

31 May 1999

The Honourable Anna Bligh MLA  
Minister for Families, Youth and Community Care  
Minister for Disability Services  
Parliament House  
BRISBANE

Dear Minister

On behalf of the Commissioners it is my pleasure to present the Report of the Commission of Inquiry into Abuse of Children in Queensland Institutions.

Yours sincerely

Leneen Forde AC  
Chairperson

## COMMISSIONS OF INQUIRY ORDER (NO. 1) 1998

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#### **Short Title**

1. This Order in Council may be cited as Commissions of Inquiry Order (No. 1) 1998.

#### **Commencement**

2. This Order in Council commences on 13 August 1998.

#### **Appointment of Commission**

3. Under the provisions of the *Commissions of Inquiry Act 1950* and all other enabling powers Leneen Forde AC, Jane Thomason and Hans Heilpern are appointed to make full and careful inquiry without undue formality with respect to the following matters:-
  - A. (i) In relation to any government or non-government institutions or detention centres established or licensed under the *State Children Act 1911*, *Children's Services Act 1965* or the *Juvenile Justice Act 1992*:
    - (a) whether any unsafe, improper or unlawful care or treatment of children has occurred in such institutions or centres; and
    - (b) whether any breach of any relevant statutory obligation under the above Acts has occurred during the course of the care, protection and detention of children in such institutions or centres.

- (ii) If a non-government institution, prior to being licensed under the *Children's Services Act* 1965, was registered under the *Infant Life Protection Act* 1905 then statutory obligations under the *Infant Life Protection Act* 1905 and such period of registration are also deemed to be within the scope of the Inquiry as prescribed by paragraphs A(i)(a) and (b) above.
- B. In the context of the need to resolve these matters as soon as possible, to:
  - (i) examine the outcomes of any previous investigations;
  - (ii) be aware of and take into account the scope of any current investigations or proceedings by other authorities into matters falling within the ambit of paragraph A above; and
  - (iii) receive information from the Children's Commissioner and examine any allegations in relation to these matters which have been made to date under the *Children's Commissioner* and *Children's Services Appeals Tribunal Act* 1996.
- C. After such inquiry as the Chairperson deems appropriate, refer to the appropriate authorities any instances where there appears to be sufficient evidence to prosecute for a criminal offence, take disciplinary proceedings, or pursue a charge of official misconduct against any person under any Act in respect of such lack of safety, impropriety or unlawful care or treatment of children.
- D. To make any recommendations as may be considered appropriate in relation to:
  - (i) any systemic factors which contribute to any child abuse or neglect in institutions or detention centres;
  - (ii) any failure to detect or prevent any child abuse or neglect in institutions or detention centres; and
  - (iii) necessary changes to current policies, legislation and practices.
- E. By 1 March, 1999 make full and faithful report and recommendations in relation to the subject matters of inquiry and to transmit same to the Minister for Families, Youth and Community Care and Minister for Disability Services.

#### **Applicable Act**

- 4. Apart from Section 19C, all other provisions of the *Commissions of Inquiry Act* 1950 shall be applicable to the Inquiry.

### **Appointment of Chairperson**

5. That Leneen Forde AC be appointed as the Chairperson of the Commission established by this Instrument.

### **Ministerial Directions**

6. The Minister for Families, Youth and Community Care and Minister for Disability Services is to give the necessary directions herein accordingly.

### **END NOTES**

1. Made by the Governor in Council on 13 August 1998.
2. Published in the gazette on 14 August 1998.
3. Not required to be laid before the Legislative Assembly.
4. The administering agency is the Department of Families, Youth and Community Care.

## FOREWORD

I am pleased to present the final report of the Commission of Inquiry into Child Abuse in Queensland institutions.

I have been impressed by the courage of those who came forward, often moved by the hardships they have endured, and saddened that such abuses were somehow permitted to take place. The accounts that I have heard and read have left a lasting impression and I will never forget them. For all those who came forward to tell their stories, and to all victims of abuse in institutions, I dedicate this report to you, and hope that it will be a small step on the long road to healing and reparation.

I acknowledge also the many hardworking, good, dedicated people who have selflessly devoted their lives to the care of children over many years. I have great admiration for their contribution, and am sensitive to the fact that such innocent people may feel hurt by the findings of the Inquiry. It is important to emphasise that, while we did hear substantial evidence of abuse against children in institutions, not all children were involved, nor all staff.

I took this job to enquire into the truth. I have done that to the best of my ability. I could not have done so without the support, wisdom and encouragement of my late husband, Angus McDonald, who, even though he was terminally ill, knew that it was a vitally important task I should undertake. I wish to extend my special thanks and appreciation to my co-commissioners and Inquiry staff for their friendship, support and understanding as I coped with personal hardship.

I urge all Queenslanders to contemplate the experiences of children in institutions, how it came to pass that many of them were abused and mistreated, and why it has taken so long for their stories to be told. It was society that failed those children. In acknowledging that, we must ensure that the same wrongs are not repeated, and that this Inquiry has a positive outcome.

To understand and learn from the past, we must all accept responsibility for children—our most valuable and vulnerable asset. Let us resolve to ensure that systems and policies leave no room for abuse, and create a framework for building a better future.

**Leneen Forde**  
Chairperson

## EXECUTIVE SUMMARY

### INTRODUCTION

In August 1998 the Minister for Families, Youth and Community Care established a Commission of Inquiry to examine whether there had been any abuse, mistreatment or neglect of children in Queensland institutions. The Commission was given a tight timeframe to report to the Government, initially to be 1 March 1999 and extended to 31 May 1999.

This is no ordinary report. This was no ordinary Inquiry. For the Commissioners and staff of the Inquiry, the experience has been deeply moving and deeply disquieting. We have heard repeated reports of physical and sexual abuse in government and non-government institutions over decades, which have resulted in irreparable damage to the lives of many Queenslanders. Why did this happen? How can anyone possibly repair the damage done? How can we as a society ensure that such violations never again occur to children whose care we have entrusted to the State?

The Commission has taken a child- centred approach to its deliberations. Children are our most precious resource. They are our future. Their experience as children will determine what kind of adults they become and what kind of society there will be. One act of abuse or mistreatment towards a child is one act too many. Repeated acts of abuse that have gone unrecognised and unaddressed are inexcusable. Although there have been many reasons presented to the Commission as to how and why the abuses took place, none excuse the abuse, nor do they excuse the failure of those in authority in government, churches and society in general to effectively deal with complaints of abuse. We have failed these most disadvantaged and powerless children in the past. It is vital that we do not continue to do so.

The challenge placed before the Commission has been daunting. It encompassed the period from 1911 to the present day, and more than 150 orphanages and detention centres. The paucity of written records and archival material, the small proportion of ex-residents of institutions who came forward, and the understandable reluctance of current residents to speak freely of their experiences in institutions have made our task more difficult.

Over 300 people provided information to the Commission and shared their often tragic life experiences. Many of them showed great tenacity and survival after years of hiding their deep secrets, with no one to tell. For individuals, their childhood experiences, the separation from their parents and siblings and their placement in orphanages and detention centres have deeply scarred them and had an immeasurable impact on the rest of their lives. These experiences continue to affect victims and families to this day. We heard stories of children feeling worthless, vulnerable, stigmatised, unloved and being denied opportunities, and adult lives filled with poor personal relationships, broken marriages, suicide attempts, uncertainty and insecurity.

A number of witnesses to the Inquiry have described severe and prolonged trauma. In some cases, up to fifty years have elapsed between the abuse and the disclosure to the Inquiry. We recognise that this raises questions about the accuracy of these memories. The issue was also raised by witnesses who feared that they would not be believed. After reviewing the literature, we conclude that there is no completely accurate way of determining the validity of abuse reports without corroboration. There are many factors that can influence the accuracy of memories. We have been guided by the substantial literature that recognises delayed recall and dissociation but caution the reader that the detail of witnesses' memories cannot be automatically interpreted as a literal, historical reality. In many cases, we have heard similar accounts corroborated by several witnesses, and archival material has provided substantial corroboration of the broad thrust, if not the detail, of witnesses' evidence.

We recognise that for some victims it is the process of sharing their experience that offers an opportunity for progressive self-healing, and above all it offers the chance to be heard, believed and acknowledged. We acknowledge the courage and the inner strength required of the many victims who appeared before the Inquiry.

We have recognised the need to place historical matters within the context of the prevailing social attitudes and economic circumstances, but the abuses disclosed went far beyond the prevailing acceptable limits. We also understand the often extreme constraints placed on carers, who may have been inadequately prepared for their task and who had far too many children in their care. In some cases, those directly responsible for the children may also have been vulnerable as a result of limited quality relationships and social support systems. We heard that relationships among staff in some institutions were discouraged and they were permitted limited contact with the outside community. Sometimes, the carers also were drawn from the same institutions.

We believe that it is important to place on the public record that few of the children historically placed in orphanages were, in fact, orphans. Most were either removed from their families by the State, or placed in orphanages by their parents, who for various reasons (such as the death or illness of one parent) were unable to look after them. In the case of indigenous children, this occurred simply because of the colour of their skin. Very few of the British child migrants (erroneously referred to at the time as ‘war orphans’) were orphans.

Another disturbing matter for the public record is that many children who have been incarcerated in the State’s reformatories, detention centres and similar institutions over the years should never have been incarcerated at all. Some boys were sent there simply because they reached the age of 14 years and could no longer stay in an orphanage; girls were often placed there for being in ‘moral danger’, which generally referred to being active sexually; others were placed there for minor offences such as truancy or running away. These children then associated with children who were convicted of criminal offences, were treated like criminals, were labelled as criminals, and were treated far more harshly than their behaviour ever warranted. Little wonder that many of these children subsequently fell into criminal activities and have bitterly resented their unjust incarceration.

While we have been deeply moved and indeed disturbed by the events of the past, we are conscious that there remain approximately 300 Queensland children in residential institutions and detention centres today. Their safety and protection is a critical concern. We cannot rebuild their childhood for past survivors, but we do have a responsibility to ensure that children in care today suffer no harm while in that care. Understandably, the Commission heard from few children currently in care in institutions—it is unlikely that such children would have the confidence to come forward. As a result, we have taken a number of steps to seek the views of children in institutions today, in both residential and detention settings, and to assess their risk of abuse in those institutions. Sadly, our findings indicate that there remain some risk situations, where children may still be exposed to abuse and mistreatment. It is vital that these be addressed.

We acknowledge that we have seen only a small proportion of children who were in institutions and that some children may have had pleasant or at least neutral experiences in those institutions. Indeed the Commission has heard from a small number of witnesses from orphanages who came forward to express strong support for the institutions where they were resident. However, we have taken the clear view that one child abused while in the care of the government is one child too many.

### **The process**

There have been two major thrusts of the Inquiry: first, an investigation into institutional abuse that has occurred in the past, based on oral and written evidence and from archival research; and second, a review of the current systems, which included reviews of legislation, policy and practice, evidence from public and private hearings, and inspections of facilities.

We adopted a broad range of strategies to inform likely stakeholders and the general public about the Inquiry. The Inquiry consulted with stakeholder groups, invited individuals who had resided or worked in institutions within the Terms of Reference to come forward, and invited submissions from other interested individuals and organisations.

We were conscious of the constraints faced by indigenous people in coming forward. This was evidenced by the limited submissions received from indigenous people, despite their disproportionately high representation in many institutions covered by the Terms of Reference. In response to this we took a range of steps to increase the likelihood of information being obtained from indigenous people.

Predominantly the hearings have been conducted in private. This has been for two main reasons. First, the sensitive and private nature of the evidence given led many witnesses to request full confidentiality. Second, during the period of the Inquiry there was a substantial amount of civil litigation and outstanding criminal proceedings in relation to the subject matter of some of the evidence. Public hearings would have prejudiced these proceedings, and persons named adversely in public hearings can be unjustifiably prejudiced if evidence is taken before an opportunity to respond has been given.

In addition to hearings and interviews, the Inquiry received evidence in the form of written submissions from individuals and organisations. Expert evidence was also received through written submissions and public hearings.

To ensure full coverage of the matters within the Terms of Reference, we commissioned a number of independent experts to examine a broad range of areas relevant to the Inquiry. The research unit of the Inquiry carried out literature reviews to provide context, and to inform the Inquiry about current developments in the field of institutional child abuse. These studies were guided by current literature, and were supported by a number of submissions to the Inquiry from academic and professional experts. In addition, we carried out a systematic review of archival evidence.

### **The report**

The report has been designed to provide readers not only with our findings but also information on the very complex subject of child abuse in institutions. As our brief has covered a period of several decades, we have also sought to examine the relevant social, economic, legislative and religious climate in Queensland during different periods of time. The main thrust of our findings is presented in Chapter 5 which covers orphanages and residential care, Chapter 7 which covers industrial schools and detention centres, Chapter 9 which covers detention centres today, and Chapter 11 which covers legislation and departmental practice. In Chapter 12 we summarise our findings. Closed reports on the Inquiry findings with regard to St Joseph's Home, Neerkol and Karrala House have been separately provided to the Minister as they are the subject of current litigation.

## **THE FINDINGS AND RECOMMENDATIONS**

The Terms of Reference for the Inquiry relate, in part, to all government or non-government institutions or detention centres established or licensed under the *State Children Act 1911*, the *Children's Services Act 1965* or the *Juvenile Justice Act 1992*. The brief was to determine:

- (a) whether any unsafe, improper or unlawful care or treatment of children has occurred in such institutions or centres
- (b) whether any breach of any relevant statutory obligation under the above Acts has occurred during the course of the care, protection and detention of children in such institutions.

In relation to (a) above, the Inquiry finds that unsafe, improper and unlawful care or treatment of children has occurred in such institutions and centres.

In relation to (b) above, the Inquiry finds that breaches of relevant statutory obligations under the above Acts have occurred during the course of the care, protection and detention of children in such institutions.



## **Past unsafe, improper or unlawful care or treatment**

The Inquiry found that there have been incidents of unsafe, improper or unlawful treatment of children in many institutions licensed and established under the relevant Acts.

Those that may result in criminal prosecution have been referred to the Queensland Police Service. In the case of other allegations of abuse, the passage of time, the fact that a number of alleged perpetrators are now deceased and the difficulty in obtaining corroborative evidence meant that detailed findings could not be made. It has been possible, however, to make general findings on the nature of the abuse of children that took place in institutions within the Terms of Reference of the Inquiry.

The main categories of abuse identified by the Inquiry are emotional abuse, physical abuse, sexual abuse and systems abuse.

### *Emotional abuse*

Children need care, protection and nurturing in an environment where there is trust and support. Instead, many institutions were austere places, staffed by people lacking the training and in some instances the personal capacity to provide the warmth and nurturing necessary for the healthy development of children. Until the early 1960s, most institutions were run on the basis of strict discipline, with little awareness of the developmental or even the educational needs of children. Impersonal treatment and the lack of respect for children's individuality were commonplace.

In many institutions the emotional abuse of children went far beyond neglect of their emotional needs. Behaviours on the part of some carers amounted on occasion to mental cruelty. Sometimes, demeaning, humiliating remarks were made on an almost daily basis, which had the effect of undermining the children's confidence and their sense of self-worth. Emotional abuse can be the most damaging form of abuse, and its effects were profound on the lives of many who were subjected to it.

### *Physical abuse*

Corporal punishment was common in institutions, and was permitted under the Regulations in certain circumstances. The Inquiry found incidents of gross excesses in physical abuse in many institutions, beyond any acceptable boundary in any period. Aside from individual incidents of abuse, the Inquiry found in some institutions, at certain periods, a culture of physical punishment and brutality engendered or tolerated by the management. Westbrook, during the time when Roy Golledge was Superintendent, provided the most extreme example of such a culture.

### *Sexual abuse*

Complaints of sexual abuse, perpetrated either by other residents, by staff, or by visitors to the institution, emerged from almost all of the institutions under consideration. In some cases, the individuals alleged to have committed the offences have already been charged and in a small number of cases, have already been dealt with. In many instances, the alleged perpetrators were long dead or could not be clearly identified.

Disclosure, difficult for any victim of sexual abuse, is even more difficult with the power imbalances and vulnerability encountered in residential or institutional care. Children are often fearful that if they tell others about the abuse it may result in further abuse or re-victimisation by the system. Many witnesses said they were disbelieved and often punished for reporting abuse.

### *Systems abuse*

Many children historically have been the victims of the systems designed to provide care and protection for them. The Inquiry has found a range of ways that children have been harmed while within the system. Some of the harm has been caused by ignorance on the part of providers of the needs of children, some by failures in the system to monitor and track the needs of individual children, some by a lack of commitment by government to provide

adequate resources to care for the children's wellbeing, and some by a perception that children deserved no better.

One of the most obvious causes of systems abuse is the lack of funding and resourcing that has beset children's services both in the past and in the present day. Children and young people in care should receive adequate education, vocational training, physical and mental health care, leisure and recreation, contact with the community and family, and a range of programs that prepare them to function independently and risk-free upon discharge. Many children in institutions this century have not received even a basic education, let alone the range of developmental programs that would be desirable.

Resource constraints have been a perennial problem for institutions. Despite this, consecutive government departments continued to place children in institutions without regard to their capacity to provide proper care for the numbers they were receiving. The overcrowding at many denominational orphanages up to the late 1960s meant that it was impossible for children to receive adequate, individual care and attention.

A recognition of the relationship between the Department and the denominations which ran the licensed institutions is essential to an understanding of how institutional care could fail children in so many respects without intervention from the Department. The levels of funding on which almost all of the denominational institutions operated were patently insufficient to allow the provision of proper individual care. Yet the Department continued to place children in those institutions because they provided a cheap means of lodging children for whose care it was responsible, and it was able to use as justification the fact that the children were, after all, in Christian care. The churches, for their part, acquiesced in this indiscriminating placement of children because of their perceived obligation to provide refuge to homeless children, however inadequate their resources might be. By doing so, they acquired an ascendancy over the Department; it was most unlikely that the Department would jeopardise its access to those placements by subjecting the institutions to scrutiny of the kind necessary to ensure that children were being cared for properly. The denominations were thus able to carry out what they considered to be their Christian mission without risk of interference from the Department. On its side, the Department maintained an irreplaceable, cheap resource, and could complacently point to the fact that the children were being raised in a Christian environment.

Another insidious form of systems abuse to which many children were subjected was the implementation of practices that led to children who had not been convicted of criminal offences serving indeterminate periods in an institution primarily for convicted children. Neglected children, or children on care and protection orders, could, with administrative approval, be transferred to 'correctional' facilities until they reached 18 years of age if it was considered that their behaviour warranted some form of treatment program or, for some boys, simply because they had reached the maximum age accepted at an orphanage.

Similarly, children committed to care and control orders because they were considered to be in 'moral danger', 'uncontrollable' or 'likely to fall into a life of vice or crime or addiction to drugs' could remain in the care of the Director at a 'correctional' institution until they reached 18 years of age. The Inquiry heard from a number of witnesses who were unjustly incarcerated for extended periods of time for little more than their personal circumstances of neglect or purported endangerment. These examples are in stark contrast to the position of sentenced children, whose period of incarceration could be no longer than two years.

### **Past breaches of statutory obligations**

It has been found that breaches of the Regulations in relation to food, clothing, education and corporal punishment were commonplace.

#### *Food*

Inmates at institutions licensed pursuant to the *State Children Acts* were, according to the Regulations, to be given 'plain, wholesome food' in line with an approved dietary scale, a

copy of which was to be hung in the institution's dining room. The *Children's Services Act 1965* required merely the provision of 'adequate' food.

At various times both the quality and quantity of the food given to children in institutions was inadequate. Indeed, the Inquiry heard numerous complaints of hunger being commonplace, prior to the 1960s. The Inquiry finds that in the period up to and including the 1960s there were breaches of this legislation.

### *Clothing*

Regulations 25 and 46 of the Regulations under the *State Children Acts* provided that all inmates of an institution were to be supplied with outfits, the details of which were prescribed. Regulation 18 permitted the clothing received with children on their admission to be 'utilised for the purposes of the institution'. Section 40 of the *Children's Services Act 1965* required the provision of 'adequate' clothing.

Many of the witnesses to the Inquiry who had lived in institutions prior to the 1970s spoke of being given ill-fitting, stigmatising and insufficient clothing. The Inquiry finds that in the period up to and including the 1960s there were breaches of this legislation.

### *Education*

Section 37 of the *State Children Act 1911* required that children between five and 14 years of age be sent to a State school or other school approved by the Director. Regulation 9 under that Act required that school-age children in institutions be given 'secular instruction in accordance with the syllabus of work required by the Department of Public Instruction in State schools' (i.e. a standard education). The *Children's Services Act 1965* (section 40) required the person in charge of an institution to secure for each child 'adequate education ... of such a type and form as is approved by the Director or, in the absence of such an approval, as is in the best interests of such child'.

One of the strongest impressions left on the Inquiry was the poor quality of education received by many of the witnesses. A number were illiterate, or close to it, despite having spent their childhoods in the care of the State; others who had, in their adult lives, displayed significant ability had not been able to achieve a higher level than Scholarship. The limitation on their education was one of the most profound and enduring losses suffered by former residents. The Inquiry finds that in the period up to and including the 1960s there were breaches of this legislation.

### *Discipline and corporal punishment*

Regulation 23 of the Regulations under the *State Children Act 1911* empowered the Superintendent of an institution to punish any State child guilty of misconduct. All complaints and punishments were to be entered in a punishment book. Corporal punishment was, pursuant to Regulation 24, 'to be administered as seldom as possible ... only resorted to when absolutely necessary for discipline, and not for first offences unless of a grave nature'. It could be applied only in the presence of and by direction of the Superintendent. The 1966 Regulations under the *Children's Services Act 1965* reiterated the requirement that corporal punishment be used only as a last resort, and prohibited its use on girls. It could be administered only by or under the direction and supervision of the person in charge and in the presence of a suitable witness; and it could be applied only with a leather strap of a type approved by the Department over the child's trousers. Again, a punishment book was prescribed, which had to be endorsed with the details of the punishment and the reasons for its application.

The Inquiry heard evidence of many instances of harsh discipline and finds that excessive corporal punishment occurred in a number of institutions, in breach of the relevant Regulations.

## **How the abuse was allowed to happen**

How was it that numbers of children, while under the guardianship of the State and in the care of some of our most esteemed denominational bodies, were able to be abused? This has been a difficult question to answer. There are a range of factors that have contributed. Until the early 1960s there was little understanding of the emotional needs of children, and even less understanding of the impact that harsh emotional and physical treatment has on children in later life. Ignorance played a role: both the Department and society in general believed that if children were in the care of trusted religious organisations or ‘good upstanding citizens’, they would be safe. There was also the lack of awareness or belief that sexual abuse could occur.

Institutions were under-funded, short-staffed and generally closed environments with limited opportunity for meaningful interaction with the local community. Isolation from the wider community and the lack of external scrutiny places an institution at high risk of harbouring abusive practices. Physical isolation also makes it difficult for professionals or relatives to visit.

Carers were often young, untrained and intimidated by the hierarchy of their organisations. The culture of the organisation (and thus acceptable practices in terms of emotional abuse and corporal punishment), was often established by the practices of senior staff, and it was their underlying values and norms that determined acceptable standards in the institution. Hierarchical structures make it difficult for young people and front-line workers to make complaints. In any event, complaints mechanisms did not exist, and there was minimal monitoring or inspection by the Department. All of these factors converged to create an environment ripe for abuse to occur.

The causes of institutional abuse are dealt with in detail in Chapter 2. They are summarised below in relation to the findings of the Inquiry in an endeavour to explain how the abuses were able to occur and to continue undetected.

The Inquiry has heard evidence about a number of large institutions where a great many children were cared for by relatively few staff. The larger the institution, the more difficult it is to avoid institution-focused care. Size leads to regimentation and ‘batch living’ which contributes to depersonalisation. This situation has led to a corruption of care standards.

The scant allocation of resources and support by government and society for staff and training have directly contributed to abuse of children in residential or detention settings. In many cases, institutions accepted more children than they could safely accommodate. Overcrowding was common, and often it was a challenge to meet the physical requirements of children in terms of food, clothing and warmth. The emotional and nurturing needs of children were beyond possibility, even had there been an understanding of their significance.

In some of the larger institutions, buildings housing different groups of children were physically separate, and staff and children had little contact with other sections of the institution. It was possible in these environments for abuse to be taking place in one location and for other staff and children to be unaware of its occurrence.

Historically, most positions involving the direct care of children have carried very low financial rewards and required no qualifications. This has particularly been the case in non-government organisations. The church organisations were often reliant on volunteers prepared to work long hours for minimal remuneration, such volunteers usually being drawn from the ranks of the church and apparently motivated by religious commitment.

Poor supervision and staff support have also contributed to a high-risk environment for children. Child care is difficult and challenging, and is made even more so where conditions are poor. Work hours were often extended, and a heavy workload was a consistent feature of the work of carers in orphanages, which contributed to the creation of an abusive environment. In circumstances of poor supervision, no inspections and little accountability or external advocacy for children, caregivers wielded almost unlimited power over the children.

Powerlessness has been a central feature of almost all the cases of young people being subjected to abuse in care. Children's weakness and vulnerability are characterised by their lack of power or influence, their scant knowledge of how the organisation works, and their lack of awareness of how to assert their rights or how to make complaints about those on whom they depend for the basic elements of living. Many witnesses said they had lost faith that anyone would ever take their complaint seriously.

Without standards, the monitoring of institutional practice is arbitrary and left to the discretion of the inspector or representative of the licensing authority. A consistent feature of the evidence of former staff of the Department was the virtual absence of standards and procedures prior to the 1970s, when the professionalisation of the Department largely occurred.

Historical evidence demonstrates that the Department failed to provide protection from abuse for children in residential care facilities. Its performance fell far short of the requirements outlined in the Regulations. Notwithstanding the Director's guardianship of State children, the Department appears to have ceded responsibility for the protection of children from abuse to the institutions.

### **Abuse, neglect and mistreatment of children today**

#### *Residential care facilities*

Although the Inquiry found far fewer incidents of abuse and breaches of Regulations in contemporary institutions, there were some. There are also a number of shortcomings in the oversight, management and operation of residential care facilities today that place children at potential risk of harm.

The Inquiry found clear indicators of the risks of abuse in the areas of funding, standards monitoring and casework practice. There is a significant disparity in the way services operate, the degree to which they are monitored and supported by the Department of Families, Youth and Community Care (DFYCC) and the extent to which the children and young people in care are at risk. The Inquiry found examples where services failed to meet their obligations under the law and where services were at risk of failing to prevent abuse of children in care.

An examination of current practice in residential care in Queensland found that the Practice Standards used by DFYCC for residential care are no more than a set of principles and aspirations, unconnected to any mechanism to assess whether agencies are meeting them. Because compliance with the Standards requires resources and time on the part of both the Department and the agency, there is little incentive for either party to attend to the application of the Standards to the services.

Managers of some residential services were unsure of their rights or of the processes involved when a staff member is suspected of abusing a child in care. In all cases, the response was to 'immediately inform the Department'. Beyond this, however, there seemed to be little understanding of the rights of the agency as an employer, their obligations to protect the child, and their responsibilities to the accused staff member, other staff and the informant (where there is one).

Police checks are relied on to 'clear' staff to be employed in residential facilities for children and young people. There was very little evidence of comprehensive reference and qualifications checks or intensive interview procedures. Because of the difficulties of attracting qualified staff to work in residential care, agencies were reluctant to make it more difficult to recruit.

If a fundamental characteristic of abuse in care is its pervasiveness in the culture of the organisation and its secrecy—either between the child and the staff member, or on the part of the organisation in order to protect itself—ad hoc inspections are unlikely to be useful. It is unlikely that abuse will be detected by a 'flying visit' from an Official Visitor or a licensing officer. For abuse to be uncovered—whether it is rife through the organisation or a once-only

incident—a range of strategies need to be in place that will provide blanket coverage of the organisation and inhibit any attempts at organised abuse of residents.

There are a number of risk areas:

- A number of residential care institutions are currently isolated.
- Recruitment and selection procedures in residential care facilities are inadequate.
- There are deficiencies in the design of the physical environments in some facilities.
- The absence of clear standards creates the potential for abusive situations to occur.
- The procedures and mechanisms for reporting and managing abuse are inadequate.

The Inquiry found little evidence that the Department of Families, Youth and Community Care actively works in a systematic way to reduce the risk of abuse of children in care in residential care facilities.

### *Detention centres*

Detention centres house large numbers of troubled children and young people. An important part of their role should be rehabilitative and diversionary, to prevent young people graduating to the adult prison system. They are failing in that role. The Inquiry found that in a number of ways they offer less to the young people incarcerated than the adult prison system does, in terms of privacy, facilities, safety and programs. The detention centres suffer from inadequate physical facilities, a lack of staff training and supervision, a paucity of programs for detainees and an over-emphasis on security.

Current practices blur essential distinctions between the operation of incentive schemes and disciplinary systems. The wide level of discretion regarding the type of ‘consequences’ (disciplinary measures) that can be imposed permits the response to be appropriate to the situation, but it also increases the risk of inappropriate and in some cases abusive and/or unlawful sanctions.

Detainees’ visits may be restricted as a consequence of misbehaviour. Access to family and friends is essential for the wellbeing of young people in detention, and it is unacceptable that the already limited opportunity for visits may be further reduced. It also fails to comply with the general principles of juvenile justice provided in section 4 of the *Juvenile Justice Act 1992* and in particular section 4(f)(iii), which requires a child offender to ‘be dealt with in a way that strengthens the child’s family’.

Regulation 16(1) of the *Juvenile Justice Regulations 1993* provides that a child can be separated in a locked room only if the child is ill, the child requests it, for routine security purposes in accordance with departmental guidelines, for the child’s protection or the protection of other persons or property, or to restore order. The Regulation implicitly recognises the potential psychological and emotional harm that may be caused by separation in a locked room. The current practice of isolating young people suggests that its potential harm and the regulatory requirements have been confused or overlooked.

The frequency with which detainees in Queensland’s juvenile detention centres are searched indicates that their dignity, privacy and psychological wellbeing are repeatedly ignored in favour of scrupulous security procedures. Searches of any kind are intrusive, embarrassing and reinforce the relative powerlessness of the person subjected to them. Unclothed searches are especially so, particularly for self-conscious adolescents, many of whom have suffered physical and sexual abuse.

The Regulations permits the use of reasonable force if necessary to carry out any of these searches. Although all centres keep a register of unclothed and body searches, the registers do not indicate if force was used. The physical restraint of a non-compliant young person to permit workers to forcibly remove his or her clothing is unacceptable. Intentional repeated

strip-searching of a detainee at random intervals is clearly in breach of section 14(3)(c) of the 1993 Regulations, which prohibits as discipline ‘an act that involves humiliation, physical abuse, emotional abuse or sustained verbal abuse’ .

There is a high level of consciousness among all staff in the centres about the potential for detainees to attempt to harm themselves. Despite this, all centres continue to provide ample opportunity for self-harm in shared bathrooms and in many detainee rooms.

Complaints mechanisms that exist are poorly developed and inadequate to provide meaningful data on current operations. There is little awareness of the need for monitoring and review processes in the centres. Whatever the reason, limited monitoring and inadequate complaints systems increase the chance for child abuse and neglect to occur and go unreported.

Section 215(1) of the *Juvenile Justice Act 1992* provides that a detainee or parent of a detainee may complain about any matter affecting the child. The Inquiry was unable to find a departmental procedure for general detainee complaints, although procedures exist for complaints of alleged misconduct by staff and the role of Official Visitors in receiving complaints. Thus it is not known how complaints made to departmental staff (as opposed to the Official Visitor) about general conditions such as food, clothing, access to property or visits are to be made, dealt with and recorded. The lack of such departmental procedures breaches section 215 of the Act.

Aside from the potential risks to all young people in detention centres, comment must be made on two groups of young people who are disproportionately represented in the centres and for whom there may be alternatives to incarceration. The first group are those young people on remand—almost half of all detainees at any one time—and alternative placement options are urgently required for these children. The second group are indigenous young people, who are grossly over-represented in juvenile detention centres.

The Inquiry found a number of serious shortcomings in the operation of juvenile detention centres that do not meet legislative requirements or acceptable standards. These shortcomings indicate that young people detained in detention centres today may be at risk of abuse or mistreatment, and are certainly living in physical facilities that are far inferior to adult correctional centre facilities and that fall short of the legislative requirements and the relevant UN Conventions. The current operation of these centres is unlikely to rehabilitate young offenders, and is more likely to increase their disaffection with society and their risk of subsequent offending.

### **Deficiencies in the current legislation**

The current legislative framework for children in institutions consists of three major pieces of legislation. The legislative base for the provision of residential care services for children and young people is provided by the *Children’s Services Act 1965*. This legislation will be superseded by the *Child Protection Act 1999*, which was assented to on 30 March 1999 but has not yet been proclaimed. For juvenile detention centres, the legislative base is provided by the *Juvenile Justice Act 1992*.

There are a number of important shortcomings in the current legislative provisions for care and protection of children in institutions:

- There is no legislatively mandated reporting process for abusive incidents involving children and young people in residential care and in detention centres.
- There are no legislative requirements for DFYCC to conduct regular supervisory or inspection visits to residential care services or to detention centres.
- There is no legislative requirement that DFYCC collect information relating to the abuse of young people in out-of-home and institutional care.
- There is no legislative provision for advocacy services for young people in residential care or in detention centres.

- There is no provision in legislatively prescribed licensing requirements that residential care services be subject to regular review processes or evaluations, or for records of these processes to be considered in licensing decisions.

### **Consequences for victims of abuse**

There is still a great deal that is not understood about the outcomes of child abuse. It is not an easy subject to study and it is often difficult to disentangle the effects of abuse from the effects of other factors such as disrupted families. There is, however, a general consensus that outcomes are often profoundly negative.

The relationships of abuse victims may be dysfunctional. Low self-esteem and self-worth, compounded by a lack of education, can develop into mental health problems that further limit the victim's capacity to achieve his or her human and economic potential. Witnesses described a number of enduring effects of their institutional experiences, including a lack of self-esteem, an inability to trust others, and relationship problems exacerbated by anger and aggression. Striking features of witnesses' evidence were suicide attempts and relationship failures. For a number of witnesses, admission to an institution started a process of institutionalisation that ended in gaol.

The Inquiry recognises that it is not often possible to link a specific instance of institutional abuse to a specific problem faced by an individual in later life. However, there is little doubt that children who have been exposed to severe or prolonged abuse are facing long-term problems that will disrupt or damage the rest of their lives, and affect all those significant others around them.

The effects of childhood maltreatment cannot be categorised easily and outcomes can vary a great deal among survivors according to the type of abuse, its duration, the child's relationship with the abuser, and resilience factors that may have gone some way towards protecting the child.

Although the following sections are arranged according to the different forms of abuse, this is not meant to understate the complexities involved in discussing the outcomes of child abuse, nor the compounding effects on children who experience a range of abuses. There is substantial overlap between different types of abuse; children that experience one form of abuse are far more likely to experience other forms.

### *Physical abuse*

There are seven main outcomes of physical abuse: aggressive and violent behaviour, non-violent criminal behaviour, substance abuse, self-injurious and suicidal behaviour, emotional problems, interpersonal problems, and academic and vocational difficulties ( Malinosky-Rummell & Hansen 1993).

There is now little doubt about the relationship between childhood physical abuse and emotional and psychological problems in later life. These problems include anxiety, depression, hostility, paranoid thoughts, psychosis and dissociation disorders (see, for example, Fox & Gilbert 1994; Middleton & Butler, in press). Adolescents and adults who exhibit violent behaviours have often been abused as children. Such violent behaviours can include violence towards people inside the family, violence toward authority figures, homicidal behaviours, fighting or violent criminal acts, and rape ( Riggs et al. 1990; Straus et al. 1980; Kroll et al. 1985; Rosenbaum & Bennett 1986; Pollock et al. 1990).

A number of behavioural problems are related to corporal punishment, such as sleep disturbances, temper tantrums, aggressive behaviour, nightmares, headaches, frequent crying, anger and withdrawal. Involuntary urination or enuresis are common experiences for children who suffer corporal punishment ( Hyman 1987).



### *Sexual abuse*

Child sexual abuse is now widely accepted as causing mental health problems in adult life. Specifically, child sexual abuse has an impact on social, sexual and interpersonal functioning, and affects the child's developing capacities for trust, intimacy, mastery of their world, and sexuality. When discussing outcomes of child sexual abuse, distinction should be made between severe physically intrusive forms of sexual abuse involving penetration, and other less intrusive forms such as touching or exposing genitalia to a child. In general, intrusive forms of abuse result in more profoundly negative consequences.

It is now well documented that sexually abused children experience difficulties at school with academic performance and behaviour. These difficulties are likely to have a negative influence on later educational attainment, and restrict the skills and discipline necessary to maintain an effective role in the work force (Tong et al. 1987; Cohen & Mannarino 1988; Einbender & Friedrich 1989).

Child sexual abuse involves a breach of trust or an exploitation of vulnerability, and frequently both. Sexually abused children not only face an assault on their developing sense of sexual identity, but a blow to their construction of the world as a safe environment and their developing sense of others as trustworthy. In those abused by someone with whom they had a close relationship, the impact is likely to be all the more profound.

A history of child sexual abuse is reported to be associated with insecure and disorganised attachments (Alexander 1993; Briere & Runtz 1988; Jehu 1989), and increased rates of relationship breakdown (Beitchman 1992; Bagley & Ramsey 1986; Mullen et al. 1988; Mullen et al. 1994). Poor self-esteem in adults has also been shown to be associated with child sexual abuse, and is thought to be an outcome of the more intrusive forms of abuse involving penetration (Romans et al. 1996). Child sexual abuse also affects the mental health of many survivors (Briere & Runtz 1988; Winfield et al. 1990; Bushnell et al. 1992; Mullen et al. 1993; Romans et al. 1996 and 1997; Silverman et al. 1996; Bucky & Dallenberg 1992; Spanos 1996).

### *Emotional abuse*

Although emotional abuse has the most destructive consequences for children (Garbarino & Vondra 1987), it is rarely assessed in studies of childhood physical abuse and neglect (Rosenburg 1987). In fact, it has been well documented that physical and/or sexual abuse usually occur alongside emotional abuse (Egeland et al. 1983; Garbarino & Vondra 1987), so it is difficult to assess the severity of the consequences of specific emotional abuse. There is, however, a developing agreement that emotional maltreatment is a fundamental cause of negative developmental outcomes for children (Garbarino 1990; Navarre 1987).

For children exposed to psychological abuse over some years, the resulting inability to develop good relationships with others creates a vulnerability to further abuse. It may result in exposing the child to further risk from carers who do not understand or respond well to the child's dysfunctional behaviours.

## **CONCLUSION**

Over the years significant numbers of children in the care of the State in government and non-government institutions have been subjected to repeated physical, emotional and sexual abuse. The scope and scale of the abuse varied among institutions and varied at different times by different perpetrators. Not all institutions were involved, nor were all children in care abused. However, some key commonalities among the abuses included an abuse of power, a betrayal of trust, a reluctance of people in authority to acknowledge or deal with the abuse, and an official response which showed more concern for the protection of the institution and the abusers than for the safety of the children, particularly where cases of sexual abuse have not been referred to the police for prosecution.

Aside from these abuses, we found in a number of institutions a failure to provide for the basic human needs of children. Many children in institutions received limited education, little

instruction in life skills and an emotional coldness that had a profound impact on their later lives. We acknowledge that most non-indigenous children in the orphanages had come from backgrounds with serious problems. Consistently, we found that the impact of their placement in orphanages and their experiences in them have affected their lives in a profoundly negative way. We found little to convince us that historically the government, through the Department, had any vestige of a system in place that would enable it to properly monitor the care of children in institutions.

There have been significant improvements over the past two decades through professionalisation of the Department and the staff of institutions, and the implementation of improved systems. However, in reviewing contemporary detention centres and residential care facilities it is clear that there remain a number of deficiencies in the current systems and programs, and we have concluded that there is still potential risk of abuse to children in care. Adequate accountability systems are not in place, in institutions or on the part of the Department, to ensure that children are protected, and to ensure that where abuse occurs it is appropriately dealt with. Improving monitoring and accountability is the centrepiece of our recommendations for the future.

In making our recommendations we conclude that although it was individuals who perpetrated each act of abuse, they alone cannot shoulder the whole responsibility. Some measure of responsibility must be taken by those to whom the abuses were reported and who did not act, those in charge of the institutions who did not have sufficient safeguards in place to protect the children, those members of religious organisations who turned a blind eye, the staff and the management of the Department of Children's Services who did not adequately monitor the children in their care, successive State Governments that have not sufficiently valued children to adequately resource the Department entrusted with their care, and society, which ignored or accepted what happened to children in the care of the State. As a State, we must face up to past wrongs and make proper redress, and ensure that when children are in our care we do them no harm.

## **RECOMMENDATIONS OF THE INQUIRY** **(in the order that they appear in the report)**

### **Recommendation 1 (Chapter 5 p. 98)**

That the Department continue to give effect to the recommendation of the *Daffen Report 1998* that funding to Petford Training Farm as a residential facility for young people be terminated.

### **Recommendation 2 (Chapter 5 p. 106)**

That the Department undertake a project similar to *Connecting Kin*, developed by the NSW Department of Community Services in 1998, to identify the repositories of information relevant to the lives of former State wards in Queensland.

### **Recommendation 3 (Chapter 5 p. 106)**

That the Department notify all non-government organisations that have been involved in the care of children in Queensland that it is willing to accept any surviving records relating to State wards and that it will retain those records and provide the individuals and families concerned with access to them.

### **Recommendation 4 (Chapter 6 p. 118)**

That the Queensland Government increase the budget of the Department by \$103 million to permit it to meet the national average per capita welfare spending for children, and agree to maintain the increase in line with the national average. The additional resources should focus on the prevention of child abuse through supporting 'at risk' families, respite care, parenting programs and other early intervention and preventative programs for high-risk families.

**Recommendation 5 (Chapter 8 p. 189)**

That there be a concerted whole-of-government effort to reduce the gross over-representation of indigenous children in juvenile detention centres.

**Recommendation 6 (Chapter 8 p. 191)**

That alternative placement options be developed for young people on remand in order to reduce the number placed in juvenile detention centres.

**Recommendation 7 (Chapter 9 p. 210)**

That the Department review the practice of unclothed searches with a view to reducing their use, and that detailed documenting (date, time, reason and process used) of every such search be made.

**Recommendation 8 (Chapter 9 p. 215)**

That the Department ensure:

- contact with family and friends is treated as a basic entitlement of all detainees, essential to their psychological wellbeing and successful reintegration, and that it should not be apportioned according to behaviour
- contact with family and friends is actively encouraged, and that efforts are made to ensure that visits are relaxed and positive for detainees and visitors alike
- contact by detainees with partners and 'significant others' is given the same status as that given to parents and siblings
- procedures that deny a young person contact and support from their family are examined and eliminated unless a substantial case can be made for their retention
- visiting times are varied to accommodate the needs of working parents, shiftworkers and those with small children.

**Recommendation 9 (Chapter 9 p. 216)**

That the Department explores mechanisms for increasing community involvement in juvenile detention centres.

**Recommendation 10 (Chapter 9 p. 218)**

That the Department work closely with Queensland Health to establish adequate, high quality mental health services for juvenile detainees, staffed by in-house specialised mental health personnel with whom a child and adolescent psychiatrist and allied mental health staff can consult part-time.

**Recommendation 11 (Chapter 9 p. 224)**

That the Department and Education Queensland jointly review the allocation of special education resources for children in institutions and prepare a detailed report to both Ministers, by 31 December 1999, on the current availability and any gaps, as well as a clear plan for rectification.

**Recommendation 12 (Chapter 9 p. 227)**

That the Department ensure that all young people in detention centres, whether sentenced or on remand, have access to:

- a range of programs that will both engage them and be of future vocational benefit
- community-based educational, vocational and related services to assist reintegration and to help reduce the isolation and separation felt by detainees
- appropriate recreational facilities and sporting instruction as central components of programmed activities, recognising the importance of sport as a factor in achieving reintegration and reducing recidivism.

**Recommendation 13 (Chapter 9 p. 236)**

That the closure of Sir Leslie Wilson Youth Detention Centre be accomplished as planned by the end of 2000, or before, and that the refurbishment of John Oxley and Cleveland Youth Detention Centres proceed as a matter of urgency.

**Recommendation 14 (Chapter 9 p. 236)**

That the Minister for Families, Youth and Community Care establish an expert working group to provide advice regarding options available as an alternative to the construction of a proposed new juvenile detention centre at Wacol.

**Recommendation 15 (Chapter 9 p. 237)**

That the Department implement in full the detailed recommendations of the consultant responsible for the review of juvenile detention centres, contained in Appendix 13.

**Recommendation 16 (Chapter 11 p. 258)**

That legislation be enacted to make mandatory the reporting of all abusive situations that come to the attention of departmental employees and persons employed in residential care facilities and juvenile detention centres.

**Recommendation 17 (Chapter 11 p. 258)**

That requirements for the Department to conduct regular inspection and monitoring of residential care facilities and juvenile detention centres be specified in legislation.

**Recommendation 18 (Chapter 11 p. 258)**

That the Department have a legislatively imposed responsibility to collect information relating to abuse of children and young people in residential care facilities and juvenile detention centres.

**Recommendation 19 (Chapter 11 p. 258)**

That the provision of advocacy services for young people in residential care facilities and juvenile detention centres be required by legislation.

**Recommendation 20 (Chapter 11 p. 258)**

That legislation be enacted to require that licensing of residential care facilities be subject to an independent written evaluation.

**Recommendation 21 (Chapter 11 p. 261)**

That by December 2000 the Department:

- assess the needs across Queensland for residential care
- review the effectiveness of current models of residential care (e.g. family group homes compared to larger institutions such as BoysTown)
- develop criteria for equitable distribution of facilities and appropriate models of care
- develop medium- and long-term plans for future development of residential care, taking into account the distribution and needs of children throughout the State
- review funding and provision of residential services for indigenous young people to ensure quality of services and cultural appropriateness.

**Recommendation 22 (Chapter 11 p. 262)**

That in order to ensure effective links between standards of care, service agreements, quality assurance, licensing and legislative requirements for residential care, the Department:

- review the *Practice Standards for the Conduct of a Licensed Residential Care Service* to ensure consistency with the statement of standards outlined in the *Child Protection Act 1999* and develop clear performance indicators that are incorporated into service agreements
- develop a system of independent external accreditation based upon the standards required under the Act
- require that all residential care facilities be subject to independent evaluation as a condition of being granted a licence or renewal of a licence.

**Recommendation 23 (Chapter 11 p. 263)**

That the Department establish a short-term residential facility to enable proper and comprehensive assessments when children are first admitted to care.

**Recommendation 24 (Chapter 11 p. 264)**

That the Department develop and implement an information system that records individual complaints and trends in institutional abuse.

**Recommendation 25 (Chapter 11 p. 264)**

That amendments be made to the *Children's Commissioner and Children's Services Appeals Tribunal Act 1996* to ensure the independence of the office of Children's Commissioner, and provisions be made for its attachment for administrative support services to the Premier's Department.

**Recommendation 26 (Chapter 11 p. 265)**

That the office of the Children's Commissioner be strengthened by:

- investing it with the role of Independent Inspector of residential care facilities and juvenile detention centres with wide powers of inspection in relation to such matters as

the treatment of residents, preparation for release, morale of residents and staff, quality of health care and education, physical facilities and management

- empowering the Commissioner to conduct Inquiries into matters affecting children and young people including the authority to investigate and resolve complaints about the provision of services to children and young people
- establishing a comprehensive research function to enable research to be conducted into all matters relating to the rights, interests and wellbeing of children and young people in residential facilities and juvenile detention centres
- providing the Commissioner with the power to monitor the role of the Department in overseeing the care of young people in residential facilities and detention centres.

**Recommendation 27 (Chapter 11 p. 265)**

That there be a Children's Services Appeals Tribunal constituted as a separate entity to the Children's Commission whose procedures are inquisitorial rather than adversarial in nature.

**Recommendation 28 (Chapter 11 p. 266)**

That there be a review of the Official Visitors' program focusing on the legislative base, policy and procedural guidelines, actual practice, and effectiveness of the service.

**Recommendation 29 (Chapter 11 p. 266)**

That the Official Visitors' program be maintained and extended with a view to providing a comprehensive monitoring function of all residential facilities for children and young people, including those not funded by the State but which, nevertheless, provide a similar service and including juvenile detention centres.

**Recommendation 30 (Chapter 11 p. 266)**

That visits from Official Visitors be regular and frequent, and the number of Visitors reflect the size of the client base.

**Recommendation 31 (Chapter 11 p. 266)**

That Official Visitors be empowered to act as advocates for children and young people in care, by listening to, giving voice to, and facilitating the resolution of, their concerns and grievances.

**Recommendation 32 (Chapter 11 p. 267)**

That Official Visitors be provided with complete orientation and training in alternative care practice, standards of residential care, advocacy issues and practice, and developing trusting relationships with young people.

**Recommendation 33 (Chapter 11 p. 267)**

That Official Visitors be given access to relevant information about children and young people in care, and that they be bound by the same rules of confidentiality as other Commission and departmental staff.

**Recommendation 34 (Chapter 11 p. 269)**

That by December 2000 the Department develop and implement policies which ensure that:

- there is a range of easily accessible, confidential complaints mechanisms for children
- children making complaints are protected and any worker about whom a child has made a serious complaint is separated from children in the facility, without loss of pay and other employment conditions, pending the outcome of the investigation of the complaint
- a rapid response to complaints is made and the action taken is documented
- senior officers of DFYCC or other personnel independent of the service with substantial experience in matters relating to child abuse carry out the investigation
- all allegations of abuse in out-of-home care are made the subject of mandatory reporting by institutional staff and are notified to the Children's Commissioner and the Office of the Director-General, DFYCC
- all serious complaints result in review processes to identify systemic problems and to provide recommendations for improvement
- all documentation relating to complaints or allegations of abuse is subjected to external review and audit, to ensure that required procedures have been followed
- a central database of caregivers is established to identify patterns of complaints and trends in institutional abuse.

**Recommendation 35 (Chapter 11 p. 270)**

That by December 2000 the Department prepare:

- detailed and standardised procedures for record-keeping that must be maintained by residential facilities, detention centres and the Department
- quality assurance mechanisms, including monitoring and review processes, that can measure whether appropriate standards are being maintained, that individual cases of abuse are detected and dealt with, and whether staff have the necessary conditions to work effectively
- detailed time-limited plans for their implementation across residential institutions caring for children.

**Recommendation 36 (Chapter 11 p. 273)**

That by December 2000 the Department:

- review issues affecting field staff responsible for children in care, including excessive caseloads, inadequate personal and professional supervision, high turnover, insufficient resources and training, and implement measures to address them
- establish the minimum requirement to operate each institution and provide adequate funding to ensure that the facilities can operate safely
- require through service agreements and service standards for residential services that staff are recruited through transparent merit selection processes, that clear human resources development and management standards are applied and that these standards be part of a contract, review and evaluation process. This must include, as a minimum, clear job descriptions and regular progress and performance monitoring of staff
- require scrupulous screening of all staff and other people in regular contact with children in residential care facilities and juvenile detention centres, not only through police checks (including fingerprints and records of charges laid) but also extensive interviews to ensure their suitability to be in contact with children or young people in care or detention
- require that criminal history and Child Protection Register checks be conducted on an ongoing basis, at a minimum of five-yearly intervals, for all residential care and juvenile detention centre staff

- address staff training requirements (initial and ongoing) for residential care services by the application of Service Standards and provision of training for all service providers
- require that an accredited core training program be completed by all residential care workers and that orientation programs to clarify staff roles and expectations be conducted, as well as refresher training programs for staff at regular intervals
- review staffing and supervision arrangements within detention centres, with risk assessment procedures applied to determine appropriate supervisory arrangements and the optimum staffing balance of permanent to casual staff to provide cost-effective service delivery by experienced staff, while minimising risk.

**Recommendation 37 (Chapter 12 p. 288)**

That the Queensland Government and responsible religious authorities issue a formal statement acknowledging the significant harm done to some children in Queensland institutions licensed under the *Infant Life Protection Act 1905*, the *State Children Act 1911*, the *Children's Services Act 1965* and the *Juvenile Justice Act 1992*, formally apologise for that harm and make a commitment to prevent further abuse.

**Recommendation 38 (Chapter 12 p. 288)**

That the Queensland Government and relevant religious authorities organise a reconciliation event for former victims of abuse in orphanages and detention centres after consultation with them.

**Recommendation 39 (Chapter 12 p. 288)**

That the Queensland Government and responsible religious authorities establish principles of compensation in dialogue with victims of institutional abuse and strike a balance between individual monetary compensation and provision of services.

**Recommendation 40 (Chapter 12 p. 288)**

That the Queensland Government and responsible religious authorities fund an independent 'one stop shop' for victims of abuse in institutions that provides a range of services such as:

- ongoing counselling for victims and their families
- facilitation of educational opportunities including literacy programs
- advice regarding access to individual records, documents and archival papers
- specialised counselling services for indigenous victims of abuse
- assistance to former child migrants for reunification with their families.

**Recommendation 41 (Chapter 12 p. 288)**

That the Department develop transitional programs to prepare young people in the care of the State for independent living and help them to make the transition by providing assistance to gain employment, education and housing.

**Recommendation 42 (Chapter 12 p. 288)**

That the Queensland Government establish a process for the implementation and review of the recommendations of this Inquiry, requiring annual progress reports to Parliament on the implementation of recommendations over the next two years.



## ADMINISTRATIVE HISTORY OF THE DEPARTMENT

The present Department of Families, Youth and Community Care is referred to throughout as either 'DFYCC' or 'the Department'. The following information is provided in order to clarify the different manifestations of the Department over the period covered by this report.

Inspector of Orphanages	–1911
State Children Department	1911–August 1966
Department of Children's Services	August 1966–June 1987
Department of Family and Youth Services	June 1987–December 1987
Department of Family Services	December 1987–December 1989
Department of Family Services and Aboriginal and Islander Affairs	December 1989–February 1996
Department of Families, Youth and Community Care	February 1996–

## LIST OF ABBREVIATIONS: LEGISLATIVE

Abbreviation	Full title
AAA	Aboriginal Affairs Act 1965
APA	Aboriginals Protection and Restriction of the Sale of Opium Act 1897
APPA	Aborigines Preservation and Protection Act 1939
CCA	Children's Court Act 1907
CCCTA	Children's Commissioner and Children's Services Appeals Tribunal Act 1996
CJA	Criminal Justice Act 1989
CSA	Children's Services Act 1965
ILPA	Infant Life Protection Act 1905
IRSA	Industrial and Reformatory Schools Act 1865
JA	Justices Act 1886
JJA	Juvenile Justice Act 1992
OPA	Offenders Probation Act 1886
OA	Orphanages Act 1879
PSA	Public Service Act 1996
PSEA	Public Sector Ethics Act 1994
SCA	State Children Act 1911
VAA	Vagrancy Amendment Act 1863
WPA	Whistleblowers Protection Act 1994

## LIST OF ABBREVIATIONS: OTHER

Abbreviation	Full title
ACISP	Alternative Care and Intervention Services Program
AJJA	Australasian Juvenile Justice Administrators
AIHW	Australian Institute of Health and Welfare
ALRC	Australian Law Reform Commission
AR	Annual Report
BMP	Behaviour Management Plan
CJC	Criminal Justice Commission
CSIU	Corrective Services Investigation Unit
DAIA	Department of Aboriginal and Islander Affairs
DCS	Department of Children's Services
DFS	Department of Family Services
DFSIA	Department of Family Services and Aboriginal and Islander Affairs
DFYCC	Department of Families, Youth and Community Care
DNA	Department of Native Affairs
EQ	Education Queensland
HREOC	Human Rights and Equal Opportunity Council
QA	Quality Assurance
QCORR	Queensland Corrections
QCSC	Queensland Corrective Services Commission
QGG	Queensland Government Gazette
QPD	Queensland Parliamentary Debates
QPP	Queensland Parliament Papers
QPS	Queensland Police Service
QSA	Queensland State Archives
SCAN	Suspected Child Abuse and Neglect
SCD	State Children Department
SRAT	Suicide Risk Assessment Team
TAFE	Technical and Further Education
YDC	Youth Detention Centre

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## CHAPTER 1: THE INQUIRY

### 1.1 INTRODUCTION

To appreciate fully the focus of the Inquiry, it is important to be aware of some background information. This chapter describes the scope of the Inquiry and the processes and methods used to obtain information on which to base its findings. Because the Terms of Reference for the Inquiry were very broad, it was important to put some boundaries in place to ensure that its objectives could be adequately met. During the period the Inquiry was in operation—from September 1998 to May 1999—information was sought from a wide range of sources: from ex-residents and staff of the institutions covered by the Terms of Reference, current and former employees of the Department of Families, Youth and Community Care (DFYCC), from professional experts, from current literature, and from both commissioned and archival research.

### 1.2 SCOPE OF THE INQUIRY

The Terms of Reference for the Inquiry were established by Order in Council. The Inquiry was commissioned to enquire into institutions established or licensed under the *State Children Act 1911*, the *Children's Services Act 1965* or the *Juvenile Justice Act 1992* and institutions registered under the *Infant Life Protection Act 1905*. Appendices 1 to 4 set out a summary of the provisions of these Acts insofar as they are relevant to the Terms of Reference.

The Inquiry restricted its investigations to the period between 1935 and the present on the assumption that residents and staff from institutions operating prior to the 1930s would be unlikely to present themselves to the Inquiry. In addition, it was possible to review archival documentation comprehensively for the period selected.

The Terms of Reference also referred to Acts under which a number of institutions were licensed. The Terms of Reference of the Inquiry encompassed 159 institutions. These varied in the type of client groups they served and services they offered, and they are listed in Appendix 5. The Terms of Reference did not cover all forms of out-of-home care, and excluded foster care and institutions providing care for children with disabilities or those suffering from acute or chronic health problems.

The majority of people who came forward to give evidence recounted experiences that occurred in the past, often in institutions that have since closed. This is not to suggest that children in institutions today are no longer at risk of abuse. To provide a balanced review of institutions—both historical and contemporary—substantial resources were invested to review current policy and practice in those institutions in operation today.

There have therefore been two major thrusts of the Inquiry:

- an investigation into past institutional abuse, with evidence from public and private hearings, interviews, written submissions and archival research
- a review of current systems that included studies of legislation, policy and procedural guidelines, evidence from public and private hearings, interviews and written submissions, and inspections of facilities.

The Inquiry also reviewed recommendations from previous investigations into related areas and identified responses to recommendations for institutional and systems reform. The following section explains how the Inquiry was conducted, and the sources of information that contributed to its findings.

### 1.3 THE INQUIRY PROCESS

#### Appointment of Commissioners

On 13 August 1998, Ms Leneen Forde AC was appointed Chairperson of the Commission of Inquiry, and Dr Jane Thomason and Mr Hans Heilpern were appointed co-Commissioners.

### **Informing stakeholders**

The Inquiry adopted a broad range of strategies to inform likely stakeholders and the general public about its operation. It consulted with stakeholder groups, invited individuals to come forward who had resided or worked in institutions within the Terms of Reference, and called for submissions from other interested individuals and organisations.

Three hundred and sixty letters were written to government and community agencies concerned with the welfare of children; to advocacy and support groups for former residents of the relevant institutions; to academic institutions; and to professional organisations throughout Australia with relevant expertise. These letters enclosed the Terms of Reference, a list of the institutions covered by the Acts, and an invitation to make a submission. Appendix 6 lists the academic institutions and organisations that made formal written submissions to the Inquiry. Appendix 7 lists other persons consulted in the course of the Inquiry.

The Chairperson and Counsel Assisting the Inquiry attended meetings of stakeholder groups in conjunction with the Queensland Crime Commission. At these meetings the Terms of Reference were explained and input to the Inquiry process invited. The Commissioners held other meetings with the chairpersons of related permanent Commissions in Queensland, including the Children's Commission and Project Argos (Queensland Police Service), as well as with other stakeholder groups.

To notify individuals who had resided or worked in institutions of the existence of the Inquiry, advertisements were placed in national, metropolitan, provincial and major Queensland rural daily newspapers. These gave details of the Inquiry and invited submissions from any person with information relating to the Terms of Reference.

The Commissioners conducted interviews with the media in Brisbane, Cairns, Townsville and Rockhampton to inform the public about the progress of the Inquiry, and issued press releases from time to time.

### **Accessing the indigenous community**

The Commissioners met with the Brisbane Council of Elders as well as representatives of indigenous groups and organisations at the Aboriginal Coordinating Council in Cairns. The aim of these meetings was to inform indigenous groups about the Inquiry and to enlist their support and guidance in encouraging people to come forward. The Chairperson also took part in radio interviews broadcast on indigenous radio stations in Brisbane and north Queensland.

Letters were written to approximately 150 Aboriginal and Torres Strait Islander organisations and corporations throughout Queensland informing them of the Inquiry and inviting them to make submissions or to encourage current and former residents of institutions to come forward.

Because the Commissioners were conscious of the constraints on indigenous people, an indigenous project officer was appointed to the Inquiry in January 1999 to address these problems and to implement a specific strategy to maximise opportunities to hear from indigenous people. Private hearings were held at the Jagera Arts Centre in Musgrave Park for indigenous people wanting to give evidence. A series of interview days was also conducted at Brisbane Women's, Moreton A and Borallon Correctional Centres at which indigenous counsellors and solicitors attended.

Original research was also commissioned to provide a voice for those indigenous young people who had suffered abuse in institutions and who did not feel able to come forward.

### **Receiving evidence from witnesses**

The Inquiry appointed a male and a female intake officer with extensive investigative experience. These officers took initial calls from persons expressing an interest in providing information to the Inquiry. Callers were given a range of options to provide information, which included written submissions, oral tape-recorded interviews with appropriately

qualified Inquiry staff (either in person or by telephone), or through public or private hearings before the Commissioners. Care was taken to ensure that all aspects of contact were treated with respect, sensitivity and confidentiality.

People making enquiries were provided with a copy of the Terms of Reference of the Inquiry, a general information sheet, and documents setting out suggested guidelines on preparing written submissions. A contact report was completed for every initial contact to ensure that records of contact were maintained and that appropriate follow-up was carried out. The majority of witnesses requested either tape-recorded interviews or attendance at hearings before the Commissioners.

The Inquiry conducted 166 interviews. Where appropriate, they were conducted by solicitors from Aboriginal and Torres Strait Islander legal services. Experienced counsellors were present during the majority of the interviews and held debriefing sessions afterwards. Of the 166 interviews, 31 were from institutional staff and 135 from ex-residents. Interviews were conducted at the Inquiry office in Brisbane, and in Townsville and Rockhampton, as well as at a number of adult correctional institutions, including Arthur Gorrie, Sir David Longland, Moreton A and B, Brisbane Women's, Borallon, Lotus Glen and Woodford Correctional Centres. The Inquiry heard 33 interviews at these centres. Six interviews with indigenous people were conducted at Jagera Arts Centre in Musgrave Park.

The Commissioners heard evidence from 105 residents and staff of institutions in private hearings. Of these, 85 were ex-residents and 20 were current and former institutional staff. It was considered to be in the interests of both witnesses and the public to conduct hearings in private, for a number of reasons:

- The sensitive and private nature of evidence led to many witnesses requesting privacy and confidentiality.
- During the period of the Inquiry, there was a substantial amount of civil litigation and outstanding criminal proceedings in relation to some of the evidence. Public hearings could have prejudiced these proceedings.
- Persons named adversely in public hearings can be unjustifiably prejudiced if evidence is taken before an opportunity to respond has been given to them. The Inquiry timeframe did not allow for giving notice of adverse allegations in advance, nor was cross-examination appropriate or practicable in most cases.

In addition to hearings and interviews, the Inquiry received evidence in the form of written submissions from 151 individuals. This group represented ex-residents, staff or others with an interest in the institutions or systems relevant to the Inquiry. Appendix 8 provides a list of witnesses to the Inquiry who agreed to be identified.

Expert evidence was received from a range of professional and academic experts through written submissions and public hearings. Appendix 9 identifies those expert witnesses who appeared at public hearings, and the nature of their evidence.

A series of public hearings was dedicated to allegations of the handcuffing of juvenile offenders at the John Oxley Youth Detention Centre in September 1989. These allegations had been longstanding and the subject of public controversy and media speculation. The level of concern was such that it was considered to be in the public interest to conduct these hearings in public. Evidence was heard from 17 witnesses (see Chapter 7 for a detailed report).

### Visits and inspections

The Commissioners and other members of the Inquiry staff inspected a number of facilities in current use, including all the juvenile detention centres operating in Brisbane and Townsville, the government-operated TARA residential care facility at Townsville, and BoysTown in Beaudesert. Other facilities no longer operating were also inspected to allow the Commissioners and staff the opportunity to interpret evidence in a more meaningful way. These included the former institutions of Silky Oaks Haven for Children, Nazareth House, St Joseph's Home, Neerkol and Kalimna Vocational Centre for Girls. Consultants to the Inquiry who assisted in a review of operating facilities carried out other inspections.



*Photograph 1.1: Inquiry staff and police on site inspection—Inquiry photograph*

### Commissioned research and reviews

The Inquiry commissioned a number of experts to examine a broad range of areas relevant to the Inquiry. These included literature reviews, primary research (including archival research) and reviews of current facilities. Appendix 10 contains a full list of research commissioned for the Inquiry. These studies included:

- interviews with young people in juvenile detention centres throughout Queensland
- examination of the major issues in relation to indigenous young people in juvenile detention centres
- the history of indigenous young people in Queensland institutions
- a review of current non-government residential care facilities in Queensland
- a review of current juvenile detention centres in Queensland
- a review of relevant current legislation, policy and practice.

### In-house research and archival investigations

The research unit of the Inquiry carried out a number of literature reviews to provide context to the investigations, and to examine current developments in the field of institutional child abuse. Specifically, these related to the legal framework under which the Inquiry operated, current theory and knowledge of institutional child abuse, current child welfare and juvenile justice systems, and the history of Queensland institutions relevant to the Inquiry. These studies were informed by current literature, and supported by submissions to the Inquiry from academic and professional experts.

The Inquiry invested substantial resources in a review of archival evidence. However, because of time constraints, a complete review of the available archives was not possible.

At the request of the Inquiry, DFYCC made available some 1,300 institutional files. However, time constraints did not allow for a systematic examination of the many thousands

of client files held by DFYCC, nor relevant staff files. In general, only the files of those clients and staff who appeared as witnesses, or were mentioned in evidence, were requested.

Specific non-government agencies responsible for the management of institutions were also asked to furnish the Inquiry with inventories of their records. To ensure fairness to these agencies, they were given the opportunity to comment on possible findings. The variation in approach in their responses has been interesting, and perhaps indicative of how far along the road to understanding the past and reconciliation with former residents affected by their experiences some organisations have come. Some religious organisations responded with solicitors' letters and offered no cooperation; others were unable to assist because of the passage of time; still others showed a genuine interest in assisting and making constructive comments. The Inquiry particularly acknowledges the helpful approach of the Rockhampton Congregation of the Sisters of Mercy, who ran St Joseph's Orphanage at Neerkol. Other religious bodies that responded positively were the Brisbane Congregation of the Sisters of Mercy, who were responsible for St Vincent's Orphanage at Nudgee; the Sisters of the Good Shepherd Provincialate (which ran Mount Maria Youth Centre), and the Council of Silky Oaks Children's Haven, which continues to run the Silky Oaks residential facility.

The Children's Commissioner was also asked to produce all files falling within the Terms of Reference that contained allegations of unsafe, improper or unlawful care or treatment of children, or any breach of statutory obligation in the course of the care, protection and detention of children in the institutions. More than 200 files were produced in response to that request, the contents of which were then taken into account in the investigative process.

## **1.4 WITNESSES: RESIDENTS AND STAFF OF INSTITUTIONS**

### **The decision to come forward**

It has been recognised that many factors played a role in preventing some people from coming forward to the Inquiry. Some victims may never have told anyone about their abuse. Potential witnesses needed to have a considerable amount of trust in the process. Previous residents may have lost trust in government institutions that were responsible for their care and protection in the past. Where people had made prior complaints and were not believed, they would need to feel confident that this experience would not be repeated.

*... a couple of my brothers were sexually abused and I've told them about this Inquiry and they have no confidence in it whatsoever ... one of them has even said that 'the only thing that would ever change anything would be a shotgun.'*

Many residents of orphanages do not want their history of institutionalisation to be made public. Coming forward may be difficult where people have concealed their past from important people in their lives. Other victims wrongly take responsibility for their abuse and are too ashamed to acknowledge the events.

For others wishing to tell their stories, there may be a desire to wait and see how the government responds to those who do come forward. They may first want to assess the strength of the political will to hear and support previous residents and to act on making improvements to current and future systems.

Other important factors include the degree of publicity and the presence of support groups for certain institutions. Publicity about events in certain institutions may act as a community validation of ex-residents' experiences. People feel that their stories may be believed, since many others have described similar events. This was the case for some institutions. On the other hand, the Inquiry found archival evidence of abuse in other institutions, yet few or no former residents came forward from these.

In addition, there are victims of abuse still within the child protection or criminal justice systems who do not feel secure enough to discuss any abusive experiences while they are still within those systems.

As well as those who have chosen not to come forward to tell their stories of abuse, it is recognised that other residents of institutions have had positive experiences. The Inquiry has examined many institutions for a period of over fifty years. No doubt there have been periods when young people have received the best care available as the result of the good practice of caring individuals.

The nature and range of these factors show the difficulties many people would have faced in making the decision to come forward.

### Adult memories and disclosure of childhood abuse

A number of witnesses to the Inquiry described severe and prolonged trauma from childhood abuse—in some cases stemming from events experienced up to 50 years ago.

Experts continue to debate the validity of recovered and repressed memory. An examination of the relevant literature reveals that many factors can influence the accuracy of memories. Even with corroboration there is no totally reliable way of determining the validity of reports of abuse following a significant lapse of time. The Inquiry was aware of the problems associated with trauma, memory and the accuracy of recall on the part of witnesses. Similarly, the Inquiry was informed by recent work in the field of disclosure of childhood abuse.

### Profile of witnesses

To assist interpretation of the findings of the Inquiry, Figures 1.1 and 1.2 below show the age breakdown of those witnesses who divulged their age during private hearings and interviews.

*Figure 1.1: Interviews*

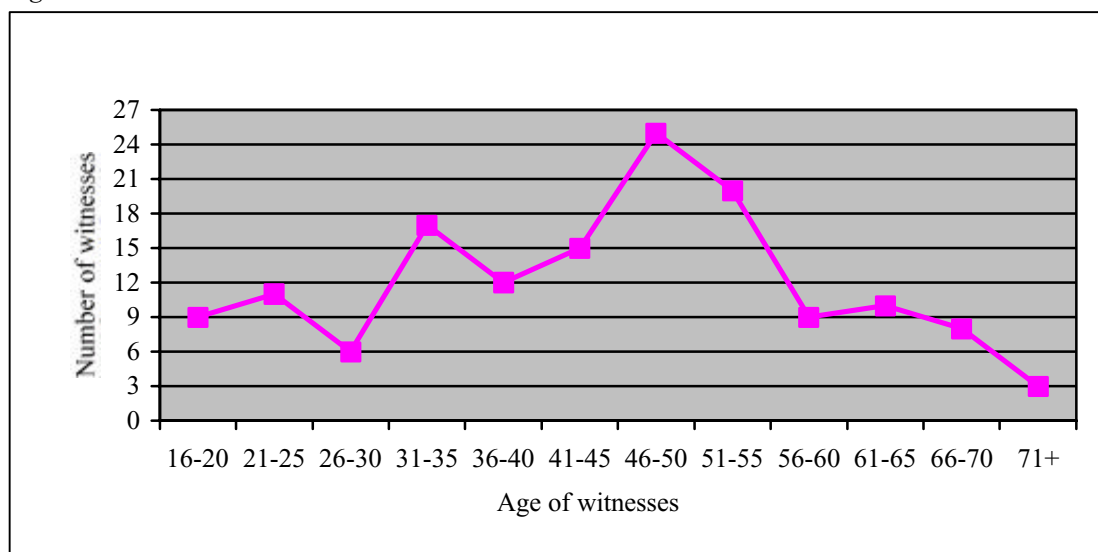
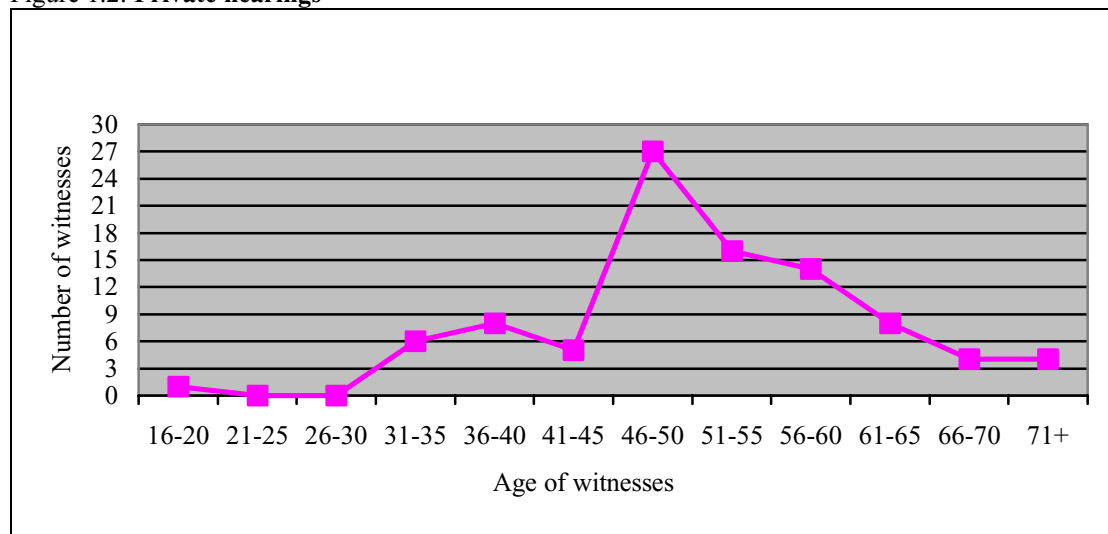


Figure 1.2: **Private hearings**



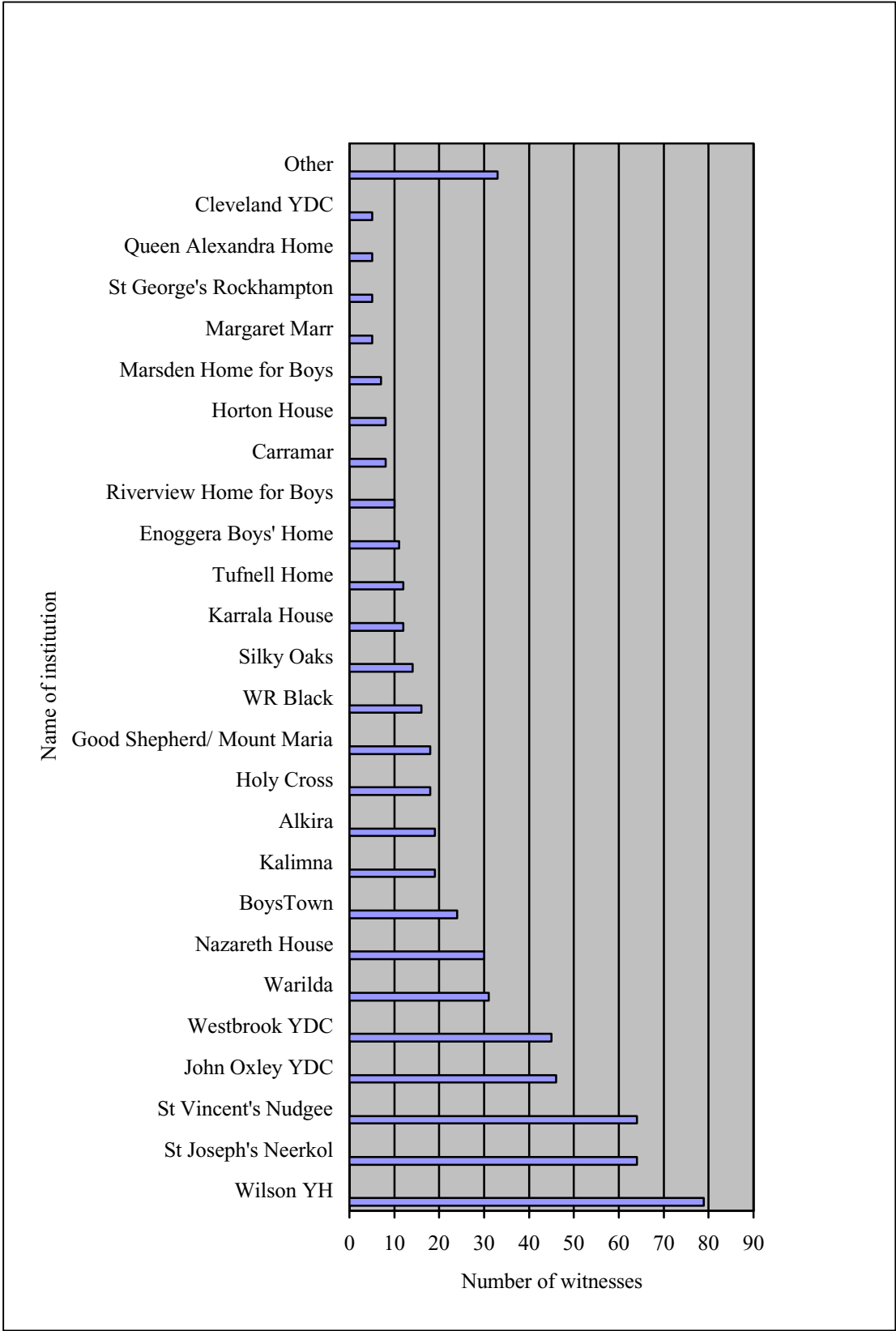
Most of the witnesses who were former residents were between 40 and 60 years of age. Although it may seem reassuring that younger people with more recent institutional experiences have not presented themselves, this may reflect the time it takes individuals to come to terms with their past to the point where they feel able to discuss their experiences. A number of witnesses chose to present their stories as written submissions rather than giving evidence in person at hearings or interviews.

#### **Profile of institutions mentioned in evidence**

Of the 159 institutions that were established or licensed under the Acts covered by the Inquiry, 45 (28.3 per cent) were mentioned either during hearings and interviews or in written submissions. Figure 1.3 identifies the institutions most commonly referred to in evidence. Where witnesses discussed their experiences in more than one institution, separate entries were made for each institution.

Although certain institutions were mentioned in evidence more often than others, it would be erroneous to interpret these figures as an indication of a more abusive environment.

Figure 1.3: Institutions mentioned by witnesses





### *Witness support program*

In recognition of the emotional stress involved in coming forward, counsellors were available to assist witnesses in preparing to give evidence to the Inquiry. Witnesses were provided with counselling support throughout the hearings and interviews.

During their contact with the Inquiry, witnesses were encouraged to maintain contact with counsellors for support. This also gave counsellors the opportunity to continually assess the need for ongoing emotional and practical support, as well as the individual's willingness to access such assistance.

Counsellors were also available to assist witnesses during the months following their attendance at the Inquiry. Many witnesses experienced symptoms of post-traumatic stress. Various self-management strategies were discussed as well as the option of referral for on-going counselling. Counsellors consulted with a number of agencies and professionals with the aim of identifying practitioners with skills and experience in the area of childhood trauma and abuse. They also offered to provide ongoing consultation at the request of the witness.

Witnesses who identified as indigenous were offered the option of support from an indigenous counsellor. This counsellor then remained available for follow-up support, or to arrange a referral to a culturally appropriate practitioner.

## **1.5 GLOSSARY OF TERMS**

Appendix 11 provides a description of the types of facilities investigated by the Inquiry which included campus-style facilities, family group homes, industrial schools, nursing or infant homes, orphanages or congregate care, receiving and assessment centres, reformatories, training and farm schools, transitional hostels and juvenile detention centres, as well as other terms used throughout the report.

## CHAPTER 2: EXPLAINING CHILD ABUSE

### 2.1 INTRODUCTION

Child abuse is a complex matter. This chapter sets out to provide an overview of its complexities and the factors that may go some way towards explaining how abusive situations have occurred, and still do occur, in institutional settings.

Any analysis of the empirical evidence of the causes of child abuse can become clinical and distant from the devastation that people are living with every day of their lives. This devastation often extends to the people with whom survivors share their lives—spouses, children, parents, work colleagues and friends. The consequences for survivors of institutional abuse are discussed in detail in Chapter 12.

### 2.2 DEFINITIONS OF CHILD ABUSE AND NEGLECT

The Terms of Reference of the Inquiry include ‘whether any unsafe, improper or unlawful care or treatment of children has occurred’ within the institutions or centres covered by the relevant Acts. The focus of the Inquiry has been on neglect, physical, sexual and emotional abuse, and systems abuse, where the policies and procedures (or the lack of them) of the government of the day resulted in abuse or neglect of children in care.

Social and cultural attitudes play a role in defining when an acceptable child management practice becomes abusive. When disciplining children, for example, there is no clear demarcation between an acceptable disciplinary practice and a physically abusive act. An example of how attitudes have changed over time can be seen in how society today views corporal punishment as a means of disciplining children.

It is still useful to clarify what is meant by the terms physical, sexual and emotional abuse and neglect. These definitions also help to provide a framework for understanding the causes of different forms of abuse (Garbarino 1990).

#### **Emotional abuse**

This term is used to cover a wide range of abuse not falling into the other categories. It includes such behaviours as rejection, denial of emotional responsiveness, stimulus deprivation, degrading of children, forcing children to live in dangerous environments, and inflicting emotional pain such as fear, humiliation and distress.

#### **Sexual abuse**

Child sexual abuse can be defined as different types of ‘unwanted and potentially harmful sexual experiences to which children are exposed’ (Fergusson & Mullen 1999). The Australian Institute of Health and Welfare considers child sexual abuse to be an act ‘which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards’ (AIHW 1995). The term ‘child sexual abuse’ has been used to include experiences ranging from a single episode of an adult exposing his genitalia through to multiple, violent and penetrative sexual assaults. The consequences of sexual abuse will, therefore, be as varied as individual experiences.

#### **Physical abuse**

Any act that results in non-accidental injury and that involves overt physical violence or excessive punishment can be regarded as physical abuse. As with other forms of child abuse, physical violence can vary according to the type, intensity, duration and severity of the injury sustained. The injury can result from punching, beating, kicking, biting or burning a child. Sometimes, physical abuse can result from over-discipline or punishment inappropriate to the child’s age or condition (James 1994).

#### **Neglect**

Neglect is more difficult to describe or detect than abusive actions since it is often defined as what carers have failed to do for children. Community attitudes towards the definitions of

neglect of children in care are as sensitive as those towards other forms of maltreatment. According to the Australian Institute of Health and Welfare (1995), neglect is:

*Any serious act of omission or commission which, within the bounds of cultural tradition, constitutes a failure to provide conditions that are essential for the healthy physical and emotional development of a child.*

Child neglect is characterised by a failure to meet the basic needs of children: adequate nutrition, shelter and clothing. It includes putting a child at risk of harm through inadequate supervision, or through psychological and emotional neglect. Other specific forms of neglect include refusing or delaying general or mental health care, abandonment or desertion, failing to ensure personal hygiene, and failing to provide for educational needs (James 1994; Hegar & Yungman 1989; Zuravin 1991).

### **Systems abuse**

Systems abuse can be defined as ‘preventable harm done to children in the context of policies or programs which are designed to provide care or protection’ (Cashmore et al. 1994). Such abuse may result from what individuals do or fail to do, or from the lack of suitable policies, practices or procedures within systems or institutions. In fact, a large proportion of the examples and the ‘causes’ of systems abuse relates to *neglect* rather than to *abuse*.

Systems abuse can take a number of different forms. However, in its simplest but probably least recognised form, systems abuse may occur when a child’s needs are simply not considered; they are, effectively, ‘invisible’. This may be a consequence of conflicting political priorities or interests, or because of adult ignorance. Agencies making decisions that affect children may not have children’s needs on their agenda, or the children may be unable to indicate that there is a problem; thus their needs may be overlooked.

More commonly, essential services may be lacking, or those provided may be inadequate, inappropriate or inaccessible. This may have a number of causes: cultural differences; the fact that children, young people and their carers do not know that the services exist or how to access them; geographical limitations; or the fact that entry to programs or services is based on criteria that children with multiple needs cannot meet (Cashmore, expert submission).

## **2.3 CAUSES OF INSTITUTIONAL CHILD ABUSE**

### **General**

The Inquiry heard many reports from witnesses of physical, sexual and psychological abuse and neglect of children in the care of Queensland institutions. The nature and extent of this abuse was varied, as were the outcomes for survivors. As we come to terms with the recognition that children were, and continue to be, abused, it is natural to ask how such abuse could occur—especially since these institutions are designed to care and protect the most vulnerable of our children. Seeking explanations will help not only in developing effective preventative strategies, but also in supporting healing and reconciliation through a deeper understanding of the circumstances that led to the abuse.

It is essential to recognise that child abuse cannot be explained by a single factor and that, in fact, there are a number of interrelated factors that contribute to child maltreatment (Vondra 1990). The illustration opposite demonstrates this complexity.

Therefore, although there is a commonly held belief that abusers are in some way abnormal or evil, and that child abuse could be prevented by ensuring such people are not employed in institutions, this does not reflect the reality.

# Societal Factors

Political Dimensions

Value of Children in Society

## Government Factors

Denial of Abuse

Perceptions of Youth

Societal Guilt

Federal Leadership

Role of the Criminal Justice System

## Department Factors

Recognition of the difference between familial and institutional abuse

Placement Strategies and Options

## Institutional Factors

Investigatory Programs

Response to Previous Inquiries

Management of Reported Abuse

Physical Environment

Organisational Dynamics and Culture

Bureaucratic versus Child Orientation

Allocation of Resources

## Individual Factors

Staff Salaries and Qualifications  
Staff Recruitment and Selection  
Staff Induction Program  
Staff Training and Development

Complaints Mechanisms

A Voice for Young People

Intersectional Collaboration

Work Load and Conditions

Quality Assurance  
Monitoring and Evaluation

A Voice for Young People

A Voice for Young People

A Voice for Young People

Practice Standards  
Supervision and Support

Leadership Styles

A Voice for Young People

A Voice for Young People

Accountability Mechanisms

Policy and Procedure Guidelines

A Voice for Young People

Legislation and Statutory Base

Enforcement of Standards

Licensing Practices

Community Pressure to Isolate

Public Awareness or Interest

Recognition of UN Convention and Guidelines in Practice

Licensing Practices

A Voice for Young People

Community Involvement

Source: Forde Inquiry, 1999

As with research into the consequences of abuse, investigations into its causes have suffered from a lack of a clear and consistent definition. Many theorists use the terms ‘child maltreatment’ or ‘child abuse’ to encompass a range of abuse from physical abuse to emotional abuse and neglect. The term ‘child abuse’ is used in this section of the report to include a range of abusive practices.

The empirical base explaining the causes of child abuse is strongest when it relates to individuals—usually parents. This is because of a predominance of research into familial abuse. In examining institutional factors leading to abuse, much of the literature is based on professional opinion, which has provided the basis for the following section.

Currently, multiple causes are considered when seeking explanations of abuse. Although it is now accepted that many factors—individual, situational and societal—can contribute to abuse, there is still little research addressing how these factors combine to cause abuse. Without this knowledge, groups at risk cannot be targeted as effectively as they might be (Belsky 1984; Ammerman & Hersen 1990).

This section looks at the causes of institutional abuse in terms of the special vulnerability of children; the institution itself; the agencies and departments responsible for overseeing, licensing and monitoring institutions; the Federal and State Governments; and society in general.

### *Perpetrators*

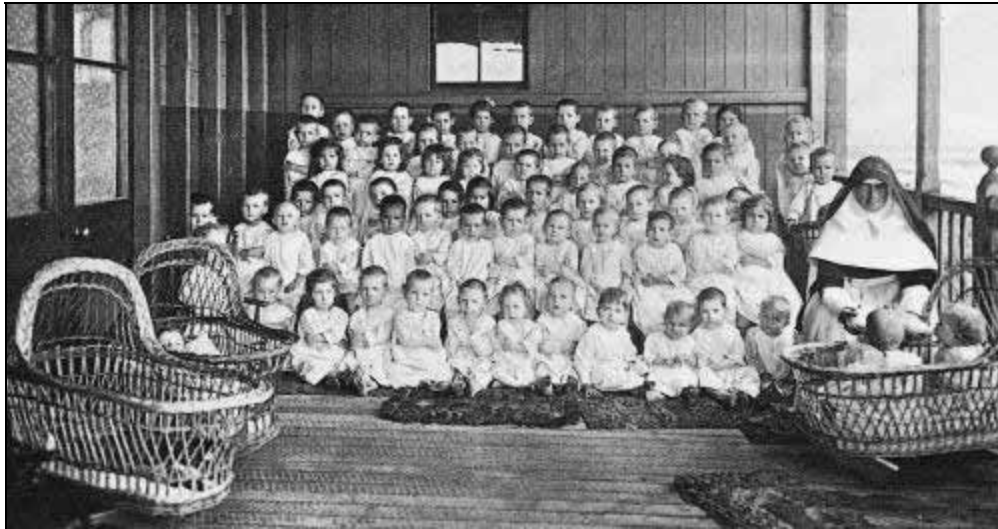
Perpetrators of institutional child abuse include staff or other adults in contact with children, and commonly other older children who are also resident at the institution.

Adult carers, either in families or institutions, bring with them experiences from their own families, and their interactions with teachers, other adults and children. The quality of the relationship between a child and a primary attachment figure or caregiver is accepted as the basis by which children learn to conduct personal relationships (Ainsworth et al. 1978). If this is troubled or insecure, it will reduce the quality of the child’s future relationships with other adults as well as with their own (eventual) children, or children they may care for.

Caregivers need the emotional support and help provided by social networks for their own functioning and wellbeing (Levitt et al. 1986). Caregivers without satisfying social networks tend to be dissatisfied with their caregiving role, have poorer parent/child interactions, and provide poor home environments for child growth and development (Stevens 1988).

In many of the institutions run by religious denominations, those directly responsible for child care may have been vulnerable as a result of limited quality relationships and social support networks. Many were discouraged from developing close relationships with the children, and even each other; many others were unable to develop any form of support network outside the closed institutional community. Although relationships were not discouraged in all institutions, these forms of ‘self-discipline’ were features of many religious orders until more recent times. Some former caregivers told the Inquiry about their own isolation and loneliness:

*I used to get lonely, yes. I remember reading about one of the residents—one of the past children from there saying he used to sit on the verandah and watch the road, the cars going up and down, you know—the road—the distance—and wish that he was in the car. And I felt quite understanding, because that’s exactly what I did myself sometimes. I’d look out the back window and think ‘I wish I was miles from here.’ It was lonely and you sort of had no life of your own. You just lived for the babies.*



**Photograph 2.1: Nursery, St Vincent's Orphanage, Nudgee—Annual Report of the Director, State Children Department**

### *The special vulnerability of children*

Children are totally dependent on adults; they cannot survive physically or emotionally without the protective care of an adult. Children will protect their access to adults at all costs, adapting tenaciously to any mysterious conditions an adult places upon them (Summit 1992). When in institutional care, it is reasonable to assume that these especially vulnerable children see the relationship with their carers as particularly precarious.

Adults often ask how is it that children do not resist sexual abuse or at least tell other adults about the abusive experience. This is to underestimate the vulnerability of children, the special understanding of children that child abusers—particularly child sex offenders—may possess, and the tendency of the potentially protective adult to question the word of a child.

Summit (1992) highlights the way in which the abuser and the protective adult exploit the vulnerability of children. This is relevant in terms of the adults in the lives of children in institutional care, individuals working for government services and society at large. He argues that the vulnerability of children goes beyond their physical size and includes their lack of power. Children are taught not to challenge the demands of adults. If they engage in sexual activity with adults, they are often confused and guilty. To ask why children do not resist or disclose the abuse is to ignore the overwhelming power imbalance between the child and the abuser.

Summit (1992) further emphasises children's vulnerability as a result of their need to be taught. This leaves them open to exploitation, and places them in a position where their ideas and feelings do not count. Adults tend to listen to children's views when they meet their expectations. When these are not met, adults tend to hesitate to accept from a child something they do not already know. A child, therefore, is in no position to teach an adult that they should suspect someone of abusive behaviour who has been endorsed by the community as a trustworthy person.

Children in out-of-home care with a history of abuse are especially vulnerable to further abuse and neglect. Neglecting the education, health and emotional needs of children in out-of-home care is common, but seldom recognised. In addition, these children are more vulnerable to physical and sexual abuse because of their own sexualised behaviour, or because they misread or misinterpret others' behaviour. Children who have already been abused may be reluctant to complain since the intervention following the previous abuse did not keep them safe. They may quite rightly expect that they will not be believed and, indeed, abusers often rely on this, targeting children in such circumstances because of their neediness. Furthermore,

any abuse may not be easily recognised or taken seriously since the signs of current abuse may be confused with those of past abuse (Cashmore, expert submission).

It is this special vulnerability that children bring with them to the institutional care and control setting. Recognition of these factors will greatly assist in the development of more appropriate preventative strategies.

## **Institutional factors**

### *General*

As outlined previously, individuals can bring a number of risk factors to the institutional setting. However, even where children are free from risk of abuse by individual care workers, other factors can operate within the institution itself that can lead to abuse. These can be either factors that cause the caregiver to become abusive, or those that lead to abuse from programs or policies. The latter is known as systems abuse, which is referred to earlier (Cashmore et al. 1994). This section introduces the nature of institutional factors involved in child abuse. A more comprehensive review of current legislation, policy and practice factors can be found in Chapter 11.

The dynamics and culture of an institution play an important role in whether or not child abuse is likely to occur. Institutional norms and values lead to certain approaches to child management, work and organisation, power and control, and the openness of the institution. Organisational culture is a complex field, but a number of issues are discussed here that are likely to relate directly to child abuse.

### *Models of child management*

Although practice manuals and guidelines are important in determining how children are managed, the underlying values and norms held by staff will greatly influence how those standards are applied. Where staff have a fundamental belief in the rights of children, the environment may be more conducive to quality care. Genuine empowerment of children also enables them to take a greater role in protecting themselves (Kiraly 1996).

All humans are capable of relating to others in a violent, domineering, exploiting or oppressive fashion. The ideology of an institution will determine whether staff will choose to treat children in an environment of growth and development or one of violence (Gil 1984).

### *Neutralisation of societal norms*

Caregivers' perceptions of the nature of their charges will influence how they care for them. For example, where carers perceive young people to be 'bad', children become dehumanised or devalued. Where residents have become dehumanised, the usual constraints on abuse and violence are tenuous and children are more likely to be verbally abused, beaten, sexually abused, tied up or even locked up (Chenoweth 1995).

Carers correctly perceived that the children of destitute families had no source of power to assert their rights, and that the community paid scant attention to how they were cared for. Such devaluing of young people in care makes possible a neutralisation of societal norms or moral concerns. This process of neutralisation depends on maintaining some moral distance from the child.

One form of abuse is called role dispossession. An example of this is when young people are admitted to an institution and are stripped of their identity. This can happen through compulsory showers, haircuts, the wearing of institutional clothing, or confiscation of personal possessions. Loss of identity can prevent the new inmate from presenting his or her normal self. During the orientation period, the inmate often must endure 'obedience tests' or perhaps will-breaking contests. These are designed to demonstrate that an inmate who shows defiance will receive immediate, visible punishment.

In addition to these losses, residents of institutions may be required to adopt postures, movements or gestures that would normally be considered demeaning.

*You'd kneel—that was another punishment. Sometimes you'd be just on your own. If it was an individual punishment, you usually got that outside her cell at night, she'd leave you, or you knelt beside your bed and she'd forget about you. You'd be kneeling with maybe your hands on your head or arms extended ... You had to put it up straight and you weren't allowed to lower your elbows ... and if you opened your eyes or when you started to droop and you got the bamboo under your elbows or back or your knees, or whatever it was you were supposed to be keeping straight.*

Other means of 'dehumanising' can include insistence on inmates exhibiting humiliating behaviours, such as begging for simple things, or suffering indignities from others. These activities create a conflict within the inmate as to previously held perceptions of self. Such treatment invades the territories of self, where inmates would normally place boundaries between themselves and their environment.

Many of these dehumanising actions have been described in evidence given to the Inquiry. It is the successful implementation of this process that lays the foundation for child abuse to occur and continue over long periods of time.

At another level, the scant allocation by government and society of resources, support for staff and training shows a distinct lack of interest in how children are cared for in residential or detention settings. These poor standards legitimate poor standards of care and behaviour on the part of staff (Wardhaugh & Wilding 1993).

### *Models of work and organisation*

Wardhaugh and Wilding (1993) identified a number of characteristics of work and organisations associated with the corruption of care. Hierarchy, concentration of 'troublesome' clients in one place, the size of the institution, and the bureaucracy merit discussion.

Hierarchical structures are not conducive to good care of children and young people. Although perhaps necessary in certain institutions, such structures make it difficult for young people and front-line workers to make complaints. In such institutions, it is common for those *not* working directly with young people to set the standards for care. Caregivers, who *are* in direct contact, may then have little regard for the standards, believing that they are not based on what conditions are really like.

An institution may adopt either a bureaucratic or a child orientation. Usually, the more distant child protection officers become from the children they serve, the more likely it is that the bureaucracy will be served rather than the child. Even at the level of the residential setting, meeting the needs of children may be considered secondary to meeting the needs of the institution. Conforming to rigid, usually inequitable, regimes inhibits the realisation of children's potential. The resultant feelings of frustration and powerlessness can easily fuel abusive situations.

When institutions place 'troublesome' clients all in one place, the risk of abuse is higher. In the case of 'difficult' children, a modest degree of violence is accepted in dealing with them. These environments allow a culture of violence that quickly leads to more abusive situations. Poorly trained staff may become more defensive and utilise more control than necessary. In addition, children with challenging behaviours may not have regular visits from supportive families or other adults, which leaves them more vulnerable through lack of contact with the outside community (Wardhaugh & Wilding 1993).

The Inquiry has heard evidence about a number of large institutions where many children were cared for by relatively few staff. The larger the institution, the more difficult it is to avoid institution-focused care. Size leads to regimentation and 'batch living', which contributes to depersonalisation. This situation can easily result in a corruption of care standards (Wardhaugh & Wilding 1993).



Group dynamics play an important role in institutional abuse. A climate where staff are not trusted, or where there are no comfortable ways of differing from or challenging another's ideas, should be considered a high-risk environment. The institution may also be at risk if staff do not support each other, or if they perceive that practice standards come before personal loyalties. Corrupt practice can also arise from 'in-groups' and cliques. This can put the institution at risk by making it difficult to identify practice problems, and to deal with them fairly and effectively (Kiraly 1996). Problems can be expected at those institutions where supervisors or managers appoint friends and family to be direct carers, often bypassing standard recruitment procedures.

### *Power, domination and control*

Powerlessness has been a central cause for almost all the young people who have been subjected to abuse in care. Their weakness and vulnerability is characterised by their lack of power or influence, limited knowledge of how the organisation works, little awareness of how to assert their rights, or how to make complaints about those on whom they often depend for the basic elements of living (Wardhaugh & Wilding 1993).



*Photograph 2.2: Westbrook detainees and guard—Courtesy Queensland Newspapers*

In the institutional setting, the adult abuser is able to maintain power and domination over the child victim because of the degree of control that carers have over the children's lives (Chenoweth 1995). Abusers are often able to control what the child may eat, when the child may eat it, what time he or she goes to bed, whether or not the child is able to have exercise, see friends or relatives, or even go to the toilet. Crossmaker (1991) points out that this control serves to reinforce compliance and makes it difficult for children to make complaints. Where chemical or mechanical restraint is used as a method of control, the young person in care will have even less control over their bodies, the environment or the actions of others against them.

Jones (1994) argues that for vulnerable children in institutional care there is a powerful combination of traditional and charismatic authority vested in the adult carer. For children who enter institutional care there is often pre-existing oppression from their previous social and material circumstances. Therefore these children are already vulnerable to the power of an adult abuser. Furthermore, these children may have already been rejected by the traditional authority of their families, and directed to institutional care by the authority of the welfare system. There is great appeal in the charismatic leader who offers to provide a sense of self-esteem and power not previously experienced.

It should also be noted that, although carers have almost total power over young people in care, there might also be a degree of powerlessness on the part of the carer. If they are taken for granted by the institution, not recognised for the difficult work they do, given little

support, or not consulted about the organisation of their work, then this will induce feelings of powerlessness. Where carers feel powerless, they may exert more power on the most vulnerable in the organisational hierarchy to boost their self-esteem. If their status as 'full moral beings' is damaged through powerlessness, carers may cease to behave in an ethical or professional fashion (Wardhaugh & Wilding 1993).

Caregivers have the opportunity to exert additional power over children where there exist poor supervision, no inspections and little accountability or external advocacy for children. Children, on the other hand, have no opportunity to exercise power or identify legitimate outlets for their feelings of frustration (Wardhaugh & Wilding 1993).

### *Isolation of the institution*

All systems develop their own rules that define their contact with the outside world. Childcare systems are no different in this respect (Department for Family and Community Services, SA 1995). Closed institutions evolve for a number of reasons. In some cases it may be a deliberate attempt to ensure that the institution is not exposed to external scrutiny. However, in most cases, isolation is the result of poor practices, however unintentional. Children in closed or secure institutions, where there are no strategies for parental and community involvement, have little access to contacts in the wider community. Within the closed institution of the family, reports of abuse often come from neighbours, teachers, or other people with whom that child has contact outside the home (Mercer 1982). Isolation from the wider community clearly places an institution at high risk of indulging in abusive practices.

Physical isolation prevents professionals or relatives from visiting. The failure to provide regular visits, mechanisms for monitoring and staff training in these isolated environments has featured in many institutional abuse investigations (Doran & Brannan 1996).

When friends, relatives or associates of staff are employed, it becomes very difficult to report or discuss suspicions of abusive practices. Caregivers in institutions often close ranks when an abusive event is reported, rendering the system relatively closed to effective investigation.

Another serious consequence of isolation is that children may not be adequately prepared for the transition to life outside the institution. Some children come to feel safer within the institution than outside it. Children in detention centres, for example, may re-offend in order to return to a situation that is at least familiar to them (Cashmore et al. 1994). The Inquiry heard numerous examples of children graduating from the care setting only to find that they were totally unprepared for normal life in the community.

*I remember in the orphanage, people used to come and take you out for a day and I went to this house once—and this is just to give you an example of how little we knew about what you do at places—and these people had a whole lot of people there for lunch and when I walked in they offered me an apple. Would I like an apple? And I was—I ate the apple, but I didn't know what to do with the apple core. I was too scared to ask, so I ate the apple core, and then they asked me for the apple core. I just didn't—I couldn't ask. I just didn't know what to do.*

### *Status of childcare work*

The status accorded to childcare workers generally is reflected in the financial compensation they receive, and in the qualifications required to enter the field of work. Most positions to do with the direct care of children carry very low financial rewards, and often do not require qualifications. Associated with low pay is a lack of career development opportunities. Therefore, direct care workers cannot expect promotion or an increase in salary as the result of good work performance (NSW Community Services Commission 1996).

### *Recruitment and selection*

Quality recruitment and selection processes have two aims. First, they identify and employ the highest quality of staff available; and second, they ensure that high-risk individuals are identified and removed from the selection process. With the relatively high turnover rate in residential care workers, difficulties emerge when there is pressure to recruit staff urgently.

This can lead to shortcuts being taken in hiring procedures, with possibly serious results (Bloom 1992). Nepotistic or 'word-of-mouth' recruitment practices are of concern and can often result in further isolation of an institution.

Standards in recruitment and selection have been developed for some time, and there are many examples of quality recruitment and selection guidelines for childcare workers (see, for example, the Warner Report 1992). However, even when quality guidelines are in place, it is essential that the licensing authority monitors these practices (Utting 1997).

### *Staff training and development*

Many childcare workers lack the qualifications or experience to manage children with challenging behaviours. Although in the past little was known about how to deal with such children, substantial work has recently been done in the area of behaviour management. Ongoing training can be made available to all staff on a regular basis, giving the resultant well-trained childcare worker more options to deal with children's behaviour (Mercer 1982). In-house training not only develops practical childcare skills, but also provides an excellent opportunity to work on the development of a positive organisational culture—one conducive to quality childcare practices. Licensing authorities can make funding dependent on training and development activities (Cavanagh 1992). Structured orientation programs should feature in any staff development program and are needed to clarify staff roles and expectations.

Poor supervision and staff support also contribute to a high-risk environment. Direct care workers need to feel supported and to believe that senior staff take an interest in what they do. Staff who work alone place themselves and the children they care for at greater risk (Kiraly 1996). Quality supervision also enables direct care workers to be regularly monitored for their state of mind and feelings, and supervisors can be someone with whom the worker can discuss difficulties and strategies (Mercer 1982).

### *Working conditions*

Child care is difficult and challenging, and is made even more so where conditions are poor. Work hours are often extended and it is not unusual for staff to work with inadequate compensation. A heavy workload is an obvious risk factor for abuse. In many of the institutions investigated by the Inquiry, staff were expected to manage large numbers of children, often with little support or preparation. Where such stresses are placed on carers it should be anticipated that order and control would take precedence over attending to the needs of individual children. In such circumstances, the slide from control into violence can be rapid (Wardhaugh & Wilding 1993).

In residential facilities where therapeutic programs are in place, caregivers are often expected to implement a variety of treatment plans instigated by a range of professionals. Sometimes it is difficult for staff to coordinate these programs adequately, resulting in added frustrations and a sense of hopelessness (Durkin 1982). Bureaucratic demands on some caregivers, when paperwork takes precedence over direct caregiving, can also lead to role strain.

### *Physical environment*

The design of the physical environment can be instrumental in allowing abuse to occur. Geographic analyses of violence within prisons show that it is concentrated around blind points at the ends of corridors and away from the surveillance of officers, especially where there is a linear layout of rooms.

Other factors in the physical environment include excessive heat, cold or noise. Without adequate heating or cooling, staff and young people become unnecessarily stressed. Excessive noise, such as yelling, banging or resounding footsteps is also stressful. The type of materials used to build the facility can exacerbate this problem. Stimulus deprivation through poor design features or décor is also a known stressor.

People respond to the expectations that a particular environment sets for them. If an institutional environment projects a fortress-like mentality, it sets up an expectation that

young people will behave in a dangerous and violent way, which in turn may influence the way in which they choose to behave. Normalised environments are easier to manage, there is less abuse of children, and less abuse of staff by residents (Wortley, Public Hearing 16 December 1998).



*Photograph 2.3: Sir Leslie Wilson Youth Detention Centre projected a fortress-like mentality—  
Courtesy Queensland Newspapers*

## **Institutional practices**

### *Practice standards*

Childcare institutions, like any other institution providing care, must have practice standards. Without policies and practice standards, caregivers are left to determine the nature and quality of care delivered to children. They have to decide how to manage challenging behaviour, how to respond to suspicions of abuse, how to manage children's complaints, and even to define what constitutes negligence or an abusive act. Without standards, monitoring of institutional practice is arbitrary and left to the discretion of the inspector or representative of the licensing authority. Practice standards need to provide unambiguous and comprehensive guidelines to direct care workers. Where standards do not address the full range of activities carried out by staff, or anticipate a reasonable range of difficulties that may arise, staff are left to use their own discretion in situations where this may not be appropriate.

### *Programs and services*

Failure to provide adequate programs and services to children in care is a form of systems abuse. Children and young people in care should expect to receive adequate education, vocational training, general and mental health care, leisure and recreation, contact with the community and family, and a range of programs that prepare them to function independently and risk-free upon discharge. Neglect of these needs places young people at great disadvantage for the rest of their lives. This form of neglect can arise from a poor understanding of the needs of children, or the lack of will to invest in such programs. Chapter 9 provides a detailed description of programs and services for young people in detention.

Some specific programs have a more direct influence on the occurrence of physical or emotional abuse. Behaviour management programs and techniques should reduce the risk of abusive situations, isolation and restraint being used to ensure the safety of a child out of control, and to protect staff and other residents. However, if these techniques are not applied appropriately, they can easily create a more volatile situation. The decision to restrain a child is always a balance between protecting the safety of the child and applying a technique that may become oppressive or dangerous in itself (Utting 1997).

Institutions that do not provide adequate recreational and leisure activities leave themselves vulnerable to unnecessary tension. Boredom and frustration create friction between young people and carers, which contributes to a pattern of abuse (Mercer 1982).

*You got no freedom, you're locked down most of the day. You look at the walls, you can't even get out to have fresh air. You're in this place all day, just looking at the walls, watching TV.*

### *Monitoring service delivery and quality assurance mechanisms*

Although the concept of quality assurance (QA) did not emerge until recent decades, there is currently little doubt about its value. Good QA practice means that the quality of service delivery is measured routinely as part of the usual service provision process. It includes mechanisms to prevent or minimise poor quality outcomes and, where problems have occurred, to detect and respond effectively. Examples of QA mechanisms for childcare settings include entry and exit interviews, reliable complaint mechanisms, and advocacy and representation for young people (Department for Family and Community Services, SA 1995). Other effective strategies to monitor service delivery could include formal and informal supervision systems, regular staff appraisal and routine internal evaluations using the practice standards as a guide for measurement.

When internal management and quality assurance mechanisms fail in an institution to the extent that a child is abused or neglected, the system cannot guarantee to adequately care for the child. If the institution had adequate monitoring systems in place, a potential breach of duty of care would have been detected before the care deficit became serious (Department for Family and Community Services, SA 1995).

### *Reporting abuse and the role of denial*

An abusive environment can flourish as a result of poor reporting and management of abuse. Although a more detailed discussion of appropriate practices to manage abuse can be found in Chapter 11, which reviews current policy and practice, this section provides a brief overview of the main factors that determine risk.

Before an abusive event can be reported, there must be an environment conducive to reporting. In some institutions there may be barriers to reporting abuse. For example, staff may not report abusive incidents where there is no cultural and legislated consensus about what acts and omissions are serious enough to require intervention. Alternatively, reporting may be low where there are difficulties in identifying whether harm to a child is the result of specific acts or omissions attributable to a particular carer (Rindfleisch & Bean 1988).

If staff members observe an abusive situation, they need to feel confident that reporting the event will not result in the loss of their job, demotion, reprisals or alienation from administrators or work colleagues (Lerman 1994). Where there is a fear of serious reprisal, moral obligations to report are obviously challenged. However, workers may reject a colleague who reports abuse for other reasons. Sometimes, adults cannot accept an adult who chooses to believe a child's word over that of another adult. This 'fraternisation' with children may be considered a threat to adult authority. Once a child has told a worker of an abusive experience, the worker may develop a sense of helplessness, as validating the child's complaint requires the worker to move through a series of levels of authority that are unwilling to believe that an 'outrageous complaint from a simple child is more credible than a reasonable denial from a sophisticated adult' (Summit 1992).

Failure to report a child's complaint can also be the result of disbelief that fellow workers are capable of abuse. Workers may forget their professional stance and deny such allegations. Professional identification with the alleged offender may challenge their 'professional self-worth and ideals' (Single 1989).

### *Management of reported abuse*

Good management of a reported case of abuse will help to reduce the risk of abuse in the future. How the institution chooses to manage the situation will be carefully scrutinised by the young people in care, the direct care workers, affiliated professionals, parents and the community.

If the child involved in an abusive situation is not supported or fears retribution by staff or their peers, the impact of the abuse is amplified. Other young people will observe and remember the victim's experiences. Equally, when a staff member is accused of abuse, feelings of shock, fear or disgust are felt by other staff throughout the institution. Relationships are challenged or broken. Previous unrelated issues may re-emerge, such as racial tension, union problems, or supervisor-worker relations. Such problems can seriously affect the culture and stability of the organisation. Not only will care delivery be disrupted, but the way in which abuse is reported in the future is likely to be affected. Where institutions do not respond directly and unambiguously, the integrity of services, reputation and future funding of the institution are compromised, as well as placing the institution at risk of litigation (Bloom 1992). Finally, where management does not respond to a substantiated case of abuse by dealing with the offender, providing counselling and support to the child, and addressing the institutional factors that allowed the abuse to occur, all stakeholders learn that abuse is not considered a serious issue.

### *Institutional complaints mechanisms*

Advocacy and independent complaints mechanisms will be discussed in Chapter 11. However, there should be other mechanisms in place at an institution for children to make complaints about the care that they receive. Providing access to a telephone or a 'complaints box' or telling children they may make complaints to their immediate carers is not sufficient. Young people may not trust that their complaints will be listened to, or may fear retribution from staff or peers. Mechanisms need to be based on principles of empowerment. This comes out of recognition of children's rights, their special vulnerability, and a genuine commitment to listen to and respect the opinions of young people.

### *Giving a voice to young people*

Involving young people in decisions that affect their lives is important for normal socialisation and development. Learning how to make decisions comes through experience and the freedom to make mistakes.

Although this appears obvious, whenever the matter of children's participation in decision making is raised, issues emerge about children's rights and their capabilities to make decisions (NSW Child Protection Council 1998). A desire to protect children may result in coercive practices that deny them the ability to participate in decision making. This is especially true where young people are perceived to be victims who require special protection. Within institutional care the victim mentality may be reinforced, interrupting the normal cognitive and psychosocial development of the young person (O'Brien 1997).

It is also frustrating for children to live in an environment where all adults 'know what is best', particularly when these adults may not know the child well, and are perceived to be making decisions based on files and reports. Children are perceptive enough to understand that they have been labelled as 'difficult', and that decisions are being made based on that assumption. The frustration and anger this creates, combined with general feelings of low self-worth, will most likely play a part in the events that lead up to a volatile and potentially abusive situation.

## **Departmental factors**

### *Philosophy and orientation*

The philosophy and orientation of departments responsible for children in institutional care will influence the quality of, and approach to, service delivery. A common complaint about

institutions and bureaucracies is that the processes reflect the needs of the system rather than those of the clients they are supposed to serve.

A child-oriented focus can reduce the level of risk of institutional abuse. This orientation is based on a set of clear principles and guidelines that start, as the paramount consideration, with the features of caregiving or services that are likely to promote children's security and wellbeing. A child-oriented focus will aim to provide timely, appropriate and accessible programs, and will listen to children and accurately assess their needs, including their need for continuity. It means giving children age-appropriate information, and allowing them to express their views or to have an advocate who is able to express those views (Cashmore, expert submission).

### *Placement strategies*

It is well recognised that harm done to children through multiple placements is a form of systems abuse (Cashmore et al. 1994). Delays in decision making or challenges made to permanent care orders result in children moving in and out of the childcare system. The more disruption that takes place, the more difficult it becomes to place the child permanently (Cavanagh 1992). Discontinuity of carers and frequent changes in residential environment will inhibit the emotional development of the child (Gilligan & Keating 1998). This, in turn, contributes to more challenging child behaviours that leave them more vulnerable to abusive caregiving.

### *Licensing practices*

A licence is required before any facility can offer residential child care. The Department of Families, Youth and Community Care (in all its forms) and the Queensland Corrective Services Commission (QCSC) have been responsible for issuing these licences. Chapter 11 reviews current practice in this area.

Licensing provides the supervising agency with the opportunity to ensure that the basic systems and practices are in place before the facility is allowed to operate. Although historically there has been a focus on physical standards, licensing can include all aspects of the administration and management of the facility (Lerman 1994). Indeed, during annual upgrades for licences, these systems and practices are assessed.

Poor licensing practices may be the result of pressure to accommodate children who have been unable to be suitably placed in the rest of the childcare system—those children who have the most challenging behaviours (Rosenthal et al. 1991). There may be only a limited number of institutions providing such care, so that to deny a licence upgrade would result in enormous pressure on the entire system.

### *Policy and practice guidelines*

The quality of practice standards was addressed previously. In fact, the development of policy and practice standards should rest at the level of the licensing authority. If the relevant department does not provide unambiguous and comprehensive practice standards, then the inference must be that the institution is responsible for determining the specific standards of care delivered. Institutional staff are not equipped to interpret the legislation and regulations, be cognisant of 'best practice' developments in the field, and develop comprehensive practice standards. Without adequate direction, childcare workers are left unsupported and stressed from trying to solve complex problems with little information about what the standards should be and the most appropriate way of handling problems.

### *Monitoring, supervising and enforcing institutional standards*

After licensing an institution and defining the practice standards, the most important function of the licensing agency or department is to ensure that the quality of service delivery is maintained, and to guarantee the welfare and safety of children.

Inspection is the principal means of external monitoring, and has several functions. It provides the institution's management with an authoritative assessment of the service. It also

provides a view that is independent of those involved in the provision of those services. Inspection is not simply 'visiting' institutions. Without a structured format for the inspection, a description of the findings, an analysis of the implications of those findings, and a response or action plan, inspection visits will have little impact. A simple way to determine the value of inspections and supervisory visits is to identify what changes they bring to the institution and the system (Utting 1997).

The provision of regular reports from the institution to the supervising authority does not, of itself, constitute monitoring. Such practice is based on the assumption that the institution can identify high-risk factors in its own setting, and that staff are both motivated and equipped to do so. It also excludes young people in care as a source of information about the quality of services.

Reporting is only one aspect of monitoring. Monitoring also involves the use of the central information system by, for example, tracking patterns of institutional abuse across the State, or identifying regular deficiencies in the system that would require a State-wide, coordinated response.

Where monitoring uncovers deficiencies in the system, the supervising department must still enforce regulations and standards of care. If the responsible authority does not follow up identified deficiencies, and ensure their correction, the residential facilities will learn that such breaches are not considered serious or important.

### *Evaluation and research*

Historical evidence, current notifications and substantiation of abuse, and recent media headlines demonstrate that child care and protection agencies are unable to provide complete protection from abuse for children in residential care facilities. As previously illustrated, institutional abuse is a highly complex problem with a multidimensional influence. There is little understanding of how the different risk factors interact with each other (Rosenthal et al. 1991). Interventions and preventative strategies are often not evidence-based, and the impact of residential care experience on children is not well understood. Without an investment in evaluation and research activities, agencies lose the opportunity to learn from their own and others' experiences.

### *Response to previous inquiries*

To reduce the risk of institutional abuse across the entire residential care system, recommendations from previous inquiries commissioned to investigate child abuse need to be incorporated into policy and strategy development for abuse prevention. Limiting responses to the facility level reinforces a view that abuse is either the result of deviant staff or poor facility management, and inhibits a systems approach to prevention. A successful response to inquiries requires a commitment on the part of the responsible agencies to implement responses fully and in a concerted and coordinated manner (Doran & Brannan 1996).

### *Institutional abuse investigatory programs*

Investigatory programs include the investigation, substantiation and follow-up of notifications of institutional abuse. The objectives of these programs are:

- to protect the child from further harm, assess the impact of the incident on the child and ensure the child's needs are met
- to determine whether there has been a violation of care standards, agency regulations and procedures or criminal codes (Department for Family and Community Services 1995).

Reports of abuse can be received from the abused child, child advocates, institutional staff or other individuals interested in the welfare of the child. How this process is conducted is another important factor in determining how abusive environments are able to flourish. Investigation should always be secondary to prevention.



The independence of the investigation is crucial. When an institution has failed to protect a child to the extent that abuse may have occurred, that institution should not be relied upon to investigate the incident. Indeed, even the supervising authority or department is not well placed to investigate abuse because of their role in child placement, monitoring and supervision. To ensure that investigations are rigorous and objective, the response must be 'as structurally and functionally independent as political and economic constraints will allow' (Department for Family and Community Services 1995).

Investigating institutional abuse requires specialist expertise. However, child protection agencies commonly conduct investigations using procedures developed for investigating familial abuse. Although some of the same procedures will apply, this practice ignores the differences between familial and institutional care and the complexity and dynamics of institutional care, and may even contribute to the low substantiation rates of institutional abuse (Nunno & Motz 1988).

The general orientation of an investigation program can be towards the removal of the perpetrator rather than towards understanding all the institutional or system factors that have led to the abusive incident. An investigatory program will have little long-term impact on the system if action is not recommended and then implemented.

### *Intersectoral collaboration*

When the various agencies that provide services for children do not provide a coordinated response, children may miss out by 'falling between the gaps' of the services, or they may receive a less-than-efficient or unhelpful response. In some cases, children are subjected to multiple assessments or interviews because the various agencies have different perspectives, requirements and methods of intervening (Cashmore, expert submission).

Close working relationships between institutions and other departments such as Health and Education mean that young people's needs are assessed by those with expertise in a particular sector, and services are likely to be more responsive to the needs of young people. However, collaboration does not mean fragmentation of services, with responsibility being passed around a number of professional groups. There should still be a 'key worker' who retains overall responsibility for the child, and who coordinates the collaboration of other professional groups.

### *Allocation of resources*

Perhaps the most obvious cause of systems abuse is the lack of resources that generally besets welfare and children's services. Neither children in care nor their caregivers have the political power or the means to galvanise support for increased resources. The problem seems to be worsening as the demand for child protection, substitute care and other children's services increasingly outstrips the available resources.

The most direct effects of resource shortage are a lack of services, inadequate or pressured services, and long waiting times for the available services. These in turn may result in stringent 'gate-keeping' to ensure that services manage their workloads. Although this may be important for workers to help them maintain quality of service, it is detrimental to children whose needs, or multiple needs, would cause too great a burden on the service.

A lack of resources and a shortage of services have other indirect effects. For example, it means that workers have to carry high caseloads that prevent them from working effectively and having the time to review their decisions and approaches, or to follow up cases to ensure that appropriate action has been taken. At the level of the facility, staff are under substantial pressure, placing them at risk of abusive practices in child management. High staff turnover, a reliance on casual staff and inadequate training also mean that it is difficult to establish a culture where the safety, security and wellbeing of children and young people are the fundamental concerns of the organisation (Cashmore, expert submission).

Another consequence of under-funding is the inability to provide anything other than residual services. That is, resources are concentrated on crisis management of child abuse rather than on preventative or supportive strategies that reduce the incidence of abuse. By focusing on the crisis end of the situation, more crises emerge from the lack of investment in preventative strategies. This applies at the community and institutional level (O'Connor, expert witness), leading to a situation where children are being placed in institutions or other alternative care arrangements that are inappropriate.

In situations of shortage there is a limited ability to provide high-cost interventions. Some children require a significant investment of money over a longer period of time, making it difficult for the department or non-government organisation responsible for the facility to purchase specialised services or packages of care for individual children. So the approach moves further from providing services based on the needs of the child towards offering the child what services are available. Shortages also force institutions to focus on 'core business', which may translate into trying to prevent young people from accessing the service, and referring them to other services. Where other sectors are similarly under-funded, they also have effective 'gate-keeping' policies, because they, too, cannot provide adequate services (O'Connor, expert witness).

Substantial resources are required to ensure that the licensing agency or supervising department can carry out meaningful monitoring, supervision and evaluation activities. Where insufficient resources are allocated to these activities, institutions learn that the licensing agency is not sufficiently concerned about standards to invest in monitoring them. Closed institutions can develop in an environment where external monitoring is not rigorous.

### **State and Federal governmental factors**

State and Federal Governments also play a part in whether or not residential care facilities and detention centres develop into abusive environments. As the focus of this chapter is on individual, institutional and departmental factors, this section will provide only a brief overview of government-related issues.

The United Nations Convention on the Rights of the Child provides an important framework to guide legislation, policy and, ultimately, practice. Article 2 addresses the best interests of the child; Article 9 deals with separation from parents; Article 12 recognises the right of children to be heard; Article 19 concerns protection from abuse and neglect; and Article 20 specifically addresses the protection of children without families. Ratification of the Convention is not sufficient in itself. Federal leadership is required to support the principles of the Convention, and it is essential that these principles be specifically enacted in State legislation (Gilligan & Keating 1998). Legislation and regulations are important precursors to the maintenance of standards and to the recognition of children's rights, especially the right for children and young people to participate in decisions that affect them.

Legislation also needs to recognise the difference between familial, foster and institutional abuse. Without this recognition, there is a lack of regulation of residential care facilities simply because they are not adequately identified in the legislation (Cavanagh 1992). Legislation designed to address only the needs of those children that represent the majority (foster care) to the exclusion of the minority (residential care and, to a lesser extent, detention) means that States must 'stretch' their intrafamilial-oriented statutes to incorporate institutional abuse (Rindfleisch & Rabb 1984). Such legislative omission can have far-reaching effects, for example conducting investigations of institutional abuse within the less-appropriate intrafamilial or foster care framework.

The criminal justice system also plays a direct role in the reduction of risk of institutional child abuse. First, through successful detection and conviction of abusers, the system acts as a deterrent to other high-risk individuals entering the system as direct care workers. Second, an effective criminal justice system that convicts offenders ensures that employees with histories of abuse can be identified during the recruitment process.

The State government determines the proportion of the social sector budget that is allocated to child and family welfare and protection. The value of investing in children, especially children from poorer families, will be reflected in the funds allocated to these services. Societal factors that influence this perception are discussed briefly in the next section.

### **Societal factors**

The value that society places on children will influence the pressure upon governments to ensure child safety, welfare and wellbeing. A community that does not believe that children are worthy of investment, or that there will be a long-term reward if such investments are made, will not exert the pressure necessary to ensure quality service delivery (O'Connor, expert submission). In many circumstances the general public is simply unaware of the situation of children in institutional care. Many do not understand the complexity of problems facing this client group, nor can they articulate their expectations of service delivery.

The media have a powerful influence on how we relate to our social world. Repeated negative images of young people have dominated the way in which the public has come to think about this section of the population. Media representations may have influenced the development of social policies in respect to young people, and the orientations of those professional practitioners who work directly with young people and their families (Bessant & Hil, 1998).

The media have developed a community perception of a juvenile crime wave. This, in turn, has fuelled public demands to 'get tough' on young people (Howlett 1995). It is these over-reactions that can lead to the acceptance of harsh treatment, controlling behaviour management strategies and excessive security in juvenile detention centres.

This fear of detention centre residents or of the socially disadvantaged has resulted in pressures to isolate institutions from mainstream society, either geographically or in terms of the integration children are granted into normal community life. In this situation, facilities are vulnerable to becoming closed systems and may manifest many of the associated risks previously described. In addition, restrictions on participation in community life have serious implications for the young person re-entering the community.

