public servant, I am profoundly disappointed of the failures of our public institutions that led to or compounded the tragedies that have emerged through these hearings.

\textsuperscript{1375} Transcript of V Philip, C9917:3-27 (Day C095).
\textsuperscript{1376} Transcript of V Philip, C9937: 45-47 (Day C095).
\textsuperscript{1377} Transcript of V Philip, C9938:21-25 (Day C095).
\textsuperscript{1378} Transcript of V Philip, C9939:10-14 (Day C095).
\textsuperscript{1379} Transcript of V Philip, C9938:45-C9939:8 (Day C095).
\textsuperscript{1380} Transcript of V Philip, C9909:35-38; C9937:29-39; C9939:16-33; C9945:35-39 (Day C095).
\textsuperscript{1381} Transcript of V Philip, C9906:27-47 (Day C095).
I acknowledge that Turana, Winlaton and Baltara were institutions that were run and managed by the Department. The Department could and should have done more to protect children from the harm that they experienced as a result of unacceptable poor practices and failings whilst under the care of state.

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

I pay homage to the bravery of the survivors who have come forward to tell their stories to the Royal Commission and offer my deepest condolences to all who have been affected by these tragic events.

The Department must and will continue to strive for improvement in our practice.

Survivors' accounts are critical to making sure that we learn from our past mistakes. It is a great service the survivors who have given evidence have performed for our society, for those who suffer in silence, and for countless others whose suffering may be prevented by the improvements that these accounts and this Royal Commission will undoubtedly spur.\(^{1382}\)

907. Dr Philip also told the Royal Commission that after hearing the experiences of former residents at the public hearing, the issues raised by some former residents regarding fears of institutionalisation as they age, are matters that the Department ought to take into account. He said that he is prepared as Secretary of the Department to hear more about the concerns and fears expressed by former residents.\(^{1383}\)

### Available findings on the responsibility of the Department

F57 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.

### 6.2 Contemporary youth justice

908. There are currently two youth justice centres in operation in the State of Victoria:
   a) Parkville Youth Justice Precinct; and
   b) Malmsbury Youth Justice Centre.

909. According to the most recent data, there were 148 young people (141 males and 6 females) in youth justice centres in the State of Victoria on an average day in 2013 to

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\(^{1382}\) Transcript of V Philip, C9884:23-C9885:44 (Day C095).

\(^{1383}\) Transcript of V Philip, C9961:22-C9962:14 (Day C095).
2014. In addition, approximately 1,210 young people aged 10 and over were under youth justice supervision on an average day.\textsuperscript{1384}

910. The data also reveals that in 2013 to 2014, 88 percent of young people under youth justice supervision were supervised in the community, and the remaining 12 percent were supervised in a youth justice facility.\textsuperscript{1385}

911. Dr Philip gave evidence about the current operation of youth justice centres in the State of Victoria and the changes that have been made to the policies and procedures after the closure of the institutions examined in this public hearing.

**Oversight**

912. Dr Philip stated that youth justice services today are overseen by various external bodies, such as the Commission for Children and Young People and the Victorian Ombudsman, and internal monitoring and oversight within the Department.\textsuperscript{1386}

913. Dr Philip gave evidence of the various internal oversight mechanisms in place today, including:

a. reporting by the Director of Secure Services to the Deputy Secretary of the North Division to the Deputy Secretary Service Design and Operation to the Secretary of the Department;

b. monitoring of the compliance and performance of Secure Services by other branches within the Department; and

c. accountability of the Director to the Divisional Performance Assurance Committee, which meets twice yearly and discusses divisional performance against a suite of measures.\textsuperscript{1387}

**Placement of children**

914. Dr Philip accepted that in the past, all children were subject to what he described as a ‘containment model’, where wards of the State were in the same institutions as those who had committed more serious criminal acts. He told the Royal Commission that the ‘biggest change in the system’ has been the separation of children who had committed criminal acts from those children who are in need of care and protection.\textsuperscript{1388}

915. Dr Philip stated that today, there is separation of youth justice services and out of home care for children and young people. Those children and young people who were

\textsuperscript{1386} Exhibit 30.0046, Third statement of V Philip, STAT.0626.005.0001 at [210]-[211].
\textsuperscript{1387} Exhibit 30.0046, Third statement of V Philip, STAT.0626.005.0001 at [211]-[215].
\textsuperscript{1388} Transcript of V Philip, C9886:44-C9887:24 (Day C095).
admitted to Turana, Winlaton or Baltara for care and protection would not be placed in a youth justice centre today.\textsuperscript{1389}

916. Dr Philip said that youth justice facilities are used as a matter of last resort. Around 85 percent of children under a juvenile justice order serve their time outside of these facilities,\textsuperscript{1390} with the focus being on more community-based services.\textsuperscript{1391} He said that the facilities are only used for those children who the Courts have determined cannot be safely and securely looked after in the community.\textsuperscript{1392}

917. Dr Philip said that upon arrival at a youth justice centre, a young person is provided with an information pack, which includes a document entitled ‘What I need to know: rights and rules in youth justice custodial precincts’, which informs them about their rights.\textsuperscript{1393} He said that in addition to that information pack, as part of the orientation, a young person is shown the unit, meet other staff and meet the other residents.\textsuperscript{1394}

918. Dr Philip stated that an introductory health session is also provided to new admissions to discuss coping skills, harm minimisation and safe sex. He stated that it gives young people an overview of the support that can be provided while the young person is in custody.\textsuperscript{1395}

919. Dr Philip stated that the two types of ‘Classification’ processes are conducted to determine the placement of young person within and between the precinct as well as the specific unit within the precinct.\textsuperscript{1396} Factors taken into account during the Classification process include age, security risk maturity, length of sentence, individual needs, presence of other related persons in the same unit, offending behaviour and rehabilitation needs.\textsuperscript{1397}

**Reporting and response to incidents of child sexual abuse**

920. Dr Philip told the Royal Commission that child sexual abuse within youth justice centres is not just a historical problem, it is an area that requires ongoing vigilance.\textsuperscript{1398} He gave evidence that sexual abuse at youth justice centres still occurs today and since the beginning of 2015, there have been two incidents of alleged sexual abuse.\textsuperscript{1399}

921. Dr Philip gave evidence that young people in custodial centres are some of the most disadvantaged people in the Victorian community and that:

\textsuperscript{1389} Exhibit 30.0046, Third statement of V Philip, STAT.0626.004.0001 at [8].
\textsuperscript{1390} Transcript of V Philip, C9887:36-43 (Day C095).
\textsuperscript{1391} Transcript of V Philip, C9888:43-46 (Day C095).
\textsuperscript{1392} Transcript of V Philip, C9888:43-C9889:9 (Day C095).
\textsuperscript{1393} Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [95]; Exhibit 30-0046, Amended third statement of V Philip, STAT.0626.004.0001 at [185]; Transcript of V Phillip, C9955:40-C9956:15 (Day C095).
\textsuperscript{1394} Transcript of V Philip, C9955:46-C9956:8 (Day C095).
\textsuperscript{1395} Exhibit 30.0046, Third statement of V Philip, STAT.0626.004.0001 at [185].
\textsuperscript{1396} Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [73].
\textsuperscript{1397} Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [74].
\textsuperscript{1398} Transcript of V Philip, C9894:43-C9895:5 (Day C095).
\textsuperscript{1399} Transcript of V Philip, C9895:31-36 (Day C095).
[M]any young people in custody have a significant history of abuse, neglect and trauma and are very often the product of, and still suffer from, a childhood characterised by disadvantage, neglect and/or abuse.\textsuperscript{1400}

922. Dr Philip stated that attitudes towards child sexual abuse have changed significantly since the closure of the historical institutions and that the attitudes about the credibility of children and young people have changed. He gave evidence that children are ‘not held responsible for sexual offences perpetrated against them’.\textsuperscript{1401}

923. Dr Philip told the Royal Commission that the values and culture of the Department are crucial, and that ‘unless people do the right thing, the system does break down’.\textsuperscript{1402}

924. Dr Philip gave evidence that monitoring systems within the centres are much improved, and pointed to the implementation of CCTV systems in all common areas, and the automatic logging of doors opened at night.\textsuperscript{1403} He also said that staff members now receive training on their roles and responsibilities based on a trauma informed approach.\textsuperscript{1404}

