

OMBUDSMAN  
TASMANIA

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**REVIEW OF CLAIMS OF ABUSE**  
*FROM ADULTS*  
*IN STATE CARE AS CHILDREN*

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Report by the  
Tasmanian Ombudsman

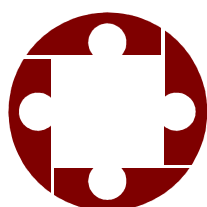
**NOVEMBER 2004**

# **LISTEN TO THE CHILDREN**

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**REVIEW OF CLAIMS OF ABUSE FROM ADULTS IN STATE CARE AS CHILDREN**

**NOVEMBER 2004**



**OMBUDSMAN  
TASMANIA**

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## FOREWORD

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In July 2003 the Tasmanian Government announced a review of claims of abuse from adults who had been in State care as children. When I agreed that my office would review the individual claims, it was in the belief that the Ombudsman's independence and impartiality would lend credibility to the review process and provide reassurance to the people who came forward that their stories would be listened to impartially and in confidence.

I knew that it would be a difficult and daunting task. I had no idea how difficult and complex it would be, nor how long it would take. We learnt very quickly that uncovering people's lives to expose secret, painful memories that had lain hidden for 30, 40 and 50 years was not a task that could be rushed. Many of the adults who came forward confessed that they had never told anyone of their childhood experiences. Others who had told someone in authority are still bitter that they were not listened to, or were not believed.

The Review is a cooperative undertaking between the Ombudsman's office and the Department of Health and Human Services ('the Department') carried out by the Ombudsman under Part 3 Division 3 of the *Ombudsman Act 1978*. A Protocol of Agreement between the Ombudsman and the Secretary of the Department set out the scope of the Review and the respective tasks of each party. The Department provided the Ombudsman's office with additional resources and a special Ombudsman Child Abuse Review Team was established to receive and review the claims. A similar team was established by the Department to undertake further research and to assist claimants in the implementation of my recommendations.

Some six weeks after the Review commenced the Premier announced that *ex gratia* payments up to \$60,000 would be available and appointed Mr Peter Cranswick QC as the Independent Assessor.

As Ombudsman my task has been to assess each claim of past abuse and to make recommendations to the Department for individual reparation (other than the providing of *ex gratia* payments). It was not my task to investigate or review the current child protection system. I agreed to prepare a report for the Minister for Health and Human Services, which would be made public and which would provide a general overview of the information collected as a result of the review of claims. As well, the report was to identify any issues relevant to current practice, which had emerged from the Review, together with appropriate recommendations. This is that report.

The Department's task is to consider and implement the recommendations for individual reparation and to liaise with service providers, including Church authorities. The outcome will be reported to the Minister by the Department.

Mr Cranswick's task is independent of the Ombudsman and the Department. It is to make decisions in respect of individual *ex gratia* payments and to prepare a report for the Premier.

As with any retrospective survey of this nature, which is essentially a collection of individual case studies based largely on interviews, disclaimers about the validity of the information and the conclusions to be drawn are essential. It is particularly important in this case because the information is highly sensitive.

The first such limitation relates to the number of people who presented with claims of abuse. As at 30 June 2003 there were 600 children on care and protection orders in Tasmania and statistics (see Appendix 3) reveal that over the period of the Review that figure has been relatively stable. The annual totals are cumulative because children need to be counted across more than one year, but by any reckoning the total number of children in State care for the full period covered by the Review would be many thousands. By contrast, the adults who participated in this Review are a small, self selected group who numerically represent only a very small fraction of the total. It is not possible to view them as a representative or reliable sample in any statistical sense of the word and the findings and the conclusions need to be seen in that light.

A total of 364 adults contacted the Ombudsman Review Team, most of them wishing to register a claim. Of those, 247 met the Review criteria and have had their claims assessed. We were surprised at the number of claims we received. Although we had no basis for predicting beforehand what the number might be, it was larger than expected. There appears to be no definitive information about the overall incidence of past abuse of children in State care. As a consequence, we have no firm idea as to how many more children in State care may have been victims of abuse over the years. It is probable that some people have been able to bury their past successfully, but anecdotal evidence from claimants about siblings and acquaintances, indicates that there are others who are still suffering, but are nervous and distrustful of authorities and reluctant and embarrassed to reveal details of what they regard as shameful incidents. The predatory way in which abusers of children operate has left indelible, life long scars. Numbers of the people we spoke to have had problems accepting that they were the victims of abuse and not co-conspirators.

While issues of statistical reliability are relevant, it cannot be denied that every victim of child abuse represents an individual human tragedy. Inevitably it must be concluded that for at least half a century, child protection systems in Tasmania, as elsewhere, have not adequately protected all of the children entrusted to the care of the State. Further, it must be concluded that many of the former institutions and Approved Children's Homes named in the Review failed in their own duty of care to children.

The Government has already confronted the issue of duty of care by initiating the Review. Because it is very likely that there are people still in the community who did not lodge a claim before the Review was closed, either because they chose not to do so at the time, or because they had not heard of the Review, I have made a recommendation that the current Review process be continued. Further details are provided in the Recommendations section of the report.

A second important consideration relates to the authenticity of the information. The Government made it clear when the Review was announced that the focus was to be on healing and closure. It was not to be on retribution, not on pursuing the 'truth' of the allegations. As a consequence, no attempt has been made by the Ombudsman Review Team to

test the information through rigorous investigation, such as the identification and questioning of possible witnesses, although there has been considerable research into files, cross referencing of information and other means of inquiry normally employed in an Ombudsman investigation. As it transpired, many of the claims were so old as to preclude the likelihood of obtaining sufficient corroborative evidence to prove allegations.

That is not to say, however, that matters of a serious nature have been ignored, irrespective of how long ago the alleged abuse occurred. At the commencement of the Review, the Ombudsman's office agreed on a Protocol with Tasmania Police for the referral of potentially criminal matters. An Assistant Commissioner and a Detective Sergeant were nominated as Liaison Officers. A total of 33 cases have been referred to Police with the agreement of the person making the claim. The position taken was that unless the abuse victim agreed and was prepared to give evidence in court, there was little likelihood of a successful prosecution. A number of other claimants also reported potentially criminal matters to the Ombudsman Review Team but declined to lay charges, usually because they were concerned about appearing in court, or because they accepted that there was little likelihood that the matter would proceed to court. At the time of preparing this report, seven cases are still active, two others have resulted in convictions, and one has resulted in court proceedings.

File research carried out by the Ombudsman Review Team indicated that, over many years, 21 allegations of abuse had been previously referred to Police, none of which had resulted in a conviction. (Appendix 5 provides further information). As part of the current process, eight of these matters were referred to Police again at the request of the claimant on the grounds that new evidence may have come to light since the matter was first investigated. Since 1990 new forensic tools, particularly DNA profiling, have also become available to assist Police with successful prosecution.

Where allegations were made of a serious, but non criminal matter, and where there was any possibility that the person named might still be alive and in a position to potentially harm children, a referral was made to the appropriate authorities for investigation. Six cases were reported to the Department's child protection authorities. Similarly, Church authorities have been advised by the Secretary of the Department of allegations made against them.

Lest it be assumed that the Ombudsman Review Team had doubts about the authenticity of the information, that is not the case. While specific allegations may not have been tested, overall the accounts provided by most claimants were considered to be credible. In addition to matters investigated by Police or child protection authorities, there was a considerable amount of corroboration provided by the claimants themselves or by a number of independent witnesses who came forward voluntarily. Possible collusion was not considered to be a significant consideration.

Another issue relates to the age of the claims. Two thirds of the adults who alleged that they had been abused as children in care were aged 45 years or older and their claims dated back 30, 40 and 50 years. Moreover most incidents occurred in institutions that have been closed for many years. On that basis it would seem reasonable to conclude that there has been a significant improvement in child care practices and procedures over the past 20 years or so. However, that does not necessarily mean that the current system of child protection is without flaws. One of the findings from the Review relates to claims of abuse from 12 young adults,

presently in the 20 to 30 age range, who have alleged abuse occurring as recently as 1998. Eight of the claims were from young women who alleged sexual abuse in a foster home. I have recommended that the Commissioner for Children undertake a detailed investigation of the 12 cases to identify any current systemic shortcomings.

The emergence of child abuse as a widespread social problem is a relatively recent phenomenon. There appear to have been a number of reasons for this, some of which may be described as commonly held assumptions. The results of the Review have helped to dispel some of these. One such relates to the sexual abuse of young boys. Historically, the community has regarded girls as much more likely to be the targets for sexual abuse than boys and has tended to be more protective of girls. The legislation of the past reflects this. While the overall incidence of allegations of sexual abuse amongst females in the Review was higher than amongst males, the difference was not as great as might have been expected, given past reports. This lends support to the view that there has been under reporting of sexual abuse of boys in the past. In line with many recent revelations, we heard numerous accounts of vulnerable, powerless young boys, who were allegedly targeted for sexual abuse in what can only be described as a calculated and ruthless manner.

Changing standards in respect of child abuse must also be considered. Sexual abuse of children is regarded with universal abhorrence and is unacceptable by any standards of human behaviour. It is a highly emotive topic and even for the Ombudsman Review Team, whose task was to remain impartial, it was not possible to remain unmoved by the anguish and despair of some claimants as they recounted the awful events of their childhood. There has been, however, a general tendency to partially excuse physical and emotional abuse on the grounds that they need to be seen in the context of the time in which they occurred. It is true that what would be perceived as abuse today was not necessarily seen as abuse 50 years ago, or even 30 years ago. Changes in societal values and approaches to disciplining children, as well as advances in child psychology and child rearing, need to be taken into account in assessing the seriousness of allegations of physical and emotional abuse.

It is not possible, however, to be dismissive of the allegations of physical and emotional abuse as simply reflecting the social and cultural mores of the day. This view did not stand up to scrutiny. The Review revealed too many credible instances of sadistic and intolerable cruelty to young, helpless children to be simply indicative of changes in the way that society disciplines even its most difficult young people.

There has also been a tendency to assume that sexual abuse is necessarily more deleterious than physical or emotional abuse in respect of its long term effects. This also did not stand up to scrutiny. One of the strongest impressions to emerge from the Review was that physical and emotional abuse can cause damage and scar lives as much as sexual abuse. It was apparent from the interviews that sustained emotional abuse almost invariably accompanied physical and sexual abuse and may well have had the most long lasting effects.

Many of the adults we spoke to have had damaged lives, marred by broken relationships, welfare dependency, prison terms, substance abuse, low self esteem, under employment and low educational attainment. Many reported an inability to extend love and affection to their own families and a lack of trust in other people. While it might be tempting to infer that such problems are a direct result of the time in care, it must be remembered that many children

came into care because of serious behavioural problems, or already severely damaged as victims of broken, dysfunctional families. Not all of the problems experienced by victims in later life can be laid at the door of the State. It is equally apparent, however, that irrespective of the legacy they took with them as children, many of the adults we spoke to had not been helped by their time in care.

It was the fervent hope of the late Premier of Tasmania, the Honorable Jim Bacon, that the Review would provide victims of past child abuse with an opportunity for healing and closure. In our view this objective has already been met in large part. While the individual reparations have still to be finalised and there are claimants still seeking assistance and support and anxious to know if they will receive an *ex gratia* payment, feedback to both the Ombudsman and the Department's Review Teams has been positive. Claimants have appreciated being able to tell their stories in confidence to someone non judgemental and they have expressed gratitude for the Government's offer of professional psychological counselling, the opportunity to be guided through their personal files, and other forms of personal assistance. The Government has also made a commitment to offer an apology to abuse victims and it is evident that for many final closure will not be achieved until they receive one.

The Government decided to offer *ex gratia* payments as part of the healing process. Compensation was not in issue because it was recognised that the suffering of many people was not compensable and because in many cases the time that had elapsed meant that it would be unlikely that abuse allegations could be proved.

It would be naïve to believe that the Government's offer of an *ex gratia* payment has had no effect on the number of claims made. Equally, it would be cynical to believe that it was the only consideration. A significant number of people came forward before the offer was made and the Ombudsman Review Team is convinced that for many others money was not the primary motivation.

I am aware that there are people in the community who would like the Government to establish a full Commission of Inquiry into child abuse, which would extend beyond the boundaries of children in State care and would presumably encompass present as well as past abuse. When the matter was initially raised, the former Premier indicated that he would be 'guided' by the Ombudsman in respect of whether a full Commission of Inquiry should be established. At the time, I made a public statement that I believed that to be a political decision and not one for the Ombudsman. I still hold to that view. However, I am prepared to put forward my views on the subject, which are partly personal and partly drawn from the results of the Review.

I do not see that a full Commission of Inquiry into child abuse can be justified based on the results of the Review. The great majority of claims were old. Recent information indicative of shortcomings in the present system was limited. This situation may change once the Commissioner for Children has completed his investigation into recent cases of abuse.

My primary concern, however, relates to resources. Commissions of Inquiry are exceedingly costly for Governments and ultimately for the community. The Government has already made a substantial financial commitment to reparation for individual victims of past child abuse and I have flagged my recommendation that, for equity reasons, the Government should continue

the current Review process. If further funding and resources were available, in my view they should be targeted primarily at strengthening the present child protection system, at identifying and implementing effective prevention strategies and at ensuring that counselling and support services continue to be made available to both adults and children. I have made a recommendation to this effect. One of the outcomes most frequently sought by claimants was an assurance that what happened to them as children would not happen to another child.

The Review disclosed a high level of welfare dependency amongst the claimants and, while this cannot all be attributed to the effects of past abuse, it highlights the generally acknowledged view that there are sound economic reasons for preventing child abuse, as well as humanitarian ones.

Secondly, I believe that Commissions of Inquiry are of greatest value in identifying and illuminating areas where the parameters and the magnitude of a significant problem are not known. We already know from many reliable sources that child abuse is a widespread social problem that extends beyond the boundaries of the State's responsibilities. This has been reinforced by the recently released Senate Report by the Community Affairs Reference Committee entitled *Forgotten Australians*. There is no reason to believe that Tasmania is markedly different from any other part of Australia. While a Commission of Inquiry would be likely to reveal evidence of child abuse on a larger scale than indicated by the present Review and might lead to the exposure of individual wrongdoers, this still would not seem reason enough for a full public inquiry. There are other processes, such as the Police and child protection authorities, which exist to deal with wrongdoing

Commissions of Inquiry are also largely dependent on witnesses coming forward to be questioned, but our experience in dealing with victims of abuse is that many would be very reluctant to provide evidence in a formal hearing, even a closed hearing. This is evidenced by the fact that many are reluctant even now to press charges against alleged perpetrators because of their fear of appearing in court. Moreover, asking people who have already told their stories to repeat them could be traumatic and counter productive.

There is also the issue of outcomes. Commissions of Inquiry normally result in many significant and far reaching recommendations, but experience shows that they are often not implemented unless there is a political commitment to do so. It is also reasonable to assert that recommendations made by an Inquiry are usually at the systemic level and rarely recommend remedies for individuals. These may be unfair generalisations, but the point to be made is that the Government has made a public commitment to individual reparation and implementation has already commenced.

Finally, there is the matter of acknowledgements. I wish to acknowledge and pay tribute to the remarkable courage and strength demonstrated by the claimants in lodging their claims and telling their stories. I can only imagine how hard it must have been for this group of people to relive their experiences and expose their lives to the scrutiny of this Review and I admire them greatly.

I also wish to acknowledge the staff of the Ombudsman Review Team. They express admiration for the courage and the resilience of the adults they spoke to, but for the staff themselves it has also been a difficult and demanding process. Almost every day for over

twelve months they have listened to heart rending stories with patience, tact and great sensitivity. There was always a danger that they too would be traumatised by the process and some have sought professional counselling. However, in the main they have found the task to be deeply rewarding and in many ways a cathartic experience. I am grateful for their dedication and professionalism.

Staff from the DHHS Review team have contributed invaluable research and advisory support to members of the Ombudsman Child Abuse Review Team. I am particularly indebted for assistance in locating old files and for the time consuming compilation of statistical information extracted from old Annual Reports for the period covered by the Review.

I am indebted to Tasmania Police for their cooperation and advice in respect of matters referred by the Ombudsman Child Abuse Review Team.

In closing, I acknowledge the Government's compassionate response to an issue that for too long has been avoided and ignored.

**Jan O'Grady**  
**Ombudsman.**

November 2004

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# 1. INTRODUCTION

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Child abuse has gained recognition as a major social issue. Revelations of the prevalence and the extent of abuse are forcing a disturbed and bewildered public to confront the reality that the State has not adequately protected all of the children entrusted to its care. Governments across Australia are addressing the issue in a variety of ways. In July 2003 the Tasmanian Government announced a Review of Claims of Abuse from Adults in State Care as Children.

## 1.1 THE CATALYST FOR THE TASMANIAN REVIEW

The immediate catalyst for the Review was a case involving child sexual abuse dating back many years which was aired on the ABC Television current affairs program *Stateline* on Friday, 11 July 2003. A man who had been in State care as a child alleged sexual abuse by his foster parent who, he claimed, was a convicted paedophile when he was placed in his care. The Government responded swiftly. The Minister for Health and Human Services ('the Minister'), the Honourable David Llewellyn, announced on the program that the Tasmanian Ombudsman had agreed to carry out an independent review of claims of abuse suffered by adults who had been in State care as children. Adults over 18 were invited to come forward. At the end of the program, a telephone Hotline number, set up to take claimants' calls from 9.00am on the following Monday, was announced. The Hotline ran for six weeks. Thereafter the Ombudsman's office accepted calls until the closing date on 31 March 2004.

## 1.2 THE SCOPE OF THE REVIEW

The Review is a joint undertaking between the Ombudsman and the Department of Health and Human Services ('the Department'). The scope of the Review was set out in a Protocol Agreement between the Ombudsman and the Secretary of the Department of Health and Human Services ('the Secretary'). (See Appendix 1.) The document specified the extent to which the Ombudsman and the Department would cooperate. No time limits were set on when the alleged abuse occurred, nor where (other than in State care in Tasmania). No time was set for completion of the Review and neither 'State care' nor 'child abuse' were specifically defined in the document.

The Minister made it clear in announcing the Review that it was intended to be a healing process which would assist adults who had been abused to gain closure. Some six weeks after the Review commenced the Premier announced that an amount up to \$60,000 could be made available to claimants as an *ex gratia* payment. The amounts would be determined by an Independent Assessor and the Government appointed Mr Peter Cranswick QC.

The Government's intention in offering *ex gratia* payments was to assist with the healing process. The payments were not intended as compensation because it was recognised that the suffering of many people was not compensable and also because in many cases the time that

had elapsed since the period in care made it unlikely that it would be feasible to prove that the alleged abuse had occurred.

### **1.3 THE RESPECTIVE ROLES OF THE THREE PARTIES IN THE REVIEW PROCESS**

#### ***The Ombudsman***

The Ombudsman's task has been to:

- determine the eligibility of people to have their claim reviewed in accordance with the agreed definition of State care and the criteria in the Protocol of Agreement;
- generally assess the strength of individual claims; and
- make recommendations to the Department in respect of reparation for individual claimants.