Societal denial of abuse has also worked against efforts to reform protective systems. When adults are faced with indicators that a child is being sexually abused, there can be an inclination to deny the situation in favour of maintaining the comfort of the status quo. Workers face conflicts when the accused is a colleague or trusted friend. Even for those observing allegations of institutional abuse in the media, there can be a desire to preserve public faith in a fair and just society. It may be easier to consider a carer in an institutional setting as the 'bad apple' rather than consider the possibility of endemic institutional and systems abuse (Summit 1992).

This may be even more desirable when it becomes apparent that, in order for institutional and systems abuse to take place, a large number of people often need to 'cooperate'. For example, institutionalised physical, emotional and even sexual abuse from staff or other inmates is often either suspected or observed by other staff members. Alternatively, staff from government departments or Official Visitors may suspect abuse. When considering the number of individuals who either cooperate directly or fail to act upon their observations or suspicions, it can be seen that the 'bad apple' explanation no longer holds true (Goddard, personal communication).

Summit (1992) posits that society has a tendency to see the individual accused of abuse as more vulnerable than the child; that the child will recover from the events, but the accused could be ruined for life. The suspect, after all, may have proven himself to be a trusted and devoted person over time. Perhaps more importantly, he has been trusted and endorsed by other reputable adults.

There can be little doubt that the adult world undervalues the contributions that children are capable of making within modern Western societies. Viewed as socially and personally 'immature' by adults, the capacities of children for making informed judgments are at best

downplayed and at worst totally ignored. Children's views are rarely canvassed, even when decisions are being made that deeply affect their lives. Perhaps the greatest indication of the subordinate status of children in contemporary society is their lack of rights compared with those of adults under Australian case law. In Australia, for example, 'non-excessive' physical punishment of children is still sanctioned legally, placing them in the invidious position of being the only people in society against whom violence is considered acceptable (Saunders & Goddard 1998).

## **2.4 CONCLUSION**

Institutional abuse is the result of myriad factors operating at several levels. This complexity, and limited understanding of the way these factors interact at the systems level, challenges society's ability to prevent child abuse continuing in institutions. Although the prospect is overwhelming, it can be prevented if strategies are targeted at all levels (individual, institutional, governmental and societal). Rather than focusing attention solely on the 'deviant' behaviour of the perpetrator, it is essential that consideration is given to all the players who are 'cooperating'—whether consciously or unconsciously—in creating a high-risk environment for children. At the same time it is important to recognise the 'convenience' of placing the blame so widely that no one is left responsible.

## CHAPTER 3: HISTORICAL OVERVIEW OF CHILDREN IN QUEENSLAND INSTITUTIONS<sup>1</sup>

### 3.1 INTRODUCTION

Contemporary systems dealing with children in State care in Queensland had their foundations in the 1860s and 1870s, when legislation was then enacted, and practices adopted, that have guided the government's involvement with the so-called 'problem' child—a child deemed in need of care and protection, care and control or other forms of State assistance. Two seminal Acts of Parliament were passed in the mid-nineteenth century—the *Industrial and Reformatory Schools Act 1865 (IRSA 1865)* and the *Orphanages Act 1879 (OA 1879)*. While neither could be considered particularly innovative, they nevertheless formed the basis of today's child and family welfare and juvenile justice systems.

This chapter considers the emergence, consolidation and aims of strategies for dealing with children classified by the State as either criminal, pre-criminal, neglected, or requiring some other form of State care. The chapter is divided into two parts: an examination of how the child welfare system developed in Queensland from the mid-nineteenth century, and an appraisal of child offenders and the State's juvenile justice system.

### 3.2 NEGLECTED CHILDREN AND THE CHILD WELFARE SYSTEM

The child welfare system in Queensland has run parallel to the juvenile justice system from the 1860s, although there have been numerous points of intersection. Indeed, for the most part the clientele of the two systems have been identical. Like the juvenile justice arena, children committed into the State welfare system have been drawn overwhelmingly from the communities of the urban poor.

Both 'client groups' shared common problems attributable to poverty. In many ways, it was something of a lottery as to whether a child designated 'neglected'—as defined under the *IRSA 1865*, the *State Children Act 1911 (SCA 1911)* and the *Children's Services Act 1965 (CSA 1965)*—would end up in the juvenile justice or child welfare system. If a child was apprehended by the police or an inspector of the Society for the Prevention of Cruelty and brought before a court, the outcome could mean a lengthy term in a reformatory or industrial school. However, should the same child be apprehended and a formal application made to the child welfare agency, the child would most likely be committed to an orphanage or fostered out to 'respectable' surrogate parents.

#### Establishment of orphanages

A child welfare system did, however, develop from the 1860s that differed in many respects from that focusing on juvenile justice. A system of orphanages and homes for destitute and neglected children was established in the mid-nineteenth to early twentieth centuries. However, the designation 'orphanage' was something of a misnomer. Departmental Annual Reports show clearly that the vast majority of children resident in orphanages from the 1860s were not, in fact, orphans. Figures from the Inspector of Orphanages Annual Report of 1887 can be regarded as typical for orphanage admissions throughout the nineteenth and twentieth centuries. Of the 107 children admitted to State care, only eight had lost both parents. Fifty-three had lost one parent and the remaining 46 were admitted as a result of desertion by either or both parents. Rather than being abandoned children, factors such as poverty and the breakdown of the family unit have been the predominant reasons for children entering State care (Schofield 1971). However, for a small number of British child migrants exported to St Joseph's Orphanage, Neerkol (near Rockhampton) after World War II, another factor can be added. These children were part of an Empire-wide social experiment designed to bolster the population base of Britain's former colonies (Bean & Melville 1990; Coldrey 1993; Gill 1997; Humphreys 1997).

### British child migrant scheme

The British child migration scheme to the British Empire lasted 350 years with the final group of children departing for Australia in 1967.

In the period 1947 to 1967 between 7,000 and 10,000 ‘orphaned’ children were sent from the United Kingdom to Australia. In fact, very few of these unaccompanied child migrants were orphans. Most had been placed in State care in Britain by a parent for reasons such as marital breakdown, illegitimacy and temporary economic hardship. After World War II the incidence of such factors soared. Many parents—particularly single women—faced raising their child (or children) without adequate financial support and in an atmosphere of social disapproval.

Consequently, large numbers of ‘unwanted’ children were placed in State care for fostering and adoption. However, research conducted by the British Child Migrants Trust has revealed that many of these children were transported to Australia without the permission of their natural parents.

Western Australia and New South Wales were the major destinations, receiving 48 per cent and 28 per cent of the children respectively. Queensland’s intake was small by comparison, amounting to 4.5 per cent of the total. Two institutions in this State received child migrants—the Salvation Army Training Home for Boys at Riverview, near Ipswich, and St Joseph’s Orphanage, Neerkol, near Rockhampton.

In the 1950s the Training Home admitted 77 boys above school-leaving age for the purpose of providing the boys with three to six months’ agricultural and dairying training before placing them in employment.

Between February 1951 and February 1956, 48 children arrived at St Joseph’s Orphanage, administered by the Rockhampton Congregation of the Sisters of Mercy. The Neerkol children were ‘recruited’ in England by the Catholic Migration Organisation under a group nomination submitted by Bishop Tynan of the Rockhampton Diocese, who became their custodian. The children were brought to Australia with the encouragement and financial backing of the British and Australian governments. Responsibility for their wellbeing lay with the Commonwealth Minister for Immigration who was their legal guardian under the *Commonwealth Immigration (Guardianship of Children) Act 1946*. This guardianship power was delegated to the relevant State-based agencies, with the Director of the Queensland State Children Department acting as the representative for the Minister.

The first group of 22 child migrants arrived at St Joseph’s in February 1951. They were followed by another 14 in July, two in October 1954, four in January 1955 and six in February 1955. Surviving records indicate that the ages of the Neerkol children ranged from 5 years 6 months to 14 years, and they were mostly female. The records reveal that only two of the children entered Australia with parental consent. Some of these migrant children had been recruited from St Anthony’s Home, Bedford, near London. Most, however, came from Father Hudson’s Homes located throughout the United Kingdom.

By 1966/67 all of the child migrants to Neerkol had been discharged from State care. The majority ended up in clerical, retail or domestic positions. At least eight went on to work in hospitals as nurses or nurses’ aides, two became teachers and three went on to become Sisters of Mercy.

In 1865 the government established Queensland’s first orphanage—the Diamantina—in Brisbane. This initiative was followed by the Roman Catholic Sisters of Mercy, whose Brisbane Congregation founded St Vincent’s Orphanage at Nudgee in 1867 for children of their faith. During the 1870s two more orphanages were opened in central and north Queensland: the Rockhampton Orphanage in 1869, administered by a volunteer committee associated with the town’s benevolent society, and the Townsville Orphanage in 1878. The last orphanage to be licensed in the nineteenth century was St Joseph’s, operated by the Rockhampton Congregation of the Sisters of Mercy. Originally located at Mackay, this institution was removed to Neerkol, some 24 kilometres from Rockhampton, in 1885. After World War I, the Anglican Church and other denominations entered the field.<sup>2</sup>



*Photograph 3.1: St Vincent's Orphanage, Nudgee, operated by Brisbane Congregation of the Sisters of Mercy—Courtesy Mercy Family Services*

### ***The Orphanages Act 1879***

This piece of legislation was of major importance in determining the fates of children in State care until the 1920s. Its provisions expanded both government and community responsibility for child care, although in reality it proposed little that was innovative. In essence, it served to regulate and organise existing methods of protective care for children. Formal provision was made in both the Act and its Regulations (issued in May 1880) for the 'hiring out' or—much less commonly—the apprenticing of children in State care to employers. However, these practices declined markedly from the late 1920s. Alternative forms of care adopted under the protection of the government's licence diversified greatly from the 1880s onwards. Adoption procedures came under the auspices of the State, and small institutions known as 'infants' homes', controlled by the religious denominations, were opened (Evans 1969). From this decade the government focused much attention on the child under two years of age—the infant—culminating in the passage of the *Infant Life Protection Act 1905 (ILPA 1905)*.

The *OA 1879* made the Townsville, Rockhampton and Diamantina Orphanages public institutions, although the northern orphanages continued to be administered by voluntary management committees. The principle of State licensing and control of denominational institutions was established, although after bitter debate in Parliament it was agreed that the Roman Catholic St Vincent's Orphanage would not become a public institution.

The Act was essentially one of consolidation. It addressed two issues of concern to the government: first, that the State was supporting the children of parents who deliberately avoided paying maintenance for their upkeep; and second, that the 'barrack-like' atmosphere of the orphanages was detrimental to the future development of the child. While the Act did not suppress the growth of this type of institution, it pointed to the problems associated with it.

### **The orphanage system**

From 1865 to 1900 the orphanage system was the mainstay of the government's child welfare strategy for dealing with neglected children in need of alternative care. In 1880, 77 per cent of the total number of children in State care were in institutions. By 1900 the percentage had declined to 40 per cent. These figures make it clear that the government was heavily reliant on the institutional-style orphanage setting for dealing with the increasing numbers of children entering State care throughout the late nineteenth century. This reliance abated in the decades following the turn of the century with the government's preference for placing children in foster care (discussed later in this chapter). By 1930 only 10 per cent of the total

number of children in care were resident in State institutions, although the percentage had risen to 15 per cent by 1965.

The orphanage system was initially based on large residential institutions housing hundreds of children in a communal environment. Until the 1890s the State-administered Diamantina Orphanage was the largest institution for neglected children in Queensland. However, the government's emerging preference for fostering over placement in a large institution for the child in need of State care led, in the 1890s, to the Diamantina changing its role to that of a receiving depot for children awaiting placement in a foster home. This change of function was formalised in 1910, when the institution was moved to Woolloowin in Brisbane and renamed the Diamantina Receiving Depot and Infants' Home. In 1967/68 it was again renamed, this time as the Warilda Receiving and Assessment Centre. The State orphanages in the north of Queensland followed suit: the Townsville and Rockhampton Orphanages became receiving depots in the early twentieth century, and became the Carramar and Birralee Receiving and Assessment Centres respectively in 1967 and 1968.



*Photograph 3.2: Rockhampton receiving depot—Annual Report of the Director of State Children Department for the year 1913*

From the 1890s the vast majority of children placed in orphanages were Roman Catholic admissions to St Vincent's Orphanage and, to a lesser extent, St Joseph's Orphanage until their closure in the 1970s and 1980s. In part, this reflects the greater poverty faced by Queensland's largely working-class Roman Catholic community. However, the preponderance of Roman Catholic children committed to these orphanages is also explained by the church's policy of caring for children of their own faith rather than running the risk of a Catholic child being fostered by a Protestant family (Schofield 1971).

### *Criticisms of the orphanage system*

Throughout the 1880s and 1890s the orphanage system had its share of critics, including the Inspector of Orphanages, parliamentarians, the press, and 'child saving' organisations such as the Society for the Prevention of Cruelty (see, for example, Annual Reports 1880–1899). The major criticism levelled at life in the orphanages was that it undermined the child's independence and individuality compared with that engendered in the 'normal' family environment (*Queensland Parliamentary Debates (QPD)*, Vol. 28, 1879). The regimented lifestyle and chains of command that inevitably arise in these 'total institutions' (Lemert & Branaman 1997) were believed to foster a spirit of dependence and lethargy in the child, undermining her or his 'character' (*QPD*, Vol. 28, 1879). Character formation was at the centre of a predominantly middle-class-led civilising mission of the poor in Queensland during the late nineteenth century and the twentieth century (Jamison 1999). The basic foundations of a 'civilised' citizenry lay, it was believed, in the transmission of 'respectable'



values via an upbringing in a ‘respectable’, stable, nuclear family unit rather than in the impersonal surroundings of the dormitory-style orphanage.

Other criticisms of the orphanage system were fairly obvious, such as the ease with which illness was spread among children due to their living in close proximity. Occasional concern was also voiced about the children’s diet. However, there was a general abatement of adverse comments on the institutions, particularly following the 1890s economic depression, and within the official publications of the Office of Orphanages and, after 1911, the State Children Department. Throughout the twentieth century the Department’s ‘public’ criticisms of the orphanages tended to focus on factors such as the poor state of the buildings in which the children were accommodated (Annual Reports 1912–1970). As Chapter 5 details, an array of problems was evident in the operation of institutions from at least the 1920s.

Despite a comprehensive set of Regulations being issued to guarantee minimum standards of care for children in institutions following the *State Children Act 1911* (*SCA 1911*), conditions in the orphanages often fell short of those required by the government (*Queensland Government Gazette (QGG)*, Vol. XCIX, 20 July 1912). While some children regarded their experiences in the orphanage environment as fairly pleasurable, others reacted adversely to the regimentation of daily life, the sometimes excessive punishments meted out to them, the impersonal treatment they received, the lack of basic amenities, and their separation from parents and siblings. Indeed, both the *OA 1879* and the *SCA 1911* (only repealed in 1965) imposed severe restrictions on a parent attempting to gain access to a child committed to the care of the Department—a situation that undoubtedly heightened the sense of loneliness felt acutely by numbers of State children.

The growth of both the social sciences and medical knowledge in the twentieth century led to an enhanced, if imperfect, understanding of the needs of children in State care. Studies of both an academic nature and popular appeal pointed to the paramount importance of parental affection and attention in child-rearing practices. While some children undoubtedly benefited by being removed from families in which they ran the risk of grave physical and psychological harm, a consensus was emerging from the middle of the twentieth century that conditions prevailing in the dormitory-style orphanages were far from ideal for raising children.

### **Regulating the orphanage system**

By the end of World War II, social attitudes regarding what were considered appropriate ways to raise children centred on more child-inclusive and ‘gentler’ approaches on the part of parents. Dr Benjamin Spock’s phenomenal bestselling book, *Baby and Child Care* (1946), highlighted and made widely accessible knowledge of these new child-centred philosophies. However, even before the post-World War II boom in ‘baby literature’, there were clearly drawn boundaries regarding acceptable treatment of children. ‘Best practice’ in this regard was adopted, in theory at least, by the government in the form of regulations guaranteeing the protection of children in its care.

Both the *SCA 1911* and the *CSA 1965* required that children should be adequately fed, clothed and cared for. Excessive physical and emotional punishment was forbidden by persons and institutions who held State children in their charge (*QGG*, Vol. XCIX, 20 July 1912; Vol. CCXXII, 19 July 1966). While opinion has inevitably shifted over time on the degree to which physical punishment is an effective means of disciplining a child, the dominant view from the late nineteenth century was that the physical and emotional punishment of children by adults should be kept to a minimum, and should never be applied gratuitously (Boss 1995; Duke 1995; Saunders & Goddard 1998).

In many State-licensed institutions these legislated standards clearly went unmet. Often this was a result of individual weakness in the supervising adult and/or lack of child-care training. The large numbers of children in the under-staffed orphanages, prior to the 1960s in particular, would not only have taxed the patience of staff, but would have militated against a caring environment so missed by many ex-residents. The Department and its officers were not

entirely to blame for this unsatisfactory state of affairs; the role performed by what became the State Children Department in 1911 was never a particularly easy one. Until the reforms initiated by the *Report of the Committee on Child Welfare Legislation* (1963) and a Public Service Commission investigation (1962), the Department was massively under-staffed and under-resourced.<sup>3</sup> The reforms also went some way towards rectifying the relatively poor quality of staff employed by the Department. Professional standards from the highest echelons to the lowest had traditionally been low. Appointments were generally made on the basis of seniority rather than competence, which was hardly conducive to a flexible and innovative service. Ill-treatment of children in State care was the responsibility of both the licensed carers and the Department, and was certainly not sanctioned by prevailing 'standards of the day'.

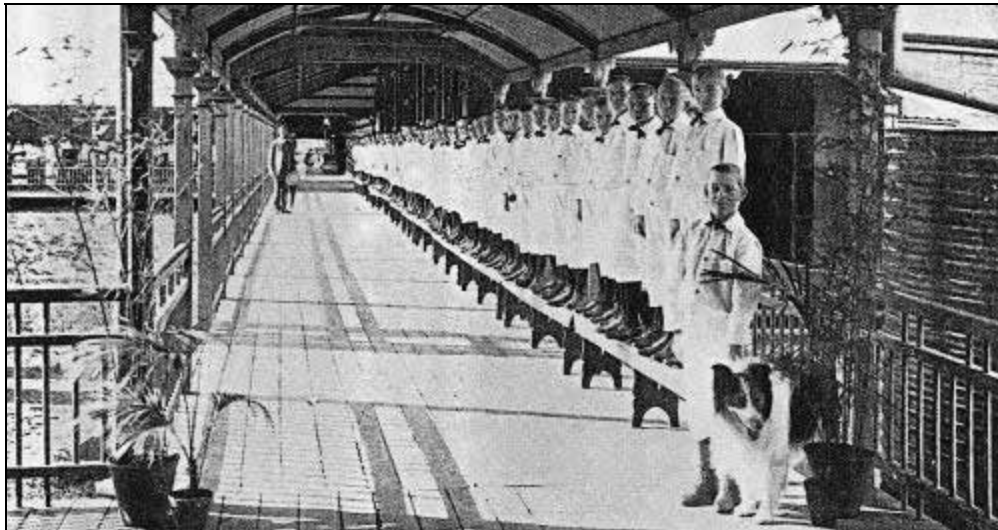
Statements in departmental Annual Reports from the late nineteenth century reveal that departmental officials were aware of the problems within the orphanage environment. Why, then, did the Department persist in placing children in this form of alternative care?

### **Government encouragement of the orphanage system**

The reasons were likely to have been twofold. First, the area of children's services was, and continues to be, poorly funded by governments. Rarely has expenditure on children's services exceeded one per cent of the annual total budget expenditure of the Queensland State Government. Orphanages, particularly those run by religious denominations, have been cheaper to finance than those operated by the government itself. Second, a deeply held belief in the value of a religious upbringing was common in Queensland until the 1960s. Children sent to denominational orphanages (and industrial schools) were, it was considered, being reared by respectable and pious persons in an environment not far removed from the upbringing a child would experience in any Christian family. The establishment of St Vincent's Orphanage, Nudgee was a good example of the motivation behind the government's desire to reduce spending on the provision of institutional care for children in its care.

The licensing of St Vincent's in 1867 established a precedent for future denominational institutions and came about largely as a result of financial expediency on the government's part. Following the economic collapse of 1866, the government-controlled Diamantina Orphanage was bursting at the seams with destitute children. Rather than face the prospect of wholly financing another institution, the government opted instead to partly fund St Vincent's (Goldman 1978). The Colonial Secretary's Office paid the same per capita allowance for each child (10 pence per day), but the Sisters of Mercy met all capital costs and building maintenance. The option of seeking out the cheapest means of dealing with children in State care has invariably been the one chosen, with the welfare ethos conveniently set aside (Schofield 1971).

However, a price has been paid historically for the government's willingness to place children in orphanages and residential institutions under the auspices of the religious denominations. It is possible that the bland official reporting in the Department's Annual Reports (1912–85) of conditions prevailing at these institutions is the result of not wishing to antagonise a valuable and cheap service provider. By divesting itself of much of the financial responsibility for the children admitted to denominational institutions the government surrendered much of its capacity to act as an arbiter of standards. At best, government regulation amounted to little more than routine inspections (Schofield 1971).



*Photograph 3.3: St Vincent's Orphanage, inspection of boys by Director—Annual Report of the Director of State Children Department for the year 1914*

## **Avoiding institutionalisation**

### *Foster care*

Options to the institutionalisation of children had existed from the 1860s. Indeed, the *OA 1879* was in part legislated to offer an arrangement thought to be closely akin to a child being reared in a 'normal' family environment. The Act promoted an innovation termed 'boarding out', or fostering as we know it today. Fostering children in government care had been tried on a small scale in Brisbane during the 1870s and found to be successful. The Act made provision for a system of licensed and paid foster mothers.

Supporters of this system, particularly the Office of Orphanages, argued that foster care would benefit the child by providing her or him with the benefits of a 'normal' family environment, something unattainable in a large residential institution. A regulation created under the Act to this end promoted the need for the most suitable 'morally appropriate' foster mother to be selected for training children in 'habits of truthfulness, obedience [and] personal cleanliness'. (*QGG* 21 May 1880). This moral training would not be interrupted by the child's natural parents, who were 'vigorously discouraged' from visiting their children by the Office of the Inspector of Orphanages.

Fostering, particularly through the prosperous 1880s, was a great success as far as the government was concerned. Its greatest virtues were that it was a cheaper method for the protection and control of children than the State orphanage system;<sup>4</sup> the system of voluntary inspection lessened the Office of Orphanages' workload; and finally the child, it was argued, benefited from the opportunity of experiencing an upbringing in a 'normal' family. This being the case, the Inspectors keenly promoted the system and were delighted with the results. For example, in 1879, 12 per cent of children in care were fostered, but by 1900 the figure had grown to 27 per cent. Taking in foster children, the records suggest, was particularly popular with rural families, since the children could be utilised as cheap labour on the farm. After 1918, however, foster homes in urban centres were more favoured by the State Children Department.

Between 1900 and 1930 the Department's policy was generally 'to place the dependent child in a home environment rather than institutional care' (Schofield 1971). However, during this period the numbers of children placed in foster homes declined from the high point of 1900, so that by 1930 only nine per cent of the total number of children in State care were fostered out. In 1965 the number was 11 per cent. There are a number of reasons for the decline of foster care in the twentieth century. Government payments to foster mothers were always niggardly and always well below the established minimum wage. Demographic changes in

the 1930s depression and in the post-World War II period led to families and potential foster mothers being unwilling to take on the responsibility of a State child or children.

### *Monetary assistance*

The single greatest factor accounting for the decline in the numbers of children in institutional care and those placed in foster care was the granting of monetary assistance to the natural mothers of children who would otherwise have been delivered into State protection. The assistance awarded was miserly, but in a positive sense made it easier for the children of very poor (overwhelmingly single-mother) families to remain within the family unit. Government authorities, however, held legal guardianship of the child until the *CSA 1965*, accusations of ‘immorality’ on the part of the mother could lead to the benefit being withdrawn and the removal of the child.

Potential recipients readily availed themselves of the new system. Indeed, between 1906 and 1930 State-assisted families became the largest client category within the Orphanages Department. From a figure of four per cent of overall clients when the scheme was introduced in 1906, the proportion reached 72 per cent in 1930, declining to 62 per cent by 1965. The capacity of needy families to maintain their children at home was further augmented from 1942 with the Commonwealth’s introduction of widows’ pensions and child endowment payments to families, further boosting the numbers of children remaining within their own homes who might otherwise have been transferred into State care (Roberts & Herscovitch 1980). The Commonwealth Government’s Sole Parent Pension, introduced by a Labor Government in 1973, and subsequent Family Allowance packages aimed at assisting low-paid workers have also made the retention of children in low-income families more possible than ever before.

### **Decline of the orphanage system**

Thus, it can be seen that both fostering and assistance payments contributed greatly to the process of ‘deinstitutionalisation’ prior to the 1930s, which went into decline from that decade until the 1970s. Whereas in 1930, 10 per cent of children were in institutions under State care, by 1965 the figure had risen to 18 per cent, with a peak of 22 per cent in 1951 (Schofield 1971). The reasons for this dramatic turnaround were not due to any intentional policy on the part of the Department. Rather, Queensland was subject to an Australia-wide demographic phenomenon that led to a shortage of foster homes which, in turn, coincided with the expansion of the churches into residential care services. A further contributing factor may have been the need of some parents for short-term care for their children, which was more easily arranged through admission to an institution than through wardship or fostering (Mellor 1990).

### **The 1960s**

The 1960s heralded the beginnings of developments that were to lead finally to the demise of the orphanage system in Queensland. In line with progressive thinking on the institutional arrangements to be made for children in State care, the dormitory-style setting passed out of vogue, to be replaced with a number of new types of residential settings such as congregate care homes, clustered group homes and, perhaps most typically, the family group home.

### *The family group home*

The family group home was modelled on the ‘cottage system’ of accommodation. These residential units, run by houseparents of ‘good moral standing’, were charged with offering an environment resembling a large family. As in previous periods, it was the religious denominations that were prominent in the operation of these institutions. In the late 1950s the Department increased its subsidy to the churches on a £1 for £1 basis. The churches built a further 13 residential institutions by 1965, but these received no government subsidy. The consequence of this was that, despite the new spatial design, the old problems of the ‘barrack-style’ building persisted. A perpetual shortage of funds left the churches at a disadvantage in securing competent, trained staff. This led, in turn, to high staff turnover that was at odds with the cottage principle of stable parental figures supervising the homes. In essence, the much-

hoped-for substitute for the foster home was left foundering because of inadequate finances (Schofield 1971).

### ***The Children's Services Act 1965***

The mid-1960s saw the passage of the first major Act dealing with State children since 1911—the *Children's Services Act 1965* (CSA 1965). The *State Children Act 1911* (SCA 1911) had been passed to consolidate and rationalise developments in the child welfare arena since the 1880s. Similarly, the CSA 1965 consolidated developments in services since the 1910s. The Act came into operation on 1 August 1966. It repealed the *Infant Life Protection Acts 1905 to 1935*, the *State Children Acts 1911 to 1955*, the *Guardianship and Custody of Infants Acts 1891 to 1952*, the *Children's Courts Acts 1907 to 1930*, and the *Children's Protection Acts 1896 to 1945*.

Importantly, the Act introduced definitions of care and control and care and protection orders which guide practice to the present day. Section 46 outlines the circumstances in which a child may be considered in need of care and *protection*. These include a child having no parent or guardian who exercises proper care and guardianship over her or him thus leading to neglect, exposure to moral danger, falling in with bad associates, and being likely to fall into a life of vice or crime or addiction to drugs. The circumstances whereby a child can be committed to care and *control*, covered by section 60, are falling or likely to fall into a life of vice or crime or addiction to drugs, exposure to moral danger, and being, or appearing to be, uncontrollable. The distinction between the two types of order is one more of form than content. A care and protection order essentially relates to an unfit guardian and the issue of parental responsibility (or the lack of it). A care and control order is more directed to the behaviour of the individual child.

The primary purpose of the Act may well have been, however, 'to remove stigma and other discriminatory attitudes relating to socially deprived children and their families'. (Annual Report 1967). In attempting to fulfil this aim, terms such as 'State child' and 'ward of the State' were replaced by the more neutral 'child in care'. The change in terminology, it was hoped, would make the community more accepting of such children (Annual Report 1967; *QPP* 1967–68). Further changes of a liberal nature also occurred with the Act. For example, those children for whom only monetary aid was granted ceased to be considered children in care and, as a consequence, guardianship was no longer transferred to the Director of the Department. Rather, guardianship remained 'with parents or such other persons who have custody of the children'. (Annual Report 1967; *QPP* 1967–68). This provision reflected a broader principle written into the Act: that every effort was made by the Department to prevent the separation of children from their families.

By the late 1960s, hopes were high for a revitalised, modern Department that would introduce the high level of professional services for government care of neglected children that had been lacking in the previous century. Whether these aspirations were realised is considered in Chapter 6, which accounts for developments in State government child welfare systems from the 1970s to the present.

### **3.3 CHILD OFFENDERS AND THE JUVENILE JUSTICE SYSTEM**

The towns emerging in late nineteenth century Queensland, such as Brisbane, Rockhampton and Townsville, were obviously a far cry from being the bustling metropolises that had been established in Europe and North America. However, they still experienced similar types of 'social problems', although on a smaller scale. Supposedly anti-social behaviours such as drunkenness, prostitution, sexual 'immorality' and gambling were just some of the vices that attracted the attention of social reformers (see, for example, *Royal Commission 1891*; *Royal Commission 1901*). Juvenile crime became a priority for the social reform agenda.

#### **The delinquent child**

Social historians are generally agreed that the concept of juvenile delinquency and criminality was largely an invention of the mid-nineteenth century middle classes, whose influence in

government circles made the 'delinquent child' an object for State intervention (Pearson 1983; Platt 1977; Stratton 1993). The fear of the delinquent child arose from concerns held by these powerful social strata over the lifestyles of urban working-class youth. This anxiety, emerging in industrialising countries in the nineteenth century, is notable for its longevity. From that time to the present, 'moral panics' centring on the 'deviant' behaviour of working-class youth have been important in shaping perceptions of the actual or potential delinquent in Queensland.

From the 1880s to the early 1900s, a furore erupted over the so-called 'larrikin' and 'larrikinness' threat. The middle-class press and 'respectable' journals bemoaned the existence of these working-class street gangs, holding them responsible for all manner of street crime and, in the case of females, levelling charges of sexual promiscuity (what today is referred to as a status offence) (Finch 1993).

The persona of the larrikin as juvenile delinquent was transferred in the 1950s to working-class youth 'gangs' termed Bodgies and Widgies. In more recent times, continuous media talk about 'youth crime waves' and politically motivated 'law and order' agendas represent the latest chapter in the demonisation of the juvenile delinquent. Research has revealed that claims of the existence of youth-based crime waves, in both historical and contemporary settings, are grossly exaggerated (Mukherjee 1997). However, the effect of these often-fallacious perceptions of juvenile delinquency on both the theory and practice of Queensland's juvenile justice system is worthy of consideration.

The *Industrial and Reformatory Schools Act* passed by the Queensland Parliament in 1865 was the first legislative provision to deal with the correction and training of aberrant children. Prior to this, the practice had been to commit children found guilty of more serious crimes to an adult gaol. The *IRSA 1865* was adapted from British models and Victorian legislation passed in 1864. Essentially, it aimed at providing for two classes of children under 15 years of age.

The first was the delinquent (those deemed to be unmanageable, incorrigible and/or exhibiting criminal tendencies). Such children, according to the Act, were 'to be sent forthwith to any reformatory school to be there detained for not less than one year and not more than seven years' (section 9). The second class of child was termed 'neglected'.

Children labelled neglected were defined as living in harmful and socially unacceptable circumstances. A charge could be brought against a child in this category if they were found to be begging in the streets or public places, frequenting taverns or other places of public resort, sleeping in the open-air and unable to confirm that they lived permanently in a residence, or living in a brothel or with any person known or reputed to be a prostitute, thief, drunkard or vagrant.

An established charge enabled justices to place the child in an industrial school for the same period of time as that served by the reformatory inmate (section 8). Both 'neglected' and 'delinquent' children were to be trained in a trade or, if over 12 years of age, placed in work (Raymer 1979).

Those responsible for drafting the Act held the view that the criminal child was more 'vicious' than the neglected child, and believed that neglected children would become 'contaminated' with criminal sentiments if the two mixed freely (*QPD*, Vol. 2, 1865). However, despite the strong rhetoric that flavoured the debate, the distinctive system of reformatories and industrial schools advocated through the *IRSA 1865* was exceptionally slow to emerge, and even then it is difficult to discern the distinctions between the two.



*Photograph 3.4: Neglected child committed by magistrate—  
Annual Report of the Director of State Children  
Department for the year 1911*

#### *The Reformatory and Industrial School for Boys, Lytton*

A reformatory for boys was eventually proclaimed at Lytton, on Brisbane's east side in 1871. It remained operational until 1900, when its 88 inmates were transferred to a new facility at Westbrook, near Toowoomba. While designated a reformatory, the institution at Lytton more properly resembled a modified industrial school (Report 1887; Seymour 1988).

Female juvenile offenders, on the other hand, continued to be confined in adult women's prisons until 1881, when the Toowoomba Courthouse was proclaimed an Industrial and Reformatory School for Girls aged nine to 17 years. Its administration, though, remained within the prison system. After some 22 years in service, the Toowoomba facility was closed in 1903 and the inmates dispersed to denominational industrial schools (Schofield 1971).

#### **Church-run industrial schools**

From the late nineteenth century the Salvation Army, and to a lesser extent other religious denominations, played a dominant role in the establishment and operation of industrial schools for boys and girls. The Salvation Army opened industrial schools for boys at Riverview in Ipswich (1898) and Indooroopilly (1922), and for girls at Yeronga (1898), Toowong (1917), Chelmer (1923), Rockhampton (1920 and 1930) and Toowoomba (1945). Other denominations opened industrial schools early in the twentieth century. The Catholic Church established such institutions for girls at Nudgee (1903), Woolloowin (1904) and Mitchelton (1933), and the Church of England set up an industrial school for girls in 1903 at Clayfield.

By the late 1950s the vast majority of these industrial schools had ceased operating as such. Mostly the facilities were transformed to conform to the changing practices in handling children committed to State care—for example placement in accommodation such as family group homes and transition hostels.

### Government reform schools

Compared with the religious denominations, the government in the nineteenth and early twentieth centuries played a secondary role in the provision of reformatory and industrial school facilities. In fact, until the *SCA 1911* transferred industrial schools to the State Children Department, the government ran just two reformatories. It is apparent that, from the outset, the State sought the active cooperation of religious organisations in the field of juvenile justice. In part, this was because it was believed that the child offender was most easily reformed in a religious atmosphere. Another motive behind State encouragement of denominational involvement in the juvenile justice system was the savings to be made in an area that had always been a low priority for government funding.

### Changing attitudes and methods

The *Industrial and Reformatory Schools Act 1865 (IRSA 1865)* must be considered important in the history of the juvenile justice system in Queensland. There is little doubt that the Act failed to introduce separate facilities within the system for the ‘criminal’ child and the ‘neglected’ child, and, despite intentions to the contrary, the inter-mixing of the two quickly became the norm. There are a number of obvious reasons why there was no system of institutions clearly demarcated as either reformatories or industrial schools. A potent factor was the parsimony of the government, combined with the relatively low number of child offenders (*QPD*, Vol. 2, 1865).

Perhaps another reason for the inter-mixing of juveniles was that their social circumstances differed little, and their misdemeanours were generally of a fairly minor type (Goldman 1978). In addition, both institutions operated on similar lines. However, of more importance than the blurring of the distinction between these two institutions is the fact that the *IRSA 1865* heralded the beginning of a process centred on changing attitudes and methods for dealing with the child offender. That process is still evident in the juvenile justice arena today.

The Act drew a sharp distinction between modes of punishment and treatment of adults and children. One of its aims was to facilitate the separation of supposedly hardened adult criminals from juveniles so as to prevent ‘contamination’ and the potential recruitment of children into the ‘criminal classes’. However, there was another express purpose in placing the juvenile offender in the reformatory or industrial school environment. It was believed that the prolonged daily regimen of stern discipline, moral supervision and occupational training would rehabilitate the errant child who, in later adult life, would demonstrate commitment to social values such as industriousness and obedience towards constituted authority.

### Rehabilitation at Lytton

The Reformatory was first located on the former prison hulk, the *Proserpine*, moving in 1881 to Signal Hill at Lytton. Life aboard the *Proserpine* apparently combined ‘great physical discomfort to the point of unhealthiness and severe detachment from the rest of society’ (Lincoln 1966). Physical conditions for inmates improved following the move, although it continued to be ‘run along the lines of a penal institution with a touch of benevolent despotism’ (Savage 1992).

The boys incarcerated within Lytton’s precincts were clearly subjected to a tough regime. Discipline was strict, with both physical and psychological punishment meted out for misdemeanours (Savage 1992). Corporal punishment was to be used, theoretically at least, only as a last resort for establishing discipline. This proviso has been maintained within government institutions for other boys in State care as well as within the State educational system (Clarke 1980; Savage 1992).<sup>5</sup> For girls at the Industrial and Reformatory School at Toowoomba—a sister establishment to Lytton—punishment was quite severe; rule-breakers were made to serve three days in solitary confinement on a bread-and-water diet.

The major emphasis at Lytton was on rehabilitation. Rudimentary education was provided in the afternoons and some daily recreation was permitted. Certain basic rights such as that of



complaint against unfair treatment were allowed for, and much effort was spent on the spiritual and moral welfare of the boys. However, the primary objective of the institution was to re-socialise these 'wayward' boys by imbuing them with the habits of honesty, cleanliness and industry. Religious instruction and occupational training were considered an important part of their rehabilitation because those qualities 'were intended to equip the children to live honest lives as members of a conforming working class' (Seymour 1988).

### **Influence of the 'child saving' movement**

The 'child saving' movement, led from the early 1880s by the Society for the Prevention of Cruelty, began to advocate alternative methods for dealing with neglected and criminal children appearing before the lower courts. From the mid-1880s, legislation was enacted allowing for non-institutional-based modes of punishment to be used on offenders.

In 1886 the *Offenders Probation Act (OPA 1886)* and the *Justices Act (JA 1886)* were passed in Queensland. Both Acts contained sections relevant to sentencing juvenile offenders. The *OPA 1886* made probation possible under certain conditions. The court was empowered to first impose a custodial sentence, which was then suspended when the offender entered into a recognisance of good behaviour. Upon discharge, the young offender no longer had to be supervised (Seymour 1988).

The *JA 1886* was modelled on English legislation, allowing for a summary trial in the lower or magistrates courts (i.e. without a jury) of children under 12 years of age who were charged with an offence other than homicide. Further, children under 16 could be tried summarily if charged with a range of specific offences (Seymour 1988). These Acts foreshadowed the *Children's Court Act 1907 (CCA 1907)*.

Both of these Acts reveal a 'softening' of the approach to juvenile offending. A discharge could be granted as opposed to an obligatory term in the reformatory or industrial school.<sup>6</sup> A summary trial in the lower court allowed the child to avoid the stigma and contamination associated with the public jury trial. These were the intentions behind the legislation. However, the actual effects may have been somewhat different. In fact, legal historian John Seymour contends that the possible effect of summary trial was that it 'widened the net' of new offenders for relatively minor misdemeanours—particularly violations of the vagrancy laws. The simplified summary procedures may well have led to the prosecution of children and youth whose behaviour may otherwise have been ignored or dealt with informally by the police (Seymour 1988).

By the early 1900s the 'child saving' ideal proved popular among juvenile justice reformers in Queensland, culminating in the passing of the *CCA 1907*. The primary provision of the Act was to formalise procedures whereby the child offender would be tried summarily in a separate court to adults. The reasons put forward for the separate proceedings should by now have a familiar ring to them. Children, particularly neglected children who were not facing a criminal charge, were to be spared the ignominy of the 'brutalising' atmosphere of the adult court. They were to be removed from an environment of 'contamination' and stigma. Further, they would be stopped from gaining notoriety among their peers—a factor that could lead, so reformers believed, to a future life of crime. The anonymity of the young defendant was further guaranteed by the exclusion of the media from the proceedings of the Children's Court (Seymour 1988).

### **The 'welfare model'**

Children's courts were placed at the centre of the 'child saving' efforts by an international movement first developed in the United States. These courts were designed to fulfil broad functions that fall under the banner of what is termed by criminologists the 'welfare model'.

The welfare model of juvenile justice views and seeks to understand individuals and individual behaviours as being shaped by their particular context and circumstances. The State is assumed to have a legitimate and obligatory role in securing the needs of individuals and the community at large through such activity as is deemed necessary for this security.

In its purest form, the court is seen not as a site for the testing of charges and the determination of guilt, but one of dispensation of that which is required to meet the needs of those who come before it. An order of the court, therefore, may be seen as assistance, or even a cure, for the accused, the extent of which is determined by the particular need of the defendant. The requirement for the protection of due judicial process is seen as inessential because the court is acting in the best interests of the child, dispensing rehabilitation rather than punishment (Cunneen and White 1995; O'Connor 1997).

For proponents of the welfare model the appropriate response of the State to juvenile crime or deviance is to focus on the offender, not the offence, and to treat the offender, not the crime. Such 'treatment' is individualised, the result of which has often been a sentence of indeterminate length—ostensibly to facilitate a thorough program of remedial treatment. The model further emphasises early intervention on the part of the State to prevent behavioural patterns that are morally or socially unacceptable (DFYCC 1998).

The welfare model (albeit in a diluted form) became popular in Queensland in the late nineteenth century and dominated theory and practice until the 1970s and 1980s. The rehabilitative ideal was partially attempted through setting up reformatory and industrial schools. The *OPA 1886* and the *JA 1886* allowed for greater discretion when dealing with juveniles and, finally, the *CCA 1907* legislated for a venue to be established where the fundamental principles of the welfare model could be exercised.

### ***The Children's Court Act 1907***

The Act was brief, containing a mere eight sections. Wide discretionary powers were granted to the Children's Court, including the ground-breaking (in Australian terms) provision allowing the magistrate to admonish the offender rather than enter a conviction. Overall, however, the Act failed to imbue in this separate court for children 'the spirit of remediation' (O'Connor 1997). Advocates of the welfare model of juvenile justice saw the primary objective of the Court as assessment and classification of the reasons that motivated the behaviour of the delinquent child. Having determined this, the role of the Court was to assess the individual offender, rather than the offence, and place her or him in an appropriate 'needs-based' remedial program for 'treatment'. The length of sentence was usually indeterminate (and usually lengthy) to allow the program to be fully implemented.

### ***Deficiencies of the Act***

This process required professional expertise well beyond the capacities of a magistrate. To operate successfully, the Children's Court needed a group of 'judicial therapists' such as child psychiatrists, social workers and probation officers. The role model for the magistrate was that of a 'doctor-counsellor' and specialist in child welfare as opposed to a lawyer (Cunneen & White 1995).

The whole system turned on the appointment of probation officers, whose responsibility it was to supervise the offender from the pre-summary adjudication stage through to the post-sentence 'treatment' phase. The appointment of probation officers was in reply to a rejection of 'barrack-type' institutions for dealing with young offenders, which were regarded under the welfare model as a method of last resort only (Seymour 1988).

Children accused of criminal offences and status offenders were both tried in the Court. In common with early nineteenth century practices, this blurred the boundaries between juveniles of 'criminal tendency' and those who were 'guilty' of transgressing moral norms. For example, most females who have appeared at the Children's Court since its inception have been charged with status offences such as 'sexual immorality' or the danger of leading an immoral life in the future. Interestingly, sentences for status offences have historically been more severe than for criminal misdeeds (O'Connor 1997).

The *CCA 1907* was deficient, however, in terms of a classical welfare model for juvenile justice. Most importantly, there was no mention of either probation or the necessity for

specialist judges. These omissions may have been expense-related, given the logistics of Queensland's scattered population base. Essentially, the reforms within the Act were minimalist, although it did establish a legislative framework and ideological impulse that has been built upon in a piecemeal fashion through the twentieth century.

### **Probation**

The most cherished tenet of the welfare model—probation—was deployed in earnest from 1913. Before 1912, Society for the Prevention of Cruelty volunteers had acted as honorary probation officers. The *SCA 1911* saw juvenile justice transferred to the more 'benign' administration of the State Children Department. With this change, staff from the Department acted as probation officers, still with the assistance of Society for the Prevention of Cruelty members. However, before World War II the 'type' of juvenile on probation was not that envisaged by the supporters of the welfare model. Rather, the vast majority of child probationers were under supervision following discharge from an institution (Seymour 1988).

The much-vaunted specialist magistrate was also slow to arrive in Queensland. Indeed, it was only after the lapse of some 23 years that an amendment to the *CCA 1907* was passed enabling the appointment of a specialist magistrate. The amendment also allowed for the Court to reside within the State Children Department which was considered a more appropriate venue for its proceedings (Raymer 1979).

### **Consolidation of the welfare model**

From the 1930s to the late 1950s a consolidation of the welfare model took place, although in a muted and modified form (Seymour 1988). In the Queensland context, the actual mechanics of the model were a far cry from those envisaged by the early child-saving movement. Arguably though, the model was most effective in articulating a paternalistic and humane approach to young offenders via the Children's Courts (Seymour 1988). Even in institutional settings for serious offenders such as Westbrook, something of this approach can be gleaned from official literature. For example, a regulation issued in 1916 outlined the role of the Superintendent:

*He shall see that the boys are treated with kindness, combined with strict discipline, and he shall check all harsh conduct on the part of the officers. He shall arrange that a suitable system of recreation is provided.*<sup>7</sup>

Unfortunately, the rhetoric of the welfare model was not always an accurate reflection of the actual treatment of inmates within the reformatories and industrial schools, as two inquiries into Westbrook revealed (see Chapter 7).

The 1950s and 1960s witnessed some changes and developments in the juvenile justice system in Queensland. Institutions declined in number as denominationally run industrial schools either closed or reconstituted themselves as residential units supervising care and control and care and protection cases. For example, in 1930 there were ten institutions catering to the child offender. By 1955 this figure had declined to seven and by 1960 to four (Schofield 1971).

The welfare model in the State was at its height in the middle decades of the twentieth century. The *Children's Services Act 1965*, in its provisions dealing with the administration of juvenile justice, was the legislative enforcement of the welfare model at its peak in Queensland. The Act repealed both the *Children's Court Act 1907* and the *State Children Act 1911* and introduced an advanced code for dealing with young offenders that heavily emphasised the use of probation. This was made easier by a 30 per cent increase in staff at the Department in 1959, thus freeing up personnel to specialise in probation work (Schofield 1971). In dealing with care and control placements, the Act clearly advocated 'treatment' over retribution (Raymer 1979).

### **The Dewar Reports**

The *CSA 1965* was influenced greatly by two Reports handed down by the Honorable AT Dewar in 1959 and 1963 (Report 1959; Report 1963). Both emphasised the environmental aspects of juvenile delinquency and recommended a treatment-minded approach. The Reports were also likely to have been influenced by the growth of the medical model, which derived much of its impetus from the broader welfare approach.

From the 1930s a more scientific approach to the treatment of delinquency was inspired by the rise to respectability of empirically based social science research into the causes of juvenile offending (Seymour 1988). The dominance of the medical profession from this period, particularly child psychiatry, and the development of a burgeoning psychological fraternity resulted in the fairly uncritical acceptance of the medical model by the 1960s. Essentially, this model understood juvenile delinquency and offending as a product of individual pathology and maladjustment to prevailing social norms. Only an extended program of therapeutic treatment under the guidance of a suitably qualified group of specialists could produce the necessary readjustment to 'normality', or so the argument went. The government from 1960 applied this approach when the Welfare and Guidance Clinic opened, followed in 1961 by the Wilson Youth Hospital for the 'assessment' of child offenders. The system was extended in 1963 when Karrala House was opened to cater for young girls designated as 'emotionally disturbed' and/or 'incurable'. Effectively, it was a detention centre for intractable girls (Schofield 1971).

Consistent with the tenor of the Dewar Report (1959) was the adoption of some alternative procedures for dealing with young offenders. In 1963, for example, the Juvenile Aid Bureau was established in Brisbane as a special police unit responsible for investigating juvenile offending, neglect and 'uncontrollability' cases and the cautioning of young offenders (Seymour 1988). These alternative procedures were deployed widely during the 1970s and 1980s (Annual Reports 1970–1989).

### **Criticisms of the welfare model**

The welfare model had always had its critics. However, they grew in numbers and stridency in the years following the passage of the *Children's Services Act 1965*. By the 1970s, and particularly in the 1980s, there began a swing away from the welfare model. One commentator contends that the shift in thinking and practice has been based on—

*a new mood of skepticism about child saving policies. This mood reflected a political climate marked by concern about law and order, growing awareness of the importance of legal rights and increased uncertainty about the efficacy of welfare services* (Seymour 1988).

Criticisms of the welfare model emanated from both the 'right' and the 'left' of the political and legal spectrums.

For conservatives, law and order issues were paramount and the welfare approach was viewed as being 'too soft' on juveniles found guilty of perpetrating unlawful acts. The law and order lobby advocated changes to the juvenile justice system that hinged on notions of the punishment fitting the crime ('just deserts') and punishment acting as a deterrent to both future offending by the sentenced individual and by others who may consider offending ('cost benefit') (DFYCC 1998).

While approving of the general philosophy underpinning the welfare model, civil libertarians also highlighted a number of shortcomings in the model that led to injustices being done to the child. These included a lack of due process, where the child's right to a trial before a jury was overlooked in the belief that the specialist court could best represent the child's interests (DFYCC 1998). Further, these critics of the model pointed to the injustices (albeit unintended) that issued from the often arbitrary judgments made about the character and circumstances of the child and thus the types of 'treatment' or rehabilitation considered appropriate. Such judgments had the potential to be even more damaging to certain children

due to the capacity of departmental officials to make decisions that determined the duration of their time in institutional care. Therefore, the decision of a magistrate of the Children's Court to commit a child to the care of the Director of the Department could result in that child drifting between institutions for many months, and in some cases years.

### **The 'justice model' in juvenile justice**

The alternative proposed to the welfare approach has been dubbed the 'justice model' and it emerged, ironically, from the two competing critiques. Within the justice model, individuals are viewed as rational actors who determine their own circumstances rather than vice versa. Because offenders are viewed as autonomous, rational actors, justice-based juvenile justice systems focus on the offence rather than the offender and punishment rather than treatment (as with the welfare model). Under this model, young people are held responsible for their actions and punished in accordance with the severity of the crime, the culpability of the offender and the impact upon the victim. Justice systems subscribing to this orientation are based on the notion that a 'just deserts' approach will act as a deterrent.

The justice model has in turn been subject to criticism for *its* failings in regard to due process in the Children's Courts and its tendency to ignore or minimise welfare factors, such as poverty, that may genuinely have contributed to a young person's offending behaviour. Further, on the question of the efficacy of the longer penalties that have accompanied justice-based legislation in producing a deterrent effect, little evidence exists to support such a theory or practice (O'Connor 1997; DFYCC 1998).

In line with State governments across Australia by the mid-1990s, the Queensland State Government expressed its commitment to justice-based models of dealing with young offenders through the introduction of new legislation. The welfare-based *Children's Services Act 1965* gave way to the justice-based *Juvenile Justice Act 1992* and its amendments in 1996 and 1998. The 'tougher' law and order philosophy adopted by the government towards juvenile offenders was reflected both in the provisions of the *JJA 1992* and in the renaming of institutions. Westbrook (closed June 1994), Cleveland, John Oxley and Sir Leslie Wilson Youth Centres were renamed 'Youth Detention Centres' in 1993/94, thought to more accurately reflect their purpose.

Also reflecting the government's commitment to a law and order stance was the removal of sole responsibility for the delivery of juvenile justice services from DFYCC in 1996. Instead a tripartite arrangement for the management of these services was put in place. The agencies involved in this new arrangement were DFYCC, the Department of Justice and the Queensland Corrective Services Commission. However, sole responsibility for the management of juvenile justice services was transferred back to DFYCC following the 1998 amendments to the Act.

In an acknowledgment of the criticisms of systems based upon the justice model, the *JJA 1992*, while reflective of the justice model, incorporates a number of important welfare provisions. These include measures to encourage the diversion of young people from the criminal justice system where possible, and a recognition of the special requirements of children and the need to take them into account in all decision making, including sentencing. Further, in passing a sentence a 'welfare-type' pre-sentence report may be ordered by the court to aid in the determination of an appropriate sentence for any young person, and detention is an option of last resort.

### **3.4 CONCLUSION**

This chapter has traced the development of the systems for dealing with children who entered State care from the 1860s. The child welfare system and the juvenile justice system were based initially on the placement of children in institutional settings such as the orphanage, industrial school or reformatory. For children designated as 'neglected', it was often a matter of chance whether they ended up in the child welfare system or the juvenile justice system.

Within the child welfare complex the development and eventual demise of the orphanage setting has been detailed. State- (and Commonwealth-) government-sponsored alternatives to institutionalisation—such as assistance payments and foster care—have been outlined and key legislation identified. This chapter has also signalled the most significant developments in the history of the juvenile justice system, highlighting the reformatory and industrial school system, the ‘welfare model’ and the ‘justice model’.

Despite the existence of different forms of care for State children, institutions have occupied an important place in government thinking and practice in the child welfare and juvenile justice arenas. However, in the provision and administration of institutional care facilities, governments have played a secondary role compared to that of religious denominations. The government’s responsibilities—via Department of Families, Youth and Community Care and its predecessor agencies—have been the operation of reformatories and detention centres, and the subsidisation and regulation of residential care facilities and industrial schools. The pressures faced by this under-resourced department to administer the child welfare and juvenile justice systems have been great, as have been the pressures faced by non-government service providers. The consequences of this longstanding situation will be considered at length in Chapters 5 and 7.

## ENDNOTES

<sup>1</sup> This chapter considers primarily non-Aboriginal children. The experiences of indigenous children in State care are dealt with in detail in Chapter 4.

<sup>2</sup> An exception here is the Enoggera Boys’ Home established in 1906. St George’s Orphanage in Rockhampton, run by the Anglican Church, was licensed in 1917. In 1929 the Congregational Church established the Marsden Home for Boys, Kallangur. The Methodists opened the Queen Alexandra Home at Coorparoo in 1911 and the Margaret Marr Memorial Home for Boys at Wynnum in 1924. The Presbyterian Church inaugurated the Blackheath Home for Children at Oxley in 1926–27 and the W R Black Home, Chelmer, in 1928.

<sup>3</sup> In 1958, 10 inspectors handled 6,602 children in care. By 1965, 31 child welfare officers were responsible for 7,296 children.

<sup>4</sup> The cost of maintaining a child in foster care, while cheaper than in a State orphanage, was marginally more expensive than for the denominational orphanages. A State orphanage child cost the government 15/7/6 per annum. Fostering cost 13/5/9 per annum and residents in a denominational orphanage 12/8/4 per annum.

<sup>5</sup> See, for example, Regulation 24 under the *State Children Act 1911* (*Queensland Government Gazette*, Vol. XCIX, No. 24, 20 July 1912); Regulation 48 relating to the Westbrook Reformatory for Boys (*QGG*, Vol. CVII, No. 17, 10 July 1916); Regulation 108 relating to the Westbrook Reformatory for Boys under the *State Children Acts 1911 to 1955* (*QGG*, No. 86, 15 November 1958).

<sup>6</sup> The options that lower court officials had at their disposal expanded greatly in the late nineteenth and into the twentieth century. Fining, corporal punishment and reduced scales of sentencing proved to be among the most popular.

<sup>7</sup> Regulation 8 under Regulations relating to the Westbrook Reformatory for Boys (*QGG*, Vol. CVII, No. 17, 10 July 1916).

## CHAPTER 4: THE HISTORY OF INDIGENOUS CHILDREN IN QUEENSLAND INSTITUTIONS

### 4.1 INTRODUCTION

This chapter focuses on the operation of government care and protection of indigenous wards of State, controlled under either the State Children Department (SCD) or under departments with primary jurisdiction for Aboriginal affairs. The Terms of Reference of the Inquiry include only those institutions established or licensed under the relevant legislation. In the case of living arrangements on the Aboriginal reserves, the industrial schools fell within the Terms of Reference, but the dormitories in which the reserves' population were accommodated did not. However, the history of indigenous children in Queensland institutions is examined within the broader context of life conditions faced by indigenous people since white settlement commenced in earnest in the mid-nineteenth century.

Information provided to the Inquiry by the Department of Families, Youth and Community Care (DFYCC) suggests that, until the mid-1960s, very few indigenous children were committed to institutions under the *State Children Act 1911 (SCA 1911)*, that is to say under State children's legislation. No admissions were registered for most of these years, and rarely were more than five admissions per annum recorded. However, departmental records show the admission of dozens of indigenous children to State institutions from the end of last century under a range of other legislation.

Although their numbers were small, indigenous children in care under State children's legislation evidently experienced similar dire living conditions to those experienced by indigenous children committed under Aboriginal legislation.<sup>1</sup> The two groups were neither housed nor schooled separately from hundreds of other indigenous children, with the regimen of controls, level of health care, education and general treatment remaining the same regardless of the specific piece of legislation under which they were placed.

From the few case files Inquiry staff were able to study in detail, it appears that indigenous children committed to the care of the SCD were often, but not predominantly, placed on Aboriginal reserves such as Palm Island, Cherbourg and Woorabinda. Both boys and girls were moved each time they became 'unsettled' (hence difficult to discipline and control), and Aboriginal reserves do not appear to have had much success at retaining 'problem' children.

Rather than assisting the familial and cultural needs of indigenous children, it appears that the three Aboriginal reserves, though licensed to receive children committed to State care, often served only to intensify the disruptive regime of State care by making available yet more placement alternatives for 'unsettled' children.

For clarity this chapter is organised chronologically in three sections: a brief historical record of indigenous children prior to 1940; the period between 1941 and 1965; and the period from 1966 to the 1980s.

### 4.2 FIRST PERIOD: 1890–1940

#### Authority to remove

During the early years of this century, indigenous children were vulnerable to removal from their families under a range of legislation, including the *SCA 1911*, the *Aboriginals Protection and Restriction of the Sale of Opium Act 1897 (APA 1897)*, the *Industrial and Reformatory Schools Act 1865 (IRSA 1865)* and the *Vagrancy Amendment Act 1863*. Prior to the passage of the *APA 1897*, the prime mechanism for removal was section 6, subsection 7 of the *IRSA 1865*, which empowered justices to commit into custody 'any child under 15 years of age, born of an Aboriginal or half-caste mother' as legally a 'neglected' child (Department of Native Affairs (DNA) 1905). Nineteenth century records reveal that some indigenous children were removed to industrial schools at Toowoomba, Lytton and Westbrook. The forced removal of these and other children (as well as

adults) accelerated with the passage of the *APA 1897*, which defined all ‘full-blood’ and all ‘half-castes’ under 16 years, or living with or as Aborigines, as ‘Aboriginals’ subject to State control.

### Industrial and reformatory schools

Industrial and reformatory schools were established specifically for indigenous children during the late nineteenth and early twentieth centuries. The first of these to be licensed was in connection with the Myora Mission Station on Stradbroke Island in 1893, although it closed in 1896. In 1911 the State government licensed the schools under the *SCA 1911*, and later under the *Children’s Services Act 1965*. In 1914 these institutions were gazetted at Deebing Creek (near Ipswich), Yarrabah (near Cairns), Barambah (near Murgon; renamed Cherbourg in 1931), Mapoon (on the Gulf Coast) and Taroom (west of Maryborough). These schools continued to be established during the 1920s and 1930s. Palm Island received its first placements of State children in 1922. Woorabinda (south-west of Rockhampton) was listed as an industrial and reformatory school in 1937, and in 1938, Purga (near Ipswich) was licensed.

Tracing exact dates for the cessation of these industrial and reformatory schools is difficult. We can ascertain, however, that Deebing Creek closed in 1915, when its inmates were removed to Purga. Taroom closed in 1926 and its inmates were transferred to Woorabinda. In 1937 Mapoon and Yarrabah were still listed as industrial and reformatory schools, but Purga closed in 1948. By the late 1960s only Woorabinda, Palm Island and Cherbourg held children committed under State children’s legislation.



*Photograph 4.1: Girls sawing wood at Mapoon (1916)—Courtesy John Oxley Library*

From the outset the government’s policy of placing indigenous children in either an orphanage environment or in ‘special’ industrial and reformatory schools connected to Aboriginal reserves was seen as a form of cheap internment for indigenous juveniles. The cost of providing for a ‘neglected’ Aboriginal child was in no way to be equivalent to that of non-indigenous children in State care. For example, in 1900 the head of Aboriginal protection in southern Queensland baldly stated that the cost of a child on reserves ‘ought not to be more than one-fifth, or certainly one-fourth, that of the charge at the orphanages’.<sup>2</sup> This attitude remained unchanged for at least the next 35 years, when government correspondence stated that ‘care of the Aboriginal child would not be as important to the State as that of its white child’.<sup>3</sup> Despite a measure of opposition to this thinking, it remained the case that both children under the control of the mission industrial and reformatory schools and those placed on reserves as orphans were funded at a mere one-third of the orphanage rate (DNA 1905).

In 1911, when the *State Children Act* was passed, there were 39 indigenous children committed as State wards to industrial schools on Aboriginal reserves. Mapoon had six, Barambah 10, Yarrabah 11 and Deebing Creek 12. Small numbers of indigenous children were also placed at Salvation Army



Homes at Breakfast Creek and Yeronga (eight) and St Vincent's Orphanage, Nudgee (four). Many of these children were not orphans but had been forcibly removed from their mothers. Indeed, for the next two decades Aboriginal children were committed to, and freely transferred between, a number of institutions catering mainly to non-indigenous children—St Vincent's Orphanage, Nudgee, the Salvation Army's institutions at Yeronga and Breakfast Creek, the Anglican-administered St Mary's Home at Taringa and the Tufnell Home at Nundah, the Townsville Orphanage and Westbrook Reformatory.

Like their non-indigenous counterparts, many indigenous children were hired out as labour. For example, a number of young girls from Deebing Creek, Barambah and St Vincent's Orphanage were hired out as domestic servants under the *SCA 1911*. As with Aboriginal labour in general, such juveniles as these under SCD control were greatly exploited. Not only were wages much lower than those of their white counterparts, but indigenous women were expected to make significant contributions towards the maintenance of their children, often institutionalised against their mothers' wishes—particularly children designated as 'quadroons' (or quarter-caste), who were believed at the time to be sufficiently white to be 'assimilable' (DNA 1913). For example, in 1917, £81/14/- was removed from the accounts of indigenous domestic workers as a contribution towards the support of their children who had been institutionalised at the Yeronga Industrial School for Girls (15), the Industrial School for Boys at Riverview (four), Purga (four), Mapoon (three), and Thursday Island (15). A further £17 was collected from men who accepted paternity of the 'orphans'.

Financial exploitation was compounded by the sexual exploitation of young Aboriginal women hired out as domestic servants. Vulnerable and isolated, many were prey for the white sexual predators connected to the often remote workplaces where the girls were sent. Many of the 'illegitimate' children born to these young women were clearly a 'by-product' of the State's domestic labour policy in operation at the time.

### **Standard of living on missions and reserves**

Conditions were severe on missions and reserves containing industrial and reformatory schools. Whether placed under care by the DNA or the SCD, circumstances, particularly for young girls, were miserable. From around 1915 onwards, an accelerated policy of removals saw hundreds of women and children 'rescued from camps' for placement on missions and settlements 'where they could be properly cared for and protected'.<sup>4</sup> Their fate was to be incarcerated 'under supervision in the dormitories', secured behind wire fencing 'so no one can get in or out', with limited movement only under close police escort, an imprisonment only relieved by perilous external employment for settlement girls or by marriage for mission girls. To remain unmarried on a mission was to be incarcerated for life.

Conditions at Barambah in 1913 fell well short of standards prevalent at other institutions accommodating State wards.<sup>5</sup> Evidence from Yarrabah in 1920 paints a similarly grim picture. The majority of new arrivals could not speak English, nor sometimes any of the Aboriginal languages spoken at the Mission. The 65 female residents were closely supervised at all times and when not in school were put to work pulling grass (for weaving as floor mats etc.) as well as cooking, washing and sewing for all dormitory inmates. Dormitory boys were less regimented, although they were also put to work outside school hours—at farming and clearing.<sup>6</sup> The breaking of the parent-child bond was perhaps the cruellest abuse. Some parents were reduced to waving to children through wire fences; others, as at Cherbourg in 1921, forcibly retrieved their children from the dormitory, the Superintendent lamenting that he could not enforce 'discipline' promptly or effectively enough to 'impress offenders'.<sup>7</sup>



*Photograph 4.2: Girls' dormitory at Palm Island (1931)—Courtesy John Oxley Library*

In 1924 at Palm Island, then licensed for two years, 76 girls and young women were kept in two sheds, and 37 boys in another. At Woorabinda in 1928 there were no dining or kitchen facilities, and the girls were confined in a bark and iron shed at the back of the hospital. By 1930 at Cherbourg, fast becoming the government's 'showpiece' institution, the girls' dormitory was a two-storey timber structure, divided upstairs, locked at night, and lit by a single kerosene lamp. While government officials lauded the tight security and barbed wire enclosure, a visiting justice in 1930 was scathing: if fire broke out the girls would pile up against the door, many to be 'crushed to death and many others smothered by the fumes and smoke'. He called for at least two permanent fire escapes but no such action was taken.<sup>8</sup>

Dormitory conditions were appalling. At Cherbourg, for example, each night women and children scrambled for blankets, and some slept on the floor with a mattress over them for warmth. Others pushed two or three beds together and slept seven or eight together for warmth, covered with only a couple of blankets, most without pillows. No provision was made for menstruating girls who went to school 'with no protection apart from their bloomers'. There were only 16 small plates, 78 large plates, 21 mugs and two dozen forks and spoons to be shared among the 90 older girls and boys. In 1935 an inspection found the walls in the girls' dormitory 'literally alive with bugs. The beds, bed clothing, pillows and mattresses are all infested ... all pillows were filthy because the previous matron withheld pillow slips in order to save washing'. Most children were allocated only 'one thin cotton dress and one pair of crepe bloomers each', and no sleepwear. This scarcity of clothes 'greatly interferes with school attendance', since children were sent away if they were dirty.<sup>9</sup> These are precisely the conditions that in a private home would have prompted State intervention in the interests of the children.

Missions and settlements were blighted by endemic illness resulting from poor diet and conditions. At Yarrabah Mission, which the government funded at only 60 per cent of the per capita level of its own settlements, an inquiry followed the deaths of 16 people in a 10-month period during 1936, seven of them children under 14. Dormitory meals consisted of dry bread and black tea for breakfast, dry bread and soup made of shin bones and onion for lunch, dry bread and black tea for dinner, with golden syrup as an extra on Sunday nights. Occasionally bananas were available, rarely pawpaw or pineapple, but there were no green vegetables, butter or milk (although babies under 18 months were given one pint (under 600 mL) per day). According to a doctor, the food supply was 'totally inadequate and definitely the cause of the prevalence of gastro-intestinal diseases'.<sup>10</sup> Yet the government exerted pressure on the Mission to further reduce spending. The Superintendent, however, protested that this could not be achieved 'without starving the inhabitants of the Mission, whose food and clothing is already less than they should be'.<sup>11</sup>



*Photograph 4.3: Boys' dormitory at Palm Island (1931)—Courtesy John Oxley Library*

### **4.3 SECOND PERIOD: 1941–1965**

#### **Life in State care, 1941–1965**

Throughout this period, SCD children were confined in dormitories at Woorabinda, Cherbourg and Palm Island together with hundreds of other settlement children.

A key plank in the removal platform for child protection, particularly for Aboriginal wards of State, was the provision of a 'legitimate' future in contrast to the 'aimlessness' of camp life. Along with their care and protection, the dormitory system was meant to prepare children for a competent life as parents and workers. While boys were moved back into reserve communities after a few years' schooling, the only escape for girls was marriage. However, the decision to marry was no more within their control than any other aspect of their lives, since it was the officials who gave or withheld permission for unions on the reserves. In fact, marriages were often organised to facilitate discipline and control, as a means of reducing overcrowding in the dormitories, as well as to remove 'problem' girls from direct management responsibility. The rhetoric of improvement through the dormitory system was rarely, if ever, matched by the reality.

Dormitory life was, as one visiting justice described it in 1941, 'dreary beyond imagination'. Although 'usefully occupied' during the day—the boys at farm labour and the girls producing the settlement's clothing supplies—children were locked up at sunset without any amenities. Occasionally the Matron might read to them or organise singing, but otherwise they were locked in the dark overnight. He urged that electricity be supplied to the dormitories, stating that 'it should surely be made available for the welfare of hundreds of young Aboriginal natives'. This stultifying routine deadened any sense of self-development engendered by schooling.<sup>12</sup>

The same situation pertained on Palm Island, where 120 women and small girls were confined in one dormitory, with another 50 in the girls' home. There were 40 in the boys' home, including orphans, committed children, and 'troublemakers' from the camps and from other settlements. Sent to report on conditions there, a Stipendiary Magistrate was horrified at the arrangements. Women and children were 'herded together' in the dormitories with only three inches between the cots, and a bucket close by in each ward the sole overnight sanitary facility. Successive reports in the late 1950s continue to chronicle deaths and ill health from preventable diseases of gastroenteritis, hookworm and chest infections. 'This is not a research problem', stated the Director of the Queensland Institute of Medical Research, 'it is essentially administrative'.

At Cherbourg the situation was similar. The Director reported that there were no facilities for families to keep food clean, nor even for washing their hands, and far too many families were living

in miserable, leaky, galvanised iron shacks with dilapidated coconut-frond walls. Such poor housing conditions made it impossible for families to reach a safe standard of cleanliness, leaving them 'prone to any contagious disease'.<sup>13</sup>

Dormitory children were all but abandoned once they reached 14, the boys literally so, being evicted from the dormitories and left 'to live with anybody who will have them'. Many of the boys without family drifted in with the 'incorrigibles' (that is, habitual offenders). Girls were forced to remain in the dormitories 'but practically nothing was done either to teach them work, which might be useful, or even to occupy their time and minds'. There was no systematic training for them in domestic work; a very few worked in the houses of officials, in the sewing rooms or in charge of smaller children. There was no other employment and not even gardens where inmates could raise produce for their own consumption. 'The system is wrong', wrote an officer from State Health, 'and responsibility must be accepted if these children become criminals'.<sup>14</sup>

### **Resistance to confinement**

Conditions in the dormitories led to frequent escape attempts by female residents. The success rate was low; most were soon captured by police and returned. Punishment for such defiant behaviour varied from the imposition of bread-and-water diets and extra work to one or two weeks in settlement gaols, or the humiliation of being paraded with shaven heads and in sugar-bag dresses.

It appears that the policy was to keep indigenous children prone to absconding on the reserves, although it was said that such children, after absconding, could not legally be captured and returned, the police having no authority unless a Department of Aboriginal & Islander Affairs (DAIA) Removal Order had been issued. The only option to regain control over such children was to return them to SCD care.<sup>15</sup> It is of interest to note that in 1941 the Solicitor-General confirmed that there were in fact no legal grounds to compel a reserve inmate to remain on a reserve, and it was therefore not legally an offence to abscond.<sup>16</sup>

In the mid-1960s the Superintendent at Woorabinda protested that facilities were inadequate and that the reserve was too short-staffed to detain children successfully. Palm Island was no better equipped for the task than Woorabinda. However, the authorities believed that being surrounded by water provided more efficient confinement, although departmental files detail many escapes.

### **Education**

The Education Acts require that *all* Queensland children be provided with at least a standard education, in standard buildings with standard equipment.

Until the 1960s, hundreds of indigenous children confined on reserves containing industrial and reformatory schools received sub-standard schooling in sub-standard buildings, often with materials discarded by white schools. One of the reasons for this was that, until the late 1950s, schools in indigenous communities were resourced from government funding allocated for Aboriginal welfare. Forced to compete for such funding with policing and removals, health and housing, staff salaries and amenities, these schools suffered as a consequence.

By 1944, while the eight children of white officials on Palm Island were properly accommodated, more than 180 Aboriginal schoolchildren were crammed into a small room, with 60 forced to learn underneath the school, where it was cold and draughty and light for books and slates was 'extremely poor ... necessitating eye strain'. Yet the teacher was refused permission to utilise the vacated white classroom, described by him as 'well ventilated and easily the best lighted classroom in the whole school building', because it was allocated for the storage of old records.<sup>17</sup>

In 1952, for the first time, Aboriginal children confined on government settlements were provided with the opportunity to progress beyond Grade 4 (usually aged 9). One witness to the Inquiry confirmed this:

*... they educated us to fourth grade, and that was the limit. They wouldn't educate us any further than the fourth grade. Actually, I was in fourth grade for five years.*

At Cherbourg, the State's showpiece, the head teacher lamented the overcrowding caused by insufficient rooms, and noted that sub-standard accommodation was retarding learning: 'Greater facilities in the children's homes will be necessary to enable homework to be performed', a reference to the lack of tables and chairs, private space and electricity. He said the children showed good interest and enthusiasm but were held back by settlement conditions: 'It is apparent now that the environment is a predominating factor militating against progress.' Long-term institutionalisation prevented either experience of or conversation on general topics, he reported, hence these children had none of the 'general knowledge of everyday matters' that white children grew up with. Although many of the children's IQ levels met State school standards, the government was clearly still budgeting according to numbers rather than needs. The head teacher stressed it was 'imperative' that the school be allocated enough 'competent' teachers for each grade 'irrespective of the number of pupils in the grade'.<sup>18</sup>

Although in 1953 the Director of Native Affairs publicly boasted that 'the native child' had now been 'prepared' for 'full primary school education' because of improved health and living standards built up over the years (DNA 1953), internal documents tell a different story. During the winter of 1956 on Palm Island, it was reported that colds were again rife among dormitory children, who were still forced to shower each morning under cold water 'when the frost is on the ground', and frequently attended school with wet heads.<sup>19</sup>

Likewise on the missions, government under-funding held back the children's education. In 1959 the Yarrabah school was described as having been in a dilapidated condition for many years. The 140 children, ranging from kindergarten level to Grade 8, were taught on wrongly sized desks and stools, 'the cause of the bad posture amongst many of the children at the mission'. Basic amenities such as blackboards, cupboards and library supplies were inadequate. Yet, as the Mission secretary pointed out, education was 'one of the vital needs to be fulfilled' if Aboriginal children were to assimilate into the general community, the government's avowed aim.<sup>20</sup>

#### **4.4 THIRD PERIOD: 1966–1980s**

##### **A period of change**

From the late 1960s, when the Department of Aboriginal and Islander Affairs (DAIA) was encouraging families to leave reserve communities (or evicting them), and weekly payments equating to only a proportion of the basic wage had replaced the former rationing system, Aboriginal families were increasingly thrown into crisis. Unemployment and lack of money contributed not only to deplorable living conditions but also to constant crises in the familial and social fabric. Not surprisingly, this upheaval is measurable in the uptake of Aboriginal children into State care.

As far as the welfare of indigenous young people was concerned, the shift can clearly be seen at this time from 'care and protection' to 'care and control' (see Chapter 3). Between 1964 and 1970, of the 102 indigenous youths who had been processed through Westbrook Training Centre (formerly the Reformatory School for Boys), 34 had been readmitted for a second period. It was said they were 'drop-outs' from the assimilation program, having spent their time in protected communities and being thought to subsequently be unable to resist the temptations of city life.<sup>21</sup> No mention is made of the deplorable social conditions over which they, and to a large extent their parents, had no control. Records from the Department of Children's Services (DCS) in the early 1970s reveal a high level of recidivism among indigenous young people from boarded-out placements or placements with relatives.

Throughout the 1970s, indigenous youths were being seen as constituting a 'problem' to the successful operation of the institutional system. They were thought to respond differently from white youths to work requirements, and they stuck together rather than mixing with other inmates, causing 'an unsettled atmosphere'. Westbrook records, for example, reveal a tendency to characterise

indigenous youth as problematic because of their race. Given such attitudes, it is a safe assumption that indigenous youth would not have been given favourable treatment with regard to levels of discipline and types of punishment.

Westbrook records show that numbers of Aboriginal admissions jumped from 13 in 1967 to 20 in 1969, 40 in 1970, 60 in 1971, and a projected 100 youths for 1972, a percentage increase of indigenous over white from 18 per cent to a peak of 40 per cent.<sup>22</sup> It should further be noted that between 1985 and 1992 the proportion of indigenous youth as a percentage of total youth in the care and control of the State rose from 32.1 per cent to 42.4 per cent, at a time when only four per cent of young people under 17 years were of indigenous descent (O'Connor 1994). As early as 1971, the Director of the DCS notified his Minister of his concern over the growing numbers of indigenous children coming into care, which was placing extreme pressure on the Department's facilities. If the situation within the Aboriginal community continued to develop, he wrote, 'these facilities will be inadequate'.<sup>23</sup>

The Superintendent of Westbrook, at a time when 41 per cent of inmates were of indigenous origin, described the situation variously as 'explosive', 'precarious' and 'the most dangerous ever'. Most of the inmates were educated only to early primary school standard, and Westbrook had 'no educational facilities' to meet their needs. He argued that this should not, however, be the responsibility of Westbrook; it had not been established, in 1900, for the 'care, control and education of Aboriginal youths', and should not be now. He was of the view that the DAIA, or the indigenous community, should provide the answers.<sup>24</sup> However, although it was conceded that infringements on indigenous culture and way of life had occurred, a 1971 proposal that a separate Aboriginal Training Home be established, staffed by indigenous officers, was rejected by the Director.

#### 4.5 A CASE STUDY

The following case study illustrates aspects of the experience of indigenous children in care.<sup>25</sup> The aim is to provide some understanding of the processes of State institutionalisation and their impact on indigenous children committed to State care in the 1960s and 1970s.

The family under examination was evicted from a Queensland country reserve in the 1960s. At 16 years of age one of the girls was charged with being a 'neglected' child, likely, the State considered, to lapse into a life of vice or crime. The proposed solution was that the girl be committed to the care of the SCD until she attained the age of 18 years.

She was six months pregnant when placed in a Salvation Army home in Rockhampton. However, after only three days she ran away and returned to her parents. She was swiftly apprehended and sent to the Holy Cross Retreat at Woolloowin, in Brisbane, before being moved on to Woorabinda, where her child was born.

Following the birth, the young mother once more absconded and returned to her parents. This time an SCD official suggested that proceedings should not be taken against her, since the only grounds for proceeding were the unsatisfactory living conditions at the camp where her family lived. The problem this presented for the authorities was that, by this criterion, 'almost every coloured child in this District would be a Neglected Child'. Given this circumstance the young woman was fortunate in being allowed to remain with her child and family, away from the strictures imposed by the SCD.

Three younger children from the family were removed soon after—a boy aged nine and two girls aged six and four. As was fairly common practice, they were sent in the first instance to the receiving depot at Birralee in Rockhampton. Subsequently, and with three more siblings, they were removed to Woorabinda, at the request of the Director of Native Affairs, as State children. Within a year the elder boy was transferred back to Birralee. He escaped from there three times before being relocated to the Anglican-run St George's Orphanage, Rockhampton. He was by then 11 years of age.

In a 13-month period of confinement at St George's Orphanage, according to the punishment register this boy was punished 28 times for misdemeanours ranging from kicking another boy to throwing stones at a newly painted wall, and shouting 'You white bastards' in the boys' bathroom.

Subsequently the Superintendent of the Orphanage noted in correspondence that 'this boy is becoming dangerous and I am convinced that he is suffering from some type of mental disturbance'. The boy's disruptive behaviour continued and was dealt with by floggings and withdrawal of privileges. The Superintendent finally requested that the SCD remove the boy and admit him 'for specialist treatment' to Wilson Youth Hospital 'as his behaviour indicates that he will become an absolute menace to society'.

At Wilson, however, psychological assessment revealed no evidence of any psychiatric disturbance. As a result, the boy was then sent to Alkira, a Salvation Army home at Indooroopilly in Brisbane. After a short time there he absconded with two other boys, during which time he was charged with an offence of breaking and entering. The magistrate admonished and discharged him. He was then placed for a while at Wilson before being readmitted to Alkira, where he was reported to have settled well into school. However, prior to his thirteenth birthday he absconded from the home and broke into a school, stealing a few items and a small amount of cash. At his court appearance he was described as being 'quiet and co-operative'. It was also clear that institutional life was making him profoundly unhappy; in a plaintive handwritten letter he stated that he was very lonely and always felt like running away. The letter also requested that he be returned to the company of his sisters who resided at St George's Orphanage. However, despite this plea he was instead sent back to Wilson where, somewhat inevitably, he staged yet another successful escape.

In the opinion of both the departmental officer in charge of the boy's case and the Superintendent at Alkira, the boy would never settle in a city environment due to his country upbringing. As St George's had refused his readmission it was suggested that he be sent to Woorabinda as soon as possible in order to alleviate his distress at being separated from his family. The Medical Officer at Wilson agreed, stating that 'the boy feels isolated and seeks attachment with some members of his family', and continued by warning that further placements in institutional care would be counterproductive. The boy was subsequently transferred to Woorabinda where he was confined in the dormitory until placement with relatives.

While this course of action was clearly in the boy's best interests, it was opposed by the DAIA. Their reasons were not clear, but are likely to have been influenced by two factors. First, a move from the dormitory would place him beyond SCD jurisdiction, and thus the responsibility of the DAIA. Second, by this juncture (1968) Woorabinda was running a cash economy, and the family's request for a fostering allowance was rejected because the fostering payments were higher than community wages and could create problems for the DAIA 'should this source of revenue be opened'. In other words, indigenous families claiming fostering allowance would mean an unacceptably high drain on government resources.

The boy was confined to the dormitory for a month, where he proved a disruptive influence. He was transferred to the overcrowded home of a more distant relative on the reserve, but his behaviour at school and in the broader community deteriorated within weeks of this placement, which led to several weeks of restraint 'under strict supervision' during the day and being locked up at night. With little sign of improvement in his behaviour he was eventually transferred back to Wilson. On arrival there, he immediately tried to escape by breaking out of the 'observation cubicle'. Three days later he was moved to Westbrook; he had not yet reached 14 years of age.

His first few months at Westbrook were characterised by continued attempts to escape interspersed with brawling with other boys. However, after this initial period it was reported that he had settled down and made some friends. The Medical Officer assessed him as 'a timid, differential [sic] boy of borderline mental defective intelligence who has had a markedly deprived and inconsistent background leading to his previous acting out behaviour'. After a time at Westbrook he was again moved, this time to the Salvation Army Boys' Home at Riverview. After six weeks there he absconded and tried to break into the Salvation Army Girls' Home, Kalimna (located at Toowong, Brisbane), in order to visit his cousin. Following his capture the authorities at Riverview refused to take him back, and he was again sent to Wilson. By this stage the boy's two-year period of care and

control under the SCD had expired, and the Department was keen to have him returned to the Woorabinda reserve.

However, he was instead removed to Westbrook and placed in the maximum-security section. He was medically assessed as 'quiet and depressed with underlying irritability' and 'paranoid about the officers'. His treatment consisted of the prescription of 25 mg of a tranquilliser three times daily. Within a short space of time he attempted unsuccessfully to escape, injuring two officers in the process. On being questioned as to his motivation for the attempted break-out, the boy stated, as he had on previous occasions, that he was 'sad and irritable', and desperate to get out of confinement. However, the Medical Officer recommended 'prolonged treatment' at Wolston Park psychiatric hospital, 'rather than institutionalisation'. His medication was tripled in dosage and issued four times daily instead of three. The boy had not yet reached his fifteenth birthday.

At Wolston Park he was admitted to Ward 15 for the criminally insane, and dosed with a tranquilliser three times daily. Six weeks later he absconded with another Aboriginal boy and headed for his family in north Queensland. Reunited with his family, he lived quietly with a married sister for approximately one year. His one transgression during this period was the unlawful use of a car, for which he was admonished and discharged. The local SCD officer suggested that he be allowed to remain with his sister while he sought work. A few months later he approached the DAIA office seeking a rail pass to visit his parents. However, instead of the hoped-for rail pass the boy found himself back in Ward 15 at Wolston Park. He was then nearly 17 years of age.

The file ends after the young man had been detained in Wolston Park for a year. In eight years of 'care' this child had been shuffled between eight institutions. Assessments undertaken at Wilson indicated that any 'settled' periods of behaviour were likely to have been chemically induced. His propensity for escape, except during his brief period at Westbrook, is testimony to the failure of this reactive response. The longest and most socially secure period he experienced was with his sister. However, at the direction of the DAIA, and against the advice of the local SCD officer, this period of relative tranquillity with his family ended. The reason proffered was that, in the opinion of the DAIA, he had not officially been judged 'sane' or responsible enough to be released.

It is unlikely that this type of case can be considered unrepresentative. Indeed, the SCD's principal child care officer for residential care, writing in 1978, acknowledged that indigenous children felt disconnected from the institutional system, and poorly understood by State authorities. As children in care they were vulnerable, and had little idea why decisions were made that led to them being removed from their families and shunted from one placement to another. To a child, this can only have felt more like abandonment than care.

#### **4.6 CONCLUSION**

For over 100 years indigenous families have suffered the devastation of losing their children to the State. Some were relinquished because of a perceived inability to cope on the part of the parents. However, the majority were seized under laws and regulations through which the State empowered its officers to banish them to indigenous reserves 'for their own good', or to institutionalise them on the grounds of parental neglect or, in the eyes of the State, otherwise unacceptable circumstances.

From the 1890s to the 1970s, indigenous children committed to State care were predominantly placed, in company with reserve children, in institutions whose food, educational and medical facilities were abysmal. They lost contact with a network of siblings and relatives, and suffered multiple placements across a range of institutions. For decades it was made clear to the State officials responsible for the welfare of indigenous children in care that existing conditions were damaging to the children's normal development in the areas of familial and social skills, emotional competencies and psychological health. Furthermore, such warnings included guarding against the likelihood of indigenous children turning to criminal activity.

Through administrative default, as well as by deliberate decree, the State of Queensland has perpetuated those same criteria of 'neglect' that were used not only to impugn the competency of indigenous parents and families, but also to deprive them of their children. Whether fostered within



indigenous communities or subjected to multiple institutional placements, indigenous children rarely escaped the cycle of poverty, deprivation and despair from which the State purported to deliver them. Deprived children were too often condemned to deprived adulthoods, the cycle ensuring that they too were prone to losing *their* children, or being imprisoned as ‘dysfunctional adults’—those who constitute the current 30 per cent of adult prisoners of indigenous descent.

## ENDNOTES

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<sup>1</sup> The 1897 *Aboriginals Protection and Restriction of the Sale of Opium Act (APA 1897)*, the 1939 *Aborigines Preservation and Protection Act* and the 1965 *Aboriginal Affairs Act*.

<sup>2</sup> QSA A/58929, 7 July 1900, Chief Protector to Under-Secretary, Home Secretary’s office.

<sup>3</sup> QSA A/4291, 17 April 1937.

<sup>4</sup> *Annual Report*, DNA, 1916, 1917.

<sup>5</sup> QSA A/69778, Barambah Inquiry.

<sup>6</sup> QSA TR1227:230, *Annual Report*, Yarrabah, 1920.

<sup>7</sup> QSA TR1227:128, 3 May 1921, Chief Protector to Under-Secretary, Home Department.

<sup>8</sup> QSA TR254 4A/22, 27 February 1930, Visiting justice to Chief Protector.

<sup>9</sup> QSA TR254 4A/6, October, December 1934, dormitory matron’s reports.

<sup>10</sup> DAIA (uncatalogued), 30 September 1936, Dr Langan to Chief Protector.

<sup>11</sup> QSA TR1227:230, 22 April 1936, Superintendent to Chief Protector.

<sup>12</sup> QSA TR254 4A/22, 28 November 1941.

<sup>13</sup> QSA TR254 3D/10, 31 March 1955.

<sup>14</sup> QSA TR254 3D/8, 13 July 1945.

<sup>15</sup> Department of Family Services, Case File 27284F.

<sup>16</sup> QSA TR254 3A/57, 27 April 1941.

<sup>17</sup> QSA TR254 3A/103, 9 February 1944.

<sup>18</sup> QSA TR254 1G/22, Cherbourg School Report for 1952.

<sup>19</sup> TR254 4A/6, April, June 1956, matron’s report.

<sup>20</sup> DAIA RK:48, 5 August 1959.

<sup>21</sup> DFS, 31/19 Part A, 17–21 April 1972.

<sup>22</sup> *Ibid.*

<sup>23</sup> DFS, 31/19 Part A, 17–21 April 1972.

<sup>24</sup> *Ibid.*, 24 September 1971.

<sup>25</sup> All material for the case study has been taken from DFYCC case file 33562F.

## CHAPTER 5: ORPHANAGES AND OTHER RESIDENTIAL INSTITUTIONS (1930–1980)

### 5.1 INTRODUCTION

*The State is not a good parent.*

The following chapter has essentially been based on the testimony of witnesses, many of whom are former residents of a number of institutions, and archival evidence, principally from the Department of Families, Youth and Community Care (DFYCC). The Inquiry has heard a considerable amount of evidence of mistreatment, abuse and neglect of children in the various forms of institutions used to house children in the last six decades. It is not possible to discuss all of this evidence in detail. The following composite section addresses a number of themes that have emerged as particularly significant in the histories of residential institutions investigated by the Inquiry. These themes, relating to the care of children in both denominational and government-run institutions, are: problems of size and funding; neglect of physical, emotional, social and educational needs; psychological, physical and sexual abuse; staffing issues; complaint mechanisms; and the role of the relevant government department.

The chapter is designed to give some overall understanding of the conditions in which residents of orphanages and other relevant institutions lived at different times after the 1930s. It is not possible within the confines of the report to detail every circumstance which might be characterised as abuse or neglect, nor is it feasible to chart the life of every institution through different administrations under which the level of care might have varied significantly. In some cases there was no evidence available to ascertain what was occurring in particular respects in some institutions; in others there was not enough information to determine what was typical and what was an aberration. Instead, by necessity, a broader brush has been applied in order to paint a larger picture. This approach has limitations. It should not be thought that the different types of abuse or neglect discussed were confined to those institutions that are named; nor, on the other hand, does it necessarily follow that a particular form of abuse was typical of all institutions within the Inquiry's Terms of Reference.



*Photograph 5.1: Warilda Children's Home at Woolloowin operated by the Queensland Government—Inquiry photograph*

The Inquiry heard evidence and reviewed archival records in respect of a number of orphanages, industrial schools, training farms and family group homes. Three of those—Warilda Children’s Home at Woolloowin, Birralee at Rockhampton and Carramar at Townsville—were government-operated, becoming ‘receiving depots’ in the early twentieth century. The balance of the institutions mentioned in evidence were church-run, by a variety of denominations. St Joseph’s Orphanage, Neerkol, was run by the Rockhampton Congregation of the Sisters of Mercy, while St Vincent’s Home at Nudgee was operated by the Brisbane Congregation of the Sisters of Mercy. Nazareth House at Wynnum, run by the Sisters of Nazareth, was initially licensed under the *Infant Life Protection Act 1905* in respect of the care of infants. In 1964 it became licensed to care for children of any age. BoysTown, a more recent facility set up by the de La Salle Brothers, was opened and licensed in 1961.

The Salvation Army ran three institutions under consideration in this chapter: Horton House at Toowoomba, Alkira at Indooroopilly and Riverview near Ipswich, all of which had been licensed between 1920 and 1945. The Enoggera Boys’ Home, Tufnell Home at Nundah and St George’s Orphanage in Rockhampton were operated by the Anglican Church, again with longstanding licensing arrangements. The Presbyterian Church ran the Blackheath Home for Boys at Oxley until 1963, when the remaining residents were transferred to the WR Black Home at Chelmer, previously run by the Church as a home for girls. The Methodist Church ran the Margaret Marr Memorial Home for Boys as a licensed institution between 1924 and 1973. The Marsden Homes for Boys at Kallangur and Booval were initially run by the Congregational Church, but were subsequently transferred to the Uniting Church. Silky Oaks Children’s Haven began life as a home run by members of the Open Brethren Church and is now run by Silky Oaks Children’s Haven as an incorporated entity.



**Photograph 5.2: St Vincent’s Orphanage, Nudgee, operated by Brisbane Congregation of the Sisters of Mercy—Inquiry photograph**

Although the evidence included in this chapter relates to a large number of orphanages, industrial schools and family group homes, most has been drawn from the following institutions: Alkira, WR Black, Blackheath, BoysTown, Carramar, Horton House, Margaret Marr, Nazareth House, Silky Oaks, St Vincent’s at Nudgee, St Joseph’s Home at Neerkol, Riverview and Warilda. (For a graphic representation of the extent to which institutions were mentioned in evidence, see Figure 1.3 in Chapter 1.) Almost all of these institutions, with the exception of BoysTown, ceased to exist or dramatically changed their form between 1960 and 1980. Accordingly, most of the evidence reviewed concerns the period between 1930 and 1980, when these large residential facilities predominated.

Most of the organisations that ran the institutions concerned have made the valid point that the witnesses coming forward to the Inquiry represent only a very small proportion of the children who actually passed through their doors. The Salvation Army has observed that only eight

witnesses came forward in respect of Riverview out of an estimated 350 residents between 1950 and 1978, 13 out of 1,500 boys at Alkira from 1941 to 1979, and seven out of 596 children at Horton between 1950 and 1979. Similarly, the Council of Silky Oaks Children's Haven points out that approximately 1,000 children were cared for at Silky Oaks during the relevant period, of whom only 14 have been heard; while 19 out of a possible 1,623 former BoysTown residents have approached the Inquiry. The proportions are slightly higher in respect of Neerkol and St Vincent's, but the point is still well made that the numbers are but a fraction of those who could have spoken. It is also argued that the accounts that have been received are, in the context of the Inquiry, inevitably reflective of adverse experiences, which are not necessarily those of the majority. The Inquiry recognises these factors, and has accordingly exercised caution in considering the evidence it has received.

Examination of contemporary records from DFYCC has served in many instances to provide corroboration of witnesses' recollections, while in some others it has cast doubt on the accuracy of recollection. On the whole, the archival material has provided an invaluable tool in evaluating and understanding much of the evidence. It is recognised that the evidence received is limited in the sense that there are likely to be many others with important information, both adverse and favourable, who have not approached the Inquiry. Chapter 1 discusses some of the reasons that victims of abuse may be discouraged from coming forward in such a context. Equally, it is acknowledged that there may be former residents with positive experiences who had no strong incentive to approach the Inquiry; and indeed witnesses with favourable recollections of Neerkol, Nazareth House and St Vincent's did come forward.

## **5.2 LIVING CONDITIONS**

### **Problems of size**

At the outset, some generalisations can be made. Residential facilities for children, until the 1970s, tended to be run as large-scale institutions housing numerous children in dormitory accommodation. The size of those institutions, and the disproportionate staff-child ratios, meant that maintaining order tended to prevail over the needs and wellbeing of individual children. Their size also militated against any integration with the local community, and any semblance of a family structure was virtually impossible. Chronic government under-funding compounded all of these problems. A staff member described the situation where she worked:

*There were too many children for anyone to be able to give them care. The buildings were old, huge, there was in, say, the girls' section two dormitories, 60 girls in each dormitory—a little girls' dormitory and big girls. And I slept in a cubicle corner of one of the dormitories with 60 girls. There were not enough resources; the physical structures were not right. I mean there should not have been 60 girls sleeping in one dormitory, however big that dormitory was. It was [an] unnatural life.*

### **Accommodation**

Under-funding and overcrowding were responsible for the relatively harsh physical conditions in which most (but not all) children in both government and church-run homes lived, at least until the 1960s. Children lived in large groups, with scant consideration for their privacy. For example, at St Vincent's, until real change began to take place in the second half of the 1950s, children were housed in separate dormitories for boys and girls, each sleeping about 60 children. Within each dormitory children were grouped according to age. The dormitory-style environment allowed for little in the way of personal space: there were no doors to the showers, nor were there separate toilet cubicles—children would sit beside each other in a row. The nursery, St Roch's, generally held between 50 and 60 infants (*St Vincent's Home*....1992).

Older children ate in a refectory, seated on forms at large tables, with up to 60 children on either side of the table. The tables were covered with linoleum under which cockroaches thrived; the children drank from enamel mugs, and meals were eaten off chipped enamel plates into which were served, in turn, the main course and dessert. One witness recalled that swallows frequently flew around the dining room and their droppings constituted a mealtime

hazard. Another witness pointed out that the conditions in which they lived sent the children a message of their lack of worth: ‘Everything said ‘You’re not worth the effort.’

Living without privacy or space in an impersonal environment was a common experience for institutionalised children. Until the early 1970s almost all of the residents of Nazareth House were girls and all were housed in dormitory accommodation. There was a nursery for infants aged under six which held between 30 and 60 children. The junior dormitory housed girls aged between six and 10, the senior dormitory those aged 11 and above. The evidence suggests that up to 60 girls were housed in the junior and senior dormitories until numbers began to decline in the mid-1970s. The building itself was daunting: located on an expansive property at Wynnum, it remains an imposing structure today. Notwithstanding attempts at the time of its licensing in 1964 under the *State Children Act 1911* (SCA 1911) to renovate and brighten it, a child care officer provided the following description in 1974:

*The design of the building itself is along the lines of a monastery, with cloisters, crucifixes, statues, etc in great abundance. First impressions of it are that it is a very cold, imposing place, and it must be extremely frightening for a child, especially one of tender years, to be placed there.*<sup>1</sup>



**Photograph 5.3: Nazareth House, Wynnum operated by Sisters of Nazareth—Inquiry photograph**

At Neerkol, up to 100 children similarly slept in large dormitories. There was one dormitory for girls, who were divided into ‘little girls’ (aged between five and 12) and ‘big girls’. The boys lived in two dormitories similarly divided according to age.

*... I seen so many kids—I couldn’t believe, you know, that—all these kids, you know, they were everywhere and—that’s when I first went there, you know. I was sort of a bit dumbfounded and I was wondering, you know—I was sort of a bit—what I was doing there, I suppose. At that time I can’t remember if, you know, if my mother—that I’d known my mother had died.*

Babies and toddlers, whose numbers usually ranged between 20 and 30, were separately housed in a nursery. The original wooden dormitories were replaced in the 1960s by brick buildings.

Although Regulation 6 of the Regulations under the *SCA 1911* required the provision of ‘sufficient and seasonable bed-clothing’, the bedding provided for the children appears to have been inadequate, at least until the 1960s. Some witnesses complained that they were not supplied with pillows; more importantly, blankets were in short supply. Only one or two blankets were available to each child, even though temperatures during the Neerkol winter

could drop to extremely low levels at night. Not surprisingly, former residents who had slept in the old wooden dormitories, which were not insulated, complained of being cold.



*Photograph 5.4: Up to 100 children slept in large dormitories at St Joseph's, Neerkol—Courtesy Neerkol witness*

Dormitory-style accommodation, although not always involving children in such large numbers, was the norm in both church- and State-run institutions. A witness who was at Warilda in the early 1970s described it (from the perspective of a child) as a 'huge, huge place'. A babies' unit held 20 to 30 babies. Older children numbering around 20 slept in dormitories, with the beds, unscreened, a couple of metres apart. Each child had an open shelf and a small unlockable cupboard; nothing could be kept private. To some extent these conditions were the product of the building itself, which dated from the turn of the century. A rebuilding program between the late 1960s and the 1970s improved matters considerably, with smaller bedrooms sleeping three, and wardrobes and dressing tables.

Both Carramar in Townsville and Birralea in Rockhampton similarly suffered from antiquated facilities. At Carramar, prior to the move into a new building in 1966, children slept on louvred verandahs. The building in which they were accommodated was described in a departmental document<sup>2</sup> as being 'in a shocking condition', with ill-ventilated, dark, dingy rooms, holes in the ceilings, walls and floors eaten by white ants, 'and cockroaches in abundance'. It was, the writer pointed out, both a health hazard and a fire risk. The move appears to have occurred at about the time of the commencement of the *Children's Services Act 1965 (CSA 1965)*, in August 1966. Section 40 of the Act required that children be given adequate lodging, and that every part of the institution in which they lived be 'maintained at all times in a fit and proper state for the care of a child'. Notwithstanding that legislative requirement, the buildings at Birralea, prior to its refurbishment in 1979, were said to be in an 'appalling' state, dirty and dilapidated.<sup>3</sup>

While generally of a poor standard, living conditions at some places were dire. By the early 1970s the facilities at Riverview are reported to have been old, dilapidated and run down. All of the power lines and poles were condemned, along with telephone lines. Male and female staff were obliged to use the boys' toilets. At the end of the 1960s the manager stated that there was nowhere suitable even for temporary accommodation.<sup>4</sup> For the majority of its existence, Riverview had no connection to the town mains water supply, relying on rain for drinking water. When the rainwater tanks were dry the whole centre depended on river water which was unfiltered and contained levels of effluent emission from the Dinmore Meatworks and the hardboard factory nearby. The Ipswich Health Department had condemned the piggery situated within the grounds of the Home. This piggery also added to the Home's water supply problems as refuse from it was pumped directly into the river whose water was then pumped back into the Home for use in the laundry and even, on occasion, for cooking. A

grant to connect to the mains water supply had been applied for and received in 1969. However, by 1972 no action to remedy the situation had yet been taken.<sup>5</sup>



*Photograph 5.5: Workshop at Salvation Army's Endeavour Training Farm at Riverview, near Ipswich (1971)—Courtesy Queensland Newspapers*

In 1971 a press report claimed that new residents and those designated as 'troublemakers' were housed in a room with up to 14 others, with only a galvanised metal bucket as a night toilet.<sup>6</sup> In 1970 the Director of the Department wrote to the Under-Secretary of the Department of Health, stating that the Minister would need just one visit to Riverview for a solution to be found to the funding problem. Indeed, he attributed the large number of abscondings from Riverview to be in part due to the 'poor standard of accommodation and the physical conditions generally prevailing at the centre'.<sup>7</sup> He concluded by urging that a rebuilding program begin immediately.

In 1972 similar concerns were voiced about the institution, this time by the Ipswich City Council, which felt that the conditions were so poor that a meeting with the Director was required. Riverview was described as 'unhygienic and primitive', and it was pointed out that standards of health and hygiene were not in accordance with the Health Act.<sup>8</sup>

A departmental report on Riverview in 1973 once again noted the appalling physical conditions at the Home, stating that such conditions could well lead to its licence being revoked. The point was made strongly that 'if a child in his own home was living in some of these conditions, then such may very well constitute evidence of physical neglect'.<sup>9</sup> In the previous year the author of the 1973 report had stated that the 'facilities and buildings are substandard and depressing. I even wonder that the local Council allows it to continue'.<sup>10</sup> A State Government Inquiry into Youth in 1975 summed up the physical state of the place: 'Old timber and galvanised iron predominate and generally the outlook is one of depression'.<sup>11</sup> The archival material reveals numerous requests from the Salvation Army itself to the government for more funding for the institution, but they do not appear to have met with a positive response.

## **Food**

Inmates at institutions licensed under the *State Children Acts* were, according to the Regulations, to be given 'plain, wholesome food' according to an approved dietary scale, a copy of which was to be hung in the institution's dining room. None of the witnesses recalled such a scale, and although food certainly was 'plain', it does not appear that wholesomeness was always achieved. The *CSA 1965* required merely the provision of 'adequate' food.

Complaints about both the quality and quantity of institutional food were common. At best, the diet was unappetising and unvarying; at worst it was entirely inadequate for growing children. Meat and fruit tended to be scarce, and there was, particularly in the larger orphanages, a heavy reliance on porridge (frequently with weevils included) and bread (often stale) with syrup. Most witnesses who had been at Neerkol prior to the 1960s complained of hunger. Some spoke of stealing leftover food from the plates of the nuns or yardmen, while others said they had resorted to local vegetation such as jujus, hibiscus and pigweed to satisfy their hunger. Former residents of both Nazareth House and WR Black described supplementing their diet with clover and grass. Other witnesses said they had resorted to retrieving scraps from waste bins. Complaints about the poor quality of the food given to the children at Blackheath reflected contemporary allegations, made by former staff of the Home in 1953, as to the inadequacy of the boys' diet. Meat was restricted to sausages and rissoles, there was an absence of fresh vegetables, and there was a policy of using donated rolled oats for porridge, even if they were found to be weevil-ridden. The Superintendent appeared to take considerable pride in his ability to economise on food.<sup>12</sup>

## Clothing

Regulations 25 and 46 of the Regulations under the *SCA 1911* provided that all inmates of institutions be supplied with outfits, the details of which were prescribed—suits, jerseys, dresses, pyjamas, bloomers—down to the last handkerchief. On the other hand, Regulation 18 permitted the clothing received with children on their admission to be 'utilised for the purposes of the institution'. Section 40 of the *CSA 1965* required, more simply, the provision of 'adequate' clothing.

A witness who had been a Sister of Mercy at Neerkol in the 1950s explained that the State Children Department provided two outfits to each child who was a ward of the State: one on admission and one on leaving the Home. During their residence there no other clothing was provided by the State, so that if a child arrived at three months of age and left for service at 14 (as many did), they received a layette and a work outfit and nothing in between. It fell to the institution to provide what clothes it could.

Many former residents of institutions prior to the 1970s raised the issue of ill-fitting, inadequate clothing. A particularly sore point was that in most institutions, presumably pursuant to Regulation 18, children's own clothes were taken from them on admission, removing a link with the outside world. Notwithstanding the requirement for separate outfitting, it was common in both church- and State-run institutions for clothing to be held communally, with the 'luck of the draw' determining whether children received garments of their own size to wear. Clothing produced at Warilda was provided to other State-run institutions. Made by all accounts entirely without regard to current fashion, it was a source of humiliation to some, at least, who had to wear it.

In some Homes there was real deprivation: there were complaints of inadequate winter clothing from former residents of Neerkol and WR Black, and boys had to do without underwear at the Enoggera Boys' Home, St Vincent's and Neerkol. In many institutions, shoes were available for wear only on special occasions, and there were numerous recollections of the sore and cracked feet that resulted:

*... we used to walk to school from the home ... it was a fair hike. The home was on the junction of the Brisbane and the Bremer River and you had to walk from there up to the main road, then along the main road to Dinmore ... they had this shale on the road ... nobody had shoes ... I used to walk up that shale in winter time ... my feet would be bleeding.*

Witnesses often spoke of feeling marked out as 'Home' children by their clothing. Sometimes it was the fact that they had to wear uniforms to school that were non-standard issue, or clearly second-hand, that made them feel stigmatised. In other cases the situation was worse: one former resident of Riverview during the early 1950s described having to wear patched clothes rather than a uniform to school. This singled him out as a 'Home' boy—a humiliating



experience. The adequacy of the children's clothing at Riverview remained an issue into the 1970s. In 1976 the headmaster of Goodna Opportunity School requested that 'the children going out to school be clothed in some more suitable clothing other than the boots and variety of dilapidated clothing that they wear at Endeavour'.<sup>13</sup>

### Personal hygiene

Satisfactory personal hygiene arrangements were another casualty of the size and under-funding of the Homes. Children seldom had access to their own toiletries, and those that were available tended to be basic in the extreme. At Neerkol and St Vincent's, at least until the mid-1950s, there were no toothbrushes or toothpaste; witnesses recalled using charcoal or a rag with soap on it to clean their teeth. The towels provided at Nudgee were made of a coarse hessian material and were shared by up to six children. Showering, particularly in the winter, was an ordeal as only cold water was available.

Another common complaint centred on the restricted use of water at some institutions. Four former residents of WR Black complained that many children were made to use the same bath water and that the water was particularly cold in winter. Similarly, children at Nazareth House were, until the mid-1950s, bathed once a week in shared bath water. At bath time girls would line up in approximately three rows, each being required to share the same bath water while being covered by a kind of modesty cloth or apron. With up to 60 residents in the junior and senior dormitories, and only three or four baths, up to 20 children may have shared the same bath water.

### Medical treatment

The three government institutions being run on a medical model—Warilda, Carramar and Birralee—had their own nursing staff. Neerkol and St Vincent's both had on staff a nun with nursing training who attended to most complaints. In both homes, the sisters who filled those roles until the 1950s appear to have carried out their tasks without much tenderness or technique.

*She [a nursing nun] was known for her cruelty and I witnessed it on one occasion where I came close to physically attacking her when I had a small child in front of me. I'd been hit by my teaching nun and had an infection from a cut from bamboo so ... I was in [the] queue and the little girl in front of me—because Nudgee you understand was on the edge of a swamp so we had masses of mosquitos ... and sandflies. And this little girl had scratched her bites and they were infected so she had marks on her legs. [Nun] had as harsh a tongue as she had a personality and she just told this little girl how disgusting she was ... and dirty for having got her bites infected, and she told her to put her foot up and she hit her on her toes with the bamboo cane ... she would have only been about six ... I can remember her little leg jumping and that because your toes are so tender.*

A letter written to the Catholic Archbishop of Brisbane in August 1931 complained of the nursing nun at St Vincent's beating children 'black and blue' and neglecting their illnesses, but she remained in her position from 1911 until the 1950s. Other institutions had no in-house nursing or medical expertise, and varying levels of willingness to seek medical treatment for children.

It appears that, prior to the 1970s, neither the State Children Department nor many denominational administrations were prepared (or perhaps, in the latter case, able) to incur the expense of providing regular medical and dental treatment at residential institutions. Former residents of WR Black, Blackheath, Nazareth House and Margaret Marr recalled this as a feature of their institutional experience. For example, at Blackheath the administrators were instructed by the Department to use the free service offered by the (then) Brisbane General Hospital, and to call a local doctor only 'in cases needing urgent attention'.<sup>14</sup> In most of the Homes under consideration here it was the norm to treat minor ailments and injuries within the institution, resorting to outside medical assistance only for serious problems. Home remedies were often applied, sometimes ineptly. Many former residents recalled with distaste fortnightly doses of Epsom salts, castor oil or senna tea. The remedy for head lice was the application of kerosene or DDT or, in some cases, shaving of the head.

Ordinary childhood illnesses such as measles and chickenpox often received little attention. Two residents of Neerkol, one in the 1940s and one in the 1950s, spoke of being left alone in the dormitory to recover from measles, with nursing care in one instance being the provision of a saint's relic to aid recovery. Although a local general practitioner who acted as Government Medical Officer attended the orphanage regularly, it is not clear how many children were seen on these visits; many former residents did not recall ever having seen a doctor during their residence there. Prior to the mid-1960s, it does not appear that any medical records were maintained. As late as 1967, a newly appointed medical adviser to the Orphanage informed the State Children Department of the complete absence of any medical histories for the children at Neerkol.

Born in 1960, E was committed to the care of the Department after it was decided that her mother was incapable of caring for her and her sisters. In June 1961 she was sent to an orphanage. She claimed a helper in the nursery used to abuse her:

*She used to get so mad ... I think too 'cause I was so naughty ... I don't know, actually I often think about it.*

It soon became apparent that E was suffering from a severe speech impediment. She gradually became aggressive towards other children and began to exhibit other behavioural problems such as head banging:

*I used to bang my head, it wasn't because I was spastic, [or] brain damaged, or anything like that. I used to try to get myself to sleep ... the only thing that would stop me was when she [staff member] used to grab me by the ears ... She'd twist them that bad, and she'd go 'You vulgar little girl', and she used to strip me off ... I don't know if you can remember bamboo sticks? Well they were really thin, and that's what she'd use to flog me.*

In 1966 a departmental official decided that E should be transferred to Brisbane because she was 'mentally defective and vicious and destructive in her habits'. It had earlier been suggested that she be sent to 'an institution for the mentally sick'.

In 1967 the young girl was transferred to St Vincent's Orphanage in Brisbane and was there examined by a psychiatrist. Her conclusion was that the child was of normal intelligence and did not require any psychiatric treatment; rather her speech defect was frustrating her, causing her to use her strength against other children. While at St Vincent's she was given speech therapy and was considered to be relating well to the therapist and the other children. However, in 1968 a decision was made to return her to the original orphanage.

It does not appear that any further speech therapy or other intervention took place following her return. In this environment, she once again began to behave in a manner typical of a troubled child. Thereafter, numerous reports were filed that referred to her aggressive behaviour, frequent tantrums and serious learning difficulties. Eventually, she was sent to an Opportunity School, but her behavioural problems continued and she was transferred to Warilda in 1972. Eventually, she was placed in Wolston Park psychiatric hospital for a period, but it was soon discovered that she had no psychiatric disorder and should never have been admitted. She was eventually discharged from institutional care in 1976.

In her evidence to the Inquiry, it was apparent that E was a normal, intelligent person, and her speech defect had long since been overcome following minor surgery. Her behavioural problems were not just the result of frustration at her speech difficulties, but were also the result of being abused at the Orphanage over a number of years. In fact, her efforts to alert others to the abuse she was suffering were hindered by the widespread belief that, because of her speech impediment, she was 'mentally defective'. In E's account, and that of other witnesses who were also residents of the Orphanage, her various problems were met with punishment from the staff, with little attempt being made to understand why she acted in such a way. Despite the report of the psychiatrist who had seen her in Brisbane, at no stage was there any therapeutic or educational intervention to assist her.

Her experiences are extreme, but they demonstrate the lack of specialist assistance available to children at many orphanages until the mid-1970s. Her case shows that, without such assistance, a child whose behaviour was considered problematic by orphanage and departmental staff could easily be condemned to a cycle of unnecessary hardship.

E is now a mother of six children struggling to come to terms with her abuse at the hands of certain orphanage staff and the sense of helplessness created by people unwilling to believe her story.

### 5.3 MANAGEMENT OF CHILDREN

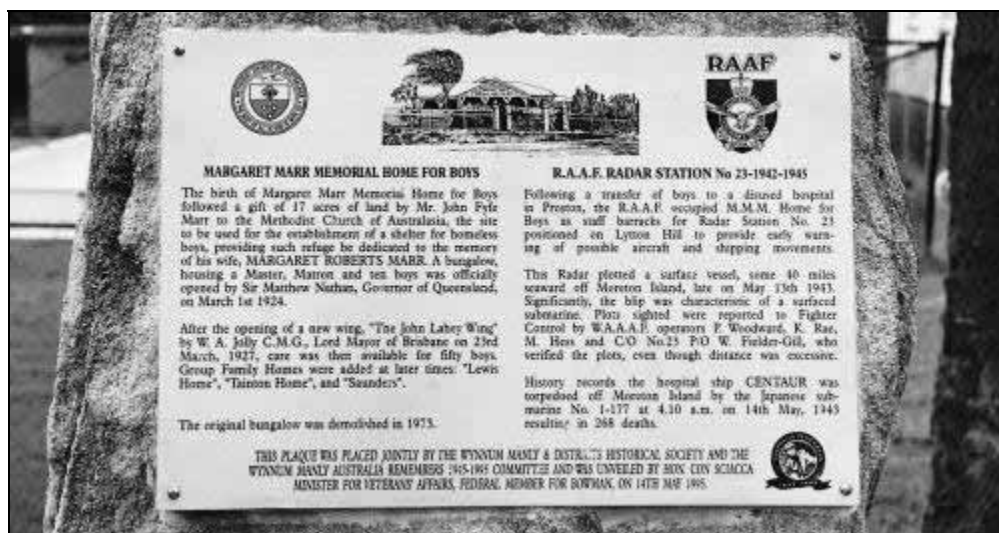
Overcrowding, lack of trained staff and lack of resources had profound implications for the management of children in Queensland institutions. The experience of one of the largest orphanages, St Joseph's Home at Neerkol, clearly illustrates these pressures. It accommodated hundreds of children at a time and, for most of its history, was regarded by the State Children Department as an unfailing recipient of children, no matter how over-burdened or under-resourced it might have been.

*... all those babies ... they'd always be ... putting their arms up, and you didn't have time to give them any individual love ... That was my one big sorrow always, that I couldn't ... love them as I wanted to ... because you didn't—you couldn't do it to the lot of them.*

The problems of over-crowding and under-funding were compounded by physical isolation. These factors, together with the fact that Neerkol was almost entirely staffed by a relatively small, locally-based religious order (the Rockhampton Congregation of the Sisters of Mercy) with little expertise in managing children, and in which certain personalities tended to dominate, led to the development of a distinct culture. That culture—the subject of a good deal of adverse evidence—bears examination, but because of pending litigation, both civil and criminal, it will be discussed in a separate section of the report, which, it is anticipated, may not be released until those matters are finalised.

#### Discipline and corporal punishment

Regulation 23 of the Regulations under the *SCA 1911* empowered the Superintendent of an institution to punish any State child guilty of misconduct. All complaints and punishments were to be entered in a punishment book. Corporal punishment was, pursuant to Regulation 24, 'to be administered as seldom as possible ... only resorted to when absolutely necessary for discipline, and not for first offences unless of a grave nature', and could be applied only in the presence and by direction of the Superintendent. The Regulations under the *CSA 1965* reiterated that corporal punishment should be used only as a last resort, and prohibited its use on girls. It could be administered only by, or under the direction and supervision of, the person in charge, in the presence of a suitable witness, and could be applied only with a leather strap of a type approved by the Department over a child's trousers. Again, a punishment book was to be endorsed with the details of, and reasons for, the punishment.



Photograph 5.6: Margaret Marr memorial plaque (Methodist Church)—Inquiry photograph

Evidence suggested that particular personalities often dominated institutions, and it was these individuals who were often inclined to inflict brutal physical punishments. A number of witnesses reported that the Master and Matron at Margaret Marr in the 1940s were in this category. Two former residents stated that the Master and Matron always wore thick leather straps over their shoulders that they used to discipline children for such misdemeanours as answering back or swearing. One resident said boys would be hit around the back, buttocks and hands and, on occasions, hard enough to draw blood. He said that the Matron or Master would hit the boys until they had ‘broken’ them, that is, until they began to cry. Another described being hit 58 times by the Master in the dining room, in the presence of other children who were made to watch and count the number of times the boy was hit.

Witnesses also described unacceptable methods of punishment administered by the Matron at WR Black in the 1940s and 1950s. Three witnesses stated that children were sometimes punished by being deprived of their meals or by being force-fed their meal if they refused to eat it. Others stated that children were made to line up, sometimes facing a wall, and ordered to hold their arms up in the air for long periods of time. If their arms dropped the Matron would hit them with either a ruler or a cane. Seven witnesses remembered that the Matron made all children line up for punishment even though it may have been only one child who had committed an ‘offence’ such as talking in the dormitory after lights out. Other allegations of serious assault were made against the same Matron; she was said to have intentionally burnt a girl with a hot iron, to have hit another across the head with a pair of scissors causing her head to bleed, and to have hit others with pieces of wood. Reports were given of children being physically disciplined for simple things such as talking, not completing chores, not finishing meals, going somewhere out of bounds within the Home, coughing and even, on occasions, for being left-handed. The ‘crime’ of left-handedness was the cause of much punishment within religious orders. Former residents told of being beaten ‘to get the Devil out of them’, the Devil being left-handed.



*Photograph 5.7: WR Black Home at Chelmer, operated by the Presbyterian Church—Inquiry photograph*

St Vincent’s Orphanage at Nudgee was, prior to the mid-1950s, built on a regime of obedience and commanded by severe discipline, with order being maintained by the suppression of ordinary childhood spontaneity. For example, children were made to sit, motionless and in silence, for long periods, with any noise or movement leading instantly to punishment. Although legislation provided that use of corporal punishment be applied only as a last resort, and in the presence and by direction of the Superintendent (in this case the Mother Superior), many of the nuns made free use of the cane or strap for minor transgressions.

The small number of nuns overseeing large numbers of children encouraged the use of older children—often those who had themselves been in the Orphanage since infancy—to enforce discipline. Not surprisingly, this power, wielded by adolescents with their own history of neglect, was abused. Older boys were permitted to patrol with straps, ready to administer a flogging to any smaller boy who stepped out of line. Witnesses recalled the evening Rosary, at which an older boy would wait in readiness to apply his strap to any boy who moved; while the morning was heralded by a blow for any child who failed to rise with sufficient speed. Older girls exercised their power with beatings, punching, ‘Chinese burns’, and the locking of younger children in cupboards. In the case of both boys and girls, witnesses named particular individuals as being especially malicious. Runaways from St Vincent’s were usually beaten on return. The threat of transfer to Westbrook was used to enforce compliance and to frighten, since Westbrook was, correctly, perceived as a much harsher and more punitive environment. Boys were in fact sent to Westbrook for absconding from the Orphanage, sometimes without prior warning.

There were similar signs of a culture of management by fear and corporal punishment in other institutions. Many staff seemed unable, or unwilling, to devise any alternative to the regular infliction of physical punishments in their quest to maintain order among large numbers of children. In any case, many could not accept that such treatment was unusual or harmful. When, in the early 1950s, the Superintendent of Blackheath was questioned about allegations that he kicked and slapped the boys about the face and head, he responded by asking ‘What boy hasn’t had a box upon the ears?’ Unfortunately for the boys, this particular Superintendent was not averse to going beyond a simple ‘clip over the ears’. He later admitted punishing a small boy by applying sticking plaster to his mouth and putting him to bed in that condition for some hours. He denied tying the child’s hands together, but this act was later confirmed by two former staff members, who also added that the Superintendent had ripped the plaster from the child’s mouth with sufficient force to leave a wound requiring treatment.<sup>15</sup>

Former residents of Alkira told of various staff members using physical punishments against children for a variety of ‘misdemeanours’ including, for example, absconding, being out of bounds, talking through meal or study time, not closing eyes while praying, talking to girls or playing with them in the school grounds, talking on the way to school, or not sitting up straight while watching television. A resident at the Home in the late 1950s and early 1960s described children being lined up, stripped from the waist down, and beaten over a vaulting horse with a length of garden hose for stealing mangoes from a nearby property. Another former resident from the early 1970s described being beaten by the Superintendent with a razor strap while bent over a desk. He said he was flogged so hard that he was unable to sit down because of the bruising.



*Photograph 5.8: Alkira at Indooroopilly, operated by the Salvation Army—Inquiry photograph*

DFYCC files from the 1970s support this picture of excessive corporal punishment. In 1970 the use of corporal punishment at Alkira was brought to the attention of the Director in a detailed memorandum from a child care officer. Between May and June of that year, 13 boys had been recorded as truanting or absconding, as a result of which, on 3 June, the strap had been used at least 44 times. According to the child care officer, the Superintendent's position on this liberal use of corporal punishment was that Salvation Army staff were acting with the tacit approval of the Department. The child care officer expressed the view that the use of corporal punishment at Alkira at that time was excessive, unjust and humiliating, and was adversely affecting the wellbeing and dignity of the boys. The basic needs of the boys at Alkira were not being met, for which the Department had to take some responsibility.<sup>16</sup>

In 1973 the Superintendent of Alkira wrote to the Director complaining that social workers seemed to be opposed 'to the occasional use of the strap'. He argued that if misdemeanours warranted extra chores and loss of privileges, surely serious offences such as truancy or a second absconding warranted more stringent punishments. He demanded a clear direction in writing on punishment protocol, and guidance on the limits of welfare officers' responsibilities.<sup>17</sup> The Director responded by pointing out that the responses to children's behaviour must be determined on an individual basis. He continued:

*Punishment as such will hardly ever be an appropriate treatment for [truancy and absconding] which responds much more readily to positive rather than negative influences.*<sup>18</sup>

In recognition of the difficulties associated with caring for around 60 boys at a time, it was suggested that numbers of boys be reduced to relieve the pressure on staff, and that boys be given a proper opportunity to settle in at the Home before being required to attend school.

In 1976 a child care officer commented on the use of corporal punishment at Alkira after a group of children reportedly misbehaved on a camp:

*It is not in the least surprising that the children offended. On the contrary, it would be surprising if they didn't. For the last two years, it has been frequently and consistently reported that corporal punishment, repressive methods and the lack of nurture at Alkira are of extreme concern. The normal behaviour for Alkira is absconding, truancy and stealing. This happens whether the children are on camp or not. How desperate do the children have to become?*<sup>19</sup>

In the 1930s a departmental inspector conducted an inquiry into conditions at the then Industrial School for Boys at Riverview. Corporal punishment was not, he concluded, being administered in accordance with Regulation 24 of the *State Children Acts*, that is only by authority of the Superintendent. Rather, all staff were allowed to inflict such punishment.

Matters appear not to have changed greatly in succeeding decades. Former residents during the period 1950–55 said that various staff members would routinely use corporal punishment against children for a variety of misdemeanours such as absconding, not staying in line on the way home from school, missing the train home from school, being outside the dormitory after hours and not eating meals. One resident said he was caned so hard that his fingers would be numb and swollen and his hands bleeding. He also told of a staff member beating him across the shoulders with a bamboo cane for breaking dining room rules. The cane had been given extra potential to inflict pain by the insertion of sand in its tip. Another former resident described how a staff member beat him with a cane for failing to complete a chore, after which he was thrown into the Brisbane River. He described having to pull himself from the water against the current only to receive another beating with the cane by the same staff member because 'he had been swimming'.

The Inquiry also considered departmental archival material from the 1970s that related to Riverview, in which numerous allegations appeared of either harsh physical discipline or abuse being meted out by various staff members against children.

In 1970 allegations were made against a staff member said to be constantly belting the boys. When questioned, the Superintendent of the Home told the Department that this was probably quite true and that he would write to the Salvation Army headquarters to have the staff member removed.<sup>20</sup>

In another case, a staff member was said to have backed a boy against a wall and struck him about the face with his hand. A child care officer recorded that the boy had bruises on his cheek and that ‘other information also suggests that a pattern of physical confrontation as a means of maintaining discipline, continues to be the norm at Riverview’.<sup>21</sup>

Further complaints against the same staff member came to the notice of the Department during 1975.<sup>22</sup> A child care officer noted in a report a number of complaints against the staff member who had apparently been punching boys in the face during the previous two years.<sup>23</sup> One such complaint involved a boy who had absconded twice following allegations of physical punishment by staff. The child care officer contacted Riverview after the first incident and requested that no further physical ill-treatment of the boy take place. However, the boy was allegedly assaulted once more by the staff member who punched him, shook him violently and hit him in the face.

