TRANSCRIPT OF PROCEEDINGS

COMMISSION OF INQUIRY INTO THE TASMANIAN GOVERNMENT'S RESPONSES TO CHILD SEXUAL ABUSE IN INSTITUTIONAL SETTINGS

At Clarendon Room, Country Club Tasmania, Country Club Avenue, Prospect Vale, Launceston

BEFORE:

The Honourable M. Neave AO (President and Commissioner) Professor L. Bromfield (Commissioner)
The Honourable R. Benjamin AM (Commissioner)

On 5 July 2022 at 10.04am

(Day 21)

PRESIDENT NEAVE: Thank you, Ms Rhodes.

MS RHODES: Thank you, Commissioners. Our first witness today is Angelique Knight, if she could come into the box.

<ANGELIQUE MEGAN KNIGHT, affirmed: [10.04am]

<EXAMINATION BY MS RHODES:

MS RHODES: Q. Thank you, Ms Knight. Could you please state your full name for the transcript?
A. Angelique Megan Knight.

Q. And you prepared a statement for the Commission dated 2 June 2022; is that correct?
A. Yes.

Q. Have you read that statement recently?
A. I have.

Q. Are the contents of that statement true and correct?
A. Yes you.

Q. Thank you. Ms Knight, you spend a lot of time at the Launceston General Hospital; is that correct?
A. That is correct, yes.

Q. Could you explain to the Commissioners how long you were there and why you were at the Launceston General Hospital?
A. I started going to 4K when I was 5; I had a lot of complex conditions due to an autoimmune, so I was in 4K off and on from 5 to 21.

Q. And, is that where you met Mr Griffin?
A. No, I met him when I was 14.

Q. But you met him when he was a nurse on Ward 4K?
A. That is correct, yes.

Q. And what was your initial impression of him?
A. I hated him. I remember him coming in and he was very touchy-feely the first time he had even come into my bedroom, the room, and I screamed out and I screamed that I wanted that man away from me.

Q. What happened when you said that you wanted that man

away from you?
A. Nothing really happened. He obviously went out and then my mum had made a complaint to the nurse in charge and said that he's not to look after me again, but nothing actually really came of that, nothing really at all, to be honest.

Q. So, he remained caring for you even though your mother had made a complaint?
A. That's correct. It felt - it wasn't, like, straight away but to me it felt like it was rather quickly him actually being my nurse again from the first initial meeting, yes.

Q. After he became your carer again did your opinion of him change?
A. Eventually. I think he - yeah, I started to like him; I guess he just had me fooled very - very easily. So, I guess I just become - like, we become close.

Q. You were on the ward as you said for a long time, till you were 21. Was your family around at the time or - sorry, I'll start that again. You say in your statement that your family weren't in the Launceston area at the time, so you were at the hospital by yourself a lot of the time; is that correct?
A. That is correct, a lot of the time, yes, even though my mum tried the best she could to sort of be there when she could.

Q. I understand that you've been following the Commission quite closely?
A. Very much.

Q. And you've heard a lot of evidence from a lot of people and about the boundary breaches that were complained of in relation to Mr Griffin.
A. Absolutely.

Q. You subsequently made a statutory declaration as part of a process with your Victims of Crime counsellor to give to police and in that statement you detail a lot of your experience with Mr Griffin and the sexual assault that occurred?
A. Yes.

Q. And in that statement there's a lot of similarities

between that and what has been noted as boundary breaches by staff at LGH. If you are comfortable I'll go through some of those with you but if you don't want to answer any questions about it or explain it, then please feel free to not comment?
A. No, yes, thank you.

Q. You talk in that statutory declaration about touching; can you explain to the Commissioners what that involved?
A. Yes, the touching began pretty much instantly, obviously from the first moment, to be honest; he was always touching me, hugging me, touching my bum, always had his arms around me. I recall even in corridors with the other nurses around; he'd, like, rub my back. It was quite inappropriate from the get-go I believe, I feel, and the touching was always - it was always there; there wasn't one time that it wasn't.

Q. You say in that statement that there was hugging and kissing and that you would run up to him when you saw him in the hospital. You talk about him also being there when you were bathing and washing you?
A. That's correct, yes.