The Ombudsman agreed to prepare a report for the Secretary of the Department and the Minister, which would provide an overview of the claims and make recommendations in respect of any issues which had emerged from the Review and had relevance for current practice.

The Government agreed to provide additional funds to the Ombudsman and a special Child Abuse Review Team was established headed by a Senior Investigator from the Ombudsman's office.

#### ***The Department***

A specialist team within the Department has the task of considering and implementing the Ombudsman's recommendations for individual reparation, healing and possible closure. This includes liaising with church organisations and other non Government service providers for out of home care. The Department is to report to the Minister on the actions taken to implement the recommendations.

#### ***The Independent Assessor***

The Independent Assessor is responsible for reviewing all individual claims and for determining the amount of *ex gratia* payments to individuals, if appropriate. The Independent Assessor will report directly to the Premier. The Ombudsman has no jurisdiction over decisions made by the Independent Assessor.

### **1.4 THE REVIEW PROCESS**

Full details of the Review process are provided in Appendix 2. In brief, most of the information was obtained from lengthy, personal interviews with claimants<sup>1</sup> and from a number of independent witnesses who voluntarily came forward. The interviews were preceded by detailed and time consuming file research to confirm dates and placements of the period in State care.

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<sup>1</sup> The term 'claimant' would not normally be used in an Ombudsman report. The more conventional term would be 'complainant'.

While it was the Government's intention to focus on healing rather than prosecution of offenders, it was recognised that the Review would undoubtedly reveal evidence of potentially criminal activities. A process for referral of such matters to Tasmania Police was agreed on in advance (see Appendix 2). Serious, non criminal allegations about an alleged perpetrator who might still be in a position to be a danger to children were referred to Child Protection authorities in the Department for investigation or to another appropriate authority.

Confidentiality was a major issue. Claimants were advised at the outset that personal information obtained from interviews would not be disclosed to any person(s) outside the Review process without their permission. However, if it was indicated that children or young persons might be in current jeopardy, the Ombudsman reserved the right to pass the information on to relevant authorities and would advise the claimant accordingly.

## **1.5 OUTCOMES SOUGHT BY CLAIMANTS**

At interview, all claimants were asked what outcomes they were seeking. Most people requested one or more of the following and normally their requests were passed on to the Department with a recommendation that they be provided:

- an apology;
- an official acknowledgement that the alleged abuse most likely occurred;
- an assurance that today's system prevents the sort of abuse they have suffered;
- guided access to personal departmental file; and
- professional counselling.

In addition to the above, claimants often identified other personal outcomes that they would like, such as assistance with locating 'lost' family members or payment of medical expenses and these were also forwarded to the Department with an appropriate recommendation.

Occasionally, additional recommendations were made to the Department by the Ombudsman, usually in respect of further action. For example, a recommendation might be made that the Department undertake further research to verify placement details.

Claimants were advised that all claims would be passed to the Independent Assessor for consideration for an *ex gratia* payment. No separate recommendations were required.

The Government has already made an in principle commitment to providing individual reparation, support and assistance towards closure and healing for claimants and in many instances, implementation has already commenced. For example, professional counselling was offered to each person immediately contact was made with the Ombudsman's office. Approximately half the claimants took up the offer of counselling. Similarly, many claimants have already taken up the opportunity to peruse their personal files. The Department will report separately on the issues related to individual reparation, support and assistance toward healing and possible closure.

## 1.6 THE CONTEXT OF THE TASMANIAN REVIEW

Many States and Territories in Australia have recently undertaken investigations or inquiries into the incidence of child abuse in institutional care or foster care. To set the Tasmanian Review in context, a brief overview of some more recent developments in other jurisdictions is provided below.

- In Queensland the Report of the Commission of Inquiry into the Abuse of Children in Queensland Institutions was tabled in the Queensland Parliament in June 1999. Otherwise known as the ‘Forde Inquiry’ it disclosed widespread and unacceptable abuse of children in State care over the period 1911 to 1999. The following year, Project Axis, which was a joint initiative of the Queensland Crime Commission and the Queensland Police Service, released a series of reports on Child Sexual Abuse in Queensland. In 2003 the Crime and Misconduct Commission released reports related to child abuse, including an inquiry into how adequately the Queensland criminal justice system handled allegations of sexual offences and an inquiry into abuse of children in foster care.
- In South Australia in June 2004, following an earlier inquiry by Robin Layton QC into child protection, the Government announced a Commission of Inquiry into Sex Abuse of Children in State Care. The Premier announced that the focus of the present Inquiry “..will centre around whether there are any cover ups or mishandling of allegations or reports of sex abuse involving children under guardianship of the State at the time”.
- On 4 March 2003 the Senate referred an Inquiry into Children in Institutional Care to the Community Affairs References Committee for completion by December 2003. The Committee’s task was to “...build a picture of the problems of institutional life and to assist in the identification of remedies to deal with these problems. The Committee will not recommend remedies for any particular person”. The Committee released its report entitled Forgotten Australians in August 2004.
- In the Australian Capital Territory in May 2004, Ms Cheryl Vardon, Commissioner for Public Administration, released a report entitled The Territory as Parent. Review of the Safety of Children in Care in the ACT and of Child Protection Management. The stated purpose of the review was to “...address deficiencies in the current policies, procedures and practices for supporting children and young people on orders in residential and foster care”.

## 1.7 DISTINCTIVE FEATURES OF THE TASMANIAN REVIEW

The Tasmanian Review has some relatively unique features that distinguish it from similar inquiries and investigations elsewhere in Australia.

- It is a cooperative undertaking between the Ombudsman, who is an independent statutory officer, and the Department of Health and Human Services. Tasmania Police has also cooperated by making special arrangements for the investigation of potential criminal allegations referred by the Ombudsman.

- It is a relatively large review given Tasmania's population size. A total of 364 people made an initial contact with the Ombudsman's Review Team, of whom 247 were eligible to participate.
- The focus of the Review is on healing and closure, not retribution.
- The Government has determined that an amount of up to \$60,000 may be paid to individual claimants to assist the healing process. An Independent Assessor, Mr Peter Cranswick QC, has been appointed to determine the *ex gratia* payments.
- The scope of the Review is very broad and is concerned with all forms of child abuse, and covers children in both institutional care and foster care.
- The range of placements encompasses both Government and non Government service providers.
- It is a retrospective Review spanning a period of over 60 years; the oldest claimant was born in 1928 and the youngest in 1985.
- The Government has already accepted in principle the recommendations put forward by the Ombudsman for individual reparation, healing and possible closure.

## **1.8 LIMITATIONS OF THE INFORMATION**

The findings and the conclusions drawn from the review of claims of past child abuse must be placed in context. Four interrelated issues warrant particular comment.

1. The first relates to the number of people who claim to have been abused. As at 30 June 2003 there were 600 children on care and protection orders in Tasmania. Appendix 3 shows the number of children who have been in State care since 1938/1939. The totals are cumulative because children need to be counted across a number of years, but by any reckoning, the total number of children in care for the full period covered by the Review would be many thousands. By contrast, the 247 claimants who have participated in this Review are a self selected group who numerically represent a very small fraction of the total. It is not possible to view them as a representative or reliable sample in any statistical sense of the word.
2. Secondly, there is the issue of probability that the alleged abuse occurred. The Government made it clear when the review was announced that the focus was to be on healing and closure, not on ascertaining the truth of the allegations. As a consequence, no attempt has been made to 'test' the information through rigorous investigation. If matters arose of a potentially criminal matter, claimants were advised of the process for referral to Tasmania Police. Similarly, if there was any possibility that an alleged perpetrator was still alive and could pose a threat to children the matter was referred to the Department for investigation or to the appropriate non Government provider. In the majority of cases, however, the age of the claims precluded the possibility of proving allegations beyond reasonable doubt.
3. Thirdly, the allegations of physical and emotional abuse need to be seen in the context of the time in which they occurred. What would be perceived as abuse today was not necessarily seen as abuse thirty, forty or fifty years ago. Changes in societal values and approaches to disciplining children, and advances in child psychology and child rearing need to be taken into account in assessing the seriousness of the allegations.

4. Fourthly, it must be remembered that many children came into care because of behavioural problems, offending, or already severely damaged as victims of abusive, dysfunctional families. Problems experienced in later life cannot all be laid at the door of the State.

## **1.9 THE REPORT**

The primary purpose of this report is to provide an overview of the material collected as a result of the Ombudsman's investigation of individual claims. It does not seek to deal with the issue of individual reparation; that will be reported on by the Department and the Independent Assessor. The report provides some recommendations in respect of issues that have emerged from the Review and are relevant to current practice. It was not otherwise the Ombudsman's task to undertake an investigation into the present child protection system.

The main body of the report is divided into seven sections. These are supplemented by key Appendices.

The main sections comprise:

- **Section 1:** Introduction
- **Section 2** provides the definition of State care used for the Review.
- **Section 3** provides the definition of Child Abuse used for the Review.
- **Section 4** provides a statistical profile of the claimants.
- **Section 5** provides an overview of the material derived from the Ombudsman's review of individual claims. The findings are drawn from an analysis of statistical information; from summaries of information presented at interview; from file research; and from information provided by Tasmania Police.
- **Section 6** provides a summary and conclusions based on information presented in previous sections. It is intended to provide a rationale for the recommendations.
- **Section 7** provides the recommendations.

Key Appendices are:

- **Appendix 1** – Protocol Agreement between the Ombudsman and the Secretary.
- **Appendix 2** provides a description of the Review process.
- **Appendix 3** provides a statistical overview of the number of children in care.
- **Appendix 4** provides background information about Child Welfare in Tasmania for the Review period. This identifies changes to the relevant legislation and to the organisation of the various State Departments responsible for child protection. It comments briefly on changes in the philosophy underpinning child protection.
- **Appendix 5** provides an overview of files where police had earlier involvement in investigations.
- **Appendix 6** – References.

## 2. DEFINITION OF STATE CARE USED FOR THE REVIEW

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'State care' was not specifically defined in the Protocol Agreement between the Ombudsman and the Department of Health and Human Services. The definition provided subsequently by the Department is as follows.

*Children or young persons under 18 years of age who were:*

- *subject to a legal order transferring guardianship to the Director/Secretary of the Department; or*
- *placed by the Department in a Departmental Receiving Home, Family Group Home, foster care on a legal or voluntary status; or*
- *placed by the Department in an Approved Children's Home (ie Homes certified under an Act for the care of children) on a legal or voluntary status;*
- *on a relative placement approved and supervised by this Department at the request of another State Department.*

The great majority of adults seeking to have their claims reviewed had been wards of the State and their legal status was clearly defined. However, various issues arose in the course of the Review in respect of eligibility and legal advice was sought on a number of occasions. One such issue related to 'private placements'. Prior to the implementation of the current legislation (the *Children, Young Persons and their Families Act 1997*), there existed Approved Children's Homes or Homes certified under an Act to care for children. Churches or charitable bodies managed these Homes. The capacity existed for parents to negotiate with the Homes to place their children there. This was a private arrangement between the Home and the parent and the State was not involved. The parent retained guardianship and was responsible for his/her child's welfare. Claimants who were privately placed were not eligible for inclusion in the Review.

A second issue arose in respect of children who had been placed into temporary care under the *Domestic Services Assistance Act 1947* and *Regulations*. This Act originally provided for a housekeeper or short term respite care in cases of family emergency. Later it became practice to admit children into temporary care on a status known as "Res DA". Parents were required to contribute to the cost of maintaining children in this way. Such cases were not under the guardianship of the Department and the Department had no authority to detain the children against the wishes of the parent. However, on legal advice, claimants in this category were deemed eligible to participate in the Review.

The status of adults who had come to Australia as child migrants was also an issue. The *Commonwealth Immigration (Guardianship of Children) Act 1946* relates to child migrants placed in Tasmania. They were under the guardianship of the Commonwealth Minister of Immigration, who delegated his powers of guardianship in respect of children living in Tasmania, to the Director of Social Services. Guardianship of an immigrant child extended until age 21. In practice, the Department exercised supervision of child migrants until they attained the age of 18 years and they were then informed that they should call at the nearest

office of the Department, if they required assistance. Following legal advice, claimants who were in care under this legislation were included in the Review.

There was also a major issue in respect of adults who had been adopted as children but at some stage had been legally in the care of the State. In some cases for example, children were adopted by their foster parents. If there was sufficient evidence to show that abuse had occurred while legally in care, the claim was accepted.

Some people who contacted the Ombudsman’s office to register a claim were reluctant to accept that they did not meet the definition of State care, particularly those who had been on private placements or had been adopted. Their argument was that they had been subjected to abuse like other children legally in State care.

The following tables show the number of claimants who met the definition of State care and indicates the reasons that some people were considered ineligible for the Review.

**Table 2.1: Total number of claims registered and subsequently reviewed**

	<b>No. of claims</b>
Total number of claims registered	364
Total number of claims considered ineligible	117
Total number of claims reviewed	247

**Table 2.2: Reasons claims not included in the Review**

<b>Reason</b>	<b>No. of claimants</b>
Abuse occurred in a hospital, school or community place other than an institution or home specifically established to care for children	15
Claims by or on behalf of adopted children	4
Comment or inquiry only	32
Referred to another body for action (eg Tasmania Police)	5
Complaints about the current system of DHHS foster care	7
In State care in another State	13
Claim withdrawn	10*
Preventative supervision	1
Private Placement	14
Offered to be witness only	16
<b>Total</b>	<b>117</b>

\* Includes 4 claimants who were possibly eligible but were not interviewed (contacted on a number of occasions, numerous interviews scheduled, but did not attend).

### 3. DEFINITION OF CHILD ABUSE USED FOR THE REVIEW

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The Review covered the full gamut of personal abuse – sexual, physical and emotional. For analytical purposes these have been categorised separately but it is recognised that the categories are not mutually exclusive and rarely, if ever, reflect the complexity of circumstances that surround the harm that has occurred to an individual. All claimants in telling their stories also raised general issues of neglect and systemic abuse, although these are not specifically discussed in the report. Such concepts are normally defined in terms of a failure or an omission by the State to provide adequately for basic and special needs of children in care, as distinct from the perpetration of overt actions of abuse on a child.

Definitions of child abuse vary considerably, particularly in respect of sexual abuse where abuse is often defined in terms of lack of consent, violation of professional boundaries, or exploitation of a power imbalance between the abused and the abuser. For the purposes of this Review, the definition of abuse used is that in the *Children, Young Persons and Their Families Act 1997* (CYPF Act) at section 3 as follows:

*‘Abuse or neglect’ means –*

- *Sexual abuse; or*
- *Physical or emotional injury or other abuse, or neglect, to the extent that*
  - *the injured, abused or neglected person has suffered, or is likely to suffer, physical or psychological harm detrimental to the person’s well being; or*
  - *the injured, abused or neglected person’s physical or psychological development is in jeopardy.*

Further elaboration as follows was provided in the Information Package distributed in year 2000 when the CYPF Act was implemented:

#### ***Sexual Abuse***

Occurs when a child has been exposed or subjected to sexual behaviours or acts that are exploitative and/or inappropriate to his or her age and developmental level. Harm that results from sexual maltreatment may include emotional trauma, physical injury or impaired development, although the harm resulting from the maltreatment may not be readily identifiable or apparent.

#### ***Physical Abuse***

Describes significant physical harm or injury experienced by a child as the result of severe and/or persistent actions or inaction, such as:

- injuries such as cuts, bruises, burns and fractures caused by a range of acts including beating or shaking; or
- inappropriate administration of alcohol or drugs; or
- attempted suffocation; or
- excessive discipline or punishment; or
- deliberate denial of a child’s basic needs such as food, shelter or supervision to the extent that injury or impairment to development is indicated.

***Emotional Abuse***

Describes the significant impairment of a child's social, emotional, cognitive or intellectual development and/or significant disturbance of a child's behaviour resulting from behaviours of family members or caregivers, such as persistent hostility, rejection or scapegoating.

## 4. STATISTICAL PROFILE OF THE CLAIMANTS

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The 247 adults who were eligible to participate in the Review had the following characteristics:

- There were more males (54%) than females (46%).
- Just under two thirds of the claimants were born before 1959, ie they are at least 45 years old; the remaining third are in the age range 35 to 45 years; a small number of claimants are in the age range 18 to 25 years. The oldest claimant was born in 1928 and the youngest was born in 1985. (See Table 4.1 below.)
- Males tended to be older than females.

**Table 4.1: Age distribution of claimants**

<b>Year of birth</b>	<b>No. of complainants</b>	<b>Male</b>	<b>Female</b>
1920 – 1929	1	1	-
1930 – 1939	23	12	11
1940 – 1949	58	38	20
1950 – 1959	70	41	29
1960 – 1969	61	32	29
1970 – 1979	25	8	17
1980 – 1989	9	2	7
<b>Total</b>	<b>247</b>	<b>134</b>	<b>113</b>

- Many claimants made multiple allegations of different types of abuse and the abuse was often sustained over a period of time. Claimants at interview were asked to provide their recollection of when they believed abuse first commenced. As Table 4.2 shows, based on the memories of adults, abuse was most likely to have commenced when the claimant was in the 6 to 10 year age range; 45 per cent fell into this category. For another third, the abuse commenced when they were in the 11 to 15 year age range, which is the age at which young offenders tended to come into care. A number of adults interviewed had been placed in care as very young children, five years or younger, and recalled instances of abuse at that age. This reflects the fact that on occasions whole families were taken into care. While such early memories are not always reliable, the likelihood is that these adults were abused over a longer time. Older children were apparently much less vulnerable to being abused. It should be noted that the information presented in Table 4.2 indicates only when abuse commenced, not the duration.

**Table 4.2: Age of claimant when alleged abuse in care first occurred\***

Age	Claimants	
	No.	%
0 – 5	38	16
6 – 10	107	45
11 – 15	92	38
16 - 18	3	1
<b>Total</b>	<b>240</b>	<b>100%</b>

**Note:** Of the 247 adults who were considered to meet the criteria for inclusion in the Review, seven were subsequently excluded, following initial interviews, on the grounds that the interview team assessed them as having ‘no case to answer’. Often this was because their status of being in State care was not confirmed after further research.

\* Refers to age at which abuse first occurred based on claimant’s recollection, notes on file, etc.

- Just over half of the Tasmanian residents live in the South of the State, which is approximately what might be expected. A reasonably large number of people (35) now reside interstate, comprising 15% of the total. (See Table 4.3 below.)

**Table 4.3: Current place of residence**

Current residence	No.	%
Tasmania – South	116	46
Tasmania – North	55	22
Tasmania – NW	40	17
<b>Sub total</b>	<b>211</b>	<b>85</b>
Victoria	10	4.5
Queensland	7	3
Western Australia	4	1.5
South Australia	5	2
New South Wales	9	3.5
ACT		
Northern Territory	1	0.5
<b>Total</b>	<b>247</b>	<b>100%</b>

- A total of 40 people who claimed to be of Aboriginal descent were interviewed, comprising 16 per cent of the total. This suggests that they are over represented in the Review, when compared with the Tasmanian population as a whole, although not with other statistics on children in care. There is ample national evidence to indicate that Aboriginal people are over represented in care and protection. There were five family groups who claimed Aboriginality included in the Review, representing 15 people who were related in some way.
- Six inmates from Risdon Prison were interviewed.
- There were 26 family groups included in the Review, which represented 79 claimants. Relationships included extended as well as immediate family members.

## 5. OVERVIEW OF THE CLAIMS

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This section discusses the main findings that have emerged from the Review carried out by the Ombudsman. The findings are drawn from an analysis of statistical data, from summaries of information presented at interview and from file research. Tasmania Police have also assisted with the provision of information.

For reasons of confidentiality, the information is presented in a relatively general form. Case studies, typical of the stories told by numbers of claimants, are used for illustrative purposes. They do not reflect the specific experiences of any one person.

### 5.1 THE AGE OF CLAIMS

Two thirds of the claims were received from people who are at least 45 years old. Most concern incidents that occurred many years ago, and a significant number of claims date back to incidents that occurred in the 1930s, 1940s and 1950s. Table 5.1 below shows the year when the alleged abuse was recollected to have commenced.

**Table 5.1: Year alleged abuse in care commenced**

<b>Year</b>	<b>Total</b>
1930-1934	1
1935-1939	4
1940-1944	9
1945-1949	17
1950-1954	22
1955-1959	34
1960-1964	35
1965-1969	32
1970-1974	31
1975-1979	27
1980-1984	14
1985-1989	8
1990-1994	5
1995-1999	1
<b>Total</b>	<b>240</b>

**Note:** Seven of the total of 247 claimants who were initially interviewed, were subsequently assessed as having “no case to answer”. The main reasons for this assessment were that the claimant was found to be ineligible (eg a private placement), but this was not determined until after the Review process had commenced.

The decade between 1960 and 1969 shows the highest reported incidence of abuse. Statistics on the number of children in State care (see Appendix 3) also indicate a ‘bulge’ in the

numbers of children in care between 1960 and 1980. However, it is likely that the prevalence of abuse in this period reflects a particular style of management and an approach to disciplining children that appears to have been unusually harsh and repressive, even allowing for our more liberal contemporary understanding of effective discipline. It possibly also reflects the State's changing approach to child protection issues. The *Child Welfare Act* came into operation in 1960 and while it was more progressive than the earlier *Infants Welfare Act* 1935, 'neglect' was still the main reason children were admitted into care and the well being of the child was assessed primarily in relation to health issues and physical development. Concerns about children's emotional well being were not paramount and little attention was given to the identification of reasons for anti social behaviour. The advent of the *Child Protection Act* 1974 introduced the concept of cruel treatment of children who had not yet attained the age of 12 years. In 1986 the *Child Protection Amendment Act* introduced the concept of maltreatment, risk of maltreatment and definitions of physical, emotional and sexual maltreatment and neglect (see Section 5(4)). This recognition of risk and maltreatment began to be recognised, largely as a consequence of advances in child psychology and effective behavioural therapy. (Appendix 4 discusses in greater detail the changing philosophy in respect of child protection.)

The fact that so many of the claims are old is encouraging. It is reasonable to assume that child protection practices and policies have significantly improved in the past 20 or 30 years.

However, claims were received from 12 young adults, presently in the 20 to 30 age range, who have made allegations of abuse commencing as recently as 1998. Nine of these claims related to foster care and eight of these were from young women who have reported allegations of sexual abuse. Of the three male claimants, two alleged single incidents of sexual abuse and one reported several incidents. In most cases, the allegations had been previously reported either to Police or to a departmental employee. These 12 claims need to be investigated in depth, particularly to identify the extent of departmental knowledge and role in the investigation of the alleged abuse.

## **5.2 DEPARTMENTAL RESIDENTIAL HOMES AND INSTITUTIONS AND APPROVED CHILDREN'S HOMES**

A detailed description of the types of accommodation used for children in care is provided in Appendix 4. In brief these included:

**Receiving Homes** were intended primarily for the accommodation of children pending more permanent placement and for children in transit. These were later known as Family Group Homes and some still operate today across the State.

**Institutions serving the whole State** were specialist facilities designed to meet the needs of a specialised group of children for whom the resources of foster homes and Approved Children's Homes were inadequate. These institutions were regarded as training institutions with the task of rehabilitating the child/young person back into the family home. The Ashley Youth Detention Centre, which today provides for children and young people who are on remand or have been convicted of criminal acts, now operates under the *Youth Justice Act* 1997. Children and young people on remand and

in custody may also be subject to orders in accordance with the *Children, Young Persons and their Families Act 1997*.

**Approved Children's Homes** were homes certified under Section 15 of the *Infants' Welfare Act 1935* or approved under Section 10 of the *Child Welfare Act 1960*. They were operated by churches or voluntary organisations and accepted wards of State from the Department. The children remained under the guardianship of the Director of the day, but some of the functions were delegated to the controlling body of the Home. In the 1970s a number of Approved Children's Homes began to introduce care in family units in cottages. Three organisations still provide cottage care across the State for the Department.

Over the period covered by the Review there were many residential facilities providing for children in State care. By the end of the 1980s however, with some few exceptions, institutional care had become a thing of the past both for the Department and the private organisations.

Table 5.2 shows the institutions and homes that were specifically named in the Review and the number of claimants who reported incidents of abuse in them. It should be noted that there were many other facilities in the period of the Review that were not named by claimants. Also, a number of claimants had more than one placement.

**Table 5.2: Institutions, Residential Care and Approved Children's Homes named by claimants**

MANAGER	PLACEMENT	NO OF CLAIMANTS	PLACEMENT TYPE
<b>DHHS:</b>	Rochebank Hostel	3	Receiving/Family Group Home
	Abermere Hostel	1	Receiving/Family Group Home
	Casablanca	2	Receiving/Family Group Home
	Gilburn	2	Receiving/Family Group Home
	Malmesbury	6	Receiving/Family Group Home
	Laroonna	1	Receiving/Family Group Home
	Omaru	1	Receiving/Family Group Home
	Ashley Home for Boys	32	Departmental Institution
	Wybra Hall	46	Departmental Institution
	West Winds Boys' Home	4	Departmental Institution
	Weeroona Girls' Training Centre	14	Departmental Institution
<b>Salvation Army:</b>	Barrington Boys' Home	16	Approved Children's Home
	Maylands Girls' Home	7	Approved Children's Home
<b>Catholic Church:</b>	Mt St Canice (Magdalen Home)	13	Approved Children's Home
	Boys' Town (Savio College)	9	Approved Children's Home
	St Josephs Orphanage/	14	Approved Children's Home
	Aikenhead House (later St Josephs Child Care Centres)		
<b>Churches of Christ:</b>	Bethany	1	Approved Children's Home

<b>Anglican Church:</b>	Clarendon Children's Home	2	Approved Children's Home
<b>Community Board of Management:</b>	Kennerley Boys Home (later Kennerley Children's Home)	24	Approved Children's Home
	Northern Tasmanian Home for Boys (also known as Glenara Children's Home)	20	Approved Children's Home
	Glendel Children's Home	1	Approved Children's Home

\* **Note:** Other placements identified in the Review:

- Royal Derwent Hospital (RDH): The RDH housed predominantly adults with mental health problems and operated under the auspices of the Mental Health Commission. The claimants alleging abuse at the RDH were wards of the State whose behaviour was such that they had been classified as 'mentally deficient' and were placed in this facility from other placements, such as an Approved Children's Home or Departmental Institution.
- At Home While Still a Ward: Some children were placed back with their parents or other family members, but they still remained a ward of the State, under the guardianship of the Director. The intention was for this to become a permanent placement, if circumstances were satisfactory, and subsequent discharge from Wardship by Ministerial approval.
- Holiday Placement: Children were sometimes sent, from Approved Children's Homes in particular, to families for placements during holidays or at weekends.
- Living on the Street: Some claimants are alleging abuse whilst they were still in the care of the State but living on the street. The alleged abuse occurred during periods when they had absconded from their placements.
- Police Custody: Some claimants allege abuse in Police Custody, while they were wards of the State. Older wards were sometimes detained overnight in police custody when they offended while missing from their approved placement.

Clear patterns of institutional abuse have emerged from the Review. For boys it is strikingly evident that abuse was most frequent in the larger institutions, particularly Wybra Hall and Ashley Boys' Home, which in general had the largest populations of boys and serviced the whole State. Wybra Hall and Ashley Home were training institutions for boys who had serious behavioural problems, were offenders, or were considered 'uncontrollable' by foster families or by their own families. At Wybra Hall they were between 9 and 14 years of age and at Ashley they were over 14 years of age. There was a high turnover of boys with many resident for only six months, or less. Recidivism was high. Claimants repeatedly described the management regime as harsh and rigid and in many respects the environment appears to have been similar to that of a prison, with a strong culture of bullying and intimidation by both staff and the boys themselves, and a distrust of informers and favourites.

Other boys homes frequently named by claimants were: Kennerley Children's Home and the Northern Tasmanian Home for Boys, both of which were run by Community Boards of Management, and Barrington Boys' Home run by the Salvation Army.

Most of the allegations relating to these institutions were of sustained physical and emotional abuse and, while they were established to cope with difficult boys which may help to explain the strictness and severity of the discipline regimes, there can be no excuse for the reports of sadistic and inhumane physical punishment that allegedly took place.

Allegations of sexual abuse were less common in the boys' homes and there is evidence to suggest that some of the reported sexual abuse was perpetrated by older boys on younger boys.

The information suggests that abusive practices were not necessarily widespread amongst staff; rather, the evidence suggests that a relatively small 'hard core' of staff members were involved in the abuse of a large number of boys over a long period. This was particularly evident at Wybra Hall and Barrington Boys' Home.

Several institutions for girls have also been named often, although to a lesser extent than the boys' homes. These are:

- *Weeroona* – a departmental training Institution;
- *Maylands* – an Approved Children's Home run by the Salvation Army;
- *The Mary Magdalen Home*, also known as *Mt St Canice* – an Approved Children's Home run by the Catholic Church;
- *St. Josephs/Aikenhead House* – an Approved Children's Home run by the Catholic Church.

Female claimants mostly complained of sustained emotional and physical abuse, but there were also instances of sexual abuse reported.

### 5.3 INSTITUTIONS

Over the period of time of the review a significant amount of care took place in institutions. These were operated as places of training by the department or as Approved Children's Homes under the sponsorship of church or community bodies.

They were generally big old homes comprising dinning halls, dormitory type accommodation with large living areas, often with big laundries. They were frequently located in a rural environment. This allowed for the keeping of animals and the growing of fruit and vegetables to supply the homes' food. Surplus produce was sold. The funds saved and the revenue raised provided facilities and items for the homes, eg swimming pool and tennis courts at Wybra.

Because of the size of these institutions the daily routine was regimented and the children were responsible for inside and outside chores. Annual reports from these institutions included details of the range of chores that the children were required to do.

Claimants frequently commented on the quality of food and the requirement to eat everything on their plate. Because institutions relied on seasonal fruit and vegetables and available meat, it could be assumed that there was not a lot of variety at particular times of the year.

During the 1960s in particular, it is apparent that corporal punishment was prevalent. Claimants indicated that cruel punishments were handed out irrationally and that they often did not know why they were being punished. According to claimants, corporal punishment was administered by a variety of instruments depending on the preference of the alleged perpetrator:

- straps, belts and whips such as a donkey whip;
- canes;
- planks of wood;
- bunches of keys;
- Chinese burns, boxing of ears and tweaking of skin, "horse bites".

Some claimants at interview displayed the scars to prove how severe the beatings were.

Claimants alleged that bullying of younger children by older children and by staff was prevalent. According to claimants, on occasions this resulted in incidents of sexual abuse ranging from fondling to intercourse. Another outcome was absconding from their placements.

In the departmental training institutions there was regular use of a secure facility for children who absconded or whose level of behaviour warranted secure care. According to claimants' personal files and institutional files children often received school exemption around the age of 14 and 15 years for a variety of reasons, often initiated by the school. For this reason boys were then sent to work outside in the garden or on the farm and girls to do domestic chores until other employment was found.

One of the recurring themes in the interviews was the regret expressed by claimants who believed that they had been denied the opportunity to realise their educational potential. It is also evident from file notations that schools often tended to label wards of State as 'slow' or even 'retarded', which would not necessarily have been accurate. Lack of educational performance may have been a reflection of emotional issues or the absence of a supportive family and friends.

### ***5.3.1 Institutions and Homes for Boys***

Ashley Home for Boys, Wybra Hall and Westwinds were departmental institutions.

The Ashley Home for Boys was originally a State farm, which was converted into a residential training facility in 1921 and renamed as the Ashley Home for Boys in 1926. Towards the end of the Review period, admission to the home was strictly monitored and limited to young people on remand or on a detention order, with rare exceptions on the permission of the Director.

Wybra Hall opened in 1956 and initially it provided care for delinquent and seriously disturbed boys only, under the age of 14 years. Following the closure of Weeroona, a training institution for girls, it catered for both girls and boys. It accommodated approximately 30 children at a time.

Westwinds, at Woodbridge, opened in 1963 and was later developed to be a home for boys of school age, normally from 9 years of age upwards, who were assessed as intellectually or educationally retarded but suitable to attend Woodbridge Area School.

Approved Children's Homes providing institutional care during the period of the review and named by claimants were:

- Northern Tasmanian Home for Boys, later known as the Glenara Children's Home, operated by a community board of management and located in Launceston;
- Kennerley Boys Home, later known as Kennerley Children's Home and providing cottage care, located in West Hobart and run by a community board of management;

- Barrington Salvation Army Home for Boys, under the auspices of the Salvation Army and located in New Town, near Hobart.

During the 1960s and early 1970s, claimants stated that a common punishment was forcing boys to fight their mates in a makeshift boxing ring in the gymnasium. The participants were often deliberately unevenly matched which usually resulted in the smaller boy being ‘punched out’. Boys who refused to box or did not demonstrate that they were trying hard enough, were punished. This often took the form of beatings by staff, or sometimes by other boys at the instigation of staff.

Another common punishment reported by claimants placed at Wybra, particularly for absconders who were always severely punished, was to place boys in a secure area known colloquially as ‘the boob’. There were various descriptions provided of the boob such as:

- The boob was a room in the tower at Wybra Hall about six to eight feet long with unbreakable windows.
- There was glass all around and the room was freezing in winter and hot in summer.
- There was a bench along one side of the room but no beds.
- Boys were given a thin mattress, one blanket and an empty Milo tin, or similar, as a toilet.
- Before being placed in the boob, boys were severely beaten, were stripped to their underwear, winter or summer, and were not allowed to shower while incarcerated.
- Boys in the boob were not allowed to go to school and the seclusions frequently lasted longer than a week.
- Food was limited to bread and jam and water.

Following discussion with former staff of Wybra, it has been ascertained that the secure room known as ‘the boob’, was located on the first floor with a northern aspect. It was a long narrow room measuring approximately 14 feet by 8 feet, with one window.

Like Wybra, Ashley had a security arrangement which, according to claimants, was constructed in the same manner as a prison cell and uncontrollable boys, on first entering the home, were immediately placed in the unit for up to 14 days to ‘soften’ them up and to ensure that they did not try to escape or cause trouble with the other boys. According to claimants and confirmed by Departmental files boys considered to be a high absconding risk or uncontrollable were placed in the secure unit for limited periods.

In all the institutions, according to departmental files and claims made during the Review, bedwetting was prevalent and the link between this and emotional disturbance was not recognised. It has been alleged that repeated bedwetting was punished and many claimants evidently hold the view that the emotional abuse they suffered as a consequence of public humiliation was worse than physical abuse.

Claimants indicated that there was a special dormitory for the bedwetters in some institutions. According to claimants, boys who had wet their beds overnight were ‘belted’ and then lined up in front of all the other boys in the dining room and called names in front of everyone. The other boys were not allowed to start eating until the bedwetters had been beaten and ridiculed.

*He remembered that after wetting his bed one night he was taken outside into the courtyard and hosed down with cold water. He was then made to sleep naked on top of his bed so that everyone could see him. He was about eight years old at the time.*

In the 1960s and into the early 1970s, boys accommodated at Wybra Hall attended Brighton Area School. Claimants report that they were frequently kept home from school if they had been particularly naughty and if a boy was punished at school, the Superintendent was told and the boy was punished again. Many of the claimants related how they had been given the cane at school for a misdemeanour and how, when they returned to Wybra Hall, they were caned with double the amount of cuts they got at school. It was the perception of claimants that the Superintendent took particular pleasure in sending the unfortunate boy who was to be caned to his office to select one of several canes that he kept there.

A number of claimants placed in institutions, including Approved Children's Homes and in foster care, referred to the humiliation of being known as 'welfare kids' at school. During the 1960s and 1970s the Wybra Boys, as they were called, were easily picked out from the rest of the school population by their 'bowl' haircuts, regulation short sleeved shirts, short pants and hob nailed boots. This attire was worn year round.

A number of claimants placed in institutions referred to the chores they were required to carry out before and after school as abusive, such as:

- The gathering of grass for the animals kept on the property at Wybra Hall, including a cage of Tasmanian Devils. Several of the claimants described their fear when made to clean out the Devil cage. One boy would have to keep the animals at bay whilst another cleaned the cage.
- Polishing the floors, particularly the entrance hall at Wybra Hall, and for punishment they were made to scrub the floors with a toothbrush.
- Weeding, milking and feeding farm animals.
- According to claimants placed at the Northern Tasmanian Home for Boys, they were forced to work excessively at all types of farming duties, including milking, and digging drains and ditches, in all weather, without footwear or protective clothing.
- Some claimants at the Northern Tasmanian Home for Boys stated that they had been forced to weed the gravel driveway using only their fingers to dig out weeds and were made to bend from the waist. Any boy who used a weeding implement or who squatted down was severely punished.
- According to another claimant at the Northern Tasmanian Home for Boys, they were often taunted by staff; one practice being to release the leg rope from a cow while it was being milked. This would result in the milk being spilt and the boy would then be beaten.

Claimants stated that retribution was swift if any boy was found not to have finished his chores properly. In some Approved Children's Homes, where boys came home for lunch, they were expected to do chores in the lunch hour.

In some institutions, under particular superintendents, mealtimes took place in silence. According to claimants any boy who either had his elbows on the table or spoke was immediately cuffed and often knocked to the floor. The boys were made to eat everything put in front of them. Refusal resulted in 'force feeding' and a belting.

The claimants reported that recreational pursuits were television and games of pool. There was an on site swimming pool at Wybra and several claimants reported how boys, who were unable to swim, would be pushed in by staff. It was reported by some claimants that there were several occasions where boys came close to drowning.

Some other claims include:

- According to one claimant after absconding, he was taken back to – by the Police. He was taken to a shed where he was stripped to his underwear, suspended by his wrists from an overhead beam and beaten.
- In one particular instance, after a severe beating, two boys were allegedly hung on coat hooks in an area known as ‘The Covered Way’ and their friends were made to parade past them in single file. (This incident was reported by an eyewitness; not by a claimant.)

The practice of selling cigarettes and tobacco in the canteen to 14 year olds at Wybra and Ashley was criticised by a number of claimants. They claimed that the staff and visiting welfare officers turned a blind eye. One claimant stated that he had written to a Minister complaining about this practice and had received a denial prepared by the Department.

Chores at Ashley, like Wybra, consisted of weeding, milking, gathering fodder, feeding the animals and doing inside work like polishing floors and general cleaning. Retribution was swift if any boy was found not to have finished his chores properly.

The routine of an ordinary day at the Northern Tasmanian Home for Boys appears to have been similar to Ashley and Wybra.

### ***5.3.2 Institutions and Homes for Girls***

Weeroona was a departmental girls’ training centre situated at Latrobe in North West Tasmania and provided placements for about 20 girls from across the State. The home was intended to provide for adolescent girls in the care of the Department who required special supervision and training due to behavioural problems, such as delinquency and promiscuity.

Weeroona was opened in 1961 and closed as a training institution in late 1979. Following the closure of Weeroona, girls were placed at Wybra Hall.

Claimants have told how they were physically abused by being struck with a cane, broom handle, piece of wood or fist and of being dragged by the hair. The girls were forced to perform manual labour which some considered to be excessive, such as scrubbing floors, attending to the many animals and birds on site and cutting wood.

The home was made up of two areas: an open section; and a small secure unit in which girls would be placed for short periods, normally 24 hours. A number of claimants allege that they were assaulted and sexually abused by those in charge in the secure cells, other areas of the home and at a holiday house used by the home. This abuse ranged from inappropriate touching to alleged rapes of some girls over a prolonged period.

Approved Children's Homes providing approved institutional care for girls during the period of the review were:

- **Maylands Salvation Army Home for Girls** was run under the auspices of the Salvation Army and located in New Town, Hobart.
- **Mt St Canice** (Magadalen Home) was run by the Catholic Church and located in Sandy Bay at the convent of the Good Shepherd.
- **St Joseph's** (Aikenhead House) was also run by the Catholic Church and originally located in Hobart. Aikenhead House was sold in the 1960s and the home relocated to a large property in Tarooma, south of Hobart, where cottages were constructed to provide cottage care. St Josephs also provided care in an additional two cottages located in other suburbs.

During the 1960s and early 1970s, claimants placed at Maylands described a regime of rigid rules and a harsh punishment routine. They allege that they were neglected in their general care and were deprived of decent food, clothes and medical attention. For the older girls lack of privacy included having to bathe with other girls. According to one claimant they only bathed once a week, two girls in the bath at the same time, with the water usually changed after 7 pairs of girls had used it. There were no concessions to privacy or when a girl was menstruating. This claimant claimed that she made numerous complaints to schoolteachers about mistreatment and was always told "not to tell tales".

Another claimant placed at Maylands related how, on her first night at the home, she was served liver as a meal. She refused to eat this. At dinner on the following nights she was served the same plate of liver until it became mouldy. She stated that she was not offered any other food by the staff and she survived on food that some of the other girls pilfered for her.

According to claimants they were often 'primed' before the welfare officer visited. They were given clean bedspreads and apparently dressed in their best and schooled in what to say (or what not to say) when a welfare check was made by visiting officers from the Department. Children were aware that if they did not comply with these directives they would be punished after the welfare officers departed.

Claimants have advised that Magadalen was commonly known as a home for 'naughty girls', who were sometimes pregnant when they came into care. Magdalen Home was also used by Police when they picked up 'wayward girls' from the streets.

One claimant described the institution as prison like, having bars on the windows, locked doors and nuns carrying keys on their belts.

Examples of abuse cited by the claimants in Catholic run institutions included:

- Enforced religious practices. Claimants advise that irrespective of their family religions, girls were forced to accept Catholic doctrines, such as 6.00am attendance at Mass, genuflection and changes to their Christian names. A claimant reported that the nuns were portrayed as 'Brides of Christ' and any attack on a nun, verbal or otherwise, would result in a punishment from God and in an apparently ongoing burden of guilt

and fear. One claimant recounted how she had had personal tragedies in her life that, until recently, she had always believed were a punishment from God because she had physically assaulted a nun by pushing her whilst at the home.

- Regular spiteful physical punishment by nuns, such as pinching and hair pulling.
- Children were not provided with sufficient food and were punished if caught stealing from the fridges or scavenging food from the rubbish bins.
- Several claims of sexual abuse in the cottages at Taroona.

There were favourable comments made about Mt St Canice and the kindness of some nuns. In the course of the Review, two former residents of the home contacted the Ombudsman’s office to describe how happy their time at Mt St Canice had been. There were no allegations of sexual abuse reported.

#### 5.4 HOMES RUN BY CHURCH AUTHORITIES

Reference has already been made above to a number of Approved Children’s Homes run by churches. Further comment is provided here in deference to the high level of public interest and concern following recent disclosures in relation to sexual abuse by clergy. Church authorities have been advised of the allegations made against them.

As Table 5.3 below indicates, 62 claimants (25 per cent of the total) reported abuse in church run Homes. Most of the complaints were made against the Catholic Church followed by the Salvation Army. Given that these were the largest homes, the number of abuse incidents reported is consistent.

The allegations related mostly to serious physical and emotional abuse but there were 17 separate incidents of sexual abuse alleged, mostly at Barrington Boys’ Home, Maylands Girls’ Home, at Boys’ Town and St Joseph’s Orphanage/Aikenhead House. No sexual abuse claims were received in respect of Mt St Canice. One allegation of sexual abuse related to the Bethany Children’s Home, run by the Churches of Christ. This abuse was allegedly committed by another child and not by a carer. There were no allegations of sexual abuse against the Anglican Church.

**Table 5.3: Approved Children’s Homes run by Churches and named in the Review**

		No of claimants
<b>Salvation Army:</b>	Barrington Boys Home	16
	Maylands Girl’s Home	7
<b>Churches of Christ:</b>	Bethany Children’s Home	1
<b>Anglican:</b>	Clarendon Children’s Home	2
<b>Catholic:</b>	Mt St Canice (Convent of the Good Shepherd; Magdalen Home)	13
	Boys Town (Savio College)	9
	St Joseph’s Orphanage /Aikenhead House	14

## 5.5 FOSTER CARE PLACEMENTS

The current legislation does not talk specifically about foster care nor is the conventional 'ward of the State' terminology any longer used. The Act now allows the Secretary to provide for children under guardianship or in custody in several ways including in placements that would previously have been described as foster care homes. Further details are provided in Appendix 4.

The number of claimants who had been in a foster care placement at some time was 111 (45 per cent of the total). There were more girls than boys who had been placed in foster care (67 females: 44 males). This appears to be consistent with the tendency in the past for girls to be placed in foster homes more often than boys – possibly because of a perception that girls were more docile and tractable. In the main, foster homes were family homes with two parents and, frequently, natural children living at home. A common claim was that the foster children were often discriminated against and neglected in favour of the natural children.

The pattern of foster care abuse is different from that of institutional abuse. In the institutions, which were limited in number compared with foster homes, there appears to have been a relatively small handful of alleged perpetrators involved; the information does not point to abuse being generally rife amongst staff. Reports from adults who had been in foster care homes indicate that 102 separate foster families have had allegations made against them. This is likely to be a relatively small number given the overall number of families providing foster care.

While for many children foster care was undoubtedly a loving, nurturing and positive experience, claimants have made allegations of experiencing all forms of abuse during their time in foster care. There were allegations of severe beatings, neglect, deprivation and sexual abuse. It is evident that girls who had been placed in foster care were much more likely than boys to be targeted for sexual abuse (17 males; 55 females). It appears that sexual abuse often involved the foster father but others were also offenders, including sons of the family, family friends, relatives and visitors to the home.

There were frequent accounts from earlier days of families with numbers of foster children, where the children slept on camp beds, were only allowed to bathe once a week and were not supplied with basic articles of hygiene such as tooth brushes or sanitary napkins. Clothing was limited and many children apparently had only one pair of shoes. Food was often of poor quality and several claimants said that the family ate 'normal' meals while the foster children ate mainly bread and jam. Christmas and Easter were no different for them and birthdays were not celebrated.

Several claimants reported that they were victimised and subjected to ridicule at school, both because they were on 'the free list' for schoolbooks (as of course were other students not in care) and because of the old fashioned clothing they wore. At one school, children on the 'free list' were reportedly called out to the front at assemblies and given left over books, rulers, pencils, etc. Most claimants previously in foster care reported that they had been unhappy at school and had not performed well.

Numbers of those who had been in foster care were very bitter that they were not believed when they had tried to tell welfare officers, Social Workers or their teachers of what was happening to them. If an official visitor was coming to the home, children were often warned that they would be punished if they complained. One girl who was in an abusive home recounts how she once ran away and went to the Police to tell them of her situation. The Police contacted the Department and a worker took her back to the home where she was given a hiding for 'telling lies'. Not being believed was a recurring theme amongst all claimants that has evidently engendered much anger and resentment over the years.

Claimants also reported that welfare officers 'never' visited the home, but this was not borne out by the file research. A more likely explanation is that they either did not recognise welfare officers or were at school when they called. The fact remains, however, that the Officers evidently did not speak to the children. This appears to have been a major flaw in the checks and balances in place at the time<sup>2</sup>.

## 5.6 ALLEGATIONS OF SEXUAL ABUSE

Two thirds (154) of the claimants alleged that they had been sexually abused at some time. Allegations ranged from vaginal and anal intercourse, often described as 'rape' by claimants, through to inappropriate touching and fondling. Most of the allegations involved the more serious forms of sexual abuse. Table 5.5 below shows that one in four of all reported incidents of abuse was of a sexual nature.

**Table 5.5: Distribution of type of abuse reported by claimants**

<b>Type of Allegations</b>	<b>No. of Allegations</b>	<b>Percentage</b>
Sexual	192	24%
Physical	313	39%
Emotional	296	37%
<b>Total</b>	<b>801</b>	<b>100%</b>

The statistics suggest that generally these were not one off opportunistic incidents; rather sexual abuse involved, in many cases, more than one incident of abuse of a child, often by multiple offenders and sometimes in multiple placements.

In the case of foster care, the foster father and occasionally the foster mother were named as the alleged perpetrators. There were also numerous instances of abuse by the son of the family, by another relative or family friend or neighbour either of the foster family or the natural family, and very occasionally by a person in authority, such as a welfare officer.

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<sup>2</sup> The departmental requirement was for a placement review to be completed every quarter. At this time there was no out of home care team to recruit, train and support carers – the Child Welfare Officers recruited, assessed and supported carers as well as court work, adoptions, miscellaneous complaints, with high caseloads, often above 70 cases per worker).

*Her foster parents took her to a holiday house owned by their friend. She thinks they arrived about mid afternoon. The friend asked her to come with him to the tractor shed where he had sexual intercourse with her. She was crying and he told her not to say anything. She didn't complain to her foster parents because they were friends of the other man. She was about 12 years old at the time.*

*She got on reasonably well with her foster parents in the beginning. Her foster father was very good to her and told her on a number of occasions that he loved her. When she was about 14 years old he started having sexual intercourse with her about twice a week. She used to cry and tell him that she didn't want to do it anymore. He would give her money each time he had sex with her.*

Thirty one complainants (18 females and 13 males) reported that they had been sexually abused in more than one placement. Twenty six allege that they were abused in two separate placements; three allege that they were sexually abused in three separate placements; and two allege that they were abused in four separate placements.

More females (87) than males (67) reported sexual abuse. Even allowing for the fact that there were more male claimants generally, the difference is perhaps not as large as might be expected and tends to support the view that there has been underreporting of sexual abuse of boys in the past. Historically, the community has tended to assume that girls were much more likely to be the victims of sexual abuse than boys and has tended to be more protective of girls. This has been reflected in the legislation. In Tasmania under the *Criminal Code Act 1924* the definition in respect of male rape and male sexual assault compared with female rape and assault was very limited. It was not until 1987 when the *Criminal Code Amendment (Sexual Offences) Act* came into effect and the gender based distinctions were largely removed that persons who sexually abused males were more easily able to be charged. Recent public revelations, including disclosures of male abuse within church systems, have helped dispel the perception by the community that females are likely to be the main target for sexual abuse.

*He (a religious) would come into the dormitory after the boys were asleep. He would place his hand over his mouth and wake him up. Then he would take off his pyjama trousers and stroke his penis. He was too scared to tell anyone. He knows that he did it to other boys too.*

Table 5.6 below needs to be interpreted with caution. It shows the age at which those claimants who have reported that they were sexually abused recall the first instance of abuse. It is not known if the first abuse they suffered was sexual or some other form of abuse. In a number of cases it appears that the first recollection may have been of physical abuse, followed by sexual abuse. This does not of course diminish the impact or seriousness of sexual abuse. Given these limitations, the table suggests that boys and girls in the 6 to 10 year age range appeared the most vulnerable to abuse, possibly of a sexual nature, while girls in the 11 to 15 year age group were twice as likely to be abused as boys of that age.

A number of those claiming sexual abuse recalled being abused when aged five years or younger. Clearly there are some problems with the reliability of such recollections, but in a number of cases there were contemporaneous reports of abuse on file, often from a relative. It

is generally assumed that adults who claimed to have been sexually abused when very young were probably subjected to ongoing abuse.

**Table 5.6: Age when abuse in care commenced for those claimants who have alleged sexual abuse (N=154)**

Age	Male	Female	Total
0-5	7	14	21
6-10	42	38	80
11-15	16	35	51
16-18	2	-	2

**Note:** The table shows only the age at which abuse in care was recollected to have commenced. It does not indicate the duration of the abuse, nor does it identify whether the abuse was sexual, physical or emotional.

Allegations of sexual abuse of boys were most frequently reported at Kennerley Boys' Home, the Northern Tasmanian Home for Boys, Wybra Hall and Ashley Boys' Home. It can be noted that the type of sexual abuse that reportedly occurred in these places may generally have been less serious than the type of sexual abuse suffered by young girls in foster homes. This may in part reflect the fact that some of the sexual abuse of males would have been molestation perpetrated by older boys on younger boys. The number of male claimants who have alleged that they were sexually abused by other boys when they were in institutions is 15.

*He was sent to – when he was very young, because his mother had died. One day he was playing near the courtyard when an older boy, aged about 13 years, took him into the scrub and anally raped him. The boy abused him several times but stopped when he said he would tell on him. He said he was too scared to report the abuse to the authorities.*

Of those 154 adults who claim to have been sexually abused, 46 have reports of abuse recorded on file. Some of the 'reports' are reasonably subjective and may simply have been notations relating to indicators of abuse, eg unexplained bruising on a child. In cases where reports of sexual abuse were made to welfare authorities, the files generally have not disclosed the outcome of any investigation. In some cases, where it is noted that children had previously complained to departmental staff of abuse, the reason that the matter had not been notified to Police may have been because it was investigated by child protection authorities and found to be unsubstantiated. The files do not record the reasons.

*She stated that he would often walk into the bedroom while she and other girls were getting dressed. She alleges that he sexually abused and raped her on two occasions while in care at his residence. On the first occasion he took her for a picnic and made her lie down under a tree. He told her not to tell anyone what had had happened. She does not think that his wife knew of this at the time. She did tell someone and she thinks that there may have been an investigation, but she was never told the results and she is not sure of this.*

The files indicate that over the Review period a total of 21 cases had been referred to Tasmania Police and in most cases it is recorded that no charges were laid. In the current

review, some eight cases have been referred to Police, which had been previously investigated. One of the reasons for re-referring is because, as a result of information provided by other claimants, new evidence may have come to light enabling a case to be prosecuted where previously there had been a lack of evidence. The outcomes of matters referred to Tasmania Police before the Review commenced are shown in Appendix 5.

## **5.7 PHYSICAL ABUSE**

Almost all of the adults interviewed reported incidents of physical abuse. Often the abuse, while unacceptable by today's standards, would have been consistent with the attitudes of the time towards disciplining children and young people, particularly in the larger training institutions where delinquent and behaviourally difficult boys and 'wayward' girls were placed. Children were caned or smacked for what we would regard today as relatively minor misdemeanours, such as bad manners, disobedience, rudeness and tardiness, and for small accidents. There were frequent reports of children being so hungry that they took fruit or bread and were then severely punished. One former inmate of Wybra Hall told of how the boys were not given any fruit, even though there was fruit on the property in abundance. On one occasion he was directed to feed the pigs a bucket of scraps that contained a whole orange. He succumbed to the temptation and ate the orange. When later asked if the pigs had eaten all the scraps, he said "Yes" and was then told that pigs don't eat oranges and beaten for telling a lie.

In earlier times, there was an expectation that children in State care would carry out chores which we would regard today as heavy physical labour. There was also little expectation that children in care would continue their education beyond the compulsory leaving age. Authorities often sought exemptions from school for children, forcing them to leave school early so that they could assist with the farm work or other chores. Files indicate that exemptions were usually sought following an assessment by the school. As noted previously, numbers of children were labelled as 'retarded' or 'imbeciles' when it may simply have been a reflection of their limited educational experience or a response to the adverse conditions in which they found themselves.

A number have also referred to being due money for the work they did that was never paid to them. The money was supposed to be put in a trust fund and paid when a child left care. The Department of Health and Human Services is pursuing the issue of lost money and will report on the outcome separately.

Of great concern is the frequency and consistency of accounts of extreme physical cruelty that would likely fall within the meaning of criminal assault.

*The playground was divided into sections. Each section was set down for a specific game and the boys were restricted in the section they could play in. He must have ventured away from the section he was allowed in. – knocked him to the ground and started kicking him because he had 'defied authority'. The beating continued for some time and only stopped when someone rang the play bell early. He lost a tooth and sprained his wrist but was not given any medical attention. He missed out on playing football that season because of his injuries.*

Numerous accounts were given of children who were severely beaten using some form of weapon or instrument deliberately intended to inflict pain, bruising and bleeding. Many referred to the fact that they had been unable to attend school because of the beatings they had received. Several referred to the fact that teachers at the school saw the results of the beatings but did nothing. Often the children were too frightened to say anything, even to Police who sometimes attended following particularly savage attacks. Some males showed the interviewers scars or medical records of injuries detected in later years that could have been ascribed to the abuse they described to the consulting doctor as having suffered while in State care. If even half of what has been reported is true, the inevitable conclusion must be drawn that institutional life attracted some adults who took pleasure in victimisation and abuse of vulnerable, powerless children.

*Boys used to get strapped across the knuckles for being naughty. Once he was strapped so badly that his little finger broke. He has never had full use of it since. He showed the interviewers his right hand.*

*On one occasion he was beaten very hard because he broke a vase. He bled so badly he had to go to the doctor. They told the doctor he had fallen off his bike. The injury to his back has been with him for the whole of his life.*

## 5.8 EMOTIONAL ABUSE

Emotional abuse is inherently a feature of sexual and physical abuse for children who have no control over their situation. It therefore came as no surprise that almost all of the adults interviewed said that the physical and sexual abuse they had suffered had been accompanied by emotional trauma<sup>3</sup>. This included deliberate alienation from their natural family as a result of actions by carers and the Department of Social Welfare. Claimants also allege humiliating and derogatory comments designed to instill fear, guilt, and feelings of rejection and low self esteem; and being forced to live in a situation where affection was withheld, where loneliness and isolation were rife, and where the child was made to feel that to be a ward of the State was to be a person of no value. Lack of action by welfare officers, by teachers and by Police when a child tried to tell someone what was happening also created permanent scars and lifelong distrust of authority. Denigration of the natural parents and offensive references such as 'no hoper families' and 'bad blood' were reported in a number of cases.

A total of 26 families have made claims and many examples were given of what was seen as the 'deliberate' breaking up of siblings by placing them in different places<sup>4</sup>, or by refusing to allow contact between siblings. Sometimes children five years of age and under were not allowed to be comforted by older brothers or sisters, presumably on the grounds that it was 'character building' to cope alone. This in turn had a profound effect on the older siblings well

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<sup>3</sup> Files reflect that considerable effort was made to encourage and maintain contact for many children but that, in a number of cases, there was a considered decision to restrict contact between children and their parents.

<sup>4</sup> Files reflect the attempts made to place siblings together however there were few co-ed placement options. Attempts were made to place boys together in one home, eg Barrington, and girls in Maylands. It was not a policy to separate siblings.

into adulthood. Many felt a sense of responsibility for what happened to their younger siblings.

*They were told when they were first taken into care that they would never be separated but, one by one, the others all left. She had little contact with them from then on. She never knew where her brother was (she thought he might be dead) and she had only one visit to her sister when she was in care. She does not know what happened to the others.*

Sixteen claimants have requested assistance to track down lost brothers and sisters, or to locate their parents' graves as an outcome of their claim. Other claimants have also made this request to the DHHS Team.

The attitude of authorities to death was also an issue. There were a number of examples given of children who were not informed that their mother or father had died; others were told of deaths in a careless, offhand manner. One boy was told of his mother's death and then told, "Well off you go to school". Children evidently had no choice but to hold their grief to themselves.

*She recalled that on one occasion her Child Welfare Office came and took her to the hospital. They told her that her mother was dying. She cried because it did not look like her mother.*

*After the visit she was returned to – and placed alone in the dormitory (all the other girls were away). She has no recollection of any staff member coming near her for the remainder of the week.*

Some were told that their parents had died when in fact they were still alive. One claimant, a former Child Migrant, who had been told that his mother was dead, discovered many years later that she was still living, as were his siblings. He attempted to contact his mother but she was not interested after the many years of separation. He greatly regrets that he had no opportunity to know his family and resents the lies he was told.

*Her little sister, who was only five years old at the time, used to cry all the time and this used to upset her. She was only about eight and one day she ran away and took her little sister with her. They played on the swings in the park all day and when it got dark they were scared and hungry. They knocked on a door and a nice lady gave them dinner and then called the Police. They begged the Police not to send them back, but they did. When she got back she was beaten so badly that she had to go to hospital. She remembers that she had to have X-rays.*

The interviewers received the distinct impression that for many of the claimants the years of emotional abuse and neglect have had a profound and adverse effect on their lives; as much, if not more so, than the perpetration of physical and sexual abuse.

*She said that he would put spiders and dead mice in the letterbox. Then he would force her to get the mail. When she found them she would scream and he would laugh. On one occasion he put a headless chook there. She screamed and became hysterical. – who was at home at the time, told him that he had gone too far and tried to convince her it was just a joke. She was about 11 years old at the time.*

Many claimants reported an inability to demonstrate affection for their own families, heavy consumption of alcohol and substance abuse, a sense of social isolation and ostracism, nightmares, low self esteem and bouts of depression and mood swings. Once they reached adulthood and became aware of other people's circumstances, many became very bitter about their lost childhoods. Many claimed that they had no photographs, memorabilia, or records of achievements and few pleasant memories of their childhood. One of the outcomes that this Review has been able to achieve is the opportunity for claimants to be guided through their personal files with the support of the DHHS Review Team. For many, this has been a revelation. For the first time some people have discovered why they were placed into care and, for some' it has been a revelation to discover that they were the victim of a domestic breakdown and were not simply rejected or unwanted by their parents as they had previously thought.

## **5.9 REFERRALS TO TASMANIA POLICE**

As part of the Review a total of 33 cases have been referred to Tasmania Police for further investigation with the approval of the claimants. Twenty three of the 33 cases have been investigated but have been filed, either for intelligence purposes due to insufficient evidence, or pending approval from the claimant to proceed with an investigation. Of the remaining ten cases, at the time of preparing this report, seven referrals remain active; two have now resulted in conviction of perpetrators and one has resulted in court proceedings. All three cases are a direct outcome of the present Review process.

Eight of the 33 cases had been previously reported to Police but no further action had ensued. The claimant had requested that they be re-referred for investigation on the grounds that new information may have come to light.

A total of 21 cases (18 female and 3 male) were recorded on file as having been referred to Tasmania Police between the late 1940s and the late 1990s. Of these, all 18 females had alleged sexual abuse ranging from inappropriate fondling through to multiple rapes over a number of years. One of the males alleged sexual abuse and the other two alleged physical abuse. In most cases it is recorded that no charges were laid due to lack of corroborative evidence. Appendix 5 provides an overview of the outcomes of the previously reported cases.

From an investigative perspective, it would appear that the most common problem faced was a lack of corroborative evidence upon which to base a prosecution, especially in the Supreme Court. Unless there was a reasonable prospect of a conviction, a suspect would not normally be indicted by the predecessors of the Director of Public Prosecutions. The chances of there being an independent eyewitness to the abuse were remote and further problems encountered were the age of the claimant at the time, the elapsed time between the alleged abuse and when

it was reported to Police and the prevailing social and practice context of the period in question. There were also legislative constraints that inhibited the successful prosecution of alleged perpetrators. Relatively recent changes have assisted Tasmania Police in this respect:

- In 1994 the addition of Section 125A to the *Criminal Code Act 1924* allowed offenders to be prosecuted for ‘Maintaining Sexual Relations With a Young Person’. This has meant that young persons do not have to specify exact days/dates/times/places for every single alleged assault on themselves. Tasmania Police advise that this Section has been used with great success.
- The broadening of the definition of statutory rape in 1987 removed the emphasis on sexual abuse being only against females and has allowed more offenders against males to be charged; and
- The implementation of the *Forensic Procedures Act 2000* provides comprehensive outlines for the obtaining and storage of forensic exhibits, such as blood and DNA.

## 5.10 MULTIPLE PLACEMENTS

Upon reviewing some files, it appeared at first that some children were moved from one place to another on a regular and frequent basis. Initially, this posed a concern. However, the reality was that some children were placed in a Receiving Home until an appropriate placement became available and, more often than not, what seemed like multiple placements were often short term holiday placements which would occur when foster carers took leave. In some cases, an existing foster arrangement would break down or a child in care might be returned to his or her family in an attempt at reconciliation.

It can be noted, however, that many children did have more than one placement, often two or three separate placements. It is distressing that 98 claimants reported that they had been abused in more than one placement (see Table 5.7 below).

**Table 5.7: Number of claimants alleging abuse in more than one placement (N= 98)**

	Male	Female
2 placements	31	25
3 placements	15	15
4 placements	5	4
4 + placements	1	2

## 5.11 ABORIGINAL CLAIMANTS

A total of 40 claimants, representing 16% of the overall number of accepted claimants, claim aboriginality. Fifteen claimants made up five family groups.

While the proportion of Aboriginal claimants in the Review is higher than the proportion of Aboriginal people in the total Tasmanian population, it is not unexpected for Aboriginal

children to be over represented in State care, particularly given some of the social attitudes prevailing at the time.

Many of the claimants have linked their claims to the Stolen Generation. One claimant claims he was taken from his mother at three months of age. He stated that, although the departmental records say he was neglected by his mother and that he was born out of wedlock, this was not the case. He argues that it was standard practice to state this on a file when the government of the day took Aboriginal children from their parents.

Several claimants were part of a very large family who were from one of the Bass Strait Islands. These claimants and other siblings were removed from the care of their mother at short notice and then split up. When one of the children was eventually taken into care at the same foster home as one of his siblings, he remembers speaking in an Aboriginal language. He claims that this was effectively eliminated by sending the two children to different schools and by failing to recognise their aboriginal culture. Similar examples were given by claimants of the denial of their cultural heritage, eg 'mutton birding'.

## **5.12 FAMILY GROUPS**

There are 79 claimants who make up 26 family groups. Many of these claimants were separated when they were placed into care, if not immediately, then after one or two years. In some cases, they have not met again. Others have been reunited through the Review process after 30 or 40 years apart.

Collusion amongst family groups does not appear to be an issue. Even where siblings are still in contact and have supported each other through the Review process, it has often been evident in the interviews that they have not discussed their experiences in State care in any depth, if at all. Quite often the abuses suffered have been at different placements.

Some family relationships were complex. The claims indicated intergenerational abuse, with both parents and children alleging abuse. Some children were not aware that the parent had lodged a claim. From the interviews it appears that in some families abuse was accepted as relatively normal.

## **6. SUMMARY AND CONCLUSIONS**

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This section provides a summary of key issues identified in previous sections of the report and is intended to provide a rationale for the recommendations. The limitations of the information need to be borne in mind.

### **6.1 FAILURE TO PROTECT ALL CHILDREN**

It is evident that over the period covered by the Review, child protection systems in Tasmania, as elsewhere, have not adequately protected all of the children entrusted to the care of the State. There is no reason to believe that systems prior to the Review period were any better.

The Government has addressed the issue by initiating the Review and offering redress to victims of past abuse. The many shocking stories presented to the Review team of vulnerable children abused by the people legally responsible for their care suggest that the Government's decision to offer redress is warranted.

The Review ran from 14 July 2003 to 31 March 2004. It received wide media coverage and the closing date was also widely advertised. During that time, 364 adults contacted the Ombudsman's office, most seeking to register claims. A total of 247 were accepted as meeting the criteria for participation in the Review; subsequently seven were found to be ineligible. It is not known how many more victims of past abuse are in the community. The Review Team accepts that, in light of the claimants' statements, there might be additional claims of abuse. Some may have chosen not to come forward because they wished to bury the past; others may not have heard about the Review in time; still others may not have wished to participate because they are nervous and distrustful of authorities and sceptical of the Government's intentions. To provide an equitable opportunity for all past abuse victims to engage in the healing process offered by the Government, it is recommended that the present Review process continue.

### **6.2 INDICATORS OF IMPROVEMENT IN CHILD PROTECTION**

Possibly the main finding to emerge from the Review was that most of the claims are old. The great majority (86 per cent) of reports of abuse reportedly commenced at least 25 years ago – in some cases they date back 40 and 50 years. Only 14 per cent of the claimants made reports of abuse having commenced since 1980.

Moreover, over half (55 per cent) of the claimants reported that the abuse they suffered occurred in institutions that were Departmental training institutions or Approved Children's Homes. All of these have been closed since the late 1980s and many were closed well before then. The Department no longer places children needing care and protection in institutional type placements.

Based on this information it is reasonable to conclude that there have been significant improvements in child protection systems over the past 25 years or so. It is also to be noted that institutional abuse was not necessarily rife amongst staff; rather, that there appears to have been a small, 'hard core' of perpetrators, most of whom are now deceased or unlikely to be in a position to have regular contact with children. Verification has been sought on this point when relevant.

### **6.3 CONCERN RELATED TO FOSTER CARE**

A disturbing finding to emerge from the Review which requires further examination relates to claims from 12 young adults, presently in the 20 to 30 age range, who have made allegations of abuse having commenced since 1990, in one case as recently as 1998. Nine of these claims related to foster care homes and eight of the claimants were young women. In most cases, the abuse was allegedly ongoing and involved more than one offender. Most of the sexual abuse cases were reported either to Police or to Child Protection. Where an investigation was undertaken, the most likely outcome was for the complaint not to be substantiated.

All 12 claims need to be investigated in depth to identify the extent of departmental knowledge and role, particularly in respect of screening procedures, and the actions taken when the abuse was reported. A recommendation will be made to this effect. Depending on the outcome of the investigation it may be necessary to look more closely at current child protection practices.

Other issues that have emerged from the Review also raise possible concerns about current foster care practices, particularly in respect of sexual abuse. The information suggests that young girls in foster care are likely to be more vulnerable to sexual abuse than boys. It should be noted that while a member of the foster family was often alleged to be the perpetrator, other persons outside the family were also named as alleged perpetrators.

There is also a suggestion that many of the reports of alleged sexual abuse of foster children were not one off opportunistic incidents. Many incidents reported involved more than one incident of abuse, often by multiple perpetrators and occasionally in multiple placements.

The overall conclusion to be drawn in respect of foster care is that it would be naïve to believe that there is no abuse presently occurring in Tasmania. However, it would be premature to make any judgments until the above recommendation for an investigation into recent cases has been completed. The great majority of foster carers no doubt provide loving, warm and nurturing family environments for children in need. To assume otherwise at this stage would be unfair and unreasonable.

### **6.4 LISTEN TO THE CHILDREN**

One of the most plaintive laments from many claimants was that they had been rebuffed or had been disbelieved when they had tried to tell an adult in authority, possibly a teacher or

someone from the Department, that they were being abused. On occasions claimants reported that they had been forced to speak out in front of the person carrying out the abuse. Inevitably they were punished or threatened as a consequence.

There are also reports on file of abuse reported by children, or occasionally their relatives, which appear not to have been progressed or acted on. Twenty one matters are on file as having been reported to Tasmania Police over the period of the Review, none of which were sustained apparently because of the difficulty of obtaining corroborative evidence. The law for many years placed little credence in the child as a reliable witness; independent witnesses were usually not available; and perpetrators were highly skilled and cunning in concealing their activities and in manipulating the children.

Recent legislative reforms, including the addition in 1994 of section 125A to the *Criminal Code Act 1924*; the broadening of the definition of rape in 1987 (*Criminal Code Amendment (Sexual Offences) Act*) and more recently, the introduction of the *Forensic Procedures Act 2000*, have significantly enhanced the ability of Tasmania Police to successfully prosecute persons who abuse children. Inevitably, however, the question needs to be asked as to whether children still have difficulty in speaking out and are they believed when they do so. Many other investigations and inquiries have addressed this same issue and have identified strategies that would be suited to Tasmania, but again, the outcome of the investigation into recent cases of abuse will indicate whether there are grounds for pursuing the matter in greater depth.

## **6.5 DAMAGED LIVES**

An overwhelming impression gained by the Review team was that many of the adults they interviewed were people who have had lives damaged by broken relationships, welfare dependency, substance abuse, prison terms, depression, low self esteem, under employment and low educational attainment. Many reported an inability to extend love and affection to their own children and a lack of trust in other people. As previously noted, this cannot all be laid at the door of the State. Many of the children came into care already traumatised as victims of abusive and dysfunctional families, or because of severe behavioral problems.

While it is reasonable to assert that the State cannot be held solely responsible for peoples' damaged lives, it must nevertheless accept a major responsibility. Irrespective of the legacy they took with them as children, what stands out is that many of the adults in the Review were not helped by their time in care. Problems of social adjustment in later life appear to have been exacerbated by the treatment they were subjected to in care. It is evident that for many years, regimentation, not rehabilitation, was the order of the day and it appears that in the past the approach was to look simply at the symptoms of misbehaviour, rather than attempt to identify and deal with the causes.

## **6.6 THE NEED FOR PREVENTION**

The Tasmanian Review has reinforced the findings of many similar inquiries, that child abuse and the damage it can cause in adulthood have become serious and widespread social problems which must be eliminated for pragmatic and economic, as well as humanitarian

reasons. The overall cost to the community of not addressing the issue is too great to be ignored. It is widely acknowledged that Governments should be directing their major efforts and resources to strengthening the current child protection system and developing effective prevention strategies. It is primarily to maximise effective resource use that no recommendation is made to mount a full Commission of Inquiry. Further elaboration is provided in the Foreword to the report.

## **6.7 LOST OPPORTUNITIES**

Regret for lost opportunities was a recurring theme in the interviews. Many people, who are now mature adults, are still bitter about their lost childhoods; many have no photographs of their parents or siblings; no records of small achievements; and no memorabilia of happy holidays, birthdays, or other important events. The Department of Health and Human Services now has a program in place based on overseas experience and entitled Looking After Children (LAC) for children currently in care, which ensures that appropriate records are maintained and that they are involved in the collection. This is to be commended.

One of the opportunities offered to claimants as part of the Review process was to be guided through their personal files. For many this was a very revealing experience, amongst other reasons because they discovered for the first time why it was that they had been placed in care. A recommendation is made to ensure that children are told immediately why they are being placed in care and what they might expect to happen to them. This should be repeated periodically and should take account of the child's social and emotional development level.

Many also expressed bitterness and regret for lost educational opportunities. A number of boys in particular said that they had been 'bright' at school but had been forced to leave early – often so that they could help with farm chores. There was no expectation, particularly for boys in the large training institutions, that they would stay at school beyond the minimum leaving age. Some were angry that they had been labeled slow or 'retarded' at school simply because they were regarded as 'welfare kids'. The impact of such labels on self esteem and actual school performance would be incalculable. Even at this stage, when many of the claimants are approaching middle age, it must be concluded that the opportunity to return to some form of education, or to upgrade existing qualifications, would be of inestimable value and a recommendation is made to this effect.

Loss of contact with family members was also a major issue and there is considerable bitterness at what is perceived to have been a practice of splitting up siblings. There were 26 family groups represented in the Review, involving 79 claimants. Many were separated when they were placed into care, if not immediately then after one or two years. In some cases, they never met again and did not know if their brothers or sisters were alive or dead. Others have been reunited as a consequence of the Review after 30 or 40 years apart. Deliberate alienation of siblings is less likely to occur nowadays, but large families are still being placed into care and it is to be hoped that the Department is cognisant of issues surrounding this. A number of recommendations have been made to assist this process.

## **6.8 BREAKING THE CYCLE OF ABUSE**

A very disturbing finding from the Review was that in some families sexual abuse appears to have been accepted as 'normal'. A total of 13 claims were made involving members of two separate families. The claims involved intergenerational abuse. Some of the claimants were apparently unaware that other family members had lodged separate claims.

It was also apparent from the Review that the commonly held belief that people who were abused as children will often abuse their own children has substance. Numbers of claimants admitted to this.

Breaking this cycle and changing the culture of acceptance in some families requires a long term strategy involving child protection and educational authorities. Education has a key role to play in the prevention of future child abuse. Teachers are in an ideal situation to establish a climate, particularly in the classroom, that makes it clear that abuse is not acceptable; that children will be listened to and that any claims of abuse will be investigated and taken seriously. A recommendation to assist this process has been made.

## **6.9 ABORIGINAL CLAIMANTS**

Forty people included in the Review claimed Aboriginality, comprising 16 per cent of the total. The proportion is higher than in the Tasmanian population as a whole, but consistent with the higher incidence of Aboriginals in care generally, which may reflect judgmental issues of the time as to the standards of care which were provided in Aboriginal families. Five family groups are represented involving 15 claimants. Many of the claimants have linked their claims to past practices associated with the 'stolen generation' and lament what they regard as the deliberate alienation from their Aboriginal heritage. File records show that in each case the children were taken into care for stated reasons of 'neglect' rather than for reasons associated with the precepts underpinning the stolen generation movement.

## **6.10 AUTHENTICITY AND LEVEL OF SERIOUSNESS OF THE ABUSE ALLEGATIONS**

In respect of authenticity of claims a significant amount of corroborative evidence, in addition to the matters referred to Police and child protection authorities for investigation, emerged as the Review progressed. Many claimants gave independent accounts which supported the accounts given by others. There were specific reports of abuse on file and other reports of behavioural indicators which supported possible abuse. Sixteen independent witnesses, some of whom were former departmental employees, came forward to verify conditions in institutions. The Review team believed that some family members may have shared their stories beforehand, but in most cases the likelihood of collusion was considered relatively remote either because claimants evidently did not know each other or because they had not been contemporaries.

On balance, the Ombudsman Review Team concluded that there was a case to answer for the great majority of the claims and that most claimants had been abused in the manner described.

## 7. RECOMMENDATIONS

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1. **It is recommended** that the Government continue the healing process commenced with the present Review by continuing to accept claims of past abuse from adults who had been in State care as children. This should be an ongoing arrangement to apply to adults who had attained 18 years as at 11 July 2003 when the Review was announced. All current arrangements for assisting and providing redress to claimants should be retained, including the availability of *ex gratia* payments. The reopening of the Review should be widely advertised. It is not known how many additional people will wish to lodge claims but it is reasonable to assume that there will be a reduction in the rate of new claims lodged, compared with the current Review. The level of resources allocated to the task should be evaluated after 12 months.
2. **It is recommended** that the Government identify options to continue the Review process. This should include establishing a small unit, independent of Government, to be a first point of contact for receipt of claims and assessment.
3. **It is recommended** that a unit be established within the Department of Health and Human Services to manage claims referred to it by the independent unit, including the provision of guided access to personal files, assessment of other needs and referral to appropriate services, and referral to an Independent Assessor for determining *ex gratia* payments.
4. **It is recommended** that the Government note that the Review did not provide sufficient information about shortcomings in the current child protection system to warrant the establishment of a Commission of Inquiry. If the investigation carried out by the Commissioner for Children (see below) reveals that there are significant systemic shortcomings, it is recommended that the Government reconsider the matter of an Inquiry.
5. **It is recommended** that the Government allocate funds to establish a private educational trust fund to assist adults who have been victims of child abuse in State care to upgrade or continue their educational studies. The approach adopted by the Forde Foundation in Queensland could serve as an administrative model. It is recognised that in some cases access to the fund will mean that some people may in effect be ‘double dipping’ given that they may have already received an *ex gratia* payment. However, an opportunity to improve educational attainment was regarded as so important for some claimants that it would be in the community’s best interests to encourage and support them. It may also be appropriate to consider allowing children currently in care to access the funding, as well as those who have been victims of past abuse. It would be necessary to liaise with the Department of Education to identify the most appropriate ways of doing this.
6. **It is recommended** that the Government liaise with church authorities to seek a contribution to the establishment of a private educational trust fund.
7. **It is recommended** that the Government liaise with church authorities to seek an apology for claimants who allege that they had been abused while in Approved Children’s Homes run by the churches and who have specifically stated that they desire an apology.

8. **It is recommended** that the Commissioner for Children be asked by the Minister for Health and Human Services to investigate the 12 recent cases of alleged abuse referred to earlier in this report. The main purpose of the investigation should be to determine what action the Department had taken when the abuse was reported and whether the actions taken were appropriate. The investigation would also include a consideration of the selection of the foster families involved. The Commissioner should be asked to complete his investigation within a specific period and to ensure that the outcomes of his investigation are made public. Depending on the outcome of the Commissioner's investigation it may be necessary to conduct a more comprehensive audit of files of children currently on care and protection orders. At this stage, it would be inappropriate to make further recommendations in respect of foster care until the results of the Commissioner's investigations are known.
9. **It is recommended** that, in relation to the provision of services for children in State care under the *Children, Young Persons and their Families Act 1997*, the Commissioner for Children be asked by the Minister for Health and Human Services to advise if there is a need to:
  - (a) evaluate the effectiveness of the Working Together protocol between the Education Department and the Department of Health and Human Services. This would take into account policies in relation to support services, curriculum development and discipline;
  - (b) place restrictions on the number of children and young people or sibling groups that can be placed with approved foster carers at any one time. This policy to take into account:
    - the number and age of the carer's own children;
    - children with high support needs;
    - children who have been sexually abused, or have sexually abused other children; and
    - the placement of more than one sibling group with a carer;
  - (c) ensure that all children are informed within 24 hours of entering care why they have been taken into care and what they can expect to happen to them;
  - (d) ensure that all children who are the subject of an assessment of risk of harm and/or enter into the care of the State be given the option of a support person whom they know and trust.
10. **It is recommended** that the Commissioner for Children be provided with adequate resources to carry out the above.
11. **It is recommended** that there be increased and improved counselling and therapeutic services for adults who have experienced either recent or past sexual abuse. Existing support and/or counselling services should be taken into account when considering the range, adequacy and accessibility of appropriate services that might be established by Government to serve the community.

## **APPENDIX 1: PROTOCOL AGREEMENT**

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### **DEPARTMENT OF HEALTH & HUMAN SERVICES AND OFFICE OF THE OMBUDSMAN**

#### **REVIEW OF CLAIMS OF ABUSE BY ADULTS WHILE IN STATE CARE IN TASMANIA AS CHILDREN**

1. Any adult person (over 18) who was placed in State care in Tasmania may request that the Ombudsman review a claim of child abuse.
2. The Ombudsman will formally advise the public of the review, including providing access via a dedicated 1800 telephone line
3. All claims will be dealt with in confidence consistent with the requirements of the *Ombudsman Act 1978*.
4. The Department of Health and Human Services will appoint a Review Liaison Officer to facilitate all aspects of the review process.
5. The Department of Health and Human Services, custodian of records concerning children in State care, will cooperate with all aspects of the review, including making files and documents available, subject to securing any appropriate or necessary consents.
6. Department of Health and Human Services staff will be available as required to participate in meetings with the Ombudsman and/or people seeking a review.
7. The Ombudsman will review all individual claims and make recommendations to the Secretary of the Department of Health and Human Services on how a matter should proceed.
8. The Ombudsman may make general recommendations in relation to the resolution of claims.
9. The Ombudsman may refer matters to the Commissioner of Police.
10. If recommended by the Ombudsman, the Department of Health and Human Services will support initial access to counselling services by claimants pending the resolution of a claim.

## APPENDIX 2: THE REVIEW PROCESS

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### THE GENERAL APPROACH

The Minister for Health and Human Services made it clear when initially announcing the Review that it was to be a healing process intended to assist survivors of past abuse to gain closure. This focus was highlighted by the Premier's subsequent announcement that *ex gratia* payments of up to \$60,000 could be available to assist with some form of redress. The money was not to be perceived as compensation, partly because the age of the claims precluded the likelihood that allegations could be proven beyond reasonable doubt, and partly because it was recognized that the abuse suffered by many people was not compensable.

Claimants who wished to consider alternative legal action were offered advice by the Department of Health and Human Services as to the options available to them. The Department also offered to pay for an initial consultation to allow claimants to seek legal advice in such cases.

All claimants were offered psychological counselling and financial assistance to attend sessions as outlined in the Guidelines for Counselling document prepared by the Department. Counselling was offered as soon as the initial contact was made with the Ombudsman's Team. If a person was subsequently deemed ineligible for the Review, counselling was normally discontinued following a reasonable transitional period. Just under half of the adults in the Review took up the counselling option.

The focus on healing largely dictated the way that information would be collected. It was recognised that for many people the process of recounting their experiences would be traumatic and difficult. For these reasons trained interviewers were used to provide claimants with an opportunity to tell their stories in a face-to-face situation. Considerable attention was given to ensuring that the interview environment was conducive to an informal, relaxed atmosphere. All interviews were audiotaped, with the approval of the claimant. On average, interviews lasted about two hours, but in many cases considerably longer, particularly when a claimant became distressed or agitated. It was decided to conduct personal interviews with interstate claimants as well, rather than use telephone or video linkups, to provide them with same opportunity as Tasmanian residents. There were 35 interstate applicants and interviews were conducted wherever possible in an urban centre. Interstate claimants were provided with financial assistance if they had to travel any distance.

The retrospective nature of the Review has had both advantages and disadvantages. It provides an extraordinary insight into how attitudes to child protection have changed over a long period. While not a primary purpose of the Review, the body of information generated is very valuable and could feasibly be used, under strict confidentiality guidelines, for research into the causes of child abuse, which might help with the prevention of future abuse. Accounts from mature adults, including 15 independent witnesses, gives credibility to the abuse reports and helps to deflect one of the most common criticisms relating to child abuse, which is that children are not reliable witnesses.

On the other side of the coin, the disadvantage of retrospectivity also relates to credibility. Traditionally, there has been considerable scepticism about the reliability and accuracy of accounts of past child abuse, particularly when they are as old as most of the claims in the Review. Disbelief is compounded by the difficulty of obtaining corroborative evidence, the reluctance of witnesses to come forward and the negative experience for many people of not having been believed as a child when they tried to tell an adult what was happening to them. Moreover, public perceptions of what constitutes abuse have changed considerably over time.

Detailed file searches were undertaken for each claimant to verify placement details and to identify any reports or indicators of abuse on file. Given the age of many of the claims, it was impressive to discover that the majority of personal files were still available as departmental records, as were many institutional files. In the main, non- Government organizations, including church organisations, have co operated in providing access to their records.

File research was a time consuming and specialist task as many claimants had more than one file, (one person had 14). Considerable cross referencing of files was also necessary and the task was made more complex because the Departments responsible for welfare of children in State care have undergone many changes in the past 50 years, as has the enabling legislation.

#### **PROTOCOL WITH TASMANIA POLICE**

At the commencement of the Review, a protocol was agreed between the Ombudsman's office and Tasmania Police. An Assistant Commissioner was nominated as the official Liaison Officer with Police and a Detective Inspector and a Detective Sergeant were the nominated officers responsible for coordinating the investigation of matters referred by the Ombudsman to Tasmania Police.

It was agreed that if in the course of the Review process a potentially criminal matter was identified, the approval of the claimant involved would be sought before the matter was referred to Police. Claimants had the option of requesting that a matter be investigated, even if Police had previously investigated it.

If the claimant wanted the matter referred to Police, the Police Liaison Officer was notified in writing. A form was signed by the claimant authorising that a transcript of the audio taped interview be released to Police.

At the commencement of each interview, a standard 'Preamble' outlining the interview process was read aloud by the interviewer. The last paragraph of the Preamble states:

*"There is one additional matter that I need to mention to you before we start. During the course of the interview you may refer to circumstances when you were in State care that may amount to breaches of the criminal law that have been committed against you. If they relate to a person still living, then they are matters that could be referred to the Police for a criminal investigation. Whether this occurs is a matter totally for you. However, if during the course of the interview we believe that you refer to a crime that has been committed against you by a person still living, we will mention that to you and offer you the opportunity to consider whether you would like to have the matter referred to the Police. You can have a break to think about it if you wish to. If*

*you want the matter referred to the Police, we will terminate our interview for the time being and help you make contact with the Police. If, after consideration, you decide that you do not want to refer the matter to Police at this point in time, we will continue with the interview. Nothing you tell us will be released to the Police without your fully informed consent. Do you fully understand what I have just said?"*

### ***The Referral Process***

If the claimant had previously made a complaint to Police about the same or a related matter and the original investigation file was found to be still in existence, that earlier file was first reviewed within the District where the investigation was conducted. The District Detective Inspector oversighted the review.

Preliminary enquiries were made, based partly on the initial information supplied at the time of the referral from Child Abuse Review Team, to ascertain whether or not the suspect was still living. The Police investigating team then made contact and the claimant was re-interviewed in depth about the specific offences allegedly committed. Normal police investigation procedures were followed, including the identification of any possible witnesses or any other relevant evidence that might assist a possible prosecution prior to contact with the suspected perpetrator.

Tasmania Police has advised that, from an operational/prosecution perspective, the main stumbling blocks in the 'old days' were similar to the problems still encountered in current investigations of child abuse. The main difficulty inherent in investigations of this type is obtaining corroborative evidence. Offenders are typically secretive, manipulative and cunning in their *modus operandi*. The chances of there being independent eyewitnesses are virtually nil and other forms of corroboration such as a recent complaint from another source, forensic evidence, and similar fact evidence have to be relied upon. Prior to the 1990's, investigators did not have the advantage of the advanced forensic tools now available to investigating officers, most notably DNA profiling.

Relatively recent legislative changes have assisted Tasmania Police with the successful prosecution of offenders in these matters:

- In 1994 the addition of Section 125A to the *Criminal Code Act 1924*, allowed offenders to be prosecuted for 'Maintaining Sexual Relations With A Young Person'. This has meant that young persons do not have to specify exact days/dates/times/places for every single alleged assault upon themselves, but rather can elaborate upon an ongoing course of systematic abuse against them. Tasmania Police advise that this section has been utilized with great effect.
- The broadening of the definition of rape in 1987 removed the emphasis on sexual abuse being only against females and has allowed more offenders against males to be charged with the appropriate crime in the circumstances; and

- The implementation of the *Forensic Procedures Act 2000*, which provides comprehensive outlines for the obtaining and storage of forensic exhibits, such as blood and DNA.

## **CONFIDENTIALITY**

Confidentiality was a major issue. The Ombudsman is required under the *Ombudsman Act 1978* to deal with all matters in confidence. Claimants were advised at the outset that personal information obtained from interviews would not be disclosed to any person(s) outside the Ombudsman's delegated Review Team, other than to members of the Department of Health and Human Services' Review team (set up specifically to deal with recommendations by the Ombudsman) and to the Independent Assessor. However, if information disclosed that children or young persons might be in current jeopardy, the Ombudsman reserved the right to decide in the public interest that the information should be passed on to the relevant authorities. It was also agreed that information capable of identifying individual claimants would not be included in any report without permission.

## **RESOURCES**

The Government provided the Ombudsman with additional resources necessary to conduct the Review. The Ombudsman appointed a special team to carry out the Review.

The team comprised:

- A Coordinator (substantively a Senior Investigator with the Ombudsman);
- An Administrative Assistant;
- A Database Manager;
- Four trained interviewers, employed on a casual basis;
- A Consultant who acted as Liaison Officer between the Ombudsman and the Department of Health and Human Services.

The Review Team was accommodated separately due to lack of space in the Ombudsman's office and the need to maintain a secure and confidential environment where claimants felt comfortable knowing that their identity was protected.

A separate version of the Ombudsman's complaints database (Raemoc) was commissioned for registering, tracking and logging information in respect of each claimant. With the increase in claim numbers, a special database (CARA) was developed to facilitate analysis and reporting. Statistics from this database have provided the basis for the present report.

## **INFORMATION COLLECTION**

### ***Hotline***

Immediately following the announcement of the Review on Friday, 11 July 2003 a Telephone Hotline was installed to take effect from the following Monday (14 July 2003) and was kept open for six weeks. Thereafter calls were made to the usual Ombudsman Office telephone number. The acceptance of claims closed on 31 March 2004, following statewide publicity. The Ombudsman reserved the right to accept late lodgements.

### ***Initial Contact***

A pro-forma was developed to record initial contact information provided by the claimant.

This recorded:

- Personal details (ie full name, previous names, date of birth);
- The nature of the claim and the placement details;
- Whether the claimant was prepared to be interviewed and the preferred form of contact (ie telephone, letter, email);
- All claimants were offered counselling at time of initial contact; however this was discontinued if the claimant did not meet eligibility criteria in accordance with policy guidelines;
- Using the basic information provided by the claimant, individual personal files were requested from the Department of Health & Human Services and an analysis of the contents was used to verify the basic details of the claim prior to an interview being arranged.

### ***File Analysis***

All records pertaining to an individual claimant were sought from the Department of Health and Human Services. The purpose was to verify whether the claimant fell within the terms of the Review and warranted an interview.

Information was also sought that might support the claim, as well as assist in the interview stage of the process, such as reports of abuse and follow up action and/or behavioural or physical indicators of abuse.

A File Overview pro-forma was completed and passed to the interview team in preparation for a personal interview.

### ***Interviews***

All interviews were conducted by two interviewers and claimants were asked beforehand if they had any preference for male or female interviewers.

Interviews were audio taped with the consent of all parties. Tapes were not transcribed unless there was a need to clarify information, the claimant sought a copy or a transcription of interview was required to assist in a police investigation where a claimant had requested a Police referral. Tapes were stored in a secure location.

Those people who were to be interviewed were invited to have a support person present; claimants wishing to have their lawyer attend in a support role were advised that they could do so but it was to be understood that support persons were asked not to disrupt the interview and that this included interjecting, answering on behalf of the person being interviewed or acting as their advocate or legal representative. A 'Guidelines for People Providing Support' document was provided to the interviewee and the support person prior to interview.

Interviews followed a standard procedure but were essentially open ended to allow claimants ample opportunity to disclose their experiences. As an introduction the claimants were told how the interview would proceed and how the information would be used. If they indicated

that they wished to proceed, they were asked to sign an Ombudsman complaint form. At the end of the interview they were specifically asked if they had been satisfied with the process.

The interviews were conducted in ways that met individual special needs; this included making special arrangements for people with disabilities and people in prison. When the Hotline was operating, a dedicated telephone line was set up within Risdon Prison to enable prisoners to contact the Review Team directly.

Interviews were conducted in major centres within Tasmania and in central locations in all other States.

### ***Assessment of Individual Claims***

Post interview, a Summary of Claim was prepared by the interviewers based on the file analysis and notes taken at interview. In making their assessments, the interviewers also took into account the claimant's presentation at interview (eg body language). They also made use of information gained from an analysis and linking of information provided by other claimants (ie where one claimant stated that they had witnessed abuse being committed on another child) or they may have made enquiries to prove or disprove a particular claim, if pertinent information emerged from interviews.

The Summary of Claim was attached to the claimant's file and passed to the Coordinator with recommendations from the interviewers in respect of the strength of the claim.

The Coordinator reviewed all files and completed a standard Assessment Report, which was passed to the Ombudsman for ratification before being forwarded to the Secretary of the Department. The Secretary then passed each completed file on to the DHHS Review team for further action.

### **APPENDIX 3: STATISTICAL OVERVIEW OF CHILDREN IN CARE FOR THE REVIEW PERIOD**

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Appendix 3 gives annual statistics of children in care in departmental and private institutions and boarded out with foster parents for the period 1938/39 to the present. The information is drawn from departmental Annual Reports for the years 1938/39 to 1989/90. After 1990 the figures were not included in the Annual Reports and they have been extracted from other sources. The information contained in Annual Reports will vary from year to year, hence the omission of admission figures for some years.

Obviously, the figures provide only an annual ‘snapshot’ as children are counted across a number of years.

The Tables for the 1930s to 1990s indicate that children came into care on a temporary basis, or were admitted as wards of State either by order of the Children’s Court or by application by parents or relatives under s37 of the *Infants’ Welfare Act* 1935 or s35 of the *Child Welfare Act* 1960 respectively. Since 1 July 2000, children are placed on a variety of care and protection orders under the *Children, Young Persons and Their Families Act* 1997.

It has not been possible to locate any consistent reporting of private placements in the non-Government institutions.

The Table below shows the general trends over the Review period. While it can only be speculative as to why there was a ‘bulge’ in the 60s and 70s, it can be noted that the highest incidence of reported abuse by claimants was between 1960 and 1970.

#### **Numbers of children in care since the late 1930s to present**

<b>Period</b>	<b>Average number of children in care</b>
1930s	585
1940s	472
1950s	460
1960s	724
1970s	834
1980s	519
1990s	579
2000 – present	496

Notes:

- i) **The** figure for the 1930s is not an average. It is based only on 1938/39.
- ii) Figures for 2000-present are only to 30 June 2003.

### 1938-1940 Children maintained by the State

<b>ADMISSIONS</b>	<b>1938/9</b>	<b>1939/0</b>
Temporary	38	
Court Order	*	
Application	*	
<b>TOTAL new admissions</b>	<b>164</b>	<b>N/A</b>

<b>PLACEMENT</b>	<b>1938/9</b>	<b>1939/0</b>
Institution	220	
Boarding out	365	
<b>TOTAL IN CARE 30/6</b>	<b>585</b>	<b>N/A</b>

Notes:

- (i) \*Details on yearly admissions incomplete.
- (ii) 1939/1940 Annual Report not available.

### 1940s Children maintained by the State

<b>ADMISSIONS</b>	<b>1940/1</b>	<b>1941/2</b>	<b>1942/3</b>	<b>1943/4</b>	<b>1944/5</b>	<b>1945/6</b>	<b>1946/7</b>	<b>1947/8</b>	<b>1948/9</b>	<b>1949/0</b>
Temporary	10	17	16	7	3	3	11	2	5	6
Court Order	*	*	*	*	*	*	*	*	36	53
Application	*	*	*	*	*	*	*	*	39	33
<b>TOTAL new Admissions</b>	<b>133</b>	<b>112</b>	<b>95</b>	<b>89</b>	<b>99</b>	<b>96</b>	<b>80</b>	<b>90</b>	<b>80</b>	<b>92</b>

<b>PLACEMENT</b>	<b>1940/1</b>	<b>1941/2</b>	<b>1942/3</b>	<b>1943/4</b>	<b>1944/5</b>	<b>1945/6</b>	<b>1946/7</b>	<b>1947/8</b>	<b>1948/9</b>	<b>1949/0</b>
Institution	202	191	200	210	228	225	258	282	273	273
Boarding out	370	-	-	-	-	-	-	-	-	-
Foster mothers	-	316	276	246	215	203	179	156	148	130
Cottage Home	-	-	-	10	11	11	11	11	11	11
Clarendon	-	14	14	16	-	-	-	-	-	-
Home of Mercy	-	11	8	9	-	-	-	-	-	-
<b>TOTAL IN CARE 30/6</b>	<b>572</b>	<b>532</b>	<b>498</b>	<b>491</b>	<b>454</b>	<b>439</b>	<b>448</b>	<b>449</b>	<b>432</b>	<b>414</b>

Notes:

- (i) \*Details on reasons for yearly admissions not included in Annual Report.
- (ii) The Cottage Home was a departmental residential care facility established in the 1940s.
- (iii) The Home of Mercy and Clarendon Children's Home were Church of England Diocesan Homes.

### 1950s Children maintained by the State

<b>ADMISSIONS</b>	<b>1950/1</b>	<b>1951/2</b>	<b>1952/3</b>	<b>1953/4</b>	<b>1954/5</b>	<b>1955/6</b>	<b>1956/7</b>	<b>1957/8</b>	<b>1958/9</b>	<b>1959/0</b>
Temporary	5	3	-	5	-	-	-	-	-	-
Court Order	41	34	66	44	99	55	60	69	75	114
Application	13	19	28	22	40	51	45	18	51	58
<b>TOTAL new Admissions</b>	<b>59</b>	<b>53#</b>	<b>94</b>	<b>66#</b>	<b>139</b>	<b>106</b>	<b>105</b>	<b>88#</b>	<b>126</b>	<b>172</b>

<b>PLACEMENT</b>	<b>1950/1</b>	<b>1951/2</b>	<b>1952/3</b>	<b>1953/4</b>	<b>1954/5</b>	<b>1955/6</b>	<b>1956/7</b>	<b>1957/8</b>	<b>1958/9</b>	<b>1959/0</b>
Institution	255	260	261	225	272	266	246	242	265	279
Foster homes	121	97	75	70	99	105	125	115	124	174
Parent/relative					51	62	152	63	120	144
Cottage Home	9	9	11	10	10	11	12	4	2	6
Receiving Home							14	12	-	4
In employment					104	65	77	136	78	66
<b>TOTAL IN CARE 30/6</b>	<b>385</b>	<b>366</b>	<b>347</b>	<b>305</b>	<b>536</b>	<b>509</b>	<b>626</b>	<b>572</b>	<b>589</b>	<b>673</b>

Notes: (i) # Discrepancies in Annual Reports.

### 1960s Wards in care

<b>ADMISSIONS</b>	<b>1960/1</b>	<b>1961/2</b>	<b>1962/3</b>	<b>1963/4</b>	<b>1964/5</b>	<b>1965/6</b>	<b>1966/7</b>	<b>1967/8</b>	<b>1968/9</b>	<b>1969/0</b>
Court Order	101	134	103	98	103	76	90	100	112	102
Application	48	37	41	42	34	26	46	65	71	72
<b>TOTAL new Admissions</b>	<b>149</b>	<b>171</b>	<b>144</b>	<b>140</b>	<b>137</b>	<b>102</b>	<b>136</b>	<b>165</b>	<b>183</b>	<b>174</b>

<b>PLACEMENT</b>	<b>1960/1</b>	<b>1961/2</b>	<b>1962/3</b>	<b>1963/4</b>	<b>1964/5</b>	<b>1965/6</b>	<b>1966/7</b>	<b>1967/8</b>	<b>1968/9</b>	<b>1969/0</b>
Institution	241	249	226	239						
Foster homes	207	232	270	271						
Parent/relative	176	186	187	165						
Cottage Home	6	6	-	-						
Receiving Home	5	16	23	27						
Hospitals %	16	14	9	13						
In employment	82	65	66	67						
<b>TOTAL IN CARE 30/6</b>	<b>733</b>	<b>768</b>	<b>781</b>	<b>770</b>	<b>771</b>	<b>771</b>	<b>784</b>	<b>827</b>	<b>847</b>	<b>880</b>

Notes:

(i) % Includes mental hospitals.

(ii) Details on placement type not included in Annual Reports after 1963/1964.

### 1970s Wards in Care

<b>ADMISSIONS</b>	<b>1970/1</b>	<b>1971/2</b>	<b>1972/3</b>	<b>1973/4</b>	<b>1974/5</b>	<b>1975/6</b>	<b>1976/7</b>	<b>1977/8</b>	<b>1978/9</b>	<b>1979/0</b>
Court Order	110	115	116	118	140	73	60	60	70	77
Application	60	54	50	66	41	31	40	16	12	19
<b>TOTAL new Admissions</b>	<b>170</b>	<b>169</b>	<b>166</b>	<b>184</b>	<b>181</b>	<b>104</b>	<b>100</b>	<b>76</b>	<b>82</b>	<b>96</b>
<b>TOTAL IN CARE 30/6</b>	<b>920</b>	<b>937</b>	<b>927</b>	<b>939</b>	<b>936</b>	<b>866</b>	<b>793</b>	<b>721</b>	<b>674</b>	<b>636</b>

Notes:

(i) No details on placement type included in Annual Reports.

### 1980s Wards in care

<b>ADMISSIONS</b>	<b>1980/1</b>	<b>1981/2</b>	<b>1982/3</b>	<b>1983/4</b>	<b>1984/5</b>	<b>1985/6</b>	<b>1986/7</b>	<b>1987/8</b>	<b>1988/9</b>	<b>1989/0</b>
Court Order	*	*	68	83	*	33	71	47		*
Applications	*	*	13	11	*	74	18	22		*
<b>TOTAL new Admissions</b>	<b>*</b>	<b>*</b>	<b>81</b>	<b>93</b>	<b>*</b>	<b>107</b>	<b>89</b>	<b>69</b>		<b>*</b>
<b>TOTAL IN CARE 30/6</b>	<b>583</b>	<b>549</b>	<b>551</b>	<b>547</b>	<b>505</b>	<b>461</b>	<b>480</b>	<b>450</b>	<b>**</b>	<b>552</b>

Notes:

(i) \*Details on yearly admissions incomplete.

(ii) No details on placement type included in Annual Reports.

(iii) \*\*No figures on numbers of children in care in 1988/1989 Annual Report

### 1990s and 2000s

The figures and placement descriptors as set out in the following tables are taken from the Australian Institute of Health and Welfare (AIHW) Child Welfare Series statistics. The reporting methods differed among the periods June 1991-June 1995, June 1996, June 1997-June 1999 and 2000-2003. The 2004 figures are not available at the time of writing.

Since 1 July 2000, children are placed on a variety of care and protection orders under the *Children, Young Persons and Their Families Act 1997*. The term “ward of State” is no longer used.

### 1991-1996 Wards in care

PLACEMENT	Jun-91	Jun-92	Jun-93	Jun-94	Jun-95	Jun 96
<b>Residential</b>						
For Children with Disabilities	2	1	1	1	0	
Juvenile Hostel	5	0	0	14	4	
Family Group Home	39	36	40	36	32	86
Campus Home	49	47	45	40	39	
Hospital/ Nursing		3	0	0	1	
Other	2	11	17	0		
<b>Juvenile Corrective Establ't</b>	19	7	10	14	6	
<b>HOME BASED</b>						
Foster Care	234	259	229	230	223	240
Living with Relatives/parents	184	357	306	198	100	182
Other Placements	12	16	20	27	12	
Living Independently	52	82	41	51	40	
<b>TOTAL in care 30/6</b>	<b>598</b>	<b>819</b>	<b>709</b>	<b>611</b>	<b>457</b>	<b>508</b>

### 1997-1999 Wards and other children in care

ORDER	Jun-97	Jun-98	Jun-99
Finalised guardianship or custody orders	301	318	295
Other final orders	146	154	133
Interim and temporary orders	38	34	12
Administrative and voluntary	23	14	
<b>TOTAL at 30/6 *</b>	<b>508</b>	<b>520</b>	<b>440</b>

### 2000-2003 Children on Care and Protection Orders

ORDER	Jun-00	Jun-01	Jun-02	Jun-03
Guardianship or custody orders/arrangements	310	374	397	462
Supervisory orders	144	50	23	37
Interim and temporary orders	16	29	43	101
<b>TOTAL as at 30/6*</b>	<b>470</b>	<b>453</b>	<b>463</b>	<b>600</b>

**Notes:**

(i) \*AIHW Child Welfare Series 1997-2003 Tables: *Children on care and protection orders: type by State and Territory at 30 June* .

## APPENDIX 4: BACKGROUND INFORMATION ABOUT CHILD WELFARE IN TASMANIA FOR THE REVIEW PERIOD

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### THE STATUTORY FRAMEWORK

Claims lodged under the Review covered a period of time from the late 1930s until the late 1990s. The current legislation is the *Children, Young Persons and their Families Act 1997*. The following is the principal legislation relevant to these claims and prior to the current Act:

- The *Children's Charter Act 1923*;
- The *Infants' Welfare Act 1935*;
- The *Child Welfare Act 1960*;
- The *Child Protection Act 1974*.

Other relevant legislation is:

- The *Adoption of Children Act 1920* and its Amendments of 1943, 1945 and 1960, and *Regulations*; the *Adoption of Children Act 1968* and *Regulations 1969*;
- The Commonwealth *Immigration (Guardianship of Children) Act 1946* and Amendments;
- The *Domestic Assistance Service Act 1947* and *Regulations*;
- The *Mental Health Act 1963* and *Regulations*.

### The *Adoption of Children Act 1920*

The *Adoption of Children Act 1920* and its Amendments of 1943, 1945 and 1960, and *Regulations* and the *Adoption of Children Act 1968* and *Regulations 1969* are relevant for Review purposes in that some of the claimants went on to be adopted and have alleged a lack of duty of care by the Department.

Adoptions may be general, by a relative or by someone known to the child. Under the 1920 Act there was no requirement for an assessment of the adoptive parent to be undertaken and guardianship of the child transferred directly from the birth parent to the adoptive parent.

Following a series of interstate conferences from about 1966 onwards, all States and Territories introduced new legislation governing the adoption of children. In Tasmania, with the implementation of the *Adoption of Children Act 1968*, practice changed significantly and the assessment of adoptive applicants was required. In most cases, where a general consent was signed, the Director became the guardian under section 35 of the *Child Welfare Act 1960*. This remained in place until the Adoption Order was finalised. In extremely rare cases this transfer of guardianship may not have occurred where the adoption was of a "known child".

### **The Commonwealth Immigration (Guardianship of Children) Act 1946**

The *Commonwealth Immigration (Guardianship of Children) Act 1946* and Amendments relates to those child migrants placed in Tasmania. Child migrants were under the guardianship of the Commonwealth Minister of Immigration, who delegated his powers of guardianship in respect of children living in Tasmania, to the Director of Social Services. Guardianship of an immigrant child extended to the age of 21. In practice, the Department exercised supervision of child migrants until they attained the age of eighteen years and they were then informed that they should call at the nearest office of the Department, if they required legal advice or the assistance of the legal guardian. Following legal advice, claimants who were in care under this legislation were included in the Review.

### **The Domestic Assistance Service Act 1947**

*The Domestic Assistance Service Act 1947* and *Regulations* are relevant in relation to the Domestic Assistance Service of the Department of Social Services. The service originally operated in two ways:

1. It supplied housekeepers to go into private homes to assist during times of family emergency, such as a mother being hospitalised and no-one available to care for the children;
2. It provided accommodation for children from such families up to a maximum of six weeks, on the application of the parent.

In the later years it became extremely difficult to obtain housekeepers and it became practice to admit children into temporary care on a status known as 'Res DA'. Children were accommodated in a Receiving Home, an Approved Children's Home that was prepared to receive them, in a Departmental Institution or in a temporary foster home. Parents were required to contribute to the cost of maintaining children in this way.

Such children were not under the guardianship of the Department and the Department had no authority to detain the children against the wishes of the parent. However, following legal advice, claimants who had been in care under this legislation were included in the Review.

### **The Mental Health Act 1963**

The *Mental Health Act 1963* and *Regulations* are relevant in relation to children suffering from a mental health order or classified as operating at sub-normal level.

### **The Infants' Welfare Act 1935**

The *Infants' Welfare Act 1935* states that it is "an act to consolidate and amend the Law relating to the Welfare of Children and the Protection of Infant Life".

Its definition of a ‘neglected’ child provides some understanding of the social context of the day. Relevant categories are a child who:

- *is found in a brothel or reputed brothel, or a place where opium or any preparation thereof is smoked, or who is known to associate with or be in the company of a person known to the police, to be, or reputed to be, a prostitute, whether such person is the mother of the child or not;*
- *associates or dwells with any person known to the police, to be, or reputed to be, a thief or drunkard, or with any person who has no lawful means of support;*
- *is not provided with the necessary food, nursing, clothing, medical aid, and lodging, or who is neglected, ill-treated, or exposed by his parents or either of them;*
- *being of the compulsory school age, is an habitual truant from day school, or whose parent has been convicted at least twice of neglecting to cause such child to attend school;*
- *is illegitimate, and whose mother is dead, or is unable to maintain or take charge of such child;*
- *is found by a children’s court to be an uncontrollable child.*

### **The Child Welfare Act 1960**

Under the *Child Welfare Act 1960*, a child who was 16 years or younger, could be made a ward in one of three ways. The wardship lasted until the child attained 18 years, unless earlier discharged by the Minister.

Firstly, a child found guilty of a criminal offence could be released on a variety of orders or could be declared a ward of the State. The Act represents as a general principle of administration that an erring child shall be treated not as a criminal but as a child who is or may have been misguided or misdirected. Most of these wards were discharged from wardship upon completion of their period in an institution.

Secondly, a child who was neglected or uncontrolled could be declared to be a ward of the State. The definition of a ‘neglected’ child in the *Child Welfare Act 1960* included the concept of being in need of care and protection because the parent or guardian was unfit or not exercising proper care.

Section 31(2) defined proper care and guardianship, noting that:

*“proper care and guardianship shall be deemed not to be exercised in respect of a child if he is not provided with necessary food, lodging, clothing, medical aid, or nursing, or if he is neglected, ill-treated, or exposed by his parent or guardian.”*

A child could also be neglected if the child was uncontrollable, had no fixed place of abode, was exposed to moral danger, was truanting from school, or associating with thieves, prostitutes, drunkards and opium users. The parents or a person having the care or custody of a child could also bring the child before the court as being uncontrollable.

The Act also provides for an administrative way to admit a child as a ward of the State. On application by a parent, guardian or relative under section 35, the Director, with the Minister's approval could admit the child as a ward of the State.

### **The *Child Protection Act 1974***

The *Child Protection Act 1974* was developed as an Act to provide further and better protection for children from maltreatment, and reflects a growing community awareness and understanding of the abuse of children, especially sexual abuse. Prior to its introduction, Acts had focused on neglect issues. The *Child Protection Act 1974* allowed for the investigation of allegations of maltreatment of children who had not yet attained the age of twelve (12) years (Section 8 (1)). Orders made under the *Child Protection Act 1974* were of limited duration. Legal intervention to make the child a ward of the State was still required under the *Child Welfare Act 1960*. A definition of maltreatment is found in Part 1, Section 2 (4) of the Act.

### **LICENSING AND REGULATION OF OUT OF HOME CARE**

Over the period covered by the Review out of home care for children was provided by:

- Foster homes;
- Departmental residential care, known as Cottage Homes, Receiving Homes and Family Group Homes, and Departmental institutions;
- Approved Children's Homes.

### ***Foster Homes***

The *Infants' Welfare Act 1935* provided for any female person to apply to the Director to be licensed as a foster mother and to have her home registered as a nursing home. The licence was renewed every twelve months. To be eligible for a licence, the applicant had to be of good character and able to nurse and provide for any infants in her care or charge, and to be in good health and free from any constitutional disease of physical or mental disability (Part VII).

The relevant section deals with all children under five years of age, not only children committed to the care of the State. The Director appointed inspectors and inspecting nurses to supervise and carry out the licensing and registering functions. It was the forerunner of today's 'child care'. Older claimants under the Review often began their time in care in this type of arrangement.