Complaints were commonly made to the Department involving other staff members during the 1970s. One such case involved a boy who was apparently assaulted by a staff member, who hit him in the nose and stomach prior to the boy being returned to his cell. This staff member was described by the child care officer as ‘an extremely limited and disturbed individual who is in need of care himself’.<sup>24</sup> The supervising child care officer at the time visited Riverview and noted severe bruising and swelling to the boy’s face. A short while later, the Superintendent rang the departmental officer and apologised for the way the boy had been handled.<sup>25</sup>

As with Alkira, it is evident from the archival material that there was longstanding contention between the Riverview administration and the Department as to what punishment was acceptable, with the debate becoming acrimonious at times. After the issue of the unwarranted use of a cane by a staff member was raised by the child care officer attached to the home, that officer’s group therapy classes with the boys were suspended by the acting Supervisor. The Supervisor complained that the therapy sessions highlighted ‘institutional problems, unrest, and mob psychology’ without any mention of the numerous amenities being provided for the boys.<sup>26</sup> Not long after, the child care officer was told that he could no longer meet with the boys in groups.<sup>27</sup>



*Photograph 5.9: Entrance to BoysTown (de La Salle Brothers) (1999)—Inquiry photograph*

Complaints of excessive corporal punishment at BoysTown emerged from both the evidence of witnesses and departmental files. Notwithstanding the 1966 regulatory requirements concerning corporal punishment, the evidence, both oral and documentary, shows no lessening in its use in either the 1960s or the 1970s. Witnesses from the early 1970s described a culture of behaviour management by floggings usually administered by the Director with a strap. Others described the Director using a jockey's whip to beat boys, using an open hand to strike them, and sometimes pulling them about by the hair in the course of a beating. Another Brother was also named by two witnesses as having beaten boys with his hands or fists. Similar accounts of excessive corporal punishment emerged from all four witnesses who were residents during this period.

Other witnesses described the use of certain boys (through the Alderman system) to maintain control through a combination of peer pressure, intimidation and physical assault, and the Friday night 'biff-ups', or boxing matches, which were perceived as punishment. Boys with no boxing skills were forced into the ring with bigger boys who were obliged to keep punching until the Director chose to stop the fight.

The arrival of a new Director in 1976 does not appear to have improved matters significantly. During 1978 a number of visiting child care officers expressed concern about the way in which discipline was administered. In one instance, the mother of a boy who said he had been severely flogged and punched in the stomach by a particular Brother complained;<sup>28</sup> in another a boy said that he had received a severe belting from the same Brother, evidenced by red marks across the backs of his legs.<sup>29</sup> A report in September of that year summarised the issues.<sup>30</sup> Boys were being physically punished not only by Brothers, houseparents and teachers but also by peers. Cottage captains and vice-captains were required to maintain cottage discipline, and the boys generally felt pressured to punish absconders. Absconders were strapped, and they and others were forced to participate in boxing as a punishment. The BoysTown Director held that the institution operated 'within a framework of discipline and punishment'. As with other institutions, there clearly existed a fundamental dispute between child care officers and institutions as to the appropriateness of the corporal punishment being administered.



*Photograph 5.10: BoysTown residential care facility (Beaudesert) (1999)—Inquiry photograph*

These differences of opinion as to the use of corporal punishment reflected a basic clash of philosophies which existed in relation to many of the denominations running residential facilities. A memorandum from a senior child care officer, writing about Alkira, set out the general position:

*The elements of doubt and uncertainty about what was acceptable use of corporal punishment and what was not, overlap extensively and as such are inconclusive. The*



*underlying point of these incidents and past incidents is that corporal punishment is used as the tool for modifying behaviour in emotionally disturbed children. This therefore raises the question of whether the use of corporal punishment is an effective and appropriate means of modifying behaviour (with acting out emotionally disturbed children) not only in Alkira but in every other residential caring situation.*<sup>31</sup>

It is obvious from the long-running debate between institutions and the Department that the Department considered that corporal punishment was not being used as a remedy of last resort as required by the Regulations (other means of behaviour management not being addressed). Why, then, did it not take decisive action to end a situation in which punishment was being applied in breach of the Children's Services Regulations?

### **Bed-wetting**

The treatment of bed-wetters emerged as an indicator of the level of humanity, or lack of it, displayed by different regimes. Some administrations regarded bed-wetting not as a sign of disturbance or distress but as calculated misbehaviour requiring physical punishment, public humiliation or both. Many former residents of WR Black described severe and cruel punishments inflicted by the Matron. One resident described the Matron hitting known bed-wetters at the toilet while ordering them to 'Do it, do it'. Another resident described the Matron rubbing her nose into a dirty sheet after she had wet the bed. Three residents told the Inquiry that bed-wetters were made to stand up to eat their meals in front of other residents in the dining room. One stated that bed-wetters were sometimes made to go to school without having an opportunity to wash beforehand, with two others reporting that bed-wetters were made to sleep on the bare wire bases of their beds having had their mattresses removed as punishment. One such resident described her experience:

*I used to wet the bed and mess the bed. And we'd have to take our mattresses out and clean—try to clean them up ourselves and that, and—well, I remember I was made to do a little dance and a song about myself, about wetting the bed, and I remember I used to, like, hold my skirt out like this and '[name] wet the bed, [name] dirtied the bed, [name] wet the bed.'*

The treatment of bed-wetters at St Vincent's seems to have varied. Some were subjected to verbal humiliation. Male residents of St Vincent's in the 1930s and 1940s recalled being hit with a strap under a cold shower for bed-wetting, while others remembered simply being obliged to endure a cold shower or bath.

A former resident of Blackheath who, with two brothers, was admitted to the Home in 1951 at the age of seven described a harsh regime of humiliation and punishment. He recalled being locked in a cupboard under the back stairs as punishment for a variety of misdemeanours. Bed-wetters (of whom he was one) were beaten. He and one of his brothers were made to sleep on an open verandah in a double-bunk bed. He had a mattress and one blanket in mid-winter, but no sheets, and developed a habit of urinating in his own bunk to warm himself. Urine would inevitably seep through the upper bunk. Both he and his brother were derided for their incontinence by staff and other boys.

This treatment is supported by contemporary documents. In October 1952 a visitor to the Home reported to the Department that bed-wetters were being hit with a strap as punishment—one blow for the first incident, two for the second, and so on, until the number of blows reached nine, at which point the process recommenced. He also alleged that boys who wet the bed were being humiliated by being made to wear nappies or night-dresses. The visitor also raised the matter with the Secretary of the Presbyterian Church Committee on Homes and Hostels. Ultimately, the Director of the State Children Department discussed the complaint with the Committee Secretary. Both were told that he would 'look into the matter', but there is no evidence of any further action having been taken. Consequently, after further allegations about the treatment of children at Blackheath were reported in the *Truth* newspaper, a departmental inspector visited the Home, investigated the complaints made and subsequently reported to the Director.<sup>32</sup> He questioned a number of the children, including the

witness discussed above. The boys recalled receiving numbers of blows with a strap for bed-wetting, consistent with the October 1952 complaint.

The departmental official examined the conditions in which the witness, his brother and another boy had been sleeping. He saw an area open on three sides, approximately 20 feet from the external wall of the building, in which there were two double-decker iron beds. With the onset of cooler weather, the beds had been moved further in under the building, and a sheet of iron erected as a wall on one side. The beds contained mattresses, two blankets each, and waterproof sheets, but no linen. This contrasted with his understanding of what the police had found on their visit a week earlier, when there had been a single blanket only on each bed. The area where the boys were sleeping was not lit in any way. The inspector concluded that placing the boys in this exposed area was a 'very callous' manoeuvre that 'would not assist in their rehabilitation and re-training'. As a result of these allegations, the witness and his two brothers were promptly removed from the Home. A physical examination after their removal revealed some bruising to the hip of one and to the buttocks of the others.<sup>33</sup>

### **Suppression of individuality**

Impersonal treatment and the lack of respect for children's individuality were common aspects of the institutional experience. At St Vincent's, surnames were regularly used as a means of address. Indeed, in a situation where a child had brothers and sisters, a number was generally attached, so that, for example, three sisters by the name of Brown would be addressed as Brown 1, 2 and 3. Children were allowed no personal possessions, which meant that when they were given toys or other gifts they were obliged to give them up on the assurance (which did not always eventuate) that they would be returned on their departure from the Orphanage. Presumably this rule was designed to avoid the resentment and jealousy of other children, but it understandably generated acute bitterness in the children—a bitterness still evident in the recollections of adult witnesses, who felt that the little they had as children was taken from them. Children were given little information about their backgrounds, a practice unlikely to promote any sense of identity and self-worth. Some did not even know their correct birth dates. One child, having left the Orphanage, failed to recognise his own name on a pay packet because he had never seen it written out in full; he was used to being called by a contraction of his first name, and had no idea that he possessed a second name.

At the heart of the way in which both denominational and State-run establishments were conducted was the notion that children were to be managed for the good order of the institution, rather than the institution being managed in the best interests of the children. Clearly, most institutional procedures were based on the belief that enforcement of conformity was conducive to the smooth running of a Home, while encouragement of individuality was not.

Former residents of Alkira described the highly regimented fashion in which the activities of the Home were carried out. The boys rose at a designated time, and performed their daily activities according to a set routine and timetable. A resident in the late 1950s and early 1960s spoke of being marched, military-style, to the dining room where the evening meal took place according to an invariable procedure of standing, saying Grace, eating in unison, and sitting between courses with arms folded. The point has been made on behalf of the Salvation Army that such regimentation was normal for an institution of that time, and could also be found in fee-paying boarding-schools.<sup>34</sup> That may well be so. However, it does not detract from the fact that this was not proper treatment of children, and its ill-effects were likely to be considerably accentuated by the fact that, unlike the situation of most boarders, institutional living made up the entire experience of these boys, unalleviated by any prospect of holiday breaks or return to a normal family situation.

Similar issues arose in evidence relating to other denominational institutions. In the late 1970s a report on BoysTown criticised the institution for its preoccupation with conformity, its degree of regimentation, and the general reluctance on the part of the staff to deal with the social and emotional needs of the boys. The report comments that boys with personality and behavioural problems were able to be 'contained' but not helped to resolve them.<sup>35</sup> Another

witness, resident at Nazareth House between 1970 and 1972, recalled feeling intimidated and as though the children were annoying the nuns. There was, she complained, an absence of affection, and everything that occurred was ‘ordered’, or regimented. However, that was not a universal experience; other former residents in the same period reported feeling that there was genuine care shown to them.

Similar problems of regimentation and lack of individual attention were described in the government institutions. An early (1936) resident at Warilda described feelings of alienation:

*You were just a number on the book, or somebody’s name on their books. But as far as a person goes, I could have been some dog that wandered in off the street.*

A witness placed at Carramar in 1957 recollected it as large, unfriendly and impersonal. The children were expected to be silent and compliant, and to adhere to a rigid routine. Younger children were left in their cots, unattended for long periods of time. Older children were not permitted to play in the grounds, nor were they allowed to have their own possessions. Matters had improved considerably, however, when this witness returned to the institution some three years later, after a new Matron had taken up duties. There were similar reports of Birralee that babies and children were left in cots, unstimulated, for long periods. Although, in theory, placement at Birralee was intended as a short-term option only, some children remained there for most of their childhood, becoming increasingly institutionalised.

In the larger, dormitory-style institutions some degree of impersonal treatment was to be expected. For the majority of children, this involved being treated as an unimportant member of a large group. For others, however, these feelings of insignificance were made all the more painful by more obvious disregard in the form of disparagement. Residents of Margaret Marr in the 1940s described the environment as lacking in emotional support, with boys frequently denigrated—one, for example, being given a derogatory nickname by the Superintendent and Matron. A later (1959) resident stated that the atmosphere at Margaret Marr was sterile and devoid of affection.

A former resident of Nazareth House recalled being told that bad girls ‘were gutter’ and would ‘always be gutter’, and that her left-handedness came from the Devil. Gutter imagery seems to have been a common form of denigration. A witness who had been at WR Black vividly recalled the Matron telling her:

*Your father didn’t even want you ... You’ll wind up in the gutter where you belong.*

In similar vein, a witness who had been at Alkira was repeatedly told:

*You don’t deserve what’s being done for you ... if we weren’t here you’d all be in the gutter now.*

### **Impairment of family relationships**

Many witnesses greatly resented the fact that they had not been allowed to maintain their relationships with siblings, particularly those of the opposite sex. One of the consequences of the single-sex dormitory system was that brothers and sisters were automatically separated.

*... we weren’t allowed to mix with each other or see each other ... I can’t swear I didn’t glance at them or see them accidentally some time or other. I can’t recollect, but I probably could have seen them, I don’t know ... I had no ... physical contact with them at all while I was at the orphanage—that wasn’t permitted, no. I should imagine we’d be punished because that was forbidden that there was any contact with any brothers or sisters at the orphanage.*

Where there was a further age-based division, siblings of the same sex who were a few years apart in age might also have little to do with one other. In most of the institutions under consideration here, there was little encouragement to maintain sibling relationships. The segregation of the sexes at St Vincent’s, for example, meant that boys saw girls only in school

and church, but were not, even then, allowed to communicate. Sisters and brothers might be permitted contact once a week for a very short period, although that depended on the Department and the Orphanage recognising the relationship. In one instance a witness had become aware through a comment by one of the nuns that he had a sister there, but the relationship was never formally acknowledged, much less promoted. Such a severing of the bonds between brothers and sisters had, in many instances, life-long damaging effects on the quality of their relationships.

In single-sex institutions, a similar distance between siblings was often maintained. Three sisters resident at Nazareth House in the 1950s recalled that the oldest was placed in the junior dormitory, whereas the two younger sisters were placed in the nursery. The youngest stated that she did not know who her sisters were for a long time. She was not specifically told not to communicate with her sisters, but felt it was an unspoken rule. She stated that the nuns kept them apart and, as often as they could, gave the girls different tasks. The middle sister recalls that there was no active encouragement for the children to do anything together, except when they received monthly visits from their family.<sup>36</sup> There is also evidence that in the 1950s and early 1960s the Presbyterian Committee on Homes and Hostels went as far as placing siblings in different institutions under its management. For brothers and sisters divided between Blackheath and WR Black, it was only while attending church or travelling to school that they were able to make contact.

The importance of maintaining contact with family outside the institution was also poorly recognised. Regulation 17 under the *SCA 1911* permitted visits from family to children in institutions upon presentation of an order from the Director or a district officer of the Department. However, visits were not permitted to be longer than an hour in duration, nor were they to occur more than once every four weeks. The 1966 Regulations permitted the governing authority of an institution to specify visiting times for parents or persons approved by the Director, although visits on other occasions could be authorised if they were considered reasonable and in the best interests of the child.

The 1966 Regulations, as can be seen, put considerable power in the hands of the institution, and a great deal depended on the attitude of those in charge towards the importance of family contact. A 1978 report to the administration of BoysTown drew attention to the prevailing view among staff that parental contact was to be regarded as a privilege, and that the refusal of contact was being used as an effective and appropriate means of punishment.<sup>37</sup> Family contact was to take place at the discretion of the Director of the institution, without departmental involvement. Visits were conducted on a monthly basis, but would be subject to 'satisfactory' behaviour on the part of the child. There appears to have been considerable reluctance to acknowledge any benefit in promoting children's relationships with their families, and a lack of appreciation for the role of departmental child care officers working to that end.<sup>38</sup>

Discouragement of parental contact was often the consequence of administrative expediency. For example, in the 1950s the administration of Blackheath introduced a policy whereby children were limited to only one stay with their parents outside of vacation time because more frequent visits were disrupting the routine of the Home.<sup>39</sup> At the request of the Committee on Homes and Hostels, the Department endorsed this change in practice by advising parents that they would be permitted to have custody of their children only once per year between vacations.<sup>40</sup> The isolated location of institutions such as Nazareth House, at Wynnum on the outskirts of Brisbane, and St Joseph's, at Neerkol, made it even more difficult for parents to maintain frequent contact with their children.

### **Work and recreation**

One of the consequences of low levels of funding and staffing was that many institutions relied on the labour of children to maintain their functioning. At St Vincent's, for example, children were put to work at an early age. The older girls provided domestic help, but the younger children nonetheless had their chores. A witness recalled his weekend work:

*Well, if you weren't making the beds or sweeping it or keeping it clean, scrubbing it, scrubbing the verandahs around the dormitory itself, making beds or tidying the beds. And that's the type of work that you would have to do. When it came to doing the cleaning and scrubbing, it wasn't a case for a broom, you'd have to get down on your hands and knees and scrub the floors on the verandahs, dormitories, recreation area, showers, change rooms and all of that. But that was your work ...*

Any spare time was spent teasing the fibre in coir mattresses, a task recalled without enthusiasm. Older girls looked after the babies and toddlers in the nursery. Some witnesses recalled being treated with cruelty by the older girls bathing them, sometimes being thrown into the deep baths or being held under water. Outings were virtually unknown and there were few toys for use by the children, although the home held a repository of toys to be brought out when visits by departmental inspectors were anticipated.

Five former residents of WR Black described carrying out chores which included scrubbing floors on their hands and knees, sweeping and cleaning toilets, raking the outside grounds, polishing, dusting and setting tables. One resident stated that when she was about 14 or 15 years of age (1954 or 1955) she was required to work all day doing the laundry and ironing. Her working hours were 6.00 am to 6.00 pm and she was paid 10 shillings a week.



**Photograph 5.11: Children washing the verandah, St Vincent's Orphanage—St Vincent's Orphanage Centenary Magazine**



**Photograph 5.12: St Vincent's verandah—(116 metres long) (1911)—Annual Report of the Inspector of Orphanages for the year 1910**

Some former residents complained that there was little opportunity or facility for play or recreation. It seems very few toys were made available for use by the children and little, if any, recreation was organised for their benefit. Four witnesses to the Inquiry described a doll's house that was kept in the attic. Three of these stated that the house was just for show and the fourth claimed that the residents were allowed to play with the dolls only when visitors were present. Four other residents were unable to recall any play activities being organised for the children. A former resident of Nazareth House described a 'pretend playroom':

*... and they had a rocking horse in there that we weren't allowed to touch. And on the floor they had—I remember a top that they had on the floor that I shared before, and it always fascinated me because of the colours; on the top it was green, blue, red and yellow, and it had the wooden handles that you play with, and the dolls were hanging up on hooks, or sitting up high on a cupboard, and they had a library of books in there for the children but we never could have them. No, we couldn't touch them. And it was just a pretend room. When they brought visitors in, and I don't know who the visitors were, we were too young to know who they were, but they'd bring them in and they'd open up the doors to this pretend playroom to show the visitors, and when the visitors went, you know, they'd close the doors again.*

Two former residents of Nazareth House in the late 1950s and early 1960s recalled spending most of their time working. One began work at the age of eight, working in the kitchen, waxing and polishing dormitories, and doing laundry duty. She emphasised that no help was received from outside the orphanage. Another resident from 1965 to 1969 stated that when she was 12 or 13 years of age she was placed in charge of approximately 25 children in the junior dormitory, attending to the children at night if the Sister normally on duty was unavailable. Each morning before school she was to get the children dressed, wash their faces, and then tidy the dormitory. On Saturday morning she spent between five and six hours cleaning the orphanage. In the afternoon she was expected to supervise the young children. Sunday was supposed to be her day off, yet she spent some of her time typing up records in the office. Another two residents from the early 1970s stated that they were often given two children at a time to supervise, with responsibility for their care from morning until night.

From its earliest establishment as a farm there were requests from the Salvation Army Home at Riverview for more 'boys suited to farm work' to be transferred from Westbrook. Clearly the question arises as to whether the boys were needed more for the operation of the institution than the Home was needed to care for them. Evidence suggests that the labour was arduous, with the boys being subjected to a fairly regimented work program. For example, in the 1960s some boys were rising as early as 4.45 am to work in the dairy.<sup>41</sup>

The Salvation Army in response<sup>42</sup> has cited the following extract from a 1974 submission by teachers at Riverview to the State Government Inquiry into Youth as reflective of the boys' occupations, at least at that time:

*Boys are placed on each job according to their preferences and/or ability and/or attitudes and behaviour. Due to staff shortages, boys cannot be supervised at all times. Observed failure to work or misbehaviour may incur penalties such as the loss of pay or loss of (getting out) points. Not all boys experience each job field. A Job Change parade occurs every month, however day-to-day running and boys' preferences are given first consideration, and changes do not necessarily occur. Until recently, woodwork and metalwork sections functioned in which the staff employed there tried to provide training in those areas. These operations have been done away with and the sections are no longer staffed. In all, the work focus of the institution is on its own internal running. Any work experience outside of these fields remains a collection of simplified maintenance tasks performed with little actual training or supervision.*

*During the day the boys spend any free time in the recreation area. Records and radio may be listened to from the loudspeakers. Television may be watched or games may be played. A trampoline is available.*

*All boys are paid up to 20c a day with dairy rate being 25c. Boys are paid 3c a pallet, which is shared at the end of the week. All money earned or received is placed in trust. Indeed, the money earnt was used on leave or when canteen was held, enabling the boys to purchase lollies, drinks, chips, etc.*

A revealing aspect of this passage is the acknowledgement that the work was centred on the institution's needs, rather than those of the boys it housed.



*Photograph 5.13: Riverview volleyball net and trampoline (1971)—Courtesy Queensland Newspapers*

### Education

Section 37 of the *SCA 1911* required that children between five and 14 years of age be sent to a State school or other school approved by the Director. Regulation 9 made under that Act required that school-aged children in institutions be given 'secular instruction in accordance with the syllabus of work required by the Department of Public Instruction in State schools', that is, a standard education. Section 40 of the *CSA 1965* required the person in charge of an institution to secure for each child 'adequate education ... of such a type and form as is approved by the Director or, in the absence of such an approval, as is in the best interests of such child'.

One of the strongest impressions gained from evidence to the Inquiry was the poor quality of education received by many of the witnesses. They commonly complained that they were not encouraged to acquire a sound education, nor were they provided with the opportunity to do so. Children who fell behind in their lessons were left to their own devices, and as a result many were illiterate, or close to it, despite having spent their childhoods in the care of the State. Others who had, in their adult lives, displayed significant ability, had not been able to achieve any higher level than Scholarship. That limitation on their education was one of the most profound and enduring losses suffered by former residents:

*Because we had no education, I lied my way into jobs I wasn't qualified for and learnt everything I could; crammed everything, start all over again till they realised I couldn't do what I said I could and at the age of 46 I became a qualified chef. Imagine what an education would have done for me.*

Some institutions themselves provided education to primary school level. For example, St Vincent's maintained its own primary school but does not appear to have offered an environment conducive to learning. Discipline within the school was very strict. Children were caned for making mistakes, or alternatively made to wear a dunce's cap. One teacher was described by a number of the witnesses as being particularly given to beating children across the back or legs for their inability to answer questions correctly. One witness's comment probably reflects the more general experience: he believed that he was 'getting

battered to learn', and found it difficult to think for fear of the punishment should he answer wrongly.



*Photograph 5.14: School assembly at St Vincent's (1957)—Courtesy Mercy Family Services*

Most of the younger children at Nazareth House were educated on the premises by one of the nuns. A former resident recalled that students were not given any individual attention and were left to 'sink or swim'. She said that she was often required to sit at the front of the school wearing a dunce's hat. In 1974 a child care officer criticised the policy of educating the young children at the institution, observing that children under the age of eight or nine were being denied the opportunity to broaden their experiences in a normal school setting. He also noted that children were not permitted to attend an Opportunity School, although some, in his view, were in need of remedial attention. It appears, however, that from 1975 this situation was remedied; all children attended local schools, including an Opportunity School.



*Photograph 5.15: Nazareth House with school area in background (1999)—Inquiry photograph*

Similarly, boys at Riverview received little education. A full-time teacher was employed by the Salvation Army in May 1971, but it does not appear that he was in a position to offer full-time education to all of the residents. A newspaper article from July 1971 noted that boys received less than two hours' schooling per day.<sup>43</sup> It went on to identify funding constraints as an issue:



*A school which has six illiterate students and forty others who are severely retarded has been refused Federal and State education assistance because it does not give full-time schooling.*

A few years later the Education Department established a school, but its administration had ongoing problems with the Salvation Army personnel, who did not appear committed to the education of the boys. In an article published in the *Sunday Mail* in 1973, the Superintendent at Riverview indicated the low priority he gave to the formal education of the boys in his charge: 'We dare not emphasise education here. Most of the boys will eventually be employed in labouring jobs.'<sup>44</sup> Indeed, a number of school-age boys did not attend school during 1974 because the Salvation Army was using them for construction of a proposed residential development. One of the boys complained of having to cart stones out of a paddock all day.<sup>45</sup>

By 1973 a serious rift had developed between the school Principal and the Superintendent of Riverview. For the Superintendent, school would always come second to the running of the farm and the discipline of the boys. Although Riverview had a population of up to 60 boys between the ages of 13 and 17, the school enrolment was as low as 36. New arrivals were never shown the school as part of the institution and boys were sent to school only at the discretion of the Superintendent.<sup>46</sup>

Relations between the school staff and Riverview management did not improve and in 1976 the main teacher at the school resigned. In March 1976 the school at Riverview was officially closed.<sup>47</sup>

The acting Director of Special Education stated that the reasons for the school's eventual closure were:

*... that the boys were constantly moved in and out of the institution by the Department [of Children's Services]; that boys were forced to undergo punishment and chores during school hours and were not available for schooling; and that they turned up to school in their farm clothing and their personal hygiene was often unacceptable.*<sup>48</sup>



*Photograph 5.16: Riverview School (Salvation Army) (1971)—Courtesy Queensland Newspapers*

Children sent to external schools did not always fare much better. Former residents of Margaret Marr in the 1940s and 1950s claimed that they had been discouraged from sitting the Scholarship examination. Another resident of the 1940s, whose ambition was to become a carpenter, stated that he was deliberately prevented from achieving his vocational goal. Despite having satisfied the entry requirements for high school, he was told by the Matron that he 'didn't have the brains to be a carpenter' and he was eventually sent to work on a dairy

farm. Three former residents of WR Black felt that their access to formal education had been limited in that they had only completed school to Grades 7 or 8.

Witnesses from State-run institutions also complained of limits placed on their education. A resident of Warilda in the first half of the 1960s said that she was obliged to leave both the institution and the school on her sixteenth birthday in order to take up employment, although she had wanted to finish her schooling. Similarly, a witness who had been at Carramar at much the same time had been made, against her wishes, to take a commercial stream in secondary school. Her subsequent academic achievements would certainly suggest that she had been more than capable of pursuing an academic stream. One of the difficulties of pursuing an education within the government facilities, which would appear equally applicable to the church-run homes, was the lack of time and experience on the part of staff when it came to encouraging and assisting children with their homework. There was little opportunity for one-on-one help, leading to neglect of the homework requirements of less motivated or less able children. This problem may well have been compounded by the lower expectations of the performance of 'Home kids' on the part of school authorities.

It also appears that at some institutions, administrators failed to take the precaution of dividing their children between a number of schools in order to reduce the chance of their being labelled as 'Home kids'. The boys at Alkira, for example, were sent to either a local State school or an Opportunity School. One former resident from the 1950s and 1960s explained that whenever anything went missing at the school the 'Home boys' were the immediate suspects. The feeling of being set apart was exacerbated by the rule, imposed by the Salvation Army officers, that the boys were not allowed any contact with the girls at their school. According to this witness, any boy found by the officers at the Home to have talked to a girl during the school lunch break could expect to be punished. In the 1970s a greater effort was made to disperse the boys among the local schools. Nevertheless, a visiting child care officer in 1978 noted that the stigma attached to being a 'Home boy' sometimes made it difficult for the boys at Alkira to develop friendships at school.<sup>49</sup>

Feelings of stigmatisation were also felt by a number of former residents of Silky Oaks, Nazareth House, Enoggera Boys' Home and Blackheath. Until its closure in 1963, the boys at Blackheath attended a single state school. In March 1955 the situation had become so bad that the Superintendent asked the Department for permission to transfer the children from the school *en masse* as they were being denigrated and punished excessively by two of the teachers there—one of them the Head Teacher. The matter was eventually resolved by discussion.<sup>50</sup> Former residents of Nazareth House also described discrimination against them from fellow students at the primary school they attended during the 1960s. One stated that the nuns made it clear to the student body that the orphanage children were receiving their education free of charge. There was no provision for the Nazareth children to participate in any extracurricular activities with costs attached. At Horton House and Carramar, it was the type of clothes worn by the residents that made them easily identifiable as 'Home kids'. Carramar children wore a gingham dress instead of the regulation State school uniform. Similarly, the girls from Horton wore box-pleated tunics and white blouses provided by the institution rather than the regulation blue-and-white checked dresses of the State school they attended.<sup>51</sup> In relation to the Horton children, the Salvation Army has asserted that it did its best, given its funding constraints, to provide suitable clothes for the children.



**Photograph 5.17: The Enoggera Boys' Home, operated by the Anglican Church—Inquiry photograph**

Not only did institutionalised children lack, in many instances, an adequate formal education, but they were given no sex education or training in life skills. At St Vincent's, girls were not told about menstruation, and neither boys nor girls were given even the most basic information about sex or reproduction. Children left St Vincent's with no idea how to tell the time or read a timetable, let alone how to manage a budget. In a similar vein, a former departmental officer recalled a girl who had been at Birralea for most of her life. On a railway trip to Brisbane with her he gave her money to buy a pie from the dining car. After half an hour's delay he went to look for her, and discovered that, although an intelligent 13-year-old, she had no idea how to make the purchase.

The institutional experience was even more debilitating for residents who were prevented from engaging in some form of community contact. Adolescents and teenagers at St Vincent's up to the mid-1950s had very little opportunity for contact with the outside world. Many, particularly girls, went straight from primary school at St Vincent's to work within the Orphanage, giving them almost no opportunity to develop social skills. As late as 1978, a child care officer visiting Alkira observed that only four out of 20 boys were involved in activities outside the home. Many of these boys had no contact with their parents, and the only time they left the institution was to attend school. To remedy this situation, the child care officer suggested that the boys be allowed to become involved in a local YMCA.<sup>52</sup>

There was similar criticism of the administration of Horton House in the late 1970s for its failure to improve and increase interaction with the local community. In May 1978, a senior departmental officer commented on the negative effects of the isolated regime: 'Numbers of the children who have been at Horton Village for any length of time are suffering from social deprivation and institutionalisation.'<sup>53</sup> These negative effects became most apparent when wards who had been in the care of the State for many years were ultimately released from care.

*They [the staff] taught us how to sing and perform but they didn't teach us how to live. And when the Vietnam veterans came back after—they talk about not having any form of therapy to come back into the outside world. Well, they just kicked us. When Mum came and got me out of there, it was like—so foreign, you know? I'd been in this one room for so long doing dishes. There was no preparation, and everybody laughed at us, you know? Everybody laughed at us.*

A former resident of BoysTown in the 1970s complained that, despite its excellent facilities, the institution failed him miserably when it came to preparing him for life. His testimony is partially supported by a 1978 report on the institution that pays particular attention to the lack

of community integration on an individual basis, and the inadequate preparation for discharge.<sup>54</sup>

### **Protection of children and response to complaints of sexual abuse**

Complaints of sexual abuse—by other residents, by staff, by visitors to the institution, or by individuals to whom children were sent on holiday placements—emerged in almost all of the institutions under consideration.

*... we had a lady called [name] who used to take us for holidays ... for seven weeks. Well, she used to—she used to pull the blankets back and pull [sister] and I down the end of the bed and take our pants off and—interfere with us down below ... If we didn't like it or if we dared scream then she used to have her sister that wasn't all there that used to stare in the glass window at us ... and when we finally left ... and we'd go back to tell the nuns they used to tell, tell us that we were telling lies and they used to slap us more for it—thought we were making it up.*

In some cases the alleged perpetrator had already been charged, and in a small number of cases had already been dealt with. In many instances, the alleged perpetrators were long dead or could not be clearly identified. Although many accounts given to the Inquiry were compelling in the extreme, it was not possible for the Inquiry to come to any concluded view in those cases where there was an absence of either supporting evidence or an individual to defend the charges. For example, four male witnesses from one institution gave evidence of sexual assault, ranging from fellatio to penetration, by the Home's manager. Their accounts were credible and consistent, leaving the Inquiry with the view that there is a high probability that the events occurred as described. The individual in question is dead, never having had occasion to respond to the allegations. There was no corroborative evidence, and the time lapse since the events is approximately 40 years. For all of these reasons the Inquiry is not prepared to make any finding that would identify the manager or the institution involved. Those circumstances were not unique; there were a number of witnesses who gave accounts of sexual abuse which the Inquiry regarded as believable, but had no means of independently confirming.

In other instances, where a living individual could be identified and the complainant was available as a witness, the Inquiry was able to be satisfied that there was at least sufficient evidence to refer the matter to the Queensland Police Service for investigation, and some individuals have already been charged. The matters for referral are detailed in a closed section of the report to avoid prejudice to both the individuals concerned and to any future prosecutions. What has emerged very strongly from evidence to the Inquiry is that there was a failure to recognise the risk of abuse to children, a failure to treat children with sufficient respect to ensure their feeling able to complain, and a failure to give complaints sufficient credence. The last permeated most of the institutions under consideration here. Those who did complain were not believed by workers, priests or police. The following response to a report of sexual abuse is typical of what was described:

*I told Mr P and all Mr P did was backhand me across the mouth. He said 'Where would you be if it wasn't for the priests and the nuns? How dare you talk about the priests and the nuns like that?'*

Two particular cases that came to light are illustrative. The Inquiry heard evidence, which it accepts, from a witness, M, resident at St Vincent's from infancy. He told of being sexually abused at the age of 11 or 12 years by Father Errol Stanaway, the resident Chaplain at the Orphanage between 1959 and 1963. M had been working in the garden at the priest's cottage when he was told to come into the house to be punished for damaging a plant. What followed was the first of a number of attempts to sodomise the boy, in addition to forced masturbation or fellatio of the priest. This occurred approximately 14 times over a two and a half year period. There was no tenderness extended to M during this activity and his compliance was secured unwillingly under the threat of being sent to Westbrook. Ultimately the priest's advances culminated in successful anal penetration while the boy was tied to Stanaway's bed. The boy's anus was injured in the encounter, which was noticed by a visiting nun who saw

him while he was attempting to wash the blood away. M was taken to the infirmary and on his return to the Orphanage the Mother Superior questioned him as to who had caused the injury. According to M, upon being told of the perpetrator, she reacted angrily and with disbelief and had him beaten for lying.

Unfortunately, the Mother Superior is not alive to give her account of events. What does emerge from this witness's evidence and from other sources, however, is that there were at least three other children who had similar experiences with Father Stanaway; all have been greatly affected into adult life.

The failure of the Sisters at St Vincent's to recognise the risk that Father Stanaway posed is of significant concern. Eventually, however, the priest's activities came to light through the Sister in charge of the big boys' dormitory. She became suspicious of the priest and after questioning some of the boys about his activities relayed her concerns to Sister G who was Acting Superior at the Orphanage. The latter, on hearing the boys' accounts, contacted the Mother General of the Mercy Order, and a meeting was hastily arranged at the Orphanage between a representative of the Archdiocese, the Mother General, another senior nun and Sister G to discuss the matter. Sister G outlined what was known about Father Stanaway's sexual abuse of the boys. The result was that Father Stanaway was removed from St Vincent's and admitted to Mt Olivet Hospital.

The placement of Father Stanaway as Chaplain at St Vincent's in the first instance warrants particular comment. Information about him has been obtained from a number of sources including the archives of the Archdiocese of Brisbane and the recollections of Sister G, who had the task of ministering to his health needs while he was at St Vincent's. During the early 1950s he had been parish priest at St Ita's, Dutton Park. It is clear from archival correspondence that he had been a continuing problem to the Archdiocese, although particular complaints against him are not recorded. A letter from Stanaway to James Duhig, then Archbishop of Brisbane, dated 1 May 1954, complains of unfounded charges against him centring on 'charges of spiritual neglect, financial dishonesty, drug addiction, forgery, even sodomy'. Although the precise allegations against him are not known, it is clear that in 1952 he was relieved of his position as parish priest and permitted to stay on there as assistant priest. Even that arrangement proved unsatisfactory, and he was ordered to leave St Ita's Presbytery in 1954. From there, it appears that he spent a considerable period living in convalescent homes and being treated intermittently for his health complaints.

A letter written in 1959 by Archbishop Duhig to Mother Liam, Superior of St Vincent's, asks her to cooperate in allowing Father Stanaway to take up the 'light work' of chaplaincy at the Orphanage. There is then a gap in the correspondence available in archival records with the next, and last, letter being dated 25 October 1963. This is from Archbishop Duhig to Father Stanaway and advises that arrangements have been made for him to go to Mt Olivet because of his 'health and general condition'.

What happened in the intervening period emerges from Sister G's account of what took place at the meeting already referred to. The Archdiocese was represented by Monsignor Moloney, Archbishop Duhig being at that time absent from the Diocese. Sister G recounted what was known of Father Stanaway's sexual activities. Her evidence of Monsignor Moloney's response was that he had said to the Mother-General 'Well, of course, Mother, we knew that about Father Stanaway when we sent him down here.' Father Stanaway was then moved to Mt Olivet, but this is reflected on his personnel file only by the letter already referred to which ascribes the transfer to a concern about his health.

The conclusion that the Inquiry draws is that, in the placement of Father Stanaway at St Vincent's, the Church acted with complete disregard for the interests of the children of St Vincent's.

Another serious complaint to the Inquiry, and one which has been substantiated by the guilty plea of the individual concerned, was that at least two former residents of Silky Oaks were

sexually abused by Edwin Smith in the 1960s. Smith had been employed at the Home from 1959, initially as a handyman and later as the person in charge of the boys' dormitory while retaining his maintenance duties. The boys were compelled to perform acts of masturbation on him, with Smith performing similar acts on them. One boy was 10 when this abuse began, and he was repeatedly subjected to such acts over the next five years.

Criminal charges were laid against Smith in 1995. He pleaded guilty in the District Court on two separate occasions to a series of counts involving former Silky Oaks residents, and was ultimately sentenced to a term of imprisonment. Further counts alleging sexual offences involving three other former residents were stayed upon application to the District Court by his legal representatives.



*Photograph 5.18: Silky Oaks Haven for Children, operated by Open Brethren Church—Inquiry photograph*

The events concerning Smith raise a number of issues about the standard of care provided for children at Silky Oaks between 1960 and 1965. First is the question of how a person such as Smith could have been placed in a position of responsibility and trust with unlimited opportunity for abuse of the children under his control. Not only was he in charge of the daily living arrangements for the children, with access to them as they bathed, dressed and slept, but he was able to assign chores to them and engineer situations in which he could be alone with particular children. Smith's only qualification for the role appears to have been his membership of the Open Brethren.

It must also be asked how the abuse of at least two children remained undetected for so long. A witness who was one of the children abused outlined a number of factors militating against disclosure of the abuse, and indeed some of those factors would seem relevant to the readiness of any of the children at the Home to make a complaint of any kind against a staff member. Those factors arise, in the main, out of the fact that Silky Oaks was staffed and governed by members of the Open Brethren Church. This witness described a perception among the children that, because the Council was made up of Church members, many of whom were related, any complaint against Smith, a fellow Church member, was unlikely to be favourably received or, even if believed, effectively dealt with. There was also his fear that disclosure of the sexual activity with Smith would result in the information becoming general knowledge among the congregation of the Church. He feared personal rejection, particularly by the Superintendent and his wife, if details of the sexual acts became known. He was reluctant to complain to social workers from the State Children Department who visited the home because, he said, any complaint to them would be immediately made known to the Superintendent and his wife.

The Council of Silky Oaks Children's Haven has pointed out that as soon as a complaint was received from a child resident at the orphanage of sexual abuse by Smith, the latter was dismissed. However, what clearly emerges from this evidence is that those administering Silky Oaks at the time appeared to not fully appreciate the risks involved in placing individuals in positions of power over children without any mechanism in place to monitor their conduct towards the children in their care. They failed to create at Silky Oaks an environment that was conducive to the disclosure of abuse. The consequence for the victims who spoke to the Inquiry has been profound and lasting emotional damage, with a long-term effect on their self-esteem, their capacity to sustain close relationships and, more generally, their ability to lead normal adult lives.

The circumstances giving rise to sexual abuse at Silky Oaks and St Vincent's were by no means unique to those institutions. There is, plainly, always some risk of abuse in circumstances where children are in the power of adults, but the level of that risk varied from institution to institution. In some instances a dangerous naiveté led to adults being given access to children whom they then abused; in other cases an individual (usually, but not always, male) with power in the hierarchy used his position to exploit children in his care. In some institutions children were at risk of sexual assault from other children. At St Vincent's, older boys were allowed to stay on as employees at the Orphanage after they had reached working age. They were, it appears, largely given the run of the Home, with little or no control exercised over their contact with the other boys. Complaints of sexual assault by one such individual were received, and it can certainly be said that this practice exposed the younger children to, at the least, the risk of abuse. Similar risks went unrecognised or were not acted upon elsewhere. A witness who had been at Warilda at the age of eight in the early 1970s described being 'stood over' by an older girl to perform sexual acts under threat of bashing if she did not comply. She was too fearful to report the situation to anyone.



**Photograph 5.19: Warilda Children's Home at Woolloowin, operated by the Queensland Government—Inquiry photograph**

There were also reports of sexual abuse between residents at Riverview. One former resident from the early 1970s told the Inquiry that older boys would sexually assault younger boys. In November 1973 a senior child care officer wrote a number of reports on Riverview, raising concerns about homosexual activities. One report stated the belief that:

*The physical conditions at Riverview, the staff situation, the program for boys and the symptom of discontent amongst the boys contributed to abscondings and homosexual assaults.<sup>55</sup>*

He went on:

*There are, in fact, two or three known incidents of outright rape including a very bad incident two or three months ago. This usually happens with a big boy standing over a younger, smaller and more immature boy. Again, the only answer seems to be the provision of adequate staff supervision coupled with an on-going educational programme for the boys.*<sup>56</sup>

Discussing homosexual activity between boys, the senior child care officer stated:

*As far as homosexuality is concerned, it seems that about 50 per cent of the boys are known to have actively taken part in homosexual activity while at Riverview.*<sup>57</sup>

These issues were highlighted when the Department considered sending boys from Westbrook to Riverview. A memorandum in 1973 suggested that:

*There are real worries and real dangers about sending any boys there. The lack of adequate and suitable staff, the danger of rape and other homosexual assaults and the shambles that this whole place looks causes obvious problems. Practically every boy that [sic] has been placed at Riverview lately, and certainly everyone that has been placed there from Westbrook, has absconded in short time.*<sup>58</sup>

In another report relating to a proposed redevelopment of their program at 'Mulgowie', a farm near Laidley, the senior child care officer voiced specific concerns about the lack of safety for boys at Riverview. This was due in his opinion to poor staff-boy ratios as well as the employment of inappropriate staff. He stated:

*The current absconding rate and the incidence of homosexual assault including straight out rape and stand-over tactics will be repeated at Mulgowie unless the staff-boy ratio is improved and a generally more competent staff is employed.*<sup>59</sup>

In December 1973 the Director of the Department wrote to a senior Salvation Army officer noting that a number of 'serious incidents of homosexual assaults' had taken place between boys at Riverview. One of these was on a boy from Alkira visiting his brother on the weekend. Following this, the Director suggested 'that numbers at Riverview be reduced to 30 and that no "new boys" under the age of 14½ be admitted to Riverview'.<sup>60</sup> Similar concerns about homosexual assault were also raised by teachers at the institution in a report handed to the Education Department.<sup>61</sup>

#### **5.4 STAFFING AND FUNDING ISSUES**

The point has already been made as to the inappropriateness of Mr Smith's employment in a position of responsibility at Silky Oaks. The issue is important in understanding how abuse came to occur at a number of institutions, and cannot, as has been pointed out in a submission to the Inquiry by the Council of Silky Oaks' Children's Haven, be divorced from the question of funding. During the 1950s and early 1960s, when Silky Oaks was being run as a dormitory-style facility, staff were unqualified, lowly paid, and drawn largely from the congregation of the Open Brethren. One witness described some of the workers as 'nearly as needy as the children', explaining that they had often been institutionalised and were in need of comfort and reassurance themselves. As the submission explains, the home was run, as were other church-run institutions, as a voluntary organisation. Until the late 1950s it received no government funding for building, and, until the early 1970s, no contribution to staffing costs. Consequently, staff received no more than board and pocket money, with the introduction in the 1970s of a bare minimum wage, which as late as 1994 was only \$14,000 per annum for a 6-day working week. The church was therefore reliant on volunteers prepared to work long hours for minimal remuneration. Such volunteers were usually drawn from the ranks of the church, and were apparently motivated by religious commitment.





**Photograph 5.20: These five nuns spent, between them, over 200 years at St Vincent's—St Vincent's Orphanage Centenary Magazine**

The Sisters of Mercy at St Vincent's Orphanage at Nudgee were not only untrained but had, in many cases, followed their vocation from Ireland, where living conditions were tougher than those generally experienced in Australia. They tended to be young, inexperienced women accustomed to the rigorous discipline of living under a Rule. The strictness that lay at the centre of their practice as nuns may have carried over into their ministrations to the children, although in fairness it must also be said that a number of witnesses remembered particular nuns who had shown them great kindness. Some may have been recruited too young; some were as young as 15 when they arrived in Australia, and others may not have had a temperament suited to dealing with children in need of care. Very few had ever seen an orphanage, let alone worked in one.<sup>62</sup>

*I didn't know what an orphanage was, never seen one ... None of us had training in child development as we understand it today ... there wasn't much of it around at the time ... There were no psychologists around, we didn't understand psychology. I went racing around gobbling up books from anyone who would talk to me about it because I had no idea what to do, no idea at all.*

Another important factor is that, prior to the mid-1960s, the need for support and individual attention for children who had experienced family upheaval was not well recognised, nor was there any general perception that dealing with children required training of any kind. The Sisters on staff at St Vincent's were largely untrained in childcare work until the late 1960s—a situation common throughout the child welfare sector prior to that date. The lack of specialist training in child care and adequate resources, as reflected in low staffing levels, militated against providing a loving and caring environment for individual children within the orphanage system.

*I remember walking into the little girls' dormitory one night and stopped to speak to one, or someone had been sick or something and I stopped at one bed. The next thing I knew I had 60 little girls on top of me and that was the tragedy of the place. I just said to someone else at the time 'My God, where are their mothers?' You know, these little girls were starved so if you touched one they were all on for a hug, you know, you couldn't hug 60 a night, one person.*

Even with an increase in the professional training available to childcare workers in the 1960s and 1970s, financial constraints meant that problems of inappropriate staffing did not disappear. By this stage there was a move in residential facilities to smaller units and employment of houseparents. Finding suitable houseparents was a perennial problem. A submission on behalf of the Anglican Archdiocese of Brisbane in respect of Enoggera Boys' Home notes a procession of employees through the Home in the 1970s. In that decade there

were three different Superintendents, and 14 different married couples employed as houseparents at the Home over a period of eight years. Nine couples left before their year of tenure had expired:

*Generally, they were unsuited to the position. Expectations of doing good by caring for 'poor lonely boys' were dashed after a few months.*<sup>63</sup>



*Photograph 5.21: Enoggera Boys' Home dormitory, operated by the Anglican Church—Inquiry photograph*

At Horton House in the late 1970s the administration was equally hindered by the unavailability of houseparents of suitable disposition, and the absence of appropriate training for them once selected. Departmental files indicate that behavioural management skills were lacking, with a reliance on corporal punishment to discipline the children.<sup>64</sup> Although it was not, so far as the Department was able to establish, extreme, it was administered in disregard of the fact that the Children's Services Regulations prohibited such punishment for girls.<sup>65</sup> The punishment register required by the Regulations was not always properly kept.<sup>66</sup> Alkira similarly was encountering difficulties with its houseparents: in 1978 complaints were made to the Department of one couple's excessive use of punishments within weeks of their arrival.<sup>67</sup> After numerous such incidents had been reported, one of the houseparents was counselled by a child care officer and a senior member of the Salvation Army. Apparently, this had little effect and it was recommended by the Department that the houseparents be dismissed. The Salvation Army hierarchy ultimately dispensed with their services.<sup>68</sup> Problems with houseparents were to continue, however, and in 1980 another couple was reported to have been slapping boys across the face, kicking them and physically dragging them from room to room.<sup>69</sup>

At St Vincent's, too, the houseparents appear to have been of variable quality. Some were described as caring, helpful people; others were clearly unsuitable to look after children— particularly difficult adolescents. Witnesses complained of both physical and sexual abuse from houseparents. On the whole (although not without exception) it seems that complaints of abuse were acted upon, leading to, in some instances, criminal charges being laid and/or the removal of the offending houseparents. It appears, however, that in some instances children did not have sufficient confidence in the hierarchy to report abuse. The unfortunate situation of adolescents, whose behaviour was at times difficult, being responded to with violence by houseparents seems to have been replicated in a number of institutions.

Chronic under-funding of the institutions was also reflected in staff-child ratios that were inconsistent with proper care—a problem common to many institutions. At Alkira, houseparents (usually a married couple) were responsible for approximately 24 children per couple. The male houseparent generally held outside employment, so the wife might find

herself responsible for managing 24 boys on their return from school. At best, even assuming a 12:1 ratio, it was not possible to provide a caring, nurturing environment with individualised attention to each child. When Blackheath closed in 1963, and its residents were transferred to WR Black, the Matron at the latter institution found herself in difficulties. A departmental officer reported that:

*The combining of these two homes with some 60 children presents in my opinion a real problem requiring a large staff under a Matron of long experience and strong personality ... The new Matron is attempting to cope with it with few untrained staff and not a very effectual personality.*<sup>70</sup>

Fortunately, the Presbyterian Church quickly developed a scheme to establish family group homes in various suburbs. Within two years, children from WR Black were transferred to the new family group homes or to temporary foster homes. In May 1965 only 12 children remained at the home and some of these were soon to be moved to a newly completed home at Aspley.

It appears that the Department had many reservations during the 1970s regarding the standard of care provided at Riverview. Staff numbers were relatively low and many of the Salvation Army staff were deemed to be inappropriate and unsuitable to be in a caring role.<sup>71</sup> At night and on weekends, three men supervised up to 60 boys. Such low staffing levels must have meant that the main function of staff was controlling the children rather than caring for them.

Staff appear to have been overworked and without sufficient time off work. The poor staff-child ratio meant that older boys were employed as de facto staff to supervise other boys.<sup>72</sup> One of these boys was responsible for 'night duty', which required him to remain awake and alert between 11.00 pm and 7.00 am.<sup>73</sup> In 1975 it appears to have been common practice at Riverview for certain boys to be given authority over younger boys. Some young men over 18 were employed as a type of 'junior officer' at the institution. One child care officer reported a particular staff member standing by while bigger boys punched and hit smaller boys, 'thus covertly, if not actively, encouraging aggressive behaviour'.<sup>74</sup>

Another departmental report on Riverview in 1973 commented adversely on the conditions endured by both the staff and the inmates:

*In the child care area, then, the institution is very much understaffed and even if it was up to the establishment [i.e. approved staffing numbers] it would still be under when measured on minimal child care standards. Conditions for staff are poor, provisions for time off and other basic entitlements are unsatisfactory and wages paid are low which, of course, is reflected in the calibre of at least some of the staff employed.*<sup>75</sup>

## **5.5 CHANGES IN THE LARGE-SCALE RESIDENTIAL FACILITIES**

The years from 1960 to 1980 saw dramatic changes in the size and structure of residential facilities. The experience of St Vincent's bears examination, because it was in the vanguard of that change. It already had, in the mid-1950s, the good fortune to have a progressive Superior, Mother Liam, who had done a good deal to transform an essentially Dickensian institution. Other examples that came to the Inquiry's attention were predominantly of the dominance of powerful personalities to negative effect, but hers is an example of the positive impact a strong individual could have on the culture of an institution. Her arrival marked, by all accounts, a real move from management based on the interests of the institution to management based on the interests of individual children. All witnesses who spoke of her, whether their experiences of the Orphanage had been happy or bitter, regarded her as a positive influence.



*Photograph 5.22: St Vincent's enormous dining tables seated 400 children—St Vincent's Orphanage Centenary Magazine*

Regardless of the shortage of funds, Mother Liam set about making the Orphanage a more pleasant environment. Buildings were cleaned and painted. Partitions were used to break up the dormitories into four-bed areas instead of the existing rows of 50 or so beds. New quilts, bedding, mosquito nets and towels were purchased. Children were given toothpaste and toothbrushes and taught how to use them. The enormous dining tables and form seats in the refectory were disposed of and replaced by small tables with chairs. For the first time eating arrangements bore some resemblance to those in an ordinary family home. Children ate from china plates and used china cups and saucers. Condiments such as salt and pepper were placed on the tables. The food improved and was more attractively presented, with more fruit, vegetables and meat being served. A commercial-style kitchen was installed, with a dishwasher, putting an end to the old unsanitary practice of children washing up in large troughs.

Under Mother Liam, the Sisters worked hard at introducing the children to the outside world. Families were found to take them on holiday and weekend placements. In some instances there was evidence that the children had been exposed to abuse in such placements, and certainly it is clear that the nuns had little experience or capacity to screen potential receiving families. Others, however, recalled the times spent with their holiday family as positive experiences, with one man describing the affectionate relationship with his holiday family that has to date lasted for 40 years.

Since children went more often on outings and picnics, boys who had left school and had obtained employment were given pocket money, enabling monthly outings to the local swimming pool or to the pictures. Films were, very occasionally, brought in and shown at the Orphanage, and the range of activities available to the children increased dramatically. Coaches were brought in for boxing, football and hockey, while choir teachers and ballet teachers gave lessons to the girls.

For the first time some attention was paid to the need for the girls and young women to have a social life. Mother Liam encouraged organisations for young Catholics to come to the home in order to foster the making of outside friendships, and dances were held. She took a large step in this process of de-institutionalisation by allowing the girls to select material from bolts of material she had bought, to be made up by a dressmaker in designs of their choice. For the first time they could wear attractive clothes of their own choosing to dances and holiday placements, instead of the ugly, uniform garb which had previously marked them out as Orphanage girls.

The more difficult staff were gradually removed over time. A young nursing nun from the Mater Hospital replaced the elderly, irritable Sister previously in charge of the pharmacy. The process of change was not immediate or complete; children were still being beaten in the classroom, but the nun responsible was eventually moved after some of the girls plucked up the courage to complain to Mother Liam. A special education section was introduced to teach those children (mainly boys) with no basic numeracy and literacy skills. Children ran away less because, said one witness:

*When Mother Liam came it was a place that people could call home, kids stopped running away—there wasn't a reason to run away.*

The 1960s was a decade of significant change in the way St Vincent's was administered. It became something of a groundbreaker in both its policy and practice; it was in the vanguard of the move away from mass institutionalisation of children in Queensland. There was a move towards lowering the number of children in the institution and encouraging integration into the community. Important advances were made in education; an Opportunity School was established for intellectually disabled children in 1966, and in the late 1960s for the first time children began to be sent to outside schools. The selection of appropriate schools was undertaken carefully, with a view to avoiding clusters of St Vincent's children at any one school, thus preventing the stigma that has traditionally attached to Orphanage children.



**Photograph 5.23: The Sisters from Nudgee established their first family group home, 'Loreto', at Kangaroo Point (1964)—St Vincent's Orphanage Centenary Magazine**

In 1964 the first experiment with a family group home took place. A house capable of housing five children was purchased at Kangaroo Point. Meanwhile an admission policy was developed, replacing the previous ad hoc arrangement under which children whom the State Children Department sought to place would be accepted regardless of the Orphanage's capacity to cater for them. The admission policy (initially administered through the Catholic Family Welfare Bureau) entailed focusing on those children whom it was considered could be offered adequate care. Children with disabilities were no longer taken, and children under five were not accepted unless they were part of a family being admitted. At first the Orphanage also declined to accept children over 14, although later a program for 'disturbed' adolescents was set up. The existing population of the Orphanage was altered, with the older boys and men at risk of sexually abusing the younger boys being moved out. As a consequence of the changes begun in the mid-1960s, numbers at the Orphanage declined from 253 in 1967 to 61 in 1976.

The Orphanage employed its first social worker in 1969 (relatively soon after degree studies became available in the discipline). Soon after, a Social Work Unit with two social workers and a psychologist was established. The part-time services of a psychiatrist were also

available. Foster parent placements continued and in the late 1970s St Vincent's was able to set up its own foster parent program. The purchase of more family group homes took place through the 1970s with the purchase of houses at Wavell Heights, Ascot and Bracken Ridge. A family group home complex was built at Nudgee itself and opened in 1970.

When the shift to smaller facilities took place in the late 1960s and 1970s, the problems associated with large institutions promised to be a thing of the past. However, not every denomination was able to implement the new policy. At Horton House, for example, there was a concern in the late 1970s that the reorganisation of the institution into cottage homes had not been entirely successful, and that the home was continuing to operate as an old-style institution.<sup>76</sup> The cottages were not functioning independently. They adjoined each other and shared a common recreational area. They did not contain separate cooking and dining facilities, and the main meal of the day was still eaten in a large dining hall.<sup>77</sup> Excursions were organised for all of the children rather than separate activities being arranged for individual cottages.<sup>78</sup> The District Officer in Toowoomba believed that these limitations did not reflect the philosophy of the Salvation Army but the failure of individual houseparents and the manager to implement the stated philosophy of the Army and the Department.<sup>79</sup> The Salvation Army itself has pointed out that there was no funding to provide the facilities needed to allow the cottages to function independently.<sup>80</sup>

## **5.6 COMPLAINT MECHANISMS AND RESPONSES**

A common fault in residential institutions prior to the 1970s was the absence of complaints mechanisms for children dissatisfied with aspects of their treatment. Until the introduction of child care officers who visited regularly, the majority of children had no one to speak to about their problems, and even then, as in the case of Silky Oaks, many children were hesitant in voicing their concerns to departmental staff. A number of former residents of WR Black recalled suffering continuing persecution at the hands of the Matron employed there between 1938 and 1963. One stated that a church representative regularly visited the Home, but that he did not speak to the children to hear their grievances. Five others said that they either had no one to tell about mistreatment or were too afraid to report any misconduct for fear of reprisal from the Matron. Another former resident described being drilled by the Matron to keep quiet which she duly did, afraid of the repercussions of speaking out. The Inquiry also heard that other staff members sat with the children in the dining room during mealtimes and witnessed the Matron physically abusing children, but did nothing to defend them.

In 1939 an in-house investigation was convened by a church official into the Matron's alleged misconduct towards residents. She was ultimately exonerated of any misconduct. This Inquiry has been unable to examine the proceedings of the investigation as the Presbyterian Church has no surviving documentation.

The point has already been made that the administration at St Vincent's often failed to be sufficiently alive and responsive to sexual offences against the children in its care. Another problem that emerged from the evidence, and which appeared still to exist as late as the 1970s, lay in the management of children who had been the subject of sexual abuse. These children do not seem to have been counselled, much less kept informed about what was actually happening. Some witnesses carried a great deal of bitterness and inappropriate guilt resulting not only from their experiences but also from their feelings of having been disbelieved. In the case of Father Stanaway, for example, the official story circulated by the Church was that ill-health had compelled his retirement to Mt Olivet. The resident M was never told that Stanaway's wrongdoing had been discovered, and has gone through life thinking that it was his word alone against the Order and the Church, and that he could not expect to be believed.

## **5.7 PETFORD TRAINING FARM**

The discussion of matters in the preceding sections has been limited to those institutions where archival evidence and testimony were sufficient to warrant comment. It reflects the issues of neglect, ill-treatment and abuse as they emerged across the residential facilities at large. There were many more institutions, large and small, where witnesses, archival evidence or raised

incidents pointed towards neglect or mistreatment. However, there was insufficient information on these to enable the Inquiry to reach any clear view, and time and resources did not permit a fuller investigation. One such institution was Petford Training Farm, near Cairns.

During the course of the Inquiry, the Minister for Families, Youth and Community Care suspended referrals to, and commissioned an independent review of, Petford Training Farm. At that time, the Inquiry had received no submissions from persons who had been at Petford (however, two former residents later appeared before the Inquiry in March 1999). It was therefore decided that, rather than duplicate the review, the Inquiry would await the outcome and consider its findings and recommendations accordingly. The review team consisted of Peter Daffen and Caroline Munns, and their report was presented in October 1998.

The Petford Training Farm is a residential care facility, located approximately 170 kilometres south-west of Cairns, which has operated with government funding since 1986, although it had been in operation privately since 1978. Residents were predominantly Aboriginal, aged between 12 and 18 years, from the Cape, Gulf and other communities in far north Queensland. Referrals were accepted from the Department, local schools, communities and children's families. There had been up to 40 residents at Petford, although at the time of the review there were only six. Funding from the Department for 1997/98 was \$226,192. The program centred around horsemanship and related rural skills. Vocational training, literacy and formal educational training were limited and lacked continuity.

The review found a number of fundamental problems in the operation of Petford: a lack of record-keeping, accountability, operational standards, admission procedures, referral, case management, daily logs, incident books and discharge procedures; a high staff turnover; inadequate education; the remote location; and inadequate infrastructure. The review recommended that funding assistance from the Department to Petford Training Farm cease.

The Inquiry has considered the findings and recommendations of the review. A large number of risk factors for institutional abuse were identified, including geographical isolation, absence of proper human resource management practices (in addition to high staff turnover), absence of attention to basic management and accountability, a lack of adherence to practice standards, inadequate monitoring mechanisms and poor physical facilities. On the basis of the information contained in the review, and the presence of these risk factors, the Inquiry is of the view that the Petford Training Farm has all the hallmarks of a high-risk institution for abuse of residents.

#### **Recommendation**

That the Department continue to give effect to the recommendation of the *Daffen Report 1998* that funding to Petford Training Farm as a residential facility for young people be terminated.

### **5.8 ST JOSEPH'S ORPHANAGE, NEERKOL**

Sixty-four former residents and staff gave evidence to the Inquiry. This institution is currently the subject of litigation and cannot be discussed in any detail in this report. A detailed analysis will be forwarded to the Minister in a closed report.

### **5.9 ROLE OF THE GOVERNMENT—THE STATE CHILDREN DEPARTMENT TO 1980**

Many former residents of residential facilities gave evidence to the Inquiry about their experiences with the State Children Department (from 1966 to 1987 the Department of Children's Services) during their time in State-established or State-licensed institutions. The Inquiry also heard from 11 former staff of the Department and two former employees of the Department of Health. An extensive review of archival material held by DFYCC has also informed this section. A number of areas requiring examination are outlined below.

## Overcrowding

Overcrowding and under-staffing were common problems in a number of Queensland orphanages, at least until the late 1960s. For example, during the 1950s between 10 and 15 nuns cared for between 300 and 400 children at Neerkol. The impact of this on the children's care was that one nun was responsible for the care of 45 boys in the big boys' dormitory, while another nun with a single assistant had charge of 94 girls, big and little. In the nursery, a single nun, with the help of two 14-year olds, looked after 25 to 30 babies and toddlers. Mt Maria (Good Shepherd) records also reveal overcrowding at the Home, of which the Department was aware, since the Sisters of the Good Shepherd had identified their inability to provide sufficient care within the available resources and expressed their concern to the Department. Archival records show, however, that the Department was reluctant to decrease the number of children at the Home because of a lack of suitable accommodation elsewhere.

One of the senior nuns described the departmental indifference to the orphanage's plight:

*As long as they can ring up and say 'We're sending two children, six children, 10 children, down today, thank you very much, Sister,' down with the phone, that's all the Department wanted.*

Orphanages were generally expected by the Department to take every child in need of accommodation, no matter how stretched their resources.



*Photograph 5.24: Neerkol School verandah, No. 1, No. 2 and No. 3 dormitories—Annual Report of the Inspector of Orphanages for the year 1910*

Two conclusions were obvious to anyone considering the staff-child figures at many denominational orphanages over the decades until the late 1960s: first, that it was not possible for children there to receive adequate, individual care and attention; and second, that children were inevitably being required to perform an inordinate amount of domestic labour. Notwithstanding this, the Department continued to place children in the institutions, without regard to their capacity to provide proper care for the numbers they were receiving, until restructuring or closure of the facilities in the 1960s and 1970s.

## Absence of meaningful inspection or supervision

Section 49(1) of the *State Children Act 1911* required all State children to receive a minimum of one visit every three months from an officer of the Department to ascertain that their 'treatment, education and care' was satisfactory. Regulation 2 under the Act required inspections of receiving institutions at least once per month. The inspector was to observe that all the Regulations were being carried out, and to report on ways in which the comfort of the inmates could be improved.<sup>81</sup>



The performance of the Department seems to have fallen far short of these requirements. From the 1920s through to the 1970s, although there existed State Children's Inspectors (or, as they were later known, District Officers), many witnesses formerly resident at Neerkol, WR Black, St Vincent's, Nazareth House, Margaret Marr, Holy Cross, Kalimna and Mt Maria did not actually recall having been spoken to by an inspector at any time while at the institutions. As one witness said:

*Where were Children's Services during my stay at [the orphanage]? I never saw them, not once! And I want to know why! I was their client. It was confirmed by [orphanage inspector], who signed an admission form, dated 6 September 1966. I and my brother were, as of that date, under the expressed 'care and protection of the Director'. Ha! I would love an opportunity to laugh in his face. Never in my ten and a half miserable months at [the orphanage], did I ever see him or any of his staff.*

When inspectors did visit the orphanages, their visits were usually anticipated, and preparations were made by way of extensive cleaning and improving of external appearances. One witness from St Vincent's recalled preparations for an anticipated visit in the early 1950s when quilts (not otherwise used) were placed on beds, the unappealing refectory tables were covered, and boxes of toys were brought out in the infants' section. The children were not encouraged to speak to the inspector, and the possibility of extending an opportunity for complaint does not seem to have been entertained either by departmental staff or by those in charge of the home.

There appears, in fact, to have been no real enquiry of children in orphanages by departmental officers as to whether the discipline they received was proper, whether their food, accommodation and clothing were adequate, whether they received appropriate medical attention, much less whether they were placed at risk of abuse. The attitude of the inspectors appears to have been that the staff were performing worthy work in extremely difficult circumstances and that their endeavours ought not to be scrutinised or questioned. Indeed, it appears that on occasion their endeavours were overstated by the inspectors. An inspector's Annual Report to the Department on an orphanage about which the Inquiry has heard extensive allegations of abuse was glowingly worded:

*These children in [the orphanage] are members of an extremely happy family and it can safely be said that they have far more enjoyment than any other child in their own home and although State children are placed in employment and as foster children in excellent homes, they could never be as well off or feel as happy as those accommodated at [the orphanage].*

This lack of regular or thorough inspection was borne out in the archival investigations. For most institutions there were no documentary records of any formal inspections having been carried out, and those that were found were incomplete. Evidence suggests that there was no active overseeing of the care given by the orphanages or consideration of individual children's needs. The lack of assessment of individual children's circumstances is unsurprising in light of the statistics quoted by Professor O'Connor in evidence:

*In 1958 nine or 10 inspectors were responsible for overseeing 6,602 children in State care. By 1965, 31 child care officers were responsible for 7,296 children in State care.<sup>82</sup>*

In DFYCC files, the Inquiry found a 1965 report from the fire brigade on the safety of buildings at Holy Cross (a training school dealt with in detail in Chapter 7). The fire brigade inspector's report condemned the main building in which the girls were resident as a fire hazard:

*I have no hesitation in condemning these three wooden buildings as unsuitable for occupancy of any kind, and strongly recommend that they be replaced with a building of, at least, two fire-resistant materials.<sup>83</sup>*

The inspector regarded as particularly dangerous a practice of locking the doors and gates of the areas where the girls resided:

*Whilst one can appreciate the necessity of maintaining security, I feel sure that ... the locking and bolting of escape doors is defeating the purpose for which they are intended and in an emergency could precipitate a tragedy.*

The statement mirrors the concerns of one ex-resident who gave evidence that at night the girls were locked in the dormitory without any supervision by staff, and therefore without anyone who could unlock the doors in the event of a fire. She stated that there were bars on the windows and that if a fire had begun there would have been no way of getting out. It appears that despite the report the Department did nothing to prevent girls being accommodated in the dormitory, showing a complete disregard for their safety.

### **Failure to encourage family relationships**

Until the 1960s the Department did not keep children in its care informed about their families. It took no responsibility for ensuring that sibling relationships were promoted within the institutions, nor for maintaining ties with family outside. Generally, departmental officers tried to dissuade parents from making their children State wards. However, this was more, it would seem, from concern about the financial burden placed on the State than from any belief in the value of the family. Once children were in care, departmental contact with parents was directed to extracting maintenance payments, with little effort expended in encouraging them to maintain links with their children or to get them back to the family. Children were not kept informed of their family circumstances; some believed for years, wrongly, that their parents were dead, that they had no siblings, or that their parents did not want them. Some parents, of course, had scant interest in maintaining contact with their children in care. However, the true illustration of neglect is that the Department did little or nothing to promote family relationships that might have been salvaged, at least to some extent.

The situation improved considerably from the mid-1960s when the first qualified social workers began to be employed by the Department, heralding a gradual improvement in its level of involvement with the children in its care.

### **Monitoring of risks of abuse**

Notwithstanding the Director's formal guardianship of the children in his care, the Department appears generally to have ceded responsibility for protecting children from abuse to the institutions, to the extent of allowing the institutions almost unlimited discretion as to the adults to whom children in care could be exposed. No enquiry appears to have been made as to the suitability of staff; nor does any restriction appear to have been put on adults who had access to any given institution, for example visiting members of religious organisations or members of the community who had the approval of the institution's hierarchy. At St Vincent's, for instance, there is strong evidence that two men who came to the Orphanage to take boys out to sports activities and the drive-in (and who were initially perceived as good, generous Catholics) were in fact fondling and even sodomising the children. The nun in charge of the boys' dormitory eventually suspected that some form of sexual interference with the boys was taking place on these excursions, and the two men were barred from the premises. The issue for present purposes is that there is no indication that the Department ever enquired as to the identity of the adults with access to the children.

Indeed, in an earlier period archival evidence indicates a willingness on the part of the Department to allow relatively unrestricted access to children, assuming that a status as good citizen was a sufficient basis on which to allow male adults to take children on outings. In a letter to the Convenor of the Presbyterian Church Office on 20 June 1949, the Director of the Department advised that the Rotary Club had expressed an interest in taking children from church institutions on weekend outings. The Director indicated the Department's approval and continued:

*No permit will be necessary from this Department; the fact that the persons concerned being members of Rotary will be sufficient guarantee of their bona fides and that the children will be well cared for. When an approach is made to you by a member, I should be pleased if you would permit him to have a child.*

Although no complaints have been received by this Inquiry concerning mistreatment by a Rotary Club member on such a visit or outing, it is clear that the Department's sanguine approach provided no safeguard of the interests of children.

### **Management of abuse allegations**

Historically, it is clear that the Department lacked any semblance of an adequate system for receiving and investigating complaints of abuse by children in institutions.

Prior to the mid-1960s the lack of contact between individual children and departmental staff meant that any children who wished to voice complaints of sexual abuse and excessive physical discipline would have had no one independent of the Home to whom they could speak.

Even after that period, the Inquiry heard, there were no standard protocols within the Department for dealing with allegations of sexual abuse, and expertise to detect abuse was lacking. One former child care officer told the Inquiry that he doubted that the training he received would have enabled him to recognise signs that a child might have been abused; he would have been at a loss unless the child clearly articulated the abuse. Archival investigations suggested that there was limited, if any, documentation of abuse, and records of the type and number of complaints were not maintained.

Other former departmental officers told the Inquiry that the Department took a 'conservative' line when it came to dealing with complaints about staff in institutions. There appeared to be a prevailing belief that once a child was placed in an institution he or she was 'in a place of safety', thereby creating a culture within the Department of reluctance to act on complaints or allegations of abuse. There was, said one witness, an 'attitude that this didn't happen, that these were church-run institutions and that the Church simply didn't abuse ... children'. Another former officer said that when complaints were made, the Department's attitude was:

*We really don't want to hear what's going on and we've had this institution, we've worked with [the institution] in the past and we need this institution, we need somewhere to put these girls. So, don't tell me a lot about what's going on.*

Several former staff members said that when allegations of abuse were made against a staff member the approach was to remove the staff member from the institution, and not to involve the police. That practice left open the possibility of staff members against whom allegations of abuse had been made obtaining employment in other institutions caring for children.

A number of other witnesses formerly employed as child care officers made the complaint, generally borne out by the tenor of the archival records, that when they raised concerns regarding the corporal punishment of children at institutions the Department was not prepared to take the issue up with the institutions involved. A former departmental officer from the 1970s explained that part of her difficulty in expressing her concerns arose from the fact that she was unable to write directly to the Director. Instead, she was required to make her submissions through the hierarchy of the Department, and she was not convinced that they would reach the Director.

### **Underfunding and failure to support welfare workers**

As noted in Chapters 3 and 6, Queensland's child welfare system has always been significantly underfunded in comparison with other States. One consequence of this has been the large, and often unmanageable, caseloads carried by frontline staff. A former departmental staff member said:

*There has always been an air of desperation in the Department, and child care officers are asked to do virtually the impossible, with huge caseloads and very little resources.*

A former departmental officer told the Inquiry that he wrote a report in 1985 pointing out that the Department could not meet its statutory obligations, which resulted in the provision of 40 additional field staff. More often, however, complaints of gross under-resourcing appear to have fallen on deaf ears. The Inquiry heard of one example of a child care officer whose casework amounted to spending half a day at an institution with 75 children—an absurdly inadequate allocation of resources. Another former departmental manager from the late 1960s worked on the Sunshine Coast where there were three or four child care officers with caseloads of around 250 children each; clearly those children can have had little chance of real support. These are examples only, but they reflect repeated accounts received by the Inquiry of chronic under-funding and over-burdening of staff.

Another issue has been the geographic coverage of the State. There has been in the past, and continues to be, very poor coverage by the Department outside the south-east corner, both in terms of sufficiency of staff numbers for the work on hand and adequacy of placements. As one former departmental officer said: 'It is never possible to do all that needs to be done and it is worse in the regional offices.'

### **Professionalisation and the implementation of standards and procedures**

The Inquiry spoke to a number of individuals who had been involved in child care and protection within both the residential facilities and the Department itself during the 1960s and 1970s. The consensus of opinion was that by the mid-1960s a significant body of knowledge, expertise and training was becoming available by which the standard of care in the institutions could be judged. By that time, it ought to have been apparent that the practice of child management in the institutions was out of step with current understanding of child development and behavioural management. Certainly by the 1970s it is evident from the many confrontations between professionally trained officers of the Department and institution staff on the issue of corporal punishment that the Department was well aware of out-dated, counter-productive, often brutalising practices, but lacked the will to take decisive action.

A consistent feature of the evidence of former departmental staff was the virtual absence of standards and procedures prior to the 1970s, when the professionalisation of the Department largely occurred. Former staff indicated that in the 1960s and 1970s there was little observation of human resource standards. Job descriptions were not provided, and merit selection processes were not in place. One former employee said:

*My understanding of the role of the liaison officer wasn't very clear but I came to gather that the role was simply to admit people, admit young girls to [the institution]; to visit with the staff and not to do very much more than that.*

The same lack of clear guidelines applied to institutional performance. A former staff member said she did not recall ever being shown written specifications detailing what was expected of the institution she was supervising, by way, for example, of a required standard of services.

Placement of children also appeared to suffer from a lack of any procedures or guidelines. There were no real assessment procedures for children coming into care. A former staff member from the late 1960s told the Inquiry that the only rough criteria used for placing children were sex and age. Another said that there was no pattern for how children were put into care: in some cases parents would contact the Department and request, successfully, for their children to be taken into care; but in other situations where children were in grave danger they could not get an interview with the Department.

Case management in the 1960s was similarly wanting. There was, according to the evidence, no systematic or planned way in which work with children was done. Another former staff member noted the persistent lack of evaluation and research in the Department:

*We never researched anything in the Department. Nothing is ever evaluated and researched and used for a constructive policy for the future.*

The development of standards largely commenced in the 1970s. According to a former staff member, the push for standards and a minimum quality of care in residential facilities came from the child welfare officers in the first half of the 1970s. As part of that drive, admission and discharge procedures and a case history requirement for admissions were developed around 1974.

### **The Department and the denominational institutions**

By continuing to accept children even when their resources were stretched, the churches provided an irreplaceable service for the Department. It appears that, in return, the Department developed at least a tacit policy of not upsetting the church groups because they were a convenient and cheap way of placing children.

Several former staff said that there was an attitude in the Department ‘not to get the churches too offside’ because they ‘didn’t want to lose those facilities’. One former staff member said that the Department continued to deal with organisations like the Salvation Army because the then Director genuinely believed that large-scale residential care was preferable, and had difficulty in conceiving of an alternative. She quoted him as saying, ‘We’ll have all these girls, you know, with babies and where are we going to put them all?’



*Photograph 5.25: Tufnell Home chapel at Nundah, operated by the Anglican Church—Inquiry photograph*

An example of the Department’s pragmatic approach to placement of children is found in the licensing of Nazareth House. Departmental records disclose little relating to this decision, but it coincided with an increasing resistance on the part of St Vincent’s to the indiscriminate placement of children there. Evidence received by the Inquiry included complaints of sexual and physical abuse and excessive corporal punishment at Nazareth House prior to 1964. Given that this institution had previously accommodated children on a private basis, plainly licensing could not have been responsibly approved without a careful review of the standard of care previously offered. There is, however, no record of any investigation into the appropriateness of granting a licence to Nazareth House.

There appears to have been a tacit understanding between the Department and the institutions that the latter’s internal operations were a matter for them. For example, in a letter to the Director of the Department, the Presbyterian Convenor of Homes and Hostels outlined the way that the Church felt WR Black should be run. The State was to finance the care of children, safeguard the physical interests of each child, and provide them with an education. The State should not ‘interfere in the internal arrangements or staffing of the Homes’. The

religious training and moral upbringing of the children would be left ‘to the discretion of the Church Committee’.<sup>84</sup> A former child care worker from a church-run home in more recent years described the attitude there. The staff did not speak to the (then) Department of Family Services: ‘What happened in [the institution] was [institution] business.’

Evidence was provided to the Inquiry that, because of the absence of departmental policies and procedures, admissions and discharges were very much at the discretion of the institutions. It was common for the Superintendent of the institution to have discretion as to whether a child would be discharged from an institution. For example, at Kalimna (a training school discussed in detail in Chapter 7), the Salvation Army, not the Department, set the time period for which the girls would stay—usually 9–12 months. A former staff member said:

*There was no order of the Court saying how long [the girls] would be incarcerated for. It was purely, as I said, at the discretion of the Army and I don't think there was any input or I don't think the Department had very much influence in determining when a child would be released. Therefore the Department did not have the discretion to release the girls, and this attitude seemed to be tolerated by the Department.*

In the early 1970s the Department had made moves to ‘appoint workers on a permanent basis to liaise with various institutions’. However, it appears that permanent liaison workers assigned to institutions did not always have an easy time. Organisations that had been accustomed to a high degree of autonomy did not welcome the scrutiny of the new, often young, professional child care officers.

Archival documents suggest that relations between Superintendents and child care officers often involved friction. Child care officers often felt strongly that institutional practices were damaging, while the denominational institutions for their part saw the child care officers as ideologically opposed to their very existence. A letter from the Superintendent of Marsden at Kallangur in 1974 expressed his perception that the Department was ‘anti-institutional’ in a report released to denominational homes in that year: ‘There is no mention in the Report of anything worthwhile achieved in any Denominational residential facility larger than Family Group—every reference is in some degree derogatory.’<sup>85</sup>

According to former departmental officers, because the church groups were for a long period left to run the institutions with little involvement or support by the Department, there was considerable resistance when the Department did eventually seek to assert its position as the legal guardian of the children. There was a concerted effort to ‘claw back to the Department its legal responsibilities’ after it had let a tradition of institutional autonomy develop. Some religious organisations, it was said by witnesses, possessed sufficient political clout to be able to resist change. Some, indeed, were viewed as untouchable.

Certainly, the review of the archival evidence indicates that even where there were significant allegations of abuse and mismanagement there was little will to take decisive action. This appears to have been due to a combination of factors. One disincentive to action was the paucity of alternative placement options for children. Second, there was a lack of political will to close such institutions because of a feared electoral perception that the government was not doing enough to look after ‘problem’ children. Finally, where the Department had made grants to the institutions for capital works programs or for equipment, there was a considerable reluctance to abandon the investment.

## **5.10 INFORMATION MANAGEMENT**

In recent years there has been a greater awareness of the importance of providing former State wards with information about their time in care (*Bringing Them Home* 1997). Such information can help people to understand why they were placed in care, to deal with current personal issues that may have been the result of their time as wards, to re-establish contact with family members, to strengthen their sense of identity and to recover aspects of their family history. Much information can be made available for young people currently in the system or recently released from care, but for those who were wards prior to the 1980s the

situation is less promising. For many in this latter group, the search for information about their past can be a painful and often fruitless experience. Indeed, the paucity of surviving records and the problems associated with locating such material have made the work of the Inquiry all the more difficult.

The main source of information for former wards of the State are the records held by a variety of government departments, in particular DFYCC. There are strict secrecy provisions limiting access to records of former children in the care of the Department, but in cases where there is a legitimate right of access, the Department will make available the relevant material from its files. Unfortunately, a substantial quantity of older personal and administrative files were lost during the 1974 flood and as a consequence many requests for information do not result in the location of a significant amount of material. Nevertheless, it would appear that the Department has been doing its best to overcome such problems and to provide former wards with information about their time in care.

The introduction of the *Freedom of Information Act* in 1992 has led to an increase in the number of requests for information and has encouraged the Department to streamline its procedures for granting access to records. The establishment of the Community and Personal Histories section of the Department in 1992/93 represented a significant improvement in the service provided for Aboriginal and Torres Strait Islander people researching their personal, family or community histories. Similarly, non-indigenous people are well served by the Information Service Branch of the Department.

For those State wards who were residents of non-governmental institutions, usually denominational homes, there is little surviving documentation to complement government records. A few organisations retained substantial collections of administrative records and staff and client files for the institutions under their control, but the majority have failed in this regard. There are a number of reasons for this, including mismanagement, accidental loss through fire or flood, and deliberate destruction. It is acknowledged that there has been no legal requirement obliging non-governmental organisations to retain non-current records; however, it must now be recognised that there is a moral obligation to preserve and make available information that may assist former wards to reconstruct their personal histories. There needs to be a greater effort on the part of most non-government organisations to locate and preserve their historical records.

In 1998 the New South Wales Department of Community Services published *Connecting Kin*, a guide to the records held in that State relating to people who have been separated from their families. The guide is a comprehensive inventory of records held by government and non-government bodies, and also includes useful information relating to institutions, welfare organisations and terminology, and important legislative provisions. The publication of a similar volume in Queensland would assist former wards of the State in their quest for knowledge about their past.

**Recommendation**

That the Department undertake a project similar to *Connecting Kin*, developed by the NSW Department of Community Services in 1998, to identify the repositories of information relevant to the lives of former State wards in Queensland.

**Recommendation**

That the Department notify all non-government organisations that have been involved in the care of children in Queensland that it is willing to accept any surviving records relating to State wards and that it will retain those records and provide the individuals and families concerned with access to them.

## 5.11 CONCLUSION

Many institutions were physically and emotionally barren places for children in care to live. Many were staffed by people unable or unwilling to provide the children with the love, protection and support they needed and deserved, and to which they were entitled. Others were staffed by people who abused children or were unable or unwilling to prevent children from being harmed by others. The abuse took many forms: direct physical abuse such as excessive floggings, sexual abuse, emotional deprivation, humiliation, isolation for extended periods of time, lack of education, and hunger. This abuse was, in many cases, not simply a ‘one-off’ incident in an environment that was otherwise caring and supportive. It happened to many children almost daily—and even when abuse was not actually taking place, there was always the threat or fear of it.

A former child care officer with many years of experience explained her view of responsibility:

*If the government is saying to people ‘You cannot parent your children. We will take them from you and we will do it’, the government better do it very right. Very well, and very right.*

The history of institutional care in Queensland up until the 1980s, however, has been one of sacrificing children’s interests to expedience. The cost rather than the quality of care was often the prevailing criterion in determining how children should be housed and managed. In turn, that unwillingness to spend money in funding care provision has resulted in children being kept in conditions that were at best spartan and at worst squalid. It has led to their care being provided by over-extended, unskilled workers in environments lacking in love and support; it has deprived many of educational opportunities and adequate life skills; and it has allowed conditions to flourish that led at times to the most brutal abuse and neglect.

However, lack of funds and poor physical environments were just two of the factors that led to the abuse of children. Until the early 1960s there was little understanding of the emotional needs of children, and even less of the impact of harsh emotional and physical treatment on children’s later lives. Ignorance played a role; both the Department and society in general believed that if children were in the care of trusted religious organisations or ‘good, upstanding citizens’ they would be safe. There was also a lack of awareness or knowledge of sexual abuse or of the possibility that it could occur.

Institutions were under-funded, short-staffed and generally closed environments, with little opportunity for meaningful interaction with the local community. In some of the larger facilities, there was even little interaction between different sections of the same institution. Carers were often young, untrained, and intimidated by the hierarchy of their organisations. Complaints mechanisms did not exist, and there was minimal monitoring or inspection by the Department. Neither the State nor the institutions and their auspicing bodies did enough to prevent abuse taking place. All of these factors converged to create an environment ripe for the abuse of children.

## ENDNOTES

<sup>1</sup> Assessment of Nazareth House completed by a child care officer, 3 October 1974, DFYCC 96I/6/0.

<sup>2</sup> Memorandum from Deputy Director, State Children Department, to Under-Secretary, Department of Works, 20 May 1965, DFYCC 5I/2.

<sup>3</sup> Memorandum from District Officer to Director, 18 September 1979, DFYCC 4I/1.

<sup>4</sup> Letter to Salvation Army, 23 December 1969, DFYCC 8I Part B.

<sup>5</sup> Memorandum from resident child care officer (AWC), January 1972, DFYCC 90I/4/0 Part A.

<sup>6</sup> *Sunday Sun*, 14 November 1971.

<sup>7</sup> Letter from Director to Salvation Army, 9 October 1970, DFYCC 8I Part B.

<sup>8</sup> Ipswich City Council to Director, 15 November 1972, DFYCC 90I/4/0 Part A.



- <sup>9</sup> Memorandum from senior child care officer, 29 November 1973, DFYCC 90I/4/0 Part A.
- <sup>10</sup> Memorandum from senior child care officer, 18 May 1972, DFYCC 90I/4/0 Part A.
- <sup>11</sup> Submission to the Commission of Inquiry into the Nature and Extent of the Problems Confronting Youth in Queensland (1975) by Teachers at the Endeavour Training Farm School, November 1974, DFYCC 90I/4/0 Part A.
- <sup>12</sup> Notes on Deputation to the Premier, 9 April 1953, DFYCC 22I.
- <sup>13</sup> Memorandum from child care officer, 28 April 1976, DFYCC 90I/4/0 Part A.
- <sup>14</sup> Letter from Superintendent, 20 May 1952, DFYCC 22I.
- <sup>15</sup> Notes on Deputation to the Premier, 9 April 1953, DFYCC 22I.
- <sup>16</sup> Memorandum from child care officer, 8 June 1970, DFYCC, 18I Part E.
- <sup>17</sup> Salvation Army to Director, 13 September 1973, DFYCC 90I/1/0 Part A.
- <sup>18</sup> Director to Salvation Army, 27 September 1973, DFYCC 90I/1/0 Part A.
- <sup>19</sup> Memorandum from child care officer, 22 March 1976, DFYCC, 90I/1/0 Part A.
- <sup>20</sup> Departmental memorandum, 19 November 1970, DFYCC 8I Part B.
- <sup>21</sup> Memorandum from child care officer, 15 October 1976, DFYCC 90I/4/0 A.
- <sup>22</sup> Memorandum from child care officer, 20 December 1975, DFYCC 90I/4/0 Part A.
- <sup>23</sup> Ibid.
- <sup>24</sup> Memorandum from supervising child care officer, December 1975, DFYCC 90I/4/0 Part A.
- <sup>25</sup> Ibid.
- <sup>26</sup> Letter from Salvation Army, 18 April 1975, DFYCC 90I/4/0 Part A.
- <sup>27</sup> Memorandum from child care officer, 1 April 1975, DFYCC 90I/4/0 Part A.
- <sup>28</sup> Report of Deputy Director, 5 October 1978, DFYCC 96I/2/0.
- <sup>29</sup> Memorandum from child care officer, 5 April 1978, DFYCC 96I/2/0.
- <sup>30</sup> Report from child care officers to Director, 22 September 1978, DFYCC 96I/2/0.
- <sup>31</sup> Memorandum from senior child care officer, 24 October 1975.
- <sup>32</sup> *Truth*, 5 April 1953; report from Inspector, State Children Department, 8 April 1953, DFYCC 22I.
- <sup>33</sup> Report from Inspector, State Children Department, *ibid.*
- <sup>34</sup> Salvation Army Submission to Inquiry, 28 April 1999.
- <sup>35</sup> Report from child care officers to Director, 22 September 1978, *op cit.*
- <sup>36</sup> It would appear that by the mid-1970s the practice had ceased at Nazareth House.
- <sup>37</sup> Report from child care officers to Director, 22 September 1978, *ibid.*
- <sup>38</sup> Memorandum from child care officer to Director, 22 September 1978, 96I/2/0.
- <sup>39</sup> Letter from General Secretary, Presbyterian Committee on Homes and Hostels, 26 November 1953, DFYCC 22I.
- <sup>40</sup> Ibid.
- <sup>41</sup> Memorandum from child care officer, 22 June 1962, DFYCC 8I Part A.
- <sup>42</sup> Salvation Army Submission to Inquiry, *op cit.*
- <sup>43</sup> *Australian*, 24 July 1971.
- <sup>44</sup> *Sunday Mail*, 24 June 1973.
- <sup>45</sup> Memorandum from child care officer, 30 October 1974, DFYCC 90I/4/0 Part A.
- <sup>46</sup> Director, Special Education Services, to Director, 22 October 1973, DFYCC 90I/4/0 Part A.
- <sup>47</sup> Letter from Director General of Education, 24 March 1976, DFYCC 90I/4/0 Part A.
- <sup>48</sup> Director to senior child care officer, 29 March 1976, DFYCC 90I/4/0 Part A.
- <sup>49</sup> Memorandum from child care officer, 8 June 1978, DFYCC 90I/1/0.
- <sup>50</sup> Report from Inspector, State Children Department, 28 March 1955, DFYCC 22I.
- <sup>51</sup> Memorandum from child care officer, 15 February 1978, DFYCC 90I/6/0.
- <sup>52</sup> Memorandum from child care officer, 8 June 1978, *op cit.*
- <sup>53</sup> Memorandum from senior child care officer, 24 May 1978, DFYCC 90I/6/0.
- <sup>54</sup> Report from child care officers to Director, 22 September 1978, *op cit.*
- <sup>55</sup> Memorandum from senior child care officer, 29 November 1973, *op cit.*
- <sup>56</sup> Ibid.
- <sup>57</sup> Ibid.
- <sup>58</sup> Memorandum from senior child care officer, 2 November 1973, DFYCC 3I/19 Part A.
- <sup>59</sup> Memorandum from senior child care officer to Director, 5 November 1973, DFYCC 90I/4/0 Part A.
- <sup>60</sup> Director to Salvation Army, 3 December 1973, DFYCC 90I/4/0 Part A.
- <sup>61</sup> Report from teachers, November 1974, DFYCC 90I/4/0 Part A.
- <sup>62</sup> Evidence of Witness to Inquiry, 27 October 1998.
- <sup>63</sup> Anglican Diocese of Brisbane Submission to Inquiry, 9 April 1999.
- <sup>64</sup> Memorandum from child care officer, 24 February 1978, DFYCC 90I/6/0.
- <sup>65</sup> Memorandum from child care officer, 3 April 1978, DFYCC 90I/6/0.
- <sup>66</sup> Memorandum from child care officer, 24 February 1978, *op cit.*
- <sup>67</sup> Memorandum from child care officer, 26 July 1978, DFYCC 90I/1/0 Part A.
- <sup>68</sup> Memorandum from child care officer, 8 November 1978, DFYCC 90I/1/0 Part A.

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- <sup>69</sup> Memorandum from child care officer, 8 July 1980, DFYCC 90I/1/0 Part B.
- <sup>70</sup> Memorandum from child care officer, April 1962, DFYCC 25I Part B.
- <sup>71</sup> Memorandum from child care officer, 5 September 1973, DFYCC 90I/4/0 Part A.
- <sup>72</sup> Ibid.
- <sup>73</sup> Ibid.
- <sup>74</sup> Memorandum from child care officer, 1 April 1975, op cit.
- <sup>75</sup> Memorandum from senior child care officer, 29 November 1973, op cit.
- <sup>76</sup> Memorandum from senior child care officer, 24 May 1978, DFYCC 90I/6/0.
- <sup>77</sup> Memorandum from child care officer, 7 April 1978, DFYCC 90I/6/0.
- <sup>78</sup> Memorandum from child care officer, 21 November 1978, DFYCC 90I/6/0.
- <sup>79</sup> Memorandum from child care officer, 7 April 1978, op cit.
- <sup>80</sup> Salvation Army Submission to Inquiry, 27 April 1999.
- <sup>81</sup> *Queensland Government Gazette*, Vol. CXLV, No. 16, 25 July 1935.
- <sup>82</sup> Professor Ian O'Connor, expert witness, Public Hearing, 12 November 1998.
- <sup>83</sup> Fire Brigade Inspection Report, 17 January 1965, DFYCC 96I/3/0.
- <sup>84</sup> Convenor of Homes and Hostels to the Director, 30 June 1938, DFYCC 25I Part B.
- <sup>85</sup> Superintendent to Director, 12 November 1974, DFYCC 99I/1/0 Part B.

## CHAPTER 6: THE MODERN CHILD WELFARE SYSTEM IN QUEENSLAND

### 6.1 INTRODUCTION

Child welfare systems and policies have always reflected the economic and social mores of the day, and the changes that have occurred since the *Children's Services Act 1965 (CSA 1965)* was enacted in early 1966 have been similarly influenced. Such economic factors as the recession of the early 1960s and the dominance of economic rationalism in the 1980s have contributed to a continuing reduction in welfare sector funding. This chapter briefly summarises the key elements of the contemporary child welfare system in Queensland and recent developments in the care and protection of children.

### 6.2 DEVELOPMENTS IN CHILD PROTECTION AND INSTITUTIONAL CARE

During the 1960s the then Department of Children's Services (DCS) began to replace the traditional 'inspectors of orphanages' with university-trained personnel with social work degrees or equivalent qualifications. This professionalisation of the statutory workforce brought a new focus to child protection assessment and services, although critics saw a burgeoning 'child protection industry' as serving workers rather than families. However, child welfare theory and practice promoted an enhanced understanding of the child's psychological and social development, as well as a better understanding of the harmful effects of child abuse and neglect. Subsequent practice in the Department reflected these new concepts of child development and standards of care, and acknowledged the importance of attachment to carers (Bowlby 1979) and the development of trust (Erikson 1963). Whereas the previous framework reflected an emphasis on the conviction of abusive parents, the new aim was:

*... to help parents to function more adequately and wherever practicable to keep family units intact, or work toward their restoration (DCS 1972).*

There were a number of initiatives in the 1970s in response to the rapid increase in child protection notifications. Such notifications now included child sexual abuse, a phenomenon which society had difficulty in accepting as a reality, perhaps exemplified by the inability of the media to report it in a responsible and child-centred manner.

A Coordinating Committee on Child Abuse was constituted by State Cabinet in November 1978 and subsequent amendments to the *Health Amendment Act 1980* prompted a number of significant changes, including:

- the establishment of Suspected Child Abuse and Neglect (SCAN) Teams throughout Queensland, with core members from the Department of Health, the Department of Children's Services (DCS) and the Queensland Police Department
- mandatory reporting of child abuse by medical practitioners to the Director-General of the Department of Health
- a 96-hour hold order to retain the child in hospital for medical assessment.

In response, the DCS put in place the following initiatives:

- a Central Register to record data on child protection cases
- a Crisis Care Service in Brisbane, operating seven days a week, 24 hours a day, to deal with calls about child protection and juvenile justice concerns
- a specialist Sexual Abuse Treatment Program
- a Child Protection Unit to function as a specialist resource unit within the Department to provide support and consultation to departmental officers and represent the Department on metropolitan SCAN teams
- a Special Needs Unit to facilitate the adoption or placement of older children and children with disabilities
- a Centre for the Prevention of Child Abuse.

There were also changes in the approach to institutional care. For Australia between 1983 and 1996 there was:

- a decrease in the number of children and young people in out-of-home care, from 17,000 to 14,677
- an increase in the number of children and young people placed in foster care or community-based care, from 9,860 to 12,859
- a decrease in the number of children and young people placed in residential care, from 7,140 to 1,818 (Bath 1998).

Since the 1970s there has been a deliberate move towards closing large conglomerate care facilities and small group homes in all Australian States, although the substitution of other placement models to address the often extreme needs of this client group remains problematic. Issues relevant to this question are discussed in the section dealing with adolescents later in the chapter.

Significant changes to the child protection system in Queensland are incorporated in the Child Protection Reform Strategy as part of the implementation of the new *Child Protection Act 1999* (CPA 1999). Some of the features, such as a flexible response capacity, have been implemented in Queensland for some time. Others are still in need of further development—for example the clarification of the role and responsibility of the Department of Families, Youth and Community Care (DFYCC) in three components of child protection: prevention and early intervention, family support, and child protection intervention. The first two categories require more development, but the policies and procedures for child protection intervention under the new Act are well advanced and should be implemented late in 1999.

The Charter for Children in Care (Clause 71) is detailed in Schedule 1 of the new Act. This reflects the special obligations and responsibilities the State has to children who are under child protection orders and in protective custody or guardianship. The fundamental aims of the Charter are to be comprehensively applied to children who come into the child protection system in Queensland.

An important element in modern child protection systems is the need for flexible and individualised case planning. The new Act endeavours to advance this principle and sets out, among other things, the obligations of the Director-General to children in care and their families to ensure accountability, provision of information and the empowerment of the family. There was no prior legislative base for these policies. Greater flexibility to address individual needs is further secured in time-limited orders. These range from Temporary Assessment Orders (three days), Court Assessment Orders (four weeks), and Child Protection Orders which include Directive and Protective Supervision (one year) and Custody and Guardianship Orders (not including long-term guardianship) (two years, with possible extensions). Previously the only available time span for an order was until the child was 18 years of age or until released from the order by the Director-General or through an appeal to the Children's Court.

### **6.3 PROFILE OF CHILDREN IN CARE**

Children are committed to the care of the State for many complex reasons. History suggests that a major factor was related to parental incapacity to financially sustain the family unit. During the latter part of the nineteenth century, the number of children in care increased significantly, the main cause being recorded as the breakdown of the family unit brought about by drought, recession and unemployment.

In contemporary times in Queensland, as in the rest of Australia, children usually come into State care because they have been, or are, at high risk of being significantly harmed by their parent(s), or by a person who has access to the child, and from whom the parent(s) will not, or cannot, protect the child.

When a child comes into the care of the State, DFYCC supports the principle that, as far as possible, work will be directed towards returning the child home as soon as possible.

The grounds for an order under the *CSA 1965* focused the blame on parents irrespective of the circumstances. Hence, child protection workers were forced to adopt an investigative approach in terms of evidence rather than assessment of harm to the child, which is the focus of the *CPA 1999*. The new approach enables a more collaborative and inclusive involvement of parents. The new Act also provides for greater clarity in the areas of alternative care, with legislative requirements for departmental contact with the family and six-monthly reviews. The decision about where a child is placed and with whom can be appealed to a Tribunal.

The decision that a child be placed in residential care stems from the initial child protection notification made to DFYCC. Once information about a child has been received, a departmental officer decides whether there are any identifiable child protection concerns. If it is determined that a child has been harmed, or is at risk of harm from a parent or other person living in the child's home, a child protection notification is recorded.

Efforts are made to canvass community support and assistance, but where this is insufficient, formal child protection intervention procedures are implemented to ensure the child's safety. This may be on a voluntary basis—that is, with the agreement of the family—and in this situation the case will be registered as a child protection follow-up case. In the alternative situation, when voluntary intervention is unlikely to meet the child's protective needs, statutory child protection intervention is required. In such a situation, the involvement of the Department is no longer voluntary and may result in an application being made to the Children's Court for a child protection order. The ultimate decision is made by the Court not the Department. In such a case the child would most likely be placed in out-of-home care.

Within the Department's statutory role, and in line with child protection authorities world-wide, there has been a heavy emphasis on investigative procedures, with little time available for even the most rudimentary family support tasks. Although theoretically this has changed over recent years, the reality of grass roots service provision is that investigation, now called child protection assessment, still monopolises the workload.

Numerous judgments and decisions are necessary along the way, each requiring a high level of clinical assessment skill. Often these assessments must be made under pressure from a number of sources, for example time urgency (Queensland's child protection services have specific response times) and anxiety about the potential injury to, or death of, the child in the event of delay or error. The assessment of whether or not the child is at risk is the key factor in ensuring the safety of the child, yet the necessary intrusion into a family must be balanced by the right of parents to exercise their primary responsibility to care for their children. This task is one of the most difficult in the field of child welfare.

There is often a risk of bias, especially in cases of neglect, where middle-class standards of departmental staff may be imposed on a family whose view of the world is very different, yet who pose no threat of harm to a child or children. Other potential areas of bias involve religion, ethnicity and culture; for example, in indigenous families, alternative care within the extended family is part of a cultural norm. Careful and sensitive supervision, even of experienced intake officers, will, in some measure, reduce the risk of biased assessment.

### **Recent statistics on children in care**

In March 1997 DFYCC reviewed the earlier Child Protection Register, and implemented an improved data recording system, the Child Protection Information System. Records show that there were 3,186 children on protective orders as at 30 June 1998, an increase of 3.9 per cent over the previous year. Of these, 2,864 children were on care and protection orders (guardianship transfers to the Director-General), 366 children were on protective supervision orders (guardianship remains with the parents), and 44 children were on both. A further 1,042 children were receiving a child protection follow-up service.

These figures indicate that, although there has been a huge increase in the number of notifications of abuse or neglect (1,000 in 1980–81 up to 17,233 in 1997–98), the number of children on protective orders (where the abuse or neglect has been confirmed) has increased at a much slower rate:

- at 30 June 1993, there were 2,942 children on protective orders
- at 30 June 1998, there were 3,186 children on protective orders.

This slower rate of children coming into State care is likely to be due to an expanded range of voluntary intervention options, together with more emphasis being placed on helping the family to protect the child. An alternative explanation is that children are being left in unsafe situations because of poor assessments.

The age profile of children on orders and admitted to orders in 1997–98 indicates that, while there was a significant number of admissions of younger children, older children comprise the majority of children on orders:

- 57.1 per cent of children admitted to orders during the year were aged 5–14 years
- 57.4 per cent of children on orders at 30 June 1998 were aged 10–17 years
- 2.4 per cent of children under one year of age were admitted to orders during the year
- only 13 children aged 15–17 years were admitted to orders during the year, yet this age group comprises 23.9 per cent of all children on orders (760 children).

This suggests that younger children are more likely to be returned home more quickly, whereas older children, especially adolescents with disturbed behaviour, are at risk of ‘welfare drift’. This process of welfare drift occurs where there is a lack of effective case planning. Further contributing towards the process is the failure to instigate regular case reviews to assess the changing needs of the child, a lack of ongoing support for care providers, and a failure to take into account the benefits ensuing from contact with natural parents and family.

Without these mechanisms, children become ‘invisible’ in the system and their emotional needs remain unmet. In many cases, a series of failed placements exacerbates their already troubled situation and in some cases this culminates in a drift towards the streets and homelessness.

Returning to the data presented above for children on orders, a gender breakdown reveals that 52.2 per cent of children on orders at 30 June 1998 were boys and 47.8 per cent were girls.

The number of indigenous children on orders at 30 June 1998 was 803 (a 3.5 per cent increase over the previous year). The rate of protective orders per 1,000 indigenous children was 17.9, making them six times more likely to be subject to orders than non-indigenous children (whose rate was 2.9 per cent).

Children who are on orders are placed in either shared family care (home-based care with approved care providers) or residential facilities, although some may remain with their family. Of the 2,156 children under orders at 30 June 1997, 2,041 (94.7 per cent) were in shared family care and 115 (5.3 per cent) in residential facilities.

While these statistics are useful, a detailed needs analysis conducted by DFYCC officers in 1994 provides a more comprehensive picture. A representative sample of 192 families chosen from families involved in child protection interventions gives further insights into the demographic features of the child protection caseload (DFYCC 1994). Of the children surveyed:

- there were the same number of males and females
- the majority lived with family members (38.5 per cent with parents and 15.6 per cent with extended family)
- 56.3 per cent were aged 11 years or younger
- 92.2 per cent were Australian born, from an English-speaking background
- 31.3 per cent were of indigenous background
- 22.9 per cent had been the subject of three or more substantiated abuse notifications
- almost half had been subject to a guardianship order for two years or longer
- 30.2 per cent were not subject to any court order
- 38.5 per cent were placed in alternative care, the vast majority in shared family care.

Of the parents interviewed:

- 52.2 per cent reported annual incomes of \$16,000 or less
- compared with the total Queensland population, parents in the study were almost three times more likely to be single parents (47.8 per cent) and over four times more likely to be on government pensions (51.1 per cent)
- for 13.3 per cent of families, the highest level of education completed by either parent was primary school; more than half had completed high school, a quarter had completed a certificate, diploma or trade, and in only one family had a parent completed a tertiary degree
- a number did not have access to transportation that would enable them to access much-needed services (47.8 per cent did not have access to a car, and 53 per cent of those without a car did not have access to public transport)
- 17.8 per cent did not have a phone in their home.

Of further interest are the impediments to the parents' ability to act protectively towards their children. These included:

- inability to recognise and meet their own needs (60 per cent)
- experience of childhood abuse (40 per cent)
- suffering from physical illness or disability (9 per cent)
- suffering from a psychiatric disorder (10 per cent)
- alcohol or drug abuse (40 per cent)
- fear of the offending parent (8 per cent)
- other unresolved emotional issues (60 per cent).

These factors illustrate, to a limited extent, the obstacles parents face in trying to parent their children, as well as the extent of the help they need. More sobering is the indication that 83 per cent of these multiple needs remained unmet. These included:

- families not being assisted to develop adequate personal and community supports
- parents not being assisted to develop the skills necessary to meet their child's needs, nor to address and cope with their own personal problems and stressors.

For the children in care, 76 per cent of identified needs remained unmet, and for adolescents, 69 per cent of identified developmental needs were not completely met. Of the reasons listed, 41.1 per cent of unmet needs were statutory responsibilities, while 37.1 per cent were due to clients being unable or unwilling to personally address problematic issues. Community issues accounted for 13.5 per cent of unmet needs. A link was identified between relevant departmental staff not identifying areas of need and their lack of perceived time available to

meet with children, parents and care providers in order to make assessments and negotiate services. In addition there was evidence of a lack of service coordination.

Particularly relevant to this Inquiry is the declining percentage of children in residential care. In June 1987, Queensland had a capacity of approximately 390 residential placements, compared with 186 in June 1996 (DFYCC, *Challenges*, 1998). As at June 1998, 41 per cent of children on an order were living at home or with relatives. In addition, 39.6 per cent were in shared family care placements (previously foster or approved person placements) (DFYCC 1997/98).

### **Adolescents in the welfare system**

Another area where the State as ‘corporate parent’ (the term is now used to designate the complex interaction between various departments such as Child Welfare, Education and Health who are all involved in determining a child’s experience and future) has significant problems is in the provision of services for adolescents, where the welfare needs of the young person may be complicated by, and lost within, the requirements of the juvenile justice system. This duality has a long history, beginning with the *Industrial and Reformatory Schools Act 1865* which provided for two classifications of children under 15 years—unmanageable children with criminal tendencies and neglected children.

Practice, however, has long blurred the demarcation. The *CSA 1965* separated children in need of protection from children who committed offences by providing two categories of guardianship orders—care and protection and care and control. Following a period of welfare focus, a justice model of intervention gained support during the 1980s. The *Juvenile Justice Act 1992* introduced separate jurisdictions for young and adult offenders, and a range of distinctive orders and programs. An integrated approach was established with a clear philosophy and direction (QCSC 1997; DFYCC, *Securing*, 1998). As well as certain obligations to justice administration and crime prevention, the State has a duty of care to provide:

- a safe, humane and age-appropriate environment that minimises the potential harm to children arising from the detention experience
- an alternative to family care that facilitates, wherever possible and appropriate, the ongoing and enhanced involvement of parents in the care of their children
- services, work practices and environmental conditions that are sensitive and responsive to gender, cultural and religious beliefs and practices, geographical origins and individual needs of children in detention.

Adolescents in non-detention residential care are often emotionally and behaviourally disturbed. The magnitude of this work is very evident, and Clark (1997) portrays a realistic image of this group:

*The young people presented with cumulative developmental losses that are associated with a childhood marked by deprivation and disadvantage and particularly with abuse and neglect. Children and young people who have been maltreated show impairments in social skills with peers and adults, and in self-esteem. They are more aggressive, withdrawn and impulsive than non-maltreated children. In adolescence, the losses are coupled with greater social deviance and ‘acting out’ behaviour ... a significant proportion (23.6 per cent) ... were assessed as mildly intellectually disabled or, in the case of the younger ones, developmentally delayed.*

An indicator of current problems in welfare systems for children and adolescents is the average annual growth rate of 18 per cent for children on supervised or custodial orders, with the general population having increased by only two per cent. Stronger coordination is required inter-departmentally, especially between DFYCC, Queensland Health and Education Queensland personnel.



### Special needs placement

The DYFCC through the Shared Care Program in the non-government sector is developing non-placement and placement services that are flexible and responsive to needs, such as Special Needs Placements. In these programs recruitment is geared towards finding carers who can devote full-time care on a one-to-one basis (no other children can be in the household) for a 90-day period, with substantial support from professional staff. Carers are paid \$18,000 per year regardless of whether or not a child is with them, and are expected to offer support to other carers when no child is placed with them.

Although still in the early days of implementation, difficulties have already arisen in the recruitment of appropriate carers. There is, nationally, an intention to move away from small group care and to replace it with kinship care or one-to-one care, because, it is held, the group model is unable to meet the extensive needs of this client group.

However, these alternative models are not without their own inherent difficulties. Violent behaviour, intimidation and property damage are serious issues in adolescent group home settings, and these can be more threatening and damaging in a one-to-one situation. Kinship placement may embody the dysfunctional patterns of interaction which indicated the need for care in the first place.

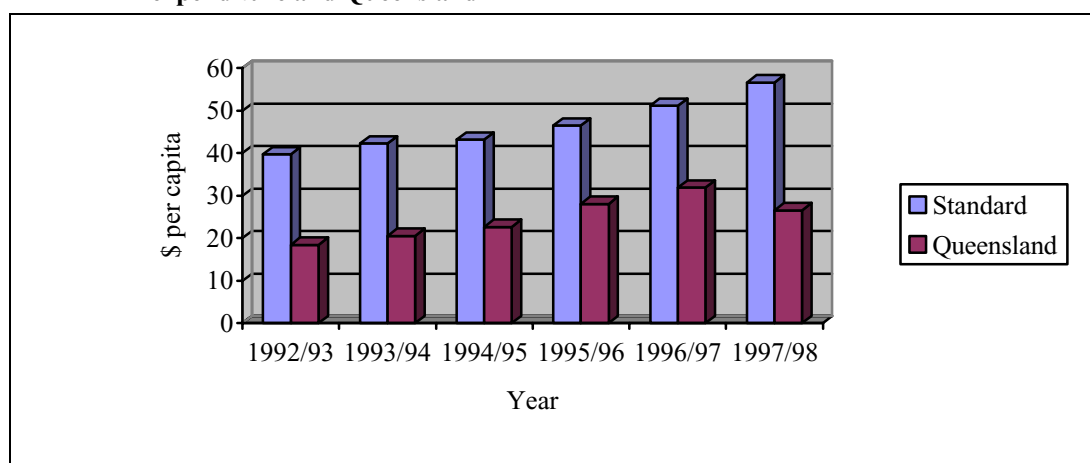
Clark (1997) found that there were some young people with a history of failed foster placements behind them who were quite adamant that they did not want to continue trying. Other studies suggest that adolescents are not generally keen to be placed with foster carers because of their feelings of loyalty to their own families (Willow 1996). For these young people a small group residential is needed. Advocates of the Special Needs Placement model stress the essential provision of substantial support for all participants if risks are to be managed and goals achieved.

A shortcoming of the Queensland model is the 90-day limit which some believe is insufficient to address the complex and multiple problems of many adolescents in care and, more particularly, for those leaving care. The DFYCC is piloting a new care program with 'one-off' funding. Given the need, such programs are a vital source of help to young people returning to a fragile family environment or facing an independent but uncertain future. It appears that a range of out-of-home care, from one-to-one special needs through foster carers to small group residential care, will continue to be necessary to address the range of needs of children and young people.

### Funding issues

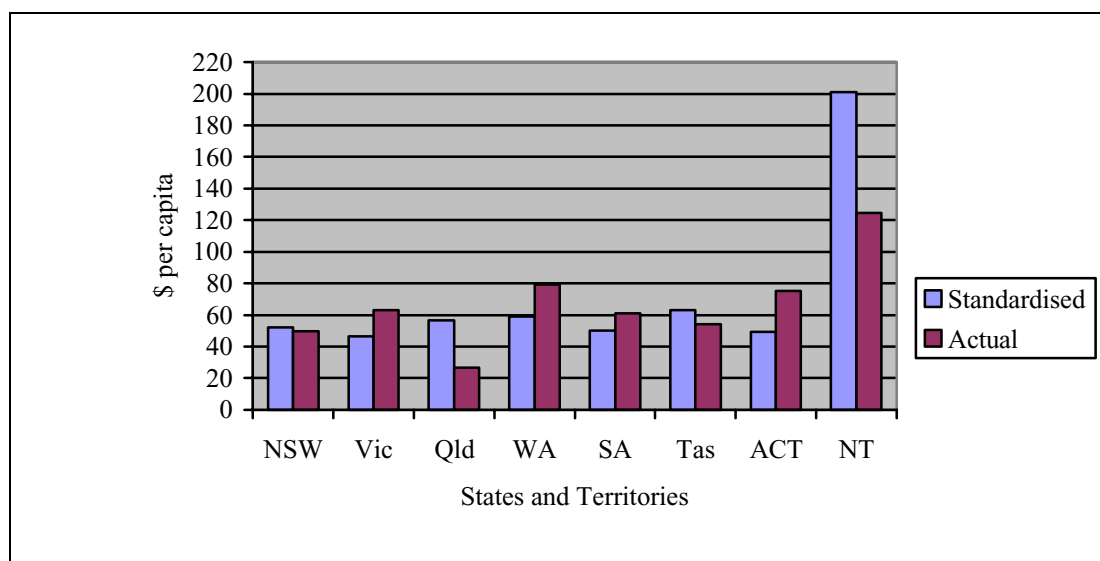
Child welfare in Queensland has for many years been underfunded in comparison to the rest of Australia.

**Figure 6.1: Family and child welfare per capita expenditure, 1992/93–1997/98, standardised expenditure and Queensland**



Sources: Commonwealth Grants Commission, *Report on General Grant Relativities, 1998 Update* (data presented by Dr Ian O'Connor, Public Hearing, Forde Inquiry, 12 November 1998); DFYCC, Director-General, 1999.

**Figure 6.2: Family and child welfare per capita expenditure 1997/98, comparison of standardised expenditure and actual expenditure for Australian States and Territories**



Source: DFYCC, Director-General, 1999.

Figures 6.1 and 6.2 are based on Commonwealth Grants Commission data. Figure 6.1 illustrates family and child welfare per capita expenditure for the years 1992/93 to 1997/98, comparing standardised expenditure to actual expenditure for Queensland.

Standardised expenditure is calculated as an adjusted figure for the different levels of spending required by individual States taking into account their varying demographic circumstances. Standardised expenditure is derived from an adjustment to a national standard, which is a weighted average of all States' standardised expenditure.

Figure 6.1 shows clearly that in Queensland, from the early 1990s, actual expenditure on family and child welfare has been well below standardised expenditure. In 1997/98 Queensland spent \$26.57 per capita in the family and child welfare category, which was only 47 per cent of the \$56.62 required to provide a standard level of service in Queensland.

Figure 6.2 reveals that Queensland expends the lowest percentage (47 per cent) relative to the standard compared with all other States and territories.<sup>1</sup>

In real dollar terms Queensland's actual expenditure for 1997/98 was \$91.072 million, of which \$80 million was spent on child protection services. Of this amount 88.75 per cent (\$71 million) was expended on child protection intervention services, with few resources (11.25 per cent, or \$9 million) for prevention and family support services.<sup>2</sup>

An additional \$30.05 per capita or \$102.982 million would be required to bring Queensland expenditure on family and child welfare in line with the costs required to deliver nationally comparable, standard-level service.<sup>3</sup>

This underspending in Queensland has numerous adverse consequences for DFYCC's performance in the field of child welfare, one of the most important being issues relating to staff performance and client outcomes.

#### **Recommendation**

That the Queensland Government increase the budget of the Department by \$103 million to permit it to meet the national average per capita welfare spending for children, and agree to maintain the increase in line with the national average. The additional resources should focus on the prevention of child abuse through supporting 'at risk' families, respite care, parenting programs and other early intervention and preventative programs for high-risk families.

### **Staffing issues in the welfare system**

Staffing levels in Queensland have not kept pace with demand. There has been an average 7 per cent per annum increase in the number of family services officers over the past five years, while notifications have increased by 14 per cent per annum. These staffing levels are coming from a very low base (186 family services officers in 1992/93 to 240 in 1997/98).<sup>4</sup>

Queensland's system has historically been efficient; expenditure is low and outputs are high relative to other jurisdictions. For example, an average caseload for a family services officer in Queensland is 25 to 35 cases plus six notifications per month. The average caseload in Western Australia and Victoria is 15.<sup>5</sup>

Although direct comparisons of caseloads are difficult because there are differences in the way jurisdictions undertake child protection, clearly caseloads in Queensland are high. Family services officers are involved in all tasks including intake, investigation, casework and case management. In other States, intake functions may be undertaken centrally, and there is much more outsourcing of casework to the community sector.<sup>6</sup>

The main consequence of underspending on prevention and family support is higher rates of statutory intervention. For example, Victoria achieves low rates of statutory intervention and a reduction in the length of time children spend on guardianship orders because it invests in early intervention.<sup>7</sup>

Inadequate spending on intervention services means departmental officers cannot keep pace with the escalating demand, leading to a real decline in service quality over time. On a range of indicators, outcomes for children and families are poor:

- Placement turnover is high.
- Children are leaving care without sufficient support or independent living skills.
- There is a high level of over-representation of indigenous children on order.
- There is insufficient monitoring of, and departmental support for, placements.
- Educational outcomes for children in care are poor (DFYCC, Director-General, 1999).

The departmental case management framework sets out minimum standards for intervention from intake to case closure. The framework includes a process for case assessment, planning, implementation and review. However, departmental officers are frequently not able to meet the minimum standards. For example, family meetings (to inform and involve families in case decision making) and placement meetings (to make foster carers aware of the particular needs of a child placed with them) are not undertaken as often as they should be.<sup>8</sup>

The nature of child welfare work demands highly trained and well-supported staff. The work is both emotionally and physically draining, and early staff burnout is common. External professional development and line supervision are essential. Faced with the adolescent's anger, frustration and possible violence, workers need assistance in dealing with their own natural reactions of resentment and revenge. Without thoughtful assistance and review of both personal and professional attitudes, there is the ongoing risk of inappropriate responses from staff that might culminate in abusive incidents, the tragic results of which have been in evidence during this Inquiry.

The morale of child welfare workers is also affected by inadequate funding, which prevents them from operating effectively. As well, there are the consequent costs in ongoing damage and despair felt by children, young people, their families and carers. High-quality, regular supportive supervision of child welfare workers is an essential component to maintaining an effective workforce.

Many community-based programs experience difficulty in obtaining and retaining sufficiently expert and experienced staff because of their inability to keep pace with remuneration or career opportunities more readily available in the statutory sector. However, even where

industrial Awards have been won, the ability of non-government organisations to meet increased remuneration rates has been limited. Some organisations have kept costs contained by reducing staffing levels while paying workers at increased rates. This has an appreciable negative affect on service delivery.

## 6.4 CONCLUSION

This chapter has briefly summarised the key contemporary issues in child welfare relevant to the Inquiry. The child welfare system has been, and continues to be, beset by funding inadequacies, which impact on the staff and services that can be provided. One key effect of this has been the overwhelming focus on child protection interventions, and a virtual absence of focus on prevention and family support. There have been measurable increases in notifications of child abuse and neglect this decade, and a continuing but lower rate of increase in children on protective orders. The majority of children on child protection orders are older children, and indigenous children are six times more likely to be placed on a child protection order than non-indigenous children. The placement of adolescents is a significant challenge to the system, as many of them are emotionally and behaviourally disturbed. Residential services are not equitably distributed across the State in response to need, leaving some areas of Queensland without access to residential care services. A significant positive development has been the enactment of the *Child Protection Act 1999*, which provides a strengthened legislative basis for the protection of children in care.

## ENDNOTES

<sup>1</sup> Actual family and child welfare per capita expenditure for Australian States and Territories 1997/98 expressed as a percentage of standardised expenditure is: Queensland, 47; Victoria, 135; New South Wales, 95; Western Australia, 134; South Australia, 122; Tasmania, 85; ACT, 153; Northern Territory, 62 (DFYCC, Director-General, 1999).

<sup>2</sup> DFYCC, Director-General, 1999.

<sup>3</sup> Op cit.

<sup>4</sup> Op cit.

<sup>5</sup> Op cit.

<sup>6</sup> Op cit.

<sup>7</sup> Op cit.

<sup>8</sup> Op cit.

## CHAPTER 7: 'CORRECTIONAL' FACILITIES (1900–1998)

### 7.1 INTRODUCTION

This chapter examines how the Queensland government has provided institutional care for young people deemed to be in need of 'correction'. It is essentially an analysis of the reformatory schools and detention centres that were established to confine children charged with or convicted of criminal offences. The institutions in this category are Cleveland Youth Detention Centre in Townsville, John Oxley Youth Detention Centre in Brisbane, Karrala House in Ipswich, Westbrook Training Centre near Toowoomba, and Wilson Youth Hospital in Brisbane. Also included in this chapter are the three denominational training schools located in Brisbane—Holy Cross, Kalimna and Mt Maria—that received the vast majority of girls committed to the care and control of the Director until the establishment of Karrala House in 1963. The chapter concludes with the Inquiry's findings in relation to the John Oxley handcuffing incident of 26 September 1989. Karrala House remains the subject of litigation and cannot be discussed in any detail. A complete case study has been forwarded to the Minister in the form of a closed report. Cleveland will not be addressed in this chapter since the Inquiry did not receive any substantial complaints with respect to that institution.

### 7.2 SENTENCING PROVISIONS

It is important to bear in mind that for many years most of the above institutions did not exclusively receive convicted children and those on remand. Under the *State Children Acts*, the Children's Court could direct that neglected children be sent to a reformatory. Furthermore, neglected children resident in orphanages or industrial schools could be transferred to a reformatory for misconduct. Such children could remain in the care of the Director until they reached 18 years of age (or, with Ministerial approval, 21 years of age). Under the *Children's Services Act 1965 (CSA 1965)*, children could be admitted to the care and protection of the Director either by application or by way of a court order. Similarly, a child could be committed to the care and control of the Director either by application to a Children's Court in cases where the child had not been convicted of a criminal offence, or if, having been found guilty of an offence, the child had been sentenced by a court to a period of up to two years on a care and control order. Care and protection children could only be placed at a 'child training centre' or 'correctional' facility if Ministerial approval had been obtained. Care and control children, however, could be placed directly in such institutions.

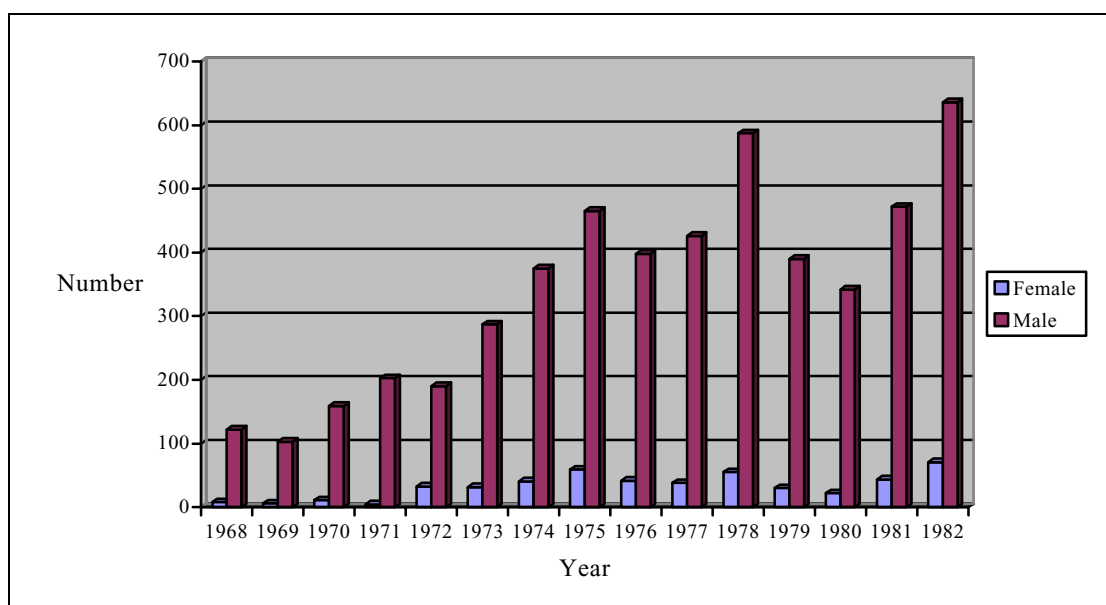
One of the most glaring inequities in these sentencing provisions was the possibility for children not convicted of criminal offences to receive what amounted to an indeterminate sentence in an institution primarily for convicted children. Neglected children, or care and protection children as they later became known, could, with administrative approval, be transferred to 'correctional' facilities until they reached 18 years of age if it was considered that their behaviour warranted the imposition of some form of treatment program. Similarly, children committed to care and control orders under application because they were considered to be in 'moral danger', 'uncontrollable', or 'likely to fall into a life of vice or crime or addiction to drugs', could remain in the care of the Director at a 'correctional' institution until they reached 18 years of age. In the most extreme case, a 13-year-old child committed to a care and control order for running away from home, repeatedly truanting from school or being considered to be sexually active could remain in the care of the Director at a 'correctional' institution until he or she turned 18—in effect, a five-year sentence. Another child of the same age who had been convicted of a number of criminal offences and committed to a care and control order could not be placed in a correctional facility for more than two years.