Q. And, please don't answer if you don't feel comfortable: in terms of that touching, that touching did turn intimate?
A. Yes.

Q. And you say that people noticed this behaviour?
A. Absolutely.

Q. Do you know if anyone did or said anything about the behaviour?
A. Not to me. I just always got told, "That was just Jim, he's a touchy-feely kind of guy".

Q. You also make comments in there about sexualised conversations with Mr Griffin; are you able to make any comment about that to the Commission?
A. I remember, obviously it must have been early on, I was still only 14 and I sort of got, you know, my [redacted] and he used to come and see me at the hospital and I remember conversations constantly, we'd be in the kitchen and he'd be talking about, things we had done and what I'm doing with my boyfriend and if we had had sex and stuff like that, and then he'd comment that he'd

teach me a few things and he'd show me a good time.

Q. And, what did you understand that to mean?
A. I just - I assumed it was very sexualised, the comment.

Q. And he would often invite you to go to Melbourne with him or to go camping with him?
A. That's correct, on the Spirit when he used to work there; that was quite often and I was only, like, 14 at the time when he first started that, and he said that he'd just tell them that I was his daughter so I wouldn't have to pay and he'd show me a good time over there.

Q. But you never went on any of those?
A. No, my mum would never have let me anyway; like, mum was always a bit - she just didn't like him. She just didn't know why she didn't like him.

Q. You said before that people noticed: when you say people noticed, are you referring to staff?
A. I am, yes.

Q. You also say in your statement that when you were getting married you invited Mr Griffin to your wedding; can you explain that?
A. Yes. I got married the first time in 2019 and I had asked him to give me away, and he was - it was planned for a long time and he was, he was going to, he was excited, he was over the moon. And then I recall a week before something happened and I was told that it was inappropriate and that he couldn't give me away at my wedding but that he could become my MC. I find it really, you know, if that was so inappropriate, what else was inappropriate that other people noticed? It's just hard really.

Q. And so, when he said that he couldn't because it was inappropriate, do you know who had told him that?
A. Apparently he didn't actually say but I think it was a discussion between the Head of Nursing and that, yeah.

Q. All of these behaviours that you've described, how long were they going on for?
A. Since I was 14 until late 20s. Obviously, I was a bit more vulnerable when I was in the LGH, and obviously now that I've become an adult it was my choice then to see him. I just hate myself that I - that I kept going. Sorry.

Q. That's okay. Please, if you need to pour yourself some water and take some time, please take your time.

COMMISSIONER BROMFIELD: You did nothing wrong.
A. Thank you.

MS RHODES: Q. Ms Knight, you did nothing wrong and we've heard a lot of evidence of how grooming occurred. Why do you feel that it's your fault?
A. I think, because I always just thought it was me. I feel like, if I had have said something when it started, that it could have stopped.

Q. Now, you were 14 when it started and there were adults looking after you in hospital.
A. Yes.

Q. Do you think the adults should have done something to protect you?
A. Absolutely, without a doubt.

Q. Do you think it's unfair to expect a child to protect themselves from someone like this?
A. I think that's really unfair to think that, yes.

Q. Is there anything further you would like to say about your experiences with Mr Griffin before I move on to the responses that you received?
A. No, that's pretty much it.

Q. Thank you. This --

COMMISSIONER BENJAMIN: Would you like a five-minute break before we go on to that?
A. I'd love one, thank you.

COMMISSIONER BENJAMIN: All right, we'll take a five-minute break and we'll come back.

PRESIDENT NEAVE: We'll just rise.

SHORT ADJOURNMENT

MS RHODES: Thank you, Ms Knight, are you ready to continue?
A. I am.

Q. Thank you. I want to ask you now about the responses that you have had when you have tried to tell your story to other people. I'll take it back a step. You found out that Mr Griffin had died?
A. I did.

Q. And then you made a decision to go to the police station to make a statement about the abuse that had occurred?
A. Yes, I did.

Q. What was the response from police when you went to do that?
A. I kind of felt like it was a waste of time when I got there, like, it really took a lot for me to go in there. And, when I went in there I spoke to the lady, I assumed she was just reception at the first counter, and then she went and spoke to a police officer, or I thought it was a police officer just in the next cubicle, and then she came back to me pretty quickly and said, "Sorry, there's nothing we can do, we can't charge a dead person, but I'm sorry that this has happened".