925. Dr Philip told the Royal Commission that within 24 hours of a young person entering custody, he or she undergoes an initial primary and mental health assessment by a Registered Psychiatric Nurse to identify any physical health issues and safety or risk factors.\textsuperscript{1405} Dr Philip said that staff members are trained to deal with and recognise children who may have been victims of sexual abuse.\textsuperscript{1406}

926. Dr Philip gave evidence that there are various mechanisms in place to provide young people with opportunities to raise concerns and disclose abuse. He stated that this includes daily catch ups with key workers, weekly catch ups with unit coordinators, dedicated unrecorded telephone lines with the Ombudsman, and support through members of the Cultural Support Team for children and young people of culturally and linguistically diverse backgrounds.\textsuperscript{1407} He said that children now have access to a broad group of people to whom they can report incidents, including:

a. Youth Justice staff within the centre;

b. Professional health workers who visit children on a regular basis;

c. Community workers;

d. Child Protection Workers;

\textsuperscript{1400} Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [22].
\textsuperscript{1401} Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [34].
\textsuperscript{1402} Transcript of V Philip, C9898:12-18 (Day C095).
\textsuperscript{1403} Transcript of V Philip, C9899:2-28 (Day C095).
\textsuperscript{1404} Transcript of V Philip, C9899:30-35 (Day C095).
\textsuperscript{1405} Transcript of V Philip, C9890:27-44 (Day C095); Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [72].
\textsuperscript{1406} Transcript of V Philip, C9892:39-44 (Day C095).
\textsuperscript{1407} Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [118]-[119].
e. Visitors from the Commission for Children and Young People via an independent visitors program; and

f. Ombudsman.  

927. Dr Philip gave evidence that where it is identified that a child has experienced sexual abuse either before or while in custody, provision is made for the child to receive support and counselling. A number of specialised programs can be provided to residents depending on their needs. 

928. In addition, where an incident, such as child sexual abuse, occurs at a youth justice facility, the current policies require staff members to prepare incident reports. These incidents are classified by staff members into one of the following categories:

a. Category 1 incidents: client to client and staff to client sexual assault, 

b. Category 2 incidents: events that threaten the health, safety and wellbeing of young people or staff,

(c. Category 3 incidents (now known as Significant Event Case Notes): minor non-critical client events.

929. Dr Philip stated that Category 1 and Category 2 incidents are reportable incidents. Category 1 incidents, which include sexual assault, must be sent to the Department as soon as possible and within one working day of the incident. That alerts the Department about the incident, which leads to an assessment, investigation and, depending on the incident, a report to the police. 

**Child to child abuse**

930. Dr Philip said that the incident reporting data gathered by the Department demonstrates that in the past five years, the majority of sexual abuse and problem sexual behaviours reported within youth justice custodial settings is child to child. 

931. Dr Philip told the Royal Commission that sexual activity between residents is prohibited, and that sexualised behaviour is the biggest challenge staff face in keeping children safe. He said that there is now greater awareness of the need to
932. Dr Philip stated that there are a number of systems in place to address and minimise sexualised behaviour by residents in youth justice centres, including the use of single bedroom accommodation. The ‘Youth Justice Custodial Services Practice Manual’ (YJC Manual) supports and encourages staff to intervene in lower-level behaviours before they become more serious by providing practical strategies for working with young people who engage in inappropriate sexual behaviours in custody.

933. Dr Philip said that the YJC Manual also outlines a ‘flagging system’ which assists staff to recognise and appropriately respond to sexualised behaviour by residents. He said that all staff are trained to observe and act on issues of concern, and that this may lead to the creation of individualised behaviour management plans.

934. Dr Philip gave evidence about programs for young people who have been convicted of sexual offending, or have sexually abusive behaviours, including:

a. The ‘Male Adolescent Program for Positive Sexuality’ (MAPPS), an intensive group treatment for adolescent males within the juvenile justice system;

b. Therapeutic Treatment Orders, which direct the young persons in the community to attend an appropriate treatment program.

**Reporting to the police**

935. Dr Philip gave evidence that all allegations of sexual abuse or assault must be reported to the police within 24 hours, and that this is set out in the relevant Departmental policy and the YJC Manual. He described the process of when and how staff are to report allegations and incidents of a criminal nature to the police, as set out in the relevant policy, as follows:

a. First, ensure a safe environment for clients and staff;

b. Secondly, ensure a safe environment for clients and staff;

c. Thirdly, call for immediate medical assistance if needed, listen carefully and reassure the client, preserve forensic evidence;

d. Fourthly, call police. If an immediate response is required call 000.
936. He stated that the young person is informed that police will be notified regardless of whether the alleged victim has consented to the matter being reported.\textsuperscript{1426}

**Searches**

937. Dr Philip gave evidence that young persons are routinely searched when they are admitted to custody, after being on temporary leave, and before they are placed in isolation. He said that officers have the power to conduct a search when they hold a reasonable belief that this is necessary for the safety and security of the centre.\textsuperscript{1427}

938. Dr Philip told the Royal Commission that intrusive searches of body cavities are not permitted in any youth justice facility today. He gave evidence of a number of safeguards contained in the YJC Manual that are in place to ensure that young people are searched in a manner that minimises the risk of trauma, embarrassment or indignity. He stated that the safeguards include

- a. two staff members must be present during a search;
- b. the staff member physically conducting the search must be of the same gender as the young person;
- c. during an unclothed search, the second staff member must position themselves in such a way that they can observe the staff member undertaking the search, but cannot see the young person being searched;
- d. all searches must be undertaken with appropriate speed and efficiency and with regard to the dignity and self-respect of the young person; and
- e. all searches must be recorded in the search register, which includes the date, time, place and names of the staff members undertaking the search and the legal basis under which the search occurred.\textsuperscript{1428}

**Consent**

939. Dr Philip stated that unless there is a life-threatening situation, medical tests or treatment of any kind do not proceed without the consent of the young person, if they are determined by the medical practitioner to be capable of giving consent.\textsuperscript{1429} Medical practitioners provide the young person with the information to make an informed consent, and discuss any potential side effects and possible consequences if treatment is not provided.\textsuperscript{1430}

\textsuperscript{1426} Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [104].
\textsuperscript{1427} Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [55].
\textsuperscript{1428} Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [58].
\textsuperscript{1429} Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [173]-[174].
\textsuperscript{1430} Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [175].
940. Dr Philip stated that testing for sexually transmitted infections only occurs with the informed consent of the young person concerned, and usually involves a urine test. If a vaginal swab is required, this is done by the young person in private.\textsuperscript{1431}

Leave and visits

941. Dr Philip gave evidence that the Department conducts a formal and systematic risk assessment before a young person is released for day or weekend leave.\textsuperscript{1432} He said that the Department liaises with community and child protection workers to understand the home situation, and this informs the risk assessment.\textsuperscript{1433} The Director of Secure Services is involved in signing off on first time leave.\textsuperscript{1434}

942. Dr Philip told the Royal Commission that a child subject to a child protection order or custodial order is not to be exposed to a family member known to have sexually abused the child, without care and close management and supervision.\textsuperscript{1435}

943. Dr Philip gave evidence that personal visitors are only allowed to visit residents in youth justice facilities if they are on an approved visitor list.\textsuperscript{1436} Visits may be supervised, and ‘an assessment of the risk level [is] undertaken to determine the appropriate staffing level to ensure appropriate supervision of the visit’.\textsuperscript{1437}

Absconding

944. Dr Philip gave evidence that as a result of hearing the evidence of former residents in this public hearing, the Department has amended the YJC Manual to formalise existing practice relating to absconding. The YJC Manual now requires that the most senior staff member on site at the time of admission must meet with the young person to discuss the reasons that they absconded, that this conversation must be recorded, and that the young person should be offered support from the health service.\textsuperscript{1438}

Recruitment, training and supervision of staff

945. Dr Philip told the Royal Commission that the YJC Manual outlines the competencies, technical skills and knowledge essential for working in youth justice,\textsuperscript{1439} and that the recruitment process includes psychometric testing.\textsuperscript{1440} He said that the process for recruitment focuses on the Department’s organisational values,\textsuperscript{1441} and is based on processes which are ‘up-front’ and ‘public’, unlike the ‘ad hoc’ processes employed in the past.\textsuperscript{1442}