The uncertainty of this system served to compound the trauma that was being suffered by already troubled children. They were admitted to institutions for 'offences' that are considered by today's standards to be extremely trivial, and were forced to remain there without any knowledge of when they would regain their liberty. Their release date was arbitrarily determined by a range of specialists, the variety of which was dependent on the institution in which they were confined. Departmental care workers and institution staff

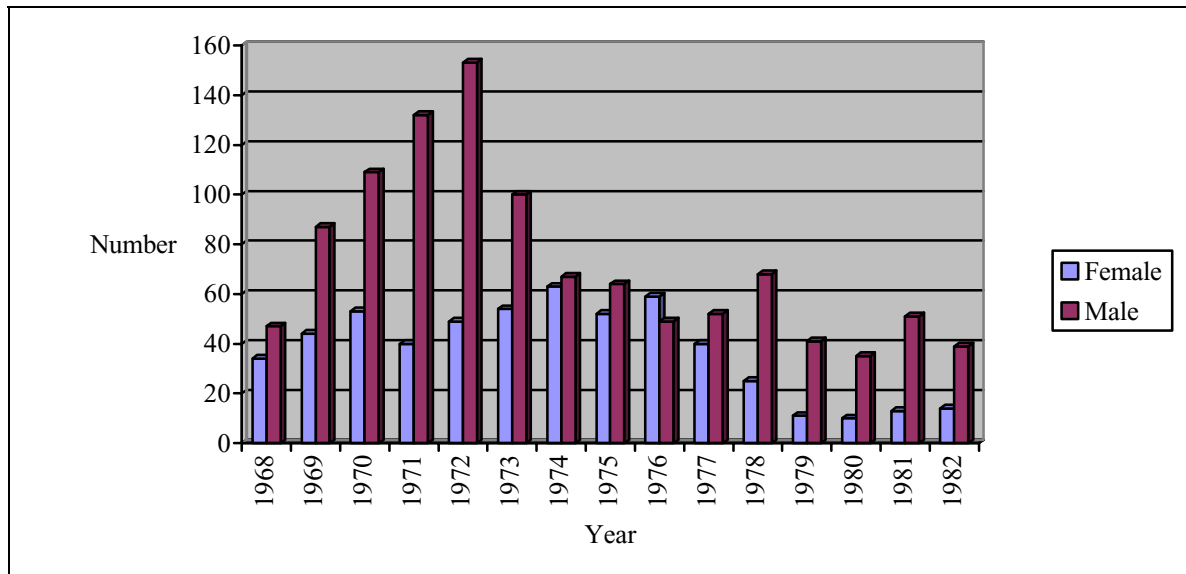
played the major role at Westbrook. Medical specialists influenced by psychiatric approaches to the treatment of juvenile delinquency were most influential at Wilson. Commonly, it was the staff of the denominational institutions, rather than the Department, that determined how long residents would remain in their facilities. This situation amounted to an abdication of the government's responsibility to prevent the deprivation of the liberty of its citizens. For those young men and women who were committed to denominational institutions that partially or exclusively catered for care and control children, it was often the expectation that they attain a predetermined number of points or pass through certain grades before they were released.<sup>1</sup> In such a system, where demotion was much easier to achieve than promotion, it was possible for a child to remain in care for an excessively long period. Whether in a State-run detention centre or in a denominational institution licensed to receive care and control children, many detainees were dependent on the arbitrary decisions of adult officialdom for their freedom.

A further inequity occurred in the implementation of these sentencing provisions. While boys were more likely than girls to be committed to care and control orders because they had actually been convicted of a criminal offence or were considered likely to offend sometime in the future (see Figures 7.1 and 7.2), girls were much more likely to be committed to such orders because they were considered to be in moral danger (see Figure 7.3). The label of 'uncontrollability', however, was attributed much more evenly (see Figure 7.4). The result was that girls were more likely to be institutionalised for offending against society's moral code, offences that usually amounted to defying the sexual norms prescribed for young women. The retention of the 'moral danger' provision was a de facto means for imposing a custodial sentence on girls whose behaviour was deemed to be unacceptable by sections of the community but not actually in breach of the Criminal Code.

*Figure 7.1: Numbers of children committed to care by children's courts and higher courts for offences, June 1968–June 1982*



**Figure 7.2: Numbers of children ordered into care as likely to lapse into a career of vice and crime, June 1968–June 1982**



**Figure 7.3: Numbers of children ordered into care and control as a result of being exposed to moral danger, June 1968–June 1982**

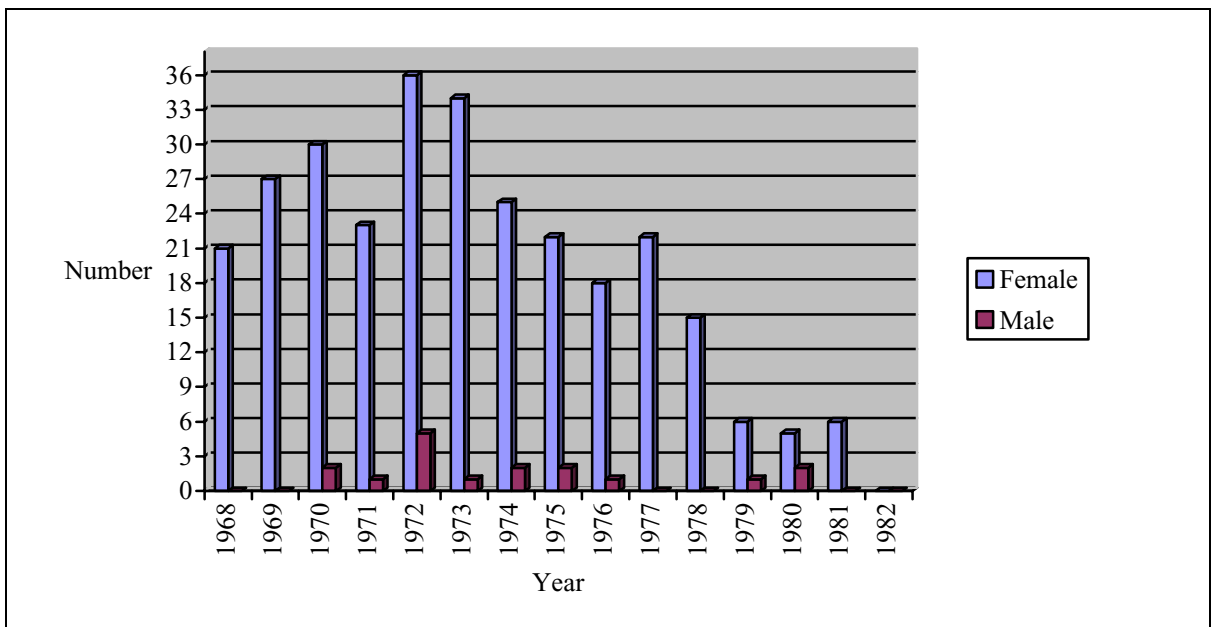
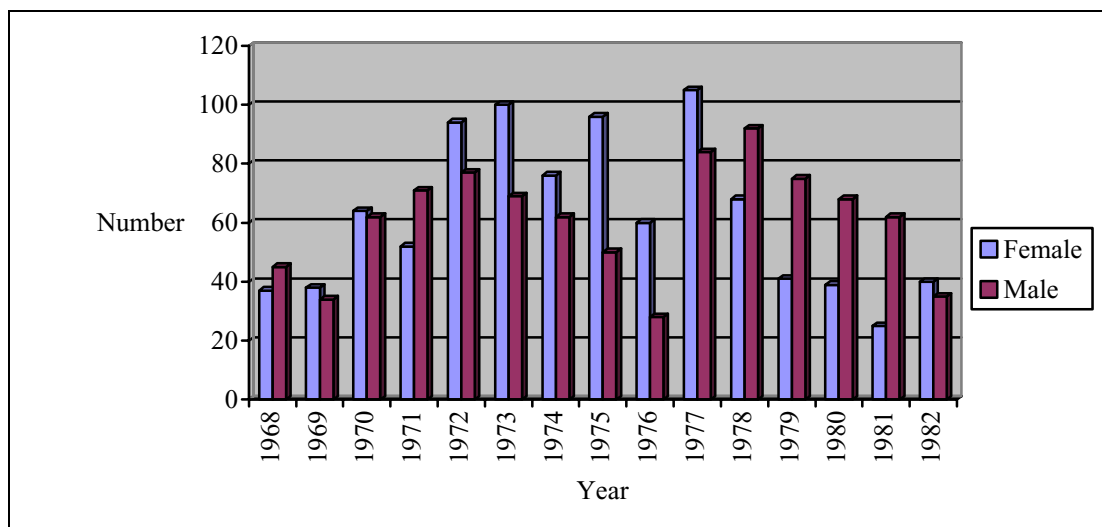


Figure 7.4: Numbers of children ordered into care as uncontrollable, June 1968–June 1982



### 7.3 WESTBROOK

Westbrook stood at the apex of the ‘correctional’ system for boys in care and was without doubt its most feared institution. The Inquiry heard many stories of the threat of being sent to Westbrook being used to great effect by orphanage and industrial school staff. A former resident of an orphanage recalled his response to receiving one such threat from a nun:

*I was a kid in the little boys’ dormitory. I must have been playing up. I was a 9-year old and I stood on the verandah of the dormitory, on the verandah of the convent, and I stood there all day one day, waiting for Mr P to come to take me to Westbrook. I never had so much fear in all my life.*

Sadly, this fearsome reputation was only partially the result of its strict system for rehabilitating ‘wayward’ youths. The possibility of suffering some form of abuse at the institution was the greatest dread for the majority of boys in danger of being ordered to undergo a period of training there.



Photograph 7.1: Westbrook Training Centre—a State-run institution for boys—Courtesy Queensland Newspapers

Westbrook was established as the Reformatory School for Boys in 1900 and operated continuously on the same site outside Toowoomba as a State-run institution for boys. From its



inception until its closure, it operated as a training farm in which the primary reformatory technique was agricultural labour. From 31 December 1912 it was administered under the *State Children Act 1911*. In 1919 it was renamed the Farm Home for Boys, Westbrook. It was renamed again in 1966 as the Westbrook Training Centre, and in 1987 as Westbrook Youth Centre. Later still it was re-designated the Westbrook Youth Detention Centre until its closure at the end of June 1994.

Convicted and neglected boys were sent to Westbrook until 1961. From that year, it was generally only boys aged 15 or older who were on remand or sentenced to secure custody who were kept there. Until the 1950s the average number of boys detained at Westbrook was 100–110. After the Wilson Youth Hospital was opened in 1961, numbers decreased to a daily average of 50–60 until the early 1980s. A new remand and admission section was opened in March 1987, and from then Westbrook had an operational capacity of 72 beds which remained largely unchanged until its closure in 1994.

There have been a number of previous Inquiries conducted into Westbrook. In the post-World War II period in particular there were three. The first, and most important, was conducted by Mr AE Schwarten SM following a mass break-out of an estimated 36 boys on 14 May 1961. A decade later, in June 1971, Mr PD Peel was appointed to conduct another Inquiry following newspaper reports that raised concerns about the administration of the institution and the treatment of inmates. The final Inquiry was conducted into the circumstances surrounding the disturbances and escapes that occurred in March 1994, prior to the closure of the institution. The present Inquiry has benefited from the reports and findings of these, and other, government Inquiries, along with a substantial volume of archival material. It has also received information in the form of submissions, interviews or sworn evidence from 42 former residents of Westbrook who were there between 1945 and 1994. This evidence has enabled this Inquiry to evaluate certain aspects of the institution between the 1950s and the 1990s, in particular the way in which residents were treated throughout this period.

Three significant events appear to have profoundly influenced the operation of Westbrook. The first was the appointment of Roy Golledge as Superintendent in 1952, following the sudden death of his predecessor, Thomas Macmillan. The second was the Schwarten Inquiry in 1961, which led to the replacement of Golledge shortly afterwards. The third was the introduction and influence of child welfare professionals in the mid-1970s and, in particular, the appointment of Alec Lobban, a senior child care officer, as Superintendent in 1977.

### **The early years**

The first Superintendent of the Westbrook reformatory school was Walter Richmond, a former schoolteacher. In 1916 he was replaced by Thomas Jones, who was appointed to institute a program of reform and to implement the new regulations formulated in that year to direct the management of the institution (*Queensland Government Gazette (QGG)*, Vol. 107, No. 17, 10 July 1916). With tertiary qualifications and extensive practical experience in agricultural science, Jones set about revising Westbrook's work practices. Within a decade he had increased the total area under cultivation from 30 to 320 acres and introduced a greater variety of crops. Reflecting this new emphasis, the institution was renamed 'Farm Home for Boys, Westbrook' in 1919. At this point, many badly needed repairs were made to the reformatory buildings and, in an effort to diminish the custodial aspect of the institution, the walls were demolished. However, although Jones concentrated on improving the agricultural and husbandry programs, he did not institute a significant program of rehabilitation for the inmates. Agricultural labour was seen as the primary reformatory technique and little thought was given to adding some variety to the work program.

In 1947 the Department appointed Thomas Macmillan as Superintendent—the first occasion that an appointment to manage the institution had been made internally. Following his death in 1952, his deputy, Roy Golledge, was promoted to the position of Superintendent.

### The Schwarten Inquiry, 1961

Abscondings were a persistent problem for the Westbrook administration throughout the 1950s, with an average of about eight escapes per year. In 1960, however, the institution experienced a sharp increase, with a total of 18 boys successfully absconding during the year.<sup>2</sup> The changing atmosphere did not pass unnoticed by the press. Newspaper articles drew attention to the likelihood of a mutiny occurring and warned that fatalities would inevitably result from the brutality of the Westbrook regime. On 14 May 1961 between 30 and 40 inmates broke ranks and ran in an attempt to escape. Another 31 boys absconded on 9 June 1961. Schwarten was later to conclude that a contraband copy of a *Truth* newspaper article of 14 May 1961 had actually been the catalyst for the first breakout, but many boys had already been planning to abscond in any case (Schwarten Report). The result of the mass absconding was a barrage of press reports and radio interviews, questions in Parliament, and numerous complaints from ex-inmates and parents of inmates. Even the majority of warders were calling for an inquiry to investigate the problems at Westbrook and to prove that they were not the 'sadistic' thugs that the *Truth* had made them out to be.<sup>3</sup>

The Schwarten Inquiry interviewed 54 current inmates, six ex-inmates, 11 warders and Superintendent Golledge. The present Inquiry found the findings of Mr Schwarten to be consistent with conclusions drawn from the evidence it has since heard from former residents.<sup>4</sup> After hearing all witnesses and assessing other evidence, Schwarten was left with the general opinion 'that the atmosphere at Westbrook was retributive and repressive, where even laughter was frowned upon' (Schwarten Report). He continued:

*To the inmate Westbrook must have appeared a punitive establishment in which he was required to sit out a period of detention, the length of which he did not know, except that it could continue until he attained his 18th birthday. To those detained for any considerable length of time it must have meant stagnation and mental anaemia, a condition conducive to the breakdown in morale and discipline and fruitful ground for the incorrigible to work upon, and this was the position the staff was called upon to face and to meet.*

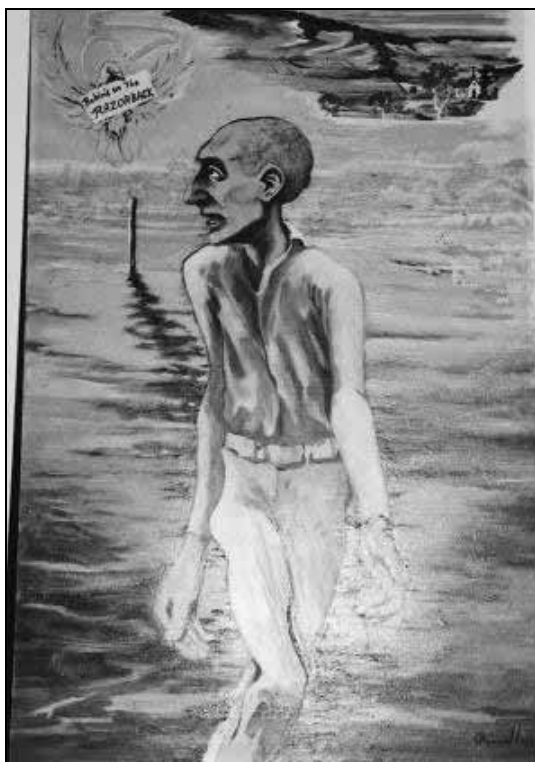
Without adequate resources and training, the staff had been placed in the position of having to act as guards only, and they adopted the only methods they knew to maintain discipline and security.

Mr Schwarten reported on the many complaints made by the inmates. Criticisms were made of the deficient clothing, poor standards of food, crowded, cheerless dormitories, inadequate hygiene and excessive drill. Punishment, however, was the issue that provoked the greatest number of complaints. Indeed, almost half of Schwarten's final report was devoted to the institution's punishment practices. He summarised the inmates' complaints as follows:

*The strap was excessively used, was over severely used, punishment for breaches of discipline was unduly harsh and excessive, there was inequality of punishment and uneven justice, and ... inmates were physically assaulted by the Superintendent and certain warders and the schoolteacher in a manner that was vicious and brutal.*

He found that castor oil had been administered as a punishment for offences like eating produce from the fields and pants-wetting. On one occasion the Superintendent himself administered the punishment by forcing back the head of the offender and pouring the oil straight from the bottle into his mouth. Minor offenders were also punished by being made to 'walk the path'. A former resident described this punishment, which was mentioned by numerous witnesses:

*Well, they had about half a dozen posts in a row, about three metres apart, and they were about 25 to 30 yards long and sort of run up a bit of a hill ... and you had to march up and down that all your spare time, and turn around at the end and march back down like that, all day, all your spare time.*



*Photograph 7.2: ‘Walking the path’ (painted by Robin Parnell)  
—Inquiry photograph*

These minor offenders were also required to spend their evening recreation time standing to attention at the front of a room. The length of this punishment was entirely arbitrary, varying from a few hours to a few months, and offenders were not informed of the expected duration. Absconders generally received the longer sentences as partial punishment in addition to the strap. Sunday, or visitors’ day, was the only day that offenders were not required to walk the path—no doubt to conceal this practice from public scrutiny.

It was the infliction of corporal punishment that became the main preoccupation of Schwarten. The regulations explicitly provided for the use of corporal punishment, but they were surprisingly vague on the manner and circumstances in which it should be employed. It was simply stated that the Superintendent could administer corporal punishment to any inmate guilty of misconduct, and that all incidents had to be recorded in the punishment book. Furthermore, the punishment should be used as seldom as possible, and ‘only when absolutely necessary for discipline, and not for first offences unless of a grave nature’ (*QGG*, Vol. 99, No. 24, 20 July 1912). A 1958 amendment to the regulations stipulated that corporal punishment could only be applied to the gluteal (buttocks) region (*QGG*, No. 86, 15 November 1958).

Schwarten made a number of criticisms of Gollidge’s use of corporal punishment. First, he found that it was used far too frequently—386 occasions in the period from August 1957 to December 1958—and it was often used to punish boys guilty of trivial offences. He also found that inmates were occasionally flogged without proof of any offence having been committed. Corporal punishment was also used to extract confessions or information from inmates innocent of any offences. Boys were not informed of the number of strokes they were to receive prior to the commencement of a flogging, and the Superintendent would frequently adjust the number depending on the demeanour of the offender. A former resident described the experience:



*You'd take your pants down and bend over and he flogged you till you screamed enough ... You had to scream out 'Ooh Sir, Ooh Sir!' and if you kept screaming he eventually laid off.*

*Photograph 7.3: 'Ooh Sir!' (painted by Robin Parnell)*  
—Inquiry photograph

Schwarten also drew attention to the degrading practice of applying corporal punishment in public. This had always been a common occurrence at the institution, even when the strap was applied to bare buttocks. However, the spectacle generally provoked a show of solidarity among the boys as most would turn away to demonstrate their disgust. Finally, the punishment book did not accurately record the frequency of floggings, as many incidents were simply not chronicled by the Superintendent or entries were made in which the number of strokes was less than had actually been inflicted (Schwarten Report).

Superintendent Golledge was singled out for special criticism, for he was the one responsible for the infliction of corporal punishment. He not only used the strap, but frequently kicked and punched inmates, and hit others with a piece of hose. Many of the disciplinary problems at Westbrook were the result of his brutality. What makes Schwarten's observations even more condemnatory was the fact that he was not an opponent of corporal punishment himself. Indeed, he thought that abolishing the penalty could well result in a loss of discipline and control (Schwarten Report).

The Report also included a number of other important recommendations, including the promulgation of a revised set of regulations, the immediate increase in the clothing issue to each inmate, the need to segregate offenders according to age and individual needs, the introduction of staff training and improved selection procedures, the separation of boys into privileged and unprivileged sections on the basis of a weekly points system, and the approval of smoking for boys older than 16. Schwarten also suggested that inmates younger than 16 should be removed from association with older boys and placed in an institution based on the 'cottage system', in which groups of 78 boys lived in small family units with suitably qualified houseparents.

The mass escape and the ensuing Inquiry were the inevitable results of institutional practices that had remained free from independent scrutiny and had long been ignored by successive governments. Aware of the need for a dramatic transformation, the Department instituted a variety of changes at the institution. The outcome heralded a new era in the provision of correctional treatment for young male offenders. A security unit was hurriedly opened in September. Recalcitrant inmates were confined indefinitely within this unit, and were

required to participate in an extensive program of physical training in the adjacent fenced compound. The Chief Prison Officer from Brisbane Prison was also seconded to advise the Superintendent and to train the staff in security matters. As a result, wire fences were erected in various sections of the establishment, glass windows were either grilled or removed, lighting was secured, distress alarms were installed, routine searches of inmates were established and the inmates were segregated according to security risk. These changes ensured that the institution would become even more like an adult prison.

### *Evidence from former residents*

The Inquiry heard from 13 witnesses who were residents during this period. Two of these former residents felt they were treated reasonably; others expressed less favourable opinions. As with the Schwarten Report, while there was criticism of the clothing, standards of food, lack of education and the dormitories, the major criticism was of the excessive discipline and physical abuse.

Eleven witnesses from this era referred to beatings or floggings by Golledge. One former resident vividly described the period when Golledge was acting Superintendent:

*Westbrook was a place of extreme violence, institutionalised cruelty, both physical and emotional. Severe public floggings and bashings and verbal abuse and poor diet created an atmosphere of tension and fear, which adversely affected all of the boys, not only those directly assaulted, but those who witnessed those assaults. Apart from Golledge, there were five staff members who [participated] in violent acts committed on boys, acts which were initiated by Golledge ... There was no doubt in my mind that he enjoyed flogging boys. These floggings were always administered publicly and always on the naked buttocks. His floggings were administered with a heavy leather strap... He was a voyeur inevitably present in the bathhouse where ... his responsibilities did not necessarily take him, and elsewhere where boys were in a state of partial or complete undress. He often espied ... through the dormitories' windows as the boys undressed for bed ... He invariably carried his strap in his pocket ... He had an obsessive interest in boys caught masturbating or performing sexual acts with other boys.*

The same witness described a boy being strapped with a belt at least 40 times by Golledge (and then by another officer) for stealing a carrot while working in the orchard. He says that the boy was about 15 years old and physically immature. After the beating he was made to kiss the other officer's boots. Before he dressed, he was ordered to repeat to Golledge this statement: 'Thank you, Sir, for teaching me the evil of my ways.' The witness also said that he was frequently assaulted for a variety of trivial offences by an officer who was in charge of the dairy. He witnessed public floggings, including the flogging of a boy for absconding. When brought back after his escape, the boy had bruising about his face and two black eyes. He claimed that at no time did Golledge administer less than 12 strokes, and it was frequently between 25 and 30 strokes. This was supported by another witness who referred to severe floggings of 60 strokes administered for running away.

This description of physical abuse at the hands of Golledge was corroborated by the other witnesses from this period. One described his own experience of a public flogging:

*Now I might have been talking to someone but I wouldn't be making a lot of noise, you wouldn't be game to. Anyhow, then he started on me. It's all in that [Schwarten] Inquiry anyhow. ... he just started to bash, grab me by the ears and all my ears were half bloody pulled out and bashing my head against a tin wall and knocked me from there inside the bathhouse and give me a kicking in there, and kicked me in the side of the head ... and ripped all the side of my face up here with big scars all down the side of my face.*

Another witness described assaults on boys by the officer in charge of the dairy and by another officer.



**Photograph 7.4: Westbrook boys working in the dairy (1958)**  
—Courtesy Queensland Newspapers

A former resident stated that he was transferred to Westbrook from an orphanage having been designated ‘uncontrollable’. He was not informed that he would be going to Westbrook, only that he would be found work on another farm. After being escorted by the police to his new institution, he was immediately confronted by the harsh discipline:

*And then I went up to Westbrook—they took me to Westbrook and I was told to toe the line. I no sooner toed the line than this bloke comes over—the Superintendent—and whacks me fair in the ear, and says ‘You’ll toe the line here, mate. You know what you’re here for. Get over there, get dressed.’ In with this crowd of other kids—hundreds. I didn’t know what the hell was going on ... Well I just mingled and sort of went on for about a week and went back and asked him one day, I said ‘I shouldn’t be here ... I’ve committed nothing,’ I said. He give me a belting and told me to get on me bloody way, and that was it. He was always a bastard of a man, that fella—Golledge.*

The witness had originally been committed to the care of the Department because his mother had died and his father was unable to care for him and his four siblings. After being returned to his father in the late 1950s, he was again committed into care because his father found him ‘uncontrollable’. He had not been convicted of a criminal offence before being designated a State ward or while working as a farm labourer, and he maintains that his transfer to Westbrook occurred because he had repeatedly absconded from an abusive employer.

Apart from the floggings or beatings described by the witnesses, a number also referred to the practice of certain boys being appointed as ‘sergeants’. Their role appears to have been to assist in the maintenance of discipline among the other boys. In particular, it seems that when boys escaped it was the role of the sergeants to bring them back. One witness, appointed as a sergeant against his wishes, stated that his experience of being a sergeant at Westbrook has rendered him devoid of humanity and destroyed him spiritually. He appeared to have suffered great emotional trauma from being forced to brutalise other inmates.

Some witnesses referred to boys being made to box with other boys to resolve differences between them—much to the enjoyment of the staff. Other disciplinary techniques used by the staff were making residents ‘kangaroo walk’, complete ‘hundreds’ of pushups and participate in forced drill. The cutting of hair with horse clippers was also reported to have been used as a punishment. It was little wonder that some former residents expressed the view that to be sentenced to an adult prison was a relief after the harsh regime of Westbrook. One witness said:

*Boggo Road Gaol compared to Westbrook when we were children was like going to a holiday resort. It was absolutely beautiful for all its bad conditions—it was just lovely compared to Westbrook. There were no beatings.*

G was a former resident of Westbrook in the period that Golledge was Superintendent. He had also spent time in Silky Oaks Haven for Children and the Salvation Army Home at Riverview before graduating to the adult prison system. He described to the Inquiry the brutality of the Westbrook regime:

*It was hell, hell from the moment you walked in the door. Beatings, the food, the floggings, the path, the kangaroo hopping, the compounds, the work conditions, the showers, the clothes ... everything. I still got scars on me back from [the beatings]. I still carry the scars and I still have big troubles in the side of me head where I got kicked there by the Superintendent and I've always had trouble even to this day from all this.*

*X was a boy that lived at Enoggera, not far from me. He was a good friend of mine. X went to Westbrook for something he did wrong ... a few months before I'd arrived there. He was only there a very short time [before] he escaped one morning. And he asked me to go with him. I wished I would have; he never went back. But anyhow I didn't because I was not strong enough .... I was only a small child, and I thought well I might get out because Judge A said I'll be out of there, for sure, within three months. So I said, 'No I'll stick around'. He went early one morning about 5 o'clock .... We were outside the bathhouse, a fog came over Toowoomba and he bolted through the side gate and got up in the mountains, and then he got away. I got a very bad flogging over that ... with my hair taken off—'cause I was speaking to X and they said 'You must have known he was going to run away.' Well I did know he was going to run away but I couldn't go up the office and say he was going to run away otherwise I would have got killed by all the boys anyhow ... I was in a 'no win' situation ... and I got flogged over that and put on the path [for about three months]. It was about 25 metres long ... and your hair was taken off by four-inch horse clippers ...*

*I was taken up the office, called out on parade. It wasn't straightaway after that, it was probably a few days later ... probably waiting to catch X to get us together. But anyhow, I was called on parade, taken up to the office ... one morning, and you had to take your pants down. And he'd start screaming at you, calling you humbug and a mongrel and a dog and all these things and just roaring at you. And you'd take your pants down and then you'd have to bend over and then he would produce a strap ... and wrap it around his arm—about two and a half feet [long and] ... about a quarter of an inch thick ... You'd bend over and he'd flog you ... You'd drop your pants too—you'd take your pants off and they'd fall down to the ground ... You had no underwear there ... You didn't have any. You weren't allowed to. I never seen any underwear ... He flogged you and, you know, it all depends ... what mood he was in [as to] what sort of flogging you received—till you screamed enough and you learned ... you had to scream out, 'Ooh Sir, ooh Sir!', and if you kept screaming 'Ooh Sir, ooh Sir!', he eventually laid off you. And then they produced the horse clippers and [a staff member would then] take all your hair off .... And put [you] on the path for maybe 10 or 12 weeks ... You had to march up and down ... all your spare time, and turn around at the end and march back down like that, all day, all in your spare time. Now that went on for quite a long time ... Your hair was taken off with horse clippers, and I had parts of my scalp missing at times but that was a part of the treatment ... they were pretty big heavy things.*

*[I saw] many ... terrible floggings. You'd see him flog them over the back with blood running down their ... back. I've had blood running down myself. Couldn't lay on my back or my backside for weeks from some of the floggings I've received. On a few occasions some of the new guys wouldn't know to sing out, 'Ooh, Sir!', and he'd keep flogging them till they'd submit ... and then once they'd start singing out ... he would stop flogging them. You know, it might only go two or three times after that. I mean, they were floggings, they weren't—they were not just hits on the bum. I mean, there was bits of skin [from] off your bum and blood was running down your back and down your bum and you couldn't lay on your back ... One flogging I had I couldn't lay on my back in that bed for a long, long time. I had to lay on my stomach because the pyjamas would be sticking to the blood on [my] scab.*



*Photograph 7.5: Westbrook dormitory—Courtesy Queensland Newspapers*

### *Sexual abuse*

Ten witnesses resident during the period in question told of sexual abuse. Six of them reported sexual abuse among boys and five reported sexual abuse by staff members.

Two witnesses said they were sexually abused by other boys. One said that in 1951 he was pack-raped many times by two or more boys, the first incident occurring within a fortnight of his arrival at Westbrook. Another recalled being sexually molested by a fellow inmate who put his hand on his penis. A former resident from this period said that he was aware of sexual abuse by bigger boys and of boys being raped in the shower. This was supported by another witness who said that sexual abuse between inmates happened all the time, mainly in the shower room. Two witnesses named two smaller boys who were sexually molested by other boys. One of these witnesses said that most of the older boys in Westbrook had a smaller boy who would act as their ‘girlfriend’ and have to submit sexually. He testified that the officers were aware of this practice.

Five witnesses reported that they had been sexually abused by members of staff. One witness stated that he was fondled and examined by Golledge on arrival at Westbrook, and suggests that Golledge had an unnatural sexual interest in the boys. Another said that he was sodomised on one occasion by an officer in charge of the dairy. Yet another witness had knowledge of sexual abuse by staff, although he did not experience it himself.

### **From the Swarten Inquiry to the 1970s**

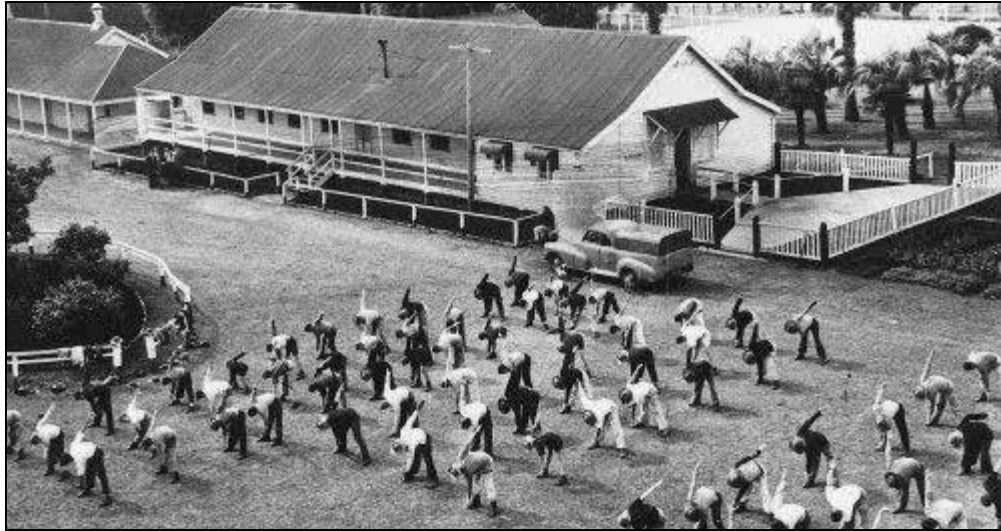
Golledge was replaced by Kevin Sullivan, a former prison warder. New regulations were introduced which set guidelines for the use of corporal punishment, a privilege system was instituted to facilitate better classification of inmates according to their behaviour, and a major rebuilding program was undertaken. But even as this rebuilding program was taking place Westbrook was having to cope with new challenges brought about by the gradually changing inmate population. Many more offenders were now being sentenced to detention, most of whom came from the Brisbane metropolitan area. There was also evidence to indicate that the recidivism rate was increasing and that greater numbers of indigenous youths were being admitted.<sup>5</sup>

In spite of the attempts to improve the conditions at Westbrook, these new pressures ensured that controversy would continue to plague the institution. A decade after it had played a role in initiating the Swarten Inquiry, the *Truth* again attempted to lift the veil of secrecy surrounding the closed institution. The newspaper printed allegations of excessive punishments, inadequate food, cases of mental illness and widespread homosexuality among the inmates, and also included details of a foiled plan for a mass breakout (*Sunday Truth*, 23



& 30 May 1971). In response, the government launched its second magisterial Inquiry into Westbrook.

The month-long Peel Inquiry confirmed that an escape attempt had been planned by about 20–30 boys (not the 90 reported in the *Truth*) but that they had decided among themselves not to carry it out (Peel Report). Mr Peel found most other allegations to be either incorrect or exaggerated. He did, however, condemn the practice of punishing troublesome inmates with an open-handed slap, and identified a few isolated incidents of staff using excessive force to control individual boys (Peel Report). Peel also conceded that there was a certain amount of homosexual activity among the inmates, but that it was infrequent, especially since the Inquiry had been ordered (Peel Report). There was also evidence to support the allegation that ‘unreasonable or excessive drill’ had been imposed by some of the training officers (Peel Report). In spite of Peel’s benign findings, there remained a great deal of suspicion about the happenings at Westbrook.



*Photograph 7.6: Westbrook drill—Courtesy Queensland Newspapers*

Another serious problem came in the form of a steady increase in admissions. This had led to extreme overcrowding before the Peel Inquiry had even been contemplated. At the end of 1970 a departmental official reported on the dire state of affairs:

*The numbers we have had at the Westbrook Training Centre recently and the rate of intake has reached a crisis point and is beyond our capacity to handle effectively. There are too many committals, too many interstate youths having to be accommodated, too many inappropriate placements, and too many readmissions particularly of over 17 year olds.*<sup>6</sup>

To make matters worse, abscondings were again occurring at an alarming rate—85 in 1971 and 83 in 1972.<sup>7</sup> The overcrowding was forcing staff to transfer new admissions from the remand and assessment section to other sections before the proper assessment procedures could take place. The situation continued to worsen during the next few years as the numbers of boys on remand gradually increased. In April 1973, 37 per cent of Westbrook’s inmate population were on remand (29 out of a total of 80 boys)—many of whom had to be accommodated in the medium security unit because remand was full.<sup>8</sup> By the end of the following year, the entire network of institutions to accommodate boys committed to the care and control of the Director was at breaking point.

The situation was summed up by the Department’s senior child care officer: ‘Children in care are suffering because of superficial assessment, overcrowding, the risk of homosexual assault, and lack of ability to appropriately classify and place children in appropriate facilities.’<sup>9</sup> In response, the Director instituted a firm policy of non-admission to care and control

institutions for the month of November, along with an indefinite procedure of requiring senior authorisation before any child could be placed in an institution.<sup>10</sup> The urgent measures introduced had an immediate impact. By placing with their parents children who would normally have been sent to a care and control institution, the Department found a temporary solution. A process of reducing numbers had begun, not because of a new enlightened philosophy with regard to the treatment of juvenile delinquency, but as a result of pressure created by overcrowding in Queensland's existing facilities.

Another obstacle to the maintenance of discipline at Westbrook was the burgeoning number of admissions of indigenous boys. Apparently, the main problem was that they banded together and maintained a strict code of loyalty. Some victimised the younger white boys, making threats and forcing them into unwanted sexual activity.

As well as causing problems for the Westbrook staff, there is also evidence that indigenous youths were discriminated against while in confinement. The Schwarten Inquiry had unearthed evidence of discrimination in the application of punishment, with indigenous offenders receiving more strokes than white inmates for identical offences. There were also allegations that Superintendent Golledge persistently applied greater force when he strapped indigenous youths, and that he frequently used racist expressions when referring to them (Schwarten Report). In 1971 the Visiting Justice was severely criticised for stating that there was no racial discrimination at Westbrook. A departmental officer clearly thought that there was, citing examples of indigenous inmates being held in the security section for longer periods than non-indigenous boys, and staff using racist terminology in the presence of inmates, as well as among themselves.<sup>11</sup>

With the multitude of challenges facing Westbrook in the early 1970s, it is no surprise that serious incidents were to occur. For example, in 1974 a training officer caught three boys engaging in sexual activity in the medium security unit. It was alleged that the boys were removed from the dormitory, taken to a nearby bathhouse and assaulted by two officers, then marched in the nude to the maximum security section and made to perform drill for two hours between 10.00 pm and midnight with a number of other inmates (the regulations did not sanction drilling for longer than 20 minutes at a time). They were again allegedly beaten by three officers while performing the drill.<sup>12</sup> An exhaustive police investigation took place, but not enough evidence could be gathered to prosecute the officers. There seems little doubt, however, that the incident took place.<sup>13</sup>

Regardless of the outcome, the incident highlights the powerlessness experienced by youths confined in detention centres. They could allege that they had been assaulted or adversely treated by staff, but their opportunities for redress were extremely limited. Given that it was virtually impossible for there to be any corroboration by impartial witnesses, it was nearly always their word against that of the officers. In the above case, there were two main impediments to a successful prosecution of the staff concerned. The first was the amount of time that had elapsed since the event in question; the second was that the status of the boys as detainees would always cast doubt upon their allegations—their accusations could always be interpreted as being motivated by malice. There were few incidents in closed institutions like Westbrook where these factors did not work against the inmates.

#### *Evidence of former residents*

The Inquiry heard eight witnesses from this post-Schwarten period. Their testimony suggests that changes were made after the departure of Golledge. One witness even suggested that Westbrook was transformed by the departure of Golledge. Others said that the change in the culture of Westbrook was somewhat more gradual, and that physical abuse in particular continued to occur, although not to the extent of the reported excesses of the Golledge era.

#### *Discipline and physical abuse*

Witnesses continued to complain of harsh physical discipline during this period. One witness stated that the Superintendent, Mr Sullivan, punished him with 48 hours in the cells and 21

days in maximum security for allegedly tearing his hat band. Two other witnesses from this period said that they were made to put on boxing gloves and fight with other boys as a punishment.

Another witness from this period told of being assaulted by a warder the morning after his arrival at Westbrook. He said that this warder knocked him to the floor and then threw a cast-iron bed over him, leaving a wound that was not stitched. He also stated that he was flogged with whips and straps by another warder. One day, after the beatings, the first warder found him crying and he began punching him in the head until he stopped. This witness also claimed that, when he was returned after an absconding attempt, he was locked in a cage for 48 hours. His description of the cage resembles the maximum security compound described by other witnesses. The former resident also described receiving another flogging at the hands of a warder while at work in the dairy.

This same witness described another punishment technique employed by the warders:

*They used to make you climb this tree back to front in the raw ... and when you were up there they used to feel your bum. The warder ... everything they made you do they'd make you strip. They'd make you do pushups fast. And this warder, he'd come in and drop-kick you in the guts.*

Several witnesses complained of excessive drill, and being made to 'duck walk', or 'crab walk', as punishment. One former resident stated that boys were drilled excessively for many hours during the day. Another said that he received his share of hidings, with fists and boots. He emphasised that belts were no longer used. Inmates were sent to the compound where they were drilled as punishment, and where there were also cells. He was thrown naked into a cell for throwing a stone at a roof (in a contest with another boy to see which one could hit the roof). After he was drilled, and after a few days in the compound, he was let out. He never absconded, but recalled that for those who did 'it was normally drill for three weeks if you shot through and got caught, and you got a terrible flogging'. He remembered inmates who were brought back. They would be dragged back by the hair or the leg or arm, while the staff were kicking them. He said that escaping was the worst possible sin, and the flogging would go on until the boy was unconscious. The compound was used for drilling, and boys would be made to march and to run doubled up. Punishment for 'offences' such as not attending school, not listening or not being focused on a book could be three hours' drill. The same witness also reported being hit by a warder in the dairy. If his account of Westbrook is accepted, there was still a great deal of physical abuse at that time. The practice of excessive drilling condemned by the Schwarten Report seems to have still been a frequent form of discipline.

### *Sexual abuse*

Two witnesses from this period reported knowledge of sexual abuse. One said he was aware of sexual assaults between inmates. Another said he saw a boy who was bruised all over and who said he had been raped and bashed by an officer commonly referred to as 'the fat rooster'. The victim told the witness he was going to escape, and the next day they heard that he had indeed escaped and had taken a car and been killed when he crashed it.

### *Outside supervision and opportunities for complaint*

A former resident stated that the Director of the State Children Department visited Westbrook a number of times and walked around examining the place. However, no improvements were perceived as resulting from his visits. Another witness placed the blame for the abuse at Westbrook on the Department for not adequately supervising the institution. He did add, however, that in his last four months departmental representatives visited every month. In his opinion the Department was making an attempt to improve matters, and the system was gradually changing. During a second period of detention in Westbrook, this same witness detected a positive change in the way residents were addressed: 'Even the way they spoke to you was a bit more civilised.' His observations suggest that, by this time, the punitive culture of Westbrook was gradually changing, apparently coinciding with greater involvement by the Department.

The same witness stated that a Visiting Justice attended the institution on a monthly basis to hear the boys' complaints. However, this seemingly positive gesture fell short of fulfilling its function as a complaints mechanism. The Visiting Justice heard the boys' complaints in a general assembly with the deputy Superintendent in attendance. The witness alleged that most boys with serious complaints were too intimidated to speak up. He remembered that after he complained about the food 'They gave me all the food I wanted which consisted mainly of bread, and said for every crumb ... I would do an hour's drill.' It does not appear that there was a system in place that enabled boys to make complaints in safety about their treatment at Westbrook.

### **The post-1970s: the impact of child welfare professionals**

Ill-health forced the premature retirement of Sullivan in 1977. In a significant departure from past policies, the Department chose as his replacement Alec Lobban, a senior child care officer. The nature of his background suggests that the authorities intended to institute fundamental changes to the philosophy informing the policies and procedures at Westbrook. In fact, when Lobban prepared a report in 1974 assessing the suitability of Westbrook as a training centre, he found it difficult to identify a clear philosophy guiding the operation of the institution. He argued that Westbrook was torn between three competing aims—punishment, instruction, and rehabilitation.

Lobban's report highlighted a number of other fundamental deficiencies in the system at Westbrook and made some important recommendations to improve the situation. The distance from Brisbane limited the possibilities for employing more capable staff, hindered effective communication between the Centre and government departments, and reduced the possibility of the boys maintaining contact with their family and community. Lobban also considered that the institution was too large with a capacity of 96. Much of the report was critical of existing staffing arrangements. Little attention had been given to staff recruitment procedures and in-service training. As a consequence, many training officers were poorly educated and incapable of making even the most basic assessments of detainee behaviour. The predominant perception was that their role was essentially custodial and that they were not to be involved in the rehabilitation of the inmate population.

With Lobban's appointment, modifications were immediately made to existing practices. The first significant change occurred in the area of in-service training for staff. With the appointment of Trevor Carlyon as the Centre's first psychologist, a training course was quickly reorganised and modernised.<sup>14</sup>

At the close of 1978 Lobban prepared another report on the state of Westbrook.<sup>15</sup> The Centre was now described as fulfilling four functions: a remand centre, an assessment and treatment centre, a training centre, and a detention centre. Boys were generally aged 15–17, with only a few older and younger boys. All boys were admitted by the courts and were in the care and control of the Department. In rare cases, care and protection boys were admitted if their behaviour was deemed uncontrollable.

Within four weeks of admission a boy's child care officer was required to present a report to the Review Committee which consisted of the Superintendent, supervising child care officer, deputy Superintendent, matron and psychologist. It was supposed to involve the boy's offending history, a family assessment, plans for accommodation after release, a personality assessment, other psychiatric information, and any other relevant details. The Review Committee then considered this report, along with an assessment of the boy's performance while in detention, and decided on an appropriate treatment program and length of stay.

Lobban's report also drew attention to the poor educational arrangements at Westbrook. At that time, there were two two-hourly classes being offered each week. In a report prepared by the psychologist, it was revealed that the boys were on average two grades behind in their level of education, and many were functionally illiterate. He emphasised that there was a clear need to establish a compensatory education program at the Centre to complement the existing

treatment plan.<sup>16</sup> The changes, however, were slow in coming. In 1981 the Youth Advocacy Centre complained that the educational needs of detainees were not being met at Westbrook and Wilson.<sup>17</sup> In a memorandum to the Department, Lobban reiterated the sentiments of the psychologist's 1978 report, but again nothing was done to improve the situation.<sup>18</sup> A full-time teacher was eventually appointed in 1986, but a schoolroom was not erected until 1989.

There were other positive changes under the administration of Lobban. In 1979 a new remand section was opened. Two years later the dormitory system was finally abolished and each boy was confined in a separate room, significantly enhancing the degree of privacy and safety (although there were serious ventilation problems during the summer months).<sup>19</sup> The program of community work that had tentatively been established in the mid-1970s was further developed under Lobban. In 1980 a number of boys were found employment in workshops for the intellectually disabled run by the Endeavour Foundation. The project was regarded as a success, ensuring that others would be organised. The experience gained by the detainees occasionally led to permanent employment.<sup>20</sup>



*Photograph 7.7: A positive change: each boy was confined in a separate room (although there were serious ventilation problems during the summer months)—Courtesy Queensland Newspapers*

In 1982 Lobban was seconded to work at head office, and Trevor Carlyon was formally appointed Superintendent the following year (the position was renamed 'Manager' in 1985). Carlyon continued to refine the program that he and Lobban had established during the previous few years. Westbrook was now quite a different institution from the one it had been a decade earlier.

There is little doubt that the brutality of the Westbrook regime was diminished under the new methods of Lobban and Carlyon, although it did not disappear altogether. There was a dramatic reduction in abscondings in the period immediately after Lobban relieved Sullivan in mid-1977; there were 31 abscondings before August and only eight in the second half of the year.<sup>21</sup> Despite complaints from some training staff and their union in 1980, serious assaults on staff were infrequent occurrences and were generally handled professionally by management. From July 1977 to August 1980 there were eight assaults on staff—a slight but distinct reduction from previous years.<sup>22</sup> Methods for addressing behavioural problems had gradually evolved from the reflex infliction of punishment to the more subtle use of cautions, reprimands, loss of privileges, restitution and brief isolation.<sup>23</sup> During Carlyon's term as Manager, the use of the 'time out' procedure had become the normal response to bad behaviour. Isolation in a bare cell or room for a short period of time was considered to be more effective than more direct punishments that tended to reinforce undesirable behaviour.

### *Evidence of former residents*

The Inquiry heard from 13 former residents of this period whose accounts varied significantly. Four complained of harsh treatment. One said that he was mentally abused and that the officers deliberately used to aggravate him because they knew he had a temper. Another stated that the training officers were a law unto themselves and would 'just start bashing you around for anything'. He was placed in a cell in 'the pound' for seven days and was told that an inmate had hung himself in that cell. A training officer would come round at night and make horrible noises to scare him. He referred to this as emotional abuse and said that the training officers had no compassion for children whatsoever. The same witness gave evidence of a solitary confinement area with 15 or 16 separate cells. He says the sections were remand, medium, privileged and 'the pound'. In medium, there were six to eight dormitories. Of solitary confinement in the detention unit he said 'It was horrific ... you couldn't imagine it unless you experienced it. You can't put it into words.' He said that a torch was shone through the window every four or six hours, a meal was brought three times a day and inmates were allowed to sit in front of their cells to eat it. They were allowed to exercise outside the cell for one hour each day. Another witness said 'Westbrook was just—at times terrifying because you were so alienated and helpless there'.

Some witnesses suggested that there were staff who were racist, or who treated indigenous inmates less favourably. Witnesses from the late 1970s and early 1980s suggested that indigenous boys were picked on more frequently by the officers and did not get as many privileges. It was alleged that they would receive more beltings and would go into the detention unit more often for a lot less. One suggested that this was 'because they [the staff] knew that there was very little chance of having family contact at the time they were there'. Another former resident recalled that some staff were racist. He could not remember them uttering racist remarks to him, but if non-indigenous boys requested things like phone calls, they would get them immediately, whereas sometimes indigenous boys would be denied the same privilege. Only one witness thought that the staff at Westbrook were not racist.

Five witnesses did not complain of harsh treatment during this period. One witness praised the work of Alec Lobban. He said that after Lobban was appointed circuit training (running around a tree with a pack full of rocks) was banned and boys started to receive an education in the chapel area. He tried to do his junior and maths there at night. Towards the end of his time, 'the pound' was unofficially closed and a new remand building was erected. The witness said:

*When Alec Lobban came in everything stopped, all the staff got a bit scared really of Alec. The grudge fights no longer happened, the officers changed overnight ... there wasn't any more detention ... there was punishments, but they were loss of privileges ... when I was up there, there was a lot of changes. Out of interest, I would like to know what happened. Politically, there must have been something. It was just too abrupt looking back on it. There was an in-house counsellor.*

A short time after leaving Westbrook, this resident obtained a boilermaker's apprenticeship and in 1981 he wrote to Mr Lobban to thank him and the Centre for the opportunities he had received.

### *Outside supervision and opportunities for complaint*

One former detainee recalled that the opportunity for complaint about the institution had not changed from previous years. The inmates were still asked to make their complaints to the visiting magistrate in the presence of staff. Another from this period said that departmental youth workers visited Westbrook, but he did not feel inclined to work with them. He added that the visiting magistrates attended periodically, but they were ineffective in bringing about any change; they listened to complaints, but nothing happened. One witness said he was unaware of the visits of any inspectors, but he did recall being visited by a child care officer who informed him that he was soon to be released.

### *Discipline and physical abuse*

It was noted above that reports of the discipline at Westbrook during this era varied. Some former residents had no complaints. One witness, who said he was treated very fairly at Westbrook, also claimed that there were floggings if detainees 'played up'. Another former resident said that as punishment for being caught smoking, the whole dormitory had to go to the gym in the evening and exercise naked. Staff in maximum security would set up boxing matches between inmates. Sometimes boys who did not want to fight were given no choice. He complained that people from the Department came to watch these boxing events.

Another witness said that punishment took the form of a good flogging by three or four officers. He identified a scale of offences. Punishments were two or three days in 'the pound', circuit training or a good flogging, normally with fists or a piece of wood that was hidden in the drawers. Inmates who tried to be assertive in any way were a target for punishment. He also reports grudge fights organised by the officers in which inmates were forced to fight in a boxing ring in the gym. These were held at least three times a week and officers on duty placed bets. Everyone was required to fight and there could be as many as nine fights in an afternoon, with injuries often being sustained. The loser might be made to do circuit training.

### *Sexual abuse*

Three witnesses from the period reported sexual abuse. One stated that some staff would encourage public ejaculation competitions. Apparently, an officer liked to watch these competitions. This witness alleges he heard from other boys that some inmates went away on weekends to a property with training officers and he believed that the trips were used to sexually abuse the inmates. He says that other inmates told him that they were sexually abused at Westbrook. Another witness from this period was informed about sexual abuse between residents, but was not aware of any sexual abuse by staff. Another former resident of a few years later did not witness any sexual abuse by officers, but on quite a few occasions witnessed abuse between inmates that was ignored by staff. Some detainees purchased sex from others with cigarettes.

### **The 1990s and closure of Westbrook**

Although improvements took place under the guidance of Lobban and Carlyon, the 1990s again reflected an unstable and volatile period for Westbrook. One reason was management instability. Following the departure of Carlyon, there were regular changes to the management of the institution and to the departmental structure within which juvenile detention was managed. There was even a lengthy period of time, prior to 1993, in which the Centre had no permanent manager.<sup>24</sup> In the early 1990s there were a number of serious incidents reported to the Department, including abscondings, attempted abscondings and other disturbances. Other factors reported as contributing to the precarious conditions were the higher proportions of young people detained for serious offences, increasing levels of sophistication among detainees, and the inability of youth workers to manage the changing behaviour of detainees. There were also increasing concerns that the geographical isolation of Westbrook caused problems for parents and relatives wanting to visit detainees, and made transportation to and from courts and other services in Brisbane difficult. The utility of providing tuition in farming skills for a detainee population that was predominantly urban was also being questioned.

A review of youth detention centre services was conducted by the Department of Family Services and Aboriginal and Islander Affairs between September 1993 and March 1994. Between 18 and 25 March 1994 serious disturbances occurred at Westbrook, and senior departmental officers were subsequently appointed to conduct an investigation. They reported to the Director-General on 8 April 1994, and highlighted a number of major concerns about the ability of Westbrook to provide for the health and wellbeing of its detainee population.<sup>25</sup> These included:

- basic needs of boys for nurture and physical safety not being met
- verbal and physical abuse between boys

- verbal and physical abuse between staff and boys
- the extent of drug abuse by boys before they came to Westbrook and during their stay
- the need for drug treatment services for boys and specific training for staff
- the lack of access to psychiatric services for boys who were suicide risks or otherwise disturbed.

On 12 April 1994 the Minister announced a number of revisions to the system for juvenile detention. These included the closure of Westbrook and renovations to two other existing youth detention centres (Cleveland and John Oxley). It was also proposed that a new youth detention centre be constructed close to Brisbane and that on its completion the Sir Leslie Wilson Youth Detention Centre be closed. Westbrook was eventually closed at the end of June 1994.

### Summary

In reviewing the evidence in respect of Westbrook as a whole, it would appear that until the early 1960s it was run on the basis of strict discipline with little awareness of the emotional needs of the boys and little attention to nurturing them or educating them adequately. During the 1950s, and up to the time of the Schwarten Report, there were particularly gross excesses in physical abuse that appear to be attributable to the influence of Golledge, Superintendent from 1952 to 1961. The worst excesses appear to have ended with his departure, but it seems clear that some unsatisfactory disciplinary techniques were retained and used by staff, along with some cases of physical abuse. Departmental supervision was only slightly improved after the Schwarten Inquiry, and the institution remained largely hidden from outside observation. The situation began to improve in the early 1970s when childcare professionals began to have a greater involvement in the running and supervision of the Centre.

The most significant effort to overcome past practices and improve conditions for the residents came with the appointment in 1977 of Lobban as Superintendent. The improvements in the way in which boys were treated, and the greater attention paid to nurturing, education and welfare, coincided with—or at least followed—a transformation in professional practices generally and a change in community attitudes towards the treatment of children in care. Regrettably, this era was short-lived and the situation again degenerated in the 1990s, resulting in the closure of Westbrook in 1994.

The evidence from witnesses to the Inquiry and from archival material shows Westbrook to have been a harsh environment, with a heavy emphasis on punitive measures and little on rehabilitation and treatment. Under the administration of Golledge in particular, control and punishment measures were brutal and sadistic, and far exceeded any acceptable social norm. Allegations of sexual abuse were made against both detainees and staff members. Many witnesses attributed serious and ongoing psychological and social effects to the trauma they experienced in Westbrook. It is questionable whether Westbrook was able at any period to protect and care adequately for the children detained there, other than perhaps briefly during the 1980s. Far from assisting in their rehabilitation, many of the incarcerated children would have left the institution more damaged and dangerous to the community than when they were admitted.





*Photograph 7.8: Holy Cross at Woolloowin, operated by the Brisbane Congregation of the Sisters of Mercy—Inquiry photograph*



*Photograph 7.9: Kalimna Vocational Centre at Toowong, operated by the Salvation Army—Inquiry photograph*



*Photograph 7.10: Mt Maria at Mitchelton, operated by the Sisters of the Good Shepherd—Courtesy Queensland Newspapers*

#### **7.4 DENOMINATIONAL HOMES: HOLY CROSS, KALIMNA AND MT MARIA (1950s–1970s)**

The Inquiry heard evidence from a number of former residents of the denominational homes for girls. Thirteen former residents, principally from the 1950s and 1960s, gave evidence of their time at Mt Maria, three of whom spoke favourably of the institution. There were also 13 former residents of Holy Cross, most of whom were residents in the late 1950s and early 1960s, four of whom, all resident after 1961, made no adverse comments about their treatment there. The Inquiry also heard from 13 women who had been residents of Kalimna from the late 1950s to the mid-1970s. A former departmental child care officer also gave evidence in relation to Kalimna.

##### **Background**

At around the same time as Westbrook was being established, the government closed the reformatory for girls at Toowoomba, leaving the denominational industrial schools as the only institutions for the reception of delinquent girls. By the 1950s three institutions had emerged to assume the role of accommodating ‘incorrigible’ and ‘immoral’ girls: the Industrial School for Girls, Woolloowin (administered by the Sisters of Mercy), the Home of the Good Shepherd at Mitchelton (run by the Sisters of the Good Shepherd), and the Industrial School for Girls, Toowong (run by the Salvation Army). In 1962 the Salvation Army home was rebuilt and renamed ‘Kalimna Vocational Centre’. In 1966 the Home of the Good Shepherd was renamed ‘Mt Maria Re-Education Centre’, and the Industrial School at Woolloowin became known as the ‘Holy Cross Home’.

From this point, the Salvation Army generally accepted girls committed by the courts, while the Catholic institutions took a large number of private admissions as well. The system worked satisfactorily (at least as far as the government was concerned) as long as the girls admitted to the homes were compliant enough not to cause a significant drain on resources. The situation was more complex for those girls who resisted institutionalisation and were labelled ‘uncontrollable’. None of the denominational homes were equipped to accommodate especially troublesome girls, and often they exercised their right to refuse to admit those they considered too difficult to handle or to discharge those who had become unmanageable after admission.

It had long been departmental policy to admit these uncontrollable girls to one of Queensland’s mental institutions—the Brisbane Mental Hospital and Wolston Park were popular choices—but by the late 1950s the number of girls considered uncontrollable had begun to increase. Between 1957 and 1959, 13 girls were admitted to Ward 16 of the Brisbane Mental Hospital. It was considered that the majority of these girls were ‘quasi-medical’ cases at best, and it was only a matter of time before a public protest would be lodged.<sup>26</sup> Lamenting these admissions to psychiatric institutions, the Director of the State Children Department placed on record his belief that ‘Some of these girls could have been saved with a more modern establishment to deal with them’.<sup>27</sup> Less than a year later he suggested that those quasi-medical cases not suited to psychiatric treatment, and unable to be controlled at the industrial schools or at a psychiatric clinic, should be sent to prison.<sup>28</sup> It would appear that the only options the State could provide for treating the girls most in need of attention were admission to a psychiatric hospital or to prison—even when it had been established that their problem was behavioural rather than a psychiatric disorder.

The problem was exacerbated by frequent overcrowding in the three denominational homes. In a congested environment, the behavioural problems of the girls became even more difficult to manage, let alone treat. By 1961 the situation had become so serious that in order to facilitate new admissions girls were being discharged before they were considered ready to leave.<sup>29</sup> Probation was utilised to alleviate some of the strain on the institutions, but the small number of ‘lady Inspectors’ placed limitations on how far the existing system could be extended. After relying on the services of the Catholic Orders and the Salvation Army for the previous six decades, it now appeared that the government had little alternative but to establish a State institution to accommodate delinquent girls. A new institution, Karrala House, was subsequently established in 1963.

Even with Karrala House, the three denominational training centres continued to fulfil an essential function throughout the 1960s and 1970s. Without the option of sending girls to these institutions, the Department would certainly have been faced with an accommodation crisis.



*Photograph 7.11: Mt Maria dormitory—Courtesy Queensland Newspapers*

Both Mt Maria and Holy Cross were large, dormitory-style facilities. Mt Maria generally accommodated between 30 and 50 State girls, along with a similar number of young women and girls with intellectual disabilities. They were confined in two dormitories, which were converted into recreational group rooms in 1958, and, in its latter years, a small transitional hostel for six girls.<sup>30</sup> Holy Cross also housed a large number. From 1904 it housed unmarried mothers and their babies, as well as delinquent and neglected girls. In 1961 it was reported as having 88 girls in residence (although only 19 of these were in the care of the Director).<sup>31</sup> Kalimna was a smaller and, for its time, more modern facility. It had a capacity in the range of 30–40, and was divided into two main sections. The first was a hostel section used by girls who paid weekly board and went out to work each day; the second contained small dormitories with three beds in each. There were also solitary confinement rooms for the punishment of troublesome residents. The older, pre-1962 building had been divided into dormitories of 4–6 beds each.

### **Labour**

Each institution operated a laundry for the instruction of the girls and as a major source of income. Just as it had been in the past, domestic labour was still seen as the appropriate reformatory technique to be employed for delinquent girls. The Inquiry heard evidence from former residents suggesting that the girls were made to work long hours at monotonous tasks and in trying conditions. Some former residents of Holy Cross claimed to have worked in the laundry for the full term of their pregnancy. A former resident stated she had to work five days a week in the steam laundry from morning until night, standing on her feet all day folding sheets that were being passed through a large pressing roller. In spite of her pregnancy, she had to bend over into large trolleys to pull out wet and tangled sheets—a task she considered both fatiguing and dangerous. In addition to this, she was required to do housework in the Home in the mornings before starting in the laundry. This included polishing floors and cleaning bathrooms and the recreation room. She added that she was made to return to work as soon as she returned from hospital after having her child.



*Photograph 7.12: Holy Cross entry/despatch section of laundry building—Inquiry photograph*

Women who had been residents of Kalimna in the 1960s and 1970s gave evidence that they were required to work in the laundry doing commercial washing and ironing. Others were required to scrub floors. It appears that the residents were paid little, if at all, for the work performed. One resident described it as a ‘slave labour camp’. Another, now qualified in occupational health and safety, considered the laundry a hazardous place and said that the girls frequently suffered burns.

It should be noted that the Salvation Army has rejected the claim that work in the laundry was tantamount to slave labour and that injuries were frequently suffered by the girls. The organisation admits that the facility may not have met 1999 health and safety standards, but contends that it was typical of its kind at the time. The Army also rejected the claim of a few girls that they did not receive any income for the work in the laundry.

### **Earning release**

One frequently criticised aspect of the program at Kalimna was the system for determining the length of stay for each inmate. Originally, girls were compelled to stay at Kalimna for a minimum of 10 months, but this was reduced to six in 1976 after some lobbying by the Department of Children’s Services. The institution had, for many years, operated on what was called a ‘Bow-change’ system, in which the girls were required to pass through three grades before considered for discharge. (They had to spend at least two months in the third grade before they could be released.) Prior to 1972 the girls were required to wear coloured ribbons to indicate their current grade. One of the problems with this system was its inflexibility. The reasons for admission were irrelevant once a girl passed through the front door. Conformity to the Kalimna regime was the only significant factor determining her eventual release. The subjectivity of the assessment process could also result in girls being penalised for minor infractions and it was not uncommon for girls to remain at Kalimna for nine to 12 months.<sup>32</sup> In reality, the State gave to a private institution the power to determine how long a person was deprived of their liberty—the most fundamental of all rights. In any civilised society this power lies exclusively with the State.

### **Medical treatment**

Evidence was heard that girls resident at Holy Cross were generally given prenatal check-ups at the Royal Brisbane Women’s Hospital. One resident stated that she never saw a doctor at Holy Cross, even through the term of her pregnancy.<sup>33</sup> She also stated that there was a nun in the dispensary who would try to ‘cure’ everything with two Aspros, regardless of the complaint. The same resident complained that she was sent back to work with a cut to her leg from which she still bears a long scar. Another resident complained that although she had severe bronchitis when she arrived and was coughing up blood she received no treatment. She

also stated that every winter she had bronchitis and was not treated. The same resident, however, said that she was on one occasion sent to hospital when she had pains in her side.

One former resident stated that each time she was returned to Kalimna after absconding she would be required to submit to a doctor's examination to determine whether she had been sexually active. Another former resident stated that on admission to Kalimna, or when she was brought back after absconding, she was taken to a gonorrhoea clinic and given an internal examination to make sure she was free from disease. She stated that she was required to undertake this examination even though she had told the Matron that she had never been sexually active. The Salvation Army has stated that examinations took place only in exceptional circumstances.

### **Solitary confinement**

It appears that at each institution solitary confinement was used as a means of disciplining particularly troublesome girls, especially those who repeatedly attempted to abscond. This was in spite of the fact that the Children's Services Regulations did not provide for the seclusion of a child in a locked room as a form of punishment. A former Mt Maria resident recalled being locked in the basement at the institution (possibly under the stage in the hall) for a period of one week. Former residents of Holy Cross related stories of being locked in small rooms for varying lengths of time. Nuns' quarters, storerooms, broom closets and other small rooms were all identified as having been used for the confinement of girls believed to be misbehaving. A former resident stated that there was a solitary confinement area above the dormitory in which girls were locked if they did not comply with instructions. Another recalled that on three occasions she was locked in a nun's cell room—a small room with a bed, cupboard, chair and a bucket for use as a toilet. She was placed in there on two occasions for a week each time for absconding from the Home. She said that on one occasion when she returned in company with another girl, a Sister sniffed her and said 'She's been with a man'. She was then placed in solitary confinement. She said that during one of her weeks in solitary she was permitted only one shower, and that if she needed to have a bowel movement a Sister would escort her to the toilet and back to make sure she did not speak with anyone else.

At Kalimna there were three solitary confinement rooms located near the main building.<sup>34</sup> The rooms were only large enough to contain a bed and a bucket in the corner for a toilet. One resident estimated each as being 10 feet long and six feet wide. It has been alleged that solitary confinement (or 'pop', as it was known to the girls) for two to 14 days was used as an induction procedure for young women being admitted to Kalimna. Residents were informed that they were required to spend time in solitary confinement as a settling-in period, to 'think about what they had done'. This was unusual given that on some occasions the girls were transferred to Kalimna without any knowledge of the reason for their transfer. One resident, admitted on two occasions between 1960 and 1962, stated that on her second admission the normal 14-day period in 'pop' was extended to 24 days because she refused to have a 'basin' haircut. She finally gave in.

Former residents subjected to periods of solitary confinement have drawn attention to the psychological effects resulting from this form of punishment. A former resident of Kalimna, now qualified in social work and occupational health and safety, said:

*I consider being locked in solitary confinement for long periods of time more than physical abuse. It was emotional abuse. It was cruelty to the soul ... In hindsight, I don't know why I didn't commit suicide and I probably came close to it ... and ... I just don't understand why other girls didn't, because we were pretty fragile kids anyway and to lock you up like that was just horrendous. It is soul destroying. It is like torture. It makes you ... so compliant.*

It would appear that at Kalimna some girls were required to spend significant periods in solitary confinement, usually for offences such as absconding or being violent. One resident described her experience in solitary confinement as follows:

*The room was pitch dark. There was no light. There was just a bed in the corner. No toilet, no water. Three times a day they would come down and they would open the door up, give you your lunch, take you out to your toilet which was just outside the door, stand there while you went to the toilet. In the morning you would have your shower. They stood there while you showered, went to the toilet and went straight back in. You ate your food in the dark. You know, you might as well have been blind. You ate in the dark. There was one window that was around a foot, right up on the top of the building, right up high and it used to shine in the morning and I never used to forget, it was so lovely to see a little ray of light, and I could see the bars, the three bars, and I used to just lay there and look, and then the light would go, for the rest of the day and night it would be dark.<sup>35</sup>*

There were also allegations that solitary confinement was used for minor breaches of discipline, like talking in the bathroom or while at work. One resident claimed that she would be locked in solitary confinement if she did not take medication. In another case, a girl was placed in solitary confinement for refusing to eat her vegetables. In 1977 a girl on remand who was well advanced in pregnancy was placed in solitary confinement at Kalimna by the Juvenile Aid Bureau. She subsequently spent two nights there before appearing in court.

The Salvation Army has strongly denied that the Kalimna administration used solitary confinement for minor offences. It has emphasised that there was a policy at the institution that the detention room doors were left open for girls undergoing admission procedure. It has also asserted that the punishment was only sparingly used for serious offences (and for short periods of time when resorted to), citing evidence from a 1977 departmental report that conceded that the detention rooms were necessary given the small number of staff supervising in excess of 30 girls. As the Inquiry has discovered with the other Salvation Army residential facilities, the difficulty of confirming or discounting the claims of former residents has been compounded by the paucity of surviving records held by the Salvation Army administration. The Inquiry was offered little in the way of administrative documentation pertaining to Kalimna, and nothing that would constitute punishment books or case files for former residents.



**Photograph 7.13: Kalimna—dark hallway on lower level (note doorways are staggered)—Inquiry photograph**

### Other forms of abuse

Some former residents of Holy Cross recalled being subjected to the particularly demeaning practice of having their heads shaved as punishment for certain misdemeanours. They also related accounts of how they received corporal punishment, usually with the use of a cane, for some offences. One former resident stated that the nuns would instruct older girls to hit younger ones with their hands or objects such as hairbrushes, or to pinch them or pull their hair. At Kalimna, where the supervision was often carried out by the older girls, there were also cases of younger girls being physically abused by their more senior peers. The threat of transfer to Karrala House was also used to keep girls compliant.

Former residents of Holy Cross in the 1950s gave evidence to the Inquiry suggesting that life in the institution was a psychologically damaging experience for some girls. Some described being given jobs that were inappropriate for teenagers. One resident described being made to look after women with mental disabilities:

*One lady was an epileptic and she was pregnant and I had to look after her and shove a spoon down her mouth, you know, put her tongue down when she had a fit and she was told nobody would want a damaged baby, so the baby would be taken off her and put in another home.*

Another former resident vividly described being coerced by the Sisters into signing the adoption papers for her newborn child, and then being placed in solitary confinement for resisting instructions. Another resident complained that she was not provided with any counselling at Holy Cross following the adoption of her baby. She described herself as being in a dream-like state, as if she was lost. She said she was not given any further medical examination and was put straight back into the laundry, without any time to convalesce, after she returned from hospital.

### Visits

Visiting rights were regulated according to behaviour. At Kalimna, girls were allowed to write to their families only once a fortnight, and to receive two-hourly visits on a fortnightly basis if departmental approval had been obtained. Mail from parents was censored. In 1977 a childcare liaison officer expressed her concern that the Salvation Army staff did not encourage contact with families and did not make any attempt to provide therapy for them. The Salvation Army has rejected this claim, insisting that much time was spent providing counselling and support for families. The Salvation Army also pointed out that the Department required all mail to residents to be censored by institution staff.

### Education

Schools were conducted at Mt Maria and Holy Cross from early in their respective histories. Some former residents complained that they were denied any form of schooling while at Mt Maria. Others were unable to recall receiving much more than a couple of hours each day. It was in the 1960s that this institution established an academic curriculum for its residents. However, for those aged 16 and over, and for those under 16 who were not interested in school, the curriculum was more vocationally oriented, involving cooking, dressmaking, sewing, a variety of hobbies and physical activities. Similar complaints were made about Holy Cross during the 1950s. In 1972 two child care officers expressed concern at the policy, then in place at Mt Maria, of new admissions of school age being made to work in the laundry until it was considered that their behaviour indicated they had settled in.<sup>36</sup> They related that the Sister in charge had stated that the reason for this was because she did not have sufficient teaching staff to deal with disruptive behaviour. The child care officers were of the view that the number of teaching staff was sufficient, especially in comparison with Kalimna. In 1956 a woman wrote to the Director of the State Children Department regarding a girl who had been held at Holy Cross. The girl stated that she had been a State ward for three years and while at Holy Cross had often expressed an interest in being taught some school work. She suggested this to the Sister Superior, who replied 'Do you know your prayers yet? If you know your

prayers and can say them, you will be all right.’ The girl in question could neither read nor write. She also had little knowledge of any kind of domestic science.<sup>37</sup>



*Photograph 7.14: New admissions of school age were made to work in the laundry at Mt Maria—  
Inquiry photograph*

Until the 1970s residents of Kalimna received no formal education, as most girls were in the 14–17 age group and therefore above school leaving age. There was some limited instruction in sewing, knitting, crocheting, leatherwork and hairdressing. During the early 1970s the administration began to take in many more girls in the 12–14 age group and fewer older girls. This change in focus necessitated the introduction of a full-time education program. It did not take long for conflict to occur between Education Department teachers and the Kalimna staff. Against the wishes of the teachers, Salvation Army staff would intervene in matters of behaviour management during classes. The teachers were prevented from taking their students out of the institution for social development or social awareness field trips. (At that time, the annual excursion to the Exhibition was the only opportunity for the girls to leave the institution.) The Education Department considered that the educational facilities were in need of improvement. The situation came to a head in September 1977 and, as a result, the Education Department closed the school facility. With the loss of the school, the institution itself was forced to close a month later. From 1957 until its closure, approximately 600 girls had passed through Kalimna.

By this time both Holy Cross and Mt Maria had closed as well. The former effectively closed in April 1973, when it was decided that it would take only care and control girls who were pregnant and considered manageable. Government funding then ceased. Mt Maria was also forced to revise its role as a care and control facility in the following year. Contemporary records disclose that this was largely due to a rapid depletion of staff and an inability to recruit properly trained Sisters to bolster numbers. The institution was forced to close in December 1974 as the Sisters felt that they were no longer able to deliver the appropriate standard of care to the residents. From 1931 until its closure, Mt Maria had housed over 1,800 residents.<sup>38</sup>

### **Summary**

For much of their histories, the denominational training schools were large, impersonal institutions where the labour demanded of the girls was both arduous and monotonous, and not likely to significantly enhance their future employment prospects, and where solitary confinement was used to discipline recalcitrant inmates. The emphasis was on punishment, with little or no effort made to assist in the rehabilitation of the girls. However, these were institutions that received little government funding, which made it virtually impossible to implement a more individually focused treatment program or to employ staff more attuned to the problems and sensitivities of the girls. These institutions were components of a wider



system that survived on a limited budget, and had done so for many years, and they quickly became redundant as essential improvements were made to that system in the 1970s. It is not surprising that many of the residents believed they were damaged by their experiences at these institutions.

*Nobody wanted to know my side of the story—this goes for my whole time as a State ward—nobody wanted to know.*

A is a 42-year old woman. She is the third child in a family of eight children, all of whom spent substantial parts of their childhood in care, due mainly to their parents' illness and mental health problems. Records reveal repeated applications for family assistance and benefits, as neither parent was able to sustain regular employment. At the age of five A was diagnosed with a serious hip ailment, and spent prolonged periods in hospital during the next two years. Departmental records suggest that her condition resulted in those around her spoiling her, leading to later behavioural problems.

Her official files first mention her at the age of 12, when she was remanded in the Children's Court (as a first offender) and deemed to be 'in need of care and control in that she is following into a life of crime'. This prognosis stemmed from incidents of stealing (aged 8) and 'wagging' school (aged 10). At this time a police report described A as having 'a brilliant mind', although 'sullen', 'withdrawn' and 'with no real friends'. She was eventually admitted to the Mt Maria Re-Education Centre in August 1968.

Her memories of Mt Maria include participating in laborious work in the laundry and then having to wash her own clothes by hand, being victimised by older girls and some staff, being provided with little opportunity for exercise, being denied nutritious food, not receiving any information about bodily changes (like menstruation), and having to do her primary schooling by correspondence because she was younger than most of the other residents. Her unhappiness at the institution led her to abscond in May 1969 and she was transferred to Karrala House. Repeated abscondings prompted the authorities to transfer her to Wolston Park psychiatric hospital in April 1971. The Director later informed her father that the decision to admit her to an institution for the mentally ill was made 'in view of her unpredictable behaviour'. Her file does not contain evidence of a psychiatric assessment being made. She has mixed opinions about her treatment at Wolston Park, but she categorically asserts that it was an inappropriate environment for a young girl. It was there that she was introduced to hard drugs and later treated for an addiction.

After absconding from Wolston Park, A travelled interstate and then overseas. In time, her situation improved and she eventually returned to Queensland many years later. She is now a professional who has obtained tertiary qualifications. A has very definite opinions about how her time in care should have been managed and also about how children in need of help should be treated today:

*I don't think juveniles in care should be treated as criminals, because even if a young person has committed a criminal act, there's more to it ... Children aren't responsible for the circumstances which have led up to the point where they're involved in criminal activity. If they're involved in criminal activity and the State has stepped in, that's the time when all stops have to be taken out to direct that individual into a better kind of future and you're not going to achieve that by destroying the self-esteem ... It really worries me that people say 'Well, lock them up and come down on them hard', you know, 'Nip it in the bud' kind of philosophy ... How you nip it in the bud is essential ... You can't hope to change the thinking of a young person if they're only put in the care of punitive, oppressive people. They need to be surrounded by encouraging people who have patience and tact, and the best wishes for a better future for that kid, whether they like that particular personality or not. And it's not about spoiling them, it's [about] looking for what can be built on within that personality.*

## **7.5 KARRALA HOUSE**

The Inquiry heard from 10 witnesses resident at Karrala House for various periods between 1963 and 1971. This institution is currently the subject of litigation and cannot be discussed in any detail in this report. A more detailed analysis will be forwarded to the Minister in a closed report. The following is a brief summary of the history of Karrala House.

In 1961 the Nicklin Government stated its intention to establish a Training Home for Girls at the Ipswich Mental Hospital in its vacant female ward. On 17 January 1963, by Order in Council, a Training Home for Girls was established in accordance with the provisions of the *State Children Acts 1911 to 1955*. It was initially to be known as Moreton House, but by the time of its official opening in February 1963 it had been formally named Karrala House.



*Photograph 7.15: Karrala House, a State-run institution for girls (1967)—Courtesy Queensland Newspapers*

Although the institution came under the jurisdiction and management of the Director of the State Children Department, Ministerial approval was granted for the appointment of the Medical Superintendent, Dr RA Atherton, the Matron and the Assistant Matron of the Ipswich Mental Hospital as a committee of management.<sup>39</sup> Approval was also granted for Atherton to act as the Superintendent of the Home and, under the jurisdiction of the Director, to accept the full control and management of the institution, staff and inmates. Co-operation between the State Children Department and the Health Department in this regard had already been attempted, with some success, in the operation of the Wilson Youth Hospital, and accordingly both were intent on further incorporating the welfare and medical models into a consistent approach to institutional care. With the Schwarten Inquiry into Westbrook a not too distant memory, there appears to have been a determination to make the goals of new institutions rehabilitative in nature rather than exclusively custodial.

However, this new philosophy existed more in theory than in practice, as the perpetual concern of behaviour control continued to dominate decision making at Karrala. In its 1963 Annual Report the Department reported that Karrala House was established ‘for the purpose of dealing with the more emotionally disturbed girl and those girls in denominational homes who are incorrigible and are continually upsetting other inmates’.<sup>40</sup> In a 1962 memorandum to the Director of Mental Hygiene, Dr Atherton expressed the following view:

*As indicated earlier, I believe that this Home would fulfil the most useful function by taking the more recalcitrant type of girl who is hardened to ordinary handling in a private or Church Home... Discipline should be as rigid as that in a Prison which would be the place these girls would find themselves but for their age. As Prison is a deterrent to crime so, in my opinion, should the discipline and consequent fear of return to this Home be a deterrent to the girls from returning to an antisocial or asocial form of behaviour.<sup>41</sup>*

The government, it seems, was content to allow the churches to carry on the business of reforming wayward girls. Its commitment in respect of Karrala House was limited to providing a quasi-penal institution to facilitate the task of extracting and disciplining ‘problem’ girls and returning them back to the denominational homes for future care.<sup>42</sup>

A total of 547 girls were to pass through Karrala before its closure in 1971. Most of these girls had not been convicted of a criminal offence, but had committed status offences. In the majority of cases, it appears that sexual behaviour perceived as inappropriate prompted the Children’s Court to make an order for care and control.<sup>43</sup> Girls initially admitted to one of the denominational training homes or a similar institution for care, whose behaviour and

emotional disturbance was such that they could no longer be cared for in that home, were also admitted to Karrala House.<sup>44</sup>

The institution was eventually closed in October 1971, after the inauguration of the new girls' section at Wilson Youth Hospital. All inmates remaining at Karrala House were transferred to this new unit.

## **7.6 WILSON YOUTH HOSPITAL, 1961 TO THE PRESENT**

In addition to interviewing current residents of the Sir Leslie Wilson Youth Detention Centre, the Inquiry heard evidence from a further 42 former residents and from eight former staff members of the institution in its various periods of existence. Evidence given by male former residents dated back to 1962, the year after the Wilson Youth Hospital was opened. A number of women who gave evidence had been detained at Wilson at various times from 1971, when the girls' remand and assessment unit was added to the existing facility.

### **Background**

Wilson Youth Hospital was established as a remand, assessment and treatment centre for boys in response to recommendations made in the Dewar Report of 1959. It received its first intake of boys in July 1961. Children admitted to Wilson were, pursuant to section 10 of the *State Children Act 1911*, under the care, management and control of the Director of the State Children Department (SCD) who was their guardian. However, although administrative matters concerning the Hospital remained in the hands of that Department, the medical, nursing and training officer staff were provided by the Division of Youth Welfare and Guidance, which was attached to the Department of Health and Home Affairs. For all practical purposes, the Department of Health had the management of the children at Wilson at this time, notwithstanding the legal position of the Director of the SCD as their guardian.

In 1965 an Agreement was entered into between the Department of Health and the SCD, under which Wilson Youth Hospital was transferred to the control and administration of the SCD from 2 January 1966.<sup>45</sup> Under that Agreement, the Division of Welfare and Guidance was to provide clinical services at the Hospital. Certain officers (psychiatrists, other doctors, psychologists, occupational therapists and schoolteachers) were to be appointed and managed by the Department of Health. Other staff (including the manager, orderlies and nursing staff) were to be under the control of the SCD. Under the Agreement, the Director of the Department was to refer children 'in need of Child Guidance treatment' to the Division of Welfare and Guidance. A request for assessment in such cases was to be directed to the Senior Medical Director of the Division of Welfare and Guidance (at that time Dr BJ Phillips).



*Photograph 7.16: Wilson Youth Hospital—Courtesy Queensland Newspapers*

Once the Division of Welfare and Guidance undertook the treatment of a referred child, all staff, including officers of the SCD, were required to carry out the directions of the treating doctor. The Director of the Department agreed that he would not give permission for anyone (including welfare officers or social workers) to have access to a State child under treatment without the agreement of the Senior Medical Director.

There is a good deal of evidence to suggest that the effect of this Agreement was, in practical terms, to exclude the Director of the Department from his own institution. It was an extraordinary situation in which ultimate authority was vested in the Senior Medical Director to the exclusion of the children's own guardian. Within the institution itself there existed a system of dual control between the medical staff on the one hand, and the nurses and orderlies employed by the SCD, who had the day-to-day management of the children, on the other. It is against this complex background that the evidence of witnesses to the Inquiry must be understood.

### **The Wilson Youth Hospital, 1961–1971**

#### *Admission procedures*

Boys who were placed at Wilson during the 1960s were given a medical examination on admission. They were then placed for a period, which according to witnesses ranged from a couple of days to as long as two weeks, in an observation cell. As the name implies, while there they were kept under observation and were seen by psychiatrists or staff consulting to the Hospital. The perception of the witnesses was that movement to the dormitories upstairs depended on behaviour during this period. While under observation, the boys were kept isolated from other children, exercising in a small secure yard. The cell itself was bare, and on other occasions was used as a punishment cell. The major complaint made by witnesses was of boredom, but it was also a frightening and alienating experience, particularly for children on their first admission.

#### *Management and discipline*

On a daily basis, the boys were supervised by male orderlies with no medical or other formal training, or any qualifications in the management of children. They were answerable to the manager of the Hospital. The 1965 Agreement prescribed that the manager and orderlies were solely responsible for custody, order and discipline when the children were not under the care of an occupational therapist or remedial teacher. It also provided that the manager and orderlies were to consult with the treating psychiatrist concerning disciplinary measures to avoid conflict with his treatment. It does not appear, however, that this was interpreted as indicating any active role for medical staff in intervening to prevent excessive or inappropriate forms of punishment. Although, in theory, the manager was answerable to the Director, his communications appear to have been limited to providing written reports on specific incidents, which could not have afforded the Director any real opportunity of understanding how children were faring in the institution. At the same time, the restriction imposed by the Agreement on the Director's right of access to the institution meant that the childcare workers of his Department were powerless to monitor and intervene in respect of the children at the Hospital.

Witnesses who gave evidence of their experiences in the 1960s said that corporal punishment, in the form of strapping by the manager of the Hospital, was administered for misbehaviour. Such corporal punishment was permissible where absolutely necessary, both under the Regulations of the *State Children Acts* and under the Children's Services Regulations. The Regulations under the *State Children Acts* provided the Superintendent of an institution (in this case the manager) with a general power of punishment for misconduct. The Children's Services Regulations, on the other hand, allowed for punishment by way of forfeiture of privileges and recreation, special duty, physical exercises and corporal punishment. Notwithstanding the lack of reference to solitary confinement as an option, a number of the witnesses complained of being punished for misbehaviour by being locked up in a cell that contained nothing but a mattress, pillow and blankets. From their evidence, confinement

could last as long as two weeks. One witness spoke of being placed on a bread-and-water diet for the first 72 hours of his confinement.

There were also complaints of physical abuse by orderlies who slapped and kicked the boys and hit them with the keys they carried. Names of particular orderlies who were given to abuse of this kind recurred in the evidence, although it should also be said that some orderlies who showed kindness and fairness were also identified. Some witnesses also said that the staff did not intervene to protect them from assault by other children, or worse, confined them with other boys who they knew would attack them. One witness resident at the institution during this period said that he had been raped by other inmates in the toilet block in circumstances in which a nearby orderly ought at least to have suspected what was happening but did not intervene. Two witnesses spoke of being administered medication as a means of subduing them, but there was no evidence of widespread use of sedatives to maintain discipline. The corporal punishment and, on occasions, physical abuse to which the boys were subjected were, of course, completely at odds with the concept of the institution as a medical facility. As one witness put it:

*It was called a hospital, but I don't know why; maybe you needed the hospital when they were finished.*

### *Treatment and education*

Wilson had been set up as a psychiatric facility, based, it appears, on the perception of the Senior Medical Director that delinquency was primarily a psychiatric rather than a social problem. In a 1977 letter to the Director-General of Health, he advised that between 50 per cent and 70 per cent—closer to the latter figure—of children admitted to ‘Child Welfare Institutions’ were suffering from psychiatric disorders.<sup>46</sup> What was required, it followed, was medical intervention, in the form of psychotherapy and ‘chemotherapy’, generally involving the use of anti-convulsants, sedatives and tranquillisers. A strong emphasis was placed on investigating organic causes of behavioural problems; each child’s medical history was examined to ascertain whether there had been any birth abnormalities, and EEGs were a standard diagnostic tool.

Education did not rate highly in that regime. The first intake of boys from Westbrook had been accompanied by the appointment of a teacher who ran a small school at Wilson, classified as a Special School. In 1964 a second teacher was appointed. Those witnesses who were at Wilson in the first half of the 1960s spoke of schooling of a remedial kind, at the ‘Dick and Dora’ (i.e. elementary) level, but at least it was regular. By 1966 that situation had begun to change. In a Memorandum of 24 February 1966 to the Director of the State Children Department, the manager of the Hospital advised that the ‘number of boys at school age [was] ... beyond the capacity of the school facilities’.<sup>47</sup> Twenty-two pupils whose grades ranged from opportunity level to secondary school by correspondence were attending but 16 boys were not. It was of concern to the head teacher that the Education Act required him to report boys of school age not attending school. The manager proposed that further accommodation for pupils be set up, but it was noted that this would require further teaching staff.

One of the witnesses resident at the Hospital in 1966 said that he perceived increasing friction between the teachers and the staff. Certainly the teachers’ role was not highly valued by Dr Phillips who, in a letter to the Director of the Department, expressed the view that ‘It would be to the advantage of the children if the school at Wilson were disbanded and that the matter be arranged along “therapeutic group lines”’.<sup>48</sup> Although no formal response appears to have been made to him at the time, it appears that the school in fact ceased to exist. In its place, the Child Guidance Therapist, Mr Conrad, assisted children with correspondence lessons. Other therapists subsequently appointed by the Health Department undertook a similar role.

### **Wilson Youth Hospital, 1971–1984, the girls’ section**

In 1971 a Girls’ Remand and Assessment Unit was constructed to replace Karrala House. During the following decade, this section became the subject of considerable public debate, centring on issues of sedation, confinement and lack of meaningful activity for the girls held

there. A clear difference emerged in the way in which the boys' and girls' sides were managed, the former being more akin to a training school, and the girls' section run on a medical model. During this period the friction that had previously existed to some extent between the Department of Children's Services and the Department of Health in relation to the running of Wilson escalated into, at times, open conflict. This polarisation appears to have been largely due to the influx of trained social workers into the Department and the divide that existed between their approach and the psychiatric management of delinquency considered appropriate by the Senior Medical Director.

### *Admission procedures*

Female witnesses who gave evidence of their experiences at Wilson during the 1970s almost without exception spoke of the ordeal of admission. A strip-search was followed by a shower, sometimes in the presence of male as well as female staff. They were then required to submit to delousing with DDT (a powerful insecticide), whether there was any evidence of infestation or not. For the purposes of the delousing treatment they were obliged to wear a cotton cap for the following three days. Personal possessions were removed and the girls were required to wear institutional clothing, manufactured at Warilda and bearing no resemblance to current fashion. A witness described her experience in the following way:

*When you first go into Wilson they have the admitting area and you sort of know what's ahead of you because you have to take all your clothes off and they're peering into your vagina and everywhere else and if you're 15 years old and nobody's seen you naked, you're—it's uncomfortable, and then they look in your ears and under your tongue and in your hair and then they delouse you like you're some sort of cattle or something. And then after you finish that process everything that you're wearing is put in a bag and sealed and stapled.*

The existence of these practices is confirmed in a Memorandum from a child care officer in July 1975 who observed them first-hand when returning a child to Wilson.<sup>49</sup> She deplored the unnecessary, humiliating and depersonalising application of the DDT treatment; she observed that the provision of second-hand, ill-fitting clothing exacerbated the poor self-image of the girls; and she commented that the removal of all items of personal jewellery added to 'the depersonalisation and negativism of this system at Wilson Youth Hospital'. It does not appear that the expression of her views produced any change in admission practices.

The feature of admission to Wilson that was remembered with most loathing by witnesses was the gynaecological examination to which each girl was required to submit. One witness described the experience of being held down by male staff and forced to undergo vaginal examination by a male practitioner as similar to the trauma of sexual abuse that she had suffered earlier in her life. Another recalled her first examination:

*Soon after arrival we had to have a pap smear. I didn't know what that was and had always been extremely self-conscious about my body. When I was told by the doctor to get on the table and open my legs I was terrified and refused. He told me to get on the table and open my legs or he would get two male orderlies to come and do it for me. Sobbing and feeling degraded, I complied. While I was in the vulnerable position he completed the violation by saying 'You've had sex lots of times, haven't you?' I was so traumatised by this experience I still cannot be examined by a male doctor.*

Gynaecological examinations were a regular feature of life in the girls' section at Wilson. Girls who refused to undergo them were not permitted to use the swimming pool or, for some reason which is not apparent, the trampoline.

### *Management and discipline*

Children could be admitted to Wilson because they were on remand for, or had been convicted of, a criminal offence. Equally they could be admitted merely as children in the care and control of the Director of Children's Services because they had, for instance, been declared 'uncontrollable' (for truanting) or were deemed to be 'exposed to moral danger'. Even children in the care and protection of the Director could, with Ministerial approval, be

admitted. Girls at Wilson were generally within the ‘uncontrollable’ and ‘exposed to moral danger’ categories. A witness who had herself been charged with being in moral danger observed that there were other girls in Wilson with her who had been the victims of incest, while many ‘had run away from physically and emotionally abusive homes’.

An analysis of the reasons for admission, carried out in 1978 by a group of concerned citizens calling themselves Justice for Juveniles and based on the Annual Report of the Director of Children’s Services, revealed that 80 per cent of the girls in Wilson were under care and control orders for ‘status offences’, under section 60 of the *Children’s Services Act 1965*, with only 18.8 per cent having been committed to care for criminal offences.<sup>50</sup> The figures for boys were almost exactly reversed: 74.2 per cent were admitted for offences and 24.2 per cent for being uncontrollable or ‘likely to lapse into a career of vice and crime’. Significantly, none of the boys had been admitted to care for being ‘exposed to moral danger’, as opposed to 10.6 per cent of the girls.

On admission girls were placed in a remand section, regardless of the basis on which they had been admitted. One witness described it:

*Even if you’re not there for committing an offence, you’re still put in remand which still feels like a punitive thing, like you’ve done something when you know you hadn’t done anything.*

Clearly the mixing of groups at Wilson carried the dual risk of imposing a label of criminality on disadvantaged children, while at the same time exposing them to the influence of other young people with criminal histories. This point was graphically made by a witness who had been admitted to care and control on the ground that she was exposed to moral danger. In Wilson, where she was placed to remove her from such danger, she learned the finer points of car stealing and house-breaking, and had prostitution demystified for her by another inmate with considerable experience. On her release, she found work at a massage parlour.

A number of witnesses complained of the conduct of male orderlies employed to maintain order in the girls’ section or brought for that purpose from the boys’ side. Allegations made ranged from prurience, in watching girls showering or using the toilet, to sexual exploitation. Incidents of the latter type were from time to time raised with management at Wilson or investigated by police. It does not appear that they were pursued, possibly because of a lack of corroboration. Little consideration appears to have been given to the girls’ needs for privacy and respect.

The Children’s Services Regulations prohibited the application of corporal punishment to girls, and it was not used in any formal sense. On the other hand, a number of complaints were made to the Inquiry of excessive physical force being used by male staff members to restrain non-compliant girls. One particular orderly was said to delight in bending girls’ arms back behind their backs. He was alleged to have broken a girl’s arm in doing so. Many of the witnesses spoke of being dragged roughly to the isolation area, sometimes by their hair, others of being manhandled while injections were administered.

Sedation was used as a method of subduing difficult girls. Most of the witnesses spoke of receiving regular oral doses of Melleril, with intramuscular injections of Largactil being used to subdue recalcitrants, this latter practice being advocated by a psychiatrist on the staff in early 1972. This was a time of considerable tension. The facility was overcrowded and desperately in need of air-conditioning. In one particular episode, four girls in the exercise yard began, according to the nurse reporting the incident, to sing dirty songs and throw clods of dirt at the staff, receiving the shouted encouragement of the girls upstairs.<sup>51</sup> The psychiatrist called on to assist ordered that the girls responsible for the disturbance be given Largactil, and later informed the Director of Children’s Services that ‘the Medical staff were not taking full advantage of sedation as a means of control’.<sup>52</sup>

His view was not uniformly accepted. In April 1976 a psychiatric medical officer at the Hospital, with some courage, wrote to the Minister for Health complaining about the indiscriminate use of major tranquillisers to enforce discipline at the institution. As he perceived matters, intramuscular tranquillisers were considered necessary by the nursing staff for what amounted to 'naughty, socially unacceptable behaviour'. He quoted instances of girls receiving such injections for recorded offences of 'banging door loudly' and 'kicked over chair, used obscene language'. The doctor's account of the use of forcible medication for trivial behavioural matters was reflected in the evidence of the witnesses, a number of whom recounted experiences of being held down and injected for things such as swearing at the Matron. An impression is gained from the evidence that sedation became a standard response to the slightest sign of rebellion in certain girls once they had been branded as troublemakers.

Often in conjunction with sedation, seclusion was a principal means of behaviour control, and its use attracted a good deal of controversy. It amounted to solitary confinement, which was not, as already observed, permitted under the relevant Regulations as a means of punishment. In 1971 advice was obtained from the Solicitor-General which pointed out that the Regulations contained no authorisation for the use of seclusion as a means of punishment, although the view was expressed that 'segregation or confinement' could be used 'in proper circumstances to maintain good order and discipline in the institution'.<sup>53</sup> Nonetheless, he suggested that an amendment to the Regulations be sought to put the legitimacy of its use beyond doubt.

The use of confinement remained a matter of some concern to the Medical Director of the Hospital, Dr Foley, who noted that girls were being 'arbitrarily sentenced to seclusion in the observation section for misdemeanours'.<sup>54</sup> He gave examples of seven days being imposed for absconding, and three days for striking a staff member. It might, he said, be possible to argue that 24 hours' seclusion was justifiable to maintain discipline, but this was clearly punishment. Despite his view, no amendment was sought, and the practice of confining children who misbehaved, both boys and girls, continued. In 1974 a psychiatric medical officer, who resigned because he could not accept the situation and attitudes at Wilson, pointed out among other things that 'frequent punitive, illegal seclusion of boys and girls is being implemented'.<sup>55</sup>



*Photograph 7.17: Days were spent in a locked central room containing card tables and chairs—  
Courtesy Queensland Newspapers*

Much of the disruptive behaviour appears to have been the product of boredom and frustration. In the Remand Section, according to the witnesses, the cell furnishings comprised a bed base, mattress and bolted-in table. Girls were locked in their individual cells at night, but were not permitted to enter them during the day. Days were spent in a locked central room, which contained some card tables and chairs. A request had to be made to gain access



to the toilet. There was a half-hour exercise period, during which those girls who had consented to gynaecological examination could use the swimming pool and trampoline. According to one witness:

*Most of us just sat around. We just sat in the sun with our backs up against the big brick wall during the sports because we weren't going to undergo that just to swim.*

Girls who behaved well in the Remand Section could hope to be moved to 'Privilege', a section in which they slept in dormitories and could use the toilet when they wished. There was a small verandah, which allowed only a limited view of the yard but at least gave access to some fresh air. Meals could be eaten in the dining room rather than in the section, although it meant being herded through a series of locked doors and repeatedly counted. This section contained a table-tennis table until it was removed because, according to a witness, a girl was said to have assaulted the Matron with a bat.

Girls who were misbehaving were removed to the 'Treatment' area, which was designed along similar lines to Remand. Later, a detention section containing a glass-fronted room, designed for observation, known as 'Open Tantrum', was added. Other adjoining closed cells in the same section were known as 'Closed Tantrum'. These rooms were empty of any contents. Girls confined there were kept under observation, and were often so heavily sedated before entry that they slept for much of the time. If they were alert, there was nothing at all for them to do; they were not permitted reading or writing materials, let alone cards, games, or anything else that might have helped pass the time. The administration of Wilson does not appear to have perceived anything extraordinary about this level of deprivation. In responding to criticism made by witnesses at a hearing of the Royal Commission into Human Relationships in 1975 about the lack of activities available to girls at Wilson generally, it was observed:

*Obviously girls who are dangerous and aggressive and are combative have not these facilities (i.e. reading and writing matter, drawing and painting facilities, cards, games), they are in a room by themselves until they are manageable but they are visited every few minutes by the nurse who is in charge of them.<sup>56</sup>*

A witness's perception of the observation process is slightly different:

*In Open Tantrum a nursing sister used to sit outside and every five minutes she'd have to note what you were doing. And, like, you were a specimen in a cage.*

### *Treatment and education*

According to a psychiatrist who had filled the position of Psychiatric Registrar for a brief period during the 1970s, because of the view of the Senior Medical Director that delinquency was largely a psychiatric disorder caused by an organic deficiency, the primary focus lay on extensive investigation. One witness recalled seeing a psychiatrist (a consultant to the hospital) who was extremely helpful to her. Other girls were not so fortunate. They saw the psychiatrists irregularly, a source of stress in itself, because release was dependent on the psychiatrists' approval.

Because it was accorded a lesser importance, therapy tended to be administered by inexperienced and unsupervised social work and psychology graduates. A witness who had been employed as a child guidance therapist at Wilson in this period described her function as overseeing knitting and crocheting undertaken by the girls. The principle was, she said, a somewhat Victorian notion that the exercise would be an improving one, since the finished products were sold or given away, rather than the girls being permitted to keep their work. As had been the case with the boys at Wilson for some time, there was no formal education available to the girls. Instead, once again, there was a reliance on correspondence lessons undertaken by the girls of compulsory school age with the assistance of the child guidance therapists (who had no educational qualifications). One witness (who was over the age of compulsory schooling at the time) described the frustration of attempting to continue her

study of German by correspondence without assistance. A number of the witnesses regarded the absence of education as the aspect of Wilson that had had the most impact on their subsequent lives, and it was the issue about which they were most bitter.

### **Wilson Youth Hospital, 1971–1984, the boys' section**

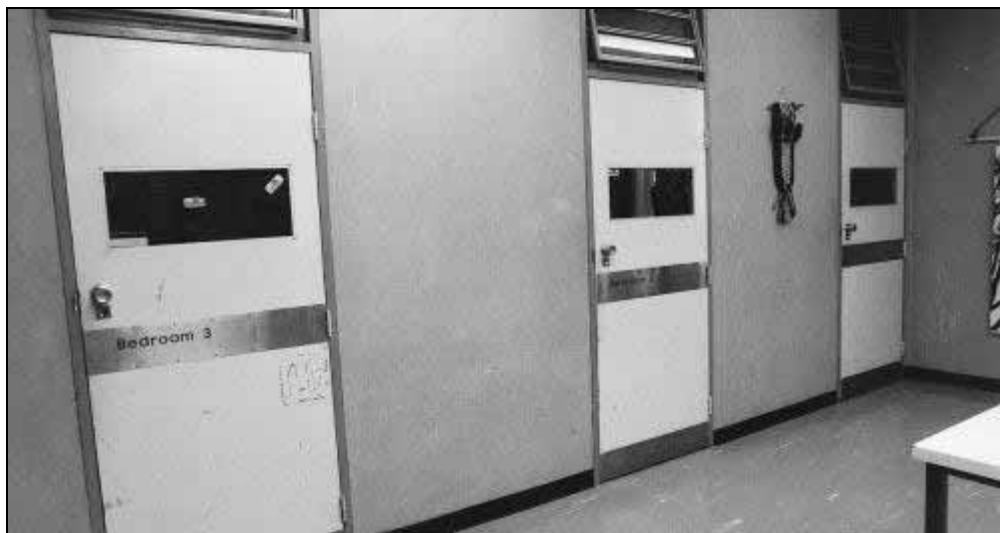
#### *Admission procedures*

The process of admission of boys to Wilson continued to be an unsettling and frightening experience. One witness who had been on the medical staff described seeing three small boys held in a cell over the weekend waiting for someone to be available to carry out the admission procedure on the following Monday. After admission, boys continued to be held in isolation for a period in what was described by another medical witness as a harmful, alienating process. The boys, he said, alternated between being 'frightened and ... angry at the stupid adults'.

#### *Management and discipline*

Witnesses who had been at Wilson during this period complained of physical brutality by certain male staff (who from 1974 began to be known as 'training officers', despite there being no change in their duties or their training). There were complaints of bashings, and of boys being dragged by the ear or hair. A letter written by a medical officer at the Hospital in July 1974 reflects some of those complaints.<sup>57</sup> The letter's author, a psychiatric consultant at the Hospital, was appalled to see an orderly lift a boy off the ground by both ears and then kick him. Another orderly standing nearby showed no sign of concern.

Other complaints made by witnesses were of training officers failing to intervene when boys were assaulted by other inmates, or encouraging such assaults. Two witnesses made allegations of serious sexual assault by training officers; these have been referred for police investigation. As with the girls, use was made of isolation as a means of punishment, but the evidence did not suggest that the use of intramuscular injection of tranquillisers was as widespread as in the girls' section.



*Photograph 7.18: Sir Leslie Wilson Youth Detention Centre, bedrooms 1, 2 and 3—Courtesy Queensland Newspapers*

#### *Treatment and education*

Some of the witnesses who had been in the boys' section at Wilson during this period said that they had been medicated on a daily basis, but others had no such experience. Certainly the use of sedatives appears not to have been a general experience on the boys' side. One witness described having monthly sessions with a psychiatrist for a period. Extensive psychological and neurological testing was, as with the girls, regularly carried out.

The boys at Wilson were somewhat more fortunate than the girls in that they played cricket and soccer and had access to woodwork and metalwork activities. There continued, however, to be very limited facilities for education. One witness, who had been admitted to Wilson at the age of nine years (a process requiring the consent of the Director of Children's Services, since he was the subject of a care and protection order rather than a care and control order), was confined in Wilson, with the exception of a short period in a church home, for about two years. He received no formal schooling at all, a setback to his education which proved irretrievable. In 1977 a consultant psychiatrist at the Hospital wrote to the Minister for Health about the need for an educational program at Wilson.<sup>58</sup> He pointed out that some boys and girls 'remain in Wilson for many months without any attention to their education in a formal manner'. Correspondence lessons were inadequate since children admitted to Wilson often needed intensive assistance with education.

Subsequently, the Department of Education provided a 'special school' teacher for the boys' section. This teacher was not able to provide anything beyond basic remedial teaching, so it was impossible for the boys to pursue normal school programs. The classroom at this time was big enough to hold five or six boys; by 1981 the number of school-age boys was 34.<sup>59</sup>

*Lies hurt and shame us. We need to stand tall and tell our stories.*

B was about eight years old when, in 1973, he was admitted to the care and protection of the Department and placed at an orphanage in central Queensland. The next six months was a traumatic time for the young boy as he was subjected to both physical and emotional abuse at the hands of the orphanage staff. The abuse led to behavioural problems, too difficult for the staff to manage and the Director duly requested that Ministerial approval be granted for his transfer to Wilson Youth Hospital.

Despite not having been accused or convicted of any crime, B was admitted to Wilson in July 1974. For the next year he was subjected to a 'treatment' program involving a variety of medication to curb his 'hyperactivity'. He had initially been told that he would be at Wilson for just two weeks to undergo an assessment by a specialist. He recalled his confusion at why he was placed in the institution:

*Some kids were in there for stealing, some kids were in there because their parents didn't want them, some kids were in there because their parents kicked the crap out of them when they were drunk. I mean the list goes on. Some were there for stealing cars. I was there for nothing.*

He maintains that his confinement in Wilson was much worse than he had experienced at the orphanage. Seclusion in isolation cells—with no water to drink, no food to eat and no mattress to sleep on or blanket to cover himself—was to become a common occurrence. Occasionally, he was even stripped naked before being placed in isolation, and he vividly recalled being taunted by a staff member as he completed his quarter-hourly rounds. While his 'treatment' program was dominated by behaviour control, he was deprived of a formal education.

At the end of his first year in Wilson, it was recommended that B be placed in a Brisbane family group home so that his treatment could be continued on an out-patient basis. But this placement never eventuated. Instead, he was sent to the Enoggera Boys' Home a few months later, only to be readmitted to Wilson in a matter of weeks. B was finally discharged from Wilson in June 1976—two years after his admission. In the following eighteen-month period he was placed with his mother and grandmother in Rockhampton and then at another orphanage. Finally B's situation began to show signs of improvement after he was placed with foster parents early in 1978. In the following year a child care officer described this couple as the first people to offer him a 'continuous caring relationship'. However, the legacy of his many years in State institutions was still evident. Of a mere seven people with whom B had significant, positive relationships, only two were not associated with the Department of Children's Services. B believes that his childhood innocence was beaten out of him during his many years of institutionalisation:

*While I was a Ward of the State, all the State could do for me was belt, flog, torture, starve and drug me. [I was] also deprived of a decent education. Not bad ... considering these are [the] people who are supposed to look after you.*

His history demonstrates how a child committed to the care and protection of the Director could be arbitrarily confined in a custodial institution for an excessively long period, have their behaviour controlled with medication, isolation and other disciplinary techniques, and be deprived of the education necessary to prepare them for their future lives. Despite his harsh treatment, B remains positive: *'I am pretty lucky in a way ... considering the beatings that I received at the hands of my protectors ... I'm still alive.'*

### *The transfer of Wilson to the Department of Children's Services*

In 1975 the Demack Report observed that the Wilson Youth Hospital was 'trying to fulfil too many functions'.<sup>60</sup> The difficulty became increasingly apparent throughout the decade. Wilson was attempting to function as a psychiatric hospital, remand centre, training school, detention centre and residential facility. The relationship between the officers at the Department of Health responsible for the Hospital and the social workers from the Department of Children's Services responsible for the management of individual children became increasingly hostile. The latter were refused contact with children other than those on the discharge list, a situation which they considered prevented them from carrying out their proper responsibilities. From the Health Department officers there were allegations of interference by the Department of Children's Services staff and they perceived that an unreasonable unwillingness to place children in church homes prevented their earlier discharge.

A 1978 letter signed by the Director of Children's Services is illuminating.<sup>61</sup> In it, the Director argued that the 1965 Agreement prevented him from exercising his legal responsibilities of guardianship, and gave him less access to children in the Hospital, his Department's own institution, than he had to children in licensed institutions or in their own homes. It was, he said, an abrogation of his responsibility. In the same document he questioned the medical model under which Wilson was run in clear and strong terms: 'To assume the person is sick because he has offended—maybe only a status offence—is itself a sick practice.' Psychiatrists were, in his view, less competent in the residential treatment of children and young offenders than trained and experienced social workers, psychologists and occupational therapists.

The increasing difficulty in maintaining the psychiatric model of management in an institution with the multiple functions of Wilson, together with the conflict with the Department of Children's Services, culminated in a decision that the Department of Health should abandon the Hospital and look elsewhere for a youth psychiatric facility. On 1 June 1983 Wilson became the sole responsibility of the Department of Children's Services.

### **Sir Leslie Wilson Youth Centre/Youth Detention Centre, 1983–1998**

After the takeover of the institution by the Department of Children's Services, the institution was renamed the Sir Leslie Wilson Youth Centre, reflecting an acknowledgment that the word 'Hospital' had become a misnomer. In-patient psychiatric services ceased, with therapists and psychiatrists relocating to the Barrett Centre at Wacol. The institution ceased to accept any children other than those who were on remand or who had been convicted of an offence. An educational program was put in place, but it remained subject to the limitations imposed by the physical constraints of the building.

Evidence heard by the Inquiry of conditions at Wilson after 1984 was relatively limited. There were some complaints of brutality by training officers. An issue which did emerge was that of race. One indigenous witness said that she had been the subject of racial abuse. Three non-indigenous witnesses (two male, one female) said that they had been the subject of assault by groups of indigenous children. In those cases, although the manager had done her best to intervene, the physical limitations of the building made it difficult to provide protection. In two instances the witnesses had to be held in isolation for their own protection.

In 1987 the functions of Wilson changed with the opening of the John Oxley Youth Centre. Girls were transferred to John Oxley and Wilson served as a short-term remand and transit facility for boys. The situation changed once more, however, in 1994 with the closure of Westbrook. The pressures of finding accommodation for the former residents of Westbrook forced the transfer of all girls back from John Oxley to Wilson, as well as the admission of some difficult boys to Wilson. These developments clearly placed the institution under considerable pressure. The institution's name was changed once again, to the Sir Leslie Wilson Youth Detention Centre, reflecting the fact that it was no longer exclusively a remand centre.

Complaints in relation to Wilson in the 1990s included allegations of assault by staff and other inmates, with one witness who had been there in 1996 also saying that there was a tendency on the part of some staff members to let the boys fight out their quarrels. So far as the evidence of witnesses to the Inquiry is any guide (and there may be reasons for more recent events not to be reported), the instances of allegations of assault are far fewer than in earlier years. Other issues raised were the lack of programs and the poor physical conditions at Wilson, which are dealt with in Chapter 9.



*Photograph 7.19: Fairleigh isolation room at Sir Leslie Wilson Youth Detention Centre—Inquiry photograph*

One of the ironies of Wilson's history is that, after an over-reliance on psychiatric approaches to the exclusion of all else in the first three decades of its existence, a significant inadequacy of the institution in the 1990s that emerged from the evidence was the lack of psychiatric services available for treatment of the small number of children with psychiatric disorders. That deficiency is exemplified by a case, which was the subject of a considerable amount of evidence, of a young woman who persistently self-harmed, on occasions amounting to attempted suicide and, in some instances, violence. It appears that the Department of Health would not, or could not, offer anything in the way of psychiatric assistance, because it was contended that her problems did not amount to a psychiatric disorder. It appears from the evidence that she was subjected to some amount of taunting and provocation by other children and, on occasions, by staff at the Centre. Some staff were intimidated by her behaviour; others, it was reported, went to considerable lengths to try to help her. What is clear is that the lack of readily available psychiatric expertise meant that Wilson staff without the requisite training and skill struggled to manage her behaviour, while treatment was simply not available to her.

Because of her suicidal tendencies, the young woman was repeatedly held in isolation. It was necessary to give her no more than a gown to wear, but on occasions that was also taken from her because of her habit of pulling threads from it to make a noose. She was generally held in a bare cell under camera surveillance by both male and female officers. The strategy for managing her behaviour was to remove all her possessions and return them one at a time for good behaviour. The practical result was that she was sometimes left with nothing by way of clothes, bedding or personal possessions for extended periods. The lack of proper medical intervention or any alternative, appropriate placement (which compelled the management at

Wilson to try to cope, unassisted and with insufficient expertise, with an impossibly difficult situation) can only be regarded as neglect, leading to mistreatment of the girl in question.

### **Summary**

Historically, Wilson and the children in it suffered from a power struggle between the Departments of Health and Children's Services, in which the obstinate insistence of the Senior Medical Director that the psychiatric approach must be universally applied prevailed for many years. During the period of the Health Department's dominance in Wilson, the Director of Children's Services (as one of the holders of the position subsequently acknowledged)<sup>62</sup> abdicated his responsibility for the children in his guardianship. The consequences of that situation for the children were an utter neglect of their educational entitlements; a damaging and alienating insensitivity to their needs (particularly reflected in the admission, sedation and seclusion procedures), an exposure of the children to the risk of physical and sexual abuse (given the absence of training and supervision of the orderlies employed), and the unnecessary stigmatisation of children as criminal and psychiatric cases.

In the post-1983 handover period, the problems of Wilson have largely centred around the complete inadequacy of the building itself, with all that this entails for the conditions in which children live there; the lack of proper staff training and the risks of abuse posed by that deficiency; and the insufficiency of the services, programs and education provided. These features are dealt with in Chapter 9, but it is worth commenting here that they are problems that have existed at Wilson for many years without redress. Many remain to this day.

## **7.7 JOHN OXLEY YOUTH DETENTION CENTRE, 1987 TO THE PRESENT**

The Inquiry heard evidence from 37 witnesses who provided written submissions or took part in interviews or hearings. It also examined archival material held by the Department of Families, Youth and Community Care. Seven witnesses were interviewed in jail where they are currently serving sentences. Seventeen of the witnesses gave evidence at a public hearing specifically in relation to allegations of handcuffing at the Centre in 1989. The Inquiry's findings regarding these allegations will be set out in a discrete section below.

### **Background**

The John Oxley Youth Detention Centre at Wacol was opened on 12 February 1987. At an approximate cost of \$5 million, the Centre was erected in a precinct that already contained an adult correctional facility, and now accommodates several. It remains the most modern of Queensland's detention centres. It was originally a centre for male and female adolescents, aged 10–15 and 10–17 years respectively, who had been committed to the care and control of the Director-General or who were on remand for offences.<sup>63</sup> The Centre was originally established on an open plan, which was intended to reflect family residential models and provide as 'normal' an environment as possible for the residents. With both boys and girls accommodated in each wing, it was considered by a youth worker that the model worked because the girls assumed the role of older sisters to the younger boys.

At its inception, it had three wings named Blaxland, Lawson and Wentworth. Each wing comprised seven single rooms, with their own toilet and shower, along with one room for three residents, with its own kitchen, dining and shared living area. Although the actual capacity was said to be 30 residents, the preferred capacity was 24 (with only one resident accommodated in the shared living areas). The original plans were drafted under the assumption that the upper accommodation sections would be air-conditioned. However, no such air-conditioning was forthcoming, resulting in intolerable conditions for both staff and residents in hot weather.

The age and nature of the residents accommodated within John Oxley soon changed as a result of a decision that Sir Leslie Wilson Youth Detention Centre cease to admit girls. The latter institution was scaled down in September 1987 to function as a remand and transit centre, chiefly for older boys being transferred to Westbrook. This meant that John Oxley would have to receive convicted and remanded girls, as well as boys under 15 on other than

short-term remands. It also meant that children with severe behavioural problems or showing signs of aggression could no longer be excluded from John Oxley, because there was nowhere else for them to go.<sup>64</sup> With the increase in boys, and the mixing of the sexes, the Centre experienced disciplinary problems involving sexual misconduct and activities resulting from teenagers 'showing off'. In addition, the physical structure was not suitable as a secure custodial setting and was more suited to housing a residential group who may have needed protection as opposed to control.

Successive managers attempted in vain to make improvements to the physical structure. Deficiencies included the existence of glass louvres that could easily be broken and used for self-harm or as weapons, and the ease with which some doors could be kicked open. Locks were welded onto the doors in 1989 to prevent this occurring, but information received by the Inquiry as late as April 1999 indicated that the current locking mechanisms in use at the Centre are inadequate. These mechanisms are able to be jammed in a matter of seconds by inserting objects such as aluminium foil in them. The jamming of the locks has resulted in delays when staff have needed to reach distressed residents quickly. The Inquiry knows of two occasions in 1999 when this occurred. On one occasion a resident was being severely assaulted by others. Staff were delayed in coming to his aid because the assailants had obstructed the locks. The victim was hospitalised for injuries sustained as a result of the assault. On the other occasion staff were delayed in reaching a resident who had set his room on fire.

The problems of the Centre were exacerbated with the closure of Westbrook in December 1994 and the consequent transfer of the older boys from Westbrook to John Oxley. The increase in residents led to overcrowding, with some residents being forced to 'double up'. Additionally, an area previously used for recreational purposes was utilised for accommodation. The overcrowding left management with no alternative but to accommodate children of all ages together, giving rise to a lack of segregation of convicted children and those in the care and protection of the Department. Several staff members confirmed that this caused problems. Many individual programs and other positive activities were halted. The increased numbers placed extra pressure on staff. The Inquiry heard from a staff member that the Centre was not adequately equipped to take the older boys from Westbrook. Evidence was also given that the residents who had been transferred from Westbrook were given additional privileges, for example permission to keep their tobacco and smoke 'wherever they liked' in the Centre. This special treatment was resented by other residents, who perceived such privileges as according the Westbrook boys special status and, therefore, more power. When management finally started to 'bring them into line', their reaction was extremely negative, and created a volatile atmosphere at the Centre.

Between January 1994 and February 1995 the Centre experienced a 40 per cent increase in occupancy,<sup>65</sup> necessitating the construction of demountable buildings to accommodate the extra numbers. These were named Stradbroke, Bribie and Fraser (Hamilton A, B and C were opened in 1999). It was soon discovered that the units became extremely hot in the summer months. An Official Visitor, in a report dated 28 October 1994, stated that he was very uncomfortable and was relieved to be out of the rooms at the end of his visits. He further stated that 'the boys were necessarily bare chested and took showers more regularly than usual'. He was advised by staff that the boys could request that the air-conditioner be turned up.

### **Control of medical supplies**

A sizeable proportion of residents were on medication. In a report dated 17 February 1995 it was stated that, of the 50 children resident in the Centre, 10 were on anti-depressant medication. Six of those were prescribed this medication to treat depression, three for excessive anger disturbances and one for Attention Deficit Disorder. All medication was prescribed by visiting medical practitioners and the visiting psychiatrist.

However, a staff member working at the Centre between 1988 and 1990 expressed the view that the control of drugs in the institution was poor. A nurse dispensed drugs two or three

times a day, but there were no control procedures to ensure that drugs had not been stolen. At night, unqualified staff had to dispense medication to the children. He stated that, during one of the riots, medication (such as Rohypnol) was possibly taken by the residents from a filing cabinet. As a result of this incident, special cabinets were installed for the storage of medication.

A monthly report dated 6 April 1995 stated that three children had injected themselves with Vegemite, having obtained the syringe from the medical trauma kit of a nurse when she was attending to another resident. As a result of this incident, a protocol was implemented to ensure that the nurse would be accompanied by staff at all times.<sup>66</sup>

### **Staffing issues**

Evidence to the Inquiry addressed a number of issues about low staffing levels, adequacy of training and competency. It should be noted, however, that some ex-residents gave evidence that certain staff at John Oxley were extremely good at their work and had a positive influence. The comments below, therefore, should not be regarded as a general indictment of all staff at the Centre.

Some staff also gave evidence that there were continual staff shortages, which placed enormous pressures on the existing staff. One stated that youth workers were expected to work for eight hours without a break because staffing levels were kept to a minimum. Another expressed concern that staff shortages led to lack of security, giving the example that sometimes teachers were left on their own with residents capable of injuring them with tools. Another staff member stated that riots and other problems were often fuelled by the lack of staff to deal with potentially explosive situations before they developed.

There were also issues of staff volatility within the Centre caused by divisive management practices. In a memorandum to the Executive Director of Youth Support dated 19 February 1990, the Acting Manager stated that there were factional tensions of such magnitude that the normal functioning of the Centre was disrupted.<sup>67</sup>

The evidence suggests that many of the staff recruited to work at John Oxley were underqualified or vastly inexperienced. Examples provided to the Inquiry included one staff member who was promoted from the position of yardsman to youth worker and who had done some shifts as a youth worker while he was a yardsman. Another staff member stated that he had no training when he commenced as a youth worker at John Oxley, having previously been a kitchen hand. Another had previously been a theatre technician. It was also claimed by another staff member, employed at John Oxley between 1988 and 1990, that he was made an acting senior youth worker after four months' service, despite receiving no training.

Some staff who gave evidence expressed their concern at the lack of training provided for them. One stated that when she started she had been told that there would not be young people with behavioural problems within the Centre. The evidence clearly established that many of the residents did have behavioural problems. She stated that she was given no training in how to manage disruptive young people. It took until the early 1990s before a Department-endorsed operational manual was prepared for the institution.

One staff member expressed the view that the lack of training led to volatility in the Centre. Another stated that he believed that staff resorted to the application of force to residents in some circumstances because they did not have the training to deal with problems in other ways. He was of the view that they frequently acted out of fear rather than professional intervention. Inattention to the sensitivities of residents being subjected to certain routine procedures was also the cause of friction. A former resident of the Centre recalled his experience of being strip-searched when a 14-year-old detainee:

*They authorised the anal search and that was the most depraving thing and he made ... he made fun of it, you know. He said 'Bet you like this you little poofster' ... 'You little faggot', and all this shit. And I was actually crying. I couldn't do nothing, I was in*



*handcuffs, right ... I'm only a child you know, I'm not that hard to handle for these blokes ... They put me in these choker holds that knock you out. I've been knocked out that many times, and I thought I was going to die so many times because they've just got these sleeper holds. And it's the scariest thing, you know. I've gone in stages where I've seen white lights ... and then they drag you off to that isolation room ... If you could see and feel it from a child's side ... it would scar you for life.*

An Official Visitor's report dated 13 May 1994 contained details of a partially investigated complaint of assault by a youth worker on an inmate. In that report, the Official Visitor stated that the matter needed further investigation, but that the information disclosed to him reflected a serious deficiency in dispute resolution and mediation skills. The Official Visitor was of the view that the situation was in need of urgent attention by the Department.

### **Major disturbances**

John Oxley has also been plagued by a history of disturbances that have led to potentially serious consequences for staff and children. This is not surprising given the combination of inappropriate premises, lack of staff training and an absence, over much of its history, of operational plans and procedures to deal with major disturbances.

Some staff who gave evidence expressed the view that, had appropriate management practices and strategic plans been in place, with appropriately trained staff, many of the disturbances would not have occurred or have escalated as they did. One staff member who was at the Centre between 1988 and 1990 stated that control of the residents was an 'exceptionally ad hoc affair', with no standard operating procedures and no emergency plans for dealing with potential violence. Another staff member likened work at the Centre to 'being in battle'. He said 'You ... weren't going to work to apply residential care skills to these young people, you were going to work to survive.'

The failure of management to control or prevent disturbances has serious implications for the welfare of the residents in that it exposes them to the risk of injury and places them in frightening situations. In relation to one of the disturbances, one such resident stated:

*Three guys started going ballistic and the youth workers retreated, locked all the outside doors so that we were all trapped in the secure yard ... Three guys started hitting into people they did not like, started throwing things around, picking up rubbish bins and things and trying to ... either hurt other people or property and they just went crazy ... trying to get out.*

On 15 March 1989 one of many disturbances occurred at the Centre. During the upheaval, two youths escaped from their rooms in the Lawson wing and:

*... went on a rampage through the Centre, releasing other residents in the process, some of whom joined in. Although nobody was seriously injured, and no child absconded, damage done to the centre was enormous ... Staff and some children were physically threatened by the ringleaders and greater harm could easily have occurred in the uncontrolled melee.<sup>68</sup>*

One staff member stated that, during one of the disturbances in 1989, a boy ripped the wash basin from the wall and broke out of his room and into the office where staff had secured themselves. The retreat by the staff meant that other residents within the wing were without protection.

On 7 April 1990 there was a disturbance at the Centre in which inmates threw stones at staff.<sup>69</sup> Another occurred on 17 September 1994 when some of the boys took control of the Lawson wing and the staff had to retreat. Some of the residents sniffed aerosol cans and ingested sleeping tablets that belonged to another resident. One of the protesters smashed a window and then most of his peers climbed up on the roof.<sup>70</sup> The disorder ended with the intervention of the riot police.<sup>71</sup>

## Escapes

The Centre also has a history of escapes and attempted escapes. A report prepared in 1994 disclosed that since April 1987 there were 106 escapes or attempted escapes from John Oxley. Some residents had attempted to escape or had escaped on more than one occasion.<sup>72</sup> As a result, security measures were increased, particularly after 1994, with the installation of razor wire, electronically controlled doors and increased use of searches. The effect was to give the institution the look and feel of a high-security adult prison and to tilt the balance between rehabilitation and security very much in favour of the latter.

## Suicide management and self-harming behaviour management

The archival material shows a history of self-harming behaviour by residents at the Centre. In a Memorandum by the Divisional Head of Protective Services and Juvenile Justice dated 11 April 1994, the following comment was made concerning a report which had been prepared by the Acting Senior Resource Officer of Juvenile Justice, Brisbane South:

*I am deeply concerned at the following comment: 'Of primary concern is a lack of awareness of the issues surrounding young people who present as a suicide risk. John Oxley Youth Detention Centre has no current mechanism for specific case planning for young people who present as a suicide risk.' This issue needs to be addressed urgently at John Oxley Youth Detention Centre and checked at each of the other youth detention centres.*



**Photograph 7.20: Cell door with steel mesh (potential hanging point) (1999)—Inquiry photograph**

It appears that by July 1994 departmental procedures, together with management plans, were in place for residents perceived to be at risk. In the individual suicide risk assessments found in the archival material, there appears to be a focus on supervision and suicide prevention by physical means rather than by counselling and detoxification assistance in circumstances where the resident was exhibiting behaviour consistent with drug withdrawal.<sup>73</sup>

It is clear, though, that the Acting Manager at the time was aware of the need for priority to be given to suicide risk management. On 21 July 1994 the Acting Manager prepared a report in relation to an escape from custody by one of the residents. In it he stated that 'It should be

emphasised that self-harming behaviours can be far more damaging to the stability of the centre than any absconding attempt.'

The archival material suggests, however, that protocols for suicide management were not always followed. A report dated 15 February 1995 by the Divisional Head of Protective Services and Juvenile Justice stated that a resident who had been assessed as a suicide risk had escaped by climbing out of the window of his room. Relevant to the issue of suicide risk protocol was that the report stated that the resident was to be checked every five minutes by staff. The resident had not been checked for approximately half an hour before the time he absconded. This demonstrates one incidence of failure to comply with standard procedures that were in place for managing suicide risks.

On the evening of 28 December 1998, a 16-year-old indigenous boy committed suicide by hanging himself from a sheet tied to a ventilation grate. The Department conducted an immediate inquiry into the suicide and prepared a report.<sup>74</sup> The ventilation grates have long been recognised as a potential hanging point. In fact, the same boy attempted suicide in the same room from the same grate in 1997. Although the inquiry into his death recommended specifically that residents' cells be air-conditioned so that the ventilation grates could be removed, and that work should commence promptly, information was received in early April 1999 that the grates are still in existence at the Centre. A coronial inquiry is yet to be held.

### **Assaults**

The archival material and the evidence given by witnesses to the Inquiry indicate a series of assaults by staff against residents, and also between residents.

#### *Assaults by staff against residents*

In a minute dated 15 June 1994 an inmate alleged that a youth worker had kneeed him in the back, scratched him on the face and pulled him by the neck. The matter was internally investigated, and the conclusion, reached by the Acting Deputy Manager and approved by the Acting Manager, was as follows: 'We are in a situation of accusation and denial and feel that no further action is possible in this matter.' The matter was neither referred to the police nor investigated further.

A resident of John Oxley between July 1994 and May 1996 gave evidence that he was hospitalised at Ipswich General Hospital as a result of an assault perpetrated by staff. He claimed that at the time inmates were staging a quiet protest prior to going to bed. Staff gave the inmates the choice of walking into their cells or being carried. Some residents were then assaulted. The resident stated that he was grabbed from behind by the hair and punched in the face. He also claimed that two officers restrained him and he was forced to the ground, whereupon he was kicked in the stomach, face and back. He stated that a staff member put his boot on his head and held it down on the floor. He was then put in his cell and was later found vomiting. He was eventually hospitalised with black eyes, hair loss (from being ripped out), one broken front tooth and a fractured rib. He stated that a staff member was convicted of assault.

Official Visitors' reports also disclose a number of assault allegations against staff. Many of these allegations were found by the Official Visitor to be unsubstantiated. In one incident, however, a resident complained that he had been roughly handled by a youth worker some 4–6 weeks previously. He was asked why he had taken so long to make the complaint and stated that his previous efforts had been ignored. The Official Visitor then spoke with one of the workers in the Centre and concluded, on advice from that officer, that there was a lack of information regarding time or detail and that no further action was possible. He stated that this position was created largely by the delay in making a complaint.

The Official Visitor also received a number of written complaints from residents about a youth worker in the Lawson wing, stating that he roughly handled the boys.<sup>75</sup> Another Official Visitor's report in July 1994 stated that the same youth worker was involved in an incident with a resident which resulted in that resident being knocked unconscious and being

taken to hospital. Other residents stated that the youth worker picked up the injured resident and threw him onto the floor against the heater. The Official Visitor noted that other complaints had been made to other Official Visitors in respect of this youth worker.

The Inquiry heard evidence of other incidences of residents being assaulted by staff. A senior staff member stated that he removed a subordinate for applying a cigarette to a resident's chest. In another case, a staff member and a resident both confirmed that an incident had occurred in which a staff member held a resident against a door and burnt him with a cigarette. On 17 February 1995 it was reported to the Minister that an incident in 1994 had resulted in charges being laid against a member of staff for unlawfully assaulting a resident and causing him bodily harm. The assailant was charged and subsequently resigned.

#### *Assaults between inmates*

The evidence clearly establishes that violence between inmates has occurred with a significant level of frequency. There appears to have been continual failure by the institution to ensure that residents are protected from the violence of other residents.

An Official Visitor's report dated 28 October 1994 disclosed that a resident sustained an injury to the eye which later required stitches. That injury was said to have been sustained during an assault by another resident. An incident report from 1–31 July 1994 discussed a number of occurrences involving physical altercations between inmates.

A staff member also gave an account of a disturbance that occurred in May 1998 when some of the male residents demolished a unit and a staff member and a resident were hospitalised with injuries. Another staff member gave an example of a young person who was moved from one section to another because he had been assaulted by other residents. The perpetrators were then moved to the same section where they assaulted him again. This second assault was so intense that a staff member had to throw himself on top of the victim. Both the staff member and the resident were sent to hospital for medical treatment. The injured staff member also gave evidence to the Inquiry. He stated that he had his hand broken by two residents who were assaulting him with toilet brushes. The resident's arm was broken. The next day when the resident returned from the hospital he had to walk through the wing which still had his and the staff member's blood on the floor and then past his attackers. The perpetrators were jeering at and threatening him. The staff in the section then informed the senior staff member in another section that the resident would be moved to his section. The senior staff member expressed surprise that the resident had been returned at all to the section where the assault had occurred. The resident has given evidence to the Inquiry and stated that he is often assaulted within the Centre.

The Inquiry heard that, despite procedures having been implemented, there was a continuing failure to ensure that residents were protected from other residents.

#### *Sexual assault*

In a report to the Minister dated 17 February 1995 it was stated that two reported allegations of sexual assault by a child on another child had been made. Those allegations were investigated by the police, but no charges resulted from the investigation. Evidence from a staff member also suggests that one female resident complained of rape by another staff member during an outing. That resident did not proceed with an official complaint, but the staff member allegedly involved resigned. Two staff members indicated their concern about possible sexual assaults by the older, bigger residents on the younger, more vulnerable ones. Another indicated that the opportunity for sexual abuse existed, particularly when residents were doubled up in the cells.

## Management and discipline

### *Separation*

The Centre has utilised two methods of separation. The first is to lock residents in their own rooms for a period of time ('lock-down'), the second is to place a resident in a supervised and locked 'time-out room'. Both techniques have been used frequently at the Centre.



**Photograph 7.21: John Oxley Youth Detention Centre time-out room (no windows, bare walls)—Inquiry photograph**

Archival records indicate the use of separation for an extensive period of time. For example, an Official Visitor's report dated 28 October 1994 indicated that one youth was in separation for 17 days. When the Official Visitor spoke with the Acting Manager about this boy, the Acting Manager stated that he considered that separation as a form of discipline had been successful in this case. A staff member stated that children would be locked in their rooms for extended periods of time for minor infringements. One resident stated that he was placed in separation for between three and four days for spilling food. This practice is of particular concern because the use of separation as a means of discipline is not permitted under the Juvenile Justice Regulations. The archival documentation also indicates other improper usage of separation.

An Official Visitor's report dated 12 September 1994 indicates that a resident was locked in his room for having shaved his head. The resident told the Official Visitor that he had been cutting his hair and accidentally put a gap in the side of it and so a youth worker assisted him to trim his hair to make it look respectable. Another youth worker saw his hair and locked him up without giving him the opportunity to explain.

An Official Visitor's report in July 1994 states that a complaint was received by a resident that on 28 July 1994 he was placed in time-out between 1.45 pm and 11.04 pm wearing only his shorts. He stated that he was freezing cold and that he had been handcuffed and taken there. The resident showed the Official Visitor marks on his wrists where the handcuffs had cut into his skin. The Official Visitor concluded:

*No matter how X behaved, I do not believe he should have been left in the time-out room for a period over 8 hours. Further, I do not consider the use of handcuffs on a 15-year*

*old boy, left in the time-out room, is appropriate. I suspect that adults in prison would not be treated in such an inhumane manner. Some attempts should have been made to talk X through his anger. This could have best been achieved by having one of the Aboriginal staff whom X trusts talk with him. This strategy or a similar one should have been adopted soon after X was placed in the time-out room. One of the Aboriginal workers asked to speak with X while he was in time-out, but was not allowed to.*

### Summary

John Oxley was originally established for a purpose very different from the one it has been required to fulfil in recent years. Its design as an open centre, reflecting family residential models, was unsuitable for the security demands placed on the Centre following the changes in admission policy at Wilson and the closure of Westbrook. A range of problems have resulted, including escapes, major disturbances, and isolated incidences of violence among inmates and between inmates and staff. Furthermore, the Inquiry has found that for many years the numbers, quality and training of many custodial staff, and some managers, did not match the requirements of their work and had consequences in terms of their relationships with and management of residents.

## 7.8 JOHN OXLEY YOUTH DETENTION CENTRE: FINDINGS ON USE OF HANDCUFFS

In public hearings before the Inquiry, evidence was heard in relation to three handcuffing incidents said to have occurred at John Oxley in and around September 1989:

- (1) the handcuffing of three residents in the secure yard
- (2) the handcuffing of X in his room
- (3) the handcuffing of Theresa Hearn to the tennis court fence.

These incidents warranted detailed and public examination, not only because they had been the subject of considerable controversy, but because they typify the consequences of the pressures caused by inadequate facilities and insufficiently trained staff in detention centres. Evidence was taken in public session because of longstanding controversy and speculation as to the circumstances and causes of the incidents alleged and the identity of the young people involved. Instead, in order to give protection to the witnesses who were former John Oxley residents, a suppression order was made to prevent publication of their names. The exception was Theresa Hearn, who did not wish such an order to be made.

The occurrence of the first of the three instances of handcuffing is beyond doubt. In addition to oral evidence in relation to this episode, there is also documentary proof in the form of a report from the Centre Manager, Mr Peter Coyne, to the Executive Director, Department of Family Services, dated 9 October 1989. This report refers to the handcuffing of three residents (two females and one male) at the Centre on the evening of 26 September 1989. The other two specific instances about which the Inquiry heard evidence involved the alleged handcuffing of two individual residents at the Centre on separate occasions. On one such occasion it was alleged that a male was handcuffed to the metal bars of the window in his room. The handcuffs on this occasion were said to be applied in such a fashion that the resident's hands were restrained above his head, with the result that the resident could neither sit nor lie down. The other occasion involved the alleged handcuffing of a female detainee to a tennis court fence at the Centre.

Insofar as the incident of 26 September 1989 is concerned, the Inquiry received some evidence that suggested the male resident handcuffed on that occasion was a Mr Daniel Alderton. This evidence was in the form of unsworn statements from a Mr Frederick John Feige and a Mr Terrence John Owens, who were both employed at the Centre at the time, the former as a youth worker and the latter as a yard maintenance man. In sworn evidence before the Inquiry, Mr Feige and Mr Owens both said they had been in error in their earlier identification of the male resident. Both swore that the male resident in question was not Daniel Alderton but rather was another resident, X. It is also noted in passing that Mr Feige claimed that, within a week or so of providing unsworn statements, he informed those to

whom he had supplied them that his identification of the resident as Daniel Alderton was wrong.



*Photograph 7.22: John Oxley Youth Detention Centre  
tennis court fence where girls were handcuffed  
—Inquiry photograph*

The Inquiry heard evidence from many other witnesses, including *X*, which supported the contention that the male resident handcuffed at the Centre on the evening of 26 September 1989 was, in fact, *X* and not Daniel Alderton. The unfortunate death of Daniel Alderton precluded any evidence being taken from him. Nevertheless, having regard to all of the evidence, the Inquiry is in no doubt that Daniel Alderton was not handcuffed at the John Oxley Youth Detention Centre on the evening of 26 September 1989. It was not disputed that the two other residents handcuffed on this occasion were *Y* and *Z*.

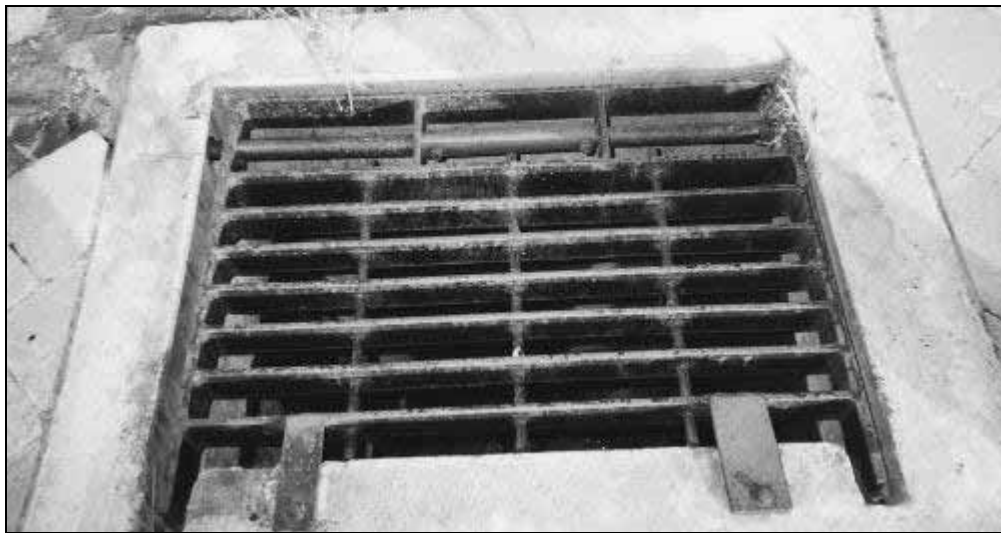
As to the incident itself, the Inquiry heard evidence from the Acting Principal Youth Worker at the Centre on the evening in question, Trevor James Cox. He was the most senior officer on duty at the time, and ranked in order of seniority below the positions of Centre Manager and Deputy Centre Manager. It is clear that the Centre Manager, Mr Peter Coyne, gave verbal directions over the telephone to Mr Cox to initially handcuff two residents, *X* and *Y*. Mr Coyne was at home in his residence, some 10–15 minutes from the Centre, when he issued these instructions. Mr Cox claimed that he was surprised by this order from Mr Coyne. He said that, although the two residents had been yelling out and making a lot of noise, to his knowledge handcuffs had not been used at the Centre prior to this evening. Other workers on duty at the Centre at the time spoke of what they considered to be the inappropriate use of the handcuffs on this occasion.

For his part, Mr Coyne claimed that his actions in ordering the initial handcuffing of two residents, and subsequently a third, was to prevent a major incident such as a riot from occurring at the Centre. The Inquiry finds, however, that the purpose of the telephone call from Mr Cox to Mr Coyne, during which Mr Coyne claims to have heard the disruptive behaviour of *X* and *Y*, was not to complain about such behaviour but rather to inform him that a resident of the Centre had been admitted to the Ipswich General Hospital in a totally unrelated matter. On the whole of the evidence, the Inquiry does not accept that the conditions

prevailing at the Centre at the time of Mr Cox's telephone call to Mr Coyne were in any way approaching conditions which might give rise to a riot.

In the Inquiry's view it was neither necessary nor appropriate for Mr Coyne to order the taking of such drastic action—the handcuffing of juvenile residents—from his position at the other end of a telephone call. He did not live a great distance from the Centre and before issuing a directive as to the handcuffing of residents he should have personally gone to the Centre and made an assessment of the situation himself. Had he done so, he may well have found that the use of handcuffs was unnecessary. He could at least have tried talking to the residents involved or taken some other form of action, such as individually walking a particular resident to calm them down, before even considering the use of the handcuffing option.

The Inquiry heard evidence, which it accepts, that the staff involved in the actual handcuffing of the residents were unsure about how to operate the handcuffs. The then Deputy Manager of the Centre, Ms Ann Dutney, stated that she had never seen handcuffs at the Centre up to this time and had no idea where the handcuffs had come from. It is apparent, therefore, that Mr Coyne had in no way trained his staff in the use of handcuffs prior to issuing the directive to Mr Cox on the evening of 26 September 1989.



**Photograph 7.23: John Oxley Youth Detention Centre stormwater grate where a boy was handcuffed overnight—Inquiry photograph**

In Mr Coyne's report of 9 October 1989 to the Executive Director, Youth Support, Department of Family Services, it is plain that one of the three residents, Z, was handcuffed to a tennis court fence for approximately one hour, while the other two residents, X and Y, were handcuffed to a stormwater grate and tennis court fence respectively for periods of 10 hours or more. This was largely confirmed by the three residents in oral evidence before the Inquiry.

In the circumstances, the Inquiry makes the following findings:

- That on the order of Mr Peter Coyne, three residents of the John Oxley Youth Detention Centre were handcuffed on the evening of 26 September 1989. Those residents were X, Y and Z. Daniel Alderton was not one of these three residents.
- That both the act of handcuffing and the length of time that X and Y were handcuffed constituted a possible breach by Mr Coyne of section 69(1) of the *Children's Services Act 1965* in that such conduct may have amounted to ill-treatment, neglect or exposure of a child in a manner likely to cause unnecessary suffering or injury to the physical or mental health of the child involved.



- That as more than 12 months have elapsed since the date of the commission of the offence, no prosecution for any such breach can now be made.
- In light of the evidence heard by the Inquiry, such handcuffing, and more particularly the duration of it, could not be regarded as reasonable punishment, nor was it reasonably necessary in order to dissuade the residents from behaving in a recalcitrant or mutinous manner. As such, in the Inquiry's view, Mr Coyne was not afforded the protection of section 69(5) of the *Children's Services Act 1965*, nor of Regulation 23(10) of the *Children's Services Regulations 1966*.
- Much of the responsibility for the incident of 26 September 1989 must lie with the Department of Family Services and its senior officers. The Inquiry is of this view for the following reasons:
  - (1) A person totally inexperienced and untrained in the management of a juvenile detention centre was appointed as Manager. Mr Coyne was approximately 28 years of age at the time of his appointment and, after obtaining a Bachelor of Social Work Degree, worked predominantly in child protection investigations. He was a Supervisor of the Department's Inala Area Office, where he was responsible for two administrative staff and approximately seven professional staff. He had no prior experience in working in a correctional institution of any kind, nor was he given any training to prepare him for taking on such an arduous task as the management of a youth detention centre.
  - (2) Once appointed, the Department failed to provide adequate supervision of, or training for, Mr Coyne.
  - (3) Mr Coyne's immediate superior in the Department had no hands-on experience in the management of a youth detention centre and thus Mr Coyne was largely left to his own devices.
  - (4) It was acknowledged by the Department that the Centre building had major design faults, especially insofar as the detention of some of the residents was concerned. The resident mix in the Centre changed as a result of a departmental policy decision, and this allowed some children with quite aggressive behaviour patterns to be detained at the Centre. The Centre was never designed to house such individuals.
  - (5) The Department did little or nothing in response to Mr Coyne's complaints about the quality of staff employed at the Centre. Many of the staff were simply redeployed from other detention centres and came with 'an institutional culture' that conflicted with the management style of Mr Coyne.
  - (6) The Department took little or no action to improve the design faults of the building and defects in the security as recommended by Mr Coyne following the riot at the Centre in March 1989.

All of the above factors had an influence on the way in which Mr Coyne responded on the evening of 26 September 1989, which, in the Inquiry's view, was simply an overreaction.

The Inquiry also received evidence in relation to two other alleged incidents involving the use of handcuffs. One of these incidents was said to have involved the handcuffing of the resident *X* in his room in the manner previously described. Although at least five witnesses spoke of seeing *X* handcuffed, *X* himself stated that he had no memory of any such occasion. The evidence before the Inquiry failed to disclose when this incident is alleged to have occurred, although at least one of the witnesses who gave evidence to the Inquiry stated that it was shortly after the incident of 26 September 1989.

In evidence to the Inquiry, Mr Coyne stated that he was unaware of the particular incident and as the use of handcuffs should have occurred only on the authority of the Centre Manager, any such use was unauthorised. He also indicated that, in his view, the manner in which *X* was allegedly handcuffed in his room would have been contrary to Regulation 23(6) of the *Children's Services Regulations* in that *X* would have been compelled to hold himself in a constrained or fatiguing position.

In relation to this incident the Inquiry makes the following findings:

- That it is satisfied that an incident involving the handcuffing of *X* in his room occurred, although he himself has no memory of it.
- That the manner of such handcuffing was in breach of Regulation 23(6) of the Children's Services Regulations 1966.
- That there is no evidence that the Centre Manager, Mr Coyne, authorised the handcuffing and the Inquiry is unable to ascertain who ordered the action.

The third specific incident about which the Inquiry heard evidence was the alleged handcuffing of a female resident, Theresa Hearn, on an occasion which Ms Hearn stated was before 26 September 1989. In public hearings before the Inquiry, Ms Hearn alleged that Mr Coyne physically handcuffed her to a tennis court fence while she was dressed only in a pair of boxer shorts, bra and singlet. She alleged that she was handcuffed in this way from about sunset on one day until approximately 3.00 am the following day. She also alleged that while handcuffed Mr Coyne repeatedly attempted to have her take medication which was not her usual form of medication. She stated that she ultimately took this medication at about 3.00 am or 4.00 am in the morning as she was very cold and did not wish to stay outside handcuffed to the fence all night. She claimed that after taking this medication she next awoke in her room handcuffed to her bed.

The Inquiry, however, was also in receipt of other versions of this incident given by Ms Hearn on earlier occasions. These versions cast doubt upon her evidence in the public hearings regarding Mr Coyne's involvement in this alleged incident. Mr Coyne, in evidence before the Inquiry, claimed to have no recollection of any such incident but maintained that the distribution of medication at the Centre was rigidly controlled and, by inference, that the issuing of medication to a resident in the circumstances alleged by Ms Hearn would not have occurred.

There was, however, some evidence before the Inquiry from the witness Frederick John Feige in which he spoke of an occasion, possibly before 26 September 1989, when Ms Hearn was handcuffed to a tennis court fence. Mr Feige's recollection of this incident was that after Ms Hearn was handcuffed she was calling out for her medication, whereupon Mr Coyne got the nursing sister at the Centre to administer it. Mr Feige was unable to recall exactly how Ms Hearn was dressed or to say whether the incident about which he spoke was the same as that referred to by Ms Hearn. The latter, however, only ever claimed to have been handcuffed to a tennis court fence on one occasion. Importantly, Mr Feige said that the handcuffing of Ms Hearn about which he spoke lasted, at most, for half an hour. Mr Feige and Ms Hearn were the only two witnesses who gave evidence at the public hearing about the alleged incident.

In view of the internal inconsistencies in the versions given by Ms Hearn herself and the apparent inconsistencies in the evidence given in the public hearings between Ms Hearn and Mr Feige, the Inquiry makes the following findings:

- That, although the Inquiry is satisfied that Theresa Hearn was handcuffed to a tennis court fence, it is unable to safely conclude that Ms Hearn was so handcuffed by Mr Coyne while dressed in the clothing she alleges or for the duration of time that she alleges.
- That Theresa Hearn was not forcibly medicated by Mr Coyne after being handcuffed as described.

## **7.9 CONCLUSION**

Prior to the 1980s, the majority of correctional institutions for young people placed an emphasis on punishment, discipline and deprivation of liberty, with little concern for rehabilitation, education and individual treatment. With no serious programs in place, the majority of detainees were in effect simply waiting out a custodial sentence, some even unsure of its duration. Following the 'depersonalising' admission process, inmates were required to conform to an inflexible regime that rarely appeared to function in the interests of

rehabilitation. Disciplinary techniques such as corporal punishment, drilling and even solitary confinement (in spite of its ambiguous status in law) were used for minor infringements.

The rigid adherence to a medical model at Wilson led to many children being unjustifiably pathologised as ill and subjected to medication, when in fact they had simply been found guilty of status offences such as running away from abusive circumstances in the home. At Wilson, medication was also persistently used to sedate inmates who refused to comply with the institutional regime.

At other institutions a range of informal punishments such as ‘walking the path’, being forced to take castor oil and hair clipping were also used to supplement those sanctioned by the regulations. There was also the risk of physical and sexual abuse from both staff and other detainees. It was at Westbrook, under the administration of Superintendent Golledge in particular, that the majority of these features took on a brutal and sadistic form. The result was that the institution failed to protect, let alone rehabilitate, the vast majority of its detainee population; instead, it produced young men who left Westbrook more damaged than when they had been admitted.

The denominational training schools for girls were also deficient in a number of respects. They were large institutions in which individual treatment could never be implemented, and where the regime was necessarily austere on account of the small number of staff on hand to supervise the excessive numbers of young women. The lifestyle was spartan, the labour tiresome and the discipline stern. Punishments were harsh, often commencing with solitary confinement and sedation for particularly troublesome residents.

Most of the institutions discussed in this chapter experienced the problem of overcrowding. It was a problem generally compounded by insufficient staffing and inadequate training for existing staff. The existence of outdated and inadequate structures at the institutions made the work of the staff even more difficult. Wilson remains to this day the most striking example of such neglect. As well as having to endure these challenging physical conditions, detainees also suffered from a lack of programs designed to assist in their rehabilitation. The result was that educational opportunities remained unexplored and vocational training failed to enhance the employment prospects of most former detainees.

The history of John Oxley would suggest that many of the problems of the past have not been completely eradicated from Queensland’s system for the detention of young offenders. Inadequately trained staff in insufficient numbers, persistent abscondings, occasional disturbances involving violence and the Centre’s structural redundancy (especially as a result of the changes made after the closure of Westbrook) are all problems that were experienced in facilities long closed. The occurrence of events such as the handcuffing incident of 1989 exemplifies how untrained, unsupervised and unsupported people can make careless decisions. Well-trained staff can prevent major disturbances and reduce the risks of abuse.

## ENDNOTES

<sup>1</sup> The boys’ institutions were Riverview, Alkira, Enoggera Boys’ Home, BoysTown, Margaret Marr, Marsden, Booval and Marsden, Kallangur, each discussed in Chapter 5. The girls’ facilities were Mt Maria, Holy Cross and Kalimna, to be dealt with in this chapter.

<sup>2</sup> Superintendent Golledge to Director, State Children Department, 18 July 1961, DFYCC 3I/19 Part B.

<sup>3</sup> EJ Brose et al. to Minister for Health & Home Affairs, 20 March 1961, DFYCC 3I/19 Part B.

<sup>4</sup> It is apparent, however, that a small number of the witnesses had read the Schwarten Report and this has been borne in mind in evaluating their evidence and recollections of events some 35 or more years ago.

<sup>5</sup> Memorandum from senior child care officer, 20 August 1971, DFYCC 3I/11 Part B.

<sup>6</sup> Memorandum from Supervision Officer, 24 December 1970, DFYCC 3I/19 Part A.

<sup>7</sup> Memorandum from Superintendent, 31 July 1978, DFYCC 3I/4.

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- <sup>8</sup> Memorandum from acting principal child care officer, 5 April 1973, DFYCC 3I/19 Part A.
- <sup>9</sup> Memorandum from senior child care officer to Director, 2 November 1973, DFYCC 3I/19 Part A.
- <sup>10</sup> Memorandum from Director, 2 November 1973, DFYCC 3I/19 Part A.
- <sup>11</sup> Memorandum from senior child care officer to Director, 6 December 1971, QSA QS1031/1. See also Visiting Justice to Director, 16 November 1971, DFYCC 3I/19 Part A.
- <sup>12</sup> Detective Senior Sergeant to Inspector of Police, Toowoomba, 2 September 1974, QSA 541/1.
- <sup>13</sup> Memorandum from child care officers to Director, 24 May 1974, QSA 541/1.
- <sup>14</sup> Memorandum from Superintendent, 8 December 1978, DFYCC 265 Training–Departmental–Westbrook.
- <sup>15</sup> Acting Deputy Director to Superintendent, 19 December 1978, DFYCC 3I/14 Part B.
- <sup>16</sup> Psychologist to senior child care officer, 14 November 1978, DFYCC 3I/8.
- <sup>17</sup> Reverend WA Dethlefs, Youth Advocacy Centre, to Minister for Welfare Services, 4 August 1981, DFYCC 3I/8.
- <sup>18</sup> Memorandum from Superintendent to principal child care officer, 17 November 1981, DFYCC 3I/8.
- <sup>19</sup> Memorandum from Superintendent to principal child care officer, 5 May 1981, DFYCC 3I/1-3; Administration Officer to Regional Director, Southern Regional Office, 9 April 1986, DFYCC 3I/11 Part B.
- <sup>20</sup> Memorandum from Superintendent to principal child care officer, 2 December 1980, DFYCC 3I/30.
- <sup>21</sup> Memorandum from Superintendent, 31 July 1978, DFYCC 3I/4.
- <sup>22</sup> Memorandum from principal child care officer to Director, 9 April 1980, DFYCC 3I/1-1; General Secretary, Queensland State Service Union, to Under-Secretary, Department of Welfare Services, 17 April 1980, DFYCC 3I/4 Part B; Director to Under-Secretary, Department of Welfare Services, 3 July 1980, DFYCC 3I/4 Part B; Memorandum from Superintendent to principal child care officer, 15 August 1980, DFYCC 3I/4 Part B.
- <sup>23</sup> Guidelines on behaviour management, c. 1980s, DFYCC QS1031/1 Discipline, Punishment and Absconding.
- <sup>24</sup> Status Report Westbrook Youth Centre Program, DFSAIA, 24 March 1993, p. 1.
- <sup>25</sup> Investigation of the Circumstances Surrounding Incidents at Westbrook Youth Detention Centre, Friday, 18 March to Sunday, 20 March 1994 and Friday, 25 March 1994. DFSAIA, 1994.
- <sup>26</sup> Director to Under-Secretary, Department of Health and Home Affairs, 2 October 1959, DFYCC 90I/7/0 Part C.
- <sup>27</sup> Memorandum from Director, 22 September 1959, DFYCC 90I/7/0 Part D.
- <sup>28</sup> Director to Under-Secretary, Department of Health and Home Affairs, 23 May 1960, DFYCC 90I/7/0 Part C.
- <sup>29</sup> Memorandum from Director to Minister for Health and Home Affairs, 10 July 1961, DFYCC 3I/19 Part B.
- <sup>30</sup> Written comment by child care officer, 15 January 1974, DFYCC 96I/5/0.
- <sup>31</sup> Seventh Annual Report, Holy Cross Retreat, Woolloowin, 30 June 1961; and Annual Report, 1961.
- <sup>32</sup> Supervising child care officer to acting principal child care officer, 20 September 1977, DFYCC 90I/7/0 E Part 3.
- <sup>33</sup> It should be noted, however, that another resident stated that she attended prenatal appointments with a doctor at the Brisbane General Hospital.
- <sup>34</sup> The exact number of solitary confinement rooms is not clear. It appears that there may have been more after 1962—five rooms described as the Intake Section and a further cell-like detention room. SA Fowler and RA Hirschfeld, 'An Evaluation of the Institutional Care of Female Delinquents in Queensland', unpublished Social Work II assignment, The University of Queensland, 1967.
- <sup>35</sup> Description given by a resident of Kalimna between 1959 and 1961.
- <sup>36</sup> Memorandum from child care officers, 18 September 1972, DFYCC 96I/5/0.
- <sup>37</sup> MW to Director, 1 November 1956, DFYCC 32I Part 1.
- <sup>38</sup> Directress & Superior, Mount Maria, to Department of Children's Services, 23 December 1974, DFYCC 96I/5/3.
- <sup>39</sup> 63I 'B' Part 2 box 3064.
- <sup>40</sup> Annual Report, 1963.
- <sup>41</sup> Medical Superintendent to Director of Mental Hygiene, 5 June 1962, DFYCC 7I/1 Part A.
- <sup>42</sup> Annual Report, 1963.
- <sup>43</sup> Deputy Director, Department of Children's Services, to Minister for Health, 21 October 1968, DFYCC 7I/13.
- <sup>44</sup> 63I 'B' Part 2 Box 3064 and AH to Senior Medical Director, 18 March 1969, DFYCC 7I/8 Part B.
- <sup>45</sup> Agreement concerning the Division of Responsibilities in relation to the treatment of State children (i.e. children in care).
- <sup>46</sup> Senior Medical Director to Director-General of Health, 26 May 1977, Department of Health file: Welfare and Guidance–General–Education of Children in Wilson Youth Hospital.

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- <sup>47</sup> Manager to Director, State Children Department, 24 February 1966, DFYCC 6I/1 Part 1.
- <sup>48</sup> Senior Medical Director to Director, State Children Department, 22 August 1967, DFYCC 6I/8.
- <sup>49</sup> Memorandum from child care officer, 1 July 1975, DFYCC 836M Part A.
- <sup>50</sup> Justice for Juveniles Group, *A Document on the Juvenile Justice System, Wilson Youth Hospital and Some Alternatives to Residential Care*, 1979.
- <sup>51</sup> Nurse to Medical Director, 12 January 1972, DFYCC 6I/11 Part 2.
- <sup>52</sup> Memorandum from Director, 14 January 1972, DFYCC 6I/11 Part 2.
- <sup>53</sup> Memorandum from Solicitor-General, 26 February 1971, DFYCC 6I/34.
- <sup>54</sup> Medical Director to Senior Medical Director, 29 November 1971, Department of Health file.
- <sup>55</sup> Letter to Director, Division of Psychiatric Services, 17 March 1974.
- <sup>56</sup> Comments on Transcript of Evidence from Royal Commission into Human Relationships (1975), Department of Health file: General Procedure re: Complaints of Mishandling of Patients at Wilson Youth Hospital.
- <sup>57</sup> Letter to the Medical Director, Division of Youth, Welfare and Guidance, 10 July 1974, Department of Health file.
- <sup>58</sup> Letter to the Minister of Health, 1 August 1977, Department of Health file: re Welfare and Guidance—General—Education of Children in Wilson Youth Hospital.
- <sup>59</sup> Memorandum to principal child care officer, Residential Care Services, 6 April 1981, DFYCC 6I/8.
- <sup>60</sup> Report and recommendations from the Commission of Inquiry into the Nature and Extent of the Problems Confronting Youth in Queensland, 1975.
- <sup>61</sup> Letter to Under-Secretary, Department of Welfare Services, 9 August 1978, DFYCC 836N.
- <sup>62</sup> Letter to Under-Secretary, *ibid.*
- <sup>63</sup> Proposal to extend and modify John Oxley Youth Detention Centre, Wacol, January 1990. See Flag 65, Volume 2, John Oxley Youth Detention Centre records, 1993–1995.
- <sup>64</sup> Proposal to extend and modify John Oxley Youth Detention Centre, Wacol, dated January 1990.
- <sup>65</sup> Brief to the Minister, 17 February 1995. Document headed Allegations Regarding John Oxley Youth Detention Centre.
- <sup>66</sup> See monthly report, 2 May 1995, to the Acting Manager from the Acting Nursing Supervisor.
- <sup>67</sup> See Flag 72, John Oxley Youth Detention Centre records, Volume 3, 1995–1998.
- <sup>68</sup> Report on the investigation into the riot at John Oxley Youth Detention Centre, 15 March 1989, by the Executive Director of Youth Support and the Deputy Director-General, Community and Youth Support.
- <sup>69</sup> See Flag 70, John Oxley Youth Detention Centre records, Volume 3, 1995–1998.
- <sup>70</sup> Official Visitor's report dated 17 September 1994.
- <sup>71</sup> The details of the Official Visitor's report are vague in regard to this disturbance, but it appears that the above summary accurately reflects the information contained in the report.
- <sup>72</sup> See Flag 45, Volume 2, John Oxley Youth Detention Centre records, 1993–1995.
- <sup>73</sup> For example, see a notification of suicide risk for AW, dated 4 July 1994, Flag 5, Volume 1, John Oxley Youth Detention Centre records, Administrative file 1988–1993.
- <sup>74</sup> Report of an Inquiry into a Death in Custody, Parts I and II, January 1999, conducted by T Macdermott, Senior Policy Adviser, Juvenile Justice, DFYCC, L Watson (independent indigenous representative) and L Burgess (independent community representative).
- <sup>75</sup> Official Visitor's report, 10 August 1994.

## CHAPTER 8: OVERVIEW OF THE JUVENILE JUSTICE SYSTEM IN QUEENSLAND

### 8.1 INTRODUCTION

Queensland juvenile justice legislation<sup>1</sup> provides that children should be detained in custody only as a last resort. The reasons for the widespread acceptance of this principle and its statutory recognition in the legislation are set out below:

- Detention centres can be ‘schools of crime’, with peer group pressure coming from unsatisfactory role models.
- The majority of offending by children is minor, opportunistic and transitory (i.e. they grow out of it).
- The incarceration of children causes them to be labelled as criminals, in their eyes and in the eyes of their families and friends. This may result in a child continuing a life of crime merely to live up to that expectation.
- Detention disrupts the normal progress of children towards adulthood, usually best achieved in their own families and communities.

Notwithstanding the principles contained in this legislation, the number of children in detention in Queensland has grown from 97 when the *Juvenile Justice Act 1992 (JJA 1992)* was proclaimed in September 1993 to an average of 145 in 1998. Despite the common perception that violent crime is committed primarily by young people, most offences for which young people are apprehended and dealt with by the police and the criminal justice system involve property, and only 12 per cent of proven offences by young people involve violence against other persons.

This chapter provides a brief overview of the juvenile justice system as it currently operates in Queensland. Based on a 1995 review of the *JJA 1992* and other work by Professor Ian O’Connor (1995), an expert in the field of juvenile justice, the chapter also takes into account the 1996 and 1998 amendments to the Act, as well as providing a review of Queensland juvenile crime statistics. The first section examines the key features of the juvenile justice system. The second section describes patterns of juvenile offending, with statistics on the criminal behaviour of young people and their involvement with the police and court system in Queensland, and the over-representation of indigenous young people in the juvenile justice system. The final section examines the use of detention in dealing with young offenders, and should be read in conjunction with the more detailed examination of Queensland’s three juvenile detention centres in Chapter 9 and the discussion of the experiences of young indigenous detainees in Chapter 10.

### 8.2 THE JUVENILE JUSTICE SYSTEM IN QUEENSLAND

The juvenile justice system is that framework of laws, policies, institutions and practices providing for the processing of children who have committed, or are suspected of having committed, an offence. The legal basis for dealing with offending children is set down in a range of laws. The laws that criminalise behaviour, such as the *Criminal Code Act 1899*, apply to adults and children. Procedures for dealing with children who are suspected, or found guilty, of committing offences are primarily set down in the *JJA 1992* and the *Children’s Court Act 1992 (CCA 1992)*.

For the past century, most Western societies have dealt with juvenile offenders and suspects separately from adults. The approach has varied over time, from simply a modified sentencing regime for convicted child offenders (the ‘justice’ or ‘due process’ model) to a totally separate system (the ‘welfare’ model) that has held children accountable for non-criminal as well as criminal behaviour, denied children formal due process legal rights, such as legal representation, and provided for indeterminate sentencing. In reality, the Australian juvenile justice system has for many years been a combination of justice and welfare approaches (Seymour 1988). With the implementation of the *JJA 1992*, Queensland has moved more towards the justice model end of the spectrum.

### **When can children be charged with a criminal offence?**

Children under the age of 10 are not criminally responsible for any act or omission and, therefore, cannot be found guilty of a criminal offence. However, they may be brought before a court on an application for care and protection under section 46(n) of the *Children's Services Act 1965 (CSA 1965)*. This can result in the child being placed in the care of the Director-General of the Department of Families, Youth and Community Care (DFYCC).

In the case of children aged from 10 years to 14 years, section 29 of the *Criminal Code Act 1899* provides that a child is presumed not to be criminally responsible for any act or omission. In order for the child to be held responsible, the prosecution has to prove that at the time of the event the child had the capacity to know that what he or she was doing was wrong.

Young people aged 15 years and older enjoy no immunity from the criminal law and are held criminally responsible in the same way as adults.

### **What happens to children suspected of committing an offence?**

Children aged 10 years and older may be held legally accountable for any offence they commit, subject to the proviso noted above in relation to criminal responsibility. Children may be apprehended and dealt with for any offence they commit. The major differences between the processing of children and adults suspected of committing an offence are:

- There is a statutory requirement for an independent adult to be present during the questioning of a child.
- The police have discretion to caution rather than charge a child offender.
- There is now provision for community conferencing as an alternative diversionary mechanism.
- There is a statutory restriction on the circumstances in which the police may arrest a child.
- A Children's Court with extended jurisdiction has been established to deal with many indictable offences.
- There is a separate sentencing code for children.

These areas of difference are briefly discussed below.

### **Cautioning**

Because most young offenders do not reoffend, efforts are made in most Australian and overseas jurisdictions to divert children from formal contact with the court system. In Queensland, section 4(d) of the *JJA 1992* states:

*If a child commits an offence, the child should be treated in a way that diverts the child from the court's criminal justice system, unless the nature of the offence and the child's criminal history indicate that a proceeding for the offence should be started.*

The Queensland Police Service (QPS) has long employed a cautioning scheme for first and minor offenders who admit guilt and consent to being cautioned. A formal caution involves a child attending a police station with his or her parents and being formally warned by a police officer about his or her behaviour and the consequences of further offending. The decision to administer a caution or proceed to court is a police decision, but section 18 of the Act provides that a magistrate may dismiss a charge if the court believes a caution should have been administered. Prior to the implementation of the Act, police cautioning was provided by way of a directive of the Commissioner of Police. The Act now gives statutory recognition to cautioning (sections 11–20).

In the case of indigenous children, the Act allows for a respected member of the indigenous community to be involved in the process of administering a caution. However, it appears that, in practice, this has only occurred in a limited number of localities.

Under section 17 of the Act, a child who is cautioned is provided with a written certificate of the caution. A caution is confidential; it is not admissible in further proceedings (except in accordance with section 18(2) of the Act) and cannot be disclosed by police.

### **Community conferences**

The 1996 Amendment to the *JJA 1992* introduced into the legislation the concept of community conferencing as another diversionary mechanism for the police (sections 18A–18P), and as an alternative process for the court during sentencing (sections 119A–119D). A community conference is a supervised meeting between the offender and the victim to discuss the offence and negotiate an agreement for restitution satisfactory to both parties. The process begins with a police officer or court referring the offence to a community conference, which is then convened by a community conference convenor. The offence is discussed at the conference and agreement reached on what is to be done to resolve the situation (section 18A(3)).

The intended benefits to the offender include taking responsibility for the results of their offence and for the way in which the conference is conducted, understanding the consequences of their actions for the victim, having the opportunity to make restitution, and limiting involvement with the criminal justice system. The victim may also benefit from the opportunity to meet and understand the child and why the offence was committed, to express their concerns and have their questions answered, to influence the way in which the conference deals with the offence, and to encourage the child's sense of responsibility. The perceived benefits to the community include a reduction in offences due to the early intervention of the community, lower public costs from unnecessary court proceedings, less likelihood of reoffending, and increasing resolution of disputes within the community without government intervention or legal proceedings (section 18A(4)).

While there has been general support for the principles of community conferencing, there remain some concerns about its implementation. A recent evaluation of three pilot programs indicates that the process seems to work satisfactorily (Hayes et al. 1998). However, the fundamental concern remains for some that police-referred community conferences, together with cautions, may now form part of a person's criminal history for the purpose of future court proceedings, both as a child and as an adult. It has been suggested that it is inappropriate for a diversionary process that does not incorporate any of the legal safeguards associated with a court process—for example ensuring that a person has had legal advice—to become part of an offending history on which a court may rely when considering future sentencing options (Youth Advocacy Centre 1998).

### **Jurisdiction of the Children's Court**

The *CSA 1965* established a separate Children's Court with jurisdiction to hear and determine all simple offences and, with the child's consent, most indictable offences, except those punishable by life imprisonment for an adult.

The *CCA 1992* established the Children's Court of Queensland. In effect, a two-tiered system of Children's Courts was created: one presided over by magistrates and the other by judges appointed from the District Court. The Act also provided for the appointment of one of these judges as President of the Court.





*Photograph 8.1: Children's Courts—Inquiry photograph*

The *JJA 1992* has introduced a number of jurisdictional changes:

- The range of indictable offences that can be dealt with summarily by the Children's Court presided over by magistrates is narrower than was the case under the *CSA 1965*, although it is still broader than the Magistrates Court's jurisdiction over adults.
- For matters not dealt with summarily, the *JJA 1992* provides defendants with the right to elect to be dealt with as follows:
  - (a) in the case of a trial, by a District Court or Supreme Court judge and jury, or by a Children's Court constituted by a Children's Court judge sitting in the absence of a jury
  - (b) in the case of a sentence, by a District Court or Supreme Court judge or a Children's Court judge.
- A statutory process of sentence review by a Children's Court judge has been introduced.

As a consequence of these changes, many offences that previously could have been dealt with summarily must now be committed to a higher court for trial or sentence. For example, break and enter offences must now be committed to a Children's Court judge or the District Court. Similarly, Children's Court magistrates may not order detention terms of greater than six months. Where a magistrate believes a longer term is appropriate, section 127 of the Act provides that he or she may commit the child for sentence before a Children's Court judge.

### **Separate sentencing code**

Both the *CSA 1965* and the *JJA 1992* provide separate sentencing codes for children found guilty of committing offences.

Unlike the *CSA 1965*, the *JJA 1992* (section 109) explicitly articulates sentencing principles. A key assumption of the Act is that children should be held accountable for their offending behaviour. According to section 4:

- (f) *A child who commits an offence should be:*
  - (i) *held accountable and encouraged to accept responsibility for the offending behaviour*
  - (ii) *dealt with in a way that will give the child the opportunity to develop in responsible, beneficial and socially acceptable ways.*

Under the sentencing principles set down in section 109, the factors the court is required to take into account include:

- the nature and seriousness of the offence
- the child's previous offending history
- any impact of the offence on the victim
- the fitting proportion between sentence and offence
- age as a mitigating factor
- the principle that a detention order should be imposed as a last resort.

The *JJA 1992* has also extended the sentencing options available to the court. The most notable changes are that a court can now impose community service orders and is empowered to directly order a child to be detained. Prior to making a detention order, a court must first order and receive a pre-sentence report. A child may be remanded in custody while the report is prepared. Under the *CSA 1965*, the court was restricted to committing a child to the care and control of the Director-General of DFYCC for up to two years. The decision to detain was an administrative decision, although DFYCC routinely acted on the recommendation of the court.

The range of dispositions available under the Act are set out below.

*Table 8.1: Sentence orders available under sections 120 and 121 of the Juvenile Justice Act 1992*

Type of sentence order <sup>2</sup>	Maximum sentence order that can be imposed
Reprimand	
Good behaviour order	one year
Fine	amount prescribed under Act in relation to specific offence
Probation order	Magistrate—one year Judge—two years, or if serious offence—three years
Community service order	child of 13–14 years—20–100 hours child of 15–16 years—20–200 hours
Detention order—immediate release	maximum program period three months
Detention order	Magistrate—one year Judge—two years, or if serious offence—maximum of seven years if life offence—10 years, or if heinous violent offence—up to and including the maximum of life

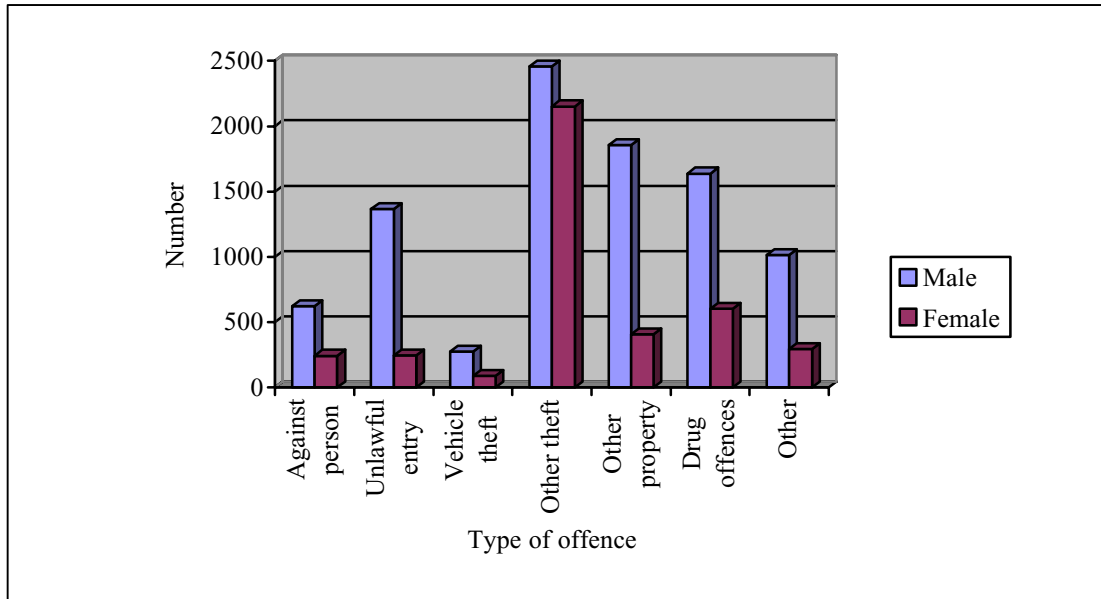
### 8.3 THE PATTERN OF JUVENILE CRIME IN QUEENSLAND<sup>3</sup>

#### Young people and the police

In 1997/98 the police dealt with 33,588 offences committed by juveniles by way of arrest, caution or other means. Offences against the person comprised seven per cent (n = 2,370) of the total, while just under 70 per cent (n = 23,276) were property offences.<sup>4</sup>

Since the 1960s cautioning has been utilised by the police as an important device for diverting young offenders away from the criminal justice system. Indeed, most juvenile offenders are dealt with by way of a caution and do not appear in court. Figure 8.1 shows the number of young men and women who received cautions for stealing in 1998.

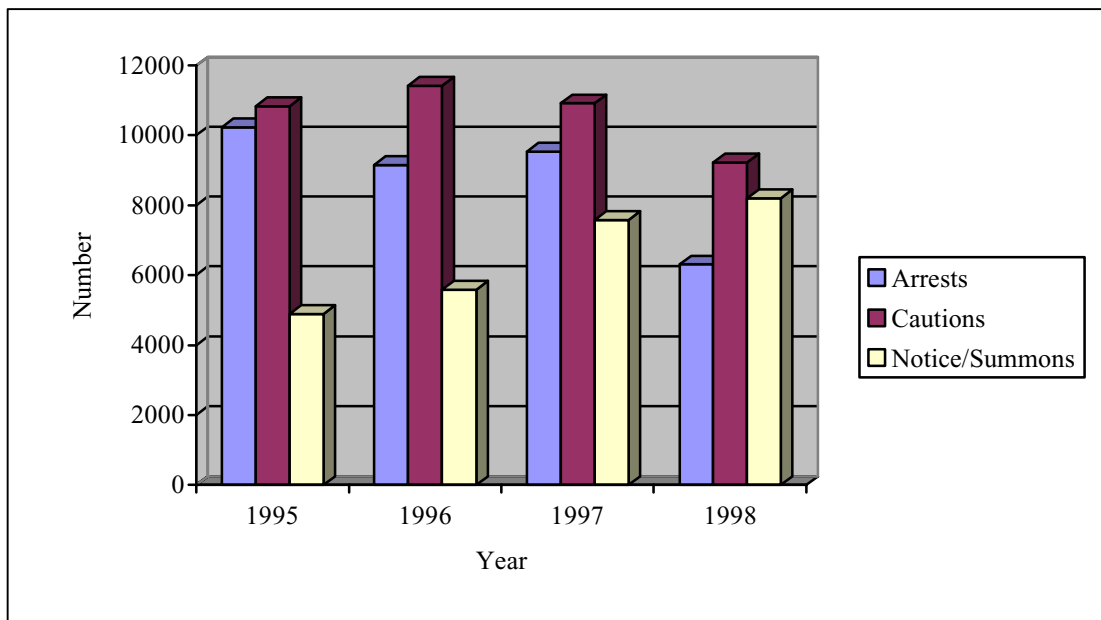
**Figure 8.1: Juvenile offenders cautioned by police, 1998**



Source: QPS Statistics

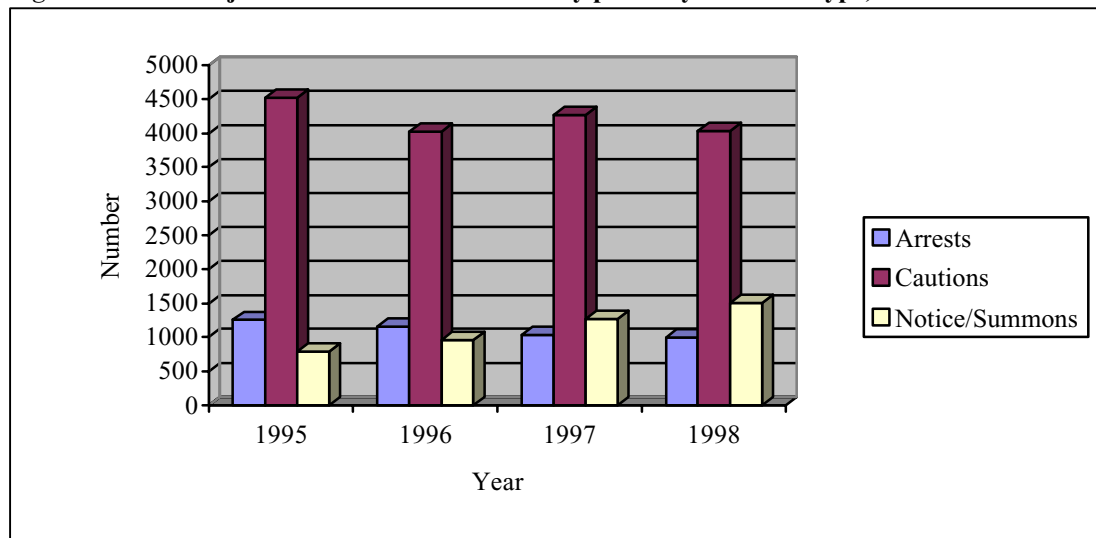
Figures 8.2 and 8.3 demonstrate that proportionately young women are more likely to be cautioned than young men are. Since 1995 there has been a steady increase in the issuing of summonses and attendance notices for the latter.

**Figure 8.2: Male juvenile offenders dealt with by police by clearance type, 1995–1998**



Source: QPS Statistics

Figure 8.3: Female juvenile offenders dealt with by police by clearance type, 1995–1998

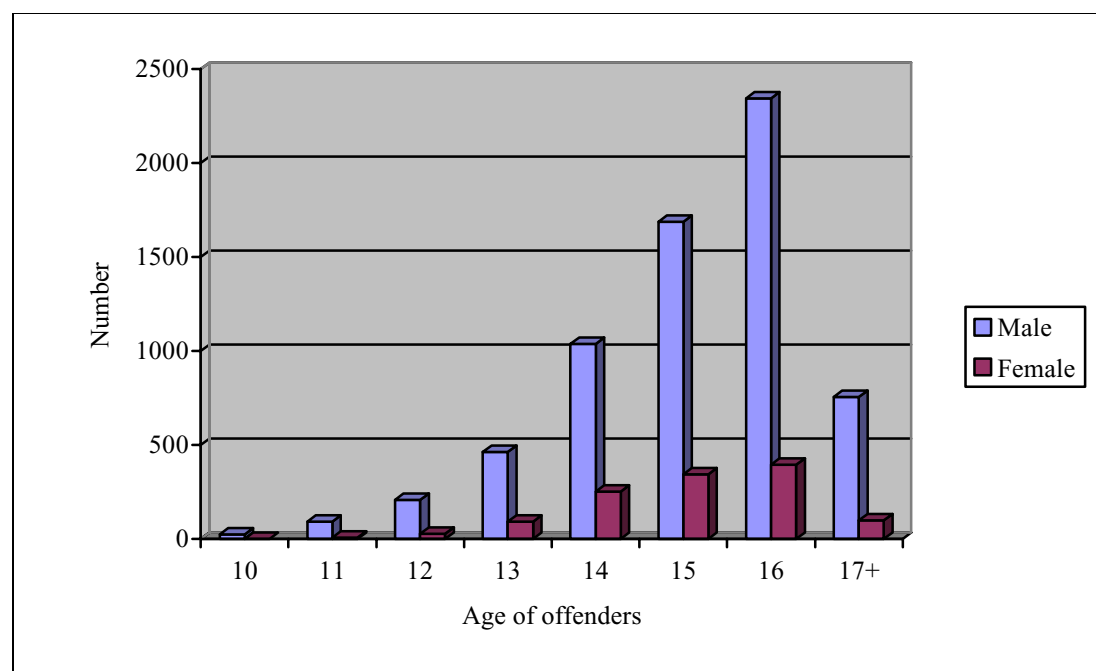


Source: QPS Statistics

### Young people and court

In 1997/98 there were 7,840 finalised court appearances by juvenile offenders, 10.5 per cent more than in the previous year. There was a similar increase between 1995/96 and 1996/97. Indigenous offenders accounted for 33.2 per cent of all finalised appearances, despite representing just under five per cent of the total juvenile population aged 10–16. Figure 8.4 demonstrates that the majority of offenders appearing in court were in the 15–16 age group. Young women accounted for 15.6 per cent (n = 1,225) of all finalised appearances for offences; young men accounted for 84.4 per cent (n = 6,615).

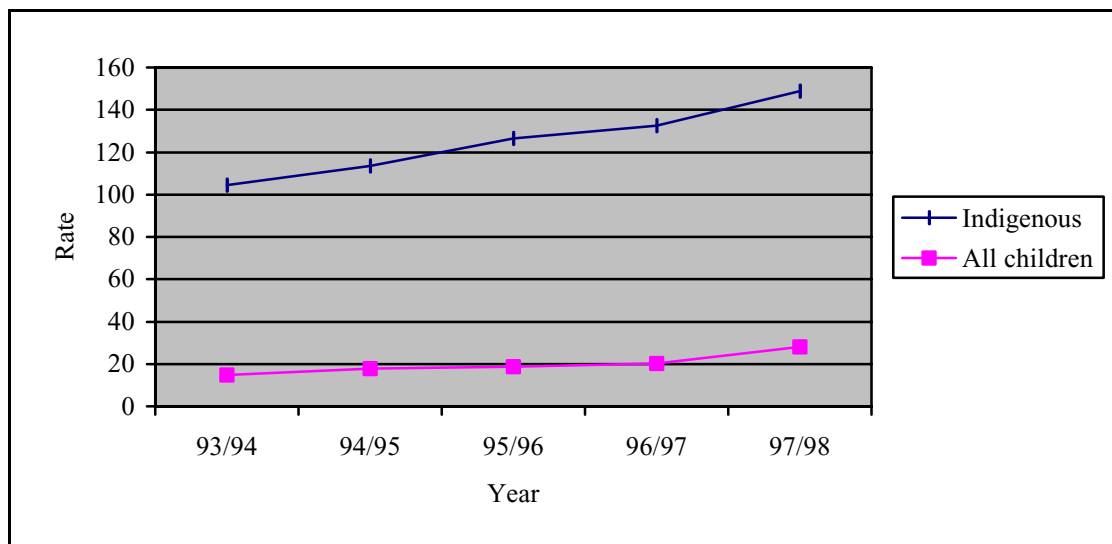
Figure 8.4: Gender and age characteristics of juvenile offenders appearing in court, 1997/98



Source: DFYCC Courts Statistics

In 1997/98, 4,416 distinct (that is, single as opposed to multiple appearances of the same person) children appeared in court. Indigenous offenders accounted for 1,222 (27.7 per cent) of these, a slight increase on the previous year. Figure 8.5 illustrates the number of distinct indigenous young people appearing per 1,000 indigenous young people, and the number of distinct children appearing per 1,000 children.

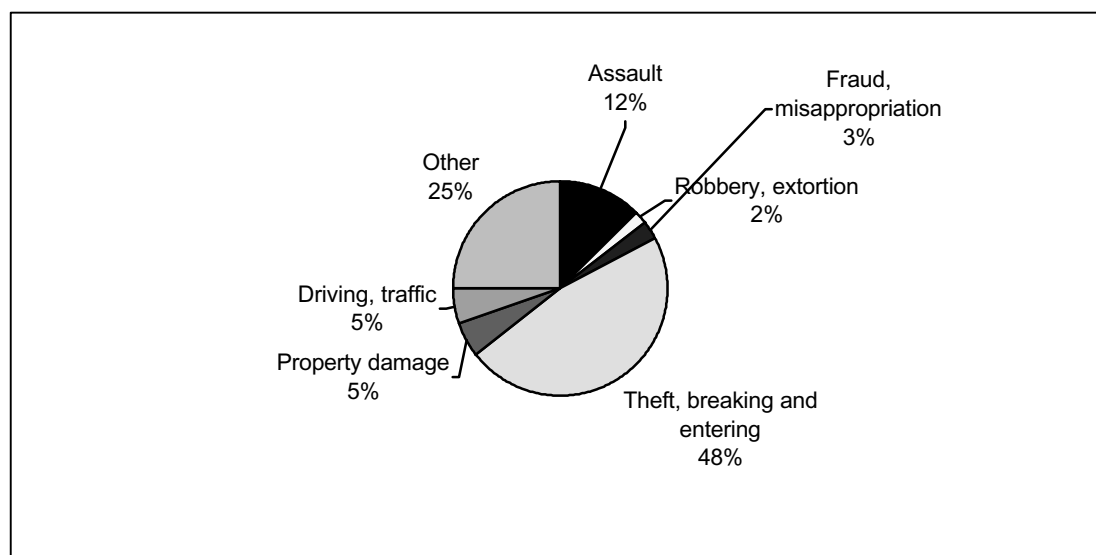
Figure 8.5: Distinct children appearing in court per 1,000 children, 1993/94 to 1997/98



Source: DFYCC Courts Statistics

Figure 8.6 demonstrates that property offences accounted for the greatest proportion of most serious proven offences for which young offenders appeared in court. Offences against the person represented 12 per cent of the total of most serious offences proven.

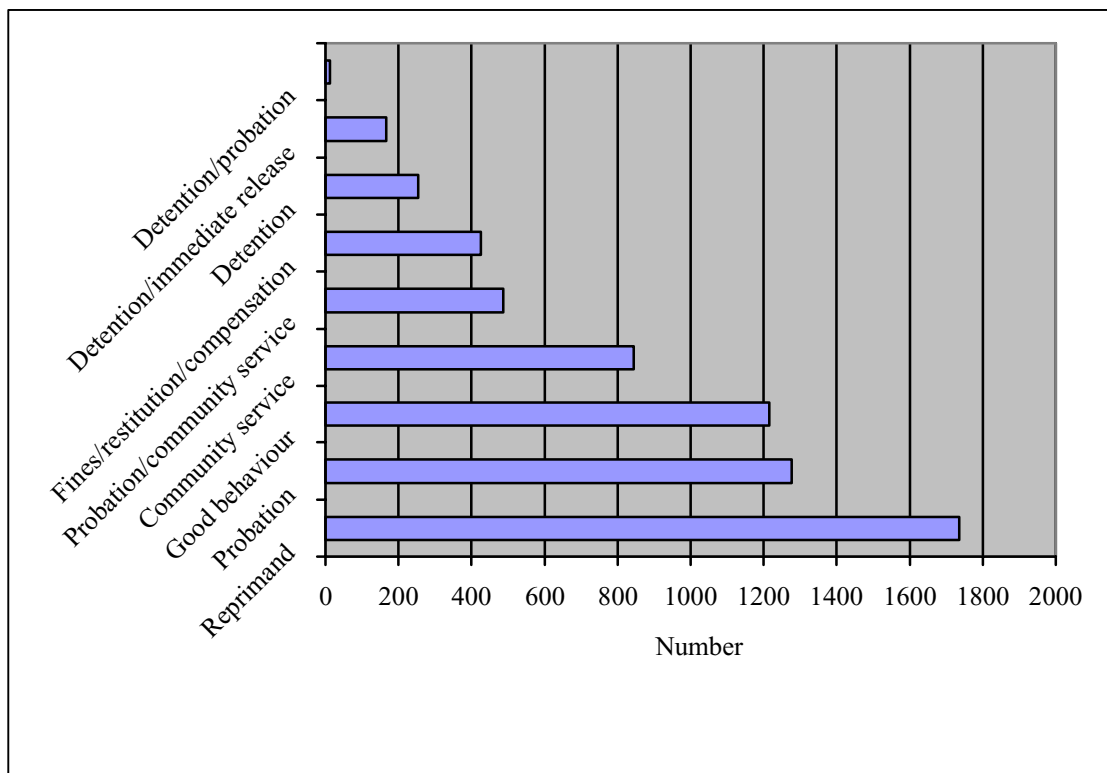
Figure 8.6: Proven juvenile offender appearances by serious offence type, 1997/98



Source: DFYCC Courts Statistics

In 1997/98 out of a total of 7,840 outcomes for the most serious offences charged, 6,416 offences were proven (that is, were not dismissed or withdrawn or committed to another court). Figure 8.7 shows that just under two-thirds of these proven offences resulted in reprimands, probation and good behaviour orders. There were also 433 detention orders: 12 detention/probation orders, 167 immediate release orders, and 254 detention orders. Only 4.1 per cent of proven outcomes for the most serious offences charged actually resulted in a child being detained (that is, detention and detention/probation orders only).

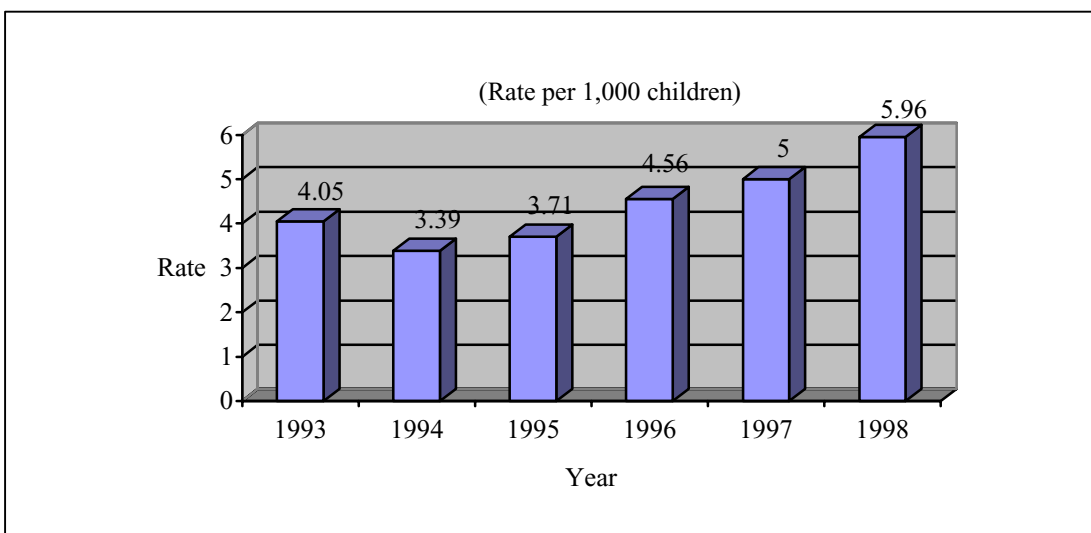
Figure 8.7: Sentencing outcomes for most serious offences proven, 1997/98



Source: DFYCC Courts Statistics

On 30 June 1998 there were 2,112 children under supervised juvenile justice orders (including probation, community service, detention, immediate release and fixed release orders). Figure 8.8 demonstrates that this represents an increase on the previous year.

Figure 8.8: Young people on supervised juvenile justice orders as at 30 June, 1998



Source: DFYCC Courts Statistics

### **The over-representation of indigenous young people<sup>5</sup>**

The over-representation of indigenous youth in the juvenile justice system is a cause of major concern to indigenous people, governments and juvenile justice administrators, and causes much social disruption in their communities of residence. According to all social indicators (housing, income, health etc.), the indigenous peoples of Australia are the most disadvantaged group in Australian society.

The over-representation in the juvenile justice system was highlighted as a major social problem by the Royal Commission into Aboriginal Deaths in Custody.<sup>6</sup> The Commission concluded that an understanding of the experience of disadvantage in Australian society is critical to understanding the reasons for disproportionate levels of offending by indigenous people. The Commission reported that the nature of the criminal justice system and the manner in which criminality is constructed is a factor:

*The exercising of the ideal of impartial justice is necessarily accompanied by the values of those who enforce the 'rule of law'.*

The Commission concluded that:

*Young Aboriginals are unnecessarily, or deliberately, made the subject of trivial charges or multiple charges, with the result that the appearance of a serious criminal record is built up at an early age.*

Racial discrimination, poor relations between police and Aboriginal youth, and the reliance of Aboriginal youth on public space for recreation increase the likelihood of indigenous young people having hostile contact with the police. Early and extended contact with the juvenile justice system is a predictor of adult involvement in the criminal justice system (Royal Commission into Aboriginal Deaths in Custody 1991; O'Connor 1993, 1994).

The level of over-representation and the process of its amplification in the juvenile justice system are evident in the Queensland juvenile justice system. In 1995/96, one-third (31.8 per cent) of all final proven appearances of juveniles in Queensland courts were indigenous children.

Indigenous and non-indigenous children appeared before the courts for similar reasons, though a slightly smaller proportion of indigenous children appeared on charges of theft and break and enter than other children. Conversely, the number of assault offences was slightly higher. Of those found guilty by the courts, indigenous children accounted for a smaller proportion of those who were reprimanded (24.9 per cent), or fined (18.5 per cent).

The 1995/96 data for Queensland shows that, while non-indigenous children constitute 96.4 per cent of the total population aged 10–16 years, they made up 68.2 per cent of all finalised proven court appearances, 75 per cent of all reprimands, 78.5 per cent of fines, 75.4 per cent of good behaviour orders, 59.4 per cent of community service orders and 46.8 per cent of detention orders.

The over-representation of indigenous children is most noticeable when examining the Queensland data on distinct children's appearances before the courts (as opposed to appearance data discussed above). During 1995/96, for every 1,000 indigenous children in Queensland aged 10–17 years, 68.7 made at least one appearance before a court. In contrast, only 7.2 in 1,000 non-indigenous children appeared before a court; that is, indigenous children were nearly 10 times more likely to appear in court.

Indigenous children are 26 times more likely to be put on a detention order. This pattern of over-representation of indigenous children in the system has remained relatively stable over recent years, despite the report of the Royal Commission into Aboriginal Deaths in Custody and numerous other reports.

There is also a tendency for indigenous children to come into the system at an earlier age. For example, in Queensland, 69 per cent of distinct children aged 12 and under who were admitted to supervised orders were indigenous, as were 50 per cent of 13 and 14 year olds. For detention orders the situation was worse; all children aged 12 and under in detention were indigenous, as were 81 per cent of those aged 13 and 14 years. Research consistently demonstrates that earlier entry into the juvenile justice system, and particularly into detention centres, is a predictor of longer-term contact with the criminal justice system.

#### Recommendation

That there be a concerted whole-of-government effort to reduce the gross over-representation of indigenous children in juvenile detention centres.

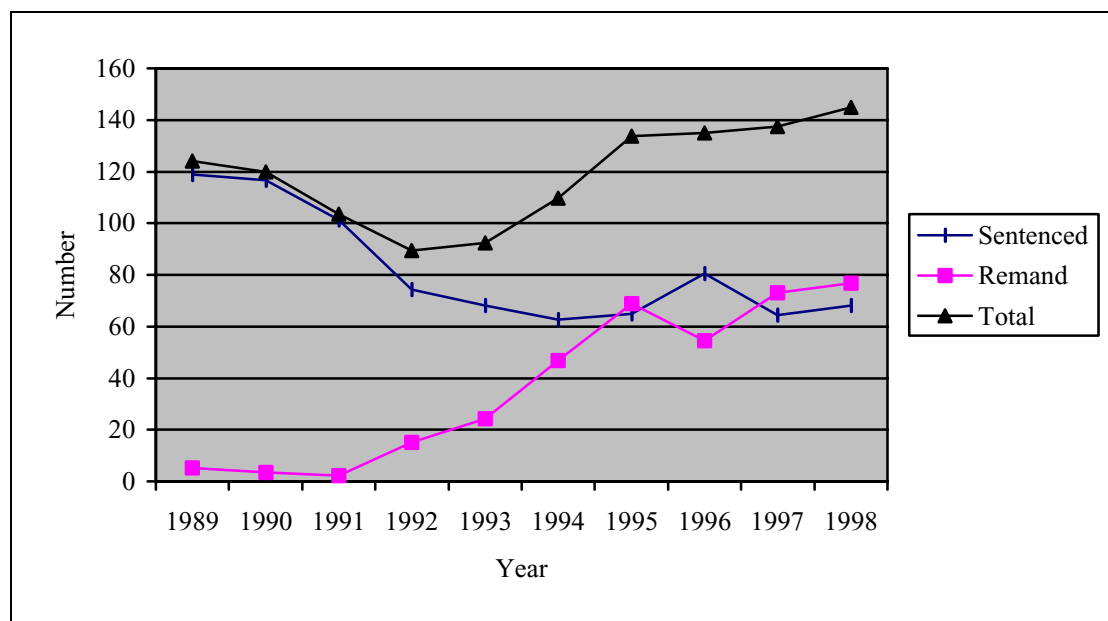
### 8.4 CHILDREN IN DETENTION

The *JJA 1992* provides the legislative framework for the establishment and management of Queensland's detention centres. Children who are remanded in custody or sentenced to a detention order are detained in one of DFYCC's detention centres. The Department currently operates three centres: Sir Leslie Wilson, John Oxley and Cleveland, which are described in more detail in Chapter 9.

#### Statistical trends

Figure 8.9 shows that since the implementation of the *JJA 1992* in 1993, the average daily number of young people in detention has risen from 89 in 1992 to 145 in 1998. In this same period the population of children aged 10–16 increased by approximately 10 per cent. Figure 8.9 also shows that the average daily number of detainees on remand only is now greater than the number sentenced for an offence. There are two main reasons for this latter increase. First, there is now a requirement under the *JJA 1992* that the court consider a pre-sentence report before imposing a detention order. Consequently, a child may be placed on remand until this report has been prepared. Second, changes in the summary jurisdiction of the Children's Court resulted in an increase in the number of committal hearings, leading to longer delays before matters could be brought before a higher court (O'Connor 1995).

Figure 8.9: Average number of residents in juvenile detention centres (remand and sentenced) 1988–1998

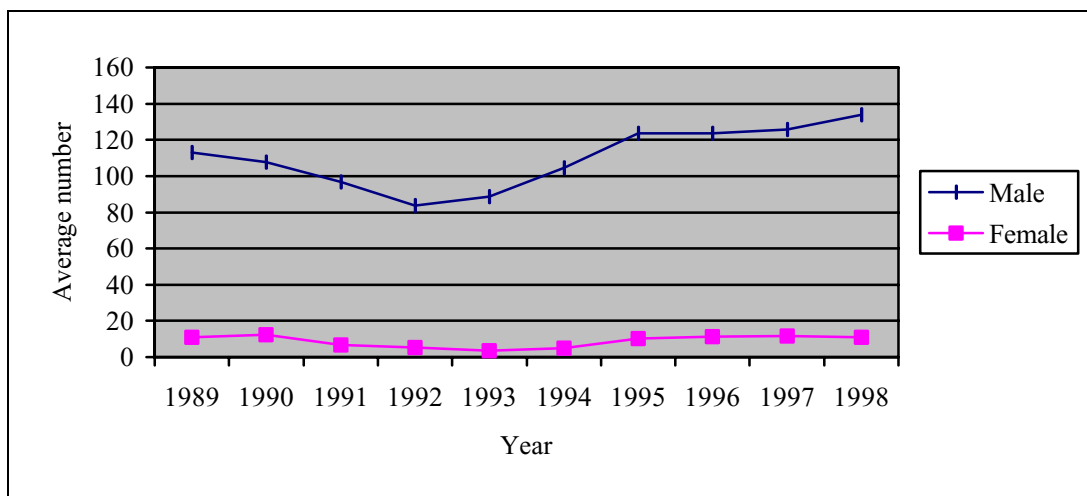


Source: DFYCC Courts Statistics

Figure 8.10 highlights the disproportionate number of young men in detention as compared to young women. On average, only 8.2 per cent of detainees in 1998 were young women.



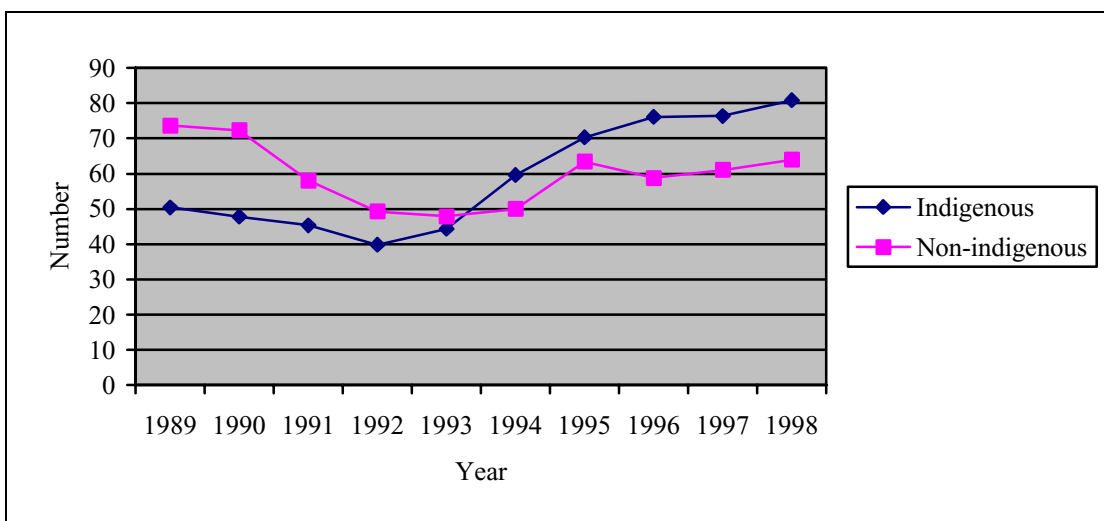
Figure 8.10: Average daily number of residents in juvenile detention centres (by sex), 1988–1998



Source: DFYCC Courts Statistics

Figure 8.11 contrasts the average annual number of indigenous detainees with non-indigenous detainees in Queensland's juvenile detention centres during the past 10 years. From 1994 the number of indigenous offenders has been higher than the number of non-indigenous offenders held in detention. The continuing over-representation of indigenous young people in juvenile detention centres has been a major concern for policy-makers and advocacy groups for many years.

Figure 8.11: Average number of residents in juvenile detention centres (indigenous and non-indigenous), 1988–1998



Source: DFYCC Courts Statistics

## 8.5 REDUCING THE NUMBER OF CHILDREN INCARCERATED IN JUVENILE DETENTION CENTRES

In contrast with Queensland, one of the primary objectives of the juvenile justice program in Victoria is to maximise the appropriate diversion of young people away from the formal criminal justice system, and that diversion should be the primary focus of juvenile justice policy. In addition, one of the underpinning principles of service delivery in that State is that young offenders should be dealt with and maintained within their community, ensuring that custodial sentences are given only in the most serious cases.

Relevant to the preliminary estimated resident juvenile population (10–16 years) for each State as at 30 June 1997, this equated to 241 per 100,000 in Victoria and 600 per 100,000 in Queensland. The latest available data from Victoria show that during 1996 there were 7,298 finalised appearances before the

Children's Court for offences. At these appearances, the outcome for the most serious offence was a detention-type order for 1.9 per cent of appearances, a community-based order for 16.8 per cent of appearances and an unsupervised-type order in 75.4 per cent of appearances. In Queensland during 1996/97 (the closest comparable period) there were 6,171 finalised court appearances for offences by juveniles (excluding committals). When looking at the outcomes to the most serious offences charged at these appearances, 3.8 per cent resulted in a detention order (excluding those immediately suspended), 39.9 per cent resulted in a community-based order and 47.3 per cent resulted in the most serious offence charged being given an unsupervised order (e.g. fine, reprimand, good behaviour). As can be seen, court outcomes for juveniles in Victoria are more heavily favoured towards minimal intervention. For example, in Victoria a fine was given as an outcome in 32 per cent of appearances<sup>7</sup> whereas in Queensland a fine was given in just under 6 per cent of appearances.

Attesting to the courts' strong focus towards less intrusive outcomes, as at 30 June 1998 there were 1,060 young people in Victoria under supervised or custodial juvenile justice orders. In Queensland there were 2,112 young people under supervised or custodial juvenile justice orders.

From information provided by DFYCC, it appears that there has not been a significant increase in juvenile crime in Queensland since 1993.

However, it is of concern to the Inquiry that more than half the children in detention centres are on remand awaiting finalisation of their charges. Many of these children will not be incarcerated even if they are found guilty of the crimes for which they are charged.

#### **Recommendation**

That alternative placement options be developed for young people on remand in order to reduce the number placed in juvenile detention centres.

## **8.6 CONCLUSION**

The juvenile justice system in Queensland is administered through the cooperative workings of a number of government departments. The principles and procedures for dealing with young offenders have been defined in a range of laws, in particular the *CCA 1992* and the *JJA 1992*. While the majority of offences committed by young people are dealt with in the Magistrates Courts, the Children's Court provides a specific environment in which more serious matters involving juveniles may be heard. In a distinct shift towards the 'justice' model, the *JJA 1992* provides a comprehensive framework for dealing with young offenders by recognising the vulnerability of children in the investigatory stages, codifying the principles that dictate the manner in which young offenders are dealt with, supplementing police powers, establishing alternative diversionary mechanisms, defining a range of sentencing orders, and identifying management structures for juvenile detention centres.

The number of young people in custody has continued to climb since the implementation of the *Juvenile Justice Act* in 1993, with an excessive number being held on remand. The over-representation of indigenous children in the juvenile justice system continues to be a major problem.

## **ENDNOTES**

<sup>1</sup> *Juvenile Justice Act 1992, Children's Court Act 1992, Children's Services Act 1965.*

<sup>2</sup> Under certain circumstances, a court may also order a combination of probation order and community service order, or detention order and probation order (ss. 121A-C).

<sup>3</sup> It should be noted that the police define a juvenile as being aged 10–16 and DFYCC 10–17.

<sup>4</sup> These figures reflect the number of offenders associated with each offence cleared per offence category; they do not provide a distinct offender count.

<sup>5</sup> O'Connor, I (1999), Unpublished extracts from articles submitted to the Forde Inquiry.

<sup>6</sup> Commonwealth of Australia (1991), *National Report*. Royal Commission into Aboriginal Deaths in Custody, AGPS, Canberra.

<sup>7</sup> If a young person who has received a fine order is having difficulty in paying the fine, he or she can return to the court and ask for an extension of time to pay. If the young person has not paid the fine within the specified time, he or she is called to account before the court. The court then has multiple options in dealing with the fine defaulter, including a change in the order schedule, turning the matter over to the sheriff (i.e. seizure of property), imposing a youth supervision or youth attendance order or, as a last resort, imposing a detention-type order (e.g. weekend detention).

## CHAPTER 9: CURRENT JUVENILE DETENTION CENTRES

### 9.1 INTRODUCTION

The Inquiry set out to assess the risk of abuse or mistreatment of children in Queensland's juvenile detention centres by undertaking two complementary investigations. The first examined systemic factors that may contribute to, or permit, child abuse or neglect or a breach of any relevant statutory obligation concerning the care of detainees. The second aimed to give detainees an opportunity to speak confidentially about their experiences in detention.

The review of systemic factors examined the standard of facilities, internal management systems and services at the centres, as well as the arrangements for detainee contact with family and community. State legislative provisions, policy and procedures affecting the management of juvenile detention centres are dealt with in Chapter 11.

The Inquiry reviewed documents relevant to juvenile justice and detention in Queensland and held interviews with senior staff of Queensland Corrections (QCORR), Queensland Corrective Services Commission (QCSC), the Department of Families, Youth and Community Care (DFYCC) and Education Queensland. Each of these departments provided additional relevant material, including a summary of specified events that occurred in each centre on 1–14 November 1998, which provided a 'snapshot' of life in each centre. The Inquiry also made contact with a small number of other agencies and individuals who visit the centres, including the Youth Advocacy Service.

An inspection was carried out of each of the centres—Sir Leslie Wilson and John Oxley Youth Detention Centres in Brisbane, and Cleveland Youth Detention Centre in Townsville. These inspections included a lengthy tour of the facilities, observation of daily routines and interaction between staff and detainees, examination of centre records, a review of a small random sample of detainee files (for which detainee consent was obtained), and interviews with staff. The inspections and interviews were conducted using slightly amended versions of a checklist and questions developed for the NSW Ombudsman's Inquiry into Juvenile Detention Centres.<sup>1</sup> These were based on the United Nations *Rules for the Protection of Juveniles Deprived of their Liberty* (UN Rules).<sup>2</sup> A limited timeframe allowed only a few staff at each centre to be interviewed, with priority being given to those with key responsibilities, and not all questions were asked in every interview. The complete list of recommendations from this review is set out in Appendix 13.

In addition, Inquiry staff interviewed 95 young people in detention centres (of a total of 128 held in custody when interviewing began in November 1998). Those interviewed comprised: 38 males aged 14–20 and seven females aged 16–17 at John Oxley, 24 males aged 11–18 at Sir Leslie Wilson and 26 males aged 14–18 at Cleveland. In order to counter fear of reprisals, all detainees were given the opportunity to speak and were encouraged to attend even if they chose to speak about unrelated topics, or not to speak at all.

The young people were asked about admission procedures, the physical environment, relationships with staff, complaints procedures, safety issues and health care, as well as open questions about what they liked or did not like about their experiences in detention. The Inquiry chose not to interpret the views and opinions of these young people, but instead to allow their voices to be heard directly. Quotes taken from their interviews can be found throughout this chapter.

## 9.2 JUVENILE DETENTION CENTRES TODAY

Standards for child detention facilities in Queensland are set out in relevant legislation and philosophy statements:

*a child—if detained in custody—should only be held in a facility suitable for children*  
section 4(b)(ii) *Juvenile Justice Act 1992*



*Photograph 9.1: Sir Leslie Wilson Youth Detention Centre—Inquiry photograph*

### Sir Leslie Wilson Youth Detention Centre

This Centre was first used as a correctional facility for young males in 1961, and was jointly administered by the Departments of Health and Children's Services until the latter assumed full control in 1983. It now serves as a reception centre for all male offenders from areas south of Mackay. Those younger than 15 years of age generally remain at the Centre after assessment, while older boys are transferred to John Oxley. It also accommodates all remanded and convicted girls from throughout Queensland. The average daily inmate population is between 40 and 50, with approximately 100 staff. Each month resident turnover exceeds 70 per cent, well above the other Centres. The Centre consists of five residential sections: Remand for boys and the more difficult cases, Flinders for the older boys with privileges, Fairleigh for the younger and more vulnerable boys, the Girls Section for both remanded and sentenced girls, and Gunyah.

Although its facilities are widely regarded as sub-standard, little upgrading work has been carried out as the Centre has been targeted for closure. It appears that few of the recommendations of earlier reports relating to interim upgrading or closure have been followed. An inspection in December 1998 showed that the Centre remains unsuitable for children.

When responsibility for juvenile detention was transferred to QCSC in 1997, that Commission reported that considerable funds—beyond those provided in the budget—were needed for urgent repairs and maintenance. The same report described it as:

*... squalid, ... [it] ... presents as quite an unacceptable risk to staff and client population alike ... It is a veritable rabbit warren which has a myriad of gates ... it is an unhealthy environment ... it is only a matter of time before a serious incident occurs because of the total dysfunctionality of the centre ...*<sup>3</sup>

This description is as apt today as it was then. While improved security systems such as metal gates and electronic locking systems have been installed, ventilation and sanitary conditions remain inadequate. Following is a female resident's description:

*It's very unhygienic and should be condemned. It's infested with cockroaches. The toilets are leaking, and one time the toilet, I didn't flush it but one of the girls flushed it, and all the [faeces] and toilet paper and that came up out of the toilet and it went on to the floor. They didn't get it fixed until a couple of days after. The toilet still doesn't work; it leaks. There is something wrong with it and the water comes out of the wall and they just go 'There is nothing we can do about it, just live with it'. The kitchen, there is a mouse in the kitchen, or rats, or whatever you call them. The toilets and that are disgusting. The whole bathroom is disgusting. But we keep our bedrooms clean.*

The Centre accommodates all detained girls and the younger and more vulnerable boys as well as children on remand, who may be highly agitated or distressed. Boys' rooms accommodate between two and six; girls occupy bunk beds in rooms designed for single occupancy. Thus, the most vulnerable and unsettled of the detainees are housed in sub-standard, shared accommodation with communal bathrooms (known to increase the risk of abuse, and containing multiple self-harm points) in buildings that hamper staff observation. It was not surprising that some staff members believe that detainees are fearful of physical and/or sexual abuse. Several boys commented on this:

*There was a fight started down in the yard. It's not a way to solve problems, but I mean that's just it in here. You can't just sit down and solve your problems with the other prisoners. You got to fight. Really. That's the only choice you got; to fight, or just stand there and get your head smacked in.*

The DFYCC has indicated that Sir Leslie Wilson will be closed as soon as possible, in conjunction with the commissioning of a new juvenile detention centre planned for a 15.5 hectare site at Wacol. The design will be a series of 'centres within a centre' rather than a single building. Residential sections will be configured as separate 'pod-style' units—considered the most appropriate design for detention centres. The expected completion date is the end of 2000, at a cost of approximately \$30 million. In the interim, \$500,000 has been allocated for upgrades to make the Centre more habitable.<sup>4</sup>

### **John Oxley Youth Detention Centre**

The Centre was established in 1987 at Wacol, an outer suburb of Brisbane that also hosts a number of adult correctional facilities. It originally operated as a facility for boys and girls aged between 10 and 14. With single accommodation for 30 detainees in three residential units (known as Lawson, Wentworth and Blaxland), this facility was regarded as a significant step forward in the provision of juvenile custodial care in Queensland. The closure of Westbrook Youth Detention Centre in 1994 necessitated the construction of three 11-bed demountable wings (Bribie, Fraser and Stradbroke), increasing capacity to approximately 60. At this time, a new perimeter fence rimmed with razor wire, a control station and a school were added, and a decision was made to restrict the clientele to longer-term remanded and sentenced boys aged 15 and over. Three new 11-bed demountable residential units (Hamilton A, B and C) were opened at the end of 1998 in response to the recent increase in juvenile detainees. In recent months, the Centre has been accommodating between 45 and 55 young offenders whose average age is 16–17. The Centre employs 103 staff.

John Oxley is the most secure of the three detention centres. Visitors might easily believe they were entering an adult gaol, a view encouraged by its location across the road from Sir David Longland Correctional Centre. The prominence of security devices in place does little to remind detainees, staff or visitors that this is a facility for young people as opposed to hardened adult criminals. This is particularly so in the original units, Blaxland, Wentworth and Lawson.



*Photograph 9.2: John Oxley Youth Detention Centre: security gates—Inquiry photograph*



*Photograph 9.3: John Oxley Youth Detention Centre: metal bolted-down furniture—Inquiry photograph*



*Photograph 9.4: John Oxley Youth Detention Centre: gaol-like entrance—Inquiry photograph*

The impact of these conditions on the self-image and socialisation of detainees can only undermine any reintegrative programs offered in the Centre. Below is an example of an often-expressed view on the part of detainees:

*What's different about adults and children? We're both doing time, just in different places. Some will say it's a detention centre, some say it's a gaol. To me it's gaol and we're all locked away. Even the teacher will tell you it's a gaol. It's a hole. We don't even get fresh air in here, not in this section.*

The Centre's single-room accommodation, each with its own toilet and shower, is a significant improvement on Sir Leslie Wilson and more in tune with current service standards. It also has greater land area, including an oval, recently made accessible to detainees. However, although the most modern of the centres and, in many respects, better designed to accommodate detainees, the Inquiry heard that the physical layout was unsuitable for containing unrest.

There are also major design faults—for example multiple possible hanging points and very steep stairs that could be a danger to residents, staff and visitors. Some sections are very hot, having been designed for air-conditioning that never eventuated. There is no view of the grounds from detainees' rooms. It is difficult to access public transport facilities, with the closest railway station more than a kilometre away.

The DFYCC has indicated that John Oxley will receive a \$3.5 million upgrade and refurbishment, the first stage of which is to be completed by 30 June 1999. This will include air-conditioning, removal of hanging points, and refurbishment of the three upstairs sections in the main building. In addition, gym equipment and features designed to create a personalised atmosphere will be installed. The second stage will include an upgrade of the medical area, additional interview rooms and separate staff entry. With the commissioning of the planned new detention centre, it is proposed that John Oxley will reduce its current capacity of 90 beds to 40. The inner yard wall can be removed and replaced with a see-through fence and a large dry moat to reduce the sense of confinement. The Centre will become a reception and short-term placement centre for males from southern Queensland.<sup>5</sup>

### **Cleveland Youth Detention Centre**

Cleveland was established in Townsville in 1980 as a remand, assessment and educational facility for north Queensland youths (both male and female) aged between 10 and 16. Initially, it consisted of an administration block, a central courtyard, a school and activities block, an outdoor recreation area and two residential units (Jabiru and Brolga), each with single-bed accommodation for eight detainees and three spare beds in double-bunked rooms. Following the closure of Westbrook in 1994, an 11-bed demountable building (Ibis) was erected, increasing the capacity to 27. In 1997 another two 11-bed demountable accommodation wings (Heron and Kingfisher) were built. The Centre now operates with a 55-bed limit and typically accommodates between 40 and 50 male youths, both on remand and sentenced. In the past, up to 90 per cent of detainees were indigenous. No young women are confined in the Centre at present, but there are plans to recommence admissions in the near future. Cleveland currently employs 95 staff, plus casual staff.

Although somewhat dilapidated, Cleveland provides the most suitable accommodation of the three centres. There are security gates and locked doors, but they do not dominate the environment as they do in the other centres. The perimeter fence permits detainees to see trees and open space beyond. However, as with all the centres, there is inadequate room for education, programs and recreation.

The DFYCC has plans to rebuild the Centre on its current site at an estimated cost of \$12 million. Plans include a new administration building, two new residential sections of 16 beds each that can be subdivided into smaller sections of eight beds, a sports and recreation centre, a secure perimeter that will provide areas for outdoor programs and recreation, and refurbishment of the existing administration building and program areas for the delivery of educational and other programs.<sup>6</sup>



*Photograph 9.5: Cleveland Youth Detention Centre: perimeter fence permits detainees to see trees and open space (note razor wire)—Inquiry photograph*

### **Common problems in detention centres**

These were noted on inspection across all centres and include:

- multiple self-harm and possible hanging points
- little provision of stimulation or warmth in many of the sections (although less so in the most ‘privileged’ units at Cleveland and John Oxley)
- poor ventilation in many areas, which can become very hot in summer
- few or no personal possessions, clothing or posters permitted in the rooms housing newly admitted detainees and those on lower ‘privilege’ levels
- recreation rooms (at John Oxley and Sir Leslie Wilson) offering little apart from music and a video game
- limited or no free access to open areas for fresh air and exercise
- poorly designed corridors and stairwells which constitute a safety hazard
- little capacity for detainees to move freely between common and private areas, program and open areas
- open areas (at Sir Leslie Wilson and Cleveland) being of insufficient size to allow reasonable sporting activities
- poor standards of facilities generally, which shows little respect for the dignity, privacy and self-image of young people
- lack of privacy in communal bathrooms in Sir Leslie Wilson and Cleveland (however, this may be necessary because of the significant number of potential self-harm points in these areas). Below is a typical comment from detainees:

*You got to share the showers and stuff, like two at a time, no doors or nothing. A bit shaming with everyone watching you have a shower and stuff. I don’t want other people looking at me while I have a shower. You don’t know if they are queer or what. You don’t know if they want to try anything on you.*



### 9.3 INTERNAL MANAGEMENT SYSTEMS

The formal QCSC philosophy document on juvenile detention, *The Integrated Approach*,<sup>7</sup> details the inherent dangers of detention for children and young people who are still developing their own identity and values. Potential harms are stated to include:

- the institutionalisation of detained children's social behaviour
- criminalisation through association with offending peers in a stigmatising custodial setting
- risk of emotional or physical intimidation and sexual exploitation by peers or adult staff in positions of power
- disruption to children's achievement of the developmental milestones of their adolescence.<sup>8</sup>

Over-emphasis on control and regimentation can cause detainees to become institutionalised, unable to make their own decisions or see a life outside. Alienated from family and community, they can, on release, find they have been 'left behind' by their peers. For some, detention can become a 'rite of passage'; once 'inside' the juvenile system, the next 'goal' becomes the adult correctional system. A senior practitioner at Cleveland regarded this as a particular problem for indigenous young people from remote areas. The risk is greater the longer a young person remains in detention, which is of concern given the significant increase in the length of time young people spend in remand since the *Juvenile Justice Act 1992 (JJA 1992)* was passed.

Caseworkers, senior practitioners and teachers interviewed during this review commonly referred to these dangers. Some said their basic aim was to ensure that detainees were no more harmed when they left the centres than when they arrived. It appears from current detention centre operations that this basic goal is not guaranteed—a view shared by detainees:

*Makes you worse if you ask me. You come in, you get worse every time you get out. Doesn't rehabilitate you. You're locked up with a whole bunch of criminals and all they ever talk about is stealing and stealing, and stealing, and stealing. It gives you ideas how to do better crime, make more money. So you go out and try it.*

#### **Behaviour management and discipline**

Many detainees have had little opportunity to learn appropriate social behaviour and skills. They can be socially immature for their age, confused by the physical changes happening to them, and have limited control of their emotions. As adolescents, many are also testing themselves and others, and have limited understanding of the consequences of their actions. The challenge for detention centres is to ensure that detainees are kept secure and safe from themselves and others, while at the same time assisting them to become socially mature and responsible individuals.

Staff interaction with detainees and behaviour management techniques establish the 'tone' of the young people's living environment. It is staff who determine to a great extent their safety, dignity and self-worth. Youth workers and section supervisors are the only source of 'intervention' for those detainees unable or unwilling to participate in education and specialist programs. They can either reinforce or undermine such programs, which are designed to assist young people's personal development and help them attain socially acceptable behaviours and attitudes:

*... it is the staff with direct care and supervisory responsibilities that are regarded as having the greatest capacity to influence the outcomes of socialisation and resocialisation strategies.*<sup>9</sup>

Interviews with young people in detention revealed that the frustration engendered by confinement often led to anger and inappropriate behaviour. Their words demonstrate a mature understanding of some of the factors that exacerbate underlying behavioural problems:

*It's just like you're screaming inside but you don't scream out. The freedom has been taken away and it is our fault that has happened. But still, you just feel enclosed because you can't go for a walk if you get angry or something. You can't go for a walk to calm down.*

The Australasian Juvenile Justice Administrators' Service Standards for behaviour management emphasise the need for staff to provide opportunities and support for young people to make decisions and to responsibly manage their own behaviour.<sup>10</sup> Casework staff and teachers interviewed echoed the need for choice and decision making. Active steps must be taken to build in opportunities for individual choice.

*Behaviour management should aim at the creation of a consistent predictable environment that reinforces acceptable, positive behaviour and reduces the likelihood of conflict. Such an environment will also reduce the chances that a teenager will be more disturbed when released than when placed into custody.*<sup>11</sup>

The QCORR Practice and Procedures Manual for detention centres, published in 1995, provides extremely limited direction on appropriate positive interventions. Procedure 3.2 'Managing behaviour' states briefly that techniques (to be developed by centres) should focus on the effective use of communication, interpersonal skills and positive reinforcement. The remainder of the 7-page document details circumstances where force and restraint may be appropriate. The only detailed guidance on the general management of detainees is in a series of procedures (6.2–6.12) requiring that an Intensive Management Unit be established in each centre for 'seriously disruptive' detainees. These have never been established and the procedures have been largely ignored. The only such established unit is the refurbished Blaxland section of John Oxley, but no detainee has yet been placed there.

Each centre has developed its own behaviour management systems, which involve the following three mechanisms: incentive schemes intended to encourage and reward socially appropriate behaviour, consequences or sanctions for unacceptable behaviour, and behaviour management plans prepared primarily for individuals who exhibit significant disruptive behaviour or who otherwise require special management.

#### *Incentive schemes*

Sir Leslie Wilson employs a colour system, with green the highest, blue average and red unacceptable. John Oxley operates a three-tiered system that has been recently modified, and was still on trial in January 1999. Cleveland uses a points system. In all centres, progression to the next more-privileged section or unit depends on sustained good behaviour.

Entitlement or privilege aspects of incentive schemes were found to be problematic and at times punitive. It is probable that these schemes were influenced by the only procedure relating to levels (procedure 6.6 'Levels in the intensive management unit'), which makes personal possessions a privilege and restricts program participation and choice. Matters considered by national and international standards to be entitlements are used as rewards. As an example, detainees on the base level have been deprived of the right to have personal possessions such as family photos, letters, books and magazines in their rooms—noted particularly at Sir Leslie Wilson and Cleveland's Jabiru section. Such personal property, however, is considered essential for detainees' psychological wellbeing and sense of privacy.<sup>12</sup> John Oxley's new incentive scheme provides for all detainees to have personal property in their rooms regardless of their behavioural level. The importance of personal items such as family photographs was mentioned by several young people:

*I got my family up there [on the wall]. I reckon they should let us all have our family up on the wall. That's what we want, to look at our family before we go to sleep.*

According to DFYCC, detention centres have conducted trials in allowing personal possessions for young people. The Department contends that there have been problems with property being stolen due to dormitory-style accommodation.<sup>13</sup> At the present time, however, the majority of bedrooms are individual units.

Contact with family and friends is also treated as a privilege. However, since such contact is essential to a detainee's psychological wellbeing and successful reintegration, it should rather be a basic entitlement and not be apportioned according to behaviour.



*Photograph 9.6: Sir Leslie Wilson Youth Detention Centre main recreation/television room in Fairleigh section (1998)—Inquiry photograph*

Access to certain programs is also used as a reward, as indicated in the rules for the girls section at Sir Leslie Wilson. Under incentive schemes, centres distinguish between educational and vocational programs (from which detainees cannot lawfully be excluded)<sup>14</sup> and other activities such as music, art and leatherwork, which young people on the base level are denied. This may mean that some detainees have no planned activities, apart from chores, to occupy their days. Boredom is already a significant issue and many young people complained about it:

*There's about 14 of us sitting in the TV room because we're not allowed to go and do programs or get out of the TV room and move around and use up all our energy. We're stuck in the TV room sitting down and watching TV, and then the staff turn around and say, 'I wonder why they're mucking up'. It's because we are stuck in the TV room all day long. We're not allowed to do nothing.*

### *Discipline and incentive schemes*

Current practices blur essential distinctions between the operation of incentive schemes and discipline. This is not assisted by procedure 3.2, which lists 'loss of privileges' as a potential sanction. Incentive schemes focus on appropriate behaviour: detainees can choose to behave well (and gain rewards) or poorly (and do without possible rewards). Disciplinary sanctions focus on specific misbehaviour to which staff determine the response. When staff routinely remove privileges, points or levels that have been earned, the incentive scheme becomes distorted and absorbed into the disciplinary system, focusing on negative behaviour and removing control and choice from detainees. The resulting confusion is exacerbated by the use of the term 'consequences'. This appears to refer to outcomes of both 'failure' to gain high levels and of specific misbehaviour.

In cases of serious misbehaviour, it may be necessary to move the detainee to a more secure section, or temporarily suspend entitlement to privileges. The incentive scheme at Cleveland recognises this distinction; if a detainee is moved to a more secure section in response to an incident, the points earned in the previous section cannot be spent in the lower section, but remain 'on the books' in case the detainee gains readmission to the higher section.



*Photograph 9.7: John Oxley Youth Detention Centre recreation room for Lawson (only one video game and speakers for music)—Inquiry photograph*

### *Rewards and choice*

There is a limited range of rewards available, particularly at Sir Leslie Wilson (and, until recently, at John Oxley). Apart from magazines and the use of a stereo, computer games are the main rewards for individuals. Some staff arrange takeaway pizzas and videos if an entire section is well behaved. Cleveland's incentive scheme, by contrast, allows detainees to choose from a range of rewards. Points earned can be 'traded' for any of a range of items and events—for example 10 points for the use of a pack of cards for the evening. The range of options increases as detainees progress to more privileged units. Cleveland also offers sentenced detainees the right to work outside the Centre's secure perimeter. The relative freedom this provides seems to be valued by detainees, as is the trust placed in them:

*I just got sent back from Ibis. That's the best one. It was all right up there. I was going to TAFE. Stay good and you'll get up there. Heaps of people are staying good to get up there.*

Incentive schemes, however, can become part of the punishment system. If detainees at John Oxley and Sir Leslie Wilson misbehave, they are often dropped to lower levels and privileges are removed. One worker, reflecting on behaviour management strategies used at Sir Leslie Wilson, stated:

*We seem to break kids' spirits here—there's little opportunity for them to have input.*

The focus is on compliance and control rather than on fostering self-esteem and positive decision making. By contrast, under Cleveland's scheme points are not deducted for inappropriate behaviour, although detainees may lose the right to purchase rewards.

### *Sanctions or consequences*

Section 14 of the Juvenile Justice Regulations 1993 (the 1993 Regulations) authorises the disciplining of children who misbehave, but requires misbehaviour to be managed in an appropriate way that takes into consideration the child's age and maturity. Certain forms of discipline—involving corporal punishment, physical contact, deprivation of sleep, food or visitors, exclusion from educational or vocational programs or medication, or deprivation of medication—are prohibited. Most significantly, disciplinary practices involving acts of humiliation, physical abuse, emotional abuse or sustained verbal abuse are also prohibited. However, the Regulations are not clear about the type of conduct that amounts to misbehaviour and the sanctions that may be used in response. This is contrary to international standards,<sup>15</sup> and such inconsistencies can frustrate detainees who may feel the rules are arbitrarily imposed depending on particular staff members and their moods.



**Photograph 9.8: Sir Leslie Wilson girls' section. This is the privileged room for those who have consistently been well behaved: torn, discoloured and dirty furniture—Inquiry photograph**

In Cleveland each section has a series of rules that are illustrative of expected behaviour and are explained to detainees. Staff determine when particular conduct should be dealt with by a sanction or 'consequence', and decide the sanction to be imposed. Procedure 3.2 'Managing behaviour' lists warnings, loss of privileges, separation and early bedtimes as examples of sanctions. A review of a section logbook showed that most sanctions fell within this range, with the addition of extra chores and exclusion from activities. Misbehaviour may also result in a loss of levels and/or demotion to another section. There is no formal right of appeal or review.

'Consequences' are to be recorded in section logbooks that are reviewed by supervisory staff. It appears, however, that little attention is paid to the appropriateness or consistency of 'consequences' imposed; most attention is given to the behaviour of the detainees. Inspection of a sample of section logbooks revealed that in those cases where senior staff initialled and dated them, reviews took place between one and three weeks after the events described.

The DFYCC is completing a new practice manual for juvenile detention centres. The Department states that the manual specifically identifies that the intention of behaviour management systems is to develop self-discipline rather than to control young people.

Revision of behaviour management and development systems includes distinguishing further between the longer-term incentives inherent in the behavioural development system and the consequences of aberrant behaviours. DFYCC is strongly supportive of the distinction made by centre staff between consequences and punishments, regarding it as preferable that young people recognise any loss of privileges, or other action taken by staff in response to misbehaviour, as a logical consequence of their own actions rather than an arbitrary punishment imposed by staff.<sup>16</sup>

#### *Potential for misuse*

The wide level of discretion in deciding the 'consequences' that can be imposed, although permitting the response to be 'attuned' to the situation also increases the risk of inappropriate and, in some cases, abusive and/or unlawful sanctions. The following incident exemplifies

this: a detainee who had threatened to harm a staff member during an assault incident was made to submit to a series of random strip-searches. The memo from the acting unit coordinator advising staff of this procedure concludes:

*Even though detainee X has stabilised his behaviour and held a mediated session with the staff member ... he has been informed that the conducting of these random unclothed searches is to remind him that threatening to harm staff members with the aid of a weapon is totally unacceptable, and this Centre will put in place ongoing strategies to ensure the risk of this type of threat occurring is minimal.<sup>17</sup>*

There was a delay of four weekdays before the imposition of the strategy, suggesting it may have been motivated more by the desire to punish the detainee than by any security concerns. Intentional repeated strip-searching of a detainee at random intervals is clearly in breach of section 14(3)(c) of the 1993 Regulations, which prohibits as discipline ‘an act that involves humiliation, physical abuse, emotional abuse or sustained verbal abuse’.

‘Extra chores’ are commonly imposed as a ‘consequence’; for example at John Oxley these can involve scrubbing floors and stairwells with scrubbing brushes. If this differs markedly from more usual cleaning methods, such as mopping or using labour-saving appliances, it echoes older, abusive practices in which people were required to use toothbrushes to clean large areas.

Another consequence of misbehaviour may be to restrict detainees’ visits. As previously noted, this is unacceptable because access to family and friends is essential for the wellbeing of young people in detention. Such a restriction also fails to comply with the general principles of juvenile justice provided in section 4 of the *JJA 1992*, in particular section 4(f)(iii), which requires a child offender to be ‘dealt with in a way that strengthens the child’s family’.

### *Separation*

Section 16(1) of the 1993 Regulations provides that a child can be separated in a locked room only in the following circumstances:

- when the child is ill
- when the child requests it
- when routine security procedures are required in accordance with DFYCC guidelines (understood to include such situations as staff changeovers, nightly bed times, industrial disputes and escapes)
- for the child’s protection or the protection of other persons or property
- to restore order.

Workers can place a child in a locked room for up to two hours. The centre manager must approve any extension beyond this up to 24 hours, beyond which departmental consent is required.<sup>18</sup> Centre managers are required to keep a register detailing all separations.<sup>19</sup>

It is unclear whether the Regulations allow separation to be used as a punishment or, alternatively, as a short-term response to prevent immediate injury, property destruction or threat to centre security. Procedural guidelines are similarly ambiguous:

*A resident may be separated or isolated in a locked room for reasons other than discipline ... Isolation in a locked room is not generally to be used for behaviour management in the first instance.*

Several staff members said isolation was used only to prevent harm or injury when a detainee was particularly disruptive, and only until the detainee settled. Others claimed the practice was in accordance with the regulatory requirements, since removing a difficult detainee ‘protected’ others in the section and/or restored order by removing the disruptive element for

a time. Centre records indicate that the practice is routinely used as a ‘consequence’ for inappropriate behaviour.

The Regulations implicitly recognise the potential psychological and emotional harm to a child that may be caused by separation in a locked room. This is indicated by the time limits imposed and the requirement for centre managers to record its use. Current practices illustrate its potential harm and that regulatory requirements have been confused or overlooked.

DFYCC procedure 3.6 ‘Separation and isolation’ refers to ‘isolation’ as placing a detainee in a locked room, and ‘separation’ as the removal of a resident from peers to an unlocked room, another area or a section for the benefit of the resident or group. This may involve young people sitting away from other detainees or possibly eating meals alone in their room.

The Regulations stipulate that all use of isolation (as opposed to separation) is to be recorded, along with details of staff observations made of the detainee during the period of isolation. However, procedure 3.6 does not require records be kept of all occasions when a child is placed in a locked room.

Detainees can be isolated in their own rooms, or in one of each centre’s completely bare ‘isolation rooms’, all of which are under camera surveillance. One such room at John Oxley has a solid metal door, with no intercom or radio. A third placement option is provided in some sections by the close-observation rooms used to accommodate ‘high-risk’ detainees. Closed-circuit cameras monitor all isolation rooms, which could mean that detainees are placed there, rather than in their rooms, more often than is necessary. Centre ‘isolation’ registers record only those occasions when a detainee is locked in an isolation room, not where detainees have been placed in their own room or in one of the close-observation rooms. For the period 1–14 November 1998, John Oxley reported three occasions on which isolation was used, Sir Leslie Wilson 21, and Cleveland 33. However, an examination of the records revealed that they can be inaccurate.<sup>20</sup>

The forthcoming new Practice Framework Manual clarifies the distinction between forms of isolation and requires improvement in the recording of its use. In addition, construction of new facilities will create outdoor spaces where a young person can safely go for ‘time out’ in preference to being confined in a room.<sup>21</sup>

### *Standard behaviour management plans (BMPs)*

Under these plans, detainees are locked in their rooms for periods of 60–90 minutes and released for 20–30 minutes before being locked up again. This pattern is repeated throughout the day. Detainees are often given cleaning chores to do when not in their rooms and are separated from other detainees. These plans are commonly imposed for 3–5 days, although this may be extended substantially if the disruptive behaviour continues (one detainee at John Oxley remained on BMP for a month.) No record is kept in any central register of such separation.

Standard BMPs can be initiated by youth workers or section supervisors and approved by unit or senior unit coordinators. Prior consultation with, or approval from, specialist staff is not required. Caseworkers usually receive copies of plans after they are implemented, seemingly to inform them of the detainee’s behaviour rather than to seek their input. One staff member who questioned the usefulness of BMPs said:

*... seven boys were put on BMPs—basically they were locked down. All of them were locked in different rooms in remand. They came out angry and got extensions. They refused to do their chores. They got put back in the rooms and they got angry.*

BMPs rely on control and compliance, an approach criticised by the QCSC.<sup>22</sup> The need for such punitive measures may well be reduced if incentive schemes were better designed and programmed activities more readily available.

Although technically complying with the time limits for separation imposed by the Regulations, it is doubtful that BMPs match its intent. The psychological impact of being repeatedly subjected to isolation would be heightened for many indigenous young people, for whom detention itself is stressful and alienating. This method of behaviour management is perhaps symptomatic of a system in which security and control have been emphasised at the expense of the developmental needs of young people.

Currently, DFYCC cannot guarantee that young people are appropriately confined, and that isolation is used only in accordance with the Regulations.

#### *Individual behaviour management plans*

Caseworkers or psychologists may be asked to design BMPs for individuals in need of specialist care, or for whom other management options have failed. These may include detainees with a psychiatric illness or limited social skills that expose them, or others, to increased risk of injury or abuse. These BMPs are developed with clearly defined outcomes and intervention strategies. They are usually discussed with section staff and the detainee, and are regularly reviewed. Although anecdotal evidence suggests that BMPs can be highly effective in equipping staff and detainees with additional coping and management strategies, their effectiveness can be undermined by section staff, since reliance is placed on their skills and on their willingness to implement the BMP in a consistent manner. One caseworker commented:

*Some staff simply do not understand if a caseworker implements a strategy to manage behaviour. The youth worker simply sees it as more work for them ... They have no training in positive interaction skills.*

#### *Group punishments*

Rule 67 of the UN Rules condemns the use of group sanctions. It appears to be a regular occurrence in all centres that an entire unit is punished for the actions of one or two individuals, for example by being required to have an ‘early bed’ or be placed on a ‘rotational lock-down’ for one or more days. Such practices can cause detainees to police one another’s conduct, possibly encouraging inappropriate methods of ‘persuasion’ for detainees considered ‘disruptive’.

## **9.4 ADMISSION, SEARCHES AND HANDCUFFS**

### **Admission process**

All detainees on admission are subjected to an unclothed search and made to shower and change into centre-issued clothing. General rules and routines are explained, and personal information taken of previous background and family contacts. The centre nurse usually sees new admissions within an hour of their arrival.

Disruption may be caused by other personnel entering or leaving the area during the course of admission interviews—a particular problem at Cleveland—which limits the privacy and quiet needed for staff to elicit often very personal and sensitive information from detainees.

Although staff in each of the residential sections are meant to explain the rules and routines to the young person within the first few hours of their arrival in their designated section, it was not possible to establish if this actually occurred.

#### *Initial placement*

All three centres usually place new admissions in the least ‘privileged’ section to allow close observation. Once settled into the centre and the section’s routines, a detainee may be transferred to other units. ‘Admission’ units are commonly the most restrictive and are therefore also used to accommodate the most recalcitrant or ‘difficult’ detainees. Thus, young people who may be distressed and confused on admission are placed alongside the most disruptive of the centre’s population. New admissions (including those on overnight remand) are at risk of witnessing, if not experiencing, abuse by other detainees, and also of



witnessing confrontations between detainees and staff. This is particularly problematic at Sir Leslie Wilson's boys' remand section, where detainees share rooms with up to four others, and at John Oxley, where detainees have little space to distance themselves from such incidents. This is also contrary to international standards, which require untried detainees to be separated from convicted juveniles.

Rule 17 of the UN Rules also requires that young people be held on remand only in exceptional circumstances, and that the highest priority be given to expeditious processing of cases to ensure the shortest possible duration of detention. The DFYCC advises of a significant increase in the average length of time young people are held on remand, as well as an increase in the number of detainees on remand. The remand section at Sir Leslie Wilson was described in graphic terms by several detainees.

*When you're in the remand section you don't get nothing at all. You only get to watch TV. That's it. I'm on the blue average now, getting up to a green average, and I asked them about the Flinders section—that's the good section, all the computers and all the programs and that. But there's some boys in there that I got bashed up from, so I said I didn't want to go into that section. I've got to stay back in remand section then. My behaviour's fine but I don't get nothing extra. Be all right if they had cards and stuff. Don't even get cards or nothing. We just sit in the TV lounge all day—boring. And they wonder why everyone starts messing around. Bored out of our heads, that's it.*

### **Detainee searches**

Searches of any kind are intrusive and embarrassing, and reinforce the relative powerlessness of the subject. Strip-searches are especially so, particularly for self-conscious adolescents, who may have suffered physical and sexual abuse. Although searches can contribute to the safety of detainees, their frequency indicates that the dignity, privacy and psychological wellbeing of young people are being passed over in favour of scrupulous security procedures.

Sections 17 and 18 of the 1993 Regulations authorise clothed and unclothed searches of detainees by staff. These are a standard feature of the admission process in juvenile detention centres, and reduce opportunities for drugs, cigarettes, sharp implements and other contraband to be brought in. During unclothed searches detainees can be asked to remove all clothing, squat, and do a series of star jumps.<sup>23</sup> The Regulations authorise a medical practitioner to search the person of a detainee:

*... if the commission considers, on reasonable grounds, that the child is in possession of a thing that may: threaten the security or good order of the centre; or endanger, or be used to endanger, the child or another person.*<sup>24</sup>

Such searches are usually referred to as body or cavity searches, and involve inspecting body cavities visually, manually or instrumentally.<sup>25</sup> While no body searches have yet been conducted, it appears that unclothed searches are commonplace.

The Regulations allow reasonable force, if necessary, to carry out any of these searches. Although all centres keep a register of unclothed and body searches, they do not indicate if force was used. It is unacceptable that physical force is used to remove a young person's clothing, and a forced body search, even when conducted by a medical practitioner, is abhorrent. The detainee's sense of personal safety, dignity and trust would be significantly undermined, seriously limiting, if not destroying, the opportunity for a constructive relationship between the staff member and the young person. Such incidents may well also affect the staff involved, possibly desensitising them to the needs of young people in detention.



**Photograph 9.9: Cleveland admissions area lacks privacy as interviews are conducted in the main staff entrance. Unclothed searches are conducted in the room on the left—Inquiry photograph**

A less confrontational response would involve placing the young person under constant supervision until the suspected item is surrendered or the person submits to the search. Although this may require additional staffing, it would better balance security needs with concern and respect for the dignity and wellbeing of detainees, and would clearly reduce the potential for abuse of young people in detention. This approach was adopted by the NSW Department of Juvenile Justice in its recently revised policy on personal searches of detainees.<sup>26</sup> Apart from initial admission to a centre, there must be a ‘reasonable belief’ that the detainee has concealed contraband before an unclothed search is carried out. Wands and metal detectors are also used, reducing the need for unclothed searches.

The current Queensland Regulations appear inconsistent with the government’s moral obligation to ensure the privacy, dignity and wellbeing of young people in its care. Current policy states that clothed searches should be conducted when there is a suspicion of contraband, before a resident leaves a work, program or education area, when a detainee returns from a legal or professional visit, and on return from leave. Unclothed searches are required to be performed on admission to the centre, on return from a period of absence, following visits with family and friends, after involvement in an attempted suicide or self-harm incident when they will no longer be under constant supervision, and after involvement in a major disturbance. They may be performed when a clothed search has failed to reveal contraband and there is continuing suspicion, when tools or items are found to be missing in a work, program or education area, on request from police prior to escort from the centre, and on return from a legal or professional visit where there are reasonable grounds to believe the detainee may be in possession of unauthorised articles. All centres have incorporated unclothed searches into their daily routine, as described by a detainee:

*I just hate it when they strip-search us if we go to the dentist or something. And like, we’re handcuffed to them and they’re handcuffed to us, and we’re lying there and then we come back and there will be a strip-search. We have been strip-searched before we leave. What’s the issue of getting strip-searched? Even when you’re there, at the dentist, you’re handcuffed. I don’t mind getting strip-searched but it’s stupid getting strip-searched for stupid things.*

It appears unclothed searches are frequently performed on detainees at the State’s juvenile detention centres. The following table details the incidence of such searches in the period 1–14 November 1998.

Table 9.1: Unclothed search register records for all centres, 1–14 November 1998

Section	Number	Reasons stated	Items found
<i>Sir Leslie Wilson YDC Register</i>			
Remand	9	6 return from school 1 visit dentist 1 bedtime, High Suicide Risk	Nil
Flinders	36	14 return from dining room 2 High Suicide Risk 2 lock-down 1 section search 16 return to section from program 1 entering room (High Suicide Risk)	Nil
Fairleigh	22	2 separation 15 random 1 after visit 4 after lunch/dinner	Nil
Girls	19 <sup>#</sup>	3 visits 1 shift change 1 bedtime 3 court 8 new admission <sup>##</sup> 1 escort return 2 High Suicide Risk	Nil
Operations	78	34 court 11 readmission 2 transfer to JOYDC 31 admission	Nil
<i>Total</i>	<b>164</b>		
John Oxley YDC Central Register	92	48 post visit 20 pre/post court 8 hospital or dental 1 release from JOYDC 2 leave of absence 4 work party/off centre 5 escort 1 pre-release 2 new admission	1 occasion— cassette
Cleveland YDC Register	21	Not recorded	Nil

# A spot review of the section logbook revealed at least one search that was not recorded in the search register. It was acknowledged that the search register may not be entirely accurate.

## New admissions for young women are recorded in their unit search register, whereas searches of young men on admission or readmission to the centre are recorded in a separate operations register.

Several matters of concern arise from a review of these records:

1. One detainee, rated a High Suicide Risk, was subjected to unclothed searches 21 times in the two-week period under review, including two days when the detainee was subjected to an unclothed search four times in the day. This raises the question as to whether such treatment would increase rather than reduce the risk of suicide.
2. One very young detainee, identified by staff as having significant psychiatric problems and a history of sexual abuse, was searched four times (two random) in the two-week period.
3. Only one cassette tape was found in this period, despite the large number of searches conducted. This object is likely to have been located with a 'pat' search.

The frequency of such searches is too high, and is out of proportion to the amount of 'contraband' found.

The DFYCC advised that the new Practice Framework Manual recommends undertaking searches in as discreet a manner as possible. The Department also pointed out that searches before and after court hearings are a security precaution required by the police to prevent objects being taken into court that may assist escape attempts, a self-harming act, or the assault of someone in, or en route to, the court. The Department considers searches essential for the prevention of drugs entering the centres.<sup>27</sup>

#### **Recommendation**

That the Department review the practice of unclothed searches with a view to reducing their use, and that detailed documenting (date, time, reason and process used) of every such search be made.

#### **Handcuffs**

Detainees are routinely handcuffed when leaving the centres to attend court, medical appointments, or even to attend funerals. There are reports of detainees being handcuffed to the dental chair or the hospital bed during procedures. Such practice indicates to the community that young people are 'criminal' or 'dangerous'. The consequent effect on young people's self-image and sense of dignity would do little to help them to feel worthwhile contributors to the community outside the centres.

Centre managers said that the decision regarding handcuffs was made each time they approved an escorted absence, and was influenced largely by the detainee's classification and the purpose of the outing. Young people on remand would almost always be handcuffed; others may be handcuffed to and from the venue. In some cases, staff were authorised to take handcuffs to use at their discretion. It appears, however, that the general rule is 'to cuff'. As one manager said, such decisions were heavily influenced by 'the terror that resides in the hearts of managers of Centres where kids have absconded post-Westbrook'. Centres can also use 'soft restraints' (usually cloth strips with velcro fasteners) to control a detainee on the premises—for example while being moved to an isolation room.

It was reported that detainees working in an unsecured yard at Sir Leslie Wilson have been cuffed to wheeled bins by legcuffs linked with handcuffs. Centres also have body belts through which cuffs can be linked. These are intended only for occasions when individuals are very violent or in danger of self-harm.

The DFYCC stated that handcuffs are not used for internal movements or for the behaviour management of detainees, the only exception being a young person acting in a manner representing an obvious and serious threat to security and order in the centre. In a State-wide comparison, Victoria is the only State that does not allow the use of handcuffs under any circumstances.<sup>28</sup>

## 9.5 CONTACT WITH FAMILY, FRIENDS AND COMMUNITY

The importance of contact with family and community is explicitly recognised in both the objectives and guiding principles of the *JAA 1992* (sections 3(e), 4(f) & (h)). Rule 59 of the UN Rules also requires that every means should be provided to ensure adequate communication between juveniles and the outside world. Contact helps to reduce the isolating and institutionalising effects of detention. It is essential for the psychological and emotional wellbeing of detainees, and necessary for the young person's reintegration upon release.

### Personal visits

#### *Statutory obligations and procedures*

The DFYCC has reasonably wide powers to permit or refuse a visitor's entry to a detention centre.<sup>29</sup> For example, all visitors must be entered on an 'approved visitor list' before they can visit detainees. In addition, visitors may be 'pat-searched' and their possessions inspected, and visits can be conducted in the presence of, or under the supervision of, a staff member.

The DFYCC has, in addition, a requirement that any person under 18 years must be accompanied by an approved adult. (procedure 3.7 'Visits to residents' notes that this requirement can be waived by the centre manager.)

Improvements in visiting arrangements are needed in all centres. Factors such as distance, transport, time, competing personal and work responsibilities and personal commitment make it difficult for families to visit. In order to reintegrate young people into the community upon release, such contact needs to be actively encouraged, and efforts made to ensure that visits are relaxed and positive for detainees and visitors alike.

#### *Visitor security*

All detainees are subjected to unclothed searches at the conclusion of visits. Visitors at John Oxley and Cleveland are not permitted to leave the premises until all detainees have been searched. This practice was criticised by the QCSC in 1988:

*The keeping of visitors confined raises the possibility of complaints or legal action for deprivation of liberty and the appropriateness of such action should be reviewed.*<sup>30</sup>

The potential to pass contraband is already restricted by the limits on items visitors may bring into the centre, the presence of staff during all visits, and the compulsory unclothed searches of detainees following all personal visits.

#### *Restrictions on visits*

Although detainees are entitled to receive visits from parents and siblings, BMPs can restrict their access to visits. In addition, the question of who is considered 'family' can be a cause of distress to detainees. The draft Service Standards refer to family and 'significant others'. In many cases, extended family members may be closer to the young person than immediate family. It is also acknowledged that not all detainees have families, nor necessarily enjoy positive relationships with them. Indeed, a number of detainees may have left the family home as a result of abuse or violence. Such detainees, however, may have other meaningful relationships that provide significant emotional and psychological support.

One community organisation reported the experiences of a parent of a 12-year-old detainee who was highly distressed following his admission to the centre. Although an initial visit by the parent was approved, staff had to be persuaded to permit an additional visit. Although clearly the appropriateness of visitors must be assured, it is of concern that such processes may be indiscriminately adhered to, despite the known identity of the visitor and the relationship to the child.



*Photograph 9.10: Sir Leslie Wilson Youth Detention Centre main visiting area—Inquiry photograph*



*Photograph 9.11: Cleveland Youth Detention Centre main entrance for visitors presents a positive picture with detainees' stories and art—Inquiry photograph*



*Photograph 9.12: John Oxley Youth Detention Centre visiting area is spacious and provides a food/drinks machine, but still feels like a cage—Inquiry photograph*

A further incident was reported where a detainee's stepfather was refused permission to enter one of the centres, and was told that all contact with the young person was to be limited to phone calls. The detainee's mother was to be allowed only 'special' non-contact visits supervised by staff, to be individually arranged through the caseworker. This, apparently, was because both adults had criminal records, which raises questions about the extent to which a person's criminal history should be used to limit contact with a young person. A number of detainees will have family members with criminal histories. Procedures that deny a young person contact and support from their family need to be examined.

In addition, some detainees are, or have been, in de facto relationships and are themselves parents. Contact with partners and 'significant others' needs to be given the same status in departmental procedures as that given to parents and siblings.

### *Information and assistance*

Rules concerning visiting times and the need for prior approval are explained to parents in an initial letter from the centre soon after the young person's arrival. There is a marked contrast in tone and content of the letters between the three centres. Sir Leslie Wilson and John Oxley require visits to be booked 24 or 48 hours in advance. Sir Leslie Wilson will not admit visitors who arrive more than five minutes late. Both enclose a list of rules to be observed during visits. In contrast, Cleveland advises parents that contact by other family members and friends needs to be arranged through caseworkers. Parents must book only 24 hours in advance to arrange a special visit. They are advised to bring identification with them, and to arrive at least 15 minutes before the end of the visiting time. Clearly, both the flexibility of the times and the approach taken by Cleveland are much more encouraging to visitors than either of the other centres. No centres provide maps or details about public transport, although this information may be provided when visits are booked.

Cleveland appears alone in arranging regular transport for visitors who may not have their own transport or who may otherwise be reluctant to visit. A similar arrangement would clearly help visitors to detainees in John Oxley, which is some distance from the nearest train station.

### **Financial assistance**

As the three centres accommodate detainees from across the State, travel costs—including petrol, bus or train fares, accommodation and meals—can easily be prohibitive for many potential visitors. Financial subsidy is available, but families and detainees are not routinely informed of its availability. Caseworkers may offer this assistance if they are aware that money is a barrier for any potential visitor or family. However, this depends upon their knowledge of the family's circumstances and their assessment of whether assistance is appropriate.

The issue of distance is even more marked for young women, all of whom are accommodated at Sir Leslie Wilson. There were several reports of the problems of young women from far north Queensland whose families may have limited access to phones, and for whom travelling to Brisbane would be vastly expensive, disorienting and stressful. There was strong support for the reopening of the young women's section at Cleveland:

*It's pretty hard because you can't get visitors because it's so far away from [distant location] and it's just not fair that [they] have to come all the way to Brisbane. Like, I know we got into trouble and that, but there should be one closer. It's the only one for girls. There should be at least another one.*

It was suggested that special arrangements need to be made in the interim to facilitate such visits, such as short-term transfers of young women to Cleveland for family visits, with travel assistance for those families who required it.

### *Visiting times*

Young people clearly need more time to be with their families:

*I reckon they should have family days and stuff. Like, it's only an hour visit and my parents live at Caboolture and it takes a while to get here and it's only an hour. They are here for an hour and then gone and that's it. They should have longer, like, maybe two or three hours.*

To support family contact for detainees, visiting times should be varied to accommodate the needs of working parents, shiftworkers, and those with small children. Some visitors are reluctant to travel long distances if their permitted visiting time is brief, or if there is a chance they may be turned away because of late arrival.

Cleveland is the most accommodating of the centres, allowing visits of two hours on Saturdays, Sundays and public holidays, in addition to hour-long midweek visits. Sir Leslie Wilson and John Oxley limit visits to one hour. John Oxley further restricts visits by designating only two visiting times for each section each week. The need to have separate visiting times for each section at John Oxley is questioned, particularly as it has the largest of the three visiting areas. This may also confuse visitors of detainees moved from one section to another. At present, only two sections are allowed evening visits.

### *Visiting facilities*

Visiting facilities generally are scant and do little to create a convivial or relaxed atmosphere. Access to the visiting areas at Sir Leslie Wilson and John Oxley is via a series of electronically controlled security gates, that would be intimidating for visitors and upsetting for young children. Further, none have facilities for small children, making visits difficult for younger siblings and detainees' own children. Sir Leslie Wilson does not provide a food or drinks machine, despite restrictions being placed on what visitors may bring to the visit. With staff present at all times, there is very little privacy and it is easy for conversations to be overheard. It is not surprising, therefore, that some detainees prefer not to see their family while in detention as it can be too upsetting for all concerned.

### *Telephone contact*

Section 22(1) of the 1993 Regulations allows a young person to make and receive telephone calls in accordance with departmental guidelines. Most centres permit regular outgoing calls from detainees to family and approved others. Cleveland appears to be the only centre to regularly permit incoming and outgoing calls in accordance with the *JJA 1992*.

The Inquiry was advised that detainees in all centres were entitled to two outgoing phone calls per week, with the possibility of earning additional calls (up to six or seven per week) for appropriate behaviour. A letter sent to families from John Oxley, however, advises an entitlement to only one outgoing call. Information provided by John Oxley and Cleveland indicates that a number of detainees received no calls in any given week. Sir Leslie Wilson provided no details of the number of calls received by detainees. Some calls, however, were from caseworkers, and it may be difficult to determine whether or not detainees received their full entitlement.

Because the phone for detainees' use is usually located in, or near, main the recreation areas, and in plain view of staff and other detainees, they have little privacy when speaking with family and friends. This can limit their ability to concentrate on their phone call, and indeed to hear what is being said. Staff also believe that it is important to observe detainees during phone calls in case they receive distressing information; a clear-sided booth would seem an appropriate solution.

Phone calls are usually limited to five minutes, and calls often have to end before both parties have had the opportunity to relax and talk easily with each other. This can often create tension and frustration:

*I speak to my mum and I have a real big family and I won't even be able to say goodbye to all my brothers or my sisters because I have to go. When you don't go, they [staff] take another phone call off you. So you have to hang up right there and then if you want some more phone calls for tomorrow or the next day. And when I say 'Hang on, I'm just*



*saying goodbye' they get all crappy at me. I get crappy at them and then the next minute I'm in trouble because all I really wanted to do is say goodbye. I only get to see my family once a week and that's for an hour and that is still pretty hard and then they say you have a five-minute phone call to go with it. That just makes me real angry. I know it's hard for my mum to have a five-minute phone call because sometimes she starts crying on the phone and I have to go. She's real sick and doesn't come up that much. I try to ring her heaps and when I say I have to go she might get upset or something. That makes me upset because I can't stay on the phone longer to settle her down.*

This accords with comments made by the QCSC:

*... the time limit of five minutes seems to be arbitrary as does the number of calls permitted for each level. If the purpose of permitting calls is to maintain family contact, consideration could be given to increasing both the duration of calls for the top two levels, and the number of calls for the lower levels.<sup>31</sup>*

The DFYCC stated that a range of alternative telephone systems are being investigated as part of the capital works program.<sup>32</sup>

#### *Other contact*

Discussions with staff revealed that efforts have been made to link detainees from remote areas with their families and communities by using videoconferencing facilities. While still less satisfactory than personal contact, such technology offers further options for maintaining these links.

#### **Recommendations**

That the Department ensure:

- contact with family and friends is treated as a basic entitlement of all detainees, essential to their psychological wellbeing and successful reintegration, and that it should not be apportioned according to behaviour
- contact with family and friends is actively encouraged, and that efforts are made to ensure that visits are relaxed and positive for detainees and visitors alike
- contact by detainees with partners and 'significant others' is given the same status as that given to parents and siblings
- procedures that deny a young person contact and support from their family are examined and eliminated unless a substantial case can be made for their retention
- visiting times are varied to accommodate the needs of working parents, shiftworkers and those with small children.

#### *Correspondence*

Families and detainees are informed that all correspondence will be opened and read by detention centre staff—usually caseworkers. This clearly raises questions concerning privacy. Centre staff believe it is necessary for security reasons, and that it prevents inappropriate and threatening letters being forwarded to, or from, detainees. It also permits caseworkers to be aware of and respond to detainees' personal problems as they arise. It is not known how widely such information is circulated to other staff.

Staff pointed out that some detainees have low literacy levels, and current practice permits caseworkers to assist detainees in reading their letters. One staff member acknowledged that he opened and read detainees' legal correspondence as well, enabling him to explain it to the detainee. This is in breach of section 214 of the *JJA 1992*, which states that 'all correspondence between a legal practitioner and a detainee is not to be opened, copied, removed or read by staff'.

Privileged letters can be handed unopened to a detainee, who can be offered assistance in reading and understanding the document. Alternatively, detainees can call the solicitor or request that someone else read the document for them. Staff need clearer guidance in this area to ensure they respect detainees' privacy and comply with legislative requirements.

### **Community organisations**

The greater the number of contacts with the community, the more detainees will be reminded of life outside the centres. In addition, the potential for external scrutiny of activities within the centres is increased. Most external organisations that attend the centres provide specific programs such as counselling and health services. Social interaction is more often provided by the smaller number of community groups who provide detainees with some support, but in the absence of a structured program. Most of these visits are limited to one-on-one or small groups, still within the normal routine and confines of the centres.

### *Outings and leave*

The lack of opportunity for detainees to have direct contact with the community makes their successful integration into the community problematic. Community contact could be in the form of outings to local recreational centres and activities, or leave to attend community-based educational or vocational programs. Similarly, detainees need assistance to plan for their release—for example with opportunities for interviews and visits to local housing, social security, educational and employment services in the community.

The DFYCC stated that access to work or educational activities outside the centres is offered to young people who have been assessed as demonstrating an acceptable risk to the community, and who are also in the final portion of their sentence.<sup>33</sup> Some staff expressed frustration that these opportunities have been almost completely curtailed in recent years, even though they had once been a routine part of life in the centres. It is understood that all centres are slowly reintroducing such programs.

The Securing the Care project will see the introduction of better planned pre-release strategies for young people, and will allow more thorough assessment of those suitable for pre-release programs.<sup>34</sup>

### **Recommendation**

That the Department explore mechanisms for increasing community involvement in juvenile detention centres.

## **9.6 ACCESS TO SERVICES**

The DFYCC is bound by legislation to provide programs and services for the health of detainees, their social, cultural and educational development, and their reintegration into the community when released from detention.<sup>35</sup>

The QCSC acknowledges the need for programs and services to cover the spectrum of young offenders' needs, including addressing offending behaviours, health care, nutrition, vocational and pre-vocational training, family integration, grief and loss, cultural and religious issues and life skills:

*The aim should be to break down the conceptual barrier between 'treatment' and normal activities and to provide a fully integrated training experience.*<sup>36</sup>

Current programs and services are inadequate in meeting the needs of young people in detention, both in their availability and in the types of services offered. Current security restrictions further inhibit detainees' access to available programs and services.

## Medical services

### *General health*

Each centre now has a nurse on 24-hour duty. Detainees can ask to see the nurse as necessary, although some felt that the nurse was not able to adequately deal with their problem:

*I've come in on drugs. I was very sick and the nurse seen me and she just gave me help with Panadols and that's all. And I couldn't sleep. Like, I didn't sleep for a few months and it was just frustrating. I was very scared then. It took me a week to get through, like, really sickness, but then it took me about a couple of months to get through the mental situation.*

A general practitioner usually attends each centre twice a week and can be called upon at other times. However, access to medical specialists caused problems because waiting times can be lengthy. Special arrangements are needed for young people to be escorted to specialists' offices, and it was reported that some specialists were reluctant to have detainees in handcuffs in their waiting rooms.

### *Dental services*

Sir Leslie Wilson has a dental clinic on the premises which operates for three hours each week. However, access to dental services is more difficult for detainees at John Oxley and Cleveland. John Oxley is restricted to two appointments a week at a local community health service. It was reported that, on average, two appointments per month are cancelled due to difficulties in arranging staff escorts. Because detainees with significant dental problems may require three or more appointments, few have access to this service. Negotiations have taken place with Education Queensland for centres to be included in the mobile dental scheme which currently visits all schools twice a year, although this may be insufficient for the needs of detainees.

### *Psychological and psychiatric services*

The common life experiences of many young people in detention, such as poverty, family dysfunction, alcohol or other drug problems and low self-esteem, are high-risk factors in the development of mental health problems. It has been estimated that the prevalence of psychiatric disorders among juvenile detainees is equivalent to that found among adolescents attending mental health clinics.<sup>37</sup> All centres reported inadequate access to mental health services, reflecting partly, perhaps, the wider shortage of community mental health services and, in particular, adolescent mental health services. John Oxley is the only centre to have a regular visiting psychiatrist, who attends fortnightly. Attempts to arrange regular visits or consultations by psychiatrists in other centres have been unsuccessful. A trial program arranged at Sir Leslie Wilson was discontinued.

Staff in all centres expressed real concern and frustration over this aspect of medical services for young people in detention. It was reported that some detainees were admitted on very high doses of medication prescribed by general practitioners, often for behavioural reasons. Psychiatric services are, therefore, vitally important not only to assess those thought to have mental health problems but also to review detainees already on such medication.

All centres reported difficulty in admitting into psychiatric facilities detainees considered to have mental health problems. Some staff recalled occasions where detainees suffering an episode of mental illness were obliged to wait some hours at local hospitals, only to be finally refused admission. Specialist mental health facilities with 24-hour specialist nursing care and close observation of behaviours in a controlled environment would allow much better assessment and treatment for detainees. Centres are currently unable to provide such care, yet they are routinely required to manage detainees exhibiting acute symptoms of mental illness.

Referral of detainees to existing services has important limitations. Because there are few, if any, specialised forensic services for children and young people, the only referrals are those presenting with dramatic symptoms (for example suicide threats). Those with less 'disruptive'

problems are often overlooked, and available psychiatric services are often inexperienced in meeting the needs of detainees. The opportunity will therefore be lost for growth through reciprocal interaction between correctional and mental health staff. At the very least, detention facilities need access to in-house specialised mental health staff with whom a child and adolescent psychiatrist and allied mental health personnel could consult part-time.<sup>38</sup>

The DFYCC has argued for caution in the creation of institutional responses to the provision of psychiatric services, and the possible negative labelling effects; it is thought to be preferable to provide services from external sources to allow for continuity of service when a young person leaves detention. The Department is currently working with Queensland Health to explore possible improvements in services provided to young people who are clients of the new Youth Justice Services, together with possible links to juvenile detention services.<sup>39</sup>

#### **Recommendation**

That the Department work closely with Queensland Health to establish adequate, high quality mental health services for juvenile detainees, staffed by in-house specialised mental health personnel with whom a child and adolescent psychiatrist and allied mental health staff can consult part-time.

#### *Detainees considered at risk of self-harm*

All centre staff are acutely aware of the potential for detainees to attempt to harm themselves. Indeed, suicide awareness training and first aid is mandatory for the majority of staff. The new Practice Framework Manual guidelines on suicide risk management have been published by the University of Wollongong (NSW) as best practice guidelines for both adult and youth custodial institutions. The DFYCC has practices laid down for the identification of young people who may be at risk of self-harm, although the actual management of those identified as being at 'high' risk requires improvement.

When a young person is admitted to a detention centre, information about that person is provided from the DFYCC computer database. This includes details of any previously known suicide attempts, depression or other 'at risk' indicators. This information, together with the detainee's initial assessment on admission, determines the allocation of an interim 'at risk' status of high, medium, low or base. This interim assessment is reviewed at the next scheduled meeting by each centre's Suicide Risk Assessment Team (SRAT). A suicide risk management plan is then developed for each detainee at an appropriate level. This may include referral for counselling, medical, psychological or psychiatric evaluation and treatment, the frequency and manner of staff observations, and accommodation and arrangements for family contact and support.<sup>40</sup>

In the past, detainees on high suicide alert were made to wear a 'suicide-proof' gown at all times, and were not allowed to mix freely with other residents or to participate in normal routines. Fortunately, detainees are now able to take part in most daily routines and to mix with others. Current restrictions relate mainly to the evenings when they are placed in observation rooms utilising camera surveillance. These rooms are generally bare, white rooms lacking any form of stimulation or comfort apart from a bed base. The young person has to sleep in a 'suicide-proof' gown or shorts, with a 'suicide-proof' mattress and blanket. All other possessions are removed from the room. The young person must also submit to an unclothed search each night.



**Photograph 9.13: John Oxley Youth Detention Centre proposed intensive supervision unit (no detainee has yet been placed there)—Inquiry photograph**

Such practice focuses on removing the opportunity for self-harm at the expense of the emotional and psychological wellbeing of the most emotionally vulnerable young people in the centres. Placing a detainee in a bare room with no comfort or personal possessions, in synthetic, hospital-type clothing and bedding, and subjecting them to daily strip-searches, can only contribute to the individual's sense of powerlessness, isolation and hopelessness.<sup>41</sup> Psychiatrists in New South Wales have expressed concern about the use of camera surveillance of detainees considered to be suffering from depression, as well as the use of bare rooms. Some consider such measures to be abusive.<sup>42</sup> It is questionable whether all of these measures need to be applied as standard procedures in all situations.

A young woman who attempted suicide twice while detained in Sir Leslie Wilson spoke of the need for counsellors:

*They got one psychologist here and that is not enough for a whole building like this. It's not enough. You can't expect everything in here, but there are some things that if we had them it would stop a lot of people coming back.*

Some staff criticised the centre practice whereby a detainee's interim suicide rating is determined largely from DFYCC computer records, as it can result in newly admitted detainees being placed on high alerts on the basis of information that may be considerably out of date. Thus, detainees can be unnecessarily subjected to the intrusive procedures described until assessment by a SRAT can be carried out.

Part of the procedure includes the use of the 'buddy' system, where an 'at risk' detainee is placed in a room with another detainee who, it is hoped, can provide extra support and company. However, this practice was understandably criticised by some psychiatrists as placing too great a responsibility on the 'buddy'.<sup>43</sup> It is not clear how regularly the 'buddy' system is used, nor if it is used for detainees on high alert.

Detainees on suicide alert are also counselled on a regular basis by the psychologist or other counsellors. However, it was not possible to gauge the adequacy of these arrangements in this review.

One final matter of concern is the design of the facilities in the centres. A significant number of detainees in all centres are, at some point, placed at some level of suicide risk alert, with the majority on base or low-level alerts. Despite this, there are ample opportunities in all centres for self-harm due to the design of shared bathrooms and many detainee rooms.

## 9.7 PROGRAMS AND SERVICES

The review examined the range of programs offered in the centres and their access to detainees. However, the programs were not reviewed with regard to the quality of their content or design. Each centre has a programs support officer to plan and coordinate all vocational, recreational and personal development programs. Therapeutic programs, such as anger management, are generally arranged by the psychologist and casework staff. The program support officer works closely with the centre schools (see 'Educational programs' later in this chapter) because some programs are arranged through, or funded by, Education Queensland and various educational grants programs. In some cases there is overlap between courses provided within the school and those offered as a programmed activity by the centre (as in the case of music and art).

### Structured programs

There are a number of structured programs provided for detainees at the centres. Table 9.2 sets out the average number of programs per detainee per day for the period 1–14 November 1998 (including education and excluding indoor and outdoor recreation).<sup>44</sup>

*Table 9.2: Number of programs per detainee per day*

Centre	Number of programs						Total	Other*
	0	1	2	3	4	> 4		
John Oxley	–	25	24	1	–	–	50	–
Cleveland	–	–	7	28	6	1	42	4
Sir Leslie Wilson	3	20	23	3	–	1	50	18
<b>Total detainees</b>	<b>3</b>	<b>45</b>	<b>54</b>	<b>32</b>	<b>6</b>	<b>2</b>	<b>142</b>	<b>22</b>

\*Other = Detainees admitted in this period for less than five days where inclusion in programs may take a few days to arrange

Out of a total of 142 detainees in this period, 102 had two or fewer programs per day (excluding indoor and outdoor recreation) comprising three or less hours of structured daily activity. Cleveland recorded the highest average number of programs per detainee, a figure assisted by its compulsory daily half-hour reading support program.

Information provided by Sir Leslie Wilson shows numerous program sessions where only one detainee attended. These sessions included leatherwork, sewing and education programs.<sup>45</sup>

With regard to drug and alcohol programs, only seven detainees at John Oxley received drug and alcohol intervention. No drug and alcohol group program appears to have been held in Sir Leslie Wilson and Cleveland in that time, although individual counselling may have included drug-related issues. Sir Leslie Wilson and Cleveland have arrangements with local organisations to provide drug and alcohol counselling for two to three hours per week.

### Remand programs

Remand detainees are commonly restricted in their access to programs and services, which means that they have very little to occupy their days. This is an important point, especially having regard to the lengthier remand periods that are currently in place. Access to structured programs and services should not rely on legal status. While certain programs may not be appropriate for those who have not been convicted of an offence, or for those detained for less than two or three months, it is nonetheless important that these young people are occupied, and have access to educational and therapeutic intervention or counselling.

### *Programs as privileges*

Concerns have been expressed earlier in this chapter about the practice of restricting access to programs (other than education or vocational ones) to those who had gained a privileged level. At the time of this review, no detainee in the boys' remand section at Wilson had attained the 'green' level required to access programs such as leatherwork and music. This limited their access to vocational programs and meant that many had no structured activities to fill their days. This was borne out by the lack of programs for this section listed in the centre's daily schedule for the period under review. The related practice of allowing those on privileged levels to have the first choice of programs also reduced the potential for detainees on remand to increase their skills in, for example, leatherwork or art by continued attendance in any one program.

### *Timetables*

The number of programs that can be accessed by detainees is largely limited by each centre's daily routine. Most programs at Sir Leslie Wilson and John Oxley cease before 3.00 pm. Although some individual counselling and therapeutic or personal development programs may occur later in the afternoon, or between 6.00 pm and 8.00 pm, most detainees have little to occupy the remainder of their day apart from 'section activities' or 'yard'. Cleveland's schedule extends over a longer period each day and allows greater flexibility in program duration and the number of activities detainees may access each day. Weekend schedules in all centres show minimal, or no, structured programs apart from 'section duties', 'yard' and 'recreation room'.

### *Separation by section*

Because of the way programs are generally scheduled, there is little mixing of detainees from different sections in any one session. It is, perhaps, most problematic for those who want to attend school for more than one session per day, as to do so would mean attending school during another section's scheduled school period. Thus, detainees who wish to study a normal school curriculum are unable to do so.

### *Community-based programs*

The focus of all services and programs for detainees is on minimising the harmful effects of institutionalisation and assisting their reintegration into the community,<sup>46</sup> which would seem appropriate and necessary if detainees are truly to be assisted in this process. Although a small number of detainees are being reintegrated into the community as part of a pre-release plan, such activities are the exception rather than the rule; case plans tend to ignore services and programs not readily available within the centres.<sup>47</sup> Access to community-based educational, vocational and related services are essential for such reintegration, and also help to reduce the isolation and separation felt by detainees.

### *Case plans*

Casework staff are pivotal to all programs provided in the centres. They assess the detainees' needs, and develop case plans specifying appropriate programs and services. Some caseworkers, however, admitted limited knowledge of case management principles, and some complained of inadequate training and the need for assistance in formulating case plans.

This was more commonly reported by indigenous casework staff, who felt uncomfortable with the demands placed upon them and the lack of support. This raises the larger question of appropriate roles for indigenous staff in casework. The indigenous caseworker in Cleveland, for example, is a well-qualified individual, and acts more as a liaison and link with indigenous families and communities than as a basic caseworker. Her skills and contacts are thus available to a higher proportion of detainees. Such a role would not be possible if she carried the same caseload as other caseworkers.

In addition, despite having limited skills or training in these areas, some casework staff are required to develop and present programs on issues such as drug and alcohol abuse, grief and loss and family violence.

It appears, then, that levels of intervention and support for detainees can vary considerably, and this was borne out by the small number of case plans reviewed. There was a considerable variance in the quality of case plans and the adequacy of referrals, follow-ups and reviews. Even the better case plans did not indicate active participation by the detainee and/or the detainee's family in determining appropriate programs, nor were timeframes indicated for referral or admission to specific courses. For example, identified needs and referrals for drug and alcohol counselling often had no recorded response.

Detainees cannot adequately address their own behaviours without having the opportunity for input into their case plans. Specific dates and times should be indicated in order to make goals and plans measurable and achievable. Detailed assessment of individual case planning is not made here as this issue is currently under examination by the Securing the Care project, initiated by QCORR and continued by DFYCC.

### *Vocational programs*

The number and variety of vocational courses available in detention centres has improved significantly as a result of links with the adult correctional system. QCORR's experience in delivering vocational courses, and its links with the TAFE system, have enabled centres to access a range of vocationally accredited programs. This is advantageous to detainees in accessing courses and employment in the community upon release. It is understood that DFYCC intends to continue permitting access to these programs.

Although staff strongly supported the increased emphasis on vocationally accredited programs, some believe that QCORR programs need modification for young detainees with limited education, and those serving short sentences.

It is clear that detainees benefit from enhanced opportunities for education and training. However, such opportunities will only be of direct and lasting benefit to detainees if offered in areas of employment known to be in demand, and ones that are suited to individual skills and life situations.

### *Educational programs*

Education Queensland operates the schools in each centre under section 14 of the *Education (General Provisions) Act 1989*. In the past they operated as annexes to local schools, but are now established as separate units. Although termed 'schools', they are not required to comply with all State school curricula and administrative arrangements. However, they have access to the same resources and supports.<sup>48</sup>

The DFYCC initially agreed to provide education for detainees of compulsory school age (up to 15), with spare spaces made available to older detainees. In practice, an attempt is made to provide education for all those who request it. Education Queensland recently announced an initiative guaranteeing all people in public education an entitlement to 24 semesters in which to complete their education, with possible extensions. This guarantee increases the Department's obligation to provide education for detainees of all ages, not just those under 15.<sup>49</sup>

The education staff at Sir Leslie Wilson have recently increased from 4.5 to 5.5, at John Oxley from 5.0 to 5.5, and at Cleveland from 2 to 5.5. This will allow additional classes to be conducted during regular school breaks. In addition, a further part-time position (15 to 20 hours per week) has been designated at each centre to assist young people in the transition from detention-based to community-based education and to assist in the reintegration of young people into the community.<sup>50</sup>



The centres' curricula are based largely on literacy and numeracy programs in recognition of the limited education of large numbers of detainees. Each detainee is intended to have an individual education program, prepared jointly by teachers and centre staff, including caseworkers. The plan is intended to include transition plans for the young person's reintegration into the community, such as linkage with mainstream schooling or other educational or vocational opportunities.

Several detainees commented favourably on the value of the school program:

*School does a lot for us. They had this program on today about helping us out for our future and that which is good. I didn't know that when I'm in TAFE I can get a tutor from these people. I wouldn't have known if school didn't have that program for us today. It gives us a goal for when we get out. We stick to it because we like it. People say 'You can't do that, you'll get nowhere once you've been locked up'. But the school will ring up places for us and enrol us before we get out, or get us a job interview for when we get out. The work, like the Maths and English that we do is proper schoolwork, but it actually gives us a certificate through TAFE as well. We have job-seeking courses in here, like at night, and school organises that as well, and hospitality courses that they organise for us. They really help you out. They go out of their way for us. School is good and [would be] even better if it was longer.*

Even though many detainees have poor educational backgrounds, most young people enrolled in the centre schools attend classes for only one hour per day—or two hours at Cleveland—and often for less than five days per week. In response, DFYCC stated that the 1.5 hours of school time is supplemented with a range of vocational training programs. In addition, the Department states that as the teaching is intensive with a very low teacher–student ratio, the amount of learning that occurs during that 1.5 hours is far in excess of an equivalent amount of time in a 'regular' classroom environment.<sup>51</sup>

Private study is virtually impossible for detainees, particularly those accommodated in Sir Leslie Wilson's dormitory accommodation and the girls' shared rooms. Most libraries are part of the school and are unavailable out of school hours. Detainees must seek permission to study in their rooms and to have access to pens and pencils. Homework centres are proposed in the educational plans of at least two of the schools. It is also proposed that the school year be extended to operate through current school holiday periods.

A senior departmental officer acknowledged that centre schools were not sufficiently resourced to provide a full five-day week of schooling, even though there have been increases over the years.<sup>52</sup> She noted, however, that even if additional staff were provided, current buildings were inadequate to accommodate them and their classes. Current security requirements also limit the number and mix of students in any class, and timetables need to take into consideration absences for court attendance, counselling and other activities.

Teaching staff in all three centres were questioned about the limited amount of schooling provided. Some expressed dissatisfaction and frustration with existing arrangements, echoing the comments of the senior departmental officer above. Others argued that the limited education and social skills of detainees meant that 'intensive' one-hour sessions (where one teacher and an aide work with between one and six detainees) were difficult for young people to sustain. They dismissed the possibility of allowing detainees 'down time' in which they could use the computers or read a book or complete learning exercises on their own in the classroom. Whether this is because of security concerns or doubts about the capacity of young people to manage their own time was not clear. It is, however, anomalous that detainees in Queensland should be considered less able to sustain educational input over a full school day than detainees in other States, such as New South Wales, where this is standard practice.



*Photograph 9.14: John Oxley Youth Detention Centre classroom in demountable: security limits detainees' access—Inquiry photograph*

Some teachers felt that other centre staff were not supportive of the school and, by their own attitudes and behaviours, effectively discouraged detainees from attending. This was borne out by reports of reduced session times resulting from centre staff placing low priority on school attendance. For example, detainees may be held in their section until all chores are properly completed, which may reduce schooling time by 15 or more minutes. Staff at Sir Leslie Wilson complained of difficulties in providing escorts for detainees to use the toilets which are some distance from the classrooms. Because youth workers assigned to the school provide the main radio contact with the centre, they cannot leave the school area, and additional staff have to be called upon for this escort duty. Delays have caused detainees to suffer the embarrassment of urinating in the classroom or, in the case of some young men, urinating off the balconies. Teachers had been placed in the position of having to apologise to detainees over this situation.

One teacher recounted an occasion in which a youth worker told her not to give a particular detainee homework to do after school hours, complaining that the young person was using it to gain additional privileges, for example time out of the section's routines for study and access to a pen. Some teachers were frustrated that their professional teaching role could be overridden by youth workers' concern for security issues—for example a detainee being banned from using any form of pen or pencil for a week.

It is puzzling that there are limited educational services in detention centres when young people have such need for this input and little else to occupy their time. Cleveland is the only centre requiring all detainees to take part in a reading support program which runs for half an hour each day and which has proved most successful. As one teacher stated:

*Some detainees would never have considered themselves capable of learning. This small compulsory exposure to learning gives detainees a chance to see themselves as learners.*

It is clear the Department has yet to decide how best to provide educational services in the centres. Indeed, statistics on attendances and classes have only recently started to be collected. It is important that detainees have positive educational experiences in the centres, to better equip them for further opportunities upon release.

#### **Recommendation**

That the Department and Education Queensland jointly review the allocation of special education resources for children in institutions and prepare a detailed report to both Ministers, by 31 December 1999, on the current availability and any gaps, as well as a clear plan for rectification.

### *Recreation and programs*

Sports and other recreational activities provide young people with opportunities to develop coordination, motor skills and general fitness; increase social skills such as teamwork and fair play; release tension and burn off energy; increase confidence and self-esteem; and develop interest in, and links with, sporting groups and clubs.



*Photograph 9.15: Cleveland Youth Detention Centre: interaction of staff with detainees (note view beyond fence)—Inquiry photograph*

Daily indoor and outdoor recreation sessions are the most consistently provided of all programs and activities, but are commonly little more than free time for young people to entertain themselves. Detainees may use sporting and games equipment but usually receive little or no training in the necessary skills, strategies and appropriate rules of the games, nor in appropriate stretching or warm-up exercises. Section staff may join in such activities, but this does not guarantee that young people will develop meaningful skills. If recreation is to be a mainstay of programmed activities, greater effort is needed to ensure appropriate structures and instruction. Detainees commonly expressed concerns about the exercise facilities:

*... should have a bigger yard, grass field. We got that concrete stuff with this real thin rubber mat on it and you can't play tackle football or nothing on it, you can only play touch. If you fall over you get all grazed up and stuff.*

The centres are beginning to acknowledge the need for more structured recreational programs, and qualified recreational instructors are being contracted to provide specific programs. For example, John Oxley employed a recreational officer during the 1998/99 Christmas school break, and has now engaged a recreational instructor to provide a sports skills program each Saturday.



*Photograph 9.16: Sir Leslie Wilson Detention Centre: secure concrete yard completely enclosed—  
Inquiry photograph*

### *Therapeutic and personal development programs*

These programs include courses related to offending behaviours, health care, nutrition, family integration, grief and loss, cultural and religious issues and life skills. It appears that programs that directly target individual needs and offending behaviour of young people have, until recently, been overlooked or considered ‘additional’ to ‘core’ educational, vocational and recreational programs.

Casework staff have traditionally been relied upon to design and present a variety of therapeutic programs, such as anger management, grief and loss, drugs and alcohol, victim empathy, self-awareness and family violence. The range of programs may differ between centres. Caseworkers have to balance these with other responsibilities such as individual case planning and reviews, pre- and post-release planning and support, attending to detainees’ general welfare needs, individual counselling and liaising with detainees’ families. Two staff are usually required to conduct each program, so it is not surprising that some therapeutic programs may be conducted only once every two or three months.

Recent efforts have been made to standardise the content and to increase the number of such programs. Trials of a small number of modules are currently being conducted and evaluated, which should provide greater consistency and quality of programs for detainees.

Community organisations and individuals are increasingly being contracted to run particular programs and provide individual counselling additional to that provided by caseworkers. However, limited resources and competing priorities still restrict the number of programs offered.

Significant gaps exist in the current range of therapeutic programs provided. Staff readily acknowledge that the vast majority of young people in detention have alcohol and drug-related problems that require skilled intervention.<sup>53</sup> Many will have offended while under the influence of drugs or alcohol, or to support their habits. Staff spoke of the need for in-house counselling and programs, with follow-up support when detainees are released.

Staff also identified the need for programs for sex offenders, as well as sexual assault counselling for detainees who are assault victims. Recent initiatives in some centres have seen nursing staff utilised to provide health education and parenting programs.

There is a notable lack of specific programs at John Oxley and Sir Leslie Wilson to cater for the needs of young indigenous offenders, in contrast with programs provided at Cleveland. Although Brisbane and Cherbourg elders regularly visit Sir Leslie Wilson and John Oxley to provide social support for detainees from their communities, they do not offer any structured

programs or services. Similarly, visits from local indigenous health and counselling services and the Murri ministry do not fulfil the needs of indigenous young people to learn more about their culture, identity and traditions. In contrast, the Te Kohanga Ote Whenua Hou Association has in recent months (October–December 1998) undertaken a 12-week language and culture program at John Oxley, funded by the centre. The program was designed to teach Maori and Polynesian young people the Maori language, to involve them in performing and visual arts, and to give them contact with members of their community outside the centre. The Association’s President has reported that it was well received by both residents and staff, and that centre management has invited the Association to repeat it. Meanwhile, the Association has been actively encouraged by centre staff to maintain contact with the 10 members of the Maori and Polynesian community within the centre. The lack of equivalent programming for indigenous young persons in John Oxley and Sir Leslie Wilson is a significant omission.

#### **Recommendation**

That the Department ensure that all young people in detention centres, whether sentenced or on remand, have access to:

- a range of programs that will both engage them and be of future vocational benefit
- community-based educational, vocational and related services to assist reintegration and to help reduce the isolation and separation felt by detainees
- appropriate recreational facilities and sporting instruction as central components of programmed activities, recognising the importance of sport as a factor in achieving reintegration and reducing recidivism.

## **9.8 MONITORING AND COMPLAINTS SYSTEMS**

The closed nature of the centres, the significant power imbalance between staff and detainees and the concentration of ‘troubled’ young people (many of whom have been abused) increase the potential for psychological, physical and sexual abuse of detainees by peers or staff. It is imperative that all detention centres have a strong commitment to provide an abuse-free environment for young people, with mechanisms to record and manage complaints and incidents of abuse and harassment.<sup>54</sup>

Complaints mechanisms currently in place are poorly developed and inadequate, with no guarantee that complaints are appropriately acknowledged or addressed. The Official Visitors’ scheme (discussed in more detail later in this section) is ineffective. Few avenues of appeal for detainees concerning their treatment were identified, and there is little proactive monitoring of staff practices. Staff training and accountability requirements have focused largely on security rather than on the welfare of detainees. A study of previous Annual Reports from the centres shows that major performance indicators focus on avoiding serious incidents such as escapes, deaths and serious assaults rather than on more positive indicators such as educational and vocational courses and the attainments of detainees.

There appears little consciousness of the need for monitoring and review processes in the centres. It is unclear whether this is due to a strong, possibly unrealistic, trust in the skills and integrity of centre staff, or to an assumption that any problems or ‘bad apples’ will quickly become obvious. Alternatively, it may be an indication of the general low priority given to conditions in detention centres. Whatever the reason, limited monitoring and inadequate complaints systems increase the chances for child abuse and neglect to occur and go unreported.

### **Inspection and monitoring**

The only regular reviews or inspections of Queensland’s detention centres and their treatment of young people are conducted by Official Visitors (see section below) as part of their routine visits to the centres. While the *JJA 1992* provides special status to the Ombudsman (among others), that office currently has little, if any, direct involvement in the operation of detention

centres. This is contrary to Recommendation 269 of the Australian Law Reform Commission and Human Rights and Equal Opportunity Council report *Seen and Heard*, which recommends that the role of each State Ombudsman's office in monitoring such centres be strengthened.

There are no regular inspections of detention centres by DFYCC. The one audit conducted of detention centres by QCSC prior to September 1998 (when 'handover' audits of each centre were conducted prior to their transfer to DFYCC) was of security needs. There have been other more focused 'reviews' of particular areas such as the Securing the Care project. These, however, are one-off events rather than part of a regular planned inspection and review process.

Where legislation requires actions to be recorded, such as the use of separation or searches, centre records often omit significant data necessary to determine their appropriateness and effectiveness. The poor quality of records examined for this report suggests that the checks that do occur are ineffective and are unlikely to detect the possible misuse of power or inappropriate response to the needs of individual young people in detention.

QCSC monitors the centres mainly through the regular submission of reports by each centre. These reports set out key data such as use of separation, restraint and attendance at programs. However, such monitoring is dependent on the centres providing full information in the reports.

It is of grave concern that there is such a lack of regular inspection and review mechanisms in place, particularly as young people in detention are vulnerable not only to abuse by others (staff and peers) but also to possible abuse and neglect arising out of the nature of the systems in place in the centres.<sup>55</sup>

### **Complaints**

Appropriate complaints mechanisms protect individual rights and allow redress. Complaints can also inform an organisation of areas requiring improvement. Children and young people are unlikely to complain to management of their treatment; they commonly do not know how to complain. Some will fear reprisal, or lack faith in likely responses. Some young people know little of their own rights and entitlements and so are unable to recognise when they should complain. In addition, the complaints process itself may impose barriers by requiring levels of literacy, patience and persistence above and beyond those usually possessed by young people, especially those in detention. Complaints mechanisms should be designed to overcome these barriers.

#### *Internal complaints mechanisms*

Section 215(1) of the *JJA 1992* provides that a detainee or parent of a detainee can complain about any matter affecting a child. The Act requires DFYCC to issue written instructions on how a complaint may be made and dealt with, although a child can also complain directly to an Official Visitor, or have their complaint referred to an Official Visitor.<sup>56</sup> This presumes the operation of an internal complaints process distinct from the Official Visitor scheme, which largely does not exist. The Department is also required to tell a young person how their complaint will be dealt with,<sup>57</sup> although the Act also permits the Department not to deal with a complaint if it 'reasonably believes to be trivial or made only to cause annoyance'.<sup>58</sup>

Draft Service Standards require that centres 'provide clear accessible and fair avenues for lodging and resolving complaints and grievances, and with the opportunity to appeal decisions'.<sup>59</sup>

Indicators of compliance include:

- that written complaints policies and procedures exist and are followed in response to formal and informal complaints
- that detainees can raise concerns without fear of retribution

that detainees know of and understand internal and external complaints systems and are satisfied with them

- that feedback is given to complainants
- that information is available on the number of complaints and of those successfully resolved.

Complaints mechanisms examined for this report do not comply with legislative requirements, nor with the draft Service Standards.

The Inquiry was unable to find a departmental procedure for general detainee complaints, although procedures exist for complaints of alleged misconduct by staff and the role of Official Visitors.<sup>60</sup> Thus, it is not known how complaints made to departmental staff (as opposed to the Official Visitor) about general conditions such as food, clothing, access to property or visits are recorded or dealt with. This is in breach of section 215 of the *JJA 1992*.

All centres appear to use (or have used) a ‘blue letter’ system, where detainees write down their concerns either on a blue form or in a letter enclosed in a blue envelope provided by staff. These are addressed to one of a number of recipients, which may include the centre manager, a legal representative, the Official Visitor, the Ombudsman, the Criminal Justice Commission or the police. (No mention is made of complaining to the head of DFYCC.) The letter is to be sent unopened to that person or agency. This system is not, however, mentioned in Sir Leslie Wilson’s information booklet for detainees, which states that they should first speak to a youth worker or family services officer. Similarly, John Oxley’s induction booklet omits mention of the system, directing detainees instead to casework staff or the shift supervisor.

Although detainee information booklets explain the complaints process, and to whom a complaint should go, they do not detail possible timeframes for a response, how and by whom they may be dealt with, possible supports for the complainant or further appeal or review mechanisms.<sup>61</sup> When questioned, many staff were unable to explain their centre’s complaints procedures (although they spoke readily of the Official Visitors’ scheme). They commonly stated that detainees could raise their concerns with anyone in the centre. It was assumed that this was adequate, but no one detailed the obligations on staff who received such complaints. This suggests a lack of knowledge and understanding by staff (not to mention detainees and their families) of internal complaints procedures and staff obligations to record, refer or take action on complaints.

Centres do not keep any central register of complaints made directly to centre staff, apart from those alleging particular staff misconduct dealt with by procedure 5.9. Some records are kept of matters raised by Official Visitors, although not in a standardised format. Even written complaints do not appear to be centrally recorded. For example, the manager at Sir Leslie Wilson was not certain how written complaints were stored—a matter of concern for someone in this role. Thus, it seems managers are unable to determine what complaints have been received, by whom, how they have been dealt with and whether the detainee has been informed of the outcome. Such an omission makes it easy, if not inevitable, for detainees’ concerns to be overlooked or forgotten, which in turn will reinforce their mistrust of the complaints process. The lack of centralised records also reduces the Department’s capacity to identify and address systemic problems.

The Sir Leslie Wilson and John Oxley induction documents end their ‘explanation’ of the complaints process with a note informing detainees that the recipient of the complaint may decide not to investigate it if they believe it is not serious or genuine, or that it has been made to cause a nuisance. Such information would only strengthen young people’s doubts about the futility of their complaints and of being believed:

*I have never seen a complaint get carried through. Nothing ever happens, so it’s just a waste of time I reckon.*

*They just say, ‘Oh, yeah, I’ll get onto that’ and then you never hear any more ... What I’ve put in a complaint about is getting more Murri staff because there’s only*

*about four here. And there are no Murri boys on the work-release program even though some [are scheduled to] get out soon.*

### *External complaints mechanisms and the Official Visitors' program*

Section 204 of the *JJA 1992* provides for the Minister of DFYCC responsible for juvenile justice to appoint one or more Official Visitors for each detention centre, one of whom must be a legal practitioner. Visits should occur at least monthly, and the Official Visitor must provide a report on each visit (section 205). They can enter the centres at any time, hear and investigate any complaints made or referred to them, and report on them (section 205(4)(a)). They have wide powers to access information for the purposes of their investigations (section 217). All interviews and correspondence between an Official Visitor and a detainee are privileged from monitoring or other intervention (section 218).

The purpose of this program is to provide an independent system for addressing complaints by young people in detention centres and/or their parent(s). The role of the Official Visitor is to deal with any complaints in a constructive and impartial manner and to provide the Director-General with information and advice concerning the development of policy, programs and service standards where necessary. The system for making complaints in detention centres is as follows:

- Detainees ask staff to record their request to see an Official Visitor in a formal register. Detention centre managers must notify an Official Visitor if the request is urgent.
- Young people can request, without notice, to see an Official Visitor at any time during a visit.
- Secure mailboxes and request slips are available in all centres for young people who wish to see an Official Visitor.
- Parents write directly to Official Visitors.
- All correspondence to or from an Official Visitor is strictly confidential and must not be opened or read by departmental staff.
- Official Visitors visit detention centres on a roster basis. However, they can visit at any time on their own initiative, or respond to an urgent request from a detainee or a departmental officer.
- Official Visitors refer matters outside their jurisdiction to the Director-General of DFYCC for consideration and, where necessary, follow-up, for example an allegation of assault or official misconduct.<sup>62</sup>

Appointments of Official Visitors are made for a specific centre and are limited to a period of two years. However, Official Visitors are eligible for reappointment.

The Official Visitor Program is the most clearly recognised process for young people to make complaints in detention centres. The scheme provides the only regular 'independent'<sup>63</sup> scrutiny of centre operations and general treatment of detainees. Evident shortcomings in the program's operations, however, significantly undermine its capacity to deal with individual complaints and to identify systemic deficiencies. Staff, managers, community organisations and some Official Visitors interviewed expressed dissatisfaction with the current system. The Inquiry received evidence about the scheme from existing and past Official Visitors, and the following section provides an overview of issues to be resolved if the scheme is to be effective.

### **Shortcomings of the Official Visitors' program for juvenile detention centres**

#### *Frequency of contact with detainees*

The most immediate shortcoming is the failure of three of the six Official Visitors to visit regularly—some have not visited the centres for over 12 months. QCSC is aware of this situation, but no action has been taken to replace them, appoint additional visitors, or request active Visitors to visit the Centre more often.



Although the three who do not attend regularly are the three indigenous visitors, no effort appears to have been made to determine if there are any cultural factors deterring indigenous appointees from performing this role. The absence of indigenous Official Visitors in the centres increases the likelihood that concerns of indigenous detainees may go unvoiced and unreported. QCSC's inaction suggests that the role of Official Visitors, and particularly indigenous Official Visitors, has not been appreciated or respected.

Official Visitors are currently required to conduct only monthly visits. This is insufficient to:

- develop rapport with or acceptance by detainees. Without some measure of familiarity and trust, young people are unlikely to speak with Official Visitors about their concerns
- provide a timely response to many complaints that may be placed in the Official Visitor locked box in that month. For example, a BMP might have been imposed and concluded, or the detainee might have been transferred
- ensure detainees have reasonable access to them. Detainees absent from the centre when an Official Visitor visits have to wait a further month to see them
- keep abreast of events within the centres that might raise concerns or explain particular actions. Such knowledge would permit Official Visitors to speak with particular detainees involved in incidents and/or review the relevant records.

These factors may explain why Official Visitors tend to receive predominantly 'low-level' complaints about the centres, such as food and general routines. Detainees have rarely complained to Official Visitors of alleged staff misconduct. Each Official Visitor should visit at least fortnightly.<sup>64</sup> If two visitors regularly visited each centre, this would permit weekly visits.

#### *Feedback to Official Visitors and detainees*

There has been a general lack of feedback to Official Visitors on their reports and highlighted issues. Centre managers also fail to provide adequate feedback to Official Visitors concerning follow-up on matters previously raised. Official Visitors and managers fail to provide adequate feedback to detainees about their complaints. Detainees and Official Visitors are both likely to become discouraged at the lack of response to their concerns, and perhaps be reluctant to 'waste' energy or time on a process that appears futile.

#### *Lack of clarity of Official Visitor functions*

Clarification is required on the following points:

- Are Official Visitors to advocate for detainees?
- Are they to monitor centres, as well as deal with individual complaints?
- Are they to serve as the main complaints mechanism for the centres?
- Are they to receive and investigate all complaints about the centres, whether they are initiated within or outside the centres?
- To what extent are they expected to conduct their own investigations, and when can they refer matters to the manager or others to examine or reconsider?
- Who is responsible for reporting the outcome of matters to the original complainant and when should this be done?

Lack of clarity in these matters has further harmed the role of the Official Visitor, particularly where the complainant's expectations of Official Visitors are not met.

### *Inadequate training and support*

Management of the Official Visitors for detention centres was absorbed into the much larger adult corrections Official Visitors' Scheme when QCSC took over responsibility for the centres. Official Visitors attended the same induction training and annual conferences, and were given the same induction booklet focusing on adult security and management issues. This would have done little to raise the Official Visitors' awareness of the needs, vulnerability and appropriate treatment of children and adolescents as distinct from adult prisoners, nor would it have alerted them to the increased reluctance of young people to make complaints.

Little instruction was given on juvenile detention centres' practices, requirements and juvenile justice issues. This information is essential for Official Visitors in their assessment of complaints and in any enquiries and investigations conducted. For example, Official Visitors were unsure whether they could claim for additional hours spent pursuing individual complaints or other issues that arose during their visits. This might deter Official Visitors from making detailed enquiries that would take a significant time.

In addition, Official Visitors appeared to feel isolated from QCSC and unable to contact them to discuss particular concerns or to seek clarification of roles.

Despite the substantial problems confronting the scheme, no other 'independent' agency has the same authority to access the centres, speak with staff and detainees, and review centre records. Official Visitors' reports, provided to QCSC's Audit section, have been included in the meeting papers for QCSC's board of management, along with details of any actions taken in response to them. These reports now include statistical information as well as details of specific issues or matters requiring more detailed intervention or follow-up. This should permit patterns in complaints to be identified, indicating areas for systemic improvements—for example in access to programs, or visiting arrangements.

The extent of the current shortcomings should call into question the value of such reports, and indeed of the Official Visitor program itself.

## **9.9 INVESTIGATION OF SERIOUS INCIDENTS**

Centre staff routinely complete incident reports on situations ranging from, for example, fighting between detainees, general intelligence information, and physical interactions between staff and detainees that may involve the use of force or restraint. Sir Leslie Wilson and John Oxley have an incident register, or logbook, in which each incident is given an identifying number. This number is included in all subsequent paperwork having regard to that incident. Cleveland has no such system, making it more difficult to ensure that incidents are brought to the attention of management and properly dealt with.

The system relies on staff identifying those occasions where an incident report is required. It appears that incident reports are often used to record the misbehaviour of a young person and the consequences rather than to highlight particular events related to the safety and/or security of the centre or its occupants. A youth worker at Sir Leslie Wilson indicated that if sufficient incident reports were recorded they could be used to justify the detainee's placement on a routine BMP. The concern with the volume of these 'behavioural' incident reports is that they may detract from the importance of any individual report.

Incident reports are reviewed daily by more senior staff in the centre, and any that relate to 'notifiable' matters are forwarded to the administering department. Further information may be requested from the centre, or it may have its own staff investigate the matter. Of incidents centrally reported, QCSC appears to have requested further investigation of those involving alleged security breaches by staff.

Incidents and complaints related to matters such as serious assaults, allegations of staff misconduct, breaches of security or attempted self-harm are detailed in DFYCC procedure 5.9 'Investigation of incidents/complaints'.<sup>65</sup> Matters involving possible staff misconduct are usually dealt with in one of three ways: by referral to the police if the incident involves possible criminal conduct—usually the Juvenile Aid Bureau or the Corrective

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Services Investigation Unit (CSIU), by referral to the Criminal Justice Commission (CJC) if the incident involves official misconduct (which usually constitutes either a criminal offence or grounds for termination of employment), or by internal disciplinary procedures.

Although serious incidents and complaints have been referred to the CJC, the majority have eventually been referred back to QCORR and the CSIU for investigation and action.

Internal disciplinary processes are generally begun only after the CJC and/or the police have decided not to investigate the matter. This procedure can create lengthy delays that would have a negative impact both on the complainant, who may begin to believe nothing will be done, and on the staff involved, who may be placed on other duties or suspended until the matter is resolved. A number of staff expressed dissatisfaction with this process.

Most inquiries and investigations of alleged staff misconduct are conducted by colleagues within the centres. Some senior staff expressed frustration at being required to conduct disciplinary interviews with staff when they have little formal training in the process, and where the process requires them to assume conflicting roles—an advocate for the complainant, supporter of staff, and an impartial investigator and decision maker. The process inevitably affects staff morale and the general environment of the centre. The current procedure requires a staff member to receive all information relating to allegations made against him or her early in the process. One manager reported that staff were circumspect in the information they provided in initial reports, for fear they would be shown to the subject of the complaint. Staff were reportedly concerned to be seen to be ‘dobbing in’ a colleague, and in some cases were fearful of possible reprisal by staff members under investigation and their friends.

## **9.10 HUMAN RESOURCES MANAGEMENT**

Appropriately selected, trained and resourced staff are undoubtedly the key to providing a safe and productive environment in detention centres.<sup>66</sup> This review did not specifically examine staffing issues, but a number of matters arose during the course of the review that are worthy of mention.

Staff training was significantly extended and standardised following the transfer of responsibility for the centres to QCSC and QCORR. New staff attend set pre-service training, the primary focus of which has been on centre security, safety and general workplace issues, with modules borrowed or modified from those used for adult correctional staff. Few staff, however, have received training in areas such as adolescent development, understanding adolescent behaviour and positive behaviour management strategies.

The DFYCC states that with the recent transfer back to the Department, new advances are planned for staff training and competency development. One initiative is a three-week pre-service training course for all full-time and casual youth workers which includes a number of mandatory training elements such as communicating with adolescents, managing difficult behaviours, suicide prevention and first aid.<sup>67</sup>

Staff receive little on-going training, even if promoted to more senior supervisory and managerial positions, which creates particular problems for middle managers who may have no training in supervision or personnel management. As already mentioned, inexperienced casework staff also receive no formal case management training, being required to learn case planning as they went along. Other specialist staff reported little training apart from centre security. There appeared little awareness of the need for professional development and training for staff. Clinical supervision appeared minimal and largely dependent on individual arrangements. The appointment of senior practitioners to provide professional support and development is not yet occurring.

Divisions between specialist staff and section staff were noted, particularly in John Oxley and Sir Leslie Wilson. Some specialist staff are advised of, rather than consulted in, decisions

affecting the general management of detainees or those made in response to particular incidents. This suggests poor flow of information and significant under-utilisation of skills that could otherwise benefit the welfare of detainees and increase the knowledge of workers.

Similar tensions appear to exist between section staff (largely youth workers and section supervisors) and senior centre management (unit and senior unit coordinators and centre managers). Section staff commonly complained of lack of consultation, understanding and support from senior management. Some felt under-utilised, and wanted more training in issues relevant to the management of young people, and greater and more meaningful involvement with detainees. Some criticised management decisions that they felt were based on budgetary, rather than safety and welfare, considerations.

Some longer-term staff recalled the time when centres were smaller and accommodated young offenders and those on care and protection orders. While most acknowledged the improvements in training and vocational services, some wished that the young people had greater access to the community and more positive daily activities and interactions, as previously allowed. Others are fearful that the return to DFYCC will see a retreat from current security procedures, and thus jeopardise staff and detainee safety and centre security. Some staff have limited knowledge or vision of alternative management strategies that rely on dynamic rather than static security—for example maintaining control and order through providing meaningful programs and activities and interactions between staff and detainees, rather than relying on locked gates, security cameras and restrictions on movements. It will be a challenge for DFYCC to allay staff concerns and gain their support as it embarks on needed initiatives to better balance security with welfare considerations.

### **9.11 THE 10-YEAR PLAN FOR JUVENILE DETENTION CENTRES**

A 10-year plan for a staged development of juvenile detention centre infrastructure has recently been approved by Cabinet. The first stage of the plan includes:<sup>68</sup>

- The design and construction of a new centre at Wacol for sentenced and longer-term remanded males and all females from southern Queensland. The centre will accommodate 86 beds initially with ‘foot printing’ to allow for expansion to 100 beds if required. The estimated cost of the new centre is approximately \$30 million.
- The rebuilding of the Cleveland Youth Detention Centre at Townsville on its existing site. The centre will retain its current capacity of approximately 50 beds for all males and females from north Queensland, both remanded and sentenced. The estimated cost of this project is approximately \$12 million.
- Upgrades and refurbishment of the John Oxley Youth Detention Centre at Wacol and reduction of its current bed capacity of 90 beds to approximately 40. Upon commissioning of the new centre at Wacol, the John Oxley Centre will be used for the reception and short-term placement of males from southern Queensland prior to either their release or their transfer to the new centre. The estimated cost of the upgrade is \$3.5 million.
- Closure of the Sir Leslie Wilson Youth Detention Centre at Windsor following commissioning of the new Wacol centre. A \$500,000 upgrade of the centre will be undertaken to maintain its viability until the new centre is opened.

This work will be concluded by the end of 2000.

Within three to five years, options will have been considered and plans determined for the second stage of the construction program. The second stage will include:

- the construction of the additional beds at the new Wacol centre to increase its capacity to 100 beds if required
- the construction of an additional 30 beds at a regional location yet to be determined.

The location of the additional beds during the second stage will depend on factors such as population growth and the gender and communities of origin of young people requiring

detention. The most likely contenders for a new regional centre are Rockhampton or Cairns, although consideration may also be given to limited expansion of the Cleveland centre if increases in the number of young people in detention do not warrant the construction of another regional centre. There are no plans for the construction of another centre in south-east Queensland or further expansion of the new Wacol centre beyond its ceiling of 100 beds.<sup>69</sup>

The DFYCC in response to requests from the Inquiry advised that:

*The design brief for the new youth detention centre at Wacol will specify that the centre incorporate separate accommodation units or 'sub-centres' providing programs and services to particular groups of young people. For example, girls will be accommodated in a unit specifically designed to meet their requirements. The unit will be physically separated from other accommodation units on the 15.8-hectare site. The actual distance apart has not yet been determined as this has to be settled in the detailed design process occurring over the next few months but buffers of between 20 and 50 metres are envisaged. The units will be placed far enough apart to ensure that activities in one unit do not disturb others, but not too far away from shared program and services facilities like the school, health centre and oval.*

*The accommodation units will have their own multi-disciplinary team and staffing structure to promote the establishment of a distinct character, and effective relationships between staff and residents. The design brief will also provide that the external appearance of the units differ, using a variety of materials, roof lines and colours for example, to reinforce difference and to avoid conveying a general effect of institutional 'sameness'.*

The Inquiry is pleased that the proposal involves the closure of the Sir Lesley Wilson Youth Detention Centre. This, of course, will not be the first time that the closure has been approved, and regrettably the Centre is still open. Its closure as soon as possible is critical.

The Inquiry has concerns about both the location and the size of the new centre.

### **Location**

The Wacol area already contains the John Oxley Youth Detention Centre, a number of adult prisons and an institution for psychiatrically ill people. This renders it an undesirable location for a juvenile detention centre.

In this regard, it is noted that Cabinet rejected a proposed site for a new centre at Townsville because:

*Whilst not in the line of sight of the [Stuart adult] correctional centre it was nevertheless unsuitable due to close association of the youth and adult systems that would result.<sup>70</sup>*

### **'Small centres servicing local communities'**

A further consideration is whether it is preferable to have two or more small centres in place of the proposed new centre at Wacol. The DFYCC has strongly argued against the idea of a number of smaller units in various parts of the State:

*A series of small centres servicing designated geographical areas was considered. Due to the distribution of young people currently entering detention, however, this arrangement would frequently result in young people being unsuitably and sometimes dangerously placed together within some of these facilities. At the extreme, this could see a 10-year-old boy entering detention on remand for a property offence placed in a living environment along with young men predominantly aged 16 years or older who have committed serious or repeated offences. The obvious difficulties of such an arrangement would be further exacerbated if a young woman found herself to be the only female occupant of the facility. Clearly, small centres whose populations are drawn on the basis of geographical origin alone have the potential to seriously disadvantage the more vulnerable young people and those forming the minority groups.*

For these reasons, the construction of another regional centre has been deferred until population growth within such a location is sufficient to warrant a facility that would

allow young people to be safely and suitably grouped in accommodation arrangements and serviced by a sufficient range of age-appropriate programs to meet their needs. The DFYCC states that it is anticipated that within three to five years the population growth within some regional centres of the State may allow this to occur.

Notwithstanding these arguments, submissions by DFYCC and others have emphasised the important role that the child's family and community play in the rehabilitation process. The Design Guidelines for juvenile justice facilities in Australia and New Zealand developed under the auspices of the Australasian Juvenile Justice Administrators Forum provides that:

*A Juvenile Justice system should have a philosophy aimed at maximising young people's chances of rehabilitation and reintegration into society.*

This points to the desirability of locating detention centres close to the communities from which young people have come, in order to enable families and other people important to the detained person to visit on a regular basis.

The Inquiry is firmly of the view that the closure of Sir Leslie Wilson is of critical importance and does not wish to see this closure delayed.

**Recommendation**

That the closure of Sir Leslie Wilson Youth Detention Centre be accomplished as planned by the end of 2000, or before, and that the refurbishment of John Oxley and Cleveland Youth Detention Centres proceed as a matter of urgency.

**Recommendation**

That the Minister for Families, Youth and Community Care establish an expert working group to provide advice regarding options available as an alternative to the construction of a proposed new juvenile detention centre at Wacol.

## 9.12 CONCLUSION

The Inquiry found a number of serious shortcomings in the operation of the State's juvenile detention centres, which do not meet legislative requirements, the relevant UN Conventions or acceptable standards. These shortcomings indicate that young people in detention centres today may be at risk of abuse or mistreatment. Centres as they currently operate are unlikely to rehabilitate young offenders, and are more likely to increase their disaffection with society and the risk of subsequent reoffending.

The facilities of all three detention centres require urgent attention. Sir Leslie Wilson, in particular, is no longer fit for its purpose, and staff and detainees are clearly at risk of harm as long as it remains open. John Oxley and Cleveland need significant improvements to meet the minimum standards of safety and care. Cleveland was the only centre to reflect the rehabilitative philosophy of juvenile detention in its approach to detainees. The Inquiry acknowledges a number of positive initiatives that have been implemented at John Oxley since recent changes in management.

Behaviour management programs at the centres were found to be overly punitive and the distinction between punishment and consequences was often blurred. The extremely limited nature of the educational, vocational and recreational programs results in boredom and disaffection throughout the detainee population. There is a pressing need for programs that will engage young people, deal with their interests and also be of future vocational benefit.

Of equal concern is the lack of adequate monitoring or complaints mechanisms in the centres to enable a young person at risk of abuse, or who has been the subject of abuse, to feel able to report the matter without fear of reprisal, and to feel confident that action will be taken. Without such mechanisms in place, all detainees are at risk of harm.

Family and community contact is essential to detainees' emotional wellbeing and is necessary for their reintegration into the community. Visiting arrangements and other means of enabling children to maintain outside contacts need improvement, especially at John Oxley and Sir Leslie Wilson.

A number of new services and programs for detainees were being developed by QCORR at the time of the review, but were yet to be introduced. The most significant of these is a centre procedures manual for staff, and the Securing the Care project, which is designed to improve coordination of services, case planning and detainee management. These target three central areas of concern identified in this chapter—inadequate procedures, poor case planning, and coordination of staff and programs.

Information provided by DFYCC, however, did not reassure the Inquiry that these initiatives would adequately address the range of problems identified in the review. Their success will depend largely on the way they are introduced. Attention must be given to training and supporting staff at all levels, explaining not only the requirements and operation of the new system, but also why procedures have been introduced. Detainees will need to be similarly prepared for their introduction.

The DFYCC must also include in its planning a process for evaluation, review and refinement of these and other initiatives. Without this, there is little way of ensuring that programs, services and management practices achieve the desired results and assist, rather than hinder, the social, cultural, educational and psychological development of young people and their reintegration into the community.

#### **Recommendation**

That the Department implement in full the detailed recommendations of the consultant responsible for the review of juvenile detention centres, contained in Appendix 13.

## **ENDNOTES**

<sup>1</sup> NSW Ombudsman's *Report of Inquiry into Juvenile Detention Centres*, December 1996.

<sup>2</sup> United Nations General Assembly Resolution 45/113, 14 December 1990 (UN Rules).

<sup>3</sup> Shennan W E, *Report of the Review into the Juvenile Detention Program in Queensland*, 15 January 1997.

<sup>4</sup> DFYCC, *Commentary on Witness Statements about Youth Detention Centres* to the Inquiry, March 1999.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> QCSC, *The Integrated Approach*, 1997.

<sup>8</sup> Ibid.

<sup>9</sup> Ibid.

<sup>10</sup> Australasian Juvenile Justice Administrators (AJJA), *Draft Service Standards for Juvenile Custodial Facilities in Australia*, September 1998, Standard 4.1 'Personal and social responsibility'.

<sup>11</sup> Rey, Professor J, Clinical Professor, Department of Psychological Medicine, University of Sydney, quoted in the NSW Ombudsman's Report, op cit.

<sup>12</sup> UN Rules, op cit, Rule 35. This restriction is also contrary to Standard 6.5 of the AJJA draft Standards, which states that the only reason young people's possession of personal effects is to be limited is for the good order and safety of the centre.

<sup>13</sup> DFYCC, op cit.

<sup>14</sup> Juvenile Justice Regulations 1993, s. 14(e).

<sup>15</sup> UN Rules, op cit. Rule 68 requires that legislation or regulations should establish norms concerning conduct constituting a disciplinary offence, type and duration of sanctions that can be imposed, the authority who can impose such sanctions and the authority who can consider appeals.

<sup>16</sup> DFYCC, op cit.

<sup>17</sup> Detention centre memo to section staff from acting unit coordinator, 10 October 1997.



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- <sup>18</sup> S. 16(2) 1993 Regulations.
- <sup>19</sup> S. 16(5) 1993 Regulations.
- <sup>20</sup> Five entries in Cleveland's isolation register did not record when detainees were removed from isolation. Eight of Sir Leslie Wilson's reported instances of isolation were not recorded in any of the Centre's isolation registers. Seven of these were recorded in section logbooks and incident reports. One occasion in which the Centre manager's approval was obtained to extend the period of isolation beyond the initial two-hour period was simply recorded in an incident report. A notation in the Centre Duty Officer's logbook at Sir Leslie Wilson indicates a further instance of isolation not included in the reported figures.
- <sup>21</sup> DFYCC, op cit.
- <sup>22</sup> QCSC, op cit.
- <sup>23</sup> Department of Family Services and Aboriginal and Islander Affairs (DFSIAA), *Practice and Procedures Manual, Juvenile Justice*, procedure 4.6, 'Searching', 1995.
- <sup>24</sup> S.19(1) 1993 Regulations.
- <sup>25</sup> DFYCC, op cit. procedure 4.6: The preconditions seem to impose no greater restrictions on the use of body searches over those ordinarily expected to apply for unclothed searches, with the exception of unclothed searches on initial admission.
- <sup>26</sup> Operational Procedures Manual for Juvenile Justice Centres, First Operational Draft, August 1998.
- <sup>27</sup> Ibid.
- <sup>28</sup> DFYCC, op cit.
- <sup>29</sup> S. 213 of the *Juvenile Justice Act 1992*.
- <sup>30</sup> QCSC, John Oxley Youth Detention Centre Handover Report, September 1988.
- <sup>31</sup> QCSC, op cit.
- <sup>32</sup> DFYCC, op cit.
- <sup>33</sup> Ibid.
- <sup>34</sup> Ibid.
- <sup>35</sup> Ss. 203(3) and 224A(1) of the *Juvenile Justice Act 1992*.
- <sup>36</sup> QCSC, op cit.
- <sup>37</sup> Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, 1993, p. 643.
- <sup>38</sup> Professor B Nurcombe, expert Submission to the Inquiry, 1998.
- <sup>39</sup> DFYCC, op cit.
- <sup>40</sup> DFYCC, *Detention Centre Practice Manual*, procedure 3.4 'Suicide prevention and intervention' issued 7 August 1996.
- <sup>41</sup> DFYCC, op cit. Procedure 3.4 states that aspects of detention such as loss of individual freedom, the strangeness of the physical environment and the level of control exercised in detention all increase the stresses on residents.
- <sup>42</sup> NSW Ombudsman Report, op cit. The report notes most psychiatrists and nursing staff involved in that review considered the provision of one-on-one supervision around the clock of young people considered at real risk of self-harm a much more humane response.
- <sup>43</sup> NSW Ombudsman Report, op cit.
- <sup>44</sup> Based on figures for each centre's events for the period 1–14 November 1998 provided to the Inquiry 7 January 1999. The exclusion of these activities is not to suggest recreational programs are of no value. In many cases, however, the particular 'program' time for these activities was little more than unstructured free time. Specific programs such as music, art, health and fitness, guitar, relaxation, weights and leatherwork—separately listed by the centres as part of the programs provided for the period 1–14 November 1998—were included in the calculation of the daily average.
- <sup>45</sup> Events for the period 1–14 November 1998: Sir Leslie Wilson Youth Detention Centre, Table 22, pp. 37–48.
- <sup>46</sup> QCSC, op cit.
- <sup>47</sup> *John Oxley Youth Detention Centre Programs Catalogue*, 1998/99.
- <sup>48</sup> Memorandum of Understanding regarding the service interface between the Department of Education and the Queensland Corrective Services Commission, August 1996.
- <sup>49</sup> Ibid.
- <sup>50</sup> DFYCC, op cit.
- <sup>51</sup> DFYCC, op cit.
- <sup>52</sup> Interview with Education Queensland, 1998.
- <sup>53</sup> A survey of 49 case plans for detainees entering and remaining at John Oxley between 1 September 1997 and April 1998 found that almost every detainee had either identified that they had drug and alcohol issues or the caseworker had identified that they need assistance in this area. Many detainees relate their offending to periods of drinking or drug use, although they often fail to identify the connection. This must be seen as an area that requires more systemic program development (*John Oxley Youth Detention Centre Programs Catalogue*, op cit).

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<sup>54</sup> AJJA, op cit., Standard 1.1 'Abuse-Free Environment'.

<sup>55</sup> The forthcoming AJJA conference is to consider the appropriate assessment mechanism to determine if State juvenile detention centres comply with endorsed standards. It may well result in inspection teams being formed to periodically review the performance of each State against agreed indicators. It is doubtful, however, that the frequency of such assessments would remedy the urgent need for regular inspections of Queensland's juvenile detention centres.

<sup>56</sup> ss. 215(2) and (3) op cit.

<sup>57</sup> S. 215(5), op cit. The detainee does not have to be advised of the outcome of a complaint, although Rule 76 of the UN Rules (op cit) requires that the detainee be informed of the response to any complaint or request without delay.

<sup>58</sup> S. 215(4) of the *Juvenile Justice Act 1992*, op cit.

<sup>59</sup> AJJA 1998, *Draft Service Standards*, op cit. Standard 1.7 'Complaints and Grievances'.

<sup>60</sup> DFYCC, *Detention Centre Practice Manual*, procedure 5.9: 'Investigation of incidents/complaints', and procedure 1.8: 'Role of Official Visitors'.

<sup>61</sup> These are indicators of compliance with the AJJA's draft national standard 1.7. Some details are set out in procedure 5.9 'Investigation of incidents/complaints' for complaints alleging staff misconduct.

<sup>62</sup> Memorandum from Acting Divisional Head, Protective Services and Juvenile Justice, 29 April 1994.

<sup>63</sup> Some have questioned the independence of Official Visitors. Although initially appointed by the relevant Minister, since the transfer of responsibility to QCSC and QCORR, Official Visitors have had to report to, and been supported by, the Audit section of QCSC. It was felt they needed to report directly to the Minister to be truly 'independent'. [Written before the transfer back to DFYCC in December 1998]

<sup>64</sup> Recommendation 268 of the Australian Law Reform Commission and Human Rights and Equal Opportunity Commission joint report, *Seen and Heard: Priority for Children in the Legal Process*, Report 84, supports fortnightly visits by Official Visitors.

<sup>65</sup> Issued 26 July 1995. This was largely incorporated into John Oxley Youth Detention Centre's *First Officer Response Procedure, Code 2*, issued 23 July 1998. The procedures do not fully recognise the needs of all young people to have independent support in the process, to seek legal advice, to be consulted prior to any medical examinations and interviews, and to be protected from reprisal (not only from the officer who is the subject of the complaint).

<sup>66</sup> NSW Child Protection Council, *Systems Abuse: Problems and Solutions*, 1994.

<sup>67</sup> DFYCC Commentary, op cit.

<sup>68</sup> DFYCC, Submission to Inquiry.

<sup>69</sup> DFYCC Commentary, op cit.

<sup>70</sup> DFYCC Commentary, op cit.

## CHAPTER 10: INDIGENOUS VIEWS ON JUVENILE DETENTION CENTRES

### 10.1 INTRODUCTION

Indigenous young people are grossly over-represented in the juvenile justice system. Although only four per cent of young people in Queensland aged 12–25 years are of indigenous origin (ABS 1998), 57 per cent of current detainees in the three juvenile detention centres (John Oxley, Sir Leslie Wilson and Cleveland) are indigenous. Recognising the special nature of this group, the Inquiry commissioned research to examine the experiences of indigenous young people in detention.

Interviews were held with several groups of people: indigenous young people who had been detained in a juvenile detention centre at some time in the past five years; service providers and members of the community who have extensive contact with indigenous young people during detention or after release; and family members of indigenous young people who have been or are in detention centres. In all there were 27 interviews with service providers and other community members, one focus group discussion, three interviews with family members and 10 interviews with recently released detainees (all male). Interviews were conducted in Brisbane, Logan, Ipswich, Cherbourg and Townsville. It should be noted that the views expressed in this chapter are those of the interviewees, and do not constitute findings of this Inquiry.

### 10.2 PRECIPITATING FACTORS LEADING TO DETENTION

All of the recent detainees said that they were first committed to detention centres for property offences. Three young people mentioned that they stole in order to finance illicit drug habits. A number alleged that police harass black youth, especially if those involved had already been in trouble with the police. A counsellor explained:

*They've [the police] got nicknames for the charges they slap on them, young Murris—assault, resisting arrest, obstructing police. That's how common they are. I think we get charged more than anyone else. That's a fact. And drunk in public and all that sort of stuff. No one else gets those charges. Usually Murris—Murris and poor white fellows.*

Petty charges accumulate in this fashion and the young person is eventually detained because he or she has breached court orders.

### 10.3 EXPERIENCES IN DETENTION

#### Detainees' relationships

The experiences of detainees were thought to be influenced by peers more than by staff. Several interviewees thought that indigenous youth were better able to adjust to life in detention than non-indigenous people, who were less likely to know other detainees:

*Some of them enjoyed it if their mates were in there if they were from their local areas. If there are mates in there from Cherbourg or a family from Cherbourg, they find it easy to settle in the place.*

However, tensions can exist between groups—whether based on racial or local allegiances—that can erupt into violence, making detention centres often dangerous places. Groups have the power to victimise 'outsiders' not protected by another group. Two recent detainees, one parent and three service providers reported that younger or smaller detainees were commonly victims, as well as those regarded as 'dogs' (detainees alleged to have reported the behaviour of their peers to staff). Punishment in the form of beatings was considered inevitable.

A number of service providers linked a detainee's attempted suicide to victimisation by older boys:

*I have only heard of it [older boys standing over younger boys] in one centre but these boys are moving from one centre to another anyway so it could have been happening wherever they were before. It is usually with the younger boys, and one young boy tried to kill himself over it because they put him back with the other bloke because they didn't know what was going on.*

Tensions arise from cultural differences among detainees—between those who live in cities and towns and those from remote communities with more distinct language and culture. The latter are rarely able to befriend urban young people. If they are without the support of a group from their community (which is very likely if they have been transferred to a Brisbane centre), then loneliness and victimisation are almost inevitable:

*The other thing, too, is that it is hard because you get, like, Murri people coming down from up north, you have got Murris down here, you know it is two completely different cultures ... they fight all the time because they don't understand each other's culture. The ones down here are more urbanised, you know, and then you've got the ones coming down from the north, and they've got their culture, and they think what they do is right, and the ones down here say no. So it's pretty hard in that way ... You know, we say it, we keep telling them all the time, don't send these kids down here. They say no, they can't help it because Cleveland is full, up there. You have to fight every time that you're going to send someone down.*

It was of concern that some witnesses believed that indigenous young people considered being sent to a detention centre as a positive experience, choosing to interpret this as a 'rite of passage'. It is important to challenge this view because it may be prejudicial to indigenous young people; for example, the bravado connected to male 'rites of passage' may be interpreted as a show of eagerness to spend time in detention, where 'positive experiences' can be shared with friends. According to the West Queensland Aboriginal and Torres Strait Islanders Corporation for Legal Aid<sup>1</sup>, indigenous young people are commonly very distressed at the prospect of losing their liberty, and ask for assistance to avoid detention.

### **Racial and cultural issues**

The issue of racism was a common theme throughout the interviews. It was claimed that staff used racist taunts when dealing with indigenous youth—for example 'You little black dog'. Detainees stayed within racial or ethnic groups and, as previously stated, fighting and tension between groups are common:

*Yes, that goes on all the time. They seem to have their black corner and their white corner, so a lot of them, they just stick together because they're in their mobs or something and they know what group to go with.*

Clashes between Tongan or Samoan detainees and Aboriginal detainees were said to be particularly common, and relationships between Polynesian staff and Aboriginal detainees were also thought to be problematic.

Cultural issues specific to indigenous people were also a common theme. Some concerns related to the cultural diversity within indigenous people; for example language barriers experienced by Torres Strait Islander and Aboriginal young people from remote communities resulted in their isolation. Mixing urban and traditional indigenous young people sometimes created problems, particularly in relation to spiritual beliefs and practices. Furthermore, staff were frequently incapable of accurately interpreting behaviour that stemmed from a cultural basis. Several interviewees mentioned that, for indigenous detainees, Sir Leslie Wilson was especially frightening:

*Well, my biggest concern is that Sir Leslie Wilson. It is not a culturally appropriate style of building. A lot of people have died in there, and it freaks the young indigenous people out, you know. These dead spirits singing out for help and that, you know, and the kids are singing out for help in the middle of the night, and the screws come along, say 'Shut up, and just go to sleep', and they don't realise that our people see things like that.*

Staff were also seen to further contribute to these problems by using the cultural beliefs of indigenous detainees to taunt them:

*Another thing was that some staff play jokes at times and put feathers near the kids' doors and the kids just freak right out ... and a big thing was that the staff used to say 'Oh yes, but these kids are not traditional'. How would they know that? It is totally wrong, because a lot of these urban kids have been brought up with culture and whether they live here or Alice Springs, they're all Aboriginal people and they all have these things. That insensitivity sometimes leads to bigger issues.*

A further source of tension related to detainees being given leave to attend funerals. There were reports of detainees not being informed of deaths within the family, and of staff not carrying out the appropriate procedures to allow them to attend funerals. Given the high adult mortality rates of indigenous people, this is a common occurrence. One young person told how he was not permitted to attend the funeral of his brother, who had committed suicide in custody:

*Yes, but most of the time they don't tell you. That's why I didn't go to my brother's funeral—because I was locked up. And I told them, I can't do nothing about it, I have to go out today. That's another thing that makes me schizo, is that they're trying to run your life and you gotta see your brother before he gets buried, six feet under you know, full on. That's pretty bad—I didn't even see my own brother fuckin' get buried. That is dirty. It made me mad, I just wanted to go berserk and kill them all.*

A number of service providers also expressed concern over the fact that detainees were allowed to attend funerals only of immediate family members; they were prevented from attending funerals of extended family, as well as other people within the community with whom they have close links. A hostel worker explained his frustration when discussing this with staff at a centre:

*They couldn't understand why. Like I talked about a little bit before, why other kids wanted to go to a funeral, you know, outside the immediate family, and they couldn't understand why. And one of the things we used to say to them, it's culturally that everybody, if you are related or not, it is just respect for the deceased and the family.*

In addition, it was reported that detainees had to be handcuffed when attending funerals, and there also had to be an escort and police dogs. The latter is considered necessary because of the limited number of escorts available, and the possibility that detainees may attempt to escape. Many service providers expressed concern about the inappropriateness of handcuffs and police dogs at funerals. Examples were also given of detainees who were acting as pallbearers still being required to wear handcuffs.

## **Mental, physical and social well-being**

### *Self-harm*

None of the detainees interviewed admitted to harming themselves, but half had seen or heard of other detainees deliberately harming themselves. This was believed to be a regular occurrence:

*Q: Alright, did you see anybody else in there that tried to hurt themselves? Did anyone try to injure themselves?*

*A: Yes, slicing them fuckin' self up and that, trying to kill themselves.*

*Q: Where would that take place? Where was that mostly happening?*

*A: John Oxley, Westbrook, there a fellow was trying to—every day people are trying to slice themselves up ... yes, when I was first in John Oxley, I woke up at 2 am in the morning, and they were taking photos, taking photos of the wall, and there was all blood just covered the whole wall from the top to the bottom. And there was a girl in the room, just straight across from me, you know we had rooms straight across from each other ... and she was in there for murder, and she used to slice herself up all the time there.*

### *Sexual behaviour and abuse*

Eighteen interviewees mentioned the issue of sexual activity in detention centres. The most common context was that of older male detainees 'standing over' or demanding sexual favours from younger male detainees. A custodial worker gave a typical description:

*Obviously, there are stand-over tactics in there, where older boys who have been in there for a longer period of time and are more comfortable with the system, stand over the younger fellows. It might be anything from standing over them and taking their drinks from them or standing over them for shoes, or it might be anything from that to, I suppose, standing over them for sexual things. I mean, even though nobody openly admits to that and nobody actually ever wants to talk about that, I suppose you generally know it goes on. The official stance on that is that there has been no evidence to support that, but just talking to the young fellows through friend of a friend who knows, who told them 'So-and-so has been standing over so-and-so for this and that'. That causes problems in the detention centres too, where it can split the boys into groups.*

Parents expressed great concern about what happened to their children inside the centres:

*I am a bit worried because recently there were a couple of rapes on little fellas in the boys' yard. Those big boys have been raping the little ones. I am worried because he is half the size of a 17-year-old. He had a drug problem and he is too little. If he gives cheek he will have no hope. He will be a victim and I'm worried.*

Several of the recent detainees discussed instances of sexual abuse as part of the problem of older boys intimidating younger, smaller ones. Service providers who had heard from young people about sexual abuse by other detainees believed that centre authorities were unwilling to acknowledge its existence:

- A: Like in six months, when I first heard about it, in six months, I had about five young Murri fellows being raped in there, and that was only in six months.*  
*Q: Were they all by other detainees?*  
*A: Yes, yes. This is at John Oxley.*  
*Q: So are the staff aware of these things happening? Do they know about it?*  
*A: Yes. When you speak to the Department, whoever is in charge—like at the moment it is Corrective Services, but pretty soon it will be Family Services, and I've been involved with Family Services, when they were involved first up. And you know, we brought up the issue of sexual abuse in there, and they said 'No, it doesn't happen'. Three or four times, I would go into Sir Leslie Wilson, and John Oxley, to talk to the kids who have been sexually abused and it is like, and these are boys, there are not too many girls that I've seen since I've been working. That is pretty bad on boys, but when you go and mention it to the authorities 'No, this doesn't happen'—officially they say no! But you know I go in there and they talk about, I reckon they know about it. But as soon as you mention it to authorities they say 'No, no—nothing like that happens in here'. Then you've got a kid that can't sit down for a couple of days, or doesn't want to come out of his room or whatever. It happens.*

A number of service providers, all with extensive experience, explained that detainees perpetrating sexual abuse were able to evade the guards' attention by having one person stand watch to alert others:

- Q: So they pretty much know?*  
*A: Oh everybody knows what's happening. You know with the young kids, when I used to go in there they used to tell me everything, you know. This one here is being raped by that fellow, and—you know ...*  
*Q: What, they would see it or someone saw them do it?*  
*A: Some of them have seen it, some of them block the doorways so they are the watch out. Because these fellows are pretty big and they say, if you don't watch out for them, you will be the next one.*



*Photograph 10.1: ‘And you know, we brought up the issue of sexual abuse in there, and they said “No, it doesn’t happen”’—Inquiry photograph*

### *Illicit drugs*

A number of interviewees spoke of illicit drug use in the centres. A mental health worker suggested that staff regularly confuse drug-related problems with mental health or behavioural problems:

*There’s someone called in just about every day of the week. Every time a new client would go in there, new resident as they call them, we were called over there to find out why they’re screaming and why they are playing up and why they are doing this. We would go in there and say ‘Who knows? They’re going into withdrawals, they’re going cold turkey’. ‘Oh no, they can’t do that, they’re too young.’ But it is happening, they are going cold turkey, that’s why they’re talking really loud, and that’s why they are running around silly and doing stupid things. Sometimes a young kid, they’re using \$300, \$400 a day just on speed, and when he goes in there, and they know—they’ve got this thing where they give them Valium and stuff like that to de-tox them. But they say after three weeks that it’s all out of the system. They’re still trying to figure out why this kid is still running around stupid. I said ‘He’s still going cold turkey’, and they said ‘No, officially it’s supposed to take them three weeks’. I said ‘Well it’s not taking three weeks’. I’ve seen people up to seven weeks, eight weeks, still going cold turkey.*

It was reported that there is a reluctance on the part of those in authority to discuss non-prescribed drug use within detention centres, an illegal activity. This may explain why providing appropriate remedial services is so problematic. It may also explain why most of the recent detainees said that those they knew with drug-related problems did not seek help from a counsellor or health worker. The same mental health worker claimed his hands were tied:

*You know, I work in there, man, and you should see the drugs ... All you can say is that it’s bad for you, that’s all you can do, because if we say that we’re going to belt your head, we are dogs and we can’t get anywhere, you know. But if the child is suicidal or stuff like that we will just go ... and say this kid is suicidal. But if they’re using drugs, you can’t say too much because then that affects us.*

Staff share this reluctance to openly discuss illicit drug use. As a result of the attitude of the authorities, there are no educational programs about safe drug use nor any provision for clean equipment.

### *Mental health services*

Staff and service providers were very concerned about the inadequacy of mental health services in centres. Mental health problems can arise from loneliness and isolation,

unresolved grief and loss and experience of physical, sexual or mental abuse. As one youth counsellor explained:

*They just don't have the skills. The kids have got problems and they just can't deal with them in there. Like when they start going off, they lock them up and there is nothing else done to address what is really going on. So that is always a concern for me as well. There is no sort of link. They don't make any links between the bigger issue and what's going on in the centres. The bigger issues in these kids' lives ... All these kids have got parents that are dead, have got no major role models, have been in foster homes and been sexually abused, physically abused, tried to commit suicide, have got drug problems. And all these kids have got the same problems so obviously they should get programs that address these things as well ... while they're locked up they should have better programs in there for them, helping them to deal with what's inside them. Then you can link it all to reasons why they are offending and stuff like that. But they can't just isolate it and just say you are offending like this because you are this sort of a person. That's the sort of thing that seems to go on—goes back on the individual. It's bigger than that—it's not just one person all the time.*

Service providers gave examples that demonstrated the lack of staff training in identifying and address underlying mental illnesses or problems in detainees. As a consequence, detainees considered to be misbehaving are placed in the detention unit, in isolation or in lock-down to 'settle down'. As previously noted, this practice often causes greater problems. It is particularly disturbing that young people on 'suicide watch' are also put in lock-down. Just as it is physically and technologically impossible to monitor behaviour between detainees, it is impossible to monitor constantly a young person alone in a cell for up to 22 hours a day.

### **Staffing issues**

Although there were few favourable reports of caseworkers or Aboriginal Liaison Officers, examples were given of detainees who had established good relationships with caseworkers and maintained contact after release. In general, the most positive comment from detainees about caseworkers was a grudging 'They're alright'.

More commonly, service providers complained about caseworkers not making themselves available to detainees—despite formal requests for visits—and difficulties in communicating effectively with them.

There were numerous complaints from detainees of harassment by staff, which sometimes brought about disruptive bad behaviour. Harsh physical treatment by staff towards detainees was reported by 11 of the 27 service providers and four of the 10 detainees. Such incidents included threats or 'bashings' in the following circumstances:

- while or before detainees were put into isolation cells or locked down in their own rooms
- as a result of detainees not following instructions
- to elicit information about other detainees
- to discourage detainees reporting actions by staff.

Overall, the interviews conveyed a conviction that harsh treatment by staff was inevitable. Few of the interviewees were surprised by behaviour they had seen or heard about. However, the difficulty of dealing with young people in detention centres was widely recognised:

*... I would say that some of the workers, probably through the stress and dealing with the kids on a one-to-one basis, or dealing with the kids constantly ... where there have been workers who have let their emotions get the better of them—definitely.*

Some of the service providers said that the centres seemed to weed out the most violent staff, but there was often a delay before centres could remove them, possibly because staff were reluctant to report the actions of their colleagues. More commonly peer pressure was used—



by staff isolating colleagues who were seen to be too rough—until they felt pressured to move on.

Service providers and some detainees acknowledged that having Aboriginal workers in the centres, particularly in the role of custodial staff, was beneficial. A former centre worker stated:

*Well, put it this way. It is a lot better than it used to be up at Westbrook and those places ... in Wilson—I couldn't say of John Oxley or the others—they have Aboriginal supervisors now. When I first started there they only had one. They had one senior. They had one worker and she was there for so long that they promoted her to a senior. But now they've got a couple of them there in each detention centre, so it has evened out. About 50 per cent are of Aboriginal descent.*

### **Work practices**

During the course of the interviews staff raised the following work-related issues:

- It was felt there was a lack of career path, especially for indigenous employees.
- There was confusion through attempting to be both an advocate for young people and, at the same time, being responsible for discipline. Indigenous employees felt their behaviour was especially vulnerable to criticism from the community.
- Although indigenous supervisors have the responsibility for taking grievances from indigenous staff and detainees to management, they felt they had no real authority.

These concerns echo the well-documented problems of indigenous workers in mainstream organisations. As the Royal Commission into Aboriginal Deaths in Custody and other studies have found, staff in liaison roles face unrealistic expectations from both community and management to 'work miracles' where other people have failed. Frequently, workers are not supported through appropriate pre- and in-service training, and lack clearly defined career development plans.

### **Procedural issues**

#### *Punishment*

'Lock-down' was the most frequently mentioned form of punishment, and could range from detainees being locked in their own rooms to being placed in a special cell. Young people were sometimes stripped before being locked down, and trips to the toilet were claimed to be at the discretion of staff. Being denied permission to go to the toilet was commonly mentioned as a reason for detainees in lock-down to engage in even more unruly or punishable behaviour. In some centres, the remand area is used for lock-down, or as an additional means of isolating the detainee:

*Yes, lock-down. The one at Leslie Wilson ... it is very de-humanising, you would not put your animals in it, basically. It is a very small room, with a wooden bed. Mattress, blankets and pillows are taken out during the day. It's cement, it's very cold, dark, and lights are operated from the outside.*

The recent detainees, while not particularly expressive on most topics, made it clear that they hated lock-down:

*When they put you in the room, with fuckin' nothing there ... I feel like killing myself, really, straight out.*



**Photograph 10.2: Sir Leslie Wilson Youth Detention Centre isolation room in lower remand—no furniture and bedding only at night—Inquiry photograph**

Punishments meted out are often inconsistent with the behaviour, at least in the eyes of those detainees and service providers interviewed. Recent detainees told of trying to be good but never getting the points ('greens') needed to gain extra privileges.

### *Schooling*

There were a number of positive reports about the commitment of teachers and the effectiveness of educational experiences provided. The biggest problem appeared to be that schooling reached a fairly limited group. Detainees over 15 years of age are not required to attend, and it appears that no pressure is put on them to do so. Indeed, 15-year-old detainees may not have even been given the option. A further shortcoming identified by interviewees was that school timetables conform to the mainstream school calendar, so that no classes are held between December and February—a long time for young people with no other meaningful way to keep themselves occupied, and a lost opportunity for young people detained for only a short while.

### *Other activities*

These are largely dependent on the physical resources available at individual centres. Sir Leslie Wilson was the source of a number of complaints as it has only a small asphalt yard, and injuries during football and basketball games are frequent. Crafts such as wood and sheet metal work, leatherwork and sewing are available and were mentioned by several detainees as favourite activities. However, these activities were also not usually available during the long summer holiday period. Some service providers criticised the lack of imagination in extracurricular activities and the failure to provide many activities that either stimulated the mind or helped young people deal with the issues facing them on release. Outside services, on the other hand, which centre staff often relied upon to provide new educational experiences or activities, were not dependable. A youth counsellor stated that promised activities sometimes never materialised, and that there were few activities providing trade skills.

Whatever the reasons, for many detainees the days were long, unstructured and boring. As one recent detainee stated, this was likely to invite unrest:

*Yes it was alright, but there was hardly enough to keep you going through the day. Like after the day at 3 o'clock there is nothing—we just all sit in front of the TV. That's why people get into fights and get into the screws all the time. 6 o'clock, 8 o'clock to bed.*

### *Visits*

A specific complaint made by indigenous detainees was that they were prevented from seeing siblings. One young man was not permitted to see his sister because she had a criminal record; however, he thought it unreasonable that he could not see her baby. Another young man said that he was not allowed to see his brothers: 'Only like your mother, missus, daughter, you can't have no one else'.

Parents of detainees had a number of specific grievances. They resented rule changes governing visits that seemed to them arbitrary and capricious. Examples of unannounced procedural changes included no longer being able to visit nephews in custody while on a visit to a son; being prohibited from bringing 'chips and lollies, and Tim Tams and Coke and everything'; and being told that one was no longer 'on the list' to be permitted to talk to a son over the phone. In addition, all three family members interviewed said that arranging transport to the centres was difficult, and two suggested that the centres should arrange transport for them. Detainees are also family members, and parents and partners found it difficult being unable to contact them to discuss important family issues.

Although centre staff try to contact parents and local indigenous community services if a young person appears depressed or is 'playing up', often there are valid reasons why parents cannot respond, even when offered assistance with travel. Parents living outside the Brisbane area have a particularly difficult time, not only because of the need to arrange transport and accommodation but also because there are invariably other children who need to be looked after.

There are some community initiatives that attempt to overcome the isolation experienced by some detainees. In Cherbourg, about a 4-hour drive from Brisbane, transport is regularly arranged for family and other community members to visit detainees. The community group also makes an effort to visit detainees from other, more remote communities. Similarly, a group of elders has regular visits, including meals, with detainees.

Some service providers visit detainees, especially those from remoter areas of north Queensland, and they believe that such visits are invaluable in alerting staff to detainees' problems that might otherwise go undetected. They gave several examples of timely interventions. Nevertheless, it is difficult to determine how much benefit detainees gain from occasional visits from service providers and community members whom they do not know.

## **The effects of detention**

### *General*

The 1994 National Aboriginal and Torres Strait Islander Survey did not ask directly about experience in juvenile detention centres. However, it did reveal that nationally 13 per cent of indigenous youth aged 13–19 years reported being harassed by the police in the previous 12 months, and that three per cent of 13–14 year olds and 25 per cent of 15–24 year olds had been arrested in the previous five years (ABS 1995). A recent study of indigenous young people in Brisbane aged 13–17 years revealed that nine per cent had already been in detention centres, and 32 per cent reported being harassed by police 'for no good reason' (Larson et al. 1997).

### *The individual*

An overwhelming number of service providers and family members were of the opinion that detention centres serve to create more hardened and effective criminals. It was believed that exposure to all levels of criminal behaviour enabled young people to ‘learn new tricks’:

*I think it hardens them. I think they come out—well, if they weren’t angry before they are going to come out [angry]—particularly if they have any bad experiences. What tool do they have ... to express the anger through, except to do what they did which got them there in the first place?*

Many young people also admitted that it was an opportunity to learn how to carry out ‘better and smarter’ crimes. Other effects reported by service providers and families included the young person’s loss of self-esteem and life skills. Of the 10 recent detainees, only one was employed (on ‘Work for the Dole’ for two days a week).

Service providers expressed strong concern that for some detainees there is quite an unhealthy dependency on detention centres:

*Some of them seem to like it because they have somewhere to sleep every night and food. And while they hate it when they get out, they kind of miss that routine. So that’s why they keep going back, because they don’t have that outside.*

A number of interviewees spoke about the institutionalisation of indigenous detainees, and the seeming normality of it all:

*From what I see, if they’re in there for long term, this is a condition and they get used to jail time. That’s the only thing that it is doing for them. Gets them being used to being locked up, used to the system, used to saying yes, no ... used to being behind the four walls. So that when they get older, they just slot straight into the system and just keep going. Most of the guys in the big jails have all done their time in juvenile detention centres and they know the system inside out. That’s all these detention centres are doing.*

*I know when I worked in detention, you know, you would see kids go out for a few months and then they would come and they were so glad to see the staff again because, you know, they cared about them I suppose. Do you know that type of thing? It is really horrendous when you think about it.*

### *The family*

The separation of children from their families was, understandably, thought to cause many problems, most obviously that they were deeply missed. However, this was not only in the emotional sense. Many detainees, especially the older ones, have family obligations. One recent detainee had a partner and a 2-year-old child. Other young people make significant contributions to their families that are often unrecognised.

In addition, there are problems stemming from the influence that offending behaviour and detention has on younger, impressionable siblings:

*... the majority of the time, it’s the eldest one gets into trouble or the second eldest one, and then the younger ones are thinking ‘I’m going to be like my brother or sister’, you know, ‘I’m going to follow their footsteps’. And I’ve seen it inside there, you know, in Sir Leslie Wilson there. One year you’ve got one lot of kids going through, and then the next year, ‘No, that was my sister last time, or my brother last time’, and I have seen a whole family in there, you know, all four of them. All in at one time but different cases—but all in there at the same time.*

The pressures on parents of having a child who regularly offends, especially those dependent on drugs, can be immense. Stories were told of families broken apart by arguments about how to deal with offending behaviour. Family members are often the first victims of stealing, and one service provider noted that once the police have labelled one family member an offender, others are targeted for police attention.

**Extract from the submission of a Moreton inmate**

I am a 42-year-old Aboriginal man. I was made a Ward of the State in 1964 and sent to an orphanage in central Queensland. My earliest memories of being there are clouded and full of sadness because I could not understand or speak English very well. I remember suffering constant racial ridicule and floggings.

The physical abuse I endured while there was executed with bull whips and various other instruments, administered by orphanage staff. Until I could comprehend what was required of me, I endured daily humiliation in front of all the children. This humiliation was also meted out to other children who were considered backward or different.

Because of the duress placed upon myself and other children, there were reactions of bed-wetting, tantrums and occasional swear words. For these we were made to punch brick walls. If it was deemed the punch wasn't hard enough, your arm was grabbed and you were given assistance. We were also made to eat soap, go without food or placed in solitary confinement in a cupboard or darkened room. I was sexually abused over a period of time there and I know of others who were as well.

I was deprived of any contact with my mother and other family members who were not placed there, and told they wanted nothing to do with me. I hated my mother for this, until I learned years later that it was not true. My mother loved me, as only a mother can, and made numerous attempts to contact and see me.

I've also learned since, from reliable powers, that segregation of half-caste children from their natural parents and cultural ways was a government and clerical policy. I do not know if you are aware or have knowledge of this.

I endured strenuous religious indoctrination from the time I arrived there, only to find the way they treated me and the other children made me ask that if there is a God, how could He let them do the things they did in His name?

Because of the instability of basic human qualities such as love, trust, understanding, and forgiveness, I have not been able to maintain lasting relationships or complete just about anything I start, to achieve a better life for myself. I've had psychiatric treatment and counselling for many years; I've attempted suicide on several occasions, and resorted to the use and abuse of alcohol and drugs to drown my ignorance and immaturity. I've lost control of my own personal morals and established ethics, and done completely stupid things—bringing me in contact with the police throughout my life.

Well, as you can see I didn't have a very strong foundation on which to build my life and it's been pretty much in disarray ever since.

I see much injustice in life's various social structures, injustices dished out by people of seemingly irrefutable reputations and qualifications. I don't trust any of them.

So it is with God's love that I wish strength for you to finally bring some justice to us children from this orphanage and help us to finally begin to heal the damage of the past and come to know the full potential of ourselves as whole, healthy, happy human beings.

**10.4 CONCLUSION**

This chapter provides some insight into the experience of young indigenous people in detention centres today. It further confirms some of the shortcomings of detention centres as outlined in Chapter 9, and points to a number of areas of concern to indigenous young people.

**ENDNOTE**

<sup>1</sup> Letter from West Queensland Aboriginal and Torres Strait Islanders Corporation for Legal Aid, 26 March 1999.

## **CHAPTER 11: EVALUATION OF CURRENT LEGISLATION AND DEPARTMENTAL PRACTICE**

### **11.1 INTRODUCTION**

The factors operating at the individual, institutional, departmental, governmental and societal levels which result in institutional child abuse were explored in Chapter 2. Key factors in relation to the performance of the Department of Families, Youth and Community Care (DFYCC) include its structure, resource allocation, policies, practices and procedures in relation to licensing and service agreements, placement strategies, monitoring of institutions, human resource practices, complaints mechanisms and reporting of abuse, accountability mechanisms and quality assurance. All of these areas need to have a sound basis in legislation in order to be effective in protecting children in institutional care from harm.

This chapter looks at whether the policies, procedures and practices of DFYCC are sufficiently comprehensive and contain adequate provision to protect children in institutional care. It reviews the relevant legislation, documentation provided to the Inquiry on departmental policies, procedures and practice, and a sample of residential care facilities currently licensed by the Department.

It is important to emphasise that the chapter does not constitute a detailed assessment of the quality or adequacy of departmental programs or services.

### **11.2 APPROACH**

The review of documentation was performed primarily on the basis of material provided by DFYCC to the Inquiry in departmental submissions, in departmental commentaries on issues raised in hearings, in correspondence and in response to specific requests made of the Department by the Inquiry. This information was supplemented by submissions made to the Inquiry by other parties.

A review of a sample of residential care services was commissioned to examine current practice in residential care in Queensland in order to determine the extent to which children and young people are placed at risk of abuse in these settings. This review focused on three broad areas: environment and accommodation, internal management of services, and resident interaction with the community. A sample of non-government facilities was selected to provide a range of service types, resident ages, auspices, target populations and locations (metropolitan and rural/remote). These sample sites were inspected to assess the safety of children and young people at the sites, the extent to which agencies comply with legal requirements, and the extent to which children and young people are exposed to the risk of abuse and neglect when placed in residential care. Specific findings about each establishment were provided separately to the services concerned and DFYCC.

### **11.3 REVIEW OF LEGISLATION**

The current legislative framework for children in institutions consists of three major pieces of legislation. The legislative base for the provision of residential care services for children and young people is provided by the *Children's Services Act 1965 (CSA 1965)*. This legislation will be superseded by the *Child Protection Act 1999 (CPA 1999)*, which was assented to on 30 March 1999 but has not yet been proclaimed. The provisions of these Acts are supplemented by those of the *Children's Commissioner and Children's Services Appeals Tribunal Act 1996 (CCCTA 1996)*, which was established to monitor and review children's services, including residential care services. For detention centres for young people, the legislative base is provided by the *Juvenile Justice Act 1992 (JJA 1992)*.

As well as these Acts, there are also a number of more general legislative provisions that apply to the operations of DFYCC and the activities of departmental staff. In the context of preventing and investigating misconduct by staff in institutional care settings, the most important provisions are contained in the following:

- *Public Service Act 1996 (PSA 1996)*, which addresses recruitment and selection and disciplinary processes, as well as work performance and personal conduct requirements for public service employees
- *Public Sector Ethics Act 1994 (PSEA 1994)*, which sets out departmental codes of conduct
- *Criminal Justice Act 1989 (CJA 1989)*, which empowers the Criminal Justice Commission (CJC) to investigate any official misconduct by departmental officers.

## **Residential care**

### *Licensing*

Part IV of the *CSA 1965* currently provides for the statutory regulation of residential care services operated either by government or non-government organisations. Section 31 of the Act authorises the Minister to license an organisation or individual and approve an institution for the ‘care, protection, education, treatment, training, control or welfare of children’. Section 34 places a responsibility on the Director-General to ‘supervise the standard attained by each licensed institution in achieving the purposes for which it exists’. Section 40 specifies the obligations of the person in charge of the institution. Section 40(e) requires the licensee, in relation to any child placed in the institution, to ‘do, observe and carry out all the acts, requirements and directions prescribed by this Act or by any order of the [Director-General] in relation to the institution and care of such child’. The special responsibility of the Director-General for children in care is specified by sections 58 and 65 which require the utilisation of the ‘powers and resources of the department so as to further the best interest of the child’. This Act makes no specific provision for practice standards for residential care.

Licensing requirements for residential care services specified by the *CPA 1999* recognise the need for each care service to satisfy the chief executive that the standard of care for the service complies with the standards of care specified by the Act, and that the applicant and persons responsible for managing the service are suitable persons (section 127). The legislation permits the chief executive to make enquiries about the suitability of persons engaged in the care of children in a licensed care service, including those relating to criminal, domestic violence and traffic histories (section 143). Section 136 limits the duration of licences to three years, with any application for renewal of the licence subject to the same provisions as are required for the original grant of the licence.

### *Recruitment and selection requirements for caregivers in out-of-home care*

The *CSA 1965* provides that the governing authority of a licensed service is to have ‘control of the appointment of all persons employed at such institution’ (section 33(1)).

In considering an application for a licence for a care service, the *CPA 1999* requires not only that the chief executive must be satisfied that the persons ‘responsible for directly managing the service are suitable persons’ but also that ‘methods for the selection, training and management of people engaged in providing the services are suitable’ (section 127).

The *PSA 1996* contains provisions addressing recruitment and selection processes for public service employees only (that is, employees in non-government organisations are excluded). Specifically, section 24 of the Act provides for fair and equitable recruitment, selection, general treatment, access to training and remuneration. Principle 24(a) addresses merit-based selection and section 78 specifies that any selection for appointment to a public service position is to be based on merit.

### *Monitoring, inspection and supervisory requirements*

The *CSA 1965* does not contain any requirements for supervisory visits to institutions by DFYCC, but section 81 includes a power to inspect and to issue orders relating to the premises.

The *CPA 1999* authorises visits and inspections of licensed institutions by authorised officers at any reasonable time (section 147(1)) but does not require these visits.

Part 4 of the *CCCTA 1996* provides for an Official Visitor program. Official Visitors are appointed by the Children's Commissioner. Their functions include 'inspecting residential facilities to find out whether the facilities provide an appropriate standard of care for residents' (section 35). Official Visitors are required to provide the Commissioner with advice and reports relating to the conduct of the facility (section 36). However, no requirement is made in this Act for inspections to be conducted at regular or specified intervals.

There are currently no legislative provisions requiring periodic inspections, monitoring or evaluation of services as a condition of obtaining or renewing a licence.

#### *Independent research and evaluation of programs*

The *CPA 1999* includes among the functions of the chief executive those of 'collecting and publishing, or helping collect and publish, information and statistics about harm to children' and 'promoting research into the causes and effect of harm to children' (sections 7(p) and (q)). The functions of the Children's Commissioner include those of 'inquiring into any matter relating to children's services' (at the request of the Minister) and 'conducting research and inquiring into matters relating to any of the Commissioner's other functions'. These include 'monitoring and reviewing, in collaboration with entities that deliver children's services, the provision of the services', as well as 'monitoring, in cooperation with other entities, the procedures developed and implemented by the entities for handling complaints about the delivery of children's services and alleged offences involving children' (*CCCTA 1996*, section 8).

There are currently no legislative provisions specifically requiring DFYCC to collect information regarding abuse in out-of-home and institutional care facilities.

#### *Reporting and investigating allegations of abuse*

There are no legislative provisions requiring the reporting of suspected child abuse except for those relating to medical practitioners and officers of the Family Court.

Section 123(2) of the *CPA 1999* prohibits 'corporal punishment or punishment that humiliates, frightens or threatens the child in a way that is likely to cause emotional harm'.

The *CPA 1999* requires the chief executive, upon becoming aware of 'alleged harm or risk of harm to a child', to 'have an authorised officer investigate the allegation and assess the child's need of protection or to take other appropriate action' (section 14(1)). Section 9 provides a sufficiently broad definition of 'harm' to a child to include institutional abuse, although this is not addressed specifically. The chief executive also has responsibility for 'establishing ways to coordinate the roles and responsibilities of service providers' to promote the 'protection of children and child protection services' and to 'investigate particular cases of harm' (section 157).

The CJC is empowered to investigate any complaints of child abuse that come to the notice of the Commission from any source, but the jurisdiction of the Commission is limited to government agencies and the conduct of public officials acting in their official capacity.

The Children's Commissioner is required to refer any complaint 'about an alleged offence involving a child' to the Police Commissioner or to any other entity on the advice of the Police Commissioner (*CCCTA 1996*, section 20).

#### *Protection for persons making allegations of abuse*

Section 144(1AA) of the *CSA 1965* protects any person 'engaged in work for the purposes of this Act' from any liability which might otherwise arise from disclosing information to the appropriate authorities for notification or investigation of child abuse matters. The *CPA 1999* protects any person acting honestly who notifies or gives information about alleged harm to a child from liability and from any breach of professional etiquette, ethics or standards of professional conduct (section 22). Further safeguards for notifiers are provided by sections 180, 181 and 182.



The *Whistleblowers Protection Act 1994 (WPA 1994)* is designed to protect persons from civil or criminal liability or from administrative processes that may arise from making public interest disclosures. The Act protects persons making public interest disclosures from reprisals by making any reprisal by a public officer a criminal offence. The Act renders the person taking such reprisal action liable to a civil claim for damages, and provides for injunctions to be sought against conduct that amounts to a reprisal.

The Act requires public sector entities to establish procedures to protect officers from reprisals by other officers, and makes provision for relocation of employees likely to be subject to reprisal.

The provisions of this legislation apply to any person or public officer making allegations relating to institutional abuse (sections 15 and 19) provided that these allegations are made to the appropriate authorities.

The *CJA 1989*, which applies to departmental facilities, staff and operations, also makes provision for the CJC to protect people giving evidence or providing information to the Commission (section 103).

### *Stability in placement and permanency planning*

The provisions of the *CSA 1965* and the *CPA 1999* do not specifically address the need for permanency planning, although the *CPA 1999* does recognise the right of the child to long-term alternative care if the child 'does not have a parent able and willing to give the child ongoing protection' (section 5). The Act allows the Children's Court to make a child protection order granting long-term guardianship of a child to a suitable family member, another suitable person or to the chief executive (sections 58 and 59).

Section 71 of the *CPA 1999* provides for a charter of rights for children who come under the guardianship of the chief executive. The Charter of Rights (Schedule 1 of the Act) includes a child's right 'to be provided with a safe and stable living environment' and 'to be placed in care that best meets the child's needs'. There is also the right to 'regular review of the child's care arrangements' (section 85). Section 86 permits the chief executive 'to remove the child from the care of the child's carer if the chief executive is satisfied it is in the child's best interests'.

If the child is placed in the care of an approved care provider, licensed care service or departmental care service, section 123 requires the chief executive to take reasonable steps to ensure that the child is cared for in accordance with the 'statement of standards'. These standards do not address the need for the child to experience stability or permanency.

### *Transition from care for young people*

The *CPA 1999* requires the chief executive to ensure that a child is provided with assistance in transition from care (section 72).

### *Child's right of complaint*

Although the *CPA 1999* (Schedule 2) summarises the child's right to appeal a range of decisions, it does not directly address the right to make a complaint. However, the *CCCTA 1996* provides that 'a person may make a complaint to the commissioner' (section 19). Official Visitors appointed by the Children's Commissioner also have the power to confer with residents of residential facilities (section 36).

### *Provision of advocacy services and information to children and young people*

Current legislation does not make specific provision for advocacy for children in residential care, except for provisions relating to Official Visitors.

The *CPA 1999* includes in the Charter of Rights (Schedule 1) the right to be provided with information, and sections of the Act requiring provision of information to interested parties also

require provision of information to a child. Of particular importance is section 189(4) which provides guidance on the detail required in information provided to a child.

## **Juvenile detention centres**

### *Operational requirements*

The *JJA 1992* places responsibility for the ‘security and management of detention centres and the safe custody and wellbeing of children detained in detention centres’ on the administering authority (section 203). Responsibilities include the provision of services to promote the health, wellbeing, and social, cultural and educational requirements of detainees, the maintenance of discipline and good order, and the security and management of the centres. The Juvenile Justice Regulations 1993 address issues relating to searches, telephone calls, isolation of detainees and the management of detainees’ behaviour.

Provisions of the *JJA 1992* relating to management of detention centres do not specifically address the required standards of behaviour for detention centre workers, but provisions of the *PSA 1996* and the *PSEA 1994*, which make behaviour subject to the departmental code of conduct, do apply to public service employees in detention centres.

### *Monitoring, inspection and supervisory requirements*

Although the *JJA 1992* makes no specific requirement for supervisory visits by the Department, it does make provision for visits at least once a month by Official Visitors (section 205). Official Visitors are appointed by the Minister, and may not be public servants, police officers, or officers, employees or persons engaged by the Corrective Services Commission (QCSC) (section 204).

Official Visitor functions are to be specified by the chief executive, and a report is required on each visit (section 205). Official Visitors are required to hear and investigate any complaints by a child or the parent of a detained child made or referred to them (section 216).

### *Recruitment and selection requirements for detention centre workers*

Workers in detention centres and other government institutions are subject to the provisions of the *PSA 1996* and recruitment and selection processes are required to be conducted in accordance with the provisions of this legislation and with the requirements of the *Equal Opportunity in Public Employment Act 1992* and the *Anti-Discrimination Act 1991*.

### *Reporting and investigating allegations of abuse*

There are no legislatively prescribed reporting provisions relating to suspected abuse of detainees in detention centres, except for those applying to medical practitioners. Although section 37 of the *CJA 1989* imposes an obligation to report complaints alleging official misconduct, this obligation is imposed only on the principal officer in a public sector organisation, not on other officers or staff members.

The CJC is empowered to investigate any complaints relating to official misconduct that come to its notice from any source, and it has the primary responsibility for investigating allegations relating to abuse of detainees by staff members in detention centres.

### *Protection rights for whistleblowers*

While the *JJA 1992* does not contain explicit protective provisions, persons employed in juvenile detention centres would be protected by the provisions of the *WPA 1994* and the *CJA 1989* as detailed above.

### *Child’s right of complaint*

Should a young person in detention wish to make a complaint, the *JJA 1992* provides a right for a child to ‘complain about any matter that affects the child’. The child may complain directly to an Official Visitor and be interviewed by the Official Visitor in relation to the complaint (sections 215,

217). Section 214 also provides for a legal practitioner representing the child to have access to the child, which would provide another avenue for the child to make a complaint. Any child in a detention centre or State-run residential institution also has a right of complaint to the Police Service.

#### *Advocacy services and provision of information to young people*

The provisions of the *JJA 1992* and Regulations do not address advocacy for children. While legal representation for children charged with offences is addressed, the legislation contains no provisions relating to the funding of these services.

Section 4 of the Act addresses the need for children to understand proceedings taken against them. This is further addressed in numerous sections of the Act that require information or notices to be given to children subject to the provisions of the Act.

### **11.4 DEFICIENCIES IN THE CURRENT LEGISLATION**

There are a number of important shortcomings in the current legislative provisions for care and protection of children in institutions. These are:

- There is no legislatively mandated reporting process for abusive incidents involving children and young people in residential care and in detention centres, even for persons employed by DFYCC.
- There are no legislative requirements for DFYCC to conduct regular supervisory or inspection visits to residential care facilities or to detention centres.
- There is no legislative requirement that the Department collect information relating to abuse of children and young people in out-of-home and institutional care.
- There is currently no legislative provision for advocacy services for young people in residential care or in detention centres.
- There is no provision in legislatively prescribed licensing requirements that residential care services be subject to regular review processes or evaluations, or for records of these processes to be considered in licensing decisions.

Recommendations that address these shortcomings are as follows:

#### **Recommendation**

That legislation be enacted to make mandatory the reporting of all abusive situations that come to the attention of departmental employees and persons employed in residential care facilities and juvenile detention centres.

#### **Recommendation**

That requirements for the Department to conduct regular inspection and monitoring of residential care facilities and juvenile detention centres be specified in legislation.

#### **Recommendation**

That the Department have a legislatively imposed responsibility to collect information relating to abuse of children and young people in residential care facilities and juvenile detention centres.

#### **Recommendation**

That the provision of advocacy services for young people in residential care facilities and juvenile detention centres be required by legislation.

#### **Recommendation**

That legislation be enacted to require that licensing of residential care facilities be subject to an independent written evaluation.

## 11.5 THE DEPARTMENT—POLICIES, PROCEDURES AND PRACTICES

### Departmental structure

#### *Residential care settings*

There are five regional offices of DFYCC—Brisbane North, Brisbane South, Southwest Queensland, Central Queensland and North Queensland—and these are responsible for the provision of support to a number of Area Offices that perform direct service delivery functions. Area managers supervise family services officers (FSOs) who have responsibility for case planning and casework for individual children with families in the geographic area. When children are placed in residential care settings at a distance from the regional Area Office responsible for them (as in the case of a child transferred from, say, Bundaberg to a facility in Brisbane) the practice is for that Area Office to retain case planning responsibilities, while casework responsibilities are given to an FSO at a geographically convenient Area Office. The exception is BoysTown, where the practice is for the regional case officer to maintain casework duties in liaison with one of two departmental workers assigned to BoysTown itself.

Area managers also have responsibility for supervision of and support for residential services within their areas. Area Offices generally have designated liaison officers who are allocated to deal with particular residential care services. Their duties include arranging placement of children with that service and ensuring that necessary documentation is completed within the specified timeframe. A community resource officer at each Area Office has responsibility for matters relating to the service agreement between the residential service and DFYCC.

Because the responsibility for development of case plans remains with the regional office, while casework responsibility lies with the FSO local to the residential service, the potential exists for failures of communication and a confusion of management responsibility between the two. Similarly, there is potential for conflict between the approach taken by the local casework officer in dealing with a child and that of the liaison officer who must deal with the service in which the child resides. This system will work only if there is exceptional communication, supervisory and management arrangements within and between Area Offices.

A compounding problem is the high staff turnover and frequent staff changes and shortages within DFYCC. Reports of quarterly review meetings between residential services and departmental representatives were characterised by continual reference to staff changes, staff shortages due to absenteeism, and consequent reallocation of responsibilities and priorities.<sup>1</sup> In this environment, it is extremely difficult to maintain the required quality of communications and relationships.

#### *Detention centres*

Managers of detention centres report to an operations director, who reports to the Youth Justice Program. Historically, detention centre staff have reported to the manager through hierarchical management arrangements. The recently formulated policy, called the 'integrated approach', recommends that specific positions in detention centres be designated to provide caseworkers with professional supervision. Also, service delivery staff have been reorganised into multi-disciplinary teams that include the caseworker, with the intention of providing greater support to staff and improving the integration of service delivery to detainees.<sup>2</sup>

Despite these proposed improvements, youth workers retain the responsibility for the majority of face-to-face contact with young people. Youth workers are not required to have professional qualifications. They may have limited experience and training and may be casual employees, yet they are required to operate in situations involving troubled and often highly disturbed young people.<sup>3</sup> It is not clear that the proposed organisational arrangements will result in these workers being provided with the supervision and support that is required to work effectively in difficult situations.

## Allocation of resources

### *Residential care settings*

Services for children and young people who live away from their families are provided or funded through DFYCC. Most services are provided by non-government organisations, funded under DFYCC's Alternative Care and Intervention Services Program (ACISP). As at 15 September 1998 there were 113 children and young people in residential services.<sup>4</sup> In 1996/97 DFYCC provided \$11.9 million<sup>5</sup> to 52 organisations to deliver 84 services for 'accommodation and/or related support services to children in the care of the Department'. This included foster care (shared care) program costs, and non-accommodation services such as 'therapeutic/assessment service or living skills program'.<sup>6</sup> It also includes funding to the Queensland Branch of Young People in Care, the Queensland Council of Social Service, and the Child, Adolescent and Family Welfare Association of Queensland.

The DFYCC provided \$6.8 million to 24 residential care services in 1998/99.<sup>7</sup> Indigenous children account for 22.2 per cent of children in care in Queensland (compared with a national average of 18.3 per cent).<sup>8</sup> Funding of services to indigenous children includes \$326,000 for six shared care programs and \$649,500 for six residential care services, a total of \$975,500, approximately 14 per cent of the amount allocated for residential services.

The DFYCC has a State-wide responsibility to identify needs for out-of-home care services and to establish priorities for funding through ACISP. These are set out each year in a state plan which is intended to provide 'an integrated overview of directions for the coming year' (DFYCC 1994).

Funding is allocated to residential services to provide a specified number of placements outlined in a service agreement. A child with high support needs may also attract a 'package of care' which is attached to the child rather than to the service. Because of a shortage of available residential care places, DFYCC often places young people in refuges that are not subject to the same licensing and service requirements as residential services.<sup>9</sup>

There are major variations in departmental funding allocated to individual residential services. For example, a family group home providing 4–6 placements is provided with funding of \$130,000, a residential with rostered youth workers is funded for four placements at a cost of \$489,000, while BoysTown receives approximately \$1.7 million for provision of up to 65 placements, although it currently has fewer than 40 residents.<sup>10</sup> These figures reflect major variations in per capita expenditure on children in institutional care. No information provided to the Inquiry indicated that variations in expenditure were always based on rational and equitable planning criteria.

A feature unique to this State's demography is that more people live outside the capital city than in it, and this explains in part why there is less of a metropolitan/rural distinction in many aspects of Queensland life. It also explains why there is a greater proportion of children in care in Queensland living outside the capital city than is the case in other States. However, residential care services tend to be clustered in the south-eastern part of the State, disproportionate to the needs that exist across the State; 85 per cent of funding goes to 63.6 per cent of the children in care. This disparity in funding levels is due 'more to historical events than to a planned approach for the entire system'.<sup>11</sup>

While DFYCC has acknowledged that current arrangements have evolved rather than been planned, and has proposed a planning approach to guide the reform of residential services in the future, it is unlikely that this can be accomplished with the funds currently available. It is clear that additional resources will be needed to provide services that meet the required standards. The *Child Protection Reform Strategy Discussion Paper* (DFYCC March 1999) acknowledges this. Part of the Strategy will be a review of child protection interventions, including residential care placements. An outcomes focus is proposed by the new approach.

**Recommendation**

That by December 2000 the Department:

- assess the needs across Queensland for residential care
- review the effectiveness of current models of residential care (i.e. family group homes compared to larger institutions such as BoysTown)
- develop criteria for equitable distribution of facilities and appropriate models of care
- develop medium- and long- term plans for future development of residential care, taking into account the distribution and needs of children throughout the State
- review funding and provision of residential services for indigenous young people to ensure quality of services and cultural appropriateness.

*Juvenile detention centres*

Funding for juvenile detention centres was budgeted at \$15 million in 1997/98, increasing to approximately \$16 million in 1998/99, for detention of a monthly average of 146 young people.<sup>12</sup>

**Licensing and service agreements***Residential care settings*

Current licensing arrangements for residential care services are provided for by *CSA 1965*. Licences are granted for three years.

The DFYCC has developed the Practice Standards for the Conduct of a Licensed Residential Care Service (PM94/16). These are available in printed form in the departmental Practice Manual and through the Department's Intranet. The Manual's purpose is to 'outline the standards to achieve a uniformly high standard of residential care in Queensland and to aid departmental staff in resourcing and utilising high quality residential care services'.<sup>13</sup> In other words, it is intended as a guide for all service providers, and for departmental staff who work with agencies and place children in care.

The Standards incorporated in the Manual appear to be a reasonably well-defined set of policies and procedures for assisting licensed residential care services and for ensuring that DFYCC is accountable for the services it licenses. The introduction to the Standards describes the scope of residential care services, the relationship between licensed residential care services and DFYCC, the standards of practice and the case management system.

The licensing procedures in operation require services to be conducted in accordance with the current Practice Standards. Detailed arrangements relating to service capacity, management, administration, reporting and staffing requirements are addressed by the service agreements but no reference is made to the Standards.

A fundamental problem with the Practice Standards is that they have no legislative or regulatory status and their official status is unclear. They are referred to by departmental correspondence as policy decisions, but even as policy they have not been fully implemented. This problem is exemplified in the Standards for corporal punishment. Appendix 2 of the Standards addresses discipline and control, making it clear that the duties and behaviour expected of caregivers in residential care settings differ from those of parents, and corporal punishment is not permitted. However, this differs from the provisions addressing discipline in the current Children's Services Regulations. This uncertainty about the status of the Standards can be seen in the operating procedures for BoysTown, for example, which still permit corporal punishment, contrary to the Standards, using terms that are very similar to the regulatory provisions.

The review of residential care services could find little evidence that either agencies or DFYCC actually use the Standards to manage their practice. Three examples were provided to support this observation.

- (i) There is a requirement that the Standards will be reviewed and amended each year by a Working Party to retain the currency and usefulness of the document but this does not routinely occur.
- (ii) One of the Standards states that ‘the location of a service, the model of direct care and staffing structures selected are to be the most appropriate for the target group of each particular service, and the needs of the target group are always the beginning point of service development’. However, there is no evidence that there is currently any rational planning or development process for residential care services.
- (iii) Another Standard states that ‘residential care services should provide placements for children/young people in their local area so that responses to the needs of children/young people and families can occur without causing disconnection from their networks’. If placement occurs outside the local area ‘it must be linked to the case plan for the child/young person, clearly identifying why the move outside their locality is required’.<sup>14</sup> This planning practice appears to happen only when it coincides with funding, auspicing and administrative convenience.

In practice, the Standards appear to be used as no more than a set of principles and aspirations, unconnected to any mechanism to assess whether agencies are actually applying them.

The provisions of the *CPA 1999* require that licensing decisions are based on an assessment that the standard of service to be provided by the residential care service is in compliance with the statement of standards contained in the Act. If these licensing arrangements are to be implemented in accordance with legislative requirements, a thorough review will be required of service arrangements, and implementation will require additional funding, appropriate training and developmental support.

When residential care services experience ongoing, serious infrastructure problems that could have implications for the health or welfare of residents (e.g. serious drainage problems), or staffing difficulties arising from the placement of young people with severe behavioural problems, or ongoing administrative and financial management problems (e.g. repeated failures to provide the required service returns and financial records), these matters are discussed in quarterly review processes.<sup>15</sup> However, there appear to be no alternative management processes or licensing review measures other than recommendations to the Minister to cease funding a facility (e.g. Petford Training Farm) to ensure that the problems are addressed satisfactorily.

#### **Recommendation**

That in order to ensure effective links between standards of care, service agreements, quality assurance, licensing and legislative requirements for residential care, the Department:

- review the *Practice Standards for the Conduct of a Licensed Residential Care Service* to ensure consistency with the statement of standards outlined in the *Child Protection Act 1999* and develop clear performance indicators that are incorporated into service agreements
- develop a system of independent external accreditation based upon the standards required under the Act
- require that all residential care facilities be subject to independent evaluation as a condition of being granted a licence or renewal of a licence.

#### **Placement strategies**

##### *Residential care settings*

Institutional care has chiefly become the placement option for young people who are difficult to place in other settings.<sup>16</sup> This trend is reflected in information provided by DFYCC for the period 1981 to 1996. In this period, the number of young people in out-of-home residential care declined from 685 to approximately 150. In 1998, young people aged 13–15 comprised more than 50 per cent of placements in residential care facilities,<sup>17</sup> although the Director-General asserts that residential care

services are providing few placements for young people aged 15–17. Residential services at times also have lengthy waiting lists.<sup>18</sup>

The characteristics of out-of-home settings have also changed, resulting in a majority of smaller services. In 1998 there were 24 services providing residential care, and aside from TARA and BoysTown, they are smaller residential establishments including family group homes and residentials supported by rostered youth workers.<sup>19</sup>

The Industry Commission regards frequency of placement changes as a performance indicator for out-of-home care services.<sup>20</sup> DFYCC acknowledges that there have often been high levels of placement disruption for children placed in residential services, particularly older children, many with major behavioural problems.<sup>21</sup>

Case planning is not systematic, and placement decisions are often made on the basis of availability<sup>22</sup> without the required comprehensive and ongoing assessments to determine the most appropriate placement plan and to secure placement in an appropriate setting.

#### **Recommendation**

That the Department establish a short-term residential facility to enable proper and comprehensive assessments when children are first admitted to care.

#### *Juvenile detention centres*

Despite the principles of the *JJA 1992* of detention being a last resort for young people who become involved in the juvenile justice system, current trends are towards greater use of detention, especially for young people on remand. A current review process is attempting to establish the reasons behind the rise in detention rates for young people on remand. A number of initiatives are also under way to attempt to address the increasing detention rates, including the development of a greater range of community placement options for young people, especially those on remand,<sup>23</sup> and these are important in providing alternatives to institutionalisation.

## **11.6 DEPARTMENTAL MONITORING OF INSTITUTIONS**

### **Monitoring and review**

#### *Residential care settings*

Institutions are required by legislation to provide monthly reports. Monitoring and review of licensed residential services should occur through quarterly review meetings between departmental and institutional representatives. These meetings review issues arising from the service agreements and from the current operations of services. Monitoring and review of the operations of TARA occur through similar meetings between TARA management and the regional and Area Office management.<sup>24</sup> These reviews should provide a basis for a collaborative approach to service planning and review. Minutes of these meetings provided to the Inquiry demonstrated that the meetings address issues such as occupancy rates, current residents, client referrals, infrastructure, and staffing and funding matters. This documentation is held at Area Office level.

These review processes are supposed to be supplemented at the level of the individual child through contact between the child and the child's designated caseworker, who retains responsibility for case planning.<sup>25</sup> DFYCC has a case management framework, with three documents comprising the case plan:

- an assessment of protective needs report
- a planning statement
- a placement agreement.



The case plan should be reviewed regularly, with review periods specified in the case management framework. Ensuring that all young people in residential care have current case plans is one of the primary methods of ensuring accountability.<sup>26</sup>

However, review meetings often do not occur regularly. One service had not had review meetings for almost 12 months. Only one of the sets of records examined by the Inquiry showed a review process with a systematic approach to problems, or planned changes in direction. Documents provided to the Inquiry demonstrated that at least some young people in residential care and in detention centres do not have current case plans and some do not have current contact with caseworkers. In one institution, four of the five residents did not have a current caseworker.<sup>27</sup>

### **Record-keeping**

The review of residential care facilities found that the standard of record-keeping was generally poor, with children's files not disclosing the history of the placement, the location and relationship of the key people in the child's life or the results of any planning or review process. On the basis of file records assessed, it would be extremely unlikely that an agency would be able to assess the effect of casework on the child or form a view of whether objectives were being reached.

### *Recording and management of allegations of abuse*

Departmental policies and procedures require notification of all instances of suspected abuse, and these are recorded in detail in a central database. A separate record system is maintained for allegations of abuse involving detention centre staff and caregivers in residential services.<sup>28</sup> However, there is no central database of abuse by caregivers. If an allegation of abuse is about a carer, and relates to a particular young person, the only way to obtain information about the past carers of that young person is from the individual's case file. There is currently no database to identify and deal with patterns of complaints or trends in institutional abuse, although a system is currently being developed.<sup>29</sup>

### **Recommendation**

That the Department develop and implement an information system that records individual complaints and trends in institutional abuse.

There are currently no procedures to subject services where substantiated child abuse has occurred to thorough external review processes to identify risk arising from operational, procedural and institutional arrangements and to develop and implement required changes; nor are there regular reviews that compare internal departmental records of incidents reported and actions taken at all departmental levels with reported incidents recorded by the central information systems of DFYCC.

### **Independent complaints mechanisms**

The Children's Commission of Queensland was established in 1996 under the *CCCSATA 1996*. The Commission acts as an independent advocate for children in care. The Act, like most other comparable human rights legislation, gives the Commission broad systematic and preventative functions in terms of monitoring and reviewing the adequacy and standards of children's services. It also provides for individual redress confined to the investigation of complaints about the delivery of children's services. The Act, however, lacks clarity in defining and enshrining advocacy in the Commission's functions. The Act and the Commission are currently under independent review, however the Inquiry recommends strengthening of the Children's Commission in a number of ways.

### **Recommendation**

That amendments be made to the *Children's Commissioner and Children's Services Appeals Tribunal Act 1996* to ensure the independence of the office of Children's Commissioner, and provisions be made for its attachment for administrative support services to the Premier's Department.

**Recommendation**

That the office of the Children's Commissioner be strengthened by:

- investing the role of Independent Inspector of residential care facilities and juvenile detention centres with wide powers of inspection in relation to such matters as the treatment of residents, preparation for release, morale of residents and staff, quality of health care and education, physical facilities and management
- empowering the Commissioner to conduct Inquiries into matters affecting children and young people including the authority to investigate and resolve complaints about the provision of services to children and young people
- establishing a comprehensive research function to enable research to be conducted into all matters relating to the rights, interests and wellbeing of children and young people in residential facilities and juvenile detention centres
- providing the Commissioner with the power to monitor the role of the Department in overseeing the care of young people in detention centres and residential facilities.

**Recommendation**

That there should be a Children's Services Appeals Tribunal constituted as a separate entity to the Children's Commission whose procedures are inquisitorial rather than adversarial in nature.

Another avenue of independent advocacy in Queensland is the State Ombudsman, whose function is to investigate complaints of an administrative character in relation to all levels of the Queensland Government bureaucracy. This largely limits the Ombudsman to dealing with complaints of systems abuse in government-run institutions, and provides only limited effectiveness in relation to processing legitimate individual grievances of children in institutional care. This gap in the Ombudsman's service delivery further indicates the lack of effective mechanisms through which children can make complaints about their treatment.

**Official Visitors' program**

The *CCCTA 1996* gives the Children's Commission a variety of roles, one of which is to respond to individual complaints, and another to monitor standards of service delivery. To enable services to be monitored, the Commission has appointed Official Visitors. Their program covers residential care facilities provided or funded by the State. Externally appointed and independent 'visitors' to institutions can provide a means of exposing deficiencies in care.

*Coverage*

There is presently limited opportunity for children and young people in residential care facilities to access the Commission's Official Visitors. The scheme has only two full-time visitors responsible for visiting all the facilities in Queensland, of which there are currently over 100, many in remote and regional areas. Visits are carried out in an ad hoc fashion with varying frequency. As of January 1999, the two Official Visitors had assessed 56 residential care facilities, but none north of Mackay.

Visits do not occur with sufficient frequency for Official Visitors to develop a rapport with or gain acceptance from children and young people in care. Young people are unlikely to discuss issues of a sensitive nature with Official Visitors before confidence and trust are developed. The Inquiry considers that a fundamental role of the Official Visitors is the development of trusting relationships so that they are better able to identify problem areas for children and young people and advocate on their behalf.

The current role of the Official Visitors appears to be focused on the inspection of residential care facilities and the determination of whether or not these facilities are providing an adequate standard of care. Although there is merit in Official Visitors performing a monitoring role, this should complement the advocacy and problem resolution roles.

The Inquiry also noted the limited jurisdiction of the Children's Commission. A separate program of Official Visitors is provided for young people in juvenile detention centres. Although outside the Terms of Reference of this Inquiry, it would seem appropriate for the Commission to extend its program to cover all children in residential facilities—those not subject to statutory care orders as well as young people in detention.

### *Access to information*

Current procedures do not allow Official Visitors to gain access to important information relevant to children and young people in care, or to gain a complete understanding about the culture of a particular residential care facility. Official Visitors require a good understanding of the young person's history and present environment before they are able to detect potentially abusive situations. This is especially relevant to systems abuse. The Children's Commission is also limited in its ability to access sufficient information to carry out a meaningful investigation into a complaint, or to decide how best to resolve it. Official Visitors seeking access to information could be subject to the same requirements of confidentiality as other Commission and DFYCC staff.

### *Reporting and feedback*

Official Visitors operate with limited resources and under legislative restraints, which makes their role extremely difficult. Their reports provide little insight into risk factors for the children, make no assessment of the skills and attributes of the staff and, importantly, make no reference to the benefits or otherwise of current placements for the children. There is no reference to case planning studies, family contact, after-care or cultural issues. Inadequate reporting can inhibit the ability of the Commission to make systematic improvements or to detect any infringements of children's rights.

Theoretically the Children's Commission has the potential to contribute much to children's services. If developed further, the role of the Official Visitor has the potential to make a significant contribution to improving ongoing practice. The monitoring of emotional, physical and sexual abuses, their documentation and investigation, and the provision of an effective response mechanism to all allegations must be secured in a legislative framework. This legislative basis would clearly set out proactive, comprehensive policy guidelines and procedural regulations.

#### **Recommendation**

That there be a review of the Official Visitors' program focusing on the legislative base, policy and procedural guidelines, actual practice, and effectiveness of the service.

#### **Recommendation**

That the Official Visitors' program be maintained and extended with a view to providing a comprehensive monitoring function of all residential facilities for children and young people, including those not funded by the State but which, nevertheless, provide a similar service, including juvenile detention centres.

#### **Recommendation**

That visits from Official Visitors be regular and frequent, and the number of Visitors reflect the size of the client base.

#### **Recommendation**

That Official Visitors be empowered to act as advocates for children and young people in care by listening to, giving voice to, and facilitating the resolution of, their concerns and grievances.

**Recommendation**

That Official Visitors be provided with a complete orientation and training in alternative care practice, standards of residential care, advocacy issues and practice, and developing trusting relationships with young people.

**Recommendation**

That Official Visitors be given access to relevant information about children and young people in care, and they should be bound by the same rules of confidentiality as other Commission and departmental staff.

**Accountability***Juvenile detention centres*

Accountability mechanisms, including inspection and monitoring, for juvenile detention centres are detailed in Chapter 9, and will not be repeated here.

While the *JJA 1992* makes no specific requirement for supervisory visits by DFYCC to detention centres, it does require monthly inspection visits by Official Visitors. Official Visitors are independent of DFYCC, although their functions are specified by the administering department and a report is required on each visit (section 36). The recently developed national standards for juvenile detention centres provide indicators for sound management and operation of the centres.

The departmental Misconduct Prevention Unit, which assists in monitoring misconduct, including misconduct involving institutional abuse, will have an important role in the monitoring process. This Unit currently has responsibility for maintaining records of departmental personnel who have been the subject of allegations of misconduct.<sup>30</sup>

Primary case planning responsibility for detainees resides with caseworkers within detention centres. The introduction of multidisciplinary care teams into detention centres is planned to improve case management and planning by providing a coordinated approach to management of detainees. Proposed Secure Care Panels will provide professional oversight. Continuing contact with the FSO responsible for the case is intended to provide an external accountability mechanism.

These case planning and management arrangements are organisationally unwieldy and require considerable coordination to operate effectively. In one example provided to the Inquiry, an FSO at the Sunshine Coast apparently had continuing case responsibility for a detainee in Brisbane.<sup>31</sup> In another case, a detainee who had been in detention for many months did not have a case plan.<sup>32</sup> It is easy, in such circumstances, for case planning responsibilities to be overlooked or neglected, especially when there are frequent changes in caseworkers, in FSOs and in the management of Area Offices.

A series of audits of the centres was conducted by QCSC and an Investigation Review Committee, which assessed the adequacy of reports and recommendations arising from investigations of complaints or allegations. Records provided to the Inquiry of investigations or assessments of complaints, however, gave no evidence of the systematic review of services or detention centres initiated automatically as a result of complaints or allegations of abuse. An exception was the recent inquiry into the death of a young detainee which was conducted by a team external to DFYCC, and which did address the broader issues surrounding this tragedy and make recommendations concerning case management arrangements, procedures evaluation, and equipment and training.

## Investigatory mechanisms

### *Residential care settings*

The *CPA 1999* requires the chief executive to facilitate investigation of allegations of harm to children and to take action for the protection of children. Section 9 provides a sufficiently broad definition of ‘harm’ to a child to include institutional abuse, although this is not addressed specifically. The chief executive also has the responsibility for ‘establishing ways to coordinate the roles and responsibilities of service providers to promote the protection of children and child protection services’ and to investigate allegations of abuse (section 157). Procedures will be required to operationalise these provisions in relation to institutional abuse.

Currently, DFYCC’s response to abuse is predominantly reactive. Procedures require that all child protection notifications be recorded and assessment processes undertaken to determine whether the allegations indicate child abuse or failure of standards of care.

Guidelines for conducting investigations relating to young people in residential care are provided for departmental staff by the Child Protection Procedures Manual. These procedures are general in nature and do not provide clear guidelines and decision-making criteria for staff. They are dependent on staff having professional knowledge and skills and being appropriately trained and supervised.

The current guidelines rely on the judgment of the Area Office manager to determine whether the matter reported is a child protection notification. If it is, a risk assessment process is employed which involves a determination of whether harm has occurred or whether there is risk of harm or abuse. Investigation of abuse allegations are to be carried out by police or by Area Office staff. Part 3 of the Procedures Manual addresses the determination of harm and the involvement of the Suspected Child Abuse and Neglect (SCAN) team. The SCAN team will also determine whether the matter is a criminal offence, to be referred for investigation by the police, or whether the matter is to be investigated by the Area Office.

The results of all investigations, whether the matter has been substantiated or not, are recorded in the central child abuse notification system. The findings in all cases would include an assessment of whether the agency had failed in its duty of care.

Current procedures relating to allegations of abuse in residential care services require that the initial assessment be carried out by the Area Office manager and investigations may also be carried out by Area Office staff. However, these personnel also have responsibility for overseeing management of the residential care services and may have well-established relationships with them, their ability to carry out an independent assessment may be compromised.

For young people in residential care settings, the current mechanisms for making a report or a complaint are through the young person’s caseworker, through a parent or friend or through internal procedures in the residential facility.

Current procedures are intended to protect the child and provide for involvement by the management of the institution. Management is informed of the outcomes of the assessment process and the investigation, if one is conducted, and the recommendations arrived at. Although management has discretion in determining the institution’s responses, DFYCC may recommend appropriate action. The licensee retains responsibility for action relating to the findings, being required to assess the risks to children in the facility and to take action to address these risks.<sup>33</sup>

Current procedures do not provide support for staff who are the subject of allegations or complaints of abuse, although a grievance process is included.

There are no departmental procedures in place to proactively assess the character and incidence of institutional abuse in order to develop and implement preventive programs. The emphasis remains on responding to complaints or reports of abuse, protecting complainants and witnesses,

investigating and determining whether offences have occurred, taking the appropriate action against those responsible, and providing care and assistance to the victims of abuse.

Current reporting mechanisms (which include providing access to a telephone, establishing a complaints box, or informing children of their right to make a complaint to their immediate carers) are unlikely to be sufficient. Mechanisms should be based on empowering young people to make full use of the range of legislative provisions available to them. Advocates or representatives are particularly important in this process.

#### **Recommendation**

That by December 2000 the Department develop and implement policies which ensure that:

- there is a range of easily accessible, confidential complaints mechanisms for children
- children making complaints are protected and any worker about whom a child has made a serious complaint is separated from children in the facility, without loss of pay and other employment conditions, pending the outcome of the investigation of the complaint
- a rapid response to complaints is made and the action taken is documented
- senior officers of DFYCC or other personnel independent of the service with substantial experience in matters relating to child abuse carry out the investigation
- all allegations of abuse in out-of-home care are made the subject of mandatory reporting by institutional staff and are notified to the Children's Commissioner and the Office of the Director-General
- all serious complaints result in review processes to identify systemic problems and to provide recommendations for improvement
- all documentation relating to complaints or allegations of abuse is subjected to external review and audit, to ensure that required procedures have been followed
- a central database of caregivers is established to identify patterns of complaints and trends in institutional abuse.

#### *Detention centres*

Complaints mechanisms are dealt with in detail in Chapter 9 and will not be repeated here.

#### **Quality assurance**

##### *Residential care settings*

Current arrangements do not require quality assurance of residential care providers, although there is a provision that services be conducted in accordance with practice standards. Licensing provisions and operating arrangements should not rely on initial assessments that quality services are being provided, but should also involve ongoing supervision to ensure that the required quality of service delivery is maintained and that the welfare and safety of children are guaranteed. Quality assurance processes should include independent research, together with review and evaluation of programs, and should result in action plans to address deficiencies identified.

##### *Detention centres*

Detention centres are moving towards quality assurance implementation to be included within a national accreditation framework based on standards. However, current processes do not address the day-to-day operations of these centres. The implementation of quality assurance must address the institutional environment of the centres and the vulnerability of young people within them.

**Recommendation**

That by December 2000 the Department prepare:

- detailed and standardised procedures for record-keeping that must be maintained by residential facilities, detention centres and the Department
- quality assurance mechanisms, including monitoring and review processes that can measure whether appropriate standards are being maintained, that individual cases of abuse are detected and dealt with, and whether staff have the necessary conditions to work effectively
- detailed time-limited plans for their implementation across residential institutions caring for children.

## 11.7 HUMAN RESOURCES MANAGEMENT

### Recruitment and conditions of employment

#### *Residential care settings*

Current staffing arrangements for TARA involve the provision of funding for permanent staff for the institution, supplemented by provisions for temporary and casual staff. Current departmental policies, procedures and practices relating to the recruitment and selection of staff apply to TARA, and address the requirements of the *PSA 1996*, which specify that all appointments must be based on merit. Recruitment procedures are identical to those employed in detention centres and are discussed in full in that context.

Staff at TARA are paid Award rates of pay and work hours as specified by the Award. Rates of pay are comparable to those payable to other public service staff. Moreover, departmental staff in residential care services have access to penalty rates, shift allowances and overtime which are not generally available to other public service staff.

While service agreements specify staffing arrangements for residential care establishments, the primary responsibility for staffing matters, including recruitment and selection, lies with the organisation auspicing the service: the *CSA 1965* provides that ‘the governing authority of a licensed service is to have control of the appointment of all persons employed at such institution’ (section 33(1)).

Although residential services have legislative responsibility for recruitment and employment of staff, current practice, as evidenced by the minutes of review meetings, is for DFYCC Area Office representatives to be involved in appointment processes, with criminal records checks and child abuse notification checks performed on preferred applicants. This practice is legislatively endorsed by the *CPA 1999*. If applicants for residential care positions are shown to have such records, their suitability for these positions is canvassed with the chair of the selection panel or the responsible officer of the auspicing service.

Although provision is made for criminal history and child protection notification checks on primary caregivers in residential care services, there is currently no provision for these checks to be conducted on other staff of the institution, including teachers, gardeners and bus drivers. These people may have unsupervised access to the children and must be subjected to the same level of scrutiny as direct care workers.

Staffing of residential services is discussed at quarterly review meetings, but provision of adequate relief staff is dependent on the resources available to the individual service and their operating arrangements.

While there is an expectation that workers in these services will be paid current award rates of pay, actual rates are dependent on the ethos of the auspicing organisation and the resources available to the services. For services without substantial financial support additional to the government grant there may not be the capacity to pay caregivers the specified rates of pay.<sup>34</sup>

### *Detention centres*

Staffing arrangements for detention centres involve the provision of funding for permanent staff for the institution, supplemented by provision for temporary and casual staff. Staff are paid award rates of pay and work hours as specified by the Award. Rates of pay are comparable to those payable to other public service staff. Departmental staff in detention centres also have access to penalty rates, shift allowances and overtime which are not generally available to other public service staff. However, for casual staff, remuneration is dependent on the availability of work.

Recruitment and selection procedures within DFYCC are conducted to address the requirements of the *PSA 1966*. The Department has developed comprehensive procedures which detail legislative requirements and departmental policies, and provide detailed guidelines to assist managers in conducting recruitment and selection. Departmental policies require formal advertisement and selection procedures for all positions, both permanent and casual. These requirements are currently more stringent than those specified in the legislation.

Procedures require that referee checks occur for applicants being considered for appointment. These checks are undertaken by telephone to obtain responses against selection criteria for the position.

Temporary short-term appointments (of up to 12 weeks) may be made as convenient, as is permitted by the legislation, but the guidelines do address the possibility that these appointments may extend for longer periods. The guidelines include a strong recommendation that temporary appointments of three to 12 months' duration be made on a merit basis, but this is not mandatory and it is not clear what monitoring and control procedures are in place to ensure that temporary short-term appointments do not extend into long-term appointments by default.

Criminal record checks are performed on all successful applicants for permanent, temporary or casual caregiver positions, whether these applicants are from within DFYCC or from outside it. All applicants are advised in the application documentation of the necessity for a criminal records check to be performed. Procedures ensure that the results of these checks are kept confidential and, if any relevant records are discovered, applicants and selection panel chairs are advised and the suitability of the applicant for the position is considered, taking into account the nature of the offence and the circumstances surrounding it. Departmental guidelines specify that persons who have records relating to child abuse or violent or sexual assault offences are not considered suitable for appointment to caregiver positions. Current legislative provisions permit these checks on applicants for positions within DFYCC.

When detention centres were administered by QCSC, criminal record checks were undertaken on all staff recruited, including part-time and casual staff. This process included all jurisdictions in Australia. Recent changes initiated by the Police Service are addressed by current departmental guidelines, which require criminal records relating only to Queensland to be obtained, with 'flagged' responses if offences have been recorded in other jurisdictions. These responses can be further investigated if necessary.

A submission to the Inquiry by a former detention centre manager suggested a failure of the system in the mid-1990s. The witness told the Inquiry that when he instigated follow-up checks of the criminal histories of centre employees, it was found that 22 staff members had recorded criminal convictions.

The process of checking the Child Protection Register does not currently apply to detention centre staff, and there may be staff currently employed within detention centres who have been the subject of child abuse notifications.

Currently, there are no procedural requirements for persons applying for positions to declare other names by which they may have been known, although known alternative names recorded by the justice system will be specified in a successful criminal records check. However, the procedures require applicants to provide a birth certificate or other formal identification document, and to



document any formal qualifications, so some safeguards are in place to guard against changes of name.

## **Staff training**

### *Residential care settings*

At TARA, the human resource management policies, procedures and practices are those of DFYCC. The staff establishment at TARA has been relatively stable in the recent past and this institution does not experience the fluctuations in resident numbers that are characteristic of detention centres. Casual staffing arrangements are used for relief work and to accommodate any special demands that arise.

All residential care workers at TARA are provided with training on an ongoing basis. Staff at all licensed residential care services are able to access departmental training programs, and reports of quarterly review meetings provided to the Inquiry demonstrated that some are able to do so, but the extent of participation of licensed caregivers in departmental training was not able to be determined from the materials provided. Current service agreements do not require the provision of training to caregivers.

### *Detention centres*

Human resource management policies and procedures in detention centres are those of DFYCC.

The use of casual staff in detention centres permits flexibility in staffing during peak periods and in response to fluctuating numbers of detainees. However, it also results in a relatively high proportion of youth worker positions being occupied by casual and temporary employees. At one detention centre there were 38 designated permanent youth worker positions, with a further 31 temporary and casual youth workers listed as being available for work.<sup>35</sup> In April 1999 this centre had 24 casual employees available for work, who filled the equivalent of five full-time positions during the month.<sup>36</sup> There are limited opportunities for casual staff to develop the required experience and skills.

The emphasis on the use of casual staff to address urgent service demands does not permit the forethought and planning required to ensure that these staff receive the required levels of management and supervision. It is important that a balance be struck between cost effectiveness and reduction of risk in developing staffing and supervisory arrangements.

Currently, there are no formal qualifications required for youth worker positions. All youth workers in detention centres (permanent and casual) are required to undergo a three-week pre-service training course. The DFYCC is currently investigating the possibility of requiring completion of certificate level training for all applicants for these positions.<sup>37</sup>

For casual or temporary staff, ongoing competency assessments have been introduced that are based on shift performance sheets. These sheets are completed by the shift supervisor and may be used to support applications for permanent positions and for developmental purposes. Casual and temporary staff are also able to access the competency logbook system. This system uses a developmental approach to training and assessment based on the acquisition of practical skills demonstrated to workplace assessors through competency logbooks. Skills range from mandatory skills to advanced skills that are required for promotion. Competencies have been linked to a nationally accredited diploma program.<sup>38</sup>

The DFYCC has well-developed training infrastructure, with training programs developed in-house and training provided by qualified personnel. Assessment of the training provided, however, is largely by means of participant feedback. Although a range of training programs are available to staff, the emphasis, especially in the acquisition of competency-based skills, remains predominantly on security-related issues.

Approaches to the provision of training have not been systematic in the past. However, an assessment is currently being conducted to ensure that all staff meet mandatory training requirements. The need for staff to be trained in behaviour management, restraint and control has been identified as a high priority in the detention centre environment, but in the report of a recent incident it was determined that the youth worker had not received this training even though he had been employed in the centre for three years.<sup>39</sup> A recent Inquiry report into a death in custody also mentioned the need for training to be provided to all staff and for retraining to be undertaken at regular intervals, and identified a need for the introduction of new procedures to be supported by training programs for staff.<sup>40</sup>

All operations staff are stated to be trained in suicide prevention and awareness,<sup>41</sup> but in the circumstances surrounding the suicide of a young indigenous person, no staff observed behaviour which provided clear suicidal intentions, case notes relating to such behaviour in the past were not addressed, and an appropriate risk assessment was not performed. The inquiry into circumstances surrounding these events mentioned that training emphasised physical prevention factors rather than the identification of factors that enable risks to be assessed and acted upon.

It is unlikely that the current training offered to unqualified youth workers prepares them fully for the demands of working in the difficult environment of a detention centre. The current emphasis on the development of vocational skills offers one method for further training these staff, but as the emphasis in this training is largely on security-related tasks, the current program would benefit from the provision of ongoing training in service delivery requirements in a human services environment, as well as ethical requirements.

### **Recommendations**

That, by December 2000, the Department:

- review issues affecting field staff responsible for children in care including excessive caseloads, inadequate personal and professional supervision, high turnover, insufficient resources and training and implement measures to address them
- establish the minimum requirement to operate each institution and provide adequate funding to ensure that the facilities can operate safely
- require through service agreements and service standards for residential services that staff are recruited through transparent merit selection processes, that clear human resources development and management standards are applied and that these standards be part of a contract, review and evaluation process. This must include, as a minimum, clear job descriptions and regular progress and performance monitoring of staff
- require scrupulous screening of all staff and other people in regular contact with children at residential care and juvenile detention centres, not only through police checks (including fingerprints and records of charges laid) but also extensive interviews to ensure their suitability to be in contact with children or young people in care or detention
- require that criminal history and Child Protection Register checks be conducted on an ongoing basis, at a minimum of five-yearly intervals, for all residential care and juvenile detention centre staff
- address staff training requirements (initial and ongoing) for residential care services by the application of Service Standards and provision of training for all service providers
- require that an accredited core training program be completed by all residential care workers and that orientation programs to clarify staff roles and expectations be conducted, as well as refresher training programs for staff at regular intervals
- review staffing and supervision arrangements within detention centres, with risk assessment procedures applied to determine appropriate supervisory arrangements and the optimum staffing balance of permanent to casual staff to provide cost-effective service delivery by experienced staff, while minimising risk.

## 11.8 INTERSECTORAL COLLABORATION

Because young people in residential services are likely to be experiencing multiple problems, a range of agencies is likely to be involved in interventions, including those addressing physical and mental health problems, physical disability, alcohol and drug dependency and behavioural problems. Caregivers are often required to implement treatment plans developed and provided by multiple experts, with little support and no specialist expertise in doing so.

Practice Standards for Residential Care Providers are intended to foster the development of services that are integrated into the community, with children encouraged to develop and maintain community contacts. However, this integration will be more difficult to attain in residential care services that provide their own school programs and where the young residents conduct the majority of their daily activities within the environs of the service. In these settings, procedures are necessary to ensure that young people maintain contact with the community.

For residential care services that operate as partly closed communities, and for detention centres, special measures may be required to bring community representatives into contact with young people. In detention centres this process has begun by encouraging community organisations to provide activities, training, development, counselling, support and advocacy services.

## 11.9 CONCLUSION

When the *CPA 1999* comes into operation the majority of the deficiencies in current legislation will be addressed. However, a number of significant gaps remain.

Organisational arrangements and responsibilities relating to the supervision of residential care facilities and the provision of services to the children and young people within them are overly complex and require the development and maintenance of sound communication and liaison arrangements in order to function effectively. Frequent staffing changes make development of these mechanisms extremely difficult. Organisational arrangements and case management responsibilities require simplification in order to ensure the effective oversight of residential care services and the children and young people within them. Regular review processes or evaluations for residential care services should be required by licensing conditions.

Youth workers in detention centres are often the more inexperienced officers and a proportion of these officers are casual staff. They are responsible for most of the face-to-face service delivery to young people in detention. Organisational structures must provide adequate supervision and support to permit them to work effectively in what are often difficult situations. Ongoing training is also required to ensure that staff have the skills needed to deliver quality services.

Current resourcing arrangements for residential care services are not based on a systematic assessment of needs or on systematic service planning. Allocation arrangements are largely historical, and clear benchmarks or standards are required for a more equitable distribution of funding. Enhanced planning processes and additional resources are needed.

Current licensing arrangements for residential care services will be reviewed as a result of the requirements of the *CPA 1999*. However, if additional resources are not available, it is doubtful whether the services will have the capacity to comply with the requirements of the service standards.

Case planning is not systematic. There has been a high level of disruption for some clients and placement decisions are currently made on the basis of availability. There is a need for a comprehensive assessment for each placement in order to determine the most appropriate placement option. Intersectoral collaboration is also important in developing and implementing appropriate case management approaches for children and young people in residential care settings and in detention centres.

There is a need for a central database of caregivers and a database to identify and deal with patterns of complaints or trends in institutional abuse. The current project to develop these systems is

important and should be given every assistance. Information systems also require improvement to assist with the tracking of children and young people through the system. Review procedures are needed to ensure that records of incidents reported and their outcomes are consistently recorded at all levels of the system.

## ENDNOTES

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- <sup>1</sup> DFYCC, *Monitoring and Review Processes in Residential Care Settings*, February 1999, p. 5.
  - <sup>2</sup> DFYCC, Response to Query from the Commission of Inquiry, 25 February 1999, pp. 7–8.
  - <sup>3</sup> Functional Review Notes and Minutes—RAPT 2, Toowoomba; Frank Gilson House, Maryborough; Heytesbury House, Goodwood, 1998/99.
  - <sup>4</sup> DFYCC, Submission to Inquiry, September 1998.
  - <sup>5</sup> This does not include payment of allowance to foster carers.
  - <sup>6</sup> The public Internet site for DFYCC identifies the budget for ACISP in 1997/98 as \$14,619,593. DFYCC 1994, p. 4.
  - <sup>7</sup> Letter of Director-General, DFYCC and attached paper, *Challenges and Directions in Delivery of Queensland's Residential Care Services*, 29 March 1999.
  - <sup>8</sup> Report on Government Services, 1999, p. 976.
  - <sup>9</sup> DFYCC, Submission, op cit.
  - <sup>10</sup> Letter of Director-General, DFYCC and attached paper, op cit.
  - <sup>11</sup> DFYCC, Submission, op cit, p. 1.
  - <sup>12</sup> Juvenile Operations Budget information.
  - <sup>13</sup> DFYCC 1994 a:1.
  - <sup>14</sup> PM94/16, pp. 4, 5 and 6.
  - <sup>15</sup> Notes and Minutes on Functional Review Processes, op cit.
  - <sup>16</sup> Letter of Director-General, DFYCC, op cit.
  - <sup>17</sup> DFYCC Submission, p. 1, op cit.
  - <sup>18</sup> Letter of Director-General, DFYCC, op cit.
  - <sup>19</sup> Ibid.
  - <sup>20</sup> Industry Commission, 1998, p. 847.
  - <sup>21</sup> DFYCC Submission, p. 1, op cit.
  - <sup>22</sup> Letter of Director-General, DFYCC, op cit.
  - <sup>23</sup> Commentary provided by Youth Justice Program, 23 March 1999, p. 15.
  - <sup>24</sup> Response of DFYCC re Monitoring of TARA, March 1999.
  - <sup>25</sup> DFYCC, Overview of Role of Field Officers in Residential Care Services, p. 12.
  - <sup>26</sup> DFYCC, Response to Inquiry, op cit.
  - <sup>27</sup> Notes and Minutes of Functional Review Processes, op cit.
  - <sup>28</sup> Advice of Director-General, DFYCC to Inquiry, 12 March 1999.
  - <sup>29</sup> Youth Justice Program, op cit, p. 90.
  - <sup>30</sup> Ibid, pp. 15, 46 and 95.
  - <sup>31</sup> Recorded in comments supporting an investigation report into a complaint by a detainee in John Oxley Youth Detention Centre provided to the Inquiry.
  - <sup>32</sup> Report of an Inquiry into a death in custody, January 1999.
  - <sup>33</sup> Child Protection Procedures Manual, s. 33.10.
  - <sup>34</sup> References in Functional Review Notes and Minutes, op cit.
  - <sup>35</sup> Details of Staff Employment Categories, Sir Leslie Wilson Youth Detention Centre.
  - <sup>36</sup> Information provided by the Youth Justice Program attached to the letter of the Director-General, DFYCC, 5 May 1999.
  - <sup>37</sup> Submission by QCSC, p. 18.
  - <sup>38</sup> Youth Justice Program, op cit, pp. 86 and 87.
  - <sup>39</sup> Letter of Director, Human Resources dated 2 November 1998 re complaint by detainee.
  - <sup>40</sup> Report of Inquiry into a death in custody, op cit, p. 16.
  - <sup>41</sup> Youth Justice Program, op cit, p. 64.

## CHAPTER 12: CONCLUSIONS

### 12.1 INTRODUCTION

The Terms of Reference for the Inquiry relate, in part, to any government or non-government institution or detention centre established or licensed under the *State Children Act 1911*, the *Children's Services Act 1965* (CSA 1965) or the *Juvenile Justice Act 1992* (JJA 1992). The aim of the Inquiry was to discover:

- (a) whether any unsafe, improper or unlawful care or treatment of children has occurred in such institutions or centres
- (b) whether any breach of any relevant statutory obligation under the above Acts has occurred during the course of the care, protection and detention of children in such institutions.

In relation to (a) above, the Inquiry finds that unsafe, improper and unlawful care and treatment of children and young people has occurred in such institutions and centres.

In relation to (b) above, the Inquiry finds that breaches of relevant statutory obligations under the above Acts have occurred during the course of the care, protection and detention of children and young people in such institutions.

What follows in this chapter is a summary of the findings of the Inquiry with regard to:

- the principal abuses and breaches of the Acts reported in evidence
- the primary factors in institutions and government that made it possible for these abuses to occur
- the effect that the experience of abuse, mistreatment and neglect in institutions has had on the lives of victims of this abuse.

The chapter concludes with some recommendations of initial steps for reparation and healing.

### 12.2 PAST UNSAFE, IMPROPER OR UNLAWFUL CARE OR TREATMENT

The Inquiry found that there have been incidents of unsafe, improper or unlawful treatment of children in many institutions licensed and established under the relevant Acts.

Those that may result in criminal prosecution have been referred to the Queensland Police Service. In the case of other allegations of abuse, the passage of time, the fact that a number of alleged perpetrators are now deceased, and the difficulty in obtaining corroborative evidence meant that detailed findings could not be made. It has been possible, however, to make general findings on the nature of the abuse of children that took place in institutions within the Terms of Reference of the Inquiry.

The main categories of abuse identified by the Inquiry are emotional abuse, physical abuse, sexual abuse and systems abuse.

#### **Emotional abuse**

Children need care, protection and nurturing in an environment where there is trust and support. However, many institutions were austere places, staffed by people lacking the training, and in some instances the personal capacity, to provide the warmth and nurturing necessary for the healthy development of children. Until the early 1960s, most institutions were run on the basis of strict discipline, with little awareness of the developmental or even the educational needs of children. Impersonal treatment and a lack of respect for children's individuality were commonplace.

In many institutions, the emotional abuse of children went far beyond neglect of their emotional needs. Behaviours on the part of some carers amounted, on occasion, to mental cruelty. Demeaning and humiliating remarks were sometimes made on an almost daily basis, which had the effect of undermining children's confidence and sense of self-worth. Emotional

abuse can be the most damaging form of abuse, and its effects were profound on the lives of many who were subjected to it.

### **Physical abuse**

Corporal punishment was common in institutions, and was permitted under the Regulations to the Acts in certain circumstances. The Inquiry found incidents of gross excesses in physical abuse in many institutions, beyond any acceptable boundary in any period. Aside from individual incidents of abuse, the Inquiry found in some institutions and at certain periods a culture of physical punishment and brutality engendered or tolerated by the management. Westbrook, during the time when Mr IR Gollodge was Superintendent, provided the most extreme example of such a culture.

### **Sexual abuse**

Complaints of sexual abuse, committed either by other residents, by staff, or by visitors to the institution, emerged from almost all of the institutions under consideration. In some cases, the individuals alleged to have committed the offences had already been charged and in a small number of cases had already been dealt with. In many instances, the alleged perpetrators were long dead or could not be clearly identified.

Disclosure, difficult for any victim of sexual abuse, is even more difficult because of the power imbalances and vulnerability present in residential or institutional care. Children are often fearful that if they tell others about the abuse it may result in further abuse or re-victimisation by the system. Many witnesses said they were disbelieved and often punished for reporting abuse.

### **Systems abuse**

Many children historically have been the victims of the systems designed to provide care and protection for them. The Inquiry has found a range of ways by which children have been harmed while within the system. Some of the harm has been caused by ignorance of the needs of children on the part of providers; some by failures in the system to monitor and track the needs of individual children; some by a lack of commitment by government to provide adequate resources to care for the wellbeing of children; and some by a perception that children deserved no better.

One of the most obvious causes of systems abuse is the lack of funding and resourcing that has beset children's services both in the past and in the present day. Children and young people in care should receive adequate education, vocational training, physical and mental health care, leisure and recreation, contact with the community and family, and a range of programs that prepare them to function independently and risk-free upon discharge. Many children in institutions this century have not received even basic education, let alone the range of developmental programs that would be desirable.

Resource constraints have been a perennial problem for institutions. Despite this, the Department continued to place children in the institutions without regard to their capacity to provide proper care for the numbers they were receiving. The overcrowding at many denominational orphanages over the decades until the late 1960s meant that it was impossible for children to receive adequate, individual care and attention.

A recognition of the relationship between the Department and the denominations that ran licensed institutions is essential to an understanding of how institutional care could fail children in so many respects without intervention from the Department. The levels of funding with which almost all of the denominational institutions operated were patently insufficient to provide proper individual care. Yet the Department continued to place children in those institutions because they provided a cheap means of lodging; and it was able to use as justification the fact that the children were in Christian care. The churches, for their part, acquiesced in this indiscriminating placement of children because of their perceived obligation to provide refuge to homeless children, however inadequate their resources might have been. By doing so, they acquired an ascendancy over the Department, since it was most

unlikely that the Department would jeopardise its access to those placements by subjecting the institutions to scrutiny of the kind necessary to ensure that children were being cared for properly. The denominations were thus able to carry out what they considered to be their Christian mission without risk of interference from the Department, notwithstanding its guardianship role. For its part, the Department maintained an irreplaceable, cheap resource, and could complacently point to the fact that the children were being raised in a Christian environment.

Another insidious form of systems abuse to which many children were subjected was the implementation of practices that led to children not convicted of criminal offences serving indeterminate periods in an institution primarily for convicted children. Neglected children, or children on care and protection orders, could, with administrative approval, be transferred to ‘correctional’ facilities until they reached 18 years of age if it was considered that their behaviour warranted some form of treatment program. For some boys, they could be sent to these facilities simply because they had reached the maximum age accepted at an orphanage.

Similarly, children committed to care and control orders because they were considered to be in ‘moral danger’, ‘uncontrollable’, or ‘likely to fall into a life of vice or crime or addiction to drugs’ could remain in the care of the Director at a ‘correctional’ institution until they reached 18 years of age. The Inquiry heard from a number of witnesses who were unjustly incarcerated for extended periods of time, often for little more than their personal circumstances of neglect or purported endangerment. These examples are in stark contrast to the position of sentenced children, who were incarcerated for a maximum two-year term.

### **12.3 PAST BREACHES OF STATUTORY OBLIGATIONS**

Breaches of the Regulations in relation to food, clothing, education and corporal punishment were commonplace in institutions.

#### **Food**

Inmates at institutions licensed pursuant to the *State Children Acts* were, according to the Regulations, to be given ‘plain, wholesome food’ based on an approved dietary scale, a copy of which was to be hung in the institution’s dining room. The *CSA 1965* required merely the provision of ‘adequate’ food.

At various times, both the quality and quantity of the food given to children in institutions was inadequate. Indeed, the Inquiry heard numerous complaints of hunger being commonplace, particularly in the period up to and including the 1960s. The Inquiry finds that in the period up to and including the 1960s there were breaches of this legislation.

#### **Clothing**

Regulations 25 and 46 of the Regulations under the *State Children Acts* provided that all inmates of an institution were to be supplied with outfits, the details of which were prescribed. Regulation 18 permitted the clothing received with children on their admission to be ‘utilised for the purposes of the institution’. Section 40 of the *CSA 1965* required the provision of ‘adequate’ clothing.

Many of the witnesses to the Inquiry who had lived in institutions prior to the 1970s were given ill-fitting, stigmatising and insufficient clothing. The Inquiry finds that in the period up to and including the 1960s there were breaches of this legislation.

#### **Education**

Section 37 of the *State Children Act 1911 (SCA 1911)* required that children between five and 14 years of age be sent to a State school or other school approved by the Director. Regulation 9 made under that Act required that school-aged children in institutions be given ‘secular instruction in accordance with the syllabus of work required by the Department of Public Instruction in State schools’ (i.e. a standard education). The *CSA 1965* (section 40) required the person in charge of an institution to secure for each child ‘adequate education ... of such a

type and form as is approved by the Director or, in the absence of such an approval, as is in the best interests of such child’.

One of the strongest impressions left on the Inquiry was of the poor quality of education received by many of the witnesses. A number were illiterate, or close to it, despite having spent their childhoods in the care of the State; others who had, in their adult lives, displayed significant ability had not been able to achieve any higher level than Scholarship. This limitation on their education was one of the most profound and enduring losses suffered by former residents. The Inquiry finds that in the period up to and including the 1960s there were breaches of this legislation.

### **Discipline and corporal punishment**

Regulation 23 of the Regulations under the *SCA 1911* empowered the Superintendent of an institution to punish any State child guilty of misconduct. All complaints and punishments were to be entered in a punishment book. Corporal punishment was, pursuant to Regulation 24, ‘to be administered as seldom as possible ... only resorted to when absolutely necessary for discipline, and not for first offences unless of a grave nature’. It could be applied only in the presence of and by direction of the Superintendent. The 1966 Regulations under the *CSA 1965* reiterated the requirement that corporal punishment be used only as a last resort, and prohibited its use on girls. It could be administered only by or under the direction and supervision of the person in charge, in the presence of a suitable witness; and it could be applied only with a leather strap, of a type approved by the Department, over a child’s trousers. Again, a punishment book was prescribed, which had to be endorsed with the details of the punishment and the reasons for its application.

The Inquiry heard evidence of consistent use of corporal punishment and finds that excessive corporal punishment occurred in a number of institutions in breach of the relevant Regulations.

## **12.4 HOW THE ABUSE WAS ALLOWED TO HAPPEN**

How was it that numbers of children, while under the guardianship of the State, and in the care of some of our most esteemed denominational bodies, were able to be abused? This has been a most difficult question for the Inquiry to answer, but it is apparent that a number of factors have been involved and the convergence of these factors created an environment ripe for abuse to occur.

The causes of institutional abuse are summarised below in relation to the findings of the Inquiry in an endeavour to explain how the abuses were able to occur and to continue undetected.

The scant allocation of resources and support by government and society for staff recruitment and training has contributed directly to the abuse of children in residential or detention settings. Institutions caring for children were under-funded and short-staffed. In many cases, they accepted more children than they could safely accommodate. Overcrowding was common, and it was often a challenge simply to meet the physical requirements of children in terms of food, clothing and warmth. The emotional and nurturing needs of children were beyond possibility, even had there been an understanding of their significance.

Many institutions within the Terms of Reference were isolated, closed institutions with no parental and community involvement. Isolation from the wider community and lack of external scrutiny place an institution at high risk of harbouring abusive practices. Physical isolation also makes it difficult for professionals or relatives to visit.

In some of the larger institutions, buildings housing different groups of children were physically separate, and staff and children had little contact with other sections of the institution. It was possible in these environments for abuse to be taking place in one location and for other staff and children to be unaware of its occurrence.



Historically, most positions involving the direct care of children have carried very low financial rewards and required no qualifications. This has particularly been the case for non-government organisations. The church organisations were often reliant on volunteers prepared to work long hours for minimal remuneration, such volunteers usually being drawn from the ranks of the church and apparently motivated by religious commitment. These carers were often young, untrained and intimidated by the hierarchy of their organisations. The culture of the organisation, and acceptable practices in terms of emotional abuse and corporal punishment, were often established by the practices of senior staff whose underlying values and norms determined acceptable standards in the institution. Hierarchical structures made it difficult for young people and front-line workers to make complaints.

The Inquiry has heard evidence about many large institutions where a large number of children were cared for by relatively few staff. The larger the institution, the more difficult it is to avoid institution-focused care. Size leads to regimentation and ‘batch living’ which contributes to depersonalisation. This situation has led to a corruption of care standards.

Poor supervision and staff support also contributed to institutions being high-risk environments for children. Child care is difficult and challenging, and is made even more so where conditions are poor. Work hours were often extended and it was not unusual for staff to work with inadequate compensation. A heavy workload has been a consistent feature of the work of carers in orphanages. These factors contributed to the creation of an abusive environment. In situations of poor supervision, no inspections, and little accountability or external advocacy for children, caregivers wielded almost unlimited power over children.

Powerlessness has been a central cause for almost all the young people subjected to abuse in care. Their weakness and vulnerability is characterised by their lack of power or influence, their scant knowledge of how the organisation works, and their lack of awareness of how to assert their rights or make complaints about those on whom they depend for the basic elements of living. Many witnesses said they had lost faith that anyone would ever take their complaint seriously.

Without standards, the monitoring of institutional practice is arbitrary and is left to the discretion of the inspector or representative of the licensing authority. A consistent feature of the evidence of former staff of the Department was the virtual absence of standards and procedures prior to the 1970s, when the professionalisation of the Department largely occurred.

Historical evidence demonstrates that the Department failed to provide protection from abuse for children in residential care facilities. Its performance fell far short of the requirements outlined in the Regulations. Notwithstanding the Director’s guardianship of the children in its care, the Department appears to have ceded responsibility for protection against abuse to the institutions.

## **12.5 ABUSE, NEGLECT AND MISTREATMENT OF CHILDREN TODAY**

### **Residential care facilities**

Although the Inquiry found far fewer incidents of abuse and breaches of Regulations in contemporary institutions, there were some. There are also a number of shortcomings in the oversight, management and operation of residential care facilities today that place children in those institutions at potential risk of harm.

The Inquiry found clear indicators of the risks of abuse in the areas of funding, standards monitoring and casework practice. There is a significant disparity in the way services operate, the degree to which they are monitored and supported by DFYCC, and the extent to which children and young people in care are at risk. The Inquiry found examples where services failed to meet their obligations under the law and were at risk of failing to prevent abuse in care.

An examination of current practice in residential care in Queensland found that the Practice Standards used by DFYCC for residential care are no more than a set of principles and aspirations, unconnected to any mechanism to assess whether agencies are meeting them. Because compliance with the Standards requires resources and time on the part of both the Department and the agency, there is little incentive for either party to attend to the application of the Standards to the services.

Managers of some residential facilities were unsure of their rights or of the processes involved when a staff member is suspected of abusing a child in care. In all cases, the response was to ‘immediately inform the Department’. Beyond this, however, there seemed to be little understanding of the rights of the agency as an employer, their obligations to protect the child, and their responsibilities to the accused staff member, other staff and the informant (where there is one).

Police checks are relied on to ‘clear’ staff to be employed in residential facilities for children and young people. There was very little evidence that comprehensive reference and qualification checking procedures were used, or intensive interview procedures. Because of the difficulties of attracting qualified staff to work in residential care, agencies were reluctant to make it more difficult to recruit.

If a fundamental characteristic of abuse in care is its secrecy and its pervasiveness in the culture of the organisation—either between the child and the staff member, or on the part of the organisation in order to protect itself—ad hoc inspections are unlikely to be useful. It is unlikely that abuse will be detected by a ‘flying visit’ from an Official Visitor or a licensing officer. For abuse to be uncovered—whether it is rife through the organisation or a once-only incident—a range of strategies needs to be in place that will provide blanket coverage of the organisation and inhibit any attempts at organised abuse of residents.

There are a number of risk areas:

- Some residential care institutions are currently isolated.
- Recruitment and selection procedures in residential care facilities need improvement.
- There are deficiencies in the design of the physical environments in some facilities.
- The absence of clear standards creates the potential for abusive situations to occur.
- There is a clear need to improve procedures and mechanisms for the reporting and sound management of abuse.

The Inquiry found little evidence that DFYCC actively works in a systematic way to reduce the risk of abuse of children in residential care facilities.

### **Detention centres**

Detention centres house large numbers of troubled children and young people. An important part of their role should be rehabilitative and diversionary in order to prevent young people graduating to the adult prison system. They are failing in that role. The Inquiry found that in a number of ways they offer less to detainees than the adult prison system does in terms of privacy, facilities, safety and programs. The detention centres suffer from inadequate physical facilities, a lack of staff training and supervision, a paucity of programs for detainees and an over-emphasis on security.

Current practices blur essential distinctions between the operation of incentive schemes and disciplinary systems. The wide level of discretion regarding the type of ‘consequences’ (disciplinary measures) that can be imposed means that the response can be appropriate to the situation, but it also increases the risk of inappropriate and in some cases abusive and/or unlawful sanctions.

Detainees’ visits may be restricted as a consequence of misbehaviour. Access to family and friends is essential for the wellbeing of young people in detention, and it is unacceptable that the already limited opportunity for visits may be further reduced. It also fails to comply with

the general principles of juvenile justice provided in section 4 of the *JJA 1992* and in particular section 4(f)(iii), which requires a child offender to be ‘dealt with in a way that strengthens the child’s family’.

Regulation 16(1) of the Juvenile Justice Regulations 1993 provides that a child can be separated in a locked room only if the child is ill, the child requests it, for routine security purposes in accordance with departmental guidelines (for the child’s protection or the protection of other persons or property), or to restore order. The Regulation implicitly recognises the potential psychological and emotional harm to a child that can be caused by separation in a locked room. The current practice of isolating young people suggests that its potential harm and the regulatory requirements have been confused or overlooked.

The frequency with which detainees in Queensland’s juvenile detention centres are searched indicates that their dignity, privacy and psychological wellbeing are repeatedly ignored in favour of scrupulous security procedures. Searches of any kind are intrusive, embarrassing and reinforce the relative powerlessness of the person subjected to them. Unclothed searches are especially so, particularly for self-conscious adolescents, many of whom have suffered physical and sexual abuse.

The Regulations permit the use of reasonable force to carry out these searches. Although all centres keep a register of unclothed and body searches, they do not indicate if force was used. The physical restraint of a non-compliant young person to permit workers to forcibly remove his or her clothing is unacceptable. Intentional repeated strip-searching of a detainee at random intervals is clearly in breach of section 14(3)(c) of the Juvenile Justice Regulations 1993, which prohibits as discipline ‘an act that involves humiliation, physical abuse, emotional abuse or sustained verbal abuse’.

There is a high level of consciousness among all staff in the centres about the potential for detainees to attempt to harm themselves. Despite this, all centres continue to provide ample opportunity for self-harm in shared bathrooms and in many detainee rooms.

Complaints mechanisms that exist are poorly developed and inadequate to provide meaningful data on current operations. There is little awareness of the need for monitoring and review processes in the centres. Whatever the reason, limited monitoring and inadequate complaints systems increase the chance for child abuse and neglect to occur in the centres and go unreported.

Section 215(1) of the *Juvenile Justice Act 1992* provides that a detainee or parent of a detainee may complain about any matter affecting the child. The Inquiry was unable to find a departmental procedure for general detainee complaints, although procedures exist for complaints of alleged misconduct by staff and the role of Official Visitors in receiving complaints. The lack of such departmental procedures breaches section 215 of the Act.

Comment must be made on two groups of young people who are disproportionately represented in the centres, and for whom there may be alternatives to incarceration. The first group is young people on remand. Almost half of all detainees at any one time are on remand, and alternative placement options are urgently required for these children. The second group is indigenous young people, who are grossly over-represented in juvenile detention centres.

The Inquiry found a number of serious shortcomings in the operation of juvenile detention centres in the form of practices that do not meet legislative requirements or acceptable standards. These shortcomings are outlined in detail in Chapter 9, and indicate that young people in detention centres today may be at risk of abuse or mistreatment, and are certainly living in physical facilities far inferior to adult correctional facilities, and which fall short of the legislative requirements and the relevant UN Convention. The current operation of these centres is unlikely to rehabilitate young offenders, and is more likely to increase their disaffection with society and their risk of subsequent reoffending.

## 12.6 DEFICIENCIES IN THE CURRENT LEGISLATION

The current legislative framework for children in institutions consists of three major pieces of legislation. The legislative base for provision of residential care services for children and young people is provided by the *CSA 1965*. This legislation will be superseded by the *Child Protection Act 1999*, which was assented to on 30 March 1999 but has not yet been proclaimed. For juvenile detention centres, the legislative base is provided by the *Juvenile Justice Act 1992*.

There are a number of important shortcomings in the current legislative provisions for care and protection of children in institutions. These are:

- There is no legislatively mandated reporting process for abusive incidents involving children and young people in residential care or in detention centres.
- There are no legislative requirements for DFYCC to conduct regular supervisory or inspection visits to residential care facilities or detention centres.
- There is currently no legislative requirement that DFYCC collect information relating to abuse of children and young people in out-of-home and institutional care or to monitor such abuse.
- There is currently no legislative provision for advocacy services for young people in residential care or in detention centres.
- There is no provision in legislatively prescribed licensing requirements that residential care services be subject to regular review or evaluation, or for records of these procedures to be considered in licensing decisions.

## 12.7 CONSEQUENCES FOR VICTIMS OF ABUSE

There is still a great deal that is not understood about the outcomes of child abuse. It is not an easy subject to study and it is often difficult to disentangle the effects of abuse from the effects of other factors such as disrupted families. There is, however, a general consensus that outcomes are often profoundly negative. This section endeavours to provide readers with some insight into how the experiences of abuse in institutions have affected victims' lives.

The consequences of abuse are in many cases serious and pervasive. Relationships may be dysfunctional. Low self-esteem and self-worth, compounded by lack of education, can develop into mental health problems that further limit victims' capacity to achieve their human and economic potential. The consequences for individuals are varied and, as outlined earlier, dependent on many factors. Witnesses described a number of enduring effects of their institutional experiences, including a lack of self-esteem, an inability to trust others, and relationship problems exacerbated by anger and aggression. One referred to the long-term impact in the following way:

*... the systematic degrading of who I was and what I believed in ... every moment of the day out there they made me feel like I was a nothing. A nobody. Worse than dog shit ... I went away believing it, I think.*

Striking features of witness evidence were suicide attempts and relationship failures. For a number of witnesses, admission to an institution started a process of institutionalisation that ended in gaol.

The Inquiry recognises that it is not often possible to link a specific instance of institutional abuse to a specific problem faced by an individual in later life. However, there is little doubt that children who have been exposed to severe or prolonged abuse face long-term problems that will disrupt or damage the rest of their lives, and affect all those significant others around them.

*Living at that hellish place has left me with enduring nightmares, emotional pain and torture, resentment, insecurity and self-loathing. I have never shaken the feeling of worthlessness. They [staff] told me I was no good—that's what I believe. I cannot express how these experiences have affected my life. I cannot shake feelings of self-*

*hatred and guilt. My education and marriage have suffered. I could not be the mother I wanted to be to my children. On occasions, I know I have let them down by lacking the strength to stand up for the right thing. I get so depressed sometimes, because I know there wasn't any way to change how things turned out for me, and for those who depended on me. [The orphanage] took away my childhood. It left me with no hope.*

The effects of childhood maltreatment cannot be categorised easily and outcomes can vary a great deal among survivors according to the type of abuse, how long it went on for, the child's relationship with the abuser, and resilience factors that may have gone some way towards protecting the child.

Although the following sections are arranged according to the different forms of abuse, this is not meant to understate the complexities involved in discussing outcomes of child abuse, nor the compounding effects on children who experience a range of abuses. There is substantial overlap between different types of abuse; children who experience one form of abuse are far more likely to experience other forms.

Because the Inquiry was concerned with institutional abuse, it is important to consider how the abuse perpetrated by trusted authority figures can have a compounding effect. When such people carry out abuses, the trauma can be intensified (Single 1989). One witness gave this account of how the perpetrator of his sexual abuse rationalised the act:

*Father [name] told me it wasn't a sin as I was one of God's chosen children and that God made boys to be special so that those who did God's work were not led into the temptation of sinning with women. I was told by him that I was to say nothing to anyone because God would be very angry with me for revealing his secret ways.*

Abuse perpetrated by representatives of the religious faith to which children belonged added more serious enduring effects.

### **Physical abuse**

There are seven main outcomes of physical abuse: aggressive and violent behaviour, non-violent criminal behaviour, substance abuse, self-injurious and suicidal behaviour, emotional problems, interpersonal problems, and academic and vocational difficulties (Malinosky-Rummell & Hansen 1993).

There is now little doubt about the relationship between childhood physical abuse and emotional and psychological problems in later life. These problems include anxiety, depression, hostility, paranoid thoughts, psychosis and dissociation disorders (see, for example, Fox & Gilbert 1994; Middleton & Butler, in press). Adolescents and adults who exhibit violent behaviours have often been abused as children. Such violent behaviours can include violence towards people inside the family, violence towards authority figures, homicidal behaviours, fighting or violent criminal acts, and rape (Riggs et al. 1990; Straus et al. 1980; Kroll et al. 1985; Rosenbaum & Bennett 1986; Pollock et al. 1990). One witness to the Inquiry spoke of his perceptions about the effect that constant beatings had on his later life:

*Well, the effect is, you know ... it's a day-to-day issue with my temper and I've got it pretty well under control. I don't like getting drunk because I get out of control and that's only because of what happened ... I could be sitting somewhere talking to friends or whatever and you might see something on TV, and off you go. No reason at all, you know?*

An Inquiry witness described how he coped with life after his institutionalisation:

*I didn't care any more. I just lost all—I didn't care about anything. I forced myself not to care. Anything bad ever happened to me I remember I had this internal sentence that I would say: 'I don't care. I don't care'. And I would keep repeating that to myself. And I think that [institution] created a lot of those little internal sentences. And I remember them all. 'This is only one minute of one day of one week of one month of one year' ... I became a very angry person as well ... sometimes I would want to kick things, I'd want to*

*bash at the wall or I'd want to hurt myself. I never—I don't think I ever—directed anger at anyone else. It was always directed at myself. And I think that getting into a lot of trouble in my life ... for about the next five years, was all about wanting to punish myself.*

A number of behavioural problems are related to corporal punishment, such as sleep disturbances, temper tantrums, aggressive behaviour, nightmares, headaches, frequent crying, anger and withdrawal. Involuntary urination or enuresis are common experiences for children who suffer corporal punishment (Hyman 1987). As already reported, many Inquiry witnesses described problems with bed-wetting during their time in institutions.

### **Sexual abuse<sup>1</sup>**

Child sexual abuse is now widely regarded as causing mental health problems in adult life. Specifically, child sexual abuse has an impact on social, sexual and interpersonal functioning, and affects the child's developing capacities for trust, intimacy, mastery of their world and sexuality. When discussing outcomes of child sexual abuse, a distinction should be made between severe, physically intrusive forms of sexual abuse involving penetration and other less intrusive forms such as touching or exposing genitalia to a child. In general, intrusive forms of abuse result in more profoundly negative consequences.

It is now well documented that sexually abused children experience difficulties at school with academic performance and behaviour. These difficulties are likely to have a negative influence on later educational attainment, and restrict the skills and discipline necessary to maintain an effective role in the workforce (Tong et al. 1987; Cohen & Mannarino 1988; Einbender & Friedrich 1989).

Child sexual abuse involves a breach of trust or an exploitation of vulnerability, and frequently both. Sexually abused children face not only an assault on their developing sense of their sexual identity, but a blow to their construction of the world as a safe environment and their developing sense of others as trustworthy. In those abused by someone with whom they had a close relationship, the impact is likely to be all the more profound.

The following quote from a former orphanage resident who was sexually abused by a highly esteemed volunteer worker exemplifies the powerlessness of the children in State care:

*And when I was first at his flat, the first time he put his hand up my trousers, I backed away. He said 'You're still a ... State ward'. And I knew what a state ward was. I knew all the implications. If you were a state ward, I could go to your house and you could put the hard word on me, or whatever, and I could say no, and you could tell Mr X [the Inspector of Orphanages] that I stole two quid. There was no court case. There was no police investigation. Mr X was the District Inspector. He could send you to Westbrook. He could just write a form.*

A history of child sexual abuse is reported to be associated with insecure and disorganised attachments (Alexander 1983; Briere & Runtz 1988; Jehu 1989) and increased rates of relationship breakdown (Beitchman et al. 1992; Bagley & Ramsey 1986; Mullen et al. 1988; Mullen et al. 1994). Poor self-esteem in adults has also been shown to be associated with child sexual abuse, and is thought to be an outcome of the more intrusive forms of abuse involving penetration (Romans et al. 1996). Child sexual abuse also affects the mental health of many survivors (Briere & Runtz 1988; Winfield et al. 1990; Bushnell et al. 1992; Mullen et al. 1993; Romans et al. 1995 and 1997; Silverman et al. 1996; Bucky & Dallenberg 1992; Spanos 1996).

### **Emotional abuse**

Emotional abuse is thought by some theorists to have the most destructive consequences for children (Garbarino & Vondra 1987), but it is rarely assessed in studies of childhood physical abuse and neglect (Rosenburg 1987). In fact, it has been well documented that physical and/or sexual abuse usually occur alongside emotional abuse (Egeland et al. 1983; Garbarino & Vondra 1987), so it is difficult to assess the severity of the consequences of specific emotional abuse. There is, however, a developing agreement that emotional maltreatment is a

fundamental cause of negative developmental outcomes for children (Garbarino 1990; Navarre 1987). A number of witnesses described repeated psychological abuse:

*I was made, by the degrading way they treated me, to feel like a worthless piece of rubbish that nobody wanted, and this feeling, engendered in me by them, followed and affected me long into my adult life.*

For those children exposed to psychological abuse over some years, the resulting inability to develop good relationships with others creates a vulnerability to further abuse. It may result in exposing the child to further risk from carers who do not understand or respond well to the child's dysfunctional behaviours.

One witness recounted his experience when he reported that he had been sexually abused:

*'How dare you tell a lie about a priest, you filthy animal, you shocking thing. You're a boy of the Devil [name], that's what you are.' You know, that's what I got and I just got flogged because of it.*

Many witnesses spoke of poor self-esteem:

*I still have got a very low self-esteem. I won't even attempt to get dressed up or anything like that ... I don't even look after myself ... even if I have to go out, and I say have to, because that'd be the only time I go anywhere ... I won't wear a pair of shoes. I won't put any makeup on ... But when I get there I get cranky because I think people are looking at me because I'm not dressed properly. Half of me knows that I should be making an effort.*

It is to be expected that where staff are caring for unreasonably large numbers of children the nurturing needs of the children will not be met. For example, a former carer described her responsibilities, the extent of which made it impossible for her to give individual love and attention to her charges:

*I was in charge of the nursery. I had 25 to 30 babies in the nursery and two girls, 14-year-old girls who were orphans too, to help me. I had about four babies that were on bottles, about six to eight months, and a couple about 18 months old. I remember I had 10 two-years-olds that had to be potty trained. And the rest would be about three to four.*

For many former residents this resulted in memories of the emotional barrenness of their experience. For example:

*It was a very lonely place. We were never allowed to talk to each other. Even the [staff] didn't talk to each other and they certainly didn't talk to us except to yell at us or abuse us. We weren't allowed to have friends and if we did we were immediately separated. For speaking, there were many forms of punishment. With 60 children there, I can remember the utter loneliness of the whole place.*

When discussing the impact on consequent relationships of being abused in an orphanage, another witness remarked:

*I haven't got relationships as such with my children ... at all. I don't know. It's my fault I suppose, that they didn't—I didn't show them any love and I could never tell any of them that I loved them. I could never cuddle them. Having babies for me was just a—it was like a vacuum. I don't even remember doing it.*

## 12.8 SUMMARY

One of the outcomes of the Inquiry has been to establish the historical record and to place before the government, religious organisations and society at large the evidence that, over decades, considerable numbers of children were subjected to inexcusable physical, emotional and sexual abuse in institutions that were established to care for them. Those children are now adult survivors of that abuse and have experienced profoundly disturbed lives as a result of their abuse. In addition they were subjected to systems abuse.

Reparation will require the government and responsible religious organisations to enter into a restorative process with survivors to redress the harm done. Accountability for the harm done cannot be characterised as a legal issue only; the government and religious organisations must also accept moral and political accountability. The approach to reparation must include the engagement of survivors in the design of the redress process, provision of independent advice to victims regarding the redress options available to them, respect for and sensitivity towards them when conducting these processes, and a recognition of the power imbalance between victims and institutions. The principle of compensation is accepted in our society as a means of restitution for damages resulting from the types of abuse many children suffered in Queensland institutions.

**Recommendation**

That the Queensland Government and responsible religious authorities issue a formal statement acknowledging the significant harm done to some children in Queensland institutions licensed under the *Infant Life Protection Act 1905*, the *State Children Act 1911*, the *Children's Services Act 1965* and the *Juvenile Justice Act 1992*, formally apologise for that harm, and make a commitment to prevent further abuse.

**Recommendation**

That the Queensland Government and relevant religious authorities organise a reconciliation event for former victims of abuse in orphanages and detention centres after consultation with them.

**Recommendation**

That the Queensland Government and responsible religious authorities establish principles of compensation in dialogue with victims of institutional abuse and strike a balance between individual monetary compensation and provision of services.

**Recommendation**

That the Queensland Government and responsible religious authorities fund an independent 'one stop shop' for victims of abuse in institutions that provides a range of services such as:

- ongoing counselling for victims and their families
- facilitation of educational opportunities including literacy programs
- advice regarding access to individual records, documents and archival papers
- specialised counselling services for indigenous victims of abuse
- assistance to former child migrants for reunification with their families.

**Recommendation**

That the Department develop transitional programs to prepare young people in the care of the State for independent living and help them to make the transition by providing assistance to gain employment, education and housing.

**Recommendation**

That the Queensland Government establish a process for the implementation and review of the recommendations of this Inquiry, requiring annual progress reports to Parliament on the implementation of recommendations over the next two years.

**FOOTNOTE**

<sup>1</sup> Paul Mullen, expert submission to the Inquiry.



## APPENDIX 1

### *STATE CHILDREN ACT 1911*

The *State Children Act 1911* commenced on 30 November 1911. It repealed the *Industrial and Reformatory Schools Act 1865*, the *Orphanages Act 1879*, the *Industrial and Reformatory Schools Act Amendment Act 1906* and section 3 of the *Children's Protection Act 1896*.<sup>1</sup>

#### **1. PURPOSE OF THE ACT**

The Act was intended to be a codification of existing laws with respect to State children and to incorporate various suggestions based on the experience of the Inspector of Orphanages.<sup>2</sup> The Act was modelled to a large extent on South Australian and Western Australian legislation passed in 1895 (amended up to 1909) and 1907 respectively.<sup>3</sup>

Except where expressly stated, the *State Children Act* was not intended to be construed to repeal or prejudicially affect the *Aboriginals Protection and Restriction of the Sale of Opium Acts 1897–1901*, the *Infant Life Protection Act 1905* or the *Children's Courts Act 1907*.<sup>4</sup>

#### **State Children Department**

The Act established the State Children Department.<sup>5</sup>

#### **2. POWER TO MAKE REGULATIONS**

Section 81 vested the Governor-in-Council with powers to make Regulations with respect to a number of specific matters, the most relevant of which were:

- the duties, powers, authorities and privileges of inspectors, visitors and other persons engaged in the administration of the Act
- the management, control and supervision of institutions
- the custody, maintenance, education, employment, placing out and apprenticing of State children; the visitation of such children; the discipline of such children; wages and rewards of such children; the management and control of the property of such children
- records to be kept at, and reports to be made by, institutions and by licensees.

Given that the focus of the Inquiry has been on the period after 1935, the Regulations in force from 16 January 1919 onwards have been incorporated in this summary of the relevant legislative provisions.<sup>6</sup> Regulations promulgated on 25 July 1935 repealed all prior Regulations made under the Act.

#### **3. POWER TO ESTABLISH AND LICENSE INSTITUTIONS**

##### **Establishing institutions**

The Governor-in-Council was empowered to establish and abolish receiving depots, orphanages, industrial schools, reformatories, training homes, training ships, farm schools, technical institutes and other institutions for the maintenance of State children.<sup>7</sup>

##### **Licensing institutions**

The Governor-in-Council was given the power to approve any orphanage, industrial school, reformatory, training home, farm school, technical institution or other institution established by private benevolence by issuing a licence.<sup>8</sup>

##### **Withdrawal of licence**

The Governor-in-Council could, on the report of the Director, withdraw his approval of a licensed institution if dissatisfied with its condition, management or maintenance. Withdrawal of approval resulted in cancellation of the licence.<sup>9</sup>

## **Other powers conferred on the Governor-in-Council**

The Act conferred power on the Governor-in-Council to make the following appointments:

- Director of the Department who was to carry the Act into operation, under the direction of the Minister<sup>10</sup>
- Deputy Director<sup>11</sup> who was to exercise all such powers, authorities and functions as the Director may direct or require as well as to act in the position of Director in the Director's absence<sup>12</sup>
- visiting Justices, inspectors and other officers with such powers and functions as deemed necessary to carry out the purposes of the Act.<sup>13</sup>

## **4. POWERS CONFERRED ON THE MINISTER**

The Minister was given power to appoint:

- matrons, warders and other servants of State institutions<sup>14</sup>
- a committee of management for any State institution and could prescribe the powers, authorities and duties of any such committee<sup>15</sup>
- as many honorary visitors as he thought proper.<sup>16</sup> The role of the honorary visitors was to assist the Department in procuring and supervising boarding-out homes (now termed foster homes) and to assist in the care of the State children sent to such homes, or placed out for hire, or discharged or released on probation under the Act.<sup>17</sup>

## **5. POWERS CONFERRED ON THE DIRECTOR**

Subject to the Act and the Minister's directions, the Director of the State Children Department had the care, management and control of all State children, whether they were inmates of institutions, placed out or apprenticed, until they turned 18 years of age. The Director had the care, management and control of State children's property until they were 21 years of age.<sup>18</sup>

The Director became the guardian of all State children, excluding parents or other guardians, unless the Minister ordered otherwise, until the child was discharged from State care.<sup>19 20</sup>

## **Responsibilities of the Director**

The responsibilities of the Director were:

- to keep records of all monies received and paid under the Act and, so far as is known, of the names, ages, dates of reception, near relatives, nationality, sex, religion and dates of discharge of all State children, and of all disposition of and dealings with such children<sup>21</sup>
- to report every year to the Minister on the working of the Act, specifying the number of children in institutions and the number placed out and apprenticed during the specified period. The report had to also set out a summary of the receipts and expenditure of the Department and any other particulars that the Minister may direct to be included in the report. These reports were required to be laid before Parliament.<sup>22</sup>

## **6. DEFINITIONS**

### **Institutions**

- 'Institution' included all State institutions established or deemed to be established under and for the purposes of the Act, and all other places for the time being under the supervision of the Department and, where necessary, included a licensed institution.<sup>23</sup>
- 'Licensed institution' included all institutions for the maintenance of State children that had a subsisting licence under the Act.<sup>24, 25</sup>

### **State child**

A 'State child' was defined as a neglected child, convicted child, or any other child received into or committed to an institution or to the care of the Department, or placed out or apprenticed under the authority of the Act.<sup>26</sup>

## **Neglected child**

A 'neglected child' was one who:

- habitually begs or receives alms, whether under the pretext of sale or otherwise, or frequents a public place for the purpose of so begging or receiving alms
- wanders about or frequents a public place or sleeps in the open air, and does not satisfy the court that the child has a home or a settled place of abode
- dwells in any reputed brothel, or associates or dwells with any person known to the police or to the Department to be a prostitute, whether such person is the mother of such child or not
- associates or dwells with any person who during the last preceding 12 months has been convicted of vagrancy, or who is known to the police or to the Department to be of bad repute, or to be an habitual drunkard
- has no sufficient means of subsistence apparent to the court, and whose near relatives are, in the opinion of the court, in indigent circumstances and unable to maintain the child, or are dead, unknown, or cannot be found, or are out of Queensland or in the custody of the law
- is under the guardianship of any person whom the court considers unfit to have such guardianship, or is living under such conditions as to indicate that the child is lapsing or likely to lapse into a career of vice or crime
- is illegitimate, and whose mother is dead or is unable to maintain the child
- being under the age of 14 years, sells or offers for sale, between the hours of seven o'clock in the evening and six o'clock in the morning, in a public place or in any place other than the child's home, matches, newspapers, flowers, or any other thing whatever
- being of the compulsory school age, is an habitual truant from day school
- being a girl, in a public place, by day or night solicits men or otherwise behaves in an indecent, improper, or disorderly manner
- not being the child or ward of the licensee, is, on more than one occasion and without lawful excuse, found in the bar, bar-room, or billiard-room of any licensed victualler or wine seller, or is on more than one occasion served with intoxicating liquor in or upon the premises of any licensed victualler or wine seller
- is brought before a court as an uncontrollable child to the intent that such child may be committed.<sup>27</sup>

When the State Children Bill was introduced into parliament, the then Attorney-General commented that the term 'neglected child' was very comprehensive: 'It not only includes a neglected child in the ordinary sense of the word but it also includes destitute children, and all children whose surroundings are such as to degrade or brutalise them or to make them tend to fall into the criminal class.'<sup>28</sup>

An authorised officer or police officer could take any child into custody who appeared to be a neglected child.<sup>29</sup> The matter would then be taken before the Children's Court, which, if satisfied that the child was neglected, could place the child in an institution.<sup>30 31</sup> Neglected children who were to be sent to institutions were not to be sent to reformatories unless the Children's Court deemed that there were special circumstances.<sup>32</sup>

## *Convicted child*

A 'convicted child' was a child found guilty or convicted of any crime or offence punishable by imprisonment.<sup>33</sup> Section 26(1) required that every convicted child over the age of 13 years committed to an institution was to be sent to a reformatory or industrial school. Convicted children under the age of 13 years who were to be sent to institutions were not to be sent to reformatories.<sup>34</sup>

## *Uncontrollable child*

A parent or near relative of a child, or an authorised or police officer, could bring a child before a Children's Court on a complaint that the child was uncontrollable.<sup>35</sup> If the Children's Court was satisfied that the child was uncontrollable, the child could be placed in an institution.<sup>36</sup>

### *Children released on probation*

Children who had been released on probation or discharged from an institution on probation and who failed to observe the conditions of their probation could be sent to an institution in the same manner as uncontrollable or convicted children.<sup>37</sup>

### *Inmate*

An 'inmate' was defined as a State child maintained in an institution.<sup>38</sup>

## **7. AFTER 18 YEARS OF AGE**

State children were not to be detained in institutions after reaching the age of 18 years unless they were over the age of 16 years when ordered to be detained in an institution and the order was for a period of two years. In those cases, the child could be detained in the institution until the expiration of the order.<sup>39</sup>

## **8. HOW STATE CHILDREN MAY BE DEALT WITH<sup>40</sup>**

State children could be:

- placed in some receiving depot<sup>41</sup>
- detained in an institution
- transferred, with the approval of the Minister, from one institution to another
- placed out<sup>42</sup> or apprenticed
- placed in the custody of some suitable person willing to take charge of such child.

In special circumstances and with Ministerial approval, an inmate of any institution could be transferred for:

- misconduct—to an industrial school or reformatory
- good conduct—from an industrial school or reformatory to another institution.<sup>43</sup>

The Director could do any of the above without reference to the parents or relatives of the child and without informing them of what had been done.<sup>44</sup>

## **9. POWERS AND RESPONSIBILITIES GIVEN TO THE INSTITUTIONS**

The Act required that any institution given a licence had to appoint a superintendent and that every time the superintendent was changed, the name of the new superintendent had to be submitted to the Minister for approval.<sup>45</sup>

Generally, the superintendent was responsible for the custody of the children in the institution and was required to see that all officers carried out their duties satisfactorily.<sup>46</sup>

The Minister was also to be notified of any changes made to the persons on the governing authority of an institution.<sup>47</sup> The governing authority of each institution was to have responsibility for the whole management and supervision of the institution, including appointment of staff. The institution and the inmates, however, remained subject to the provisions of the Act.<sup>48</sup>

The Act provided for the governing authority of every licensed institution to receive money for every State child maintained until the child was 14 years of age. The Minister could extend the age limit for children who had been returned from service, or were crippled, invalid, of unsound mind, dumb or blind, but only up to 18 years.<sup>49</sup>

The accounts of licensed institutions were subject to audit as directed by the Auditor-General.<sup>50</sup>

## **10. EDUCATION**

Every State child over the age of five years was required to be sent regularly to a State school or other school approved by the Director until the age of 14 years. That age could be extended if the child was attending school for the purpose of qualifying for and obtaining a State scholarship. If such a scholarship was obtained, the period extended for the term of the scholarship. If a State child passed the State High School entrance examination, the period could be extended for a period determined by the Minister.<sup>51</sup>

The Regulations required that:

- all officials<sup>52</sup> do their utmost to train the inmates in habits of truthfulness, honesty, cleanliness, perseverance, modesty, courtesy and temperance, and fit them to live honourable and useful lives after leaving the institution<sup>53</sup>
- inmates be given secular instruction 'in accordance with the syllabus of work required by the Department of Public Instruction in State Schools.'<sup>54</sup>

## **11. VISITS AND EXTERNAL CORRESPONDENCE**

Parents and friends could visit inmates who were entitled to receive visitors on presentation of an order from the Director or district officer<sup>55</sup> on the specified visit day. Visits were not to be longer than one hour nor more frequent than once every four weeks. Persons of known bad character were not to be permitted to visit inmates.<sup>56</sup>

All letters to and from inmates were to be sent through the superintendent who could, after perusal, forward the letter to the Director or district officer if he considered it undesirable to deliver the letter.<sup>57</sup>

It was an offence to hold or attempt to hold communications with an inmate of an institution without the authority or permission of the Director or an authorised officer.<sup>58</sup>

## **12. STATE CHILD NOT TO LEAVE STATE**

From 1917, the Act prohibited the removal of State children from Queensland.<sup>59</sup>

## **13. RECORDING PARTICULARS OF CHILDREN**

The superintendent was required to send full particulars of every State child received in their institution to the Director or district officer. Full particulars were also to be sent of children who died in the institution.<sup>60</sup>

## **14. ADMINISTERING PUNISHMENT**

The superintendent of any institution could punish any State child guilty of misconduct. All complaints and punishments were to be carefully recorded and entered in a punishment book, which was to be produced to the Director or inspector whenever he visited the institution.<sup>61</sup>

Corporal punishment was to be administered as seldom as possible, only when absolutely necessary for discipline, and not for first offences unless of a grave nature. No corporal punishment was to be inflicted except by direction and in the presence of the superintendent.<sup>62</sup>

Children in industrial schools or reformatories were to be classified, and could rise from a lower to a higher grade by good conduct, and be downgraded for misconduct. The record of conduct of each child was to be kept in a conduct book.<sup>63</sup>

## **15. FOOD**

Inmates were to be supplied with 'plain, wholesome food, according to a dietary scale approved of by the Minister.' A copy of such scale was to be hung in the dining room, and be adhered to as strictly as possible.<sup>64</sup>

The superintendent was to ensure that the food was good and sufficient, properly cooked, and served with regularity and order in the presence of an officer of the institution.<sup>65</sup>

## **16. BEDDING**

Each inmate was to have a separate bed, and be furnished with sufficient and seasonable bedclothes.<sup>66</sup>

## **17. CLOTHING**

The clothing brought into an institution by an inmate could be utilised for the purposes of the institution.<sup>67</sup> Each child was to be provided with outfits in accordance with those prescribed for children fostered out.<sup>68</sup>

## **18. MEDICAL TREATMENT**

The superintendent<sup>69</sup> of an institution was required to keep all books and records required by the Department, and promptly report to the Director or district officer the absconding, serious illness or death of a child, and any other special event.<sup>70</sup>

## **19. INSPECTIONS**

The Director or inspector could inspect an institution at any time. Such inspections were to be made at least once a month with a view to:

- ensuring all Regulations were carefully observed and all matters connected with industrial training of the inmates were properly carried out
- reporting defects or improvements considered necessary for the comfort and benefit of inmates<sup>71</sup>
- ensuring that all books and journals that were required to be kept were open to his inspection.<sup>72</sup>

## **20. TIMETABLE**

A timetable showing hours of rising, work, school instruction, meals, recreation and retiring was required to be submitted for the approval of the Minister.<sup>73</sup>

## **21. RELIGION**

Where practicable, inmates were to attend the place of worship for their denomination.<sup>74</sup>

## **22. REGULATIONS FOR WESTBROOK REFORMATORY FOR BOYS**

In 1916, 1962 and 1964, specific and exclusive Regulations were passed for the Westbrook Reformatory for Boys. Those Regulations were not affected by the Children's Services Regulations of 1966. The Regulations most relevant to this Inquiry are set out below:

### **The superintendent's role**

The role of the superintendent was expressed in the following terms:

*He shall see that the boys are treated with kindness, combined with strict discipline, and he shall check all harsh conduct on the part of the officers. He shall arrange that a suitable system of recreation is provided.*<sup>75</sup>

### **Punishment register**

The warder-teacher was required to keep a punishment register,<sup>76</sup> and was empowered to detain pupils for detention for misconduct and disobedience.<sup>77</sup> Further, the warder-teacher could, subject to Regulation 108 (see Regulation 24 (1912)), inflict corporal punishment as:

*... a final resource for offences against morality, gross impertinence, and for wilful and persistent disobedience. All degrading, injurious, and cruel modes of punishment are strictly prohibited.*<sup>78</sup>

## Corporal punishment (by persons other than the warder)

*10 July 1916–19 May 1962*

In addition to the prescription already outlined, from 15 November 1958 the use of the strap or cane on the hands as a form of punishment was prohibited and from that time corporal punishment could only be applied to the gluteal region.<sup>79</sup>

*19 May 1962*

The Regulations set out above were repealed by Regulations introduced on 19 May 1962. From that date, boys who committed ‘offences’ could be punished as follows, for the offences outlined below.<sup>80</sup>

Regulation 107 provided that:

*It shall be an offence for any inmate to:*

- (a) Disobey the Regulations governing the Institution;*
- (b) Assault any person;*
- (c) Use insulting, obscene, indecent, or profane words;*
- (d) Use threatening words to the Superintendent or any other person;*
- (e) Behave in an offensive, threatening, insolent, insulting, disorderly, obscene, or indecent manner;*
- (f) Be untruthful to the Superintendent or any other person;*
- (g) Be guilty of dishonesty;*
- (h) Wilfully destroy, damage, or disfigure any property at the Institution;*
- (i) Incite, counsel, or procure any other inmate to commit an offence;*
- (j) Abscond or attempt to abscond;*
- (k) Make, conceal, or have in his possession without authority, any tool, weapon, knife, key, implement, or other thing intended to effect, or being capable of effecting, the escape of any inmate, or the carrying out of any unlawful purpose;*
- (l) Mutiny or take part in any riot or tumult by inmates;*
- (m) Be idle, careless or negligent at work, refuse to work or wilfully mismanage his work;*
- (n) Inflict injury upon himself or counsel or procure another to do so, or prevent any injury or sore from healing; and*
- (o) Conduct himself in such manner as to prejudice the good order and discipline of the Institution.*

Regulation 107A provided:

*When an inmate has been guilty of an offence the Superintendent, having regard to the physical and mental health of the offender and his rehabilitation, may order that:*

- (i) The inmate shall be confined in a section of the Institution set apart for such inmates for a period not exceeding seven days; and/or*
- (ii) The inmate shall be confined in a single detention room separating him from all other inmates, provided that no inmate shall be held in such room for a period longer than 24 hours.*

*The Superintendent may at any time revoke such orders.*

Regulation 107B provided:

*When the Superintendent takes action in accordance with Regulation 107A, he shall forthwith report the matter to the Director and shall record in the punishment book full particulars of the circumstances necessitating such action and the period of time the inmate is to be held in the section of the Institution referred to in Regulation 107A(i) or in a single detention room.*

Regulation 107C provided:

*When the Superintendent has made an order of confinement under Regulation 107A:*

- (i) The Director, during the currency of such confinement, may order that such inmate be confined in the section of the Institution referred to in subRegulation (i) of such Regulation for a period not exceeding 21 days and/or in the single detention room referred to in subRegulation (ii) of such Regulation for a period longer than 24 hours, but not exceeding 48 hours; and/or*

- (ii) *The visiting Justice during the currency of such confinement ordered by the Director under subRegulation (i) hereof may order—*
- (a) *That such inmate be confined in such section of the Institution referred to in such subRegulation for such period and under such conditions as he considers warranted; and/or*
  - (b) *That such inmate be confined in such single detention room referred to in such subRegulation at intervals for periods no one of which shall exceed five days and the aggregate whereof shall not be longer than ten days but so that a period of seven days shall elapse between each such period of confinement.*
- Any order made under this Regulation may be at any time revoked by the person who made it.*

**Regulation 107D provided:**

*Every inmate placed in confinement shall, as soon as possible thereafter, be examined by the Visiting Medical Officer. The Visiting Medical Officer shall examine each such inmate at least twice weekly and he shall record on the personal card of each inmate particulars of such examination if he shall so deem it necessary.*

**Regulation 107E provided:**

*The Matron, or in her absence the Superintendent, shall visit inmates in confinement at least daily, keep a record of such visits, and report directly to the Visiting Medical Officer on such examinations on his next visit to the Institution.*

**Regulation 107F provided:**

*The Director, the Superintendent and the Visiting Justice, in exercising their powers under Regulation 107A and 107C, shall have regard to the opinion of the Visiting Medical Officer and Matron, and also to any psychiatric or other medical report which might be available concerning an inmate.*

**Regulation 108A provided:**

*Corporal punishment shall not be inflicted in the presence of other inmates.*

**Regulation 108B provided:**

*The punishment book shall be presented to and initialled by the Visiting Justice and the Medical Officer on each visit they make to the Institution, and shall be produced to the Director or any officers authorised by him when requested.*

## ENDNOTES

<sup>1</sup> S. 3

<sup>2</sup> The Attorney-General's second reading speech, Legislative Council, 11 October 1911, p. 1463.

<sup>3</sup> Ibid.

<sup>4</sup> S. 5.

<sup>5</sup> S. 6.

<sup>6</sup> The Regulations promulgated on 16 January 1919 repealed the Regulations of 20 July 1912 and 10 July 1916.

<sup>7</sup> S. 14. State institutions established under an Act repealed by the *State Children Act* were deemed to be established under S. 14 of that Act.

<sup>8</sup> S. 15.

<sup>9</sup> S. 18. The approval could not be withdrawn unless the report had been given to the governing authority of the institution and two months had elapsed.

<sup>10</sup> S. 7—except with respect to those matters where the Act imposed the duty on another person.

<sup>11</sup> S. 7A(1).

<sup>12</sup> S. 7A(2).

<sup>13</sup> S. 8(1).

<sup>14</sup> S. 8(2).

<sup>15</sup> S. 8(3).

<sup>16</sup> S. 9(1).

<sup>17</sup> S. 9(2).

<sup>18</sup> S. 10(1).

<sup>19</sup> S. 10(2).



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- <sup>20</sup> Ibid. The Minister could, on or before the discharge of a State child, empower the Director to remain guardian until the child was up to 21 years during which time the child would be subject to the supervision of the Department.
- <sup>21</sup> S. 12.
- <sup>22</sup> S. 13.
- <sup>23</sup> S. 4.
- <sup>24</sup> Ibid.
- <sup>25</sup> Ibid. ‘Maintenance’ included clothing, nursing, support, medical treatment, necessities, training, discipline and education.
- <sup>26</sup> Ibid.
- <sup>27</sup> Ibid.
- <sup>28</sup> *Parliamentary Debates*, 10 October 1911, p. 1463.
- <sup>29</sup> S. 20.
- <sup>30</sup> S. 21. Alternatively, the Court could commit the child to the care of the Department or, after amendments made to the Act in 1917, release the child on probation.
- <sup>31</sup> S. 20, op cit. Pending the hearing of proceedings before the Court, the child could be placed in an institution.
- <sup>32</sup> sS. 26(1) and (2).
- <sup>33</sup> S. 4, op cit.
- <sup>34</sup> S. 26(2), op cit.
- <sup>35</sup> ‘Uncontrollable’ was not defined by the Act.
- <sup>36</sup> S. 23. Alternatively, the Court could commit the child to the care of the Department or, after amendments made to the Act in 1917, release the child on probation.
- <sup>37</sup> S. 30.
- <sup>38</sup> S. 4, op cit.
- <sup>39</sup> S. 25A. There were also specific exceptions for children sentenced for offences of murder, attempted murder, manslaughter or an offence with a maximum penalty of life imprisonment.
- <sup>40</sup> S. 11.
- <sup>41</sup> ‘Receiving Depot’ is not defined by the Act.
- <sup>42</sup> S. 4, op cit. To ‘place out’ a State child was to entrust him or her to the care and charge of some person, approved by the Director, for the purpose of being maintained by such person or in such person’s house, or for the purpose of adoption, training or hire.
- <sup>43</sup> S. 26(2), op cit.
- <sup>44</sup> S. 11, op cit.
- <sup>45</sup> S. 15, op cit.
- <sup>46</sup> Regulations 3 and 4 of 16 January 1919; Regulations 3 and 4 of 25 July 1935.
- <sup>47</sup> ‘Governing authority’ is not defined by the Act.
- <sup>48</sup> S. 15, op cit.
- <sup>49</sup> S. 16.
- <sup>50</sup> S. 17.
- <sup>51</sup> S. 37.
- <sup>52</sup> ‘Official’ is not defined by the Act or RegulationS.
- <sup>53</sup> Regulation 21 of 16 January 1919; Regulation 21 of 25 July 1935.
- <sup>54</sup> Regulation 9 of 16 January 1919; Regulation 9 of 25 July 1935.
- <sup>55</sup> ‘District officer’ was the officer in charge of a district office, which was the office of the State Children Department established at Rockhampton, Townsville or elsewhere: Regulation 1 of 16 January 1919; 25 July 1935.
- <sup>56</sup> Regulation 17 of 16 January 1919; Regulation 17 of 25 July 1935.
- <sup>57</sup> Regulation 22 of 16 January 1919; Regulation 22 of 25 July 1935.
- <sup>58</sup> S. 69.
- <sup>59</sup> S. 79.
- <sup>60</sup> Regulation 19 of 16 January 1919; Regulation 19 of 25 July 1935.
- <sup>61</sup> Regulation 23 of 16 January 1919; Regulation 23 of 25 July 1935.
- <sup>62</sup> Regulation 24 of 16 January 1919; Regulation 24 of 25 July 1935.
- <sup>63</sup> Regulation 20 of 16 January 1919; Regulation 20 of 25 July 1935.
- <sup>64</sup> Regulation 7 of 16 January 1919; Regulation 7 of 25 July 1935.
- <sup>65</sup> Regulation 8 of 16 January 1919; Regulation 8 of 25 July 1935.
- <sup>66</sup> Regulation 6 of 16 January 1919; Regulation 6 of 25 July 1935.
- <sup>67</sup> Regulation 18 of 16 January 1919; Regulation 18 of 20 July 1935.
- <sup>68</sup> Regulation 25 of 16 January 1919. Regulation 46 of 16 January 1919 set out the outfits to be provided. Boys were to be provided with 2 hats, 1 brush, 1 rack comb, 1 fine comb, 3 pairs of socks, 2 suits—tweed or woollen, 2 pyjamas, 4 pocket handkerchiefs, 3 Crimean shirts, 2 pairs of boots, 3 collars, 1 pair of braces, 1 Bible or prayer-book, 1 jersey, 2 flannels, 1 toothbrush and 1 outfit box. Girls were to be provided with 2 hats, 1 warm dress, 3 print dresses—two dark and one light, 4 pocket

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handkerchiefs, 4 pairs of stockings, 1 brush, 1 rack comb, 1 fine comb, 1 cotton petticoat, 2 flannel petticoats, 4 pinafores, 2 nightdresses, 3 pairs of drawers, 2 pairs of boots, 3 cotton singlets, 2 bodices, 2 flannels, 1 Bible or prayer-book, 1 jacket or ulster, 1 toothbrush, 1 outfit box. The Regulations of 25 July 1935 had substantially the same requirements except 'outfit box' was replaced with 'suitcase'; with respect to boys, the second suit could be constituted by 2 shirt waists and 1 pair of trousers; and with respect to the girls, there was no longer a requirement to provide 4 pinafores.

<sup>69</sup> A reference to 'Superintendent' includes 'matron': Regulation 1 of 16 January 1919 ; Regulation 1 of 25 July 1935.

<sup>70</sup> Regulation 5 of 16 January 1919; Regulation 5 of 25 July 1935.

<sup>71</sup> Regulation 2 of 16 January 1919; Regulation 2 of 25 July 1935.

<sup>72</sup> Ibid.

<sup>73</sup> Regulation 12 of 16 January 1919; Regulation 12 of 25 July 1935.

<sup>74</sup> Regulation 13 of 20 July 1912; Regulation 13 of 25 July 1935.

<sup>75</sup> Regulation 8 of 10 July 1916.

<sup>76</sup> Regulation 45 of 10 July 1916.

<sup>77</sup> Regulation 47 of 10 July 1916.

<sup>78</sup> Regulation 48 of 10 July 1916.

<sup>79</sup> Regulation 108A of 15 November 1958.

<sup>80</sup> These Regulations continued in force after the commencement of the *Children's Services Act 1965* by virtue of the Children's Services Regulations promulgated on 19 July 1966.

## APPENDIX 2

### CHILDREN'S SERVICES ACT 1965

The *Children's Services Act 1965* was introduced on 1 August 1966. The provisions relevant to the Inquiry have not been substantively changed since that date. Dramatic changes were contemplated under the *Family Services Act 1987*, however those changes never came into force.

#### 1. PURPOSE OF THE ACT

The purpose of the Act is:

*to promote, safeguard and protect the wellbeing of the children and youth of the State through a comprehensive and coordinated program of child and family welfare.*

#### 2. POWER TO MAKE REGULATIONS

Section 152 vests the Governor-in-Council with wide and general powers to make Regulations with respect to the Act. There are specific powers in respect of a number of matters, the most relevant of which are:

- (f)<sup>1</sup> *the management, control and supervision of admission centres, homes, assessment, remand and treatment centres, training centres, hostels, attendance centres and other types of institutions established by the Governor-in-Council pursuant to this Act;*
- (g) *the standards, management, control and supervision of institutions, admission centres, child training centres, attendance centres and other facilities established or to be established otherwise than by the Governor-in-Council, the approval and licensing of any of the same and the duties and responsibilities of the persons in charge of any of the same towards the children in their care;*
- (h) *the custody, care, maintenance, health, education, employment, apprenticeship and placement of children in care;*
- (i) *the visiting and disciplining of children in care and other matters related to the wellbeing of such children;*
- (j) *the management and control of the property of children in care;*
- (k) *the medical, dental and nursing attention of children in care;*
- (l) *the rates of payment and assistance to be granted to institutions licensed under part 4 for the care of children and the conditions on which same shall be granted.*

#### 3. DEFINITIONS

##### Child

Section 8 defines 'child' as meaning 'a person under, or apparently under, the age of 17 years, including a person who, although not under the age of 17 years, has been dealt with by the court as though a child'.

##### Child in care

A 'child in care' is a child in the care and protection or the care and control of the Director. Parts 5 and 6 of the Act set out the circumstances and procedures whereby a child may be placed under the care and protection or care and control of the Director. Those provisions are set out below.

A child will be deemed to be in need of care and protection if:

- (a) *not having a parent or guardian who exercises proper care of and guardianship over him or her, the child is:*
  - (i) *neglected; or*
  - (ii) *exposed to physical or moral danger; or*
  - (iii) *falling in with bad associates; or*
  - (iv) *likely to fall into a life of vice or crime;*
- (b) *the child is in the custody of a person who is unfit by reason of the child's conduct and habits to have custody of the child;*

- (c) *the child is a person in relation to whom any of the offences mentioned in part 8<sup>2</sup> has been committed; or*
- (d) *the child is a member of the same household as:*
  - (i) *a child in relation to whom an offence mentioned in part 8 has been committed; or*
  - (ii) *a person who has been convicted of such an offence in relation to a child and appears to be in danger of the commission upon or in relation to the child of a similar offence;*
- (e) *the child is a member of a household a member of which has been convicted of an offence under the Criminal Code, s. 222 or 223;<sup>3</sup>*
- (f) *the child begs or gathers alms, whether or not accompanied with the pretext of a sale or otherwise, or the child is in or adjacent to a public place for the purpose of so begging or gathering alms;*
- (g) *the child is found apparently abandoned, or loitering or sleeping in a public place and has no visible lawful means of support or no settled place of abode;*
- (h) *the child carries on street trading that is not authorised by s. 113;<sup>4</sup>*
- (i) *the child takes part in any public exhibition or performance of a type referred to in this Act without a permit under part 11 so to do;*
- (j) *not being a child or ward of the licensee—the child is, without lawful excuse, in a betting shop or billiard room, or the bar-room, billiard room or beer garden of any licensed premises;*
- (k) *the child is served with intoxicating liquor in any of the premises mentioned in paragraph (j);*
- (l) *being in the care of a person other than a parent, relative or guardian of such child—the child is apparently deserted by his or her parent or guardian;*
- (m) *being under the school leaving age as provided for from time to time by law—the child is regularly absent from school without reasonable and adequate excuse;*
- (n) *being under such an age that the child is not criminally responsible for any act notwithstanding that, at the time of doing the act, the child had the capacity to know that the child ought not to do the act—the child does an act which would of itself or with other elements constitute an offence on the child's part if the child were of or over that age and had the aforesaid capacity;*
- (o) *the child is for any other reason in need of care and such care cannot be adequately provided by the giving of assistance under part 5.<sup>5</sup>*

A child will be deemed to be in need of care and control if:

- (a) *the child is falling or is likely to fall into a life of vice or crime or addiction to drugs;*
- (b) *the child is exposed to moral danger;*
- (c) *the child is or appears to be uncontrollable.<sup>6</sup>*

The guardianship of a child rests in the Director for the period the child is in his or her care. <sup>7</sup> When a child is admitted to care and protection or committed to care and control, the Director is required to utilise his or her powers and the resources of the Department to further the best interests of the child. To that end, the Director can place the child in an institution licensed or established under part 4 of the Act.

#### **4. INSTITUTIONS**

The Act defines 'institution' as including any place in which a child is cared for apart from the child's parent or guardian. <sup>8</sup>

Institutions can be either 'established' or 'licensed' under the Act.

##### **Establishment of institutions**

Section 30(1) of the Act provides that:

*The Governor-in-Council may, by order in council, establish admission centres, homes, assessment, remand and treatment centres, training centres, hostels, attendance centres and other types of institutions to provide for the care, protection, education, treatment, training, control and welfare (including religious, moral and material aspects of the same) of children in care, and may in like manner abolish any of same.*

Institutions under the operation and control of the State Children Department at the commencement of the Act were deemed to be established in accordance with this section.<sup>9</sup>

The Governor-in-Council may, by order in council, vary the purpose for which any institution established under the Act exists.<sup>10</sup>

### **Licensing of institutions**

Section 31(1) provides that the Minister may approve, by signed writing, any institution conducted or to be conducted by any person for the care, protection, education, treatment, training, control or welfare of children.

The approval must name a 'governing authority' and a 'person in charge' of the institution.<sup>11</sup> Once Ministerial approval is granted, the Director is required to issue a licence to the institution. The institution then remains a licensed institution until the governing authority surrenders the licence, the Minister revokes the licence, or the purpose for which the institution is established is varied.<sup>12</sup> Institutions licensed under the *State Children Act 1911* at the time the *Children's Services Act* was introduced were deemed to be licensed under section 31.<sup>13</sup>

### **Control and inspection of licensing institutions**

Subject to the authority of the Director, the governing authority has sole management and supervision of the institution.<sup>14</sup> The Director is required to 'supervise the standard attained by each licensed institution in achieving the purposes for which it exists.' To facilitate this supervision, the Director, or his or her agent, is able to enter the institution at all reasonable hours for the purpose of inspecting the premises and the activities carried on within them.<sup>15</sup>

### **Record-keeping obligations**

The governing authority of the licensed institution is required to keep a register of prescribed details of children in their care.<sup>16</sup> The person in charge of the licensed institution is required to enter those prescribed details into the register and to make such register available to the Director, Deputy Director or person authorised in writing by the Director.<sup>17</sup>

### **Children not in care who are placed in institutions**

If a child who is not under the care and protection or care and control of the Director is placed in a licensed institution for more than three months, the governing authority and the person in charge of the institution must notify the Director.

### **Financial aid to institutions**

The Director is required to provide remuneration to the licensed institution for the care of each child maintained in a licensed institution.<sup>18</sup>

### **Revocation of approval**

The Director may, if dissatisfied with the management, maintenance or condition of any licensed institution, give written notice to the governing authority to show why the institution should not cease to be a licensed institution. If the governing authority does not show cause within two months, the Director can recommend to the Minister that the institution's licence cease. The Minister may then revoke the approval and the institution will cease to operate as a licensed institution.<sup>19</sup>

## **5. DUTIES OF THOSE IN CHARGE OF INSTITUTIONS**

Section 40 of the *Children's Services Act* sets out the duties of the governing authority and person in charge of an institution with children in its custody. It applies to all such institutions, even if they are not licensed or established under the Act. These duties are to:

- (a) provide such child with adequate food, clothing, lodging and care;<sup>20</sup>
- (b) maintain every part of such institution at all times in a fit and proper state for the care of a child;

- (c) *secure for such child adequate education and religious training of such a type and form as is approved by the Director, or in the absence of such an approval as is in the best interests of such a child;*
- (d) *ensure that such child receives adequate medical and dental treatment;*
- (e) *do, observe and carry out all acts, requirements and directions prescribed by this Act or by any order of the Director in relation to the institution and the care of such child.*

Further legislative provisions with respect to (a), (c) and (d) above are dealt with below.

### **Health and welfare of children**

Part 8 of the Act deals with the protection of children. Section 69(1) is an offence-creating provision which provides that:

*A person having a child in his or her charge shall not ill-treat, neglect, abandon or expose the child in a manner likely to cause the child unnecessary suffering or to injure the child's physical or mental health nor suffer the child to be so ill-treated, neglected, abandoned or exposed.*

A person having charge of a child will be deemed to have neglected a child in a manner likely to cause unnecessary suffering or to injure the child's physical or mental health if:

- (a) *they are able to provide adequate food, clothing, medical treatment, lodging or care from their own resources and fail to do so; and*
- (b) *they are unable to provide these necessities from their own resources but are aware of lawful steps by which to procure them, and fail to do so.*<sup>21</sup>

These provisions do not prevent a parent, guardian, teacher or other person having lawful charge of a child from administering reasonable punishment to a child.<sup>22</sup>

### **Parents to be informed of whereabouts of child in care**

Section 131 provides:

*The Director shall cause a parent of a child in care to be informed of the whereabouts, from time to time, of such child in care unless the Director is of [the] opinion that the giving of such information is not in the best interests of the child in care concerned.*

Section 131A<sup>23</sup> states that:

- (1) *A parent of a child in care may ask the Director for information about the child's whereabouts.*
- (2) *The Director must give the parent the information unless, in the Director's opinion, it is not in the best interests of the child to provide the information.*

### **Visits to children in care**

Section 132(1) provides that a parent of a child in care may visit the child during prescribed times, or if no times are prescribed, at all reasonable hours of the day.<sup>24</sup>

Regulation 19 states:

*Subject to the approval of the Director, the governing authority of an established or licensed institution shall specify times during which parents or persons approved by the Director or an Officer of the Department, authorised by him for such purpose, may visit children in the institution: Provided that the governing authority may authorise visits on such other occasions as may, in its opinion, be reasonable and in the interests of a child.*

The Director has power to circumscribe parental visits by directing, in writing, that a parent or parents of a child in care shall not have access to the child or that the access shall be subject to conditions.<sup>25</sup> The person who has the charge of a child in care, for example the person in

charge of the institution, is required to comply with these directions.<sup>26</sup> The term ‘parent’ includes a person *in loco parentis* to a child.<sup>27</sup>

### **Medical treatment**

When a child is received into a licensed or established institution, he/she is to undergo a medical and dental examination. The result is to be recorded and the Director is to be advised of the results of the examination.<sup>28</sup>

The Director can order the medical or dental examination of any child in a licensed or established institution.<sup>29</sup> The person in charge of the institution is required to have the child medically examined when he/she considers it necessary.<sup>30</sup>

The governing authority is required to ensure that all medical and dental treatment and medications received by children in a licensed or established institution are to be in accordance with medical or dental instructions.<sup>31</sup> If the governing authority does not feel that the treatments are in the child’s interests then the matter is to be referred to the Director who shall refer it to the Director-General of Health who may order the medication to continue, alter or cease. The governing authority must report the illness, injury or death of any child in a licensed or established institution to the Director without delay.<sup>32</sup> Medical reports dealing with the child in a licensed or established institution are to be filed in the records of the institution and shall be produced on request to the Director.<sup>33</sup>

### **Education and employment**

The governing authority of a licensed or established institution must ensure that all children attend school as required by law and the Director must ensure that the child is provided with necessary textbooks.<sup>34</sup> If the child is over school age and not attending school, the governing authority is to secure regular employment approved by the Director or inform the Director of the failure to obtain, or the loss of, employment.<sup>35</sup>

### **Religious instruction**

A child in a licensed or established institution is to receive religious instruction in accordance with his/her denomination.<sup>36</sup>

### **Clothing**

The Director must provide adequate clothing for a child in a licensed or established institution, maintain and provide replacement garments and maintain the clothing in good order.<sup>37</sup>

### **Punishment of children in institutions**

Regulation 23 prescribes how punishment may be administered in institutions:

- (1) *The person in charge of an institution may punish any child for misconduct.*<sup>38</sup>
- (2) *Without in any way limiting the meaning thereof the term ‘misconduct’ for the purpose of this regulation shall mean and include all or any of the following:*
  - (a) *Failing to comply with the rules of the institution;*
  - (b) *Assaulting any person;*
  - (c) *Using insulting, obscene, indecent or profane words;*
  - (d) *Using threatening words to any person;*
  - (e) *Behaving in an offensive, threatening, insolent, insulting, disorderly, obscene or indecent manner or behaving irreverently at or during divine service or prayers;*
  - (f) *Being untruthful to an officer of the institution or visitor;*
  - (g) *Being guilty of dishonesty;*
  - (h) *Wilfully destroying, damaging or disfiguring any property at the institution;*
  - (i) *Inciting, counselling or procuring any other child to commit any other offence;*
  - (j) *Absconding or attempting to abscond;*
  - (k) *Making, concealing or having in his possession without authority, any tool, weapon, knife, key, implement, or other thing intended to effect or being*

- capable of effecting, the escape of any child or the carrying out of any unlawful purpose;*
- (l) Mutineering or taking part in any riot or tumult by children;*
  - (m) Being idle, careless or negligent at work, refusing to work or wilfully mismanaging his work;*
  - (n) Inflicting injury upon himself or counselling or procuring another to do so, or preventing any injury or sore from healing; and*
  - (o) Conducting himself in such a manner as to prejudice the good order and discipline of the institution.*
- (3) The person in charge may punish any child guilty of misconduct by any one or more of the following methods:*
- (a) Forfeiture of rewards or privileges, forfeiture or reduction of status or temporary loss of recreation;*
  - (b) Special duty for any period not exceeding seven days;*
  - (c) Physical exercises, with proper rests under supervision, for a period not exceeding thirty minutes on any one day and not extending beyond a total period of seven days.*
- (4) Every effort shall be made to enforce discipline without the use of corporal punishment.*
- (5) Corporal punishment shall be subject to the following conditions:*
- (a) It shall not be inflicted on any female child;*
  - (b) It shall be inflicted not otherwise than with a leather strap of a type approved by a director or an Officer of the Department so authorised by him and shall be applied over the child's ordinary cloth trousers;*
  - (c) It shall be administered by or under the direction and supervision of the person in charge or in his absence by or under the direction or supervision of the person accepting the responsibilities of the person in charge in accordance with Regulation 21 of these regulations and in every case in the presence of another suitable witness. The person in charge or person accepting his responsibilities and the witness shall endorse the punishment book with details of the punishment and the reason therefor and shall sign such endorsement;*
  - (d) It shall be administered as little as possible and only when absolutely necessary for discipline;*
  - (e) It shall not be inflicted in the presence of other children in the institution;*
  - (f) It shall not be inflicted on any child if the Director or a medical practitioner has given any direction to the contrary in respect of such child.*
- (6) A child shall not be punished by:*
- (a) Being dosed with medicine or any other substance; or*
  - (b) Being compelled to hold himself in a constrained or fatiguing position.*
- (7) A child shall not be allowed to administer any form of punishment to another child.*
- (8) Any punishment inflicted under this regulation may at any time be terminated or reduced by the person who ordered it or by the Director.*
- (9) Every complaint received and punishment inflicted in respect of a child shall be recorded in a punishment book and such book shall be produced to the Director or an officer of the Department on demand.*
- (10) The person in charge of or any other officer of the institution shall not strike or otherwise apply physical force to the person of a child otherwise than in accordance with this regulation. Provided that such force may be applied as is reasonably necessary for self-defence and preservation or defence of a child or other person or property, and also such force as is reasonably necessary to subdue a recalcitrant or mutinous child or to prevent absconding or to retake an absconder.*

### **Custody of a child in an institution**

Regulation 20 provides that:

*A child in care in an established or licensed institution shall not be given into the custody of any person other than an officer of the Department or a person employed at such institution without the authority of the Director or an officer of the Department authorised by him for such purpose.*



## ENDNOTES

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- <sup>1</sup> The letter in parenthesis refers to the relevant subsection of s. 152.
- <sup>2</sup> Part 8 sets out offences in relation to the health and welfare of the child and are set out below.
- <sup>3</sup> These provisions of the Criminal Code of Queensland set out sexual assault offences.
- <sup>4</sup> S. 113 sets out the circumstances in which a child is permitted to conduct street trading.
- <sup>5</sup> S. 46.
- <sup>6</sup> S. 60.
- <sup>7</sup> Ss. 55 and 64.
- <sup>8</sup> S. 8.
- <sup>9</sup> S. 30(1).
- <sup>10</sup> S. 30(3).
- <sup>11</sup> S. 31(1A).
- <sup>12</sup> S. 31(2).
- <sup>13</sup> Ibid.
- <sup>14</sup> S. 33(1).
- <sup>15</sup> S. 34.
- <sup>16</sup> Ss. 35(1)(a)–(f).
- <sup>17</sup> S. 35(2).
- <sup>18</sup> S. 37. The rate of payment is set out in Regulation 18.
- <sup>19</sup> Ss. 39(1)–(3).
- <sup>20</sup> This duty is repeated in Regulations 33 and 35.
- <sup>21</sup> S. 69(3).
- <sup>22</sup> S. 69(5).
- <sup>23</sup> Inserted by the *Children's Commissioner and Children's Services Act 1996*.
- <sup>24</sup> S. 132(1).
- <sup>25</sup> Ss. 132(2)(a) and (b).
- <sup>26</sup> S. 33(2A).
- <sup>27</sup> S. 8.
- <sup>28</sup> Regulation 11.
- <sup>29</sup> Regulation 12.
- <sup>30</sup> Ibid.
- <sup>31</sup> Regulation 13.
- <sup>32</sup> Regulation 14.
- <sup>33</sup> Regulation 15.
- <sup>34</sup> Regulation 16.
- <sup>35</sup> Regulations 33 and 35. See also s. 110 which vests a general power in the Director to arrange the employment or apprenticeship of a child in care.
- <sup>36</sup> Regulation 17.
- <sup>37</sup> Regulation 22.
- <sup>38</sup> 'Child' includes a child in care: Regulation 23(11).

## APPENDIX 3

### *JUVENILE JUSTICE ACT 1992*

The *Juvenile Justice Act 1992* was introduced on 1 September 1993, and was part of a package of legislation intended to introduce reforms to the juvenile justice system.<sup>1</sup>

#### 1. PURPOSE AND OBJECTIVES

##### **Purpose**

The Act is expressed to ‘... provide comprehensively for the laws concerning children who commit, or who are alleged to have committed, offences and for related purposes’.

‘Child’ is defined as ‘a person who has not turned 17 years’.<sup>2</sup>

##### **Objectives**

The principal objectives are:<sup>3</sup>

- (a) *To establish the basis for the administration of juvenile justice;*
- (b) *To establish a code for dealing with children who have, or are alleged to have, committed offences;*
- (c) *To provide for the jurisdiction and proceedings of courts dealing with children;*
- (d) *To ensure that courts that deal with children who have committed offences deal with them according to principles established under this Act;*
- (e) *To recognise the importance of families of children and communities, in particular Aboriginal and Torres Strait Islander communities, in the provision of services designed to:*
  - (i) *rehabilitate children who commit offences; and*
  - (ii) *reintegrate children who commit offences into the community.*

#### 2. GENERAL PRINCIPLES OF JUVENILE JUSTICE

Section 4 sets out the general principles underlying the operation of the Act, and these are set out in full below. Subsections 4(c), (f), (i) and (j) are the most relevant to juvenile detention:

- (a) *the community must be protected from offences;*
- (b) *because a child tends to be vulnerable in dealings with a person in authority a child should be given the special protection allowed by this Act during an investigation or proceeding in relation to an offence committed, or allegedly committed, by the child;*
- (c) *a child:*
  - (i) *should be detained in custody for an offence (whether on arrest or sentence) only as a last resort;*
  - (ii) *if detained in custody—should only be held in a facility suitable for children;*
- (d) *if a child commits an offence—the child should be treated in a way that diverts the child from the courts’ criminal justice system, unless the nature of the offence and the child’s criminal history indicate that a proceeding for the offence should be started;*
- (e) *if a proceeding is started against a child for an offence:*
  - (i) *the proceeding should be conducted in a fair and just way;*
  - (ii) *the child should be given the opportunity to participate in and understand the proceeding;*
- (f) *a child who commits an offence should be:*
  - (i) *held accountable and encouraged to accept responsibility for the offending behaviour;*
  - (ii) *dealt with in a way that will give the child the opportunity to develop in responsible, beneficial and socially acceptable ways;*
  - (iii) *dealt with in a way that strengthens the child’s family;*
- (g) *a victim of an offence committed by a child should be given the opportunity to participate in the process of dealing with the child for the offence in a way allowed by the law;*
- (h) *a parent of a child should be encouraged to fulfil the parent’s responsibility for the care and supervision of the child, and supported in the parent’s efforts to fulfil*

- this responsibility;*
- (i) *a decision affecting a child should, if practicable, be made and implemented within a time frame appropriate to the child's sense of time;*
  - (j) *the age, maturity and, where appropriate, cultural background of a child are relevant considerations in a decision made in relation to the child under this Act.*

### **Power to make regulations**

Section 233(1) of the Act gives a general power to the Governor-in-Council to make regulations specifically in relation to a number of matters, including:

- *standards, management, control and supervision of detention centres*
- *maintenance of good order and discipline within detention centres*
- *conditions for the release of children from detention centres*
- *medical services to children in detention*
- *searches of children in detention centres and their possessions.*<sup>4</sup>

The Juvenile Justice Regulations 1993 have been enacted in pursuance of this power.

### **3. CIRCUMSTANCES IN WHICH A CHILD MAY BE HELD IN DETENTION**

Under the *Children's Services Act 1965*, in order for children to be detained, guardianship had to be transferred from the parents to the Director-General of the Department of Family Services and Aboriginal and Islander Affairs. This was viewed as removing responsibility from parents unnecessarily.<sup>5</sup>

#### **Pre-sentence detention**

##### *Custody of child pending first court appearance*

A child who has been arrested and not released from custody must be held in the custody of the Commissioner of Police or, wherever practicable, the Commissioner should make arrangements with the Queensland Corrective Services Commission ('the Commission') for the child to be placed in a detention centre until brought to court.<sup>6</sup>

##### *Custody of child on remand*

Where a child is remanded in custody, the court must remand the child into the custody of the Commission unless the child remains the prisoner of the court.<sup>7</sup> The court must order that the Commissioner of Police deliver the child as soon as practicable into the custody of the Commission,<sup>8</sup> who may keep the child in 'places that the Commission determines from time to time.'<sup>9</sup> However a child cannot be kept in a prison (that is, an adult prison).<sup>10</sup>

#### **Post-sentence detention**

Detention for a child is a sentence of last resort. Section 165 states:

*A court may make a detention order against a child only if the court, after:*

- (a) *considering all other available sentences;*
- (b) *taking into account the desirability of not holding a child in detention, it is satisfied that no other sentence is appropriate in the circumstances of the case.*

A detention order can only be made against a child after a pre-sentence report has been ordered, received and considered.<sup>11</sup> A court must record its reasons for making a detention order against a child.<sup>12</sup>

A child must serve a period of detention in a detention centre.<sup>13</sup> After making a detention order, the Commissioner of Police is required to take the child into custody and deliver the child to a detention centre decided by the Commission.<sup>14 15 16</sup>

### **4. DETENTION ADMINISTRATION**

Part 6 of the *Juvenile Justice Act 1992* is concerned with 'detention administration'.

## Non-application of Corrective Services Act 1988

The *Corrective Services Act 1988*<sup>17</sup> does not apply to a child, unless the *Juvenile Justice Act* expressly provides for its application to a child in particular circumstances.<sup>18</sup>

## Establishing detention centres

Section 201 provides:

*The Governor-in-Council may, by regulation:*

- (a) *establish detention centres and other places for the purposes of this Act;*
- (b) *determine the purpose for which a place (other than a detention centre) may be used;*
- (c) *name a detention centre or other place.*

The following detention centres were established by Regulation 8 for the detention of children required to be held in custody under the Act or the *Young Offenders (Interstate Transfer) Act 1987*:

- Cleveland Youth Detention Centre, Old Common Road, Belgian Gardens, Townsville
- John Oxley Youth Detention Centre, Station Road, Wacol
- Sir Leslie Wilson Youth Detention Centre, Tenth Avenue, Windsor.

## Responsibilities under the *Juvenile Justice Act*

The Act imposes responsibility on the Commission ‘for the security and management of detention centres and the safe custody and wellbeing of children detained in detention centres.’<sup>19</sup>

This responsibility may be carried out:

*By using any convenient form of direction, for example, rules, directions, codes, standards and guidelines relating to:*

- (a) *detention centre organisation;*
- (b) *functions, conduct and responsibilities of detention centre officers;*
- (c) *types of programs for children detained in a detention centre;*
- (d) *contact between children detained in the detention centre and members of the public;*
- (e) *arrangements for educational, recreational and social activities of children detained in detention centres.*<sup>20</sup>

Section 203(3) provides:

*In relation to each detention centre, the Commission is responsible for:*

- (a) *providing services that promote the health and wellbeing of children detained at the centre;*
- (b) *promoting the social, cultural and educational development of children detained at the centre;*
- (c) *maintaining discipline and good order in the centre; and*
- (d) *maintaining the security and management of the centre.*

## Child’s rights and responsibilities

Section 209 provides that ‘As soon as practicable after being admitted to a detention centre, a child must be given an explanation of the child’s rights and responsibilities as a resident of the detention centre.’

If the child has difficulty understanding English, the Commission must take reasonable steps to ensure the child understands their rights and responsibilities.<sup>21</sup> Those steps may include having an interpreter and supplying an explanatory note in English or another language.<sup>22</sup>

## Complaints

A child or parent of a child detained in a detention centre may complain about a matter that affects the child.<sup>23</sup>

The Commission must issue written instructions on how a complaint may be made and dealt with. Those instructions may include directing the complaint to an Official Visitor or other appropriate authority.<sup>24</sup>

Notwithstanding any written instructions issued by the Commission, a child is entitled to complain directly to an Official Visitor, or to have their complaint referred to an Official Visitor.<sup>25</sup> However, if the Commission is of the reasonable belief that the complaint is trivial or made only to cause annoyance, it need not be dealt with—specifically, it need not be referred to the Official Visitor.<sup>26</sup>

The child must be informed how the complaint will be dealt with.<sup>27</sup>

The above matters do not limit the powers of an Official Visitor.

### *Official Visitors*

- The Minister must appoint one or more Official Visitors for each detention centre,<sup>28</sup> and at least one of these must be a legal practitioner.<sup>29</sup>
- An Official Visitor's appointment relates to the detention centre named in the appointment. Appointments cannot be for more than two years, however an Official Visitor is eligible for reappointment.<sup>30</sup>
- Members of the police service and officers of the Commission or the public service are not eligible for this position.<sup>31</sup>
- An Official Visitor has the functions and powers conferred or imposed by the *Juvenile Justice Act* or any other Act.<sup>32</sup>
- The Commission must arrange for each detention centre to be visited by an Official Visitor at least once a month.<sup>33</sup>
- A report must be prepared and submitted to the Commission by the Official Visitor in relation to each visit.<sup>34</sup>
- The Official Visitor may visit the appointed detention centre at any time, and may perform functions as directed by the Commission at any place.<sup>35</sup>
- If considered necessary, the Commission may give the Official Visitor directions relating to the security of that detention centre.<sup>36</sup>

### *Duty of Official Visitors*

The Official Visitor must hear and investigate complaints made directly to them or referred by the Commission.<sup>37</sup> However, an Official Visitor must not investigate a complaint they believe to be trivial or made only to cause annoyance or if the complaint does not relate to any function of the Commission under the Act.<sup>38</sup> The Official Visitor must give the Commission a report of any investigation conducted.<sup>39</sup>

### *Powers of Official Visitors*<sup>40</sup>

- An Official Visitor may ask a detained child, or a member of staff, to provide any information and answer any questions relevant to the investigation of a complaint.<sup>41</sup>
- An Official Visitor may examine and take a copy of any document kept under or for the purposes of the Act.<sup>42 43</sup>
- The Official Visitor must be allowed to conduct interviews with detainees out of the hearing of any person employed at the centre.<sup>44</sup>
- Detention centre staff must allow the Official Visitor to conduct an interview out of hearing of any other person and must not open, copy, remove or read any correspondence between the child and the Official Visitor.<sup>45</sup>

## Medical treatment

### *Pre-admission*

Regulation 9 requires that no child is to be admitted to a detention centre who appears to be ill, injured or intoxicated, or who appears to be in need of immediate medical treatment, until the child has been medically examined and provided with any immediate treatment required.

### *In custody*

The Commission can give consent to any medical treatment of a child in custody if—

- (a) *the medical treatment requires the consent of a guardian of the child;*
- (b) *the Commission is unable to ascertain the whereabouts of a guardian of the child despite reasonable inquiries;*
- (c) *it would be detrimental to the child's health to delay the medical treatment until the guardian's consent can be obtained.*<sup>46</sup>

Regulation 25(1) states that a child detained in a detention centre has a right to health services and medical treatment. If medical treatment or other health services require the removal of the child's underclothing, the child can ask for a medical practitioner of the same sex<sup>47</sup>, and the Commission must take reasonable steps to comply with that request.<sup>48</sup>

The Commission can request a report of the examination or treatment from the medical practitioner who treats the child,<sup>49</sup> and is obliged to keep a record of medical examinations and treatments for each child.<sup>50</sup> Such records are to be kept confidential and separate from the centre's administrative records.<sup>51</sup> They may be inspected only by the child named in the record, the child's parent, the child's lawyer on production of a subpoena or court order, or an officer of the Commission or department authorised in writing by the Commission.<sup>52</sup>

## Death of child in detention

If a child detained in a centre dies, the Commission must immediately give notice of the death to a police officer at the nearest police establishment, the child's parents, a coroner, a chaplain and, for an Aboriginal or Torres Strait Islander child, the Aboriginal Legal Service.<sup>53</sup>

## Programs and services for children

The chief executive must establish programs and services to support children who have committed offences and to help reintegrate them into the community.<sup>54</sup>

## Management of behaviour

Regulation 13(1) provides that a child detained in a detention centre must obey lawful instructions given by a staff member in the course of the staff member's official duties. A child who does not obey a lawful instruction may be disciplined by the Commission.<sup>55</sup>

Regulation 14 deals with 'management of misbehaviour' and provides:

- (1) *If a child detained in a detention centre misbehaves, the Commission may discipline the child.*
- (2) *The Commission must ensure that the misbehaviour is managed in a way that has regard to:*
  - (i) *the nature of the misbehaviour;*
  - (ii) *the child's age and maturity.*
- (3) *The Commission must not use, as a way of disciplining a child:*
  - (a) *corporal punishment;*
  - (b) *physical contact;*
  - (c) *an act that involves humiliation, physical abuse, emotional abuse or sustained verbal abuse;*
  - (d) *deprivation of sleep, food or visitors; or*
  - (e) *exclusion from educational or vocational programs;*
  - (f) *medication or deprivation of medication.*
- (4) *If it is necessary to use force to protect a child, or other persons or property in the centre, from the consequences of a child's misbehaviour, an officer of the Commission must not use more force than is reasonably necessary.*

The Commission may approve types of restraints that may be used on a child in custody.<sup>56</sup> They may be used only in the following circumstances:

- (a) *Where the child is outside a detention centre, or about to leave a detention centre, under escort by an officer of the Commission or the department;*
- (b) *Where the Commission considers, on reasonable grounds, that:*
  - (i) *it is reasonably likely that the child will attempt to escape;*
  - (ii) *the child could seriously harm himself, herself or someone else;*
  - (iii) *the child could seriously disrupt order and security at the centre.*

A register must be kept of the use of restraints, with the name of the child, the date the restraints were used, and the circumstances in which they were used.<sup>57</sup>

### *Separation*

An officer of the Commission may only separate a child in a locked room in the following circumstances:

- (a) *if the child is ill;*
- (b) *at the child's request;*
- (c) *for routine security purposes under guidelines issued by the Commission;*
- (d) *for the child's protection or the protection of other persons or property;*
- (e) *for the purpose of restoring order in the detention centre.*<sup>58</sup>

'Security' includes safety.<sup>59</sup> If the child is being separated for either of the last two purposes (that is, a prescribed purpose), the separation cannot be for more than two hours without the approval of the detention centre manager.<sup>60</sup> The separation cannot be for more than 12 hours without the Commission being informed, and the approval of the Commission must be obtained if the separation is for more than 24 hours.<sup>61</sup> However, an officer must not separate a child overnight for a prescribed purpose for more than two hours longer than the centre's normal hours of overnight confinement.<sup>62</sup>

A child separated for a prescribed purpose must be kept under observation in compliance with Commission guidelines.<sup>63</sup> This, however, does not limit the circumstances in which a child may be kept under continuous observation.<sup>64</sup>

The detention centre manager must keep a register recording the child's name, the reason for separation, the name of the staff member who supervised the separation, and the date and length of time of separation.<sup>65</sup> The manager must allow an Official Visitor to inspect the register and make a copy of any entry in it.<sup>66</sup>

### **Property**

The regulations set out a regime that applies to the following:

- *property brought into a detention centre by a child after the child is admitted to the centre*
- *property brought into a detention centre by a person who is visiting a child in a detention centre*
- *property sent to the child in correspondence.*<sup>67</sup>

The Commission may examine such property, and may then:

- (a) *keep the item in safe custody while the child is in the centre*
- (b) *allow the child to keep it for the child's use*
- (c) *destroy it if the Commission considers it perishable*<sup>68</sup>
- (d) *destroy it if the Commission considers it unhygienic or dangerous, unless it would be reasonable to take steps to make the property hygienic or safe.*<sup>69</sup>

The Commission must keep a record of the property in a property register and both the child and an officer must sign it. If the child refuses to sign the record, a staff member (other than the staff member who made the record) may sign the record.<sup>70</sup>

## Searches

### *Searches not involving removal of clothes*

Regulation 17 provides:

- (1) *The Commission may authorise a staff member to conduct a search of a child detained in a detention centre that does not involve the removal of all or part of the child's clothes.*
- (2) *The search may take place:*
  - (a) *on the child's admission to the centre;*
  - (b) *on the child's return to the centre after a period of absence;*
  - (c) *at any time that the Commission reasonably considers that the child should be searched.*
- (3) *If necessary, the staff member may use reasonable force to carry out the search.*

### *Searches involving removal of clothes*

Regulation 18 provides:

- (1) *If the Commission considers it necessary on reasonable grounds, the Commission may order a child who is to be searched to partly or completely undress.*
- (2) *The Commission must not order a child to undress in the presence of a person of the opposite sex who is not a medical practitioner or a nurse assisting the medical practitioner.*
- (3) *The child must comply with an order made or direction given for the purpose of the search.*
- (4) *If necessary, a staff member may use reasonable force to obtain compliance with the order.*
- (5) *A person must not touch a child who is ordered to partly or completely undress other than to the extent reasonably necessary to obtain compliance with the order.*

### *Body searches*

The Commission may authorise a medical practitioner to search the person of a child detained in a detention centre.<sup>71</sup> Such a search may be authorised only if the Commission has reasonable grounds to consider that the child is in possession of a thing that may:

- (a) *threaten the security or good order of the centre;*
- (b) *endanger or be used to endanger the child or another person.*<sup>72</sup>

The medical practitioner and a person acting at the direction of the medical practitioner may, if necessary, use reasonable force to carry out the search.<sup>73</sup>

### *Register*

The Commission must keep a register of all body searches and searches involving the removal of clothes.<sup>74</sup>

### *Articles located during a search*

If a person conducting a search finds a restricted or prohibited article,<sup>75</sup> or one that the person considers threatens the security or good order of the centre, the person may take possession of the article.<sup>76</sup> The article must then be given to the detention centre manager.<sup>77</sup> The detention centre manager may then:

- (a) *return the article to the child;*
- (b) *keep the article until the child is discharged;*
- (c) *if the article belongs to another person—return the article to the other person;*
- (d) *if the detention centre manager considers the article to be perishable—destroy the article;*
- (e) *if the detention centre manager considers the article to be unhygienic or dangerous—destroy the article unless it would be reasonable to take steps to make the article hygienic or safe.*<sup>78</sup>



If the property is destroyed, the detention centre manager must:

- (a) *inform the child of the destruction and the reason for destruction;*
- (b) *make a record of the destruction in the property register and the reason for the destruction.*<sup>79</sup>

If the article found is not already registered in the property register, the detention centre manager must do so,<sup>80</sup> and both the detention centre manager and the child must sign the record.<sup>81</sup> If the child refuses to sign the record, a staff member (other than the staff member who made the record) may sign the record.<sup>82</sup>

### **Religious services**

The Commission may approve the holding of a religious service at a detention centre.<sup>83</sup>

### **External contact with children**

#### *Telephone calls*

The Commission must allow a child in a detention centre to make and receive telephone calls under guidelines issued by the Commission.<sup>84</sup> The child is entitled to have that telephone call outside the hearing of any other person.<sup>85</sup> If, however, the detention centre manager considers, on reasonable grounds, that the telephone call may disclose information that is, or is likely to be, detrimental to the good order and management of the centre, a staff member may be required to listen to the conversation.<sup>86</sup> In this case, the detention centre manager must inform the child and the other party to the conversation, prior to the conversation taking place, that an officer will listen to the conversation and may terminate it on reasonable grounds.<sup>87</sup> This does not affect the right to privacy with respect to conversations with legal practitioners<sup>88</sup> or with the Official Visitor.<sup>89</sup>

#### *Correspondence*

A child detained in a detention centre is entitled to send and receive letters and other mail.<sup>90</sup> The Commission may examine letters and other mail between the child and another person that the Commission reasonably believes may disclose information, or contain property, that is, or is likely to be, detrimental to the good order and management of the centre.<sup>91</sup> This does not affect the right to privacy with respect to conversations with legal practitioners<sup>92</sup> or with the Official Visitor.<sup>93</sup>

If the Commissioner is satisfied that correspondence disclosed information that is, or is likely to be, detrimental to the good order and management of the centre, the Commission may:

- (a) *withhold the correspondence;*
- (b) *delete the information;*
- (c) *return the correspondence to the sender;*
- (d) *destroy the correspondence.*<sup>94</sup>

#### *Ordinary visitors*

The Commission may approve the entry of visitors to a detention centre either generally or in a particular case.<sup>95</sup> Section 213 provides as follows:

*The Commission may refuse entry to a detention centre to a person if:*

- (a) *in the Commission's opinion, the person's presence in the detention centre would prejudice the security or good order of the detention centre;*
- (b) *the person does not, on request, give the person's name, address or proof of identity;*
- (c) *the person refuses to comply with a request made under subsection (5).*<sup>96</sup>

The Commission may require a visit to occur in the presence, or under the supervision, of a member of the detention centre staff.<sup>97</sup> The Commission may, on reasonable grounds, ask a visitor to submit to an external physical search, or submit anything in their possession to a search, by a member of the detention centre staff.<sup>98</sup>

The Commission may also give a visitor a direction considered necessary for the security or good order of the centre.<sup>99</sup> If a visitor fails to comply with a request for search or a direction, they may be asked to leave the centre immediately,<sup>100</sup> and if they refuse to leave, reasonable and necessary force may be used to remove them.<sup>101</sup>

The detention centre manager must ensure that the name and address of each ordinary visitor to a detention centre is recorded in a visitors' book before the visitor is admitted to the centre.<sup>102</sup>

### *Access to legal practitioners*

A legal practitioner representing a child held in a detention centre is entitled to access to the child at all reasonable times.<sup>103</sup> Detention centre staff must allow the legal practitioner to conduct an interview out of the hearing of any other person and must not open, copy, remove or read any correspondence between the child and the legal practitioner.<sup>104</sup>

### **Child of detainee**

The Commission may allow a child of a detainee to be accommodated in the detention centre subject to conditions the Commission considers appropriate.<sup>105</sup>

### **Leave of absence**

A child may be granted leave of absence by written notice by the Commission subject to conditions determined by the Commission.<sup>106</sup> Leave may only be granted for a specified period, subject to specified conditions, and for one of the following specified purposes:

- (a) to seek or engage in paid or unpaid employment;
- (b) to attend any place for educational or training purposes;
- (c) to visit the child's family, relatives or friends;
- (d) to take part in sport, recreation or entertainment in the community;
- (e) to attend any place for medical examination or treatment;
- (f) to attend a funeral;
- (g) any other purpose that the Commission considers will assist in the child's reintegration into the community.<sup>107</sup>

Time spent on a leave of absence is counted towards time served of the detention period.<sup>108</sup>

If a child contravenes a condition of the leave of absence, other than a condition with respect to returning to the centre, the Commission may, in writing, vary the conditions or cancel the leave of absence.<sup>109</sup>

### **Release of a child**

Generally, a child sentenced to detention must be released after serving 70 per cent of the period of detention ordered.<sup>110</sup> However, a court may order a child to be released before that time if it is considered that there are special circumstances, for example to ensure parity of sentence. The child may be released as early as when 50 per cent of the detention period has been served.<sup>111</sup>

If a child was held in custody pending determination of the offence, that time must be counted as part of the period served, unless the time spent in custody was for another offence.<sup>112</sup> Any period of custody shorter than one day is not counted.<sup>113</sup>

The Act sets out the following example:

*C is sentenced to 10 weeks' detention. C spent 2 weeks on remand before sentence. C must be released after 5 weeks, which is 70% of 10 weeks with a further reduction of 2 weeks.*<sup>114</sup>

At the time the child is required to be released, the chief executive must make a 'fixed release order' releasing the child from detention.<sup>115</sup> That order may contain conditions that the chief

executive considers appropriate and those conditions may be amended by the chief executive at any time by written notice served on the child.<sup>116</sup>

If the chief executive is of the opinion, on reasonable grounds, that a child has contravened a condition of the order, the order may be revoked by instrument.<sup>117</sup> The chief executive may then make application to a magistrate for a warrant to arrest the child and return him/her to the detention centre for the unexpired portion of the sentence.<sup>118</sup>

### **Transfer to a prison**

Either the Commission or a detained person may apply to a Children's Court judge for an order that the unserved part of the period of detention be served as a term of imprisonment.<sup>119</sup> This can occur only if the person is aged 18 or over, or the person is aged 17 or over and has previously been held in prison custody on sentence, remand or otherwise, or has been sentenced to serve a term of imprisonment.<sup>120</sup> The court may grant or refuse the application.<sup>121</sup>

Such an order must specify the day on which it will take effect and is usually taken to be a sentence of imprisonment equal to the length of the unserved part of the period of detention.<sup>122</sup>

The *Corrective Services Act 1988* will then apply to a person imprisoned under the order.<sup>123</sup>

The person must be released on parole on the day they would have been released under a fixed release order unless:<sup>124</sup>

- the Queensland Community Corrections Board or a regional community corrections board cancels, amends or varies a parole order before the person is released on parole; or
- the person is required to be held in custody for another reason.

### **Escape**

It is an offence for a person who is lawfully detained under the *Juvenile Justice Act* to escape or attempt to escape from detention, or to be absent from a detention centre without lawful authority, or to escape or attempt to escape from the custody of a police officer or an officer of the department into which the person was placed under the Act.<sup>125</sup> The person who commits such an offence may be arrested without warrant.<sup>126</sup>

## **ENDNOTES**

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<sup>1</sup> Second reading speech, Minister for Family Services and Aboriginal and Islander Affairs, *Parliamentary Debates*, 18 June 1992, p. 5927.

<sup>2</sup> S. 5. Note: The s. 5 definition continues as follows: 'or after a day fixed under s. 6—a person who has not turned 18 years.' Section 6 provides that the Governor-in-Council may, by Regulation, fix a day after which a person will be a child for the purposes of the *Juvenile Justice Act 1992* if they have not turned 18 years.

<sup>3</sup> S. 3.

<sup>4</sup> S. 233(2), schedule 1 to the Act.

<sup>5</sup> Second reading speech, Minister for Family Services and Aboriginal and Islander Affairs, *Parliamentary Debates*, 18 June 1992, p. 5928.

<sup>6</sup> S. 41.

<sup>7</sup> This is so notwithstanding any Act to the contrary: s. 43(1). Section 43(2) provides that if an Act confers jurisdiction on a court to commit a person to a place of detention, if the person is a child, that is taken to confer jurisdiction on the court to remand the child into the custody of the Commission.

<sup>8</sup> S. 43(3).

<sup>9</sup> S. 43(5).

<sup>10</sup> S. 43(6). Prison is defined in s. 5 as 'a prison within the meaning of the *Corrective Services Act 1988*.' That Act defines 'prison' as 'any premises or place declared or deemed to have been declared as a prison pursuant to this Act.'

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- <sup>11</sup> S. 164.
- <sup>12</sup> S. 166.
- <sup>13</sup> S. 167(1).
- <sup>14</sup> S. 167(2).
- <sup>15</sup> The Commission must not admit a child to a detention centre or detain a child in a detention centre unless it is given such a warrant, or a number of other documents set out in s. 208(2).
- <sup>16</sup> S. 207(1) provides that the Commission must decide the detention centre at which the child is to be detained. Section 207(2) provides that the Commission may direct that a child detained in a detention centre be transferred to another detention centre.
- <sup>17</sup> Other than ss. 38, 40, 71 and 113–121. Section 38 provides that '[s]ubject to any direction given by the Commission in a particular case, a prisoner who is under the age of 18 years shall at all times be kept apart from any prisoner who is of or above the age of 18 years.' Section 40 provides that the 'Commission may authorise the accommodation in a prison or a community corrections centre of the child of a prisoner subject to such conditions as it thinks fit.' Section 71 permits a judge of the Supreme or District Courts to order the production of a prisoner before a court. This is usually done when a party requires a witness who is a prisoner to appear before the court; ss. 113–121 relate to 'prisoners of Court', i.e. persons in the custody of the court.
- <sup>18</sup> S. 200.
- <sup>19</sup> S. 203(1).
- <sup>20</sup> S. 203(2).
- <sup>21</sup> Regulation 11(2).
- <sup>22</sup> Regulation 11(3).
- <sup>23</sup> S. 215(1).
- <sup>24</sup> S. 215(2).
- <sup>25</sup> S. 215(3).
- <sup>26</sup> S. 215(4).
- <sup>27</sup> S. 215(5).
- <sup>28</sup> S. 204(1).
- <sup>29</sup> S. 204(2).
- <sup>30</sup> S. 204(3).
- <sup>31</sup> S. 204(4).
- <sup>32</sup> S. 205(1).
- <sup>33</sup> S. 205(2).
- <sup>34</sup> S. 205(3).
- <sup>35</sup> S. 205(4).
- <sup>36</sup> S. 206.
- <sup>37</sup> S. 216(1).
- <sup>38</sup> S. 216(2).
- <sup>39</sup> S. 216(3).
- <sup>40</sup> In addition to the powers set out above, s. 217(d) provides that an Official Visitor has powers that may be prescribed by Regulation. No such powers have been prescribed by Regulation.
- <sup>41</sup> S. 217(a).
- <sup>42</sup> S. 217(b).
- <sup>43</sup> The Official Visitor has a specific power to inspect and copy the register that must be kept of children who are placed in separation: Regulation 16(6). See 'Separation' below.
- <sup>44</sup> S. 217(c).
- <sup>45</sup> S. 218.
- <sup>46</sup> S. 212.
- <sup>47</sup> Regulation 25(2).
- <sup>48</sup> Regulation 25(3).
- <sup>49</sup> Regulation 26(1).
- <sup>50</sup> Regulation 26(2).
- <sup>51</sup> Regulation 26(4). They can only be inspected by the child, the child's parents, or on production of a subpoena or court order by a lawyer representing the child, or by an officer of the Commission or department authorised in writing by the Commission.
- <sup>52</sup> Ibid.
- <sup>53</sup> Regulation 27.
- <sup>54</sup> S. 224A(1).
- <sup>55</sup> Regulation 13(2).
- <sup>56</sup> Regulation 15(1).
- <sup>57</sup> Regulation 15(3).
- <sup>58</sup> Regulation 16(1).
- <sup>59</sup> Regulation 3.
- <sup>60</sup> Ibid.
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<sup>61</sup> Regulation 16(2).  
<sup>62</sup> Regulation 16(3).  
<sup>63</sup> Ibid.  
<sup>64</sup> Regulation 16(7).  
<sup>65</sup> Regulation 16(5).  
<sup>66</sup> Regulation 16(6).  
<sup>67</sup> Regulation 24(1).  
<sup>68</sup> The Commission must then inform the child of the destruction and the reason for destruction and record in the property register the destruction and the reason for it: Regulation 24(6).  
<sup>69</sup> Regulation 24(2).  
<sup>70</sup> Regulation 24(3)–(5).  
<sup>71</sup> Regulation 19(1).  
<sup>72</sup> Regulation 19(2).  
<sup>73</sup> Regulation 19(3).  
<sup>74</sup> Regulation 20.  
<sup>75</sup> An article can be declared by the Commission by written instrument to be restricted or prohibited.  
<sup>76</sup> Regulation 20(1).  
<sup>77</sup> Regulation 21(2).  
<sup>78</sup> Regulation 21(3).  
<sup>79</sup> Regulation 21(7).  
<sup>80</sup> Regulation 21(4).  
<sup>81</sup> Regulation 21(4)–(5).  
<sup>82</sup> Regulation 21(6).  
<sup>83</sup> Regulation 28.  
<sup>84</sup> Regulation 22(1).  
<sup>85</sup> Regulation 22(2).  
<sup>86</sup> Regulation 22(3).  
<sup>87</sup> Regulation 22(4).  
<sup>88</sup> S. 214.  
<sup>89</sup> S. 218.  
<sup>90</sup> Regulation 23(1).  
<sup>91</sup> Regulation 23(2). Note: This does not apply to correspondence the Commission decides to exclude from examination.  
<sup>92</sup> S. 214, op cit.  
<sup>93</sup> S. 218, op cit.  
<sup>94</sup> Regulation 23(3).  
<sup>95</sup> S. 213(2).  
<sup>96</sup> S. 213(3).  
<sup>97</sup> S. 213(4). Note: This is subject to s. 214 which provides that legal practitioners must be allowed to conduct an interview with a child out of the hearing of others.  
<sup>98</sup> S. 213(5).  
<sup>99</sup> S. 213(6).  
<sup>100</sup> S. 213(7).  
<sup>101</sup> S. 213(8).  
<sup>102</sup> Regulation 29.  
<sup>103</sup> S. 214(1).  
<sup>104</sup> S. 214(2).  
<sup>105</sup> S. 223. The birth certificate is not to contain information indicating the child was born in a detention centre.  
<sup>106</sup> S. 210(1).  
<sup>107</sup> S. 210(2)–(3).  
<sup>108</sup> S. 210(4).  
<sup>109</sup> S. 210(5).  
<sup>110</sup> S. 188(1).  
<sup>111</sup> Regulation 188(2). Note: The court cannot order release later than the 70 per cent mark.  
<sup>112</sup> Ss. 174(1) and (2) and 188(3).  
<sup>113</sup> S. 174(3).  
<sup>114</sup> S. 188.  
<sup>115</sup> S. 189.  
<sup>116</sup> Ibid.  
<sup>117</sup> S. 191(1).  
<sup>118</sup> S. 191(2). Note: Section 190 provides that a period of time for which a child is released from detention under a fixed release order must be counted as part of the period spent in detention for the purpose of calculating the end of the detention period. However, s. 191(6) provides that the period

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spent out of custody after the issue of a warrant is not counted as time spent in detention for the purpose of calculating the end of the detention period unless the chief executive determines otherwise.

<sup>119</sup> S. 211(1).

<sup>120</sup> S. 211(2).

<sup>121</sup> S. 211(3).

<sup>122</sup> S. 211(4).

<sup>123</sup> S. 211(5).

<sup>124</sup> S. 211(6).

<sup>125</sup> S. 219.

<sup>126</sup> S. 219(2).

## APPENDIX 4

### *INFANT LIFE PROTECTION ACT 1905*

The *Infant Life Protection Act 1905* commenced on 1 January 1906, its primary purpose being to ‘make better provision for the protection of infant life.’ It was repealed by the *Children’s Services Act 1965* which came into effect on 1 August 1966.<sup>1</sup>

#### **1. REPEAL OF PART VII OF THE HEALTH ACT**

The Act repealed part VII of the *Health Act 1900* which prohibited a person from retaining or receiving for hire or reward more than one infant (or two infants in the case of twins) under the age of one year, of which he/she was not the parent, for the purpose of nursing or maintaining such infant for longer than 24 hours in a house which was not registered under that Act. However, the government had no power to compel registration of a home in which a person was maintaining or nursing only one infant.

The infant mortality rate was very high, particularly for illegitimate infants, and the *Infant Life Protection Act* was intended to address this by establishing a regime of compulsory registration of homes in which one or more infants were being nursed or maintained.<sup>2</sup> Registration would give the government power to inspect the premises and to exercise a supervisory role.

The Act initially applied to infants under the age of three. In 1935 this was extended to apply to infants under the age of six as it was ‘considered desirable that [ *children the subject of the Act*] should be under the control of the Department until they reach school age.’<sup>3</sup>

#### **2. POWER TO MAKE REGULATIONS**

The Governor-in-Council was vested with power to regulate, among other things:

- the mode for making application for registration, the registers to be kept, and the particulars therein
- enforcing drainage and provision of sanitary conveniences for nursing homes, the cleaning and lime washing of the premises, promoting cleanliness and ventilation in the homes, enforcing the giving of notices and the taking of precautions in the case of disease likely to affect infants, and generally for the good conduct of nursing homes
- the inspection of nursing homes and infants.<sup>4</sup>

#### **Registration of nursing homes**

As stated above, the Act required the Director of the State Children Department to keep a register of every person who applied to have their house registered as a nursing home.<sup>5 6 7</sup>

Originally, section 6 prohibited a person, in consideration of any payment or reward, retaining or receiving into their care or charge an infant under the age of three years for the purpose of nursing or maintaining him or her for a period longer than 48 hours, or for the purpose of adopting the infant, unless that person was registered as the occupier of a nursing home registered under the Act.<sup>8</sup>

In 1927 the words ‘in consideration of any payment or reward’ were deleted. The prohibition did not apply to:

- relatives or lawful guardians of the infant
- a person receiving an infant for the purpose of nursing or maintaining the infant under the provisions of any Act relating to State children<sup>9</sup>
- a person exempted from the operation of the Act by special order of the Minister.

The occupier of a home in which infants were maintained or nursed was required to make a written application for registration, accompanied by a certificate of fitness signed by at least two reputable inhabitant householders of the locality. The certificate was to attest to the

belief of the householder that the applicant was a fit and proper person to be entrusted with the care and maintenance of infants.<sup>10</sup>

The Director was to refer the application to an officer designated to inspect the premises, make necessary inquiries, and make a written report to the Director. The officer was to enquire particularly into the character of the applicant, their ability to properly nurse and maintain infants, the suitability of the house in regard to situation, drainage, water supply, ventilation, sanitary conveniences and other matters, and the suitability of the locality of the house.<sup>11</sup>

### **Renewal of registration**

Registration of nursing homes lapsed on 31 December each year unless it was renewed.<sup>12</sup> To renew a registration, the district officer<sup>13</sup> of the State Children Department was required to provide a certificate of registration to the Director disclosing all facts concerning the occupier and the nursing home as at the date of renewal.<sup>14</sup> The Director had the power to:

- refuse to register any person applying for registration, or to renew any registration, unless satisfied that the applicant was of good character and able to properly nurse and maintain any infants in their care or charge
- refuse to register or renew the registration of any nursing home, unless satisfied that the house was suitable for the purpose and was situated in a suitable locality.<sup>15</sup>

### **Register of infants within home**

The nursing home occupier was to keep a roll recording the name, sex and age of each infant retained in or received into their care or charge.<sup>16</sup> The Department was similarly required to maintain a register.<sup>17</sup>

### **Duties and responsibilities of the registered person**

Section 10 of the Act set out the duty and responsibility of the registered person:

*It shall be the duty of every registered person to provide every infant, while in his care or charge, with proper and sufficient food, nursing and attention and with all other necessities of life, and to keep every part of the nursing home at all times in a fit and proper state for the reception of infants, and to do, observe, and carry out all the acts, requirements and directions prescribed by this Act or by any order of the Director in relation to the nursing home.*

It vested power in the Director to make orders for its purposes, and also imposed vicarious liability on the registered person for any act or default of any member of their family or of any person employed by them at or in connection with the nursing home.

### **Cancellation of registration**

The Director had the power to cancel the registration of any registered person if it appeared that they had been guilty of neglecting any infant in their care or charge, or were incapable of providing any such infant with proper food or attention, or that the nursing home was unfit for the reception or retention of infants, or if for any other reason it appeared to the Director desirable to do so. In addition to cancelling the registration, the Director could order the immediate removal of the infants from the nursing home to the care of the State Children Department.<sup>18</sup>

Prior to the *Infant Life Protection Act Amendment Act 1921*, the Commissioner of Police had been able to cancel the registration on 10 days' notice. There was also provision for the registered person to appeal this decision, however the notice provisions and appeal rights were repealed by the 1921 legislation.



### **Medical treatment**

If an infant in a nursing home required medical attendance the occupier was required, in cases of emergency, to call in the nearest medical practitioner.<sup>19</sup> The fees were to be paid by the person from whom the infant was received or, if that person was indigent, the Director could recommend to the Minister that the fees be paid by the government. Those arrangements were not to interfere with the right of the infant's parents or other relatives to employ at their own cost any duly qualified medical practitioner that they thought proper.

Immediately after the occupier was informed or ascertained that an infant had an infectious disease, the occupier was required to adopt all precautions necessary to prevent the spread of the disease. The occupier was obliged to isolate the infant in a room and prevent contact with any other persons except the parents or relatives of the infant or a medical practitioner or a person voluntarily in attendance on the infant. After the infant's removal from the room the occupier was responsible for its proper cleansing and disinfection.<sup>20</sup>

### **Maintenance of premises in good order**

The occupier was required to:

- maintain the yard and open space at all times in good order and to thoroughly clean the area from time to time so as to keep it in a clean and wholesome condition<sup>21</sup>
- ensure that the floor of every room or passage and every stair was thoroughly swept once each day before 10.00 a.m. and thoroughly washed once each week<sup>22</sup>
- ensure that each window, fixture or fitting of wood, stone or metal and every painted surface was thoroughly cleaned from time to time as required<sup>23</sup>
- thoroughly clean all bedclothes and bedding and every cot and bedstead in the home from time to time as required for the purpose of keeping such things in a clean and wholesome condition<sup>24</sup>
- remove all solid or liquid filth or refuse once each day before 10.00 am and thoroughly clean, at least once each day, each vessel, utensil or other receptacle for such filth or refuse<sup>25</sup>
- keep every earth closet and privy in good order and in a wholesome condition<sup>26</sup>
- maintain all means of ventilation as may be provided in any room or passage at all times in good order and efficient action.<sup>27</sup>

### **Bedding**

The occupier was required to ensure there were sufficient cots, beds and bedsteads, bedclothes and necessary utensils considered by an inspector<sup>28</sup> to be sufficient for the requirements of the number of infants in the room.<sup>29</sup>

### **Death of infants**

In the event of the death of an infant, the registered person was required to notify the police officer in charge of the nearest police station within 24 hours. Section 13 required an inquest to be held, in which the Justice of the Peace was to enquire into the immediate cause of death and any circumstances that may throw any light on the treatment and condition of the infant during its life.

### **Inspection**

Section 14 of the Act provided that the Director or any authorised police officer or an appointed inspector could inspect a nursing home and all its residents from time to time, but not less than once every three months. Visits were to be made without prior notice and at irregular periods.<sup>30</sup> A legally qualified medical practitioner could accompany the person inspecting the nursing home if it was considered desirable.<sup>31</sup> The Governor-in-Council could appoint inspectors under the Act.<sup>32</sup>

The nursing home was required to be open at any time between the hours of 6.00 am and 10.00 pm for inspection by an appointed inspector or by any authorised officer. The person

inspecting was to be allowed free access to the sleeping apartments of the infants and to be permitted to inspect the infants, their outfits, bed clothing and bedding. The occupier was obliged to answer truthfully all questions concerning the diet and general treatment of the infants in their care. In addition, at all convenient times the person inspecting was to be given access to the home and its surroundings (in addition to the rooms specifically allocated for the use of infants) in order that sanitary conditions could be examined. The inspector or authorised officer was required to conduct their investigation with due tact and courtesy and to regularly submit to the Director written reports of all inspections.<sup>33</sup>

## Offences

Under the Act a person convicted of retaining in or receiving into his/her care or charge an infant under the age of six years contrary to the Act, or neglecting to notify the death of an infant as required by the Act, must not be registered under the Act, and if registered, must have their registration cancelled together with that of their nursing home.<sup>34</sup>

## ENDNOTES

<sup>1</sup> S. 3, schedule 1, *Children's Services Act 1965*.

<sup>2</sup> Second reading speech, Infant Life Protection Bill 1905, Home Secretary, Legislative Assembly, *Parliamentary Debates*, 16 November 1905, pp. 1652–62.

<sup>3</sup> Second reading speech, Infant Life Protection Acts Amendment Bill 1935, Home Secretary, Legislative Assembly, *Parliamentary Debates*, 30 October 1935, p. 455.

<sup>4</sup> S. 21—regulations were promulgated in March and September 1905. They were repealed and replaced by regulations promulgated in 1919. Given that the focus of the Forde Inquiry has been on the period from 1935, reference has been made only to the 1919 Regulations.

<sup>5</sup> S. 7.

<sup>6</sup> S. 4 defined 'Nursing Home' to mean a house registered as a nursing home under the Act.

<sup>7</sup> S. 4 defined 'Director' as the Director of the State Children Department appointed under the *State Children Act 1911*. (With the passing of the *Infant Life Protection Act Amendment Act 1918*, most powers under the Act became exercisable by the Director of the State Children Department. Prior to the 1918 amending Act, these powers were exercisable by the Commissioner of Police. With the passing of that amending Act the Commissioner was required to hand over all records, registers and documents kept in respect of the principal Act to the Director.)

<sup>8</sup> S. 1 defined 'occupier' as the person registered as the occupier of a nursing home.

<sup>9</sup> Prior to 1911, the word 'orphans' appeared; s. 5(3) of the *State Children Act* replaced 'orphans' with 'State children'.

<sup>10</sup> Regulation 3 of 1919.

<sup>11</sup> *Ibid*.

<sup>12</sup> S. 7.

<sup>13</sup> Regulation 1 of 1919 defined 'district officer' as the officer in charge of a District Office for the time being. It further defined 'district office' as the Office of the State Children Department established at Rockhampton, Townsville or elsewhere.

<sup>14</sup> Regulation 8 of 1919.

<sup>15</sup> S. 8.

<sup>16</sup> S. 9.

<sup>17</sup> Regulation 10 of 1919.

<sup>18</sup> S. 11.

<sup>19</sup> Regulation 14 of 1919.

<sup>20</sup> Regulation 27 of 1919.

<sup>21</sup> Regulation 15 of 1919.

<sup>22</sup> Regulation 16 of 1919.

<sup>23</sup> Regulation 17 of 1919.

<sup>24</sup> Regulation 18 of 1919.

<sup>25</sup> Regulation 19 of 1919.

<sup>26</sup> Regulation 20 of 1919.

<sup>27</sup> Regulation 22 of 1919.

<sup>28</sup> S. 1 defined 'inspector' as any person appointed an inspector under the Act.

<sup>29</sup> Regulation 26 of 1919.

<sup>30</sup> Regulation 13 of 1919.

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<sup>31</sup> S. 14.

<sup>32</sup> S. 20.

<sup>33</sup> Regulation 13, op cit.

<sup>34</sup> S. 18.

## APPENDIX 5

### LIST OF FACILITIES THAT FALL WITHIN THE TERMS OF REFERENCE

#### GOVERNMENT-OPERATED FACILITIES

BIRRALEE previously ROCKHAMPTON ORPHANAGE, 124 Quarry Street, Rockhampton

- Rockhampton Orphanage established 1870
- Government assumed control following the passing of *Orphanages Act* 1879
- renamed Rockhampton Receiving Depot 1894
- renamed **Birralee** Children's Home December 1964
- renamed Birralee Receiving and Assessment Centre 1967/68
- Birralee Hostel (replacing old buildings) opened 23 November 1981
- closed 30 November 1982

CARRAMAR previously TOWNSVILLE ORPHANAGE AND RECEIVING DEPOT,

- 42 Warburton Street, North Ward, Townsville
- Townsville Orphanage established 1878
- Government assumed control following the passing of *Orphanages Act* 1879
- renamed Townsville Receiving Depot 1934
- renamed **Carramar** Receiving and Assessment Centre, also known as Carramar Children's Home December 1964
- renamed Carramar Receiving and Assessment Centre 1967/68
- changed to therapeutic intervention model; transitional arrangements until TARA programs commenced (see below) 1995

CLEVELAND YOUTH CENTRE, Old Common Road, Belgian Gardens, Townsville

- opened June 1980
- renamed Cleveland Youth Detention Centre 1993/94
- *currently operating*

DIAMANTINA see under WARILDA

JOHN OXLEY YOUTH CENTRE

- opened February 1987
- renamed John Oxley Youth Detention Centre September 1993/94
- *currently operating*

KARRALA HOUSE

- opened 18 February 1963
- second unit opened December 1968
- closed (followed by opening of Remand and Assessment Centre for Girls at Wilson Youth Hospital) October 1971

KELVIN GROVE TRANSITION HOSTEL

- opened July 1973
- closed 1976/77

ROCKHAMPTON ORPHANAGE AND RECEIVING DEPOT see under BIRRALEE

STANTON LODGE, Townsville

- opened 10 May 1984
- ceased operations 30 June 1985

TARA (Therapeutic Adolescent Residential Assessment) Unit

- established at Carramar site 1995
- *currently operating*

TARINGA TRANSITION HOSTEL, Swann Road

- opened 1973
- closed 1985/86

THE OUTLOOK, BOONAH

- officially opened 28 June 1976
- ceased to operate as a residential facility July 1979
- *currently operating as a Community Resource Centre*

## TOWNSVILLE ORPHANAGE see CARRAMAR

WARILDA previously DIAMANTINA, 84 Kedron Park Road, Woolloowin

- Diamantina Orphanage established at Roma Street, Brisbane 1865
- Government assumed control following the passing of *Orphanages Act* 1879
- moved to South Brisbane 1883
- moved to Sandgate February 1893
- moved to 84 Kedron Park Road, Woolloowin January 1910
- renamed Diamantina Receiving Depot and Infants' Home 1910
- renamed Diamantina Receiving Home 1962
- renamed **Warilda** Children's Home and Warilda Infants' Home December 1964
- renamed Warilda Receiving and Assessment Centre 1967/68
- closed January 1989

## WESTBROOK

- Reformatory School for Boys relocated from Lytton to Westbrook 5 May 1900
- transferred to State Children Department 31 December 1911
- renamed Farm Home for Boys, Westbrook 30 October 1919
- renamed Westbrook Training Centre 26 May 1966
- renamed Westbrook Youth Centre 1987
- renamed Westbrook Youth Detention Centre 1993/94
- closed 30 June 1994

## WILSON

- Wilson Youth Hospital opened (administered by Youth Welfare and Guidance Division of Health Department) July 1961
- administration transferred to Department of Children's Services 1 January 1966
- full responsibility assumed by Department of Children's Services 1 June 1983
- renamed Sir Leslie Wilson Youth Centre 1983
- function changed to a Remand Centre with opening of John Oxley YDC February 1987
- renamed Sir Leslie Wilson Youth Detention Centre 1993/94
- *currently operating*

## CONDUCTED BY THE DEPARTMENT OF NATIVE AFFAIRS

INDUSTRIAL SCHOOL, BARAMBAH later CHERBOURG ABORIGINAL SETTLEMENT

- Barambah Industrial School licensed 2 April 1914
- name changed to Cherbourg 1937
- State children first admitted 1942
- gazetted as Cherbourg Industrial School 27 January 1951
- no information has been located about when this facility closed

INDUSTRIAL SCHOOL, PALM ISLAND ABORIGINAL SETTLEMENT

- licence gazetted & first State child admitted 29 December 1922
- no inmates from 1931 to 1935
- no information has been located about when this facility closed

INDUSTRIAL SCHOOL, TAROOM later WOORABINDA ABORIGINAL SETTLEMENT

- licensed as Taroom Industrial School 2 April 1914
- name changed to Woorabinda 1937
- no State children admitted up to 1947/8
- gazetted as Woorabinda Industrial School 27 January 1951
- no information has been located about when this facility closed

## LICENSED FACILITIES CONDUCTED BY OR UNDER THE AUSPICES OF CHURCH ORGANISATIONS

### *Anglican Church*

ANGLICAN CHILDREN'S HOME, 47 Stanley Lane, Gympie

- opened and licensed 1982/83
- *currently licensed*

### ENOGERA BOYS' HOME

- established at Enoggera (previously located at Woolloowin and known as Brisbane Boys' Home) by private committee June 1906
- governed by the Synod of the Diocese of Brisbane from approximately 1925
- licensed under *State Children Act 1911* 27 June 1940
- licensed under *Children's Services Act 1965* 4 August 1966
- closed 6 October 1978

# HOME OF THE GOOD SHEPHERD, Eton House, Nundah

## SOCIETY OF THE SACRED ADVENT

- Girls' Training Home
- formally opened and named Home of the Good Shepherd June 1893
- licensed under *State Children Act 1911* 1912
- closed c. 1915

## INDUSTRIAL SCHOOL FOR GIRLS, Clayfield

- established 1903
- transferred to State Children Department 31 December 1911
- closed 21 October 1920

## INDUSTRIAL SCHOOL, Yarrabah Mission Station

- licensed under *State Children Act* 2 April 1914
- no information has been located about when this facility closed

## MORRIS HOUSE, 52 Allerslie Crescent, Taringa

### SOCIETY OF ST FRANCIS also known as Franciscan Friars and ANGLICAN CHURCH MEN'S SOCIETY

- licensed 11 March 1975
- closed 30 November 1983

## ST GEORGE'S ORPHANAGE, Parkhurst, Rockhampton

### ST GEORGE'S HOMES FOR CHILDREN EXECUTIVE COMMITTEE, DIOCESE OF ROCKHAMPTON

- licensed in Rockhampton under *State Children Act 1911* 26 October 1917
- No. 2 Home opened and licensed under *State Children Act 1911* (original home became known as No. 1 Home) 1925
- No. 3 Home known as the Mothers' Memorial Home opened 1930
- No. 3 Home closed and children transferred to No. 1 and No. 2 1931
- No. 3 Home reopened (later used as recreation hall) 1935
- Known as St George's Homes from 1953
- licensed under *Children's Services Act 1965* 4 August 1966
- No. 1 Home closed 30 June 1971
- known as St George's Home from 1976
- Group Homes at 72 Elphinstone Street, North Rockhampton and 196 Mason Street, North Rockhampton opened—eight boys transferred to each from Parkhurst January 1978
- Parkhurst closed—funding ceased officially 1 September 1979
- Elphinstone Street closed mid-1980
- Mason Street closed 25 June 1982

## ST MARY'S HOME, Toowong

### COMMITTEE OF ST MARY'S CHURCH OF ENGLAND HOME

- established c. 1919
- licensed 11 February 1975
- funding ceased (but continued to operate) 1981/82

## THE FRIARY, 132 Brookfield Road, Brookfield

### SOCIETY OF ST FRANCIS also known as Franciscan Friars

- established 1966
- licensed and funded for four beds (of the 10) 1 April 1980
- licence cancelled prior to closure of the facility 28 August 1981

## TUFNELL HOME, 230 Buckland Road, Nundah

### SOCIETY OF THE SACRED ADVENT; later THE CORPORATION OF THE SYNOD OF THE DIOCESE OF BRISBANE

- Home of the Good Shepherd operated from Eton House (rented premises), Nundah, and Ormiston House at Ormiston—present location in Buckland Road, Nundah purchased 1900
- The Tufnell Home formally opened 6 February 1901
- licensed under *State Children Act 1911* 1938
- licensed under *Children's Services Act 1965* 4 August 1966
- first family group units officially opened 31 August 1969
- funding ceased 1989/90
- services relocated to TRACC (see below) 1990

## TUFNELL TODDLERS' HOME, NUNDAH

### THE CORPORATION OF THE SYNOD OF THE DIOCESE OF BRISBANE

- opened 14 September 1947
- licensed as a separate facility under *State Children Act* April 1965
- licensed under *Children's Services Act 1965* 4 August 1966
- ceased to exist as a separate entity 1974/75

#### TUFNELL RESIDENTIAL AND COMMUNITY CARE (TRACC)

- 10 Trevallyn Drive, Daisy Hill, Logan City, established and funded December 1990
- to move to 35 Cairns Street, Shailer Park/Loganholme July 1993
- moved to 39 Dennis Road, Springwood
- *currently licensed*
- 47 Estramina Road, Regents Park (sibling residential) funded June 1996
- *currently licensed*

#### *Baptist Union*

##### BINDARI LODGE, Kangaroo Point/Tarragindi

- opened at Kangaroo Point (site of former Loreto Cottage) 1971
- licensed 6 January 1975
- relocated to 112 Prior Street, Tarragindi
- changed from hostel to shared house model (and no longer a licensed residential facility) 1995

##### FAMILY GROUP HOMES

- Iloura, 31 Duckett Street, Beaudesert
  - opened and licensed 1975
  - temporary closure May 1990
  - subsequently a family counselling centre
- Kunara, Hampton Terrace, Toombul
  - opened and licensed 1969/70
  - closed 16 December 1989
- Wahroonga, 4 Skyring Street, Rockhampton
  - opened and licensed 8 March 1974
  - no longer a licensed residential facility
- Wongabeena, Mango Avenue, Mundingburra
  - opened and licensed 1970/71
  - funding ceased 1988/89

##### TALERA LODGE, 28 Palmer Street, Greenslopes

- opened November 1977
- licensed 2 March 1978
- funding ceased 1983
- reopened 1984/85
- change of function to non-residential services approved January 1988
- Talera Centre Family Assessment and Therapy Centre opened 3 August 1988

#### *Catholic Church*

##### BOYSTOWN, Telemon Road, Beaudesert

##### DE LA SALLE BROTHERS

- opened and licensed under *State Children Act* 27 May 1961
- licensed under *Children's Services Act 1965* 4 August 1966
- *currently licensed*
- Albion Lodge, Bridge Street
  - officially opened 22 July 1965
  - licensed under *State Children Act* 7 August 1965
  - first boys moved in 24 August 1965
  - licensed under *Children's Services Act 1965* 4 August 1966
  - closed (boys transferred to Tarragindi Lodge) 28 November 1974
- Tarragindi Lodge, 14 Prior Street
  - opened 1974
  - licensed 1 April 1980
  - closed as a licensed residential care facility 30 June 1991

##### FATIMA HOME FOR CHILDREN, 104 South Street, Toowoomba

##### ORDER OF THE SISTERS OF MERCY

- licensed 5 September 1974
- ceased to operate as a residential facility June 1995

GRANADA HOSTEL, 49 Stewart Road, Ashgrove	
THE HOSPITALLER ORDER OF ST JOHN OF GOD also known as The Brotherhood of St John of God	
• opened and licensed	18 August 1979
• closed	1 December 1985
HOLY CROSS RETREAT, later HOLY CROSS HOME, Chalk Street, Woolloowin	
ORDER OF THE SISTERS OF MERCY—ARCHDIOCESE OF BRISBANE	
• established; co-located with Magdalen Asylum for unmarried mothers	1888
• licensed separately as Holy Cross Retreat under <i>Orphanages Act 1879</i> (previously included with St Vincent's Orphanage)	1895
• licensed under <i>State Children Act 1911</i>	1912
• ceased as home for young children	1959/60
• licensed under <i>Children's Services Act 1965</i>	4 August 1966
• renamed <b>Mercy Centre</b>	
• no longer a licensed residential facility	
INDUSTRIAL SCHOOL FOR GIRLS/HOME OF THE GOOD SHEPHERD, Mitchelton	
ORDER OF THE SISTERS OF THE GOOD SHEPHERD	
• licensed under <i>State Children Act</i>	1933
• renamed <b>Mt Maria</b> Re-Education Centre	1966
• licensed under <i>Children's Services Act 1965</i>	4 August 1966
• renamed Mt Maria Youth Centre	1973/74
• not used for child care purposes since	October 1974
INDUSTRIAL SCHOOL FOR GIRLS, Nudgee	
ORDER OF THE SISTERS OF MERCY—ARCHDIOCESE OF BRISBANE	
• established and licensed	1903
• transferred to State Children Department	31 December 1911
• funding ceased	1953/54
INDUSTRIAL SCHOOL FOR GIRLS, Woolloowin	
ORDER OF THE SISTERS OF MERCY—ARCHDIOCESE OF BRISBANE	
• established and licensed	1904
• transferred to State Children Department	31 December 1911
• renamed <b>Holy Cross Home</b>	1965/66
• licensed under <i>Children's Services Act 1965</i>	4 August 1966
• funding ceased	1974/75
KIAH Hostel, 156 Agnew Street, Norman Park	
ABORIGINAL AND ISLANDERS' CATHOLIC COUNCIL	
• opened	1978/79
• <i>currently licensed</i>	
LOGAN RESERVE LODGE also known as BOYSTOWN LODGE, 707–713 Logan Reserve Road, Logan Reserve	
DE LA SALLE BROTHERS	
• funded from	June 1991
• <i>currently licensed</i>	
LORETTA COTTAGE, Toowoomba	
ORDER OF THE SISTERS OF MERCY—Fatima Home Committee	
• established	1981/82
• closed	11 May 1984
NAZARETH HOUSE, Wynnum North Road, Wynnum North	
CONGREGATION OF THE SISTERS OF NAZARETH	
• opened	
• licensed under <i>Infant Life Protection Act 1905</i>	1927
• licensed under <i>State Children Act 1911</i>	10 July 1964
• licensed under <i>Children's Services Act 1965</i>	4 August 1966
• closed	28 November 1982
ST JOSEPH'S HOME, NEERKOL also known as METEOR PARK	
ORDER OF THE SISTERS OF MERCY—DIOCESE OF ROCKHAMPTON	
• established at Mackay and licensed under <i>Orphanages Act 1879</i>	14 April 1880
• transferred from Mackay	1885
• licensed under <i>State Children Act 1911</i>	1912
• licensed under <i>Children's Services Act 1965</i>	4 August 1966



- Post-Primary Girls' Transitional Hostel, 61 Spencer Street, Rockhampton, operated on 1 year trial only Jan to Nov 1974
- children transferred to Family Group Homes 1978
  - 10 Ward Street
    - purchased June 1977
    - opened 12 October 1977
    - closed early 1979
  - 74 Jessie Street
    - purchased January 1978
    - nil occupancy from June 1984
    - approved bed numbers reduced to nil 1 January 1985

#### ST MARTIN'S CENTRE, 24 Sankey Street, West End

##### ABORIGINAL AND ISLANDERS' CATHOLIC COUNCIL

- licensed May 1977
- closed as a licensed residential facility 31 December 1991

#### ST VINCENT'S ORPHANAGE, Queens Road, Nudgee

##### ORDER OF THE SISTERS OF MERCY—ARCHDIOCESE OF BRISBANE

- transferred to Nudgee from New Farm 1867
- licensed under *Orphanages Act of 1879* 27 December 1879
  - (licence to take effect from the passing of the Act, 2 October 1879)
- licensed under *State Children Act 1911* 1912
- renamed St Vincent's Home for Children 2 November 1935
- children under two years admitted from 1938
- first Opportunity School within a children's home established January 1965
- licensed under *Children's Services Act 1965* 4 August 1966
- 'Loreto' Family Group Home, 31 Collins Street, Kangaroo Point
  - opened and licensed under *State Children Act 1911* October 1964
  - licensed under *Children's Services Act 1965* 4 August 1966
  - closed (sold to Baptist Church) 1971
- 6 Family Group Homes at St Vincent's campus— McAuley, Whitley, Conlan, O'Quinn and Duhig Homes, and Curtis Hostel opened 15 February 1970
  - (Bayview Cottage continued to operate as a group home in a former dormitory building)
- off-site group homes established and Nudgee gradually phased out as a residential facility
- 'Avila' Family Group Home, 5 Royal Avenue, Wavell Heights
  - established 1972
  - licensed separately November 1972
  - renamed 'Narnia' early 1996
  - closed late 1996
- Ascot Family Group Home, 121 Tower Street
  - opened and licensed March 1978
  - relocated to 30 Talgai Street, Brackenridge
  - *currently licensed*
- Virginia, 50 Jefferis Street, share house
  - opened
  - closed (children moved to 5 Royal Avenue, Wavell Heights) late 1996
  - reopened 20 July 1998
  - *currently funded for adolescent programs at Virginia and Brackenridge*

#### THE ARK Transition Hostel, Windsor

##### CATHOLIC FAMILY WELFARE BUREAU

- opened 2 September 1977
- closed 10 December 1982

### *Churches of Christ in Queensland*

#### FAMILY GROUP HOMES

- Bundaberg, 50 Payne Street also known as **John Thompson House** 25 February 1980
  - opened
  - *currently licensed—function changing, no current placements*
- Bundamba Lodge, 26–28 Tibbets Street 6 August 1983
  - opened
  - *currently licensed*

- Frank Gilson House, 26 Jupiter Street, Maryborough  
– opened and licensed 27 November 1970  
– *currently licensed*
- Kingswood Lodge, 235 Bardon Road, Woodridge/Berrinba  
– opened June 1989  
– *currently licensed*
- Mackay, 17 Shakespeare Street  
– opened and licensed 1976  
– *currently licensed—function changing*

IRWIN BLOWERS HOUSE, 26 Sigatoka Place, Merrimac, Southport  
Emergency and short-term accommodation for teenagers

- opened 25 February 1980
- *currently licensed but not operating*

THE CHRISTIAN CENTRE (2 Family Group Homes), Moreton Street, Eidsvold  
FEDERAL ABORIGINES MISSION BOARD

- opened and licensed 1976/77
- no longer a licensed residential facility

### *Congregational Church*

MARSDEN COUNCIL and MARSDEN HOMES FOR BOYS COMMITTEE, QUEENSLAND CONGREGATIONAL UNION—  
transferred to Uniting Church

FAMILY GROUP HOME, 12 Charles Street, Brassall  
MARSDEN COUNCIL, IPSWICH

- opened and licensed 21 February 1974
- funding ceased 1981/82
- funding recommenced 28 October 1984
- no longer a licensed residential facility

MARSDEN HOME FOR BOYS, Booval

- licensed under *State Children Act 1911* 1961/62
- licensed under *Children's Services Act 1965* 4 August 1966
- licence surrendered 3 April 1974

MARSDEN HOME FOR BOYS, Narangba Road, Kallangur

- established 1929
- licensed under *State Children Act 1911* 1938
- State children first admitted 11 February 1938
- licensed under *Children's Services Act 1965* 4 August 1966
- no longer a licensed residential facility

### *Lutheran Church*

LUTHER LODGE, River Heads Road, Hervey Bay

- opened 1982
- licence returned 15 February 1996

### *Methodist Church*

FAMILY GROUP HOMES (originally known as COTTAGE HOMES) \*

- Aspley (Harrison) \*  
– opened and licensed under *State Children Act 1911* 1960  
– licensed under *Children's Services Act 1965* 4 August 1966
- Aspley, 730 Robinson Road (Nicklin) \*  
– opened and licensed under *State Children Act 1911* 1960  
– licensed under *Children's Services Act 1965* 4 August 1966
- Bardon, 50 Lorward Street (Alexandra) \*  
– opened and licensed under *State Children Act 1911* September 1960  
– licensed under *Children's Services Act 1965* 4 August 1966
- Bardon, 50 Lorward Street (Kingsbury) \*  
– opened and licensed under *State Children Act 1911* 1960  
– licensed under *Children's Services Act 1965* 4 August 1966
- Bardon (Robgill) \*  
– opened and licensed under *State Children Act 1911* 1960  
– licensed under *Children's Services Act 1965* 4 August 1966

- Drayton, 4 Gipps Street (Dahler) \*  
– opened and licensed 1975/76
- Toombul, 5 Melton Road (Moore) \*  
– opened and licensed under *State Children Act 1911* 1962  
– licensed under *Children's Services Act 1965* 4 August 1966
- Toombul, Melton Road (Stewart) \*  
– opened and licensed under *State Children Act 1911* 1962  
– licensed under *Children's Services Act 1965* 4 August 1966
- Wynnum North, 509 Tingal Rd (Lahey) \*  
– opened and licensed 6 July 1973
- Wynnum North, 509 Tingal Road (Saunders) \*  
– opened and licensed 6 July 1973
- Wynnum North, Peterson Street (Lewis) \*  
– opened and licensed 1967/68
- Wynnum North, Peterson Street (Tainton) \*  
– opened and licensed 1967/68

\* all transferred to Uniting Church, 22 June 1977; see under **Uniting Church**

#### MARGARET MARR MEMORIAL HOME FOR BOYS, Wynnum

- licensed under *State Children Act 1911* 1924
- State children first admitted 1937
- licensed under *Children's Services Act 1965* 4 August 1966
- transferred to Uniting Church 22 June 1977
- licence surrendered and Saunders and Lahey cottages licensed 1973

#### QUEEN ALEXANDRA HOME, Coorparoo

- opened (children and staff transferred from Robgill, Indooroopilly) 1 December 1911
- licensed under *State Children Act* 1917
- State children first admitted 16 February 1937
- closed 9 September 1960

### *The Open Brethren Assembly*

(Council of Silky Oaks Children's Haven)

#### SILKY OAKS HAVEN FOR CHILDREN, 218 Manly Road, Manly

- established at Cross Street, Toowong 1940
- registered under the *Infant Life Protection Act 1905* 6 Sept 1940
- transferred to Manly 1946
- licensed as a foster home and first State children admitted April 1950
- licensed as a residential facility under *State Children Act 1911* 30 March 1957
- first family group cottage completed 1965/66
- licensed under *Children's Services Act 1965* 4 August 1966
- Cornell House as part of complex opened before 1982
- Balmoral Cottage, 108 Bilyana Street, Hawthorne  
– opened 1982  
– closed (funding reallocated to Silky Oaks Family Intervention) March 1993
- Bay Cottage, 218 Manly Road, Manly West  
– opened before 1982  
– closed (funding amalgamated with Alexander Cottage) 1 January 1998
- Durack Cottage, 54 Glenala Road, Durack  
– opened before December 1981  
– closed (funding reallocated to Churches of Christ) 1993
- Farm Cottage, 227 Manly Road, Manly West  
– opened before 1982  
– funding ceased 1988/89
- Grey Cottage, 218 Manly Road, Manly  
– opened 1985/86  
– renamed **Alexander Cottage** 1991
- *currently licensed*

### *Presbyterian Church*

#### BLACKHEATH HOME FOR CHILDREN, OXLEY

- opened 1926/27
- licensed as a private institution under *State Children Act 1911* 5 April 1927
- State children first admitted 24 September 1938
- closed 9 May 1963

DAVID HENRY TRANSITIONAL LODGE, 458 Rode Road, Chermside	
• licensed	25 March 1975
• first girls moved in	7 May 1975
• ceased operating as a licensed institution	30 June 1978
FAMILY GROUP HOMES *	
• Aspley, 16 Jethro Street ( Treacher) *	
– opened	1965/66
– licensed under <i>Children's Services Act 1965</i>	4 August 1966
• Brighton, 10 Neal Street ( Rowellyn) *	
– opened	January 1965
– licensed under <i>State Children Act 1911</i>	February 1965
– licensed under <i>Children's Services Act 1965</i>	4 August 1966
• Fairfield, 119 Ashby Street ( Dowdle) *	
– opened and licensed under <i>State Children Act</i>	1963/64
– licensed under <i>Children's Services Act 1965</i>	4 August 1966
– moved to Salisbury	
• Holland Park, 2 O'Callaghan Street (Cavendish Park) *	
– opened	April 1964
– licensed under <i>Children's Services Act 1965</i>	4 August 1966
• Toowoomba, 76 Jellicoe Street	
– opened and licensed	April 1967
– closed	December 1994
• Toowoomba, 20–22 Lovett Street ( Specht) *	
– opened and licensed	1969/70
• Townsville, 11 Maskell Street, Pallarenda	
– opened	17 December 1979
• no longer a licensed residential facility	
* all except Toowoomba (Jellicoe Street) and Townsville transferred to Uniting Church 22 June 1977—see under <b>Uniting Church</b>	
INDUSTRIAL SCHOOL, MAPOON MISSION STATION	
• licensed	1937
• no information has been located about when this facility closed	
PEIRSON MEMORIAL HOME, Goodwood Road, Goodwood— 'Redcliffe' and 'Heytesbury' Farms	
PEIRSON MEMORIAL TRUST, Ann Street Presbyterian Church	
• Goodwood Home for Boys established	1955
• licensed as a foster home	30 September 1955
• licensed as a residential institution under <i>State Children Act 1911</i>	30 April 1964
• licensed under <i>Children's Services Act 1965</i>	4 August 1966
• 'Heytesbury' Cottage built, opened and licensed	21 April 1968
• original home 'Redcliffe' remodelled	1968
• 'Redcliffe' closed	January 1977
• 'Heytesbury' closed	June 1977
• 'Heytesbury' reopened	March 1979
• 'Redcliffe' reopened	September 1979
• Family Group Home, 45 Avoca Street, Bundaberg, opened and funded (included with licence for Goodwood home)	1 November 1983
• 'Redcliffe' closed	28 November 1983
• 'Redcliffe' reopened	February 1984
• 'Redcliffe' closed as a group home	
• Bundaberg funding ceased	1989/90
• 'Heytesbury' <i>currently licensed</i>	
W R BLACK HOME, 7 Laurel Avenue, Chelmer	
• officially opened	1928
• licensed as a private institution under <i>State Children Act 1911</i>	21 March 1929
• approval for children in State care to be admitted	July 1938
• State children first admitted	24 September 1938
• children of both sexes admitted following closure of Blackheath	May 1963
• closed	31 July 1965
• opened as Chelmer Children's Home as a special care centre for babies and toddlers and a family group wing	29 November 1969
• converted to three Family Group Home Units	19 January 1970
• converted to a Handicapped Children's Centre	1971

## Salvation Army

### GUNDANAH GROUP HOME, Vista Court, Gladstone

- licensed 3 September 1979
- funding ceased February 1987

### HILLDALE VILLAGE FOR BOYS, Laidley

- opened 1973/74
- no longer a licensed residential facility

### INDUSTRIAL SCHOOL FOR BOYS, INDOOROOPILLY

- licence under *State Children Act 1911* approved 27 November 1922
- ceased as Industrial School 1946/47
- renamed **Boys' Home, Indooroopilly** 1946/47
- licensed under *Children's Services Act 1965* 4 August 1966
- renamed Cooyinda SA Home for Boys 1968/69
- renamed **Alkira** SA Home for Boys (hostel aspect and sheltered workshop function transferred to SA Training Farm at Riverview) September 1969
- funding ceased 1982/83

### INDUSTRIAL SCHOOL FOR BOYS, RIVERVIEW

- established 1898
- transferred to State Children Department 31 December 1911
- closed 1926
- reopened 1935
- ceased as Industrial School 1956/57
- renamed **Home for Boys, Riverview** 1956/57
- licensed under *Children's Services Act 1965* 4 August 1966
- renamed Training Farm for Boys 1966/67
- renamed **Endeavour Training Farm** 1969/70
- ceased to operate—licence cancelled 12 January 1977

### INDUSTRIAL SCHOOL FOR GIRLS, Chelmer

- licensed under *State Children Act* 1923
- no State girls placed from 1941

### INDUSTRIAL SCHOOL FOR GIRLS, North Street, Rockhampton

- licensed under *State Children Act* 1920
- closed 1934

### INDUSTRIAL SCHOOL FOR GIRLS, Talford Street, Rockhampton/BETHESDA

- opened 1930
- **Salvation Army Home for Girls** from 1964/65
- renamed **Bethesda**
- licensed under *Children's Services Act 1965* 4 August 1966
- changed to caring for younger children in care and protection 1973/74
- closed (with opening of Gundanah Family Group Home at Gladstone) September 1979

### INDUSTRIAL SCHOOL FOR GIRLS, Toowong/KALIMNA

- licensed under *State Children Act 1911* 1917
- Salvation Army Girls' Home, Toowong 1957/58
- closed (building demolished and Kalimna built) 1961/62
- **Kalimna** Vocational Centre for Girls, Toowong opened December 1962
- licensed under *Children's Services Act 1965* 4 August 1966
- closed 29 October 1977

### INDUSTRIAL SCHOOL FOR GIRLS, Toowoomba/HORTON HOUSE, Curtis Street

- officially transferred from Yeronga; licensed under *State Children Act 1911* 1945
- known as James Horton Industrial School for Girls from 1947/48
- James Horton Memorial Home for Girls from 1953/54
- James Horton School for Girls from 1954/55
- renamed **Horton House** 1963/64
- two family group units opened (third to follow) April 1966
- licensed under *Children's Services Act 1965* 4 August 1966
- third cottage 'Ray Powell Cottage' officially opened 30 August 1969
- funding ceased 1 November 1985
- subsequently operated as a home for the disabled

#### INDUSTRIAL SCHOOL FOR GIRLS, Yeronga

- established 1898
- transferred to State Children Department 31 December 1911
- evacuated to Toowoomba during World War II and subsequently remained there

#### INDUSTRIAL SCHOOL, PURGA MISSION STATION

- licensed under *State Children Act* 1937
- State children first admitted 1941
- closed and the nine State children transferred to the custody of the Director of Native Affairs and placed in homes under his Department 1948

### *Uniting Church*

#### FAMILY GROUP HOMES

- Aspley (Harrison)
  - transferred from Methodist Church 22 June 1977
  - licence surrendered 11 August 1981
- Aspley, 730 Robinson Road (Nicklin)
  - transferred from Methodist Church 22 June 1977
  - closed 8 December 1984
  - licence surrendered 7 February 1989
- Aspley, 16 Jethro Street (Treacher)
  - transferred from Presbyterian Church 22 June 1977
  - closed 1995
- Ayr, Methodist Lane (Glen Loeman)
  - opened 1 November 1981
  - funding ceased 1989/90
  - no longer a licensed residential facility
- Bardon, 50 Lorward Street (Alexandra)
  - transferred from Methodist Church 22 June 1977
  - closed as a Family Group Home 1993
- Bardon, 50 Lorward Avenue (Kingsbury)
  - transferred from Methodist Church 22 June 1977
  - *currently licensed as a Receiving, Assessment, Placement and Therapy Program residential*
- Bardon, 40 Lorward Avenue (Robgill)
  - transferred from Methodist Church 22 June 1977
  - ceased functioning as a Family Group Home July 1978
  - licence surrendered August 1981
- Brighton, 10 Neal Street (Rowellyn)
  - transferred from Presbyterian Church 22 June 1977
  - closed 1 February 1989
  - reopened 1990/91
  - closed 1997
- Cairns, 19 Valley Street, Freshwater
  - opened 1 August 1980
  - funding ceased 1981/82
  - reopened 1982/83
  - closed 1997
- Drayton, 41 Gipps Street, Drayton, Toowoomba (Dahler)
  - transferred from Methodist Church 22 June 1977
  - closed before December 1981
  - reopened (anticipated) February 1982
  - closed 30 June 1988
  - opened as a Receiving, Assessment, Placement and Therapy Program residential August 1995
  - *currently licensed*
- Fairfield, 119 Ashby Street (Dowdle)
  - transferred from Presbyterian Church 22 June 1977
  - moved to Bellevue Avenue, Salisbury October 1986
  - closed 1993
- Holland Park, 2 O'Callaghan Street (Cavendish Park)
  - transferred from Presbyterian Church 22 June 1977
  - closed (lack of suitable houseparents) July 1978
  - reopened April 1980
  - no longer a licensed residential facility
- Ipswich, 23A Murphy Street (Chester House)
  - opened 1980/81
  - funding ceased temporarily 4 August 1984
  - closed 1996

- Nambour, 55A Carter Road (Ratray House)
  - opened 1982/83
  - closed as a Family Group Home 1993
- Toombul, 5 Melton Road and 10 Walkers Way (Moore)
  - transferred from Methodist Church 22 June 1977
  - closed as a Family Group Home 1986
  - opened as a Receiving, Assessment, Placement and Therapy Program residential 1989
  - closed 1996
- Toombul, Melton Road and 10 Walkers Way (Stewart)
  - transferred from Methodist Church 22 June 1977
  - closed as a Family Group Home 1986
  - opened as a Research, Assessment, Placement and Therapy Program residential 1989
  - closed (funding transferred to Hackwood, Caboolture) 1993
- Toowoomba, 20–22 Lovett Street (Specht)
  - transferred from Presbyterian Church 22 June 1977
  - *currently licensed*
- Wynnum North, 509 Tingal Road (Lahey)
  - transferred from Methodist Church 22 June 1977
  - closed 1985
- Wynnum North, Peterson Street (Lewis)
  - transferred from Methodist Church 22 June 1977
  - funding ceased 21 December 1988
- Wynnum North, 509 Tingal Road (Saunders)
  - transferred from Methodist Church 22 June 1977
  - no longer a licensed residential facility
- Wynnum North, Peterson Street (Tainton)
  - transferred from Methodist Church 22 June 1977
  - closed 1985

#### HARRISON HOUSE, 69 Benowa Road, Southport

- opened 1 May 1986
- *currently licensed*

#### HACKWOOD Research, Assessment, Placement and Therapy Program residential, 344 King Street, Caboolture

- opened 1993
- closed 1996

#### MARGARET MARR MEMORIAL HOME FOR BOYS, Wynnum

- licensed under *State Children Act 1911* 1924
- State children first admitted 1937
- licensed under *Children's Services Act 1965* 4 August 1966
- transferred from Methodist Church 22 June 1977
- licence surrendered and Saunders and Lahey cottages licensed 1973

### OTHER LICENSED FACILITIES

#### *Association of Bethel Home*

##### BETHEL HOME, Dalby

- established early 1950s
- licensed under *State Children Act 1911* 25 June 1964
- functioned as a boarding facility for children from country areas attending school or sheltered workshop facilities in Dalby from 1982
- Bethesda opened 1968/69
- Morris Cottage Back House opened and closed
- Bethel, known as Westaway House 1978
- closed May 1982

#### *Bethesda Children's Centre Committee*

##### BETHESDA FAMILY GROUP HOME, 12 Kirkwood Avenue, Mt Isa

- licensed 14 March 1980
- funding ceased 1981/82
- reopened 1982/83
- closed 1992

#### *Boopa Weram Kindergarten Association*

##### PEIM METTA Family Group Home, 16 Fretwell Street, Whiterock, Cairns

- opened late 1982
- no longer a licensed residential facility

### *Cherbourg Community Council*

BEEMAR YUMBA Maud Phillips Memorial Children's Shelter, Barrambah Avenue

- licensed
- *currently licensed*

1985/56

### *Crossroads Community Youth Organisation*

THE CROSSROADS, 254 Flinders Parade, Sandgate

- opened
- funding suspended
- licence surrendered—property to be sold

15 March 1980  
1 January 1985  
November 1985

### *Far North Queensland Youth Assistance Fund*

MAREEBA YOUTH CENTRE/FARM

- operational
- funded from
- funding ceased

December 1979  
December 1980  
March 1982

### *First Contact Aboriginal Corporation*

450 Main Street, Kangaroo Point

- opened
- *currently licensed*

16 December 1994

### *Independent Order of Odd Fellows*

THE LESLIE TOOTH HOME, Manly

- licence under *State Children Act 1911*, approved 20 December 1922, gazetted (not the intention of the Department or the governing body that State children be placed in the home) 25 January 1923
- closed 1931

### *One People of Australia League (OPAL)*

OPAL HOUSE, Russell Street, South Brisbane

- registered as a foster home
- licensed as a residential institution
- no children placed after
- licence renewed (but no further children admitted)

7 August 1970  
1972  
March 1974

OPAL JOYCE WILDING HOME, 2331 Logan Road, Eight Mile Plains

- opened
- licensed
- licence cancelled

early 1970  
7 August 1970  
11 February 1977

### *Petford Training Farm Aboriginal Corporation*

PETFORD TRAINING FARM

- established privately
- Petford Training Farm (Aboriginal Corporation) incorporated
- licensed as a foster home
- funded under Licensed Residential Care Program from
- *licence currently under review*

late 1970s  
August 1983  
January 1986

### *Save the Children Fund*

BEN WHITE HOUSE/AURALA

- licensed at 144 Middle Street, Cleveland
- moved to 8 Biggs Street, East Brisbane
- unlicensed 11 November to 4 December 1980
- moved to 112 Belgrave Street, Morningside
- became a specialist residential care program
- closed temporarily
- reopened at 18 Bunker Road, Victoria Point, renamed **Aurala**, later moved to 41 Wellington Street, Ormiston, then Wakerley, then 30 George Street, Ormiston
- *currently licensed*

19 February 1980  
October 1980  
early 1985  
December 1985  
May 1991  
6 January 1992

LAYTON HOUSE, 27 Prince Street, Paddington

- opened
- closed (when Ben White House opened)

19 February 1980  
March 1981



#### BUXTON LODGE, Redcliffe

- opened at 1A Irene Street 16 February 1980
- licence approved 4 July 1980
- funded from 1 July 1980
- licence issued 3 September 1980
- moved to 58 John Street, Redcliffe 29 August 1982
- closed 31 January 1983

#### *South East Qld Aboriginal Community Care Agency*

##### MI GUNYAH YOUTH HOSTEL, 5 Bowen Street, Toowoomba

- established by Toowoomba Aboriginal Corporation for Cultural and Recreational Activities (TACCRA) (previously at Alma Vale Stud) early 1991
- funding approved 19 April 1991
- TACCRA re-incorporated as South East Qld Aboriginal Community Care Agency Aboriginal Corporation 19 May 1997
- *currently licensed*

#### *Teen Challenge*

##### HEBRON HOUSE, 300 Kelvin Grove Road, Kelvin Grove

- opened at Frasers Road, Ashgrove 19 February 1979
- licensed 11 September 1979
- moved to 356 Milton Road, Torwood and Kelvin Grove Road, Kelvin Grove (Frasers Road property became known as Ashgrove Lodge)
- funded under Youth Supported Accommodation Program (not as a licensed institution) from 1 January 1985
- *currently funded*

##### PRIMMER LODGE, TARINGA

- opened and licensed (male and female adolescents) 19 April 1978
- funding ceased 1981/82

#### *United Protestant Association of Queensland (Incorporated)*

##### BEULAH HOME, Corinda

- opened
- licensed as a foster home
- licensed as an institution 4 June 1971
- licence cancelled 7 September 1974

#### *Vietnamese Community in Australia*

##### Family Group Home, Windsor

- funded from 1982/83
- no longer a licensed residential facility

#### *Yuddika Aboriginal and Torres Strait Islanders Corporation Child Care Agency*

##### Yuddika Family Group Home, 291 Draper Street, Cairns

- opened 1990/91
- *currently licensed*

## APPENDIX 6

### SUBMISSIONS BY ACADEMIC INSTITUTIONS AND COMMUNITY ORGANISATIONS

Adult Survivors of Sexual Abuse  
Alison Hunter Memorial Foundation  
Anglicare  
Australian Institute of Criminology  
Australian Institute of Family Studies  
Australian Workers Union Queensland Branch  
BoysTown Family Care  
Brisbane City Mission  
Centacare Catholic Family Services  
Child Adolescent & Family Welfare Association of Queensland  
Children's Commission of Queensland  
Churches of Christ Care  
Department of Families, Youth and Community Care  
Education Queensland  
First Contact Aboriginal Corporation for Youth  
Former Residents of St Joseph's Home, Neerkol  
Foster Parents Association of Queensland  
International Association of Former Child Migrants and their Families  
Ipswich Children's Response Working Party  
Lifeline Ipswich and West Moreton  
Mercy Administration Centre, Rockhampton Congregation of the Sisters of Mercy  
Monash University Child Abuse and Family Violence Research Unit  
National Aboriginal & Islander Legal Services Secretariat  
New South Wales Community Services Commission  
Pauline Hanson's One Nation  
Peirson Memorial Trust  
Prison Fellowship of Australia (Queensland Council)  
Queensland Advocacy Incorporated  
Queensland Association of Former British Child Migrants  
Queensland Branch, Association of Young People in Care  
Queensland Corrections  
Queensland Council for Civil Liberties  
Queensland Health  
Roman Catholic Archdiocese of Brisbane  
Royal Children's Hospital and District Health Service, Community Child Health Service  
Royal Women's Hospital  
Sisters of Mercy Brisbane Congregation  
South East Queensland Aboriginal Community Care Agency  
The Australian Psychological Society  
The Child Migrants Trust  
The Esther Trust  
The Royal Australian College of General Practitioners  
The University of Queensland, Parenting and Family Support Centre  
Townsville Community Legal Service Inc.  
Uniting Church  
University of New South Wales, Social Policy Research Centre  
Victorian Institute of Forensic Mental Health  
Whistleblowers Action Group Inc (Qld)  
Youth Advocacy Centre Inc  
Yuddika Aboriginal and Torres Strait Islanders Corporation Child Care Agency

## APPENDIX 7

### OTHER PERSONS CONSULTED

Name	Position	Organisation
Adams, Judy	Coordinator	National Child Protection Clearing House, Australian Institute of Family Studies
Alder, Christine (Prof)	Professor	Department of Criminology, University of Melbourne
Alford, Norman (Commissioner)	Children's Commissioner	Children's Commission of Queensland
Andrews, Greg	Deputy Ombudsman	NSW Ombudsman's Office
Arabena, Kerry	Director	Apunipima Cape York Health Council
Baulch, Catherine	Counsellor	Private practice
Belfrage, Stephanie	Social Worker, Counsellor	Private practice
Blatch, Maureen		Office of the Parliamentary Criminal Justice Commissioner
Bligh, Herbert	Chairperson	Brisbane Council of Elders
Briggs, Freda (Prof)	Professor	Early Childhood Unit, University of South Australia
Briton, John	Consultant	Review of Children's Commission of Queensland
Carter, Jan	Consultant	Deakin Human Services, Deakin University, Vic.
Carmody, Tim	Commissioner	Queensland Crime Commission
Cashmore Judy (Dr)		Social Policy Research Centre, University of New South Wales
Collins, Karen	Coordinator	Aboriginal & Torres Strait Islander Legal Service, Ipswich
Cooney, Vicki		Yuddika Aboriginal & Torres Strait Islander Child Care Agency, Cairns
Crooke, Gary QC	Barrister	Former Counsel Assisting, Fitzgerald and Woods Commissions of Inquiry
Daniels, Ross	Chairperson	The Esther Trust
Darlington, Yvonne Dr	Lecturer	School of Social Work and Social Policy, The University of Queensland
Davies, Ian	President	Victims of Crime Association Queensland
Dethlefs, Walter	Former Chaplain	Sir Leslie Wilson Youth Hospital
Duffy, Jan	Senior Social Worker	Aboriginal & Torres Strait Islander Corporation for Legal Services
Featherstone, Sue	Counsellor, cross-cultural trainer	Private practice
Finn, Katrina	Solicitor	Aboriginal & Torres Strait Islander Women's Legal & Advocacy Service
Finnane, Mark	Professor	School of Humanities, Griffith University
Fletcher, Karen	Solicitor	Prisoners' Legal Service
Foley, Charmaine	Coordinator	Australians for Reconciliation

Name	Position	Organisation
Gulash, Helena	Cross-cultural trainer	Private practice
Hayes, Hennessey	Lecturer	Centre for Crime Policy and Public Safety, Griffith University
Huggins, Jacki	Deputy Director	Aboriginal & Torres Strait Islander Studies Unit, The University of Queensland
Hunter, Ernest	Professor	Department of Social and Preventative Medicine, The University of Queensland
Irvine, Adrienne	Counselling Coordinator	Women's Sexual Assault Crisis Line, Royal Brisbane Hospital
Isdale, William	Director	Inquiry Legal Representation Office, Department Justice & Attorney-General
Jefferies, David	Assistant Commissioner	Queensland Police Service
Jones, Andrew	Senior Lecturer	School of Social Work and Social Policy, The University of Queensland
Jurotte, Ken	Chief Executive Officer	Aboriginal & Torres Strait Islander Corporation for Legal Services
Kilroy, Deborah	Member Management Committee	Sisters Inside
Lacy, Alfred	Project Officer	Youth Suicide Prevention Strategy, Aboriginal Coordinating Council, Cairns
Levy, Ken Dr	Acting Director-General	Department Justice & Attorney-General
Lobsinger, Chris	Counsellor	Queensland Program of Assistance for Survivors of Torture and Trauma
MacDonnell, Jane	Director-General	Department Justice & Attorney-General
McMahon, Greg	Secretary	Whistleblowers Action Group Inc (Qld)
McMahon, Michael	Counsellor	Vietnam Veterans Counselling Service
Moore, Victoria	Research Officer/Librarian	Project Axis, Queensland Crime Commission
Moran, Terry	Director-General	Education Queensland
Murray, Gwenn	Consultant	Youth Advocacy Centre Inc
Nikkel, Ronald	President/Chief Executive Officer	Prison Fellowship International
O'Regan, Rob QC	Former Chairperson	Criminal Justice Commission
O'Sullivan, Jim	Commissioner of Police	Queensland Police Service
Owen, Jan	Executive Director	Australian Association of Young People in Care
Petherick, Wayne	Consultant	Humanities and Social Sciences, Bond University
Roberts, Annie		Rape Crisis Centre, Cairns
Russell, Norton	Secretary (Qld Council)	Prison Fellowship of Australia
Ryan, The Hon Kevin	Former Commissioner	Connolly/Ryan Commission of Inquiry
Schoener, Gary	Director	Walk-In Counselling Center, Minnesota, USA
Seru, Gwen	Community Justice & Health Officer	Aboriginal Coordinating Council, Cairns

<b>Name</b>	<b>Position</b>	<b>Organisation</b>
Smith, Glenys	Counsellor	Private practice
Sidoti, Chris	Human Rights Commissioner	Human Rights & Equal Opportunity Commission, New South Wales
Smith, Jennifer	Lecturer	School of Social Work and Social Policy, The University of Queensland
Stevens, Craig	General Manager	McLisky & Young, Media Consultants
Sullivan, Robin	Children's Commissioner	Children's Commission of Queensland
Tanner, Sandra	Manager	Mokai Rosie Bi-Bayan Aboriginal & Torres Strait Islander Corporation for Women
Thearle, John Dr	Senior Lecturer in Child Health	Mater Children's Hospital
Tomison, Adam	Research Fellow	National Child Protection Clearing House, Australian Institute of Family Studies
Turgeon, Darcy	General Manager	Aboriginal & Torres Strait Islander Policy Unit, Queensland Corrective Services Commission
Uhr, John	Director	Australian Bureau of Criminal Intelligence, Australian National University
Walker, Jan Dr	Manager	Program Branch, Department of Aboriginal & Torres Strait Islander Policy & Development
Walsh, Karen	Coordinator	The Esther Trust
Wauchope, Jim	Director	Community Governance Directorate, Department of Aboriginal & Torres Strait Islander Policy and Development
Wegener, Lindsay	Director	Service Development Branch, Juvenile Justice Program, Department of Families, Youth and Community Care
West, Leonie	Coordinator	Link-up
Wilkie, Meredith	Director, Human Rights Unit	Human Rights and Equal Opportunity Commission, New South Wales
Williams, Edgar	Counsellor	Aboriginal and Torres Strait Regional Council
Williams, Graham	Assistant Police Commissioner	Assistant Commissioner, Queensland Police Service
Wilson, Paul	Consultant	Humanities and Social Sciences, Bond University
Wilson, Peter	Counsellor	Private practitioner employed by Victims of Crime Association Queensland
Wright, Judith	Consultant	Youth Advocacy Centre Inc
Zaffer, Anne	Counsellor	Sexual Abuse Counselling Service, Department of Families, Youth and Community Care

## APPENDIX 8

### LIST OF WITNESSES WHO CONSENTED TO PUBLICATION OF THEIR NAME

(Names are printed as per their request)

Alexander, Mike S	Gordon, Pam
Allaway, A W	Graham, James Desmond
Allen, William James (Bill)	Graham, Kevin
Armstrong, Kevin Wayne	Green, Donald Robert
Arnold, Deano	Haeren, Leo
Arthur, Lily J (nee McDonald)	Haeren, Marijke
Ashdown, Betsey (nee Rowles)	Haeren, Nathaly Christine
Barber, Gloria May	Hall, Michelle
Barker, Anthony Brian (Horne)	Hamilton, Sandra Dorothy
Bartlett, Merv	Hamilton, Terry (Mangan)
Blayse, Lewis	Hamilton, Vicki Ann
Beggs, Rosemary (Du Heaume)	Hartas, Bryan
Bloomfield, Peter	Hearn, Theresa
Bontje, Johannes	Henderson, Coralie Joan
Boxsell, Kevin B	Hicks, Fay
Boyde, K J	Howard, Catherine
Brosnan, Terence	Howie, K
Brown, Dianne Grace (Harrison nee Lawson)	Jerome, Paddy
Brown, Ronald H	Jones, Margaret A (Campbell)
Burr, Juanita Maria (nee Broderick, Nita)	Jordan, Alexander
Capes, Sharron	Keel, Mary (nee Howe)
Carter, Helen	Kern, Lindsay John
Chvojan-Smith, Kym (nee Molleneaux)	Kilroy, Debbie
Clark, Gregory James	Kilroy, Joe
Condon, Eric John	King, Paddy
Cook, Evelyn June (nee June Jay)	Kingsford, Gail
Cooke, Heather	Kulics, Kathy
Coombes, Wayne R	Leigh, Janette Maria (nee Lee, Jean)
Coverdale, A R	Lepp, Chantal Ann
Curtis, Sandra Elizabeth	Levy, B C
Dale, V D	Levy, Bernard
Dare, Rosa	Levy, Daria (Catherine)
Deas, Diane (Jones)	Lord, D
Delaney, Cathy	Lyke, John C
Doolan, Bevan	McCotter, Terrence
Dougan, Pauline	McDonald, Julia Francis
Du-Heaume, Anita	McGee, Eileen
Dwyer, Maxwell Colin	McGrath, R N
Eather, Mary	McQuirk, Paul
Eather, Norman L	Maguire, Beverley
Edwards, Max	Maguire, Peter Eamon
Emblem, Marilyn Beryl (nee Pidcock)	Mahaffey, Eileen
Evans, C J	Majewski, Hannelore
Ferguson, Philip	Manthey, John
Fletcher, Alan	Marczak, Karen
Fletcher, Denise Veronica	Melling, L
Ford, Bobbie	Michael, Keiran
Fottrell, Paul	Moggs, Carl Patrick (Chollhaug)
Geebung, Stanley John	Moore, Dennis
Gesch, Mary (nee Graham)	Morgan, Karen
	Morris, D

Morris, D S W G  
 Morwood-Oldham, Phoebe  
 Munt, L J  
 Murphy, Alan  
 Nugent, Janeen  
 O'Brien, J F  
 O'Brien, Thomas Graham  
 O'Keefe, Daniel L  
 Owen, David Robert  
 Paddon, D E  
 Palmer, Beverley Ann  
 Pascoe, P K  
 Patrick, Fay  
 Payne, N L  
 Payne, Rose  
 Pearson, J  
 Pemberton, George  
 Post, Bill  
 Powell, M V  
 Pringle, R J  
 Pritchard, Ann (Patterson)  
 Relton, Jennifer  
 Roberts, Lindsay  
 Rogers, Heather M  
 Rosenthal, Gregory John  
 Rush, Peggy  
 Russell-Cochrane, Pat Eileen  
 Seabrook, R L (nee Smith)  
 Shipp, Gwendoline (Tyrer)  
 Smith, Barbara  
 Smith, Frances  
 Sorbie, S M  
 Spencer, Mary (nee Corrigan)  
 Stablum Vaudrey, P M  
 Steele, Logan James  
 Stringfellow, Peter D (Copeland)  
 Swifte, Trevor J  
 Sycamore, S  
 Syed-Waasdorp, Lana  
 Thomas, Ronnie  
 Trappett, John  
 Truscott, Jennifer Robyn  
 Truscott, Lesley  
 Tubb, Graham  
 Turnbull, J J  
 Twomey, S A  
 Venclova, Anthony Terrence  
 Veness, Judith Lynne  
 Vlahos, S  
 Von Senden, L J  
 Walker, Gabrielle (nee Keating)  
 Walker, Raymond John  
 Walsh, Elizabeth  
 Walsh, R B  
 Ward, Barry William  
 Webb, Edward  
 Weekers, Patsy  
 Westra, E J

Whitfield, Theresa Mary (nee Gillon)  
 Whiting, B J  
 Wigg, Karen Ruth  
 Wiley, Patricia  
 Williams, Garnett Bruce  
 Williams, Lorraine (Roseneder)  
 Willson, Muriel Val  
 Wilson-Szoredi, Beth  
 Wimbus, Vicky (Bardon)  
 Wood, John Leslie  
 Woods, Colleen P  
 Woods, Noel Alan

## APPENDIX 9

### PUBLIC HEARINGS—PROFESSIONAL AND ACADEMIC EXPERTS

Date	Name	Position	Nature of evidence
21.09.98	Margaret Humphreys	Founder and Director, Child Migrants Trust	Issues for child migrants
21.09.98	Ian Thwaites	Senior Social Worker, Child Migrants Trust	Issues for child migrants
12.11.98	Professor Ian O'Connor	Head of the Department of Social Work and Social Policy, The University of Queensland	Funding for child welfare
12.11.98	Dr Kenneth Armstrong	Consultant Paediatrician, Royal Children's Hospital; Senior Lecturer, Department of Paediatrics and Child Health, The University of Queensland	Consequences of childhood abuse
16.12.98	Professor Ross Homel	Foundation Professor, Criminology and Criminal Justice, Griffith University	Risk factors and juvenile crime prevention
16.12.98	Dr Richard Wortley	Head of the School of Criminology and Criminal Justice, Griffith University	Risk factors in institutional abuse within juvenile detention centres
16.12.98	Professor Barry Nurcombe	Director, Child and Youth Mental Health Service, Royal Children's Hospital	Forensic mental health services for juvenile detention centres
25.01.99 27.01.99 28.01.99	Margo Maneschi	Consultant	Review of Queensland juvenile detention centres
25.01.99	Anne McMillan	Consultant	Survey of young people in juvenile detention
25.01.99	Barry Collings	Works for the Uniting Church	Managing detainees, staff training and screening, programs and historical context
25.01.99	Jacob George	Acting Chair, Indigenous Advisory Council	Deaths in custody within juvenile detention centres
27.01.99	Mark Docwra	Official Visitor, John Oxley Youth Detention Centre	Issues relevant to the Official Visitors' program in juvenile detention centres
27.01.99	Ian Davies	President, Victim of Crimes Association	Rehabilitation programs for young people in juvenile detention centres
27.01.99	Rosemary Robinson	Official Visitor, Leslie Wilson Youth Detention Centre	Issues relevant to the Official Visitors' program in juvenile detention centres



<b>Date</b>	<b>Name</b>	<b>Position</b>	<b>Nature of evidence</b>
28.01.99	Martin Grandelis	Centre Manager, John Oxley Youth Detention Centre	Juvenile detention centres—management perspective
28.01.99	Lindsay Wegener	Director, Service Development in Juvenile Justice, Department of Families, Youth and Community Care	Current issues for juvenile detention centres
29.01.99	Michael Tansky	Director, Brisbane Youth Service	Managing detainees, staff training and screening, programs and historical context
29.01.99	Professor Cindy Shannon	Director, Indigenous Health Program, The University of Queensland	Juvenile detention centres—the indigenous experience
25.02.99	Morri Young	Consultant	Review of selected residential care facilities
25.02.99	Kenneth Smith	Director-General, Department of Families, Youth and Community Care	Response as Director-General

## APPENDIX 10

### COMMISSIONED RESEARCH

The following consultants made contributions to the Inquiry in the form of commissioned research. Their reports were used to either inform the Inquiry during its deliberations, or were condensed and used as sections of the final report.

Description of research	Consultant	Organisation
Overview of child welfare systems	Beverley Fitzgerald	Independent consultant (Qld)
Overview of juvenile justice systems	Ian O'Connor	School of Social Work and Social Policy, The University of Queensland
Review of contemporary legislation, policy and practice of DFYCC and QCORR	Marjorie Weber	Consultancy Bureau (Qld)
Inspection and review of current juvenile detention centres	Margo Maneschi	Independent consultant (NSW)
Inspection and review of selected non-government residential care facilities	Morri Young	Matrix Organisation Support (NSW)
Indigenous history of children in Queensland institutions	Ros Kidd	Independent consultant (Qld)
Indigenous issues and juvenile detention	Anne Larson	Indigenous Health Program, The University of Queensland

## APPENDIX 11

### GLOSSARY

#### **Adoption**

A legal process by which a person, the adoptive parent, becomes the legal guardian of a child, the birth parent then ceasing to be the child's legal guardian. There are two forms of adoption: adoption of children who have been in substitutive care for some time by their foster parents, and adoption of young children surrendered by their parent/s.

#### **Boarding out**

The term used mainly in the nineteenth and early twentieth centuries to describe the placement of children in foster care (see **foster care**).

#### **Campus-style facility**

A number of cottage homes in close proximity to each other, each separately run by houseparents or a house 'mother'. The houseparent(s) are subject to some degree of on-site administrative control. Residents eat, sleep and attend to their daily living arrangements in their cottage, although meals may be prepared in a communal kitchen. Campus complexes have some communal buildings (e.g. a chapel). Children cared for in campus-style facilities are not necessarily there for corrective purposes; rather, it is considered that their needs are best met by a living situation as near as possible to a family home. They do not include family group homes.

#### **Care and control order**

A term that was used under the *Children's Services Act 1965*. Parts 5 and 6 set out the circumstances and procedures whereby a child could be placed under the care and control of the Director of the Children's Services Department. A child was committed either upon conviction in the Children's Court or by application to the Court. The legislation provided that a child was deemed to be in need of care and control if:

- (a) the child is falling or is likely to fall into a life of vice or crime or addiction to drugs
- (b) the child is exposed to moral danger
- (c) the child is or appears to be uncontrollable.

#### **Care and protection order**

A term that was used under the *Children's Services Act 1965*. A child could be placed in the care of the Director of the Children's Services Department under a care and protection order. A child was deemed to be in need of care and protection in a variety of circumstances, the most important of which related to a child with neither parent nor guardian to exercise proper care of and guardianship over him or her. Such a child was therefore deemed to be one or more of the following:

- (i) neglected
- (ii) exposed to physical or moral danger
- (iii) falling in with bad associates
- (iv) likely to fall into a life of vice or crime.

These children were formerly referred to as 'neglected' under the *State Children Act 1911* and the legislation it repealed.

#### **Child**

Under children's legislation in Queensland a boy or girl under the age or apparent age of 17 years.

**Child migrant**

An unaccompanied child brought to Australia through a policy developed to encourage immigration of large groups of children mainly from the United Kingdom.

**Children's Court**

A specialist magistrate's court dealing solely with children's matters. The Court was established in 1907, and features include *in camera* proceedings and the involvement of welfare personnel in the decision-making process. The idea of a children's court lay at the foundation of a welfare approach to child protection and juvenile justice (see **welfare model** and **justice model**).

**Clustered family group home**

See **family group homes**.

**Congregate care institution**

See **institution**.

**Custodial staff members**

Officers whose primary role is to ensure the secure detention of residents in reformatories and detention centres. In Queensland they have been known as warders, training officers and youth workers. The officers in charge of such establishments were initially known as Superintendents but have since been redesignated Managers.

**Detention centre (or juvenile detention centre)**

Residential establishments mainly for juvenile offenders or juveniles on remand for alleged offences. They are successors to the reformatories, and have as their major aim the secure detention of residents through active measures designed to prevent them from leaving the premises other than for an approved purpose. The centres are distinct from prisons, which are mainly for the detention of persons aged 18 or over. Detention centres that currently exist in Queensland are the Cleveland Youth Detention Centre, the John Oxley Youth Detention Centre and the Sir Leslie Wilson Youth Detention Centre.

**Director**

The person in charge of the Department of Families, Youth and Community Care (DFYCC) and its predecessors. The Director has guardianship responsibilities for children in the care of the State. Now known as Director-General.

**Family group homes**

- (a) Individual family group home. A separate residence where full-time care is given by substitute parents under conditions resembling as close as possible those in a natural family. Substitute parents responsible for the running of the home are not subject to on-site administrative control. They may be answerable to a governing authority.
- (b) Clustered family group home. Two or more family group homes in close proximity to one other. Each unit in the cluster operates separately and other than being close to similar units operates as an individual family group home.
- (c) Scattered family group home. A family group home whose grounds do not adjoin those of another family group home, or other residential child care establishment operated by the same enterprise.

**Foster care**

A form of family-based care, where the child is cared for in a family home and where guardianship rests with DFYCC (or a predecessor) or some other legal identity. Also known as shared family care.

**Foster child**

A child placed in the care of a foster parent for the purpose of being fostered.

**Foster parent**

A person in whose care a child has been placed by an agency for the purpose of the child being fostered.

**Governing authority**

The term nominated by the *Children's Services Act 1965* (s. 31) to refer to the non-government welfare organisations that sponsor residential care services.

**Guardian**

Defined by *Osborn's Concise Law Dictionary* as 'a person having the right and duty of protecting the person, property or rights of one who is without full legal capacity or otherwise incapable of managing his own affairs'.

**Hiring out**

Upon attaining school-leaving age children in State care were placed in employment by the Department until they were discharged from care. The practice was commonplace in Queensland until the 1920s, when it began to decline.

**Hostel**

An establishment managed or licensed by the Department to provide supervised accommodation for adolescents. The children in such hostels are usually working, seeking employment or studying at above primary level. Does not include boarding houses or those hostels run independently of the Department.

**Indeterminate sentencing**

A criminal justice term that refers to the practice of incarcerating a prisoner for an unspecified period of time. The decision to release is usually dependent on the prisoner demonstrating an ability and a willingness to satisfy certain standards.

**Industrial school**

Separate industrial schools for girls and boys were first established in the nineteenth century for the care and protection of 'neglected' children aged approximately 10–18 years. Inmates could be committed for periods of up to seven years. Usually, however, most were hired out to employers to perform low-paid labour. They were confined in a dormitory-style setting and were to be trained through a program of education and employment. A resident teacher generally provided education. Employment was designed to prepare boys for work service as unskilled rural labourers and girls for domestic service.

**Infants' home**

Dormitory-style institutions or simply small residential units where one or more infants were cared for. An infant is usually defined as a child under two years of age.

***In loco parentis***

The legal expression referring to the circumstances in which an organisation assumes the obligations of parenting a child or other person without formal adoption. Most commonly, such relationships exist when a child is in a residential institution, such as a reformatory or an orphanage.

**Inspector of orphanages**

A person appointed under the *Orphanages Act 1879* whose role was to inspect orphanages.

**Institution: Orphanage/Congregate care**

An establishment that provides residential care and/or the correctional treatment of children. The facility is usually congregate in design, with dormitory-type accommodation and shared eating, laundering and recreational facilities. The life of the children is generally regimented. This setting has traditionally been the field of involvement for members of religious orders.

**Justice model**

A model that emphasises adherence to the due processes of the law, young people accepting responsibility for their actions, and penalties set down by legislation and designed to reflect the severity of the offence.

**Juvenile**

See **child**.

**Medical model**

An approach to helping people based on the orientation used by many physicians that conceptualises 'deviant' behaviour solely in medical terms. The client is perceived as an individual with an illness to be cured, and regular clinical treatment is usually prescribed. The approach does not pay due regard to factors in the client's environment that may be affecting their condition.

**Neglected child**

See **care and protection**.

**Nursing home**

More commonly referred to as infants' homes (see **infants' homes**).

**Official Visitors**

Independent advocates for children in institutional care. Official Visitors should make monthly visits to institutions for the purpose of monitoring conditions and hearing complaints from residents. They are expected to prepare and submit reports on each visit and can enter a premises at any time. They receive some remuneration for their work.

**Ombudsman (Parliamentary Commissioner for Administrative Investigations)**

A public official appointed to investigate citizens' complaints against government officials.

**Orphanage**

See **institution**.

**Probation**

A status in which incarceration is suspended on the condition that the individual fulfils certain requirements. These requirements often include periodic visits to a court-designated probation officer.

**Receiving and assessment centres**

Initial short-term settings for children in the care and protection of the Director. Their primary function is to receive and assess children on an individual basis to determine the most appropriate form of future care. Children are assessed and either returned to their parents or placed with relatives, foster parents, in licensed institutions and homes, or in some other suitable placement when these are not immediately available. These centres can also accommodate children awaiting adoption or deferred adoption placement and children in custody while a care and protection application is pending before a court. For some children in the centres support and stabilisation procedures are applied, which are special programs to prepare them for placement.

**Receiving depot**

An institution where State children were accommodated before being placed in a residential facility or into foster care. In the late 1960s receiving depots in Queensland were renamed receiving and assessment centres.

**Reformatory**

Separate reformatories for boys and girls were first established in the nineteenth century for the detention of juveniles convicted of a criminal offence. There was little to distinguish reformatories from industrial schools in terms of their objectives and organisation as they were both established to reform children of the urban poor. In Queensland the functions of both the reformatory and industrial school were combined within the one institution. By the 1960s they were almost exclusively accommodating convicted juveniles and were eventually renamed Youth Detention Centres.

**Residential home**

See **institution**.

**Semi-congregate care**

A setting in which children are housed in one large building which has been sub-divided so that they can live in smaller groups than in congregate care. Compared with congregate care, the children have a more flexible lifestyle and receive more personal attention.

**Service provider**

Historically in Queensland service providers have overwhelmingly been community-based non-government organisations, usually associated with the religious denominations. Service providers operate and maintain residential facilities and are involved in long- and short-term programs to assist children in State care.

**State child**

A term used under the *State Children Act 1911*. Any child under the guardianship of the Director was deemed a State child in need of care. It included a child considered by a court to be neglected, uncontrollable or convicted of an offence. With the passage of the *Children's Services Act 1965* the terminology changed. Any child under the care and protection or care and control of the Director was from August 1966 referred to as a 'child in care'.

**Status offence**

An action that would not be considered a violation of criminal law if it was committed by someone with a different status. In this Inquiry, the term refers to offences that are so designated because of an offender's status as a juvenile.

**Training farm/school/centre**

In Queensland, a more specific term used to describe a reformatory and/or industrial school for boys that had as its main function training through rural labour. Training centre was a term later used to describe both reformatory and industrial schools for girls and boys.

**Welfare model**

A model based on the notion of a benevolent children's court acting with a degree of informality and discretion, and in the best interests of the child. In reality, however, the court was often arbitrary in its decision making and blurred the distinction between children who offended and those who were regarded as being in need of care and protection.

**Youth**

A term that has the same meaning as 'child' and 'juvenile', that is, a child under the age of 17 years.

**Youth Detention Centre**

See **detention centre**.

## APPENDIX 12

### WITNESS RESPONSES TO THE QUESTION 'WHAT WOULD YOU LIKE TO SEE COME OUT OF THE INQUIRY?'

1. Silence for all the kids who didn't make it ... for the suicides and the alcoholics, and the kids in gaol and the mental patients ... to prevent further entrenched systematic cruelty.
2. To have the community feel the enormity of the pain of our betrayal, previously dismissed lightly, and to promote understanding which still seems to be lacking.
3. I'd like to see it all come out in the open.
4. I'd just like people to know more about the truth, what happened in these institutions, you know.
5. It's just to let everybody know that it did happen.
6. One thing—make it clear that these places did exist. People will know it did happen.
7. I'd hope that it never happened again.
8. That it cannot happen today.
9. All I wanted was for what happened to be made public. For a little while—for someone—for me to be able to say to someone, 'Hey, you, because of your senseless attitude of an eye for an eye and a tooth for a tooth [you] did this to me. You created me by allowing this to happen.' Society wants to understand or wants to be educated to understand that they created us. You see? It was them—by their disinterest and their inaction.
10. I was hoping that you could achieve that something like this could never happen again, and that all foster parents and people like that should be screened and if you did have institutions with lots of children that there could be doctors and social workers that would live on the premises and, you know, that could see what was going on and sort of step in and help and try to make things a lot better, you know?
11. I don't want to see it happen to anybody.
12. I don't want to see any kid ever go through what I went through.
13. So other children don't suffer that torment in their lives because it does affect your adulthood, your childhood. You know people say 'Well, get on with it,' you know, 'just forget it' but you never do forget it. It's there every day of your life.
14. That it doesn't happen to other little kids.
15. The truth exposed. You hear certain things about certain places but there's other places that seem to be getting off scot-free, and make the public aware of what has gone on.
16. Never have to do this again, yeah. No—I just want to say that I'm glad I've got it off my chest, I've got it down on paper. I just hope to God that it's still not happening. No—that it never has to happen to anybody else.
17. Well I'm hoping that nothing can ever possibly happen today, that things are water-tight.
18. I hope it achieves public recognition of the full extent, the treatment of us girls, and that they are held accountable, both publicly and financially to the girls in order for those girls to have continued help. I am really pleased that the Inquiry is here because it's given us a door—it's opened a door for us, that we don't have to keep the secret any longer. So that, in itself, if the information is used wisely—and when I say wisely, I mean that the girls who have come forward feel their efforts were heard and listened to, and validated, then I think that that alone has made a big difference for us.
19. A better deal for the kids. Changes in the homes and all that rot—you know, a better life than what I had.
20. I think— my basic belief, alright, that if the Inquiry can make a difference to what I call people who need to be listened to, people who need to be—people who need to be picked



up for what they are right now and they need to have a chance to talk, at least to have a chance to say what they might want to say.

21. What I would like to see come from this is that the heads of our States learn by the mistakes of the orphanages.
22. No more orphanages.
23. Never again should any institution be separate from the community as a whole. Isolation is an extreme danger and allows for authoritarian rule to take place without respect of law or convention at all. So if there are to be institutions, if there are to be things like orphanages and I personally have a point that I don't think there should, but if there are then they ought to be definitely within the community framework. Children within that framework should go to schools within the community.
24. Why didn't someone check to see if they wanted us, or at least ask my father?
25. Keep them together ... foster them with other family members.
26. Don't let them break up families.
27. When you're outside your immediate family, or if you're identified as at risk within your immediate family for that matter—that you must have monitoring processes. The child must have a friend—someone who is an advocate for them.
28. Do their—their job properly, responsibly as officials, as authorities.
29. Screen them. That the children or whoever happens to be in an institution has somewhere to go, that they can trust and that they will believe—like listen to what they're—what they've got to say and not just pass it off in the run as being just said or made up or something, that it will be investigated, that nothing can possibly happen, physically or sexually to anybody regardless of their age or what institution it is.
30. That the screening of these people that take the children out of the home was better.
31. Foster parents should be looked into more and Family Services should make regular visits.
32. I would like people that are going to foster children ... to be screened thoroughly and I'd like them to get like visited from time to time and maybe someone to be able to befriend the children and get the children into their confidence to be able to talk to them and to see what is actually going on—if they are being treated properly. I was a frightened little girl all the time, too afraid to speak up. I mean I was dumb but I think if somebody had made a really friend ... get somebody in their confidence.
33. They've got to be answerable to—to somebody for their actions and they've got to be vetted and they've got to be constantly.
34. The main point is that these sort of people have been able to get through the system and do the things they've been able to do and get away with it only because at the time nobody would believe anything the kids said.
35. I do believe that people need to be trained.
36. I'd like to bring to the attention the fact that a lot of teenage women in Queensland lost their children to illegal adoption practices up here. I think the governments and the departments of the day have a lot to answer for.
37. I think there has to be a recognition that the beating of children is not normal society practice.
38. More money. There are plenty of good people around who know what to do, but there needs to be much, much greater funding, and I would go back to saying that there needs to be the resources put in for those young mothers and their tiny children.
39. You must have honesty between the workers who are in the institutions and you must have honesty between the governments who are in charge of this and above all you must get the children's trust so that you can talk to them, like, one-on-one.

40. I would most like to see the education of young children in care as to what their rights are and what is and is not acceptable behaviour by the adults who care for them. Of course these children are already so vulnerable and their thoughts of self-worth are not very high, so when they are placed in a situation where they are getting special attention, that is, being made feel special for allowing sexual abuse, they do feel special which is so wrong. I just don't want to see it happening again.
41. Abuse, you know, is still going on. I don't know how it could be stopped. I know one question that was put to me was, sort of—how do you think it could be stopped? I don't think it ever could because we were always told if we told anyone we'd be belted, and I think kids would be too scared to talk up, you know, threatened. So I don't know.
42. Speak to children, or people, on a regular basis and find out if they have ... any complaints, any concerns.
43. I think for future kids, I'd like to see laws passed that the individual be charged, not being able to hide behind who they work for or institutions they work for.
44. That our experiences may be able to show future carers or government departments, agencies that look after children some way of avoiding these things happening to children in the future, of perhaps finding some way of giving assistance to those who are extremely distressed by their childhood. I'm doing okay, but I know that there are some who are in extreme difficulties who need some assistance. Education I see as a major thing that wasn't there for us. Help children to learn life skills and social skills and where to go if they need help, who to be able to speak with.
45. If there's any justice something will be done, so I ain't holding out, but put it this way, if your recommendations at the end of the day come good it'll serve a big purpose for a lot of people out there.
46. Justice.
47. I just want justice.
48. People of today know what's right and they know what's wrong. So therefore if they do it, that they get charged. They can't say, 'this is—this is how I was told to do it.' They know what's right and they know what's wrong and they know if they're told to do something and it's wrong then they don't do it. I'd like to see them held totally responsible for their own actions.
49. I just want to know what will happen to the nuns and the priests that are alive still from the home and the social worker that I told. I want to know if something can be done about that.
50. I hope those people get charged but some of them are probably 70 or 80-odd.
51. Well, I would like to hear the people responsible for putting me into Westbrook when I hadn't done anything wrong—I believe someone must be answerable for that ... there's an admission sheet there to Westbrook and where they've got 'sentence' there's no crime committed, no crime.
52. Those people that knew they were doing wrong to face themselves, so that they can get before God and get before the families and say 'I'm sorry, I don't want to do this any more. I want to change. I need help.' Get the help they need, you know, because it's just going to go on. It's going to go into their families, it's going to go into everything they touch, and their children's children, and I don't know if it's a real answer but the thing is they're still damaged today. It won't be stopped until everyone is held accountable.
53. I think it would have to be someone outside the Department that you could go to.
54. I want these politicians to know that we can't tolerate closed loop systems any more because it's while good men stay quiet that nothing gets done. Everything that happened in the past has happened because it's been a closed loop system.
55. I would like to see them talk to kids.
56. First is that you'd like to see Family Services treat people with kindness and respect.

57. Something that is desperately needed is honesty, respect—respect for the other staff and respect for the kids.
58. If you could recommend that the government gets their finger out of the purse and helps the kids now, they'll save themselves and we might have a better world, and basically support—ongoing support, you know, like whether it's counselling or whether it's a good smack on the tail, or whatever it needs.
59. One of the things that has impacted me the most has been the lack of education. And I come from a family of achievers and I'm the loser of the family ... helping you with goal setting and things and then helping see it through, you know? And people who are prepared to give us a commitment, a long-term commitment because it's not going to be an overnight process.
60. I think there should be an Inquiry into foster care and I think there should be an Inquiry into Family Services and some of the people that work in Family Services.
61. If we would have had someone like you to talk to, as social workers or someone like that up there, and had people backing us, someone to talk to and get close to, I'm sure that ... a lot of the guys that got out of there wouldn't have been in the mess that they're in today.
62. I mean, no one—no one ever asked me why I was in, what I was doing and why I went there and what was my reasons, you know, for doing what I done or anything like that. No one thought of giving you any schooling or anything like that, you know, and—I think that should be looked into for future kids. Someone taking a real interest instead of just throwing you on some medication and treating you like an animal.
63. If there was some counselling out there I would've been there years ago, and maybe I wouldn't be in the predicament I'm in now.
64. I think the treatment of girls with problems—I'm really talking about the minor, sort of, running away from home to even more serious offenders, that the building up of self-esteem, I think, is crucial in any treatment intervention and—which is quite the opposite to Wilson. So yes, I think self-esteem and as normal an atmosphere as is possible. So family groups, in particular, because many girls did not have families or at least functional ones. So I think that's crucial—and the building up of self-esteem.
65. Anger management, I think, particularly for the more disturbed girls because I don't think there was much anger-management therapy around in '73.
66. Prevent abuse ... I think that giving parents education is something that we need to be doing, because no matter what, a young person—no matter how bad a young person's biological family is, they just want to be back there. They just want to be back there because it's their family. And if they want to be back there, can we then work with that family to get them back together, you know?
67. Why don't they have a TV show to teach people how to be good parents?
68. One of the ideas I did have was something like a government-funded, what I would call a preventative—a preventative unit.
69. Resourcing and the staffing of Family Services, but in the front line, in the firing line, you cannot be putting young inexperienced people who don't have the appropriate qualifications, who don't have the ongoing training and supervision of their casework that has occurred. We've gone through periods of economic rationalism where the supervisors have to spend their time managing budgets rather than supervising casework and that's what Family Services is all about. It's not just about managing money, it's about managing families and people and we need caseworkers not managers of budgets in positions of authority.
70. We certainly don't need more detention centres, we need much more resources being put in at primary prevention stages, we need much more support given to families, maintaining children in their families of origin, of supporting those families to cope with all stages of development of children and young people rather than waiting till we get to the stage of where they're committing crimes so that we say 'We'll lock them up' or 'We'll put barbed wire' or 'We'll make more detention centres.'

71. I still do believe that these victims are entitled to compensation.
72. For myself I'm really happy that—that this—that somehow I'm going to be able to walk away from all of this. You know, when people say to me 'Oh, well, you're never going to be able to forget' or 'You're never going to be able to heal this. You'll always have it with you.' I'm not content to be like that. I want to be able to—to leave this, because all through my life every time there's ever been success staring at me in the face I've walked away from it, and it's because of Westbrook Farm Home for Boys. I know it's connected.
73. That I be allowed to go back there ... and at least show my children.
74. Probably—probably that it'd be kind of nice for my kids to understand why I didn't fit into society.
75. If a kid makes a complaint, that complaint must be thoroughly investigated.
76. We are still extremely concerned about paedophiles and people with a bent for cruelty to children. Why they are that way we're not particularly concerned about, but we believe that they should be screened out of the system and never permitted to have anything to do with children.
77. The bureaucracy must be made accountable for their words.
78. This is what I'm saying, I'm begging, I'm pleading, the system has to be changed.
79. Evil thrives when good men do nothing.

## APPENDIX 13

### CONSULTANT RECOMMENDATIONS JUVENILE DETENTION CENTRES

#### Legislation

1. Legislation should be amended to incorporate a list of basic rights of young people in detention, in accord with the intent of Rule 7 of the United Nations' *Rules for the Protection of Juveniles Deprived of their Liberty* which requires States to incorporate the Rules into their legislation and provide remedies for their breach. This could take a form similar to (or incorporate reference to) the proposed Charter of Rights for a Child in Care contained in Schedule 1A to the *Child Protection Act 1999*.

#### Policies and procedures

1. The Department should complete the Practice Framework Manual as a matter of priority, ensuring it is in a form and quantity readily accessible to staff.
2. The Department should develop policies concerning centre operations to ensure relevant international rules, national standards and legislative provisions are incorporated and translated into departmental guidelines and requirements. Matters to be dealt with in these policies should include:
  - positive staff-detainee interactions
  - discipline
  - maintenance of family contact
  - detainee entitlements
  - inspection and monitoring requirements.
3. Staff training should accompany the introduction of any new policies and procedures.
4. Centre-based rules should be approved by the departmental central office to ensure consistency and compliance with legislative requirements and national standards.

#### Facilities

##### *Sir Leslie Wilson Youth Detention Centre*

1. Sir Leslie Wilson should be closed as a matter of urgency.
2. In the interim, major upgrading should be done as detailed in existing reviews.
3. The following additional matters should be implemented immediately:
  - The 'green rooms' to be refurbished and better resourced in terms of equipment (for example working televisions and video players) and activities (current magazines, books, paint, games) in keeping with their 'privileged' status
  - a review of the need for all beds to be stripped every day
  - provision of appropriate shelving next to each bed for detainees to store clothing and personal possessions
  - posters and personal possessions to be permitted in rooms
  - air-conditioning to be installed in all units
  - the Gunyah yard to be made secure so that all detainees can make use of it.

### *John Oxley Youth Detention Centre*

1. John Oxley should undergo a major upgrading to include:
  - air-conditioning
  - the replacement of the existing perimeter wall to reduce the sense of confinement
  - reduction of the bed capacity to 40
  - removal of hanging points
  - removal of demountables
  - redesign of the front entrance to eliminate the prison image.
2. All bolted metal tables and seats should be replaced with comfortable and conventional furniture to provide more humane accommodation suitable for young people.
3. Consideration should be given to providing freer access to recreational areas for all detainees.

### **Behaviour management and discipline**

1. Incentive schemes in all centres should be reviewed to ensure they promote self-control and self-discipline in detainees. In addition to matters discussed in the report, such reviews should also consider:
  - consistency of application (Do staff agree in their assessments of behaviour? Detainees have a strong sense of justice and will quickly become discouraged or frustrated if recognition and rewards are inconsistently applied)
  - appropriateness of the behaviours for which detainees are rewarded (For example, are detainees simply seeking compliance, or exhibiting behaviour that will assist their development as young adults?)
  - appropriateness of rewards (Do they provide sufficient incentive? Are they appropriate for young people?)
  - structure of the system (Is self-management and choice encouraged?)
  - staff training (Do staff understand the basis of the schemes and use them appropriately?).
2. The Department should require that all centres comply with legislative requirements regarding recording and monitoring the use of separation as defined by the *Juvenile Justice Act 1992*.
3. Standard behaviour management plans should no longer be used in the centres. Any detainees who appear unable or unwilling to engage in the centres' routines and incentive schemes should instead be referred to casework and other specialist staff for consideration of an individual management plan informed by adolescent psychology and developmental principles.
4. The Department should ban the use of collective sanctions.
5. Specialist staff and youth workers should be encouraged to work cooperatively with each other to determine the most appropriate intervention strategy for each young person. Specialist staff should ensure youth workers are consulted in the development of any individual behaviour management plans and understand their purpose and requirements. Specialist staff should also be available to support and assist staff implementing such plans.

### **Admissions, searches and handcuffs**

1. Young people on remand should be accommodated separately from sentenced detainees.

2. Reception units for newly admitted detainees should not be used to accommodate longer-term detainees who exhibit difficult behaviours.
3. The power to use reasonable force should be removed from the Regulations, or at least the circumstances in which it can be used should be significantly restricted.
4. The need for power to conduct body searches should be reviewed. Circumstances requiring urgent action to prevent injury to the detainee may already be accommodated under the existing law relating to urgent medical treatment. If it is decided the power remains necessary, the limited circumstances in which it may be authorised and the requirements for recording the searches should be made more specific in the Regulations.
5. Current search procedures and practices should be revised to better acknowledge the impact that frequent searching, particularly unclothed searching, may have on young people.
6. Handcuffs on detainees during escorted absences should be used only where there is a strong reason for doing so, and instances should be specifically recorded. Any presumption should favour the welfare of the detainee. Consideration should be given to developing less intrusive mechanisms to maintain security on escorts.

#### **Contact with family, friends and community**

1. Contact and admission policies and procedures should be reviewed to provide greater flexibility in recognising the varying life circumstances and relationships of detainees, and the need for consistency in interpreting and applying these policies between centres.
2. Consideration should be given to increasing the time permitted for telephone calls, the number of calls provided as an entitlement, and the acceptance of incoming calls for detainees in all centres.
3. Alternative methods should be explored to enable contact between detainees and their families and communities in remote areas.
4. The Department should ensure that guidelines concerning the handling of detainees' correspondence comply with legislation, and that staff are regularly reminded of their obligations in this regard.
5. Pre-release planning for detainees should be reviewed, including the need for increased contact with community agencies and services prior to release to assist their reintegration. Wherever possible, services should be planned to provide continuity from the centre to the community—for example by contracting community-based counsellors who can continue to work with the young person after release.

#### **Access to services**

##### *Mental health*

1. The Department should review existing selection criteria and training for nursing staff to ensure they have, or gain, knowledge of psychiatric nursing, health issues related to drug and alcohol abuse, general adolescent health needs, indigenous adolescent health needs, and cultural issues relevant to providing health services.
2. A senior health services practitioner should be engaged to offer clinical supervision and support for centre-based nursing staff.
3. The Department should contract a consultant child and adolescent psychiatrist, preferably linked to the Child and Youth Mental Health Service, to make regular visits to each detention centre, which will improve access to support, advice and admission to local mental health facilities where necessary.

4. Practices relating to the management and observation of detainees on suicide alerts should be reviewed with a view to placing greater emphasis on personal interactions and observations by staff.

### **Programs and services**

1. The Department should improve the quality and range of services.
2. Greater flexibility should be provided in scheduling programs and in permitting access to programs based on detainee interests and identified needs. Thus, mixing of detainees should be routinely permitted, with individual exceptions when specific risks are identified.
3. Detainee access to community-based services and programs should be more readily accepted and incorporated into case plans.
4. The Department should review the role, expectations, time demands and qualifications required of casework staff to ensure they are adequately trained and resourced to fulfil their core functions.
5. Any changes made to the case planning process should ensure greater emphasis is placed on the participation of young people and their families or significant others. Case plans are to detail agreements reached regarding anticipated timeframes and expected actions of both the young person and the centre.
6. Staff training should emphasise the need for all staff to support and encourage the participation of young people in programs and services.
7. The Department and Education Queensland should work together to reduce current limitations on the availability of educational services for young people in detention, and to improve facilities and opportunities for young people to study in their own time outside the classroom.
8. Centres should be funded to contract qualified recreational instructors to introduce structured sporting and leisure programs on a daily basis in the centres, including weekends.
9. Centres should be supported in arranging regular outings and recreational activities in the community for detainees.
10. The Department should either employ specialist drug and alcohol counsellors in each centre or contribute to the salary of one or more drug and alcohol specialists in the community who will provide regular counselling and programs for detainees (The benefit of the latter will allow counsellors to continue working with some detainees after their release, which is a crucial time for young people attempting to stay drug- and alcohol-free.)
11. The Department should appoint a community liaison officer at each centre to promote activities that bring the community into the centres and take young people into the community

### **Complaints and monitoring**

1. The Department should develop a comprehensive complaints system that complies with legislative requirements and relevant Service Standards. New procedures should:
  - provide timeframes for action and response
  - arrange independent support and assistance for detainees and their families where necessary
  - identify staff with responsibility for particular processes and actions



- ensure confidentiality is observed throughout the process
  - make any proven reprisal action by staff a disciplinary offence
  - exclude any ‘rider’ concerning non-investigation of trivial and nuisance complaints from initial information provided to detainees
  - be available to young people in written form in simple and direct language, and in audio or video form as part of the initial induction process
  - be explained to detainees by workers within 24 hours of admission
  - be informed by approaches taken in other states (including the NSW Juvenile Justice Advisory Committee’s *Review of the Department of Juvenile Justice’s Complaint Handling System for Detainees in Juvenile Justice Centres* (March 1996), and the NSW Department of Juvenile Justice’s 1998 internal complaints policy and procedure for both centre- and community-based juvenile justice services).
2. The Department should negotiate a reporting and response protocol with the Queensland Police Service and the Criminal Justice Commission that sets out the responsibilities and timeframes for the actions of all parties, recognising the importance of prompt investigation and determination of allegations for both young people and staff.

## **APPENDIX 14**

### **COMMISSION OF INQUIRY STAFF**

#### **COMMISSIONERS**

Ms Leneen Forde AC	Chairperson
Dr Jane Thomason	Commissioner
Mr Hans Heilpern	Commissioner

#### **LEGAL**

Ms C E Holmes	Counsel Assisting the Inquiry
Mr Paul Lyons	Solicitor to the Inquiry
Ms Kerri Mellifont	Senior Legal Officer
Ms Susan Baynes	Legal Officer
Ms Darielle Campbell	Legal Officer
Ms Vicky Martin	Interviewing Officer
Ms Margaret Moulden	Research Officer

#### **RESEARCH**

Dr Susan Dawson	Director, Research
Mr Bryan Jamison	Principal Research Officer
Mr John McGuire	Principal Research Officer
Mr Kevin Blackman	Senior Research Officer
Mr Mark Copland	Senior Research Officer
Ms Melanie Fleming	Research Officer
Ms Jennifer Peck	Research Officer
Ms Nerida Wilson	Research Officer
Ms Danielle Crooks	Research Assistant

#### **COUNSELLORS**

Ms Karen Reeves	Senior Counsellor
Ms Fiona Demnar	Counsellor
Ms Elisabeth Drew	Counsellor

#### **INTAKE**

Mr Col Hobson	Interviewing Officer
Ms Doreen West	Interviewing Officer

#### **ADMINISTRATION**

Ms Eileen Jones	Secretary to the Inquiry
Ms Marilyn Pritchard	Inquiry Administrator
Mr Stephen Smith	IT Administrator
Ms Anne Llewellyn	Finance Officer
Ms Matrisse Watego	Records Management Officer
Ms Denise Anning	Administration Officer
Mrs Rhonda Blaney	Administration Officer
Ms Glenda Catlin	Administration Officer
Ms Rachel Flanagan	Administration Officer
Ms Julie Lewin	Administration Officer
Ms Emma Thomas	Administration Officer
Ms Candace Wright	Administration Officer

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