Q. And who you did that make you feel?
A. Humiliated, disgusted, like, I was just, what was the point? You know, it's pretty serious for victim-survivors to actually get to that point to want to talk about it, which is hard enough anyway, and then to be treated like, why even bother, like, it's not even - I didn't feel like I was heard or, you know, the acknowledgment of what had actually happened.

Q. Was any support offered to you by police or any referrals made?
A. Absolutely not.

Q. Then, after that you tried to contact the LGH?
A. I did.

Q. To have someone hear your story at the LGH. Who did you speak to and what was the response?
A. I sent an email to Peter Renshaw. It took - I think I got a reply back the next day; it just seemed very generic to me, like, you know, a very basic email that he's probably sent everybody that sent him an email - that's how it felt anyway. No real acknowledgment that this had

actually happened under his watch at the LGH. I just felt - I just felt like a number to him, you know, like, it's not very - not really important, not a big deal, kind of.

Q. I understand in that email there was a list of support services?
A. There was. He had sent, like, a list of things but nothing really direct, nothing personalised; like, it wasn't actually - it just looked like a, just a list to me, like there was no other help from that.

Q. And so, did you feel supported by that response?
A. No, I didn't, at all.

Q. I understand that you know a lot of nurses at the LGH?
A. I do, quite a few, yes.

Q. Were you contacted or reached out to by any of those people?
A. No, which really hurt because a lot of them had known what - our relationship and, you know, I say that really fast because it's, you know, disturbing, but they knew how it was; well, obviously not in depth obviously, but they knew to a degree it was inappropriate, so I kind of felt betrayed that no-one had actually got in touch with me the moment they found out that he was a paedophile.

COMMISSIONER BROMFIELD: Q. Sorry, how did you find out that he was a paedophile?
A. My family friend who I used to be in hospital a lot with, her daughter was in there too, and she - because I had been asking, because he had just gone off the place, you know, face of the earth, I couldn't find him, and she found the article on The Mercury paper, sent it to me.

Q. I can't imagine what that was like.
A. I just - I just lost it, yeah. That was - I just thought it was like a dream, and then a whirlwind of emotions come from it, absolutely.

MS RHODES: You say in your statement that no-one from the LGH has made an apology or acknowledged what has occurred?
A. No, a couple of the nurses - well, two of them in particular I've been speaking to, neither of them work on 4K anymore and haven't done for a long time, I've been in touch with them and they've been really sympathetic to me

and very, you know, caring but, like I said, I do know quite a few of the nurses on 4K and disturbed that none of them that still work there or even the Head of Nursing or whatever had been in touch.

Q. Have you ever received an apology or an acknowledgment from the LGH as an organisation?
A. No, not at all.

Q. And what would that mean to you?
A. I don't think it would actually - it wouldn't change anything for me, but I think it would go a long way in knowing that someone is taking some responsibility for what happened, because it was happening under their noses.

Q. You've articulated that it was very devastating and difficult for you, and in your statement you say you had a really rough patch; the support services weren't being offered by police and you didn't feel supported by LGH?
A. No.

Q. So, how were you able to find support?
A. I had actually gone to speak to someone at the Salvation Army, and I was talking through - I just lost it, I was - I was a mess, and she got me in touch with a [redacted], she was a lovely lady, to which she was really worried and concerned of my wellbeing at the time, so referred me to Laurel House. There was an eight to 10 week wait at the time, and that was fine, I did finally get to speak to somebody from there, but I guess - I guess everybody in that situation, obviously not everybody is going to be right for them and this lady just wasn't right for me to move forward and to get, you know, to help me.

So, it was actually one of my - the nurses that I speak to - well, she's not a nurse now but she was, is also the mother of another victim - she actually told me that her daughter had been great going to Victims of Crime speaking to [redacted], and that's why I decided to get in touch with [redacted] at Victims of Crime and she's got me to where I am today, because we just - we just work well together.