\textsuperscript{1431} Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [182].
\textsuperscript{1432} Transcript of V Philip, C9909:14-33 (Day C095).
\textsuperscript{1433} Transcript of V Philip, C9909:14-33 (Day C095).
\textsuperscript{1434} Transcript of V Philip, C9909:14-33 (Day C095).
\textsuperscript{1435} Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [37].
\textsuperscript{1436} Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [38].
\textsuperscript{1437} Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [40].
\textsuperscript{1438} Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [91].
\textsuperscript{1439} Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [64].
\textsuperscript{1440} Transcript of V Philip, C9900:28-47 (Day C095).
\textsuperscript{1441} Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [59].
\textsuperscript{1442} Transcript of V Philip, C9901:9-36 (Day C095).
946. Dr Philip told the Royal Commission that prospective staff must undergo a variety of screening processes before being recruited to work in youth justice centres, including:

a. A Working with Children Check (WWCC);

b. A National Criminal History Check; and

c. International police checks (if the applicant has lived overseas for more than 12 months in the last 10 years).1443

947. He stated that there are systems and procedures in place to ensure that all staff members have a current WWCC.1444

948. He gave evidence that staff attend a four week induction program where they learn about boundaries, sexualised behaviour, how to better understand children and de-escalation.1445 Dr Philip said that staff are also encouraged to undertake training and obtain qualifications in secure services.1446

949. Dr Philip stated that all custodial staff members are formally and informally supervised to ensure adherence to legislation and compliance with Departmental policies and procedures.1447

Social workers

950. Dr Philip accepted that attracting and retaining good social workers is an ongoing problem for the Department and acknowledged that from the social worker’s point of view, the work is ‘difficult’.1448 He accepted that it is fundamental to the health and well-being of children to provide them with social workers that are consistent,1449 and he recognised the need for other systems to be in place to make sure that a child does not get stuck with a ‘bad’ social worker.1450

951. Dr Philip said that efforts have been made to retain good staff through mentoring, building connections and developing greater corporate knowledge.1451 He said that the Department recognises that they need the ‘best, most sensitive practitioners dealing with the most vulnerable’.1452

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1443 Exhibit 30-0046, Amended first statement of V Philip, STAT.0626.003.0001 at [59]-[62].
1444 Exhibit 30-0046, Amended first Statement of V Philip, STAT.0626.003.0001 at [60]-[61].
1445 Transcript of V Philip, C9907:35-C9908:20 (Day C095).
1446 Transcript of V Philip, C9907:35-C9908:20 (Day C095).
1447 Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [62]-[63].
1448 Transcript of V Philip, C9922:34-45 (Day C095).
1449 Transcript of V Philip, C9922:47-C9923:3 (Day C095).
1450 Transcript of V Philip, C9923:5-19 (Day C095).
1451 Transcript of V Philip, C9923:25-32 (Day C095).
1452 Transcript of V Philip, C9923:34-C9924:26 (Day C095).
**Culture of care**

952. Dr Philip said that the Department’s understanding of care has changed.\(^{1453}\) He said that historically institutions, such as Turana, were focused on containment.\(^{1454}\) The whole system has been evolving from a containment model to a therapeutic model,\(^{1455}\) with a trauma informed approach.\(^{1456}\)

953. As part of this understanding of care, Dr Philip said that significant efforts have also been made to extend care to support and facilitate the reintegration of young people into the community. He said that upon release, young people are supported through statutory supervision and case management and by a range of support services.\(^{1457}\)

954. Dr Philip said that a priority for him in his term as Secretary is to emphasise prevention and building ‘a much more seamless system around health, human services and education’.\(^{1458}\)

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\(^{1453}\) Transcript of V Philip, C9905:41-C9907:4 (Day C095).
\(^{1454}\) Transcript of V Philip, C9905:41-C9907:4 (Day C095).
\(^{1455}\) Transcript of V Phillip C9905:3-39 (Day C095).
\(^{1456}\) Transcript of V Philip, C9905:3-39 (Day C095).
\(^{1457}\) Exhibit 30-0046, Third statement of V Philip, STAT.0626.005.0001 at [18].
\(^{1458}\) Transcript of V Philip, C9934:7-24 (Day C095).
Part 7  Records

7.1 Importance of records to former residents

955. The Royal Commission heard evidence about the significance of former residents having access to records of their time in the care of the Department. For example, BDA stated that he requested his ward file because he ‘wanted to know more about [himself] and [his] past for [his] own personal development’.\(^{1459}\) BDB told the Royal Commission that ‘[her] childhood’s part of [her] identity’.\(^{1460}\)

956. Stephen Hodgkinson, the Chief Information Officer of the Department, gave evidence about the storage of and access to files held by the Department in relation to children who have been in the care of the State.

957. Mr Hodgkinson acknowledged the importance of former residents of state run youth training and reception centres having access to their records to:

a. try to understand their life as a child;\(^{1461}\)

b. understand any cultural affiliations they may have;\(^{1462}\)

c. get in contact with family members;\(^{1463}\)

d. understand any genetic health issues;\(^{1464}\) and

e. seek redress or compensation for sexual or physical abuse experienced as a child.\(^{1465}\)

958. Dr Philip also accepted that for former residents, accessing ward files and being provided with information relating to their families and health is extremely important.\(^{1466}\) He accepted that missing files meant missing memories.\(^{1467}\)

7.2 Overview

959. Mr Hodgkinson told the Royal Commission that requests for ward files reach the Department in a number of ways:

\(^{1459}\) Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [99].

\(^{1460}\) Transcript of BDB, C8924:30-35 (Day C087).

\(^{1461}\) Transcript of S Hodgkinson, C9769:7-14 (Day C094).

\(^{1462}\) Transcript of S Hodgkinson, C9769:40-46 (Day C094).

\(^{1463}\) Transcript of S Hodgkinson, C9769:34-38 (Day C094).

\(^{1464}\) Transcript of S Hodgkinson, C9769:40-46 (Day C094).

\(^{1465}\) Transcript of S Hodgkinson, C9770:1-5 (Day C094).

\(^{1466}\) Transcript of V Philip, C9930:12-19 (Day C095).

\(^{1467}\) Transcript of V Philip, C9931:23-28 (Day C095).
a. via an agent such as Open Place, Care Leavers Australia Network (CLAN) or the Mackillop Heritage Centre;¹⁴⁶⁸

b. via Family Information Networks and Discovery (FIND), which was established by the Department in 2004 to provide access and support for people seeking information about wardship prior to 1989;¹⁴⁶⁹ or

c. via the Freedom of Information (FOI) Unit, which deal with requests of all characters, including requests for personal information from after 1990.¹⁴⁷⁰

960. Mr Hodgkinson said that around 70% of enquiries are received by the Department via agents.¹⁴⁷¹

961. Mr Hodgkinson told the Royal Commission that over the last three years there have been significant and intensive reforms in this area, following publication of the Ward Records Plan in December 2012.¹⁴⁷²

### 7.3 Issues raised by the evidence of former residents

962. Mr Hodgkinson accepted that the process of obtaining ward files can be time-consuming and complex.¹⁴⁷³ Dr Philip accepted that former wards are often vulnerable, and will find the process of discovering their files extremely difficult.¹⁴⁷⁴

963. A number of former residents who gave evidence at the public hearing spoke of the problems and issues they had experienced concerning access to their ward files. These problems included:

a. being unaware that ward files could be accessed;

b. delays in receiving files after making a request;

c. receiving heavily redacted documents;

d. receiving incomplete files;

e. files being destroyed;

f. receiving little or no support when files are received; and

g. privacy concerns.