In Section 10, the Act notes that:

*“every child of the State may be-*

- *placed in some receiving home;*
- *detained in an institution;*
- *transferred with the approval of the Minister from one institution to another institution;*

- *boarded out, apprenticed, or placed at service with some suitable person; or*
- *placed in the custody of some suitable person who is willing to take charge of a child.”*

The GC Smith Practice Manual (1966), written after the implementation of the *Child Welfare Act 1960*, notes that “*the Department regards the fostering of children in its care as most likely to meet the emotional needs of the child satisfactorily, provided the home is carefully selected, chosen with a view to any special needs of the particular child, and adequately supervised when the child has been placed in it.*” (Page 103)

At that time the Child Welfare Officer selected the foster homes and supervised the child placed in them. The Child Welfare Officer was required to ‘*supplement the CWO’s impressions of the foster home by additional enquiries either by following up references or by discreet enquiries made in the locality, and enquiries from the police.*’ (Page 103)

It was a requirement of the *Child Welfare Act 1960* that children for whom the Department was responsible must be visited, as far as practicable, at least once every three months.

It was also a practice for Child Welfare Officers to recommend that wards be returned to the parents if circumstances improved. When the Department placed a ward in the care of his/her parents, relatives or friends, it retained guardianship and could transfer the child elsewhere if this was considered necessary. Although the Department retained guardianship, it was the practice to allow the parents to exercise the normal functions of a parent as much as possible – this was because the intention of placing the child back at home was for it to become a permanent arrangement.

By the time the Family Services Operational Manual (July 1993) was implemented, the recruitment, induction, assessment, ongoing training and support of foster carers belonged to a specialized team of workers and was quite separate from the case management of children in care. Placement of children with approved foster carers required consultation between staff responsible for out of home care and the case manager.

### ***Departmental Residential Homes and Institutions***

The *Infants’ Welfare Act 1935* allowed the Governor to establish and abolish receiving homes, children’s homes, foundling houses, industrial schools, probationary schools, reformatories, farm schools and other institutions for the care and maintenance of children of the State.

(Part IV, Division I, Section 14(1))

The terms were broader under the *Child Welfare Act 1960*, which stated that the Governor could establish and maintain institutions for the accommodation, care and maintenance of wards of the State and those children where accommodation might be necessary in connection with the administration of the Act.

The GC Smith Practice Manual (1966) notes that there were two types of State Homes:

1. *Receiving Homes* – intended primarily for the accommodation of children, pending more permanent placement and for children in transit;
2. *Institutions serving the whole State* – specialist facilities designed to meet the needs of a specialised group of children, for whom the resources of foster homes and Approved Children’s Homes were inadequate. These institutions were regarded as training institutions with the task of rehabilitating the child/young person back into the home.

Receiving Homes (later known as Family Group Homes) did not have salaried staff. The Department owned the Home and carers were usually a couple who may or may not have had children of their own. Usually the male partner continued in his employment with the female partner available full time to provide care. The Home provided care for both males and females, often across a wide age range. The number of children in care at any one time varied. The Department met the costs of the Home and carers received a board payment for children placed, and an honorarium. Family group homes still operate today across the State. It should be noted that there were occasions where children remained in Receiving Homes long term.

The staff in departmental institutions were employed under the relevant State Service legislation and were responsible to the Director. The only remaining institution is the Ashley Youth Detention Centre. The mandate for its establishment and operation derives from the *Youth Justice Act 1997* and it provides for children and young people who are on remand or have been convicted of criminal acts.

### ***Approved Children’s Homes***

A number of children’s homes operated by churches or voluntary organizations were approved under the *Infant Welfare Act 1935* and the *Child Welfare Act 1960* and accepted wards of the State from the Department. The children remained under the guardianship of the Director, but some of his functions were delegated to the controlling body of the Home.

Approved Children’s Homes provided a valuable service to the Department which sought their help with the following categories of children:

- Those, whether wards or not, requiring short term accommodation perhaps during some family emergency;
- Those who, because of some mental or physical disability or behaviour problem, required special supervision;
- Older wards who might have found it easier to adjust to such a Home than to the more intimate relationship of a foster home;
- Wards from the same family.

### **CHANGES IN THE DEPARTMENTAL ORGANIZATION**

In 1873 the office of the Administrator of Charitable Relief was established to coincide with the passing by the Tasmanian Parliament of the *Public Charities Act 1873*. This office, known

as the Charitable Grants Department administered legislation relating to the care of destitute children and the inspection and supervision of charitable institutions.

A second department, the Department for Neglected Children was created by the *Youthful Offenders, Destitute and Neglected Children's Act* 1896. This Act made provision for boarding out neglected children and visiting committees to visit foster homes and institutions.

In 1911/12 these two departments were absorbed into the Chief Secretary's Department. With the advent of the *Children of the State Act* 1918, short titled the *Children's Charter*, came the Children of the State Department.

In 1923/24 the Charitable Grants Administration was again accorded full departmental status and contained within it the Children of the State Department.

*The Infants' Welfare Act* 1935 renamed the Department as the Social Services Department and it became known until 1946 as the Social Services and Children of the State Department, nominated as the administering authority for Child Welfare purposes.

The Department was renamed the Social Welfare Department in 1961, having absorbed the Domestic Assistance Service in 1947, the Juvenile Probation Service from the Attorney-General's Department in 1954/55 and the administration of the *Adoption of Children Act* from the Registrar-General's Department in 1961.

Restructures and amalgamation of community services with health services in the 1990s have resulted in several name changes – Department of Community Services, Department of Community and Health Services and most recently to the current name, Department of Health and Human Services.

#### **CHANGES IN THE PHILOSOPHY UNDERPINNING PROTECTION OF CHILDREN IN STATE CARE**

The *Infants' Welfare Act* 1935 and the *Child Welfare Act* 1960 focused on 'neglect' as being the reason for admitting children to the care of the State. For a large part of the review period, the well being of the child was assessed primarily in relation to health issues and physical development. If a child was referred for assessment to a psychiatrist or psychologist the assessment was about performance in relation to IQ and children were often labeled as mentally deficient. The assessment report would also contain information about family background and might mention emotional impairment in relation to behaviour of the natural parents and relationships between various family members.

Whole families came into care as a result of living in impoverished conditions due to the poor financial situation and apparent lack of parenting skills of their parents. Claimants from sibling groups have noted the huge impact on their ability to parent and to form meaningful relationships within their own families because of deprivation of family life.

Successive governments have since recognized the need for financial support to families to improve family functioning and have acknowledged the links between unemployment and lack of work skills and education on negative outcomes for families. Most recently there has

been funding provided at both the Commonwealth and State level aimed at strengthening families and supporting parents in the task of bringing up their children to achieve their potential.

Similarly there has been an improved understanding about the importance of education both in the early childhood years and late secondary years. A number of claimants have commented on their inability to acquire an adequate education and noted that there was an expectation by those in charge of them that they would enter employment as soon as possible. There has also been recognition by both the Education Department and the Department of Health and Human Services that children in State care are likely to have poorer outcomes than other children and therefore special planning is required to meet the assessed needs of these children.

With the advent of the *Child Protection Act* 1974 and the amendments in 1986, the concept of maltreatment was introduced and this specifically defined categories of physical, emotional and sexual maltreatment/abuse. The effects of maltreatment on children and the importance of the role of the psychologist and support services began to be recognized. Slowly adults began to believe children who alleged that they had been or were being sexually abused, although it has taken a long time to reach the level of awareness that there is today.

On 1 July 2000 the long awaited *Children, Young Persons and Their Families Act* 1997 commenced, following the implementation of the *Youth Justice Act* 1997 the previous year. These two pieces of legislation, which reflected national and international best practice, have brought about significant changes in the delivery of care and protection and youth justice services in Tasmania.

The earlier *Child Welfare Act* 1960 directed that an erring child be treated not as a criminal but as a child who is or may have been misguided or misdirected and that the care, custody and discipline of each ward of the State must approximate as nearly as may be to that which should be given to it by its parents.

In contrast, the guiding principles of the *Youth Justice Act* 1997 state that a young person is to be dealt with, either formally or informally, in a way that encourages the young person to act responsibly for his or her behaviour.

The *Children, Young Persons and Their Families Act* 1997 states in the principles to be observed in dealing with children that the primary responsibility for a child's care and protection lies with the child's family and that a high priority is to be given to supporting and assisting the family to carry out that primary responsibility in preference to commencing proceedings under the Act. This represents a fundamental change in thinking related to children placed in the State's care. Some 30 to 40 years ago parents, who for whatever reason were not able to care for their children, could arrange for them to be placed in the care of the State. It is now very difficult for this to occur.

Under the *Children, Young Persons and their Families Act* 1997 a multidisciplinary approach is used. The object of the Act is 'to provide for the care and protection of children in a manner that maximizes the child's opportunity to grow up in a safe and stable environment and to reach his or her full potential.' (Part 1, Section 7)

On a national and international level there has been recognition that there are more positive outcomes from prevention and early intervention strategies than the provision of remedial action after the event. Removal of children from their families is the last resort and governments are attempting to encourage and assist communities to take responsibility for helping to protect children. The *Children, Young Persons and Their Families Act 1997* states that everybody has a responsibility for the care and protection of children (Part 3, Section 13(1)).

### ***Changes in Respect of Institutional Care***

Certified private institutions under the *Infants' Welfare Act 1935*, such as St Joseph's Roman Catholic Orphanage, Hobart, and the Northern Tasmanian Home for Boys, and Approved Children's Homes under the *Child Welfare Act 1960* started out as homes located in 'mansions' with large dormitories, dining rooms and laundries.

Departmental institutions were constructed in a similar manner.

In the 1970s there was local debate, reflecting national and international trends about the capacity of these institutional dwellings to meet the developmental needs of children. A number of Approved Children's Homes began to introduce care in family units in cottages with married couples, often with their own children, as cottage carers.

The *Children, Young Persons and their Families Act 1997* does not provide for Approved Children's Homes. Three organisations still provide cottage care for the Department and they are Clarendon Children's Home and Kennerley Children's Home in the South and Glenhaven in the North and North West of the State.

By the end of the 1980s institutional care became a thing of the past, both for the Department and private organizations with the exception of Ashley Home for Boys, which had become a placement for juvenile offenders. Under the *Youth Justice Act 1997* Ashley has now become a juvenile detention centre and significant reforms have taken place since the implementation of the Act.

### ***Changes in Respect of Foster Care***

As previously stated, the recruitment, induction, assessment, ongoing training and support of foster carers was eventually moved to a specialized team of workers and was quite separate from the case management of children in care. Placement of children with approved foster carers required consultation between staff responsible for out of home care and the case manager.

In order to become a foster carer today a person must first attend a series of training sessions over 8 nights or over a weekend. These sessions cover what is expected of foster carers and the variety of situations that they need to be able to deal with.

Those who wish to become foster carers after the training sessions are assessed by an Out of Home Care worker who talks with them about their own history, their reasons for

wanting to be a carer, parenting a foster child and the ways of responding to children who have special needs.

Foster carers must provide medical checks and give written permission for police and child protection record checks to be made. If these checks are unsatisfactory the applicant is not accepted as a carer. Once approved, carers are reviewed every year and the case managers of children they have cared for are contacted to discuss if there have been any concerns about the care provided.

There are very strict guidelines in place for following up concerns about the care that foster carers provide, either about possible abuse or the quality of care provided.

It is made very clear that foster carers must support children to maintain contact with their families and must not use physical discipline with children in care. Each foster carer has a placement support worker who works with them to ensure that they provide the best possible care to children.

The *Children, Young Persons and Their Families Act 1997* does not talk specifically about foster care. The conventional terminology 'ward of the State' is no longer used. In Part 7 – *Children under the guardianship or in custody of the Secretary* (Section 69) – the Act states that the Secretary may provide for the care of a child who is under his/her guardianship or custody in several ways:

- in the care of a guardian of the child or a member of the child's family;
- in the care of any person the Secretary considers suitable;
- by giving directions as to the care of the child in the place in which the child resides as the Secretary considers appropriate;
- by making arrangements for the education of the child;
- by making arrangements for the medical or dental examination or treatment of the child or for such other professional examination or treatment as may be necessary or desirable;
- by making such other provisions for the care of the child (including financial assistance) as the Secretary considers appropriate.

## **APPENDIX 5: OVERVIEW OF FILES WHERE POLICE HAD EARLIER INVOLVEMENT IN INVESTIGATIONS**

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### **1940s**

**1. Complaint of physical assault by foster mother in 194-.**

The claimant, who was aged 15 at the time, stated that police spoke with him but he was not made aware of the results of any investigation. The complaint was referred to police by his grandmother. The DHHS file confirms this. A police file is no longer in existence, and it appears that no further action was taken, possibly due to a lack of corroborating evidence.

**2. Complaint of defilement made in the late 1940s.**

The alleged offender was the son of a facility staff member at the time. The matter was prosecuted in court and subsequently Departmental policy changed to the effect that only staff and wards were to reside in the facilities.

### **1950s**

**3. Allegations of sexual abuse and rape whilst in foster care in the early 1950s.**

A file note indicates that the allegations were reported to police but that the statements provided were inadequate to run a case against the alleged perpetrator.

**4. Allegations of sexual assault and rape in the mid 1950s to 60s in foster care.**

Complainant states she advised her Welfare Officer at the time but has ascertained within the past few years that the abuse had not been documented. No indication of an early police referral on file but does indicate that the claimant wrote to the Attorney-General many years later who advised her to report the abuse to police.

**5. Allegations of sexual abuse and rapes whilst in foster care in the late 1950s to early 1960s.**

A complaint was made to Tasmania Police in 1998. At that time there was no corroborating evidence and the suspect declined to answer any questions. Since interview, the claimant intends to reapproach Police with additional information that has now come to hand.

### **1960s**

**6. Allegations of sexual abuse whilst in foster care in the late 1960s.**

An initial complaint to the claimant's Welfare Officer was not believed. Another complaint was made to a subsequent foster carer and police became involved. However, it was again impossible to lay charges due to a lack of corroborating evidence. A third complaint was made to police in the early 2000s resulting in a re-investigation and advice to complainant that the offender was to be charged, however he died before this occurred.

**7. Complaint of ongoing defilement and/or rapes in the 1960s.**

Initially reported to police around 1970 but, possibly due to lack of corroborating evidence at that time, could not be advanced further. It was re-reported in 1992 but, due to elapse of time and lack of supporting evidence, could not be advanced. The file is currently being

reviewed along with other information that has since come to light in relation to physical abuse by the foster mother. The foster father, who was the alleged perpetrator of the sexual abuse, is now deceased.

### **1970s**

#### **8. Allegations of sexual abuse in the early 1970s.**

This was reported to the home Matron who in turn advised the Department of Welfare. The alleged perpetrator was the claimant's natural father who had previously been gaoled after being convicted of incest involving a relative. Police were notified and the claimant interviewed as part of an investigation process, but there is no record of the father having been convicted on this occasion. It is unclear as to whether he was actually charged or otherwise.

#### **9. Allegations of sexual abuse whilst in foster care from mid 1970s to early 1980s.**

The claimant's DHHS file indicates that a complaint was made to the Department around 1985 but there is no indication of a police referral.

### **1980s**

#### **10. Allegation of physical abuse.**

This claimant was in foster care in the early to mid 1980s. The departmental file indicates that the natural mother had complained to the Department that her child was suffering physical abuse committed by the foster carer. The Minister subsequently responded, however there is nothing in the file to indicate police involvement at that time. The claimant was advised by Child Abuse Review Team interviewing officers of matters that could be referred to police but declined.

#### **11. Allegations of sexual abuse whilst in foster care in the 1980s.**

The matter was reported to Tasmania Police and investigated but the alleged offender was not charged due to his poor state of health. He subsequently died. Police Internal Investigations (IIU) also investigated a police officer alleged to have been involved with the offender and this investigation was reviewed by the Ombudsman in 1992. The Ombudsman found nothing untoward in the IIU investigation.

#### **12. Allegations of sexual abuse, whilst in foster care, in the early 1980s.**

This matter was reported to police and the alleged perpetrator was interviewed. He denied the allegations. Police advised DHHS that charges could not be laid because of the lack of corroborating evidence, due in part to the suspect's denials and the claimant's intellectual disability.

#### **13. Allegations of sexual abuse whilst in foster care between in the early 1980s.**

The DHHS file indicates that the Department was made aware of the allegations but, apart from warning the alleged perpetrator to stay away from the claimant after the placement broke down, it appears that a police referral was not made.

#### **14. Ongoing sexual assault claim over a number of years by brother from 9 years of age.**

Reported to police in 1994 but alleged perpetrator not charged, possibly due to lack of corroborating evidence. He was allegedly charged previously with incest in relation to another sibling. The claimant is believed to have received a criminal injuries compensation payment. The original complaint is currently subject to police review following reference from this office.

## **1990s**

### **15. Allegations of sexual harassment and rape in mid 1990s.**

The child made allegations of inappropriate behaviour by the mother's boyfriend during an access visit. Children's Protective Services were notified and police CIB subsequently advised that based on the letter there was nothing that could be done as the allegations only amounted to sexual harassment and no action could be taken until the child made a formal complaint. Seven weeks after the initial complaint, the girl then stated the man had raped her. Local police were contacted and there were several meetings with Legal Aid. A file note indicates that the girl said she would not be pressing charges.

### **16. Allegations of sexual assault in 199- when aged 11 years.**

The offender was also aged 11 years and a co-resident in State care. Reported to police and Southern Assessment Committee of the Child Protection Unit. Resolved at the time that the allegations were substantiated but criminal proceedings against the offender were not finalised. There does not appear to be any indication on file as to why but most likely due to the age of the offender.

### **17. Complaint of single episode of sexual abuse that occurred in 1990.**

Complaint first made to interstate police in 1996 but complainant changed addresses before signing a statement. Signed 6 years later. File then forwarded to Tasmania Police in 2002. Another person named as also having been in State care and sexually assaulted in a similar manner by the same offender was spoken to by police but refused to assist at that stage. The alleged offender was interviewed but denied the allegation. Police were unable to establish a *prima facie* case as there was no corroborating evidence.

### **18. Allegations of sexual abuse whilst in foster care during the early 1990s.**

Parts of the allegations had been referred to Police at the time but due to lack of corroborating evidence they were not able to charge the alleged offender. The matter has again been referred to police following discussions with the Review Team.

## **No date advised**

### **19. Allegations of sexual abuse whilst in foster care.**

Allegations against the claimant's foster father were referred to the Child Protection Assessment Committee and investigated by police. According to the DHHS file, the allegations were proven to be unsubstantiated.

### **20. Complaint of rape by person appointed by Department to assist claimant.**

Carers originally did not believe her and her Welfare Officer was unsympathetic. She reported it to police but did not give them a true account of what really happened in order to minimize her humiliation. Offender committed suicide shortly after police investigations commenced. Claimant did not receive any counselling.

### **21. Allegations against a Departmental employee**

Allegations were investigated by Child Protection and the employee was cleared. At interview by the Child Abuse Review Team the claimant was advised of matters that were able to be further referred to police and ultimately another police referral was made.

## APPENDIX 6: REFERENCES

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