Q. Sorry, do you need a glass of water?
A. Thank you.

Q. How important, is it, do you think, for yourself and other survivors to have support immediately in these situations?
A. I think it's very, very important. The longer things go on, the more issues you're going to have mentally, emotionally. I just, I think it's a dire urgency for people to be able to have that support straight away.

Q. It was through the support of [redacted] from Victims of Crime that you were able to make that statutory declaration?
A. That's correct, yes, she got in touch with one of her friends at the CIB, one of the higher people up there, and they were really happy for me to make a stat dec so it could go on their files.

Q. And, how important was that for you to do that?
A. It was very important. I feel like I needed to do that for me to accept, like, to give myself - cut myself a break really because it just felt like it was consuming, so being able to talk it out and put it out there I think made a big impact on my life.

Q. A positive impact?
A. Very much, yes.

Q. You also contacted the Premier?
A. Yes, I did.

Q. What was the response from him?
A. They were very much the same as Peter Renshaw, I just sort of got back a very basic email that I feel that he didn't write, and then sort of later - later learning of his own situations, I kind of felt really - really, like, disgusted to be honest because, if anybody is going to understand, it'd be someone that knows what you're going through, so I felt really, really ashamed, like, there was just no-one there wanting to support me at that time. I felt like I always had to find the support myself moving forward, which is really disgusting, so I didn't really - I think there was a couple of emails between myself and Peter Gutwein.

Q. And you're continuing to have the support from the Victims of Crime?
A. Yes.

Q. Can you explain to the Commissioners the impact of your experience on you?
A. It has impacted my life after it all came out. I don't - like, whenever I go to, like, public bathrooms or just stuff like that I feel so, so scared that there's cameras. I always get someone, my partner, or someone to come in with me, it worries me. I am so protective of [redacted]. I don't really let her go to many places without me because I feel like I'm the only one that can, you know, be there the right way for her, which is really, really sad, I don't - I just don't trust anybody fully with her and I've never actually been like that. I've always been a very trusting, go-lucky kind of person, but I feel that this person and the outcome afterwards, I feel like it's just changed my perspective on everything.

I'm very reserved, I'm quiet, like, I don't really go to many places, which is kind of depressing at times. I just sort of, like, sit in my own little box; sometimes I feel like I - nothing can happen to me in there. So, it's very - it has changed my life in a bad way, absolutely.

COMMISSIONER BROMFIELD: Q. It sounds like it's really broken your trust in the world?
A. Most definitely, most definitely. I don't really trust too easily these days. Very, very cautious of people and, you know, some people are quite decent and you're sort of questioning things; like, it's not nice, but I guess that's just the way things are from my own experiences that, you know, I just hope that things can get better, absolutely.

MS RHODES: Q. Ms Knight, your medical conditions are chronic conditions that you still need to seek medical treatment for?
A. Yes.

Q. How has your experience impacted your ability to seek medical treatment?
A. I really hate the LGH. Last year I got diagnosed with chronic leukaemia, so it's kind of really kicked me in the guts a bit, so I'm often sick with the other conditions that I've got. I actually just recently spent three days in the LGH which was horrendous, not that the staff weren't doing their job, you know, they're quite caring and that, but it's just my perception now: I just didn't want to be there, which is kind of sad.

Q. I know that you had an encounter at the LGH last week when you went to get treatment.
A. I did.

Q. Can you explain what happened there?
A. I was watching the Commission on my phone, obviously I was in the Emergency Department for two days, I think, before I went to the ward and, you know, I was trying to be considerate and I didn't actually have it up that loud, and then I debriefed with mum, like I'd be telling her, "They've done this and they didn't do that" afterwards and the Head of Nursing come in and seen me for the ED and had said to me that, you know, she was sorry she had to have this conversation but if I could please be discrete because she's got to support her workers because it impacts them as well. Like, no consideration to whether it actually impacted me. I did tell her that I was speaking this week, but no acknowledgment or, "I'm sorry" or, it was just, "Can you please be discrete?" It's like, "Oh, okay then", I felt --

COMMISSIONER BROMFIELD: Q. And that was the message even after you said you were coming to the Commission this week?
A. That's correct.

Q. How did you feel?
A. I felt, I felt really hurt and upset about it because, like, fair enough there's a lot of people involved, but none of this should have happened to begin with, and I felt asking me to be discrete, I just felt ashamed really, like, what I had to say no-one wanted to hear.