964. Both Mr Hodgkinson and Dr Philip gave evidence at the public hearing addressing some or all of these issues.

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¹⁴⁶⁸ Transcript of S Hodgkinson, C9777:4-15 (Day C094).
¹⁴⁶⁹ Transcript of S Hodgkinson, C9776:25-C9777:32 (Day C094).
¹⁴⁷⁰ Transcript of S Hodgkinson, C9776:25-C9777:32 (Day C094).
¹⁴⁷¹ Transcript of S Hodgkinson, C9773:21-34 (Day C094).
¹⁴⁷² Exhibit 30-0039, Statement of S Hodgkinson, STAT.0622.001.0001at [28].
¹⁴⁷³ Transcript of S Hodgkinson, C9773:16-19 (Day C094).
¹⁴⁷⁴ Transcript of V Philip, C9961:5-8 (Day C095).
Awareness

965. The Royal Commission heard from three former residents who said that they were previously unaware that they could access their ward files. Mr Latham said:

> I didn’t know you could [apply for ward files] until Leonie from CLAN said to me “We can get your records for you” and she went ahead and done it on my behalf, and that was the first I knew about them. I hadn’t been able to get it.\(^{1475}\)

966. BDA told the Royal Commission that it was not until he lodged an FOI request for another unrelated legal matter that he became aware that he could make a request to retrieve his ward file.\(^{1476}\) Similarly, BDD said he was unaware that he could access his ward files until just before he made a statement for this public hearing.\(^{1477}\)

967. Mr Hodgkinson accepted that it is particularly challenging to ensure that wards who were subject to sexual or other abuse, and may have gone on to experience substance abuse or mental health issues as a result of this trauma, are aware that they can access their ward files.\(^{1478}\)

968. Mr Hodgkinson said that the Department works closely with government agencies and community organisations that come into contact with people seeking to understand their history as a ward of the state or a juvenile offender, including CLAN, Open Place and Find and Connect.\(^{1479}\) He said that to his knowledge, the Department has not engaged with Victoria Police,\(^{1480}\) and that the Department is trying to do more to liaise with relevant agencies.\(^{1481}\)

969. Mr Hodgkinson told the Royal Commission that the Department promotes its services through their website, fact sheets and other publications.\(^{1482}\) He said that the Department ‘could do more to publicise these things’,\(^{1483}\) and is currently working on ‘finding guides’ that explain what record collections exist and how they can be accessed.\(^{1484}\)

Delays

970. Three former residents gave evidence that they experienced extensive delays before they received their files in their entirety.

971. Ms Hodkinson told the Royal Commission that she received a copy of her ward file within four or five weeks of making a request, but later discovered that an

\(^{1475}\) Transcript of N Latham, C8878:41-46 (Day C086).
\(^{1476}\) Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [98].
\(^{1477}\) Exhibit 30-0042, Statement of BDD, STAT.0620.001.0001_M_R at [81].
\(^{1478}\) Transcript of S Hodgkinson, C9772:12-20 (Day C094).
\(^{1479}\) Transcript of S Hodgkinson, C9771:28-35 (Day C094).
\(^{1480}\) Transcript of S Hodgkinson, C9772:22-27 (Day C094).
\(^{1481}\) Transcript of S Hodgkinson, C9771:43-47 (Day C094).
\(^{1482}\) Transcript of S Hodgkinson, C9771:37-41 (Day C094).
\(^{1483}\) Transcript of S Hodgkinson, C9771:43-47 (Day C094).
\(^{1484}\) Transcript of S Hodgkinson, C9772:29-45 (Day C094).
institutional-specific file in relation to her time at Winlaton should have also been provided.1485 She said:

...In February 2015, I requested a copy of my Winlaton file from the DHS. I only received a copy of my Winlaton file last week, about six months after requesting it. I had to keep chasing them up.1486

972. Katherine X said that her solicitor had to chase up the Adoption and Family Records Services for documents that were not provided to her initially.1487

973. BDA said that when he made a request with the assistance of his counsellor in early 2015, he was told that the documents were meant to come in three lots.1488 He said that he received some documents within six weeks of making the request, but is still waiting for a second bundle of documents.1489 He said that he was told that it may take a while to produce the second bundle because his assigned Department worker is on holidays.1490 At the time of his evidence before the Royal Commission, BDA said he has not heard from the Department for about two months and had not received any more documents.1491

974. Mr Hodgkinson said that on average, requests for ward files are dealt with within 32 days of application.1492 He said that sometimes the need to contact third parties to request permission to disclose information can cause delays.1493 He said that the various teams are well resourced and well trained, and that he was disappointed to hear that some former residents experienced extensive delays.1494

975. Mr Hodgkinson recognised that some survivors received their file in a piecemeal fashion. He said that there are around 80 kilometres of records in the archival collection, 30 kilometres of which relate directly to former wards of the State.1495 These records were created over time, and employ different filing and indexing systems. As a result, Mr Hodgkinson said that it’s still the case that files get lost in the collection sometimes, which means that it can take a long time to locate individual files.1496

976. Mr Hodgkinson said that part of the Ward Record Plan is to digitise the index and register to make it easier to locate other files. He said that this process will be complete for all categories of care leave records by September 2016.1497

1485 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [61].
1486 Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R at [61].
1487 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [134].
1488 Transcript of BDA, C9724:32-42 (Day C093).
1489 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [102] and [107].
1490 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [107].
1491 Transcript of BDA, C9725:5-11 (Day C093).
1492 Transcript of S Hodgkinson, C9773:36-C9774:5 (Day C094).
1493 Transcript of S Hodgkinson, C9773:36-47; C9774:1; C9813:30-C9814:1 (Day C094).
1494 Transcript of S Hodgkinson, C9773:36-47 (Day C094).
1495 Transcript of S Hodgkinson, C9774:26-37 (Day C094).
1496 Transcript of S Hodgkinson, C9774:39-46 (Day C094).
1497 Transcript of S Hodgkinson, C9775:1-8 (Day C094).
Available finding on records - delays

F59 Some former residents of State run youth training and reception centres continue to experience significant delays before receiving their ward files from the Department.

Redactions

977. The Royal Commission heard evidence from nine former residents that when they received their ward files, some documents were redacted.1498

978. Many of these witnesses said that they were told that their ward files had been redacted because they contained the personal information of other persons.1499 Ms Hodkinson and Ms Short told the Royal Commission that they were not given any explanation for why their ward file had been redacted.1500

979. BDA told the Royal Commission that he was told over the phone by an employee of the Department that documents had been redacted to protect other people’s personal information. He recalled being told words to the effect of ‘some things you can have. Other things you can’t have’.1501 BDA told the Royal Commission:

I was concerned because sometimes I couldn’t tell if a document was about me or someone else. In some instances, I couldn’t even tell what the document was about because of the amount of information that was blacked out.1502

980. Mr Cummings told the Royal Commission that when he first reviewed his file ‘[his] own memories quickly filled the blanks’ and it was ‘devastating’.1503

981. Mr Marijancevic and BDC told the Royal Commission that the redactions on the documents they received were inconsistent, that is, information that was disclosed in some documents were redacted in others.1504

1498 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [139]; Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001 at [105]; Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [132]; Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [93]; Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [64]; Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R_M at [60]; Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [86]; Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [86]; Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [104]-[105]; Exhibit 30-0044, Statement of BHU, STAT.0653.001.0001_M_R at [61].

1499 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [139]; Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001 at [105]; Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [132]; Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [93]; Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [64]; Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R_M at [60]; Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [86]; Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [86]; Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [104]-[105]; Exhibit 30-0044, Statement of BHU, STAT.0653.001.0001_M_R at [61].

1500 J: Exhibit 30-0016, Statement of K Hodkinson, STAT.0614.001.0001_R_M at [60]; Exhibit 30-0023, Statement of G Short, STAT.0647.001.0001_M_R at [86].

1501 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [104].

1502 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [105].

1503 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [133].

1504 Exhibit 30-0002, Statement of J Marijancevic, STAT.0610.001.0001_R_M at [105]-[106]; Exhibit 30-0014, Statement of BDC, STAT.0607.001.0001_M_R at [93].
982. Mr Hodgkinson said that the general approach taken by the Department is to release as much information as possible while respecting legislative requirements and obligations not to disclose certain information. He said that personal information of persons other than the applicant, and information provided in confidence (for example during court proceedings) may need to be redacted to fulfil privacy and confidentiality requirements.

983. Mr Hodgkinson said that Departmental staff responsible for applying redactions must make a series of complex judgements to balance the legislative requirements, the need to be fair to the applicant, and the general character of the file and the relationships that it describes. He said that the FOI and FIND staff responsible for making these complicated assessments and decisions have sizeable workloads.

984. Mr Hodgkinson said that achieving consistency is a key goal of the FOI and FIND teams, and that a lot of effort is put into setting guidelines, training staff and reviewing decisions. He said that in the FOI team, all work is reviewed by a team leader before it goes out, and that on a periodic basis teams will get together to discuss cases and complex decisions.

985. Mr Hodgkinson said that redaction decisions should be discussed with former residents in the process of releasing information so that they understand why redactions have been made. He said that if there is a need for whole pages to be redacted to protect information, this should be sensitively explained.

986. He accepted that it would be best practice to provide, in writing, specific rather than generic reasons for redaction decisions, but at present ‘form letters and statements’ are used to provide a ‘reasonably standard response’. He said that:

> It’s fair to say that we can always do more to provide context and explanation in those cases, and that’s something that the teams try and do, but within the constraints of time and resourcing.

987. Mr Hodgkinson recognised that from a former resident’s perspective, redaction decisions can seem unjustified or unfair, and that sometimes errors are made. He said that it is possible for two people to make different decisions based on the same information, particularly if those decisions are made years apart.

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1505 Transcript of S Hodgkinson, C9779:5-16 (Day C094).
1506 Transcript of S Hodgkinson, C9812:13-37; C9779:23-37 (Day C094).
1507 Transcript of S Hodgkinson, C9779:44-C9780:2 (Day C094).
1508 Transcript of S Hodgkinson, C9780:4-14 (Day C094).
1509 Transcript of S Hodgkinson, C9812:39-C9813:7; C9781:11-27; C9786:3-10 (Day C094).
1510 Transcript of S Hodgkinson, C9781:11-27; C9786:3-10 (Day C094).
1511 Transcript of S Hodgkinson, C9786:12-17 (Day C094).
1512 Transcript of S Hodgkinson, C9781:29-35 (Day C094).
1513 Transcript of S Hodgkinson, C9784:16-35 (Day C094).
1514 Transcript of S Hodgkinson, C9803:12-28 (Day C094).
1515 Transcript of S Hodgkinson, C9803:30-33 (Day C094).
1516 Transcript of S Hodgkinson, C9780:16-18 (Day C094).
1517 Transcript of S Hodgkinson, C9785:36-C9786:1 (Day C094).
988. Katherine X told the Royal Commission that she made an FOI for her ward file in 2009. She said that she was informed that some material, including her father’s given names, was ‘exempt from release’. 1518 She said she could not understand why his name was redacted when she was the victim and he was the perpetrator. 1519 Katherine X gave evidence that the redactions in the documents she received were inconsistent to those in her brother’s ward file, which he received in around 2010 or 2011. 1520

989. Mr Hodgkinson said that he was disappointed to hear this evidence. 1521 He told the Royal Commission that historically, the policy of the Department was not to release the name of an alleged perpetrator if this was not information known to the care leaver at the time, 1522 but this policy has now changed. 1523 He said that where it is obvious that somebody knew their perpetrator, or there has been a conviction, the name of the perpetrator is not now redacted. 1524

990. Mr Hodgkinson said that there is a process for former residents to apply for a review of redaction decisions. He said that this is currently via the Freedom of Information Commissioner, but will soon change to the Office of the Public Access Commissioner. 1525 He said that there have only been three reviews requested in the past 18 months, and that this could suggest that former residents are not aware of their rights to complain. 1526 He said that a fact sheet is provided to former residents which sets out the process if they wish to make a complaint, 1527 and that applicants should be told that there is a process of review available. 1528 A document entitled ‘Freedom of Information, Review of Decisions, Fact Sheet’ states that ‘refusal to grant access to documents or parts of documents’ is a decision that can be reviewed. 1529

Available finding on records - redactions

F60 The Department provides a standard written explanation for why documents in former residents’ ward files are redacted. It is not a matter of general practice to provide specific reasons for the redactions made, either orally or in writing.

Need to make multiple requests to obtain ward file

991. A number of former residents told the Royal Commission that there was information missing from the ward files the received.

1518 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.001_R_M at [128]-[130].
1519 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.001_R_M at [130].
1520 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.001_R_M at [133].
1521 Transcript of S Hodgkinson, C9778:25-32 (Day C094).
1523 Transcript of S Hodgkinson, C9782:31-39 (Day C094).
1524 Transcript of S Hodgkinson, C9782:41-45 (Day C094).
1525 Transcript of S Hodgkinson, C9781:37-40 (Day C094).
1526 Transcript of S Hodgkinson, C9781:42-C9782:4 (Day C094).
1527 Transcript of S Hodgkinson, C9782:11 (Day C094).
1528 Transcript of S Hodgkinson, C9784:31-35 (Day C094).
1529 Transcript of S Hodgkinson, C9815:38-C9816:17 (Day C094); Exhibit 30-0011, DHS.3148.001.0040 at 0040.
992. Ms Short told the Royal Commission that when she first requested her ward file in 1984, she received very little information about her time in church run institutions. She said that when she made a second request in 1998 or 1999, she received more documents than under the first request.\textsuperscript{1530}

993. BDB, BHU and Ms Hodkinson also gave evidence that the documents they received seem to be incomplete.\textsuperscript{1531} Katherine X stated that many of the documents that she was shown while preparing a statement for this public hearing were not in the documents she received from the Department in April 2009.\textsuperscript{1532} Katherine X also said that there were documents that appeared in her brother’s file that were missing from the documents she received, and vice versa.\textsuperscript{1533}

994. When questioned about a specific document missing from Katherine X’s ward files, Mr Hodgkinson said:

It’s possible, for example, that [this document] was filed in an administrative collection and therefore [was] not easily discoverable and then it was subsequently found.\textsuperscript{1534}

995. Mr Hodgkinson gave evidence about the complexity of the filing systems employed by the Department,\textsuperscript{1535} and said that misfiling over the years compounds this complexity.\textsuperscript{1536} He said that responding to a request for documents requires Departmental staff ‘to search through a large number of different collections in many areas of the archival collection’.\textsuperscript{1537}

996. Mr Hodgkinson said that there are many records stored outside of the State Government archives. He said that since the consolidation of the Department of Health and Human Services, it is easier to locate medical records, but that he has limited knowledge about where exactly medical records relating to former residents are currently held.\textsuperscript{1538}

997. Mr Hodgkinson told the Royal Commission that the Department works closely with private institutions that hold records relating to former residents.\textsuperscript{1539} He said that the Department tries to make sure that staff members know what record collections exist outside the Department, and how former residents can be assisted to access those records. He gave evidence that former residents may have to make multiple requests

\textsuperscript{1530} Exhibit 30-0032, Statement of G Short, STAT.0647.001.0001_M_R at [84]-[85], [88]-[89].
\textsuperscript{1531} Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [92]; Transcript of K Hodgkinson, C9131:14-31 (Day C089); Exhibit 30-0044, Statement of BHU, STAT.0653.001.0001_M_R at [60]-[63].
\textsuperscript{1532} Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [134].
\textsuperscript{1533} Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R_M at [133].
\textsuperscript{1534} Transcript of S Hodgkinson, C9790:30-33 (Day C094).
\textsuperscript{1535} Transcript of S Hodgkinson, C9790:15-28 (Day C094).
\textsuperscript{1536} Transcript of S Hodgkinson, C9790:35-46 (Day C094).
\textsuperscript{1537} Transcript of S Hodgkinson, C9790:35-46 (Day C094).
\textsuperscript{1538} Transcript of S Hodgkinson, C9797:9-26; C9818:36-C9819:5 (Day C094).
\textsuperscript{1539} Transcript of S Hodgkinson, C9796:23-28 (Day C094).
for files across different organisations, but that where they can, Department staff will try and assist people to locate records that are not held by the Department.\(^{1540}\)

998. Mr Hodgkinson told the Royal Commission that it is now a relatively rare event for no records to be located in response to a request, and that when this does occur, a note is made so that if records are subsequently found, the former resident can be notified.\(^{1541}\) He said that in the event that additional records are found after documents have already been provided, the former resident is not advised and must make a further request to access the documents.\(^{1542}\) He accepted that this is something that care leavers should be advised about.\(^{1543}\)

999. Dr Philip told the Royal Commission that:

The reality is that we are discovering that files are in cases completely unrelated to what the box is titled... This is highly unfortunate, I wish I could say something different; I can’t, and we are working as quickly and as hard as we can to try to bring some order to this system so that when people ask for their files, that they get all of the material’.\(^{1544}\)

1000. Mr Hodgkinson acknowledged that it was regrettable that in some circumstances former residents may not have all their relevant documents when they consider commencing civil proceedings against the State of Victoria, and that the Department understands the sensitivity of these issues.\(^{1545}\) Dr Philip accepted that this was ‘problematic’, and that the government is currently working with the Royal Commission regarding redress.\(^{1546}\)

### Available finding on records – need to make multiple requests to obtain ward file

F61 Former residents of State run youth training and reception centres must submit multiple requests to obtain access to the entirety of their ward files if:

a) the Department cannot initially locate all relevant documents; or

b) any of their documents are held by a non-State run institution.

### Files destroyed

1001. The Royal Commission heard from BDB, Katherine X, Mr Latham and BDF regarding the destruction of their ward files.

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\(^{1540}\) Transcript of S Hodgkinson, C9796:30-C9797:13 (Day C094).

\(^{1541}\) Transcript of S Hodgkinson, C9795:43-C9796:3 (Day C094).

\(^{1542}\) Transcript of S Hodgkinson, C9797:28-C9798:4 (Day C094).

\(^{1543}\) Transcript of S Hodgkinson, C9798:6-12 (Day C094).

\(^{1544}\) Transcript of V Philip, C9929:47-C9930:10 (Day C095).

\(^{1545}\) Transcript of S Hodgkinson, C9791:7-43 (Day C094).

\(^{1546}\) Transcript of V Philip, C9928:47-C9929:10 (Day C095).
1002. BDB told the Royal Commission that she was informed by the Department that her Turana file could not be located, and was likely destroyed. The Department notified BDB in a letter dated 1 October 2001 that states:

For clients of Turana with a year of birth prior to 1967, a decision was made by the institution to destroy all client files when the ward attained 21 years. None of these client files survived and consequently were never transferred to this Department for archiving.

1003. BDF stated that she received her ward files in around November 2014, but was told by FOI Victoria that her file was ‘officially and legally destroyed in 2003 under authority from the public records office’.

1004. Katherine X told the Royal Commission that when she received her ward files in April 2009, she was informed that ‘a second file from Winlaton’ was destroyed in 2002. This file included documents such as her admission forms and classification reports, which were believed to be duplicated in other files. Katherine X said she was never given an explanation for why the file was destroyed.

1005. Mr Latham gave evidence that at the time of making his police statement in 2009, he had no access to any documents from his ward file. It was his belief that once a ward turned 18, their records were destroyed.

1006. Mr Cadd gave evidence that he while he was employed at Turana, he recalled records being destroyed because there was no storage space. He said that he remembered on one occasion seeing a staff member tearing up files because they related to boys who had turned 21 years old.

1007. Mr Hodgkinson gave evidence that prior to the introduction of the Public Records Act in 1973, there was no legislation governing the destruction of records, and individual institutions made their own decisions with regard to record disposal. He said that since 1982, ‘Record Disposal Authorities’ (RDAs) established by the Keeper of Public Records in the Public Records Office of Victoria have set out the rules which govern destruction of some categories of records relevant to wards. He said that:

There were records that were destroyed relating to Turana in 2001 and 2004 and relating to Winlaton in 1993. Under the relevant RDA at the time, records such as...

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1547 Exhibit 30-0036, Statement of BDB, STAT.0617.002.0001_M_R at [90].
1548 Exhibit 30-0036, Annexure BDA-5, DHS.9999.013.0003_R at 0004_R.
1549 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [84].
1550 Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [86].
1551 Exhibit 30-0017, Annexure KX-31, DHS.3146.001.0254_R at 0257_R.
1552 Exhibit 30-0017, Statement of Katherine X, STAT.0615.001.0001_R at [131].
1553 Transcript of N Latham, C8877:40-C8878:6 (Day C086).
1554 Exhibit 30-0012, Statement of A Cadd, STAT.0637.001.0001_R at [63]; Transcript of A Cadd, C9044:14-37 (Day C088).
1555 Transcript of S Hodgkinson, C9786:36-C9787:6; C9806:12-17 (Day C094).
1556 Transcript of S Hodgkinson, C9786:36-C9787:6; see also C9815:26-28 (Day C094).
Trainee Information Files could be deleted legally 30 years after the date of birth of the client, and some files were destroyed on that basis.\textsuperscript{1557}

1008. Mr Hodgkinsson said that:

\[\text{[I]n some cases there were mistakes made with regard to the destruction of records because it was believed at the time that they were duplicate records, but it turned out subsequently that they were not.}\textsuperscript{1558}

1009. Mr Hodgkinsson also said that historically ward files were destroyed by institutions in compliance with the relevant record disposal authorities, and that this reflected perceptions at the time about the role of records.\textsuperscript{1559}

1010. Mr Hodgkinsson said that as a result of the Department’s increased understanding of the significance of ward files to the health and well-being of former residents, a total destruction hold was put on all records relating to care leavers in October 2012.\textsuperscript{1560} He accepted that this was too late for thousands of former wards whose files have already been destroyed.\textsuperscript{1561}

**Lack of support**

1011. The Royal Commission heard from several former residents that they received little or no support when they received their ward files from the Department.

1012. BHE said that the Department did not offer her any counselling or support when she received her files, but she has been assisted by Open Place. She said that she started having terrible flashbacks and drinking heavily not long after receiving her ward files.\textsuperscript{1562}

1013. BDF gave evidence that after requesting her ward file, FOI Victoria, Find and Connect and Relationships Australia all contacted her to say that they were concerned about sending her the ward files as there were things in there she might find upsetting.\textsuperscript{1563} BDF said that when she began reading her ward files in January 2015, she became very upset and suicidal. She told the Royal Commission that while she had received some assistance from Relationships Australia, no-one has sat down with her and gone through the documents she received, and she is afraid to do so.\textsuperscript{1564}

1014. BDB said that she found the process of accessing her files very ‘mechanical’, and that she doesn’t recall ever speaking to a Department employee through the whole process.\textsuperscript{1565} She stated:

\textsuperscript{1557} Transcript of S Hodgkinsson, C9787:8-13; see also C9806:1-10 (Day C094).
\textsuperscript{1558} Transcript of S Hodgkinsson, C9806:37-C9807:13 (Day C094).
\textsuperscript{1559} Transcript of S Hodgkinsson, C9787:19-29 (Day C094).
\textsuperscript{1560} Transcript of S Hodgkinsson, C9787:31-C9788:17 (Day C094).
\textsuperscript{1561} Transcript of S Hodgkinsson, C9788:30-44 (Day C094).
\textsuperscript{1562} Exhibit 30-0015, Statement of BHE, STAT.0613.001.0001_M_R at [65]-[66].
\textsuperscript{1563} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [83].
\textsuperscript{1564} Exhibit 30-0022, Statement of BDF, STAT.0616.001.0001_M_R at [84].
\textsuperscript{1565} Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [87].
To this day, I still can't read my file in any great detail because it is too distressing. I wasn't offered any services or support from the Department when they gave me my files. 1566

1015. Finally, BDA told the Royal Commission that when he received documents from the Department, a Department worker told him that ‘it might be best to look at the documents with a counsellor because there was some pretty heavy stuff in there’. BDA said that he wasn’t offered any services or support from the Department. 1567

1016. Mr Hodgkinson accepted that it was not sufficient to just advise someone like BDA that it might be best to look at the documents with a counsellor. 1568

1017. Mr Hodgkinson told the Royal Commission that the standard of service and support offered to clients by the Department depends on how the request was made. He said that the Department has ‘no control’ if the request is made via an agent, and that in these cases the Department relies on the agent to disclose the information appropriately. 1569 He said that that considerable effort is made by the FIND and FOI teams to sensitively deal with requests, and support clients. 1570

1018. Mr Hodgkinson said that there are a team of 11 people that deal with FOI requests of this personal nature. He said that although they are not trained counsellors, this team is educated in the sensitivities around providing access to these kind of files. He said that the FOI team may recommend third party counsellors if required. 1571

1019. Mr Hodgkinson said that members of FIND teams are all trained counsellors, and that many have decades of experience in dealing with these sorts of matters. He said that efforts are made to talk to the applicant, and to keep them informed about the process and any issues, difficulties or delays, including if permission is needed. He said that attention is given to how the records are provided, and, if necessary, to explaining why records have not been provided or are redacted. 1572

**Available finding on records - lack of support**

F62 Some former residents of State run youth training and reception centres receive insufficient support from the Department or its agents during the process of requesting and obtaining their ward files.

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1566 Exhibit 30-0003, Statement of BDB, STAT.0609.001.0001_R at [93].
1567 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [106].
1568 Transcript of S Hodgkinson, C9793:22-C9794:2 (Day C094).
1569 Transcript of S Hodgkinson, C9775:37-C9776:23 (Day C094).
1570 Transcript of S Hodgkinson, C9775:37-C9776:23 (Day C094).
1571 Transcript of S Hodgkinson, C9776:33-C9777:2 (Day C094).
1572 Transcript of S Hodgkinson, C9775:37-C9776:23 (Day C094).
Privacy concerns

1020. Mr Cummings gave evidence that when he applied to become a foster parent, the foster care agency accessed his files without his permission. He said that he was upset when this occurred. He gave evidence that the copy of his ward file that he received contained less detail than the copy he accessed via the foster care agency.

1021. Mr Hodgkinson said that his was ‘highly irregular’, and it is not current policy to release that kind of information under those circumstances.

1022. BDA gave evidence that when he made an FOI request for his ward file with the assistance of his supervisor in early 2015, he was asked for his mother’s phone number so that she could provide her consent for the documents to be released. BDA said that this was frustrating because he didn’t have those details, and felt that the Department could have obtained those details themselves.

1023. Mr Hodgkinson said that it is sometimes necessary to contact a third party about releasing information about the third party’s identity, but he couldn’t understand why BDA’s mother’s permission was required to release his file. He said that to his knowledge this was not standard policy, and was inappropriate because ‘the care leaver as an adult … has every entitlement to access their records under the FOI Act’.

1024. When told that an academic had been provided with access to files of former residents of Winlaton without the consents of those residents being obtained, Dr Philip said that was ‘distressing’ and that the focus should be on giving the ‘maximum amount of information to the people who are actually the subject’. 

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1572 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [132].
1573 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [133].
1574 Exhibit 30-0004, Statement of R Cummings, STAT.0608.001.0001_R_M at [140].
1575 Transcript of S Hodgkinson, C9817:34-44 (Day C094).
1576 Transcript of S Hodgkinson, C9817:34-44 (Day C094).
1577 Exhibit 30-0036, Statement of BDA, STAT.0617.002.0001_M_R at [99]:[101].
1578 Transcript of S Hodgkinson, C9783:6-37 (Day C094).
1579 Transcript of S Hodgkinson, C9783:39-44 (Day C094).
1580 Transcript of V Philip, C9931:8-21 (Day C095).
Part 8  Summary of available findings

Available findings on the experience of former residents of Turana

F1  During the period that Turana was in operation, some residents did not report child sexual abuse to anyone at the time it was occurring because:

a) they feared being punished;

b) they did not know who they could report sexual abuse to; or

c) they did not think they would be believed.

F2  During the period that Turana was in operation, some residents who did report sexual or physical abuse to a staff member were not believed, or were punished for reporting the physical or sexual abuse.

Available finding on the training of staff at Turana

F3  During the period that David Green and Ashley Cadd were employed at Turana (1965-1990), the Department:

a) did not provide adequate training or ensure that staff at Turana were trained in supervising and caring for residents; and

b) did not provide adequate training or ensure that the Superintendent of Turana was trained in the management and oversight of a large institution.

Available finding on the placement of residents at Turana

F4  During the 1960s, 1970s and 1980s the placement of children admitted to Turana as wards of the State in sections with children committed to Turana for criminal offences, and the placement of younger children in sections with older children at Turana, increased the risk of child to child sexual abuse.

Available findings on the supervision of residents at Turana

F5  Supervision of residents at Turana at night was inadequate. Specifically:

a) there were insufficient numbers of night duty officers to supervise residents; and

b) the physical environment made it impossible for staff to monitor each and every resident.

F6  Overcrowding was a serious problem at Turana between 1968 and 1990. Overcrowding hindered the provision of adequate supervision, and meant that residents were placed in sections based on the availability of beds as opposed to their compatibility, suitability and safety.

Available finding on absconding from Turana
Some residents absconded from Turana as a result of child sexual abuse or to avoid further incidents of child sexual abuse. Staff at Turana did not recognise this, and were not trained to deal with residents who had absconded because of child sexual abuse.

Available finding on punishment of residents at Turana

The punishment administered at Turana by some staff members was cruel, humiliating and degrading. The forms of punishment inflicted by some staff members:

- were designed to keep residents occupied and compliant;
- were an informal mechanism of command and control; and
- had the effect of discouraging residents from disclosing sexual abuse because they thought they would not be believed.

These forms of punishment were a feature of the culture of the institution; they were not mandated by formal policies or procedures.

Available findings on the response to reports of child sexual abuse by Robert Cummings

The response of staff to the sexual abuse of Robert Cummings in 1971 was to conclude that he was a homosexual, and to administer aversion therapy at the Royal Park Hospital to “cure” him of his homosexuality. Ultimately this response discouraged Robert Cummings from making further disclosures of sexual abuse, despite such abuse occurring. This response caused Robert Cummings considerable trauma.

In administering aversion therapy to Robert Cummings, Thomas Verberne did not adequately consider:

- the possibility that Robert Cummings could have been the victim of child sexual abuse;
- the vulnerability of Robert Cummings as a ward of the State; and
- how these circumstances could affect whether Robert Cummings’ submission to treatment was truly voluntary.

Available findings on policies and procedures for reporting and responding to child sexual abuse at Turana

During the period that Turana was in operation, there were no formal policies or procedures for:

- receiving or Responding to complaints of child sexual abuse, and
- reporting complaints of child sexual abuse to the Director of the Department and/or the Victoria Police.

During the period that Ashely Cadd was employed at Turana (1968-1990), there was little or no training offered to staff members at Turana in understanding child sexual abuse or
responding to complaints of child sexual abuse. The absence of this training undermined the capacity of staff members at Turana to deal effectively with complaints of sexual abuse.

**Available finding on the reporting of incidents at Turana in practice**

F13 The hierarchical staffing structure in place at Turana from 1968 (when Ashely Cadd commenced employment) to the mid-1980s prevented reports of child sexual abuse from being escalated to senior management, In practice:

a) Chief Youth Officers were relied upon to respond to complaints of child sexual abuse; and

b) reports of child sexual abuse made by residents to youth officers were rarely brought to the attention of executive staff.

**Available finding on reporting to the Department and the Victoria Police by staff at Turana**

F14 During the period that Turana was in operation, the Department provided little or no oversight of the institution. The responsibility for the day to day operations of Turana, including responding to complaints of child sexual abuse, was delegated to the executive staff members of Turana.

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

F15 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.

**Available finding on absconding from Winlaton**

F16 Some residents absconded from Winlaton as a result of child sexual abuse or to avoid further incidents of child sexual abuse. Staff at Winlaton were not trained to investigate the risk that some residents absconded because of child sexual abuse.

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

F17 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.

**Available findings on policies and procedures for responding to child sexual abuse at Winlaton**

F18 Prior to 1980, there were no formal policies or procedures in place at Winlaton for:

a) receiving or responding to complaints of child sexual abuse, and

b) reporting complaints of child sexual abuse to the Director of the Department and/or the Victoria Police.
Between 1980 and 1987, the policies and procedures for responding to ‘sexual assault’ at Winlaton:

a) did not contemplate child sexual abuse perpetrated by staff members; and

b) 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 Superintendents or the Superintendent.

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.

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.

During the period that Winlaton was in operation, some residents who did report sexual or physical abuse to a staff member were not believed, or were punished for reporting the physical or sexual abuse.

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.

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.

Available findings on strip searches at Winlaton

During the period that Winlaton was in operation, some residents were subjected to strip searches upon admission, return from leave and return from absconding. On some occasions these searches involved examination of residents’ vaginas. On some occasions male staff members, or male police members, were present during these searches.
The strip searches that some residents of Winlaton were subjected to were degrading, humiliating and invasive.

During the period that Winlaton was in operation, there were no formal procedures or policies regarding how strip searches at Winlaton were to be conducted, and no oversight by senior staff of strip searches.

Available finding on internal medical examinations at Winlaton

In the 1960s and early 1970s, BDC, Ms Short, BHE and Ms Hodkinson were subjected to internal medical examinations by doctors that attended Winlaton, or at a venereal disease clinic in Fitzroy, Victoria. This was inappropriate because:

a) the examinations were intrusive and invasive;

b) the purpose of the examinations was not explained to the residents; and

c) the residents had not given consent to the examinations.

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

d) it required the child to take responsibility or accept blame for the sexual abuse of which they were the victim.

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.

Available finding on the response of Victoria Police to Katherine X in 1979

Victoria Police did not properly investigate the allegation of child sexual abuse by Katherine X in 1979.

Available findings on the administration of Depo Provera at Winlaton

From the late 1970s, Depo Provera was administered by medical staff of Winlaton to residents as a contraceptive in circumstances where:

a) it was not approved for general use as a contraceptive in Australia; and
b) it was unclear whether consent had been properly obtained for administration.

F33 Depo Provera continued to be administered to residents of Winlaton until 1991, despite objections to the practice being made repeatedly by then Superintendent, Dr Eileen Slack.

F34 The response by medical staff at Winlaton, after Katherine X had disclosed that she had been sexually abused by her father in 1979, was to administer Depo Provera. The only consent obtained was an undated consent form signed by Katherine X’s mother.

Available finding on the reporting of disclosures of child sexual abuse by Katherine X to Victoria Police

F35 In 1979, Michael Groome, Jennifer Lines and Brian Fitzgerald did not report the disclosures of child sexual abuse made by Katherine X to the Victoria Police.

Available finding on visits to Winlaton by Katherine X’s father

F36 In 1979, Marilyn Minister permitted Katherine X’s father to visit Katherine X at Winlaton in circumstances where she was aware that Katherine X had been sexually abused by her father. This decision exposed Katherine X to a serious risk of further harm.

Available finding on Katherine X being released on weekend and day leave from Winlaton

F37 In 1979, staff of Winlaton and the Department released Katherine X on weekend and day leave without taking any action to minimise the risk that her father would continue to sexually abuse her. This exposed Katherine X to a serious risk of further harm.

Available findings on the letter to Katherine X’s father

F38 A letter, dated 9 August 1979 and signed by Jennifer Lines, was sent on behalf of Jennifer Lines and Michael Groome to Katherine X’s father. This letter was an inappropriate response to the disclosures of child sexual abuse made by Katherine X because:

a) it alerted Katherine X’s father to the disclosure of the abuse; and

b) it was sent without Katherine X’s consent.

F39 The letter dated 9 August and signed by Jennifer Lines was sent in circumstances where Katherine X had just been transferred to a less secure institution, and no safeguards had been put in place to prevent her father having further access to her. As such, it exposed Katherine X to a serious risk of further harm.

Available findings on the systems, processes and procedures for making decisions about the management, care and protection of Katherine X

F40 The lack of policies and procedures for dealing with reports of child sexual abuse at Winlaton in 1979 meant that in relation to Katherine X:

a) it was not clear who was ultimately responsible for making key decisions; and
b) responding to reports of child sexual abuse fell to inexperienced, junior staff members.

F41 The lack of policies and procedures for dealing with reports of child sexual abuse at Winlaton in 1979 meant that staff did not take clear and decisive action for the care and protection of Katherine X, which made her feel confused and helpless.

**Available finding on the response of Victoria Police to Katherine X in 2002-2009**

F42 Victoria Police did not properly investigate the allegation of child sexual abuse made by Katherine X in 2002.

**Available finding on the training of staff at Baltara**

F43 During the period 1970 to the early 1990s, the training offered to staff members at Baltara regarding child sexual abuse and responding to complaints of child sexual abuse was inadequate. The absence of this training undermined the capacity of staff members at Baltara to deal effectively with complaints of sexual abuse.

**Available findings on the placement of residents at Baltara**

F44 During the period that Grant Holland was employed at Baltara (1983 to the early 1990s), overcrowding was a serious problem. Overcrowding hindered the provision of adequate supervision, and meant that residents were placed in sections based on the availability of beds as opposed to their compatibility, suitability and safety.

F45 The placement of children admitted to Baltara as wards of the State in sections with children committed to Baltara for criminal offences, and the placement of younger children in sections with older children at Baltara increased the risk of child to child sexual abuse.

**Available finding on the supervision of residents at Baltara**

F46 Supervision of residents at Baltara between the mid-1980s and early 1990s was inadequate, particularly at night. Specifically:

- a) there were insufficient numbers of night duty officers to supervise residents, which meant that individual staff members were left alone with residents; and

- b) the physical environment made it impossible for staff to monitor each and every resident.

**Available finding on the response to reports of child sexual abuse at Baltara**

F47 During the period that Grant Holland was employed at Baltara (1983 to the early 1990s), some residents did not report child sexual abuse to anyone at the time it was occurring because:

- a) they did not believe that staff could protect them from further victimisation, abuse or reprisals;

- b) they did not think that staff would believe them; and
c) they did not think that staff would act on the report.

**Available finding on policies and procedures for reporting and responding to child sexual abuse at Baltara**

F48 During the period that Baltara was in operation, there were no policies or procedures specifically for:

- a) receiving and responding to complaints of child sexual abuse, and
- b) reporting complaints of child sexual abuse to the Director of the Department and/or the Victoria Police.

**Available finding on the reporting of incidents at Baltara in practice**

F49 During the period that Grant Holland was employed at Baltara (1983 to the early 1990s), the hierarchical staffing structure, and the culture amongst staff, prevented reports of child sexual abuse being escalated to management.

**Available finding on the historical interaction between Victoria Police and residents**

F50 Between the 1960s and early 1990s, some members of the Victoria Police treated residents of youth training and reception centres as ‘juvenile delinquents’ or ‘trouble maker’s’, who were not to be believed, or who needed to be disciplined.

**Available findings on historical policies, procedures and training of Victoria Police**

F51 Prior to 2004, members of the Victoria Police were not adequately trained to recognise, understand or respond to child sexual abuse.

F52 Between the 1960s and early 1990s Victoria Police policies and procedures regarding residents who had absconded from youth training and reception centres did not recognise that residents may have absconded because of child sexual abuse, or require that members inquire into or investigate why residents had absconded.

**Available finding on contemporary practices of Victoria Police regarding absconding**

F53 There is currently no formal requirement in Victoria Police policy or protocols that members inquire into or investigate why a child absconds from a youth detention centre.

**Available finding on the provision of policies and procedures by the Department**

F54 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.
Available finding on recruitment, training and resourcing offered by the Department

F55 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.

Available finding on the role of social workers of the Department

F56 The employment of social workers by the Department from the 1960s did not prevent, or facilitate the reporting of, child sexual abuse because:

a) some residents didn’t know who their allocated social worker was;

b) some residents were not visited by their allocated social worker;

c) some residents were only visited by their social worker infrequently; and

d) some social workers didn’t foster a relationship or environment in which residents felt comfortable reporting child sexual abuse.

Available findings on the responsibility of the Department

F57 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.

Available finding on records - delays

F59 Some former residents of State run youth training and reception centres continue to experience significant delays before receiving their ward files from the Department.

Available finding on records - redactions

F60 The Department provides a standard written explanation for why documents in former residents’ ward files are redacted. It is not a matter of general practice to provide specific reasons for the redactions made, either orally or in writing.

Available finding on records – need to make multiple requests to obtain ward file

F61 Former residents of State run youth training and reception centres must submit multiple requests to obtain access to the entirety of their ward files if:

a) the Department cannot initially locate all relevant documents; or

b) any of their documents are held by a non-State run institution.

Available finding on records - lack of support
F62 Some former residents of State run youth training and reception centres receive insufficient support from the Department or its agents during the process of requesting and obtaining their ward files.

Dr Peggy Dwyer

2 October 2015