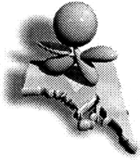
CHILDREN IN STATE CARE
COMMISSION OF INQUIRY

ALLEGATIONS OF SEXUAL ABUSE AND DEATH FROM CRIMINAL CONDUCT

Presented to the South Australian Parliament
by the Hon. E.P. Mullighan QC
Commissioner



Children in State Care and Children on APY Lands

Commission of Inquiry
South Australia

Office of the
Commissioner

Level 1
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31 March 2008

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

Your Excellency

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

Yours sincerely

The Hon. E.P. Mullighan QC
Commissioner

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Preface

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Hon. E.P. Mullighan QC
Commissioner

Acknowledgments

The extensive work undertaken by the Inquiry has been possible only because of the efforts of the Counsel Assisting, the Project Manager and the staff.

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

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

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

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

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

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

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

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Terms of reference

Schedule 1

1 Interpretation

In this Schedule –

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

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

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

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

2 Terms of reference

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

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

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

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

(2) The purposes of the inquiry are –

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

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

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

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

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

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

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

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

Explanatory note

Reference is made to 'the department' throughout this report. At March 2008, Families SA is the name of the division of the Department for Families and Communities that is responsible for the care and protection of children in State care. The term 'the department' is used to include the present department and its predecessors, which have undergone several name changes during the period covered by the Inquiry. See Appendix G for a list of the changes.

Summary

During the Children in State Care Commission of Inquiry, which started in November 2004, 792 people told the Inquiry that they were victims of child sexual abuse while living in South Australia. The 406 males and 386 females made 1592 allegations dating from the 1930s to the present against 1733 alleged perpetrators. Many told the Inquiry it was the first time they had disclosed the sexual abuse, and many said it still affected them as adults. Their evidence reflects surveys and studies conducted around the world in the past 30 years, which show that child sexual abuse is widespread, the reporting rate is low and the effects can be devastating and lifelong.

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

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

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

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

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

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

The allegations of 20 people who were not in State care, but who had been placed in non-government institutions with people who were in State care and came forward to the Inquiry, are also included in chapter 3. Their evidence of

Summary

child sexual abuse in those places of care tends to confirm the evidence of people who were in the terms of reference.

The Inquiry considers that the publication of each person's allegations is important for several reasons. It is an acknowledgment of the personal courage required to speak about their experiences; it is a significant contribution to the history of South Australia; and it is a forceful and compelling message about the vulnerability of children in State care and the need for reforms to ensure they are protected from sexual abuse and, if that fails, that their allegations receive an appropriate response.

The Inquiry believes that many adults who were sexually abused as children in State care have not come forward. Evidence received referred to other children in State care, particularly in large congregate care, who were also sexually abused. Research of records revealed names of other people who allegedly were sexually abused as children in State care, but did not come forward.

The Inquiry also received 924 names of children to investigate in order to determine whether any had died from criminal conduct while in State care (see chapter 5).

The Inquiry's approach and conduct

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

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

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

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

Sexual abuse of children in State care

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

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

> *We might not have had the ideal family, but we had my family.*
>
> *I just wanted my mum. I wanted mum. I didn't want to live with somebody else.*
>
> *To put a child in State welfare, in a home—make sure they have more contact with other siblings as much as possible because the heartache, the heartbreak and to wait so long [to be reunited with siblings] is devastating.*

Summary

Evidence given to the Inquiry demonstrates that the alleged sexual abuse occurred in every type of care from the 1940s onwards, including institutional care (large congregate care in government and non-government homes up to the 1970s), smaller group care (cottages, hostels and youth shelters from the 1960s to early 1980s), residential care units (admission, assessment and community units from the 1970s to the present), foster care (placements with other families from the 1940s to the present), family care (placement on probation to live at the family home from the 1940s to the present) and in secure care facilities (from the 1950s to the present).

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

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

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

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

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

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

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

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

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

> *I'm five and a half years old. I'm terrified—you know, scared shitless—and there's this bloke [the perpetrator] threatening to bloody kill me.*
>
> *They had a thing in there if you were a telltale, you suffered for it. You'd really get bashed up and everything else to go with it.*
>
> *I didn't feel that I could actually go to somebody and say because then I'd just be classed as a liar, troublemaker, something. I'm just a welfare child.*
>
> *You couldn't complain. Who do you complain to?*
>
> *[I] didn't have anyone else to rely upon. It's the hand that feeds you and puts a roof over your head, so you have these conflicting thoughts even as a youngster.*

> *I was ashamed to tell anyone what happened.*

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

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

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

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

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

> *I've wanted to, all my life. I've wanted to tell.*

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

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

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

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

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

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

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

Response of the State and recommendations

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

> *I've got no axe to grind. I'm not here to grind axes. I'm here to make sure it doesn't happen again to any kid.*

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

> *I think it's good that it's told so that it doesn't happen to other people.*

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

> *It's got to stop so it doesn't happen to other kids like me.*

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

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

resources are required to achieve the reforms necessary to protect children in State care from sexual abuse.

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

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

Prevention

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

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

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

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

Providing child-safe environments is also an important element of prevention. There is now a national register of sexual offenders, the Australian National Child Offenders Register (ANCOR), operated by the CrimTrac Agency. All states and territories have enacted legislation to ensure that the register receives and provides up-to-date information, nationwide. The aim of the South Australian legislation is to 'protect children from sexual predators by preventing such people from engaging in child-related work'. This includes work that involves contact with

children in juvenile detention centres, residential facilities and foster care. All government organisations are required to check whether applicants for such work have a criminal history.

In the non-government sector, it is mandatory only for schools to do a criminal history check on job holders and applicants. Organisations that provide health, welfare, education, sporting or recreational, religious or spiritual, child care or residential services wholly or partly for children are merely required to establish policies and procedures to maintain child-safe environments. The Inquiry recommends amendments to legislation to require all non-government organisations involved in child-related work to do criminal history checks before engaging anyone to do child-related work.

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

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

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

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

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

Someone to tell

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

Keeping them safe – in our care sets out a policy of 'connected care', which involves building a 'care team'. Such a policy must not, however, negate the need for every child in State care to have an allocated case worker. In May 2004, the government acknowledged that not every child in State care has been allocated a case worker and the GCYP told the Inquiry this is still true in 2007. Evidence to

the Inquiry indicates that the government finds it difficult to recruit and retain social workers, some of the reasons being heavy workloads, insufficient professional support and supervision, and an increase of inexperienced workers. This issue has been a concern since the 1960s, and was most recently addressed in the Layton report in 2003. Since then, the Inquiry has heard consistent evidence from former and current children and young people in State care about the importance to their protection of having regular contact with a case worker. The Inquiry recommends that the requirement for every child in State care to have an allocated case worker and regular face-to-face contact with that worker be formalised in *Keeping them safe – in our care.* Also, sufficient resources should be allocated to recruit and retain qualified case workers and ensure there is appropriate professional development and training on child sexual abuse issues.

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

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

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

Responding to disclosures

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

The Department for Families and Communities' Special Investigations Unit (SIU) currently handles allegations of sexual abuse of a child in State care against a carer, staff member or volunteer. Under its guidelines, the SIU must refer an allegation of sexual abuse to police within 24 hours and to conduct its own investigation in direct consultation with the police. The Inquiry considers that the Guardian for Children and Young People should have a role in this process as an independent advocate for the child: to monitor the State's response to the allegation, the progress of the complaint in the criminal justice system and the appropriateness of the child's placement and therapeutic care. (In some cases, the GCYP may be satisfied that the child has his or her own advocate of choice.) This would require legislative amendment to the role of the GCYP. The Inquiry believes it should also be mandatory for the Department for Families and Communities chief executive or the Commissioner of Police to notify the GCYP when a child in State care makes an allegation of sexual abuse. The Inquiry also recommends various legislative amendments to entrench the independence of the GCYP.

Summary

Evidence to the Inquiry from former and current children in State care establishes the need for an independent body to investigate any complaints from a child about the response to his or her allegation of sexual abuse. As one alleged victim told the Inquiry, there was no organisation 'to investigate my complaint properly that operated separate and independent and run away from under the direction and control of the Minister'. The Health and Community Services Complaints Commissioner (HCSC Commissioner) was established in 2005, with a child protection jurisdiction coming into effect in July 2006. The HCSC Commissioner has jurisdiction to receive, assess and resolve complaints about child protection services, and legislation enables that to be done independently. The Inquiry considers that the HCSC Commissioner holds an important statutory office that provides an independent complaints investigation and reparations process, which was not available to former children in State care. However, the current legislation does not permit a child under 16 to complain directly to the HCSC Commissioner. The Inquiry recommends legislative amendment to enable all children in State care to make a direct complaint, the implementation of a public awareness campaign about the role of the HCSC Commissioner in child protection, and that the role include the title of 'Child Protection Complaints Commissioner' when performing this function.

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

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

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

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

Summary

Children in State care who run away

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

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

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

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

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

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

Supporting adults who make disclosures of child sexual abuse

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

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

> *It's really up to, I guess, whoever is in power today … but a sense of recognition of what happened would be helpful.*
>
> *I've been hurt and that apology, a genuine apology, is extremely important to me, because it would help relieve some of the grief that sits there to this day.*
>
> *I would just like someone to say, 'Sorry'.*

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

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

The Inquiry also recommends that the government continue to provide free counselling for former children in State care who were victims of sexual abuse. The

Summary

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

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

Deaths of children in State care

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

The Inquiry identified three main areas of concern.

The first was that the department was unable to provide a single list of children who had died while in State care. It provided the Inquiry with eight lists from different sources, giving a total of 831 names. There was considerable overlap in names and errors in recording basic information, such as double recording of one death under slightly different names. One person recorded as dead was alive. The Inquiry also found that many children listed were never in State care (for example, had only received financial assistance from the department) and some had died after being released from State care. After accounting for those matters, the Inquiry identified from available records that of the names on the departmental lists, 421 children had been in State care and 377 had died while in State care.

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

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

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

Summary

The Inquiry investigated 15 allegations of criminal conduct linked to the deaths of children in State care.

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

The Inquiry found that there was nothing to substantiate allegations of criminal conduct in relation to a further four deaths—those of three teenagers in State care from drug overdoses and of a fourth teenager who set fire to herself.

Another death had a link to alleged criminal conduct in that it involved the suicide by a girl in State care after she made allegations of sexual abuse against her foster father. In relation to the death of a baby girl, the Inquiry considers it inappropriate to make a determination, given the currency of the matter.

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

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

List of recommendations

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

1

RECOMMENDATION 1

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

2

RECOMMENDATION 2

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

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

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

3

RECOMMENDATION 3

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

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

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

4

RECOMMENDATION 4

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

5

RECOMMENDATION 5

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

6

RECOMMENDATION 6

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

7

RECOMMENDATION 7

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

8

RECOMMENDATION 8

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

List of recommendations

RECOMMENDATION 9

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

RECOMMENDATION 10

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

RECOMMENDATION 11

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

RECOMMENDATION 12

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

RECOMMENDATION 13

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

RECOMMENDATION 14

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

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

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

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

List of recommendations

RECOMMENDATION 15

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

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

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

The training program should be mandatory for all social workers.

RECOMMENDATION 16

That adequate resources are directed towards:

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

RECOMMENDATION 17

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

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

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

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

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

The training program should be mandatory and accredited.

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

18

RECOMMENDATION 18

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

19

RECOMMENDATION 19

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

List of recommendations

20

RECOMMENDATION 20

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

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

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

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

21

RECOMMENDATION 21

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

The review should include the:

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

22

RECOMMENDATION 22

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

23

RECOMMENDATION 23

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

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

List of recommendations

RECOMMENDATION 24

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

RECOMMENDATION 25

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

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

RECOMMENDATION 26

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

RECOMMENDATION 27

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

RECOMMENDATION 28

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

RECOMMENDATION 29

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

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

RECOMMENDATION 30

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

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

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

List of recommendations

31
RECOMMENDATION 31

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

32
RECOMMENDATION 32

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

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

33
RECOMMENDATION 33

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

34
RECOMMENDATION 34

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

35
RECOMMENDATION 35

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

36
RECOMMENDATION 36

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

37
RECOMMENDATION 37

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

38
RECOMMENDATION 38

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

39
RECOMMENDATION 39

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

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

List of recommendations

RECOMMENDATION 40

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

RECOMMENDATION 41

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

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

RECOMMENDATION 42

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

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

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

RECOMMENDATION 43

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

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

RECOMMENDATION 44

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

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

RECOMMENDATION 45

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

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

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RECOMMENDATION 46

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

RECOMMENDATION 47

That the following offences be created:

(1) Harbouring a child in State care contrary to written direction.

(2) Communicating with a child in State care contrary to written direction.

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

RECOMMENDATION 48

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

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

RECOMMENDATION 49

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

The database should contain:

- the child's name and date of birth
- when the child was placed in the custody or under the guardianship of the Minister; or the details of the voluntary agreement
- the child's last place of care
- the name of the child's last carers
- the date of death
- the cause of death (as initially advised to the department)
- the circumstances of the death (as initially advised to the department)
- the source of initial advice about the cause and circumstances of death
- confirmation that the death was reported to the State Coroner and when
- if an inquest was not held, the cause of death as found by the coroner and when that finding was made
- if an inquest was held, the cause of death as found by the Coroner's Court and when that finding was made
- if an inquest was not held because of a criminal prosecution, the name of the investigating police officer and the outcome of the criminal prosecution.

RECOMMENDATION 50

That where a child dies in State care, the Department for Families and Communities maintains a physical file, which contains:

- information about when the child died and in what circumstances, including reference in the file to where the information has come from
- information from the State Coroner as to whether an inquest is to be held
- the coroner's finding as to cause of death
- a copy of the coroner's reasons in the event that a coronial inquest is held.

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RECOMMENDATION 51

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

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

RECOMMENDATION 52

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

RECOMMENDATION 53

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

RECOMMENDATION 54

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