PRESIDENT NEAVE: Q. There are things to learn from the past, presumably?
A. Absolutely. Yeah, it's just like, no-one wants to talk about it, like, but why do people not want to talk about it? I always feel like, if you don't want to talk about it, there's obviously a reason. Because when I went to the ward I was, I was still quite a bit annoyed and I told my nurse, and she's like, "Oh, you don't have to worry about that, you can talk about it" so it feels like people were hiding things and I felt like, pretty degraded, to be honest.

COMMISSIONER BROMFIELD: Q. And, we are so grateful that

you're talking about it because it's talking about it that helps stop it happening again.
A. Absolutely, and that's what I want, I want big change so no-one ever has to go through this ever again in that, you know, setting.

Q. And talking about it also helps to take away that shame that is not the responsibility of victim-survivors.
A. Most definitely, most definitely; like, I think it all helps in the long run, yeah. Thank you.

COMMISSIONER BROMFIELD: Thank you.

MS RHODES: Q. You have made some recommendations or made some comments in your statement about improvements that you would like to see at the LGH?
A. Yes.

Q. What is the main improvement that you would like to see?
A. I would like staff to have, like, a mate, like work in pairs, like a male and a female; depends, obviously there's no issues, you know, like, obviously it works accordingly. I also feel that there should be, like, a debrief person on wards, especially 4K, that speaks to every patient every night or afternoon, just to ask them, you know, do they have any issues, do they have any concerns with staff, or it could be anything. I feel like it shouldn't be a staff member, like, on the ward, it should be maybe, you know, an outsider briefed if they were to do all the wards maybe, because a lot of the time there's no-one to talk to and if people aren't - not necessarily if things are happening people aren't going to address it straight away, but at least if they're able to they might feel comfortable knowing that that's just regulations, that things might improve.

Q. You've spoken a lot about the need to speak up and talk about these things and feel heard by people.
A. Absolutely.

Q. I understand that you've not necessarily always had a positive experience when you've spoken to people about what has occurred?
A. No. No, definitely not.

Q. And that some of the comments that have come back to

you, is that, "You're lucky that things didn't go further than they did"?
A. That's correct.

Q. How do you feel when things like that are said to you?
A. I feel disgusted. I definitely don't feel lucky. It makes me feel like what actually happened to me all those years meant nothing, because obviously I wasn't - it didn't go that extra step, but to me it was bad enough. And, to me, none of it should have happened, so when people - a few people have said that to me, and it just makes me feel hurt and ashamed that I'm actually talking about it; like, what happened to me didn't matter.

Q. Thank you very much for coming to speak to the Commission, it does matter and it matters to the Commission, so thank you very much.
A. Thank you.

MS RHODES: That's the end of my questions. If the Commissioners have any questions?

PRESIDENT NEAVE: Ms Knight, you're a very, very brave woman and as Commissioner Bromfield said, we're very grateful you've spoken to us and shared your experience. The abuse that you suffered was Mr Griffin's responsibility alone. You were a little defenceless child and, as he did with other children, he broke down your boundaries in a situation where you didn't understand or know what he was doing.

We're so sorry that this happened to you, we understand that it's affected your sense of trust, but we hope very much that you will be able to move on and have a happier life in the future. We're very glad that you've been able to find some support and hope that it will help you.
A. Thank you so much.

PRESIDENT NEAVE: We hope you feel heard, but I just wanted to ask Commissioner Benjamin whether he wanted to say anything?

COMMISSIONER BENJAMIN: No, I just wholly endorse the remarks that the President made. Thank you.
A. Thank you. Thanks so much.

SHORT ADJOURNMENT

PRESIDENT NEAVE: Thank you, Ms Norton.

MS NORTON: Thank you, President. Our next two witnesses are joining us remotely; they are Ms Debora Picone and Ms Catherine Turnbull and I ask that they be sworn in.

<DEBORA MARGARET PICONE, sworn: **[11.19am]**

<CATHERINE EMMA TURNBULL, affirmed:

<EXAMINATION BY MS NORTON:

MS NORTON: Good morning to you both. I'll start with you, Ms Turnbull. Can you just state for the transcript your full name, professional address and occupation, please?

MS TURNBULL: Catherine Emma Turnbull, I am the key Child Protection Officer for South Australia Health, Department for Health and Wellbeing. My work address is 11 Hindmarsh Square, Adelaide, South Australia, 5000.

MS NORTON: Thank you. You've provided a statement to assist the Commission in its work, it's a statement dated 23 June. Have you recently reviewed that statement?

MS TURNBULL: Yes.

MS NORTON: And is it true and correct to the best of your knowledge and belief?

MS TURNBULL: Yes.

MS NORTON: Ms Turnbull, in that statement you include your CV and a summary of your relevant experience. Just by way of overview, you started work as a social worker in New South Wales; is that right?

MS TURNBULL: Correct.

MS NORTON: And in that capacity you worked in a range of hospitals in New South Wales including childrens hospitals?

MS TURNBULL: Correct.

MS NORTON: And since 2006 onwards you've held senior roles within South Australia Health; is that correct?

MS TURNBULL: Correct, yes.

MS NORTON: Professor Picone, if you could do likewise and state your full name, professional address and occupation, please.

ADJUNCT PROF PICONE: Debora Margaret Picone, Level 5, 255 Elizabeth Street, Sydney 2000, and I'm the Chief Executive Officer of the Australian Commission on Safety and Quality in Health Care.

MS NORTON: Thank you. Commissioners, I'm going to refer to that Commission as the Safety and Quality Commission where I need to, to distinguish it from this Commission of Inquiry and that will make sense to you, I'm sure, Professor Picone.

ADJUNCT PROF PICONE: Yes.

MS NORTON: Your statement: you've provided a statement dated 21 June, have you reviewed that statement recently?

ADJUNCT PROF PICONE: Yes, I have.

MS NORTON: And is it true and correct to the best of your knowledge and belief?

ADJUNCT PROF PICONE: Yes, it is with the exception that I inadvertently provided my residential address in my statement to the Commission and I'd seek to substitute that with the commercial address.

MS NORTON: We'll certainly make sure that your personal address is redacted in the version of your statement that's made publicly available.

ADJUNCT PROF PICONE: Thank you.

MS NORTON: To summarise your background, you have a nursing background. When did you start nursing, 1984 --

ADJUNCT PROF PICONE: No, 1974, back when there were dinosaurs and things on the land.

MS NORTON: And you've moved into a range of executive roles in New South Wales; is that right.

ADJUNCT PROF PICONE: That's correct.

MS NORTON: You're both a Member and an Officer of the Order of Australia in recognition, among other things, of your contribution to Health Service management, nursing education and safety and quality in healthcare; is that an accurate description?

ADJUNCT PROF PICONE: Yes.

MS NORTON: I'd just like to ask you a question at the outset. As somebody who has made the transition from ward nursing into hospital administration, what do you regard as being the necessary professional qualifications to make that transition?

ADJUNCT PROF PICONE: Look, the minimum, in my view, and this is for anybody going into a management role in Health, would be an undergraduate degree in management or a postgraduate degree in management, I think is critical.

MS NORTON: Ms Turnbull, as somebody who has made a similar transition, albeit from social work rather than nursing, do you have any views about tertiary qualifications for Health administration roles?

MS TURNBULL: Yes, I agree with Deb, that some undergraduate or postgraduate, probably most likely postgraduate training in the management field, and then mentoring or supervision arrangements ongoing.

MS NORTON: Are there opportunities within South Australia Health for those mentoring opportunities internally or are they opportunities that individuals need to seek out externally?

MS TURNBULL: Both.

MS NORTON: Are you able to provide the Commissioners with an overview of the internal mentoring that's provided within SA Health?

MS TURNBULL: There's a gender quality diversity mentoring program available in SA Health and people can apply and be

matched up to a mentor. There's also a leadership program that's run within SA Health and there's an alumni program and as part of that alumni program there's also matching up with mentors, and then there is an Office of the Commissioner for Public Sector Employment program, a leadership program where you can also be matched up to mentors, and then there's also the Australian College of Health Service Management Mentor-Mentee program and I'm currently an active mentor on that program, and that's broader than just SA Health, that's other health workers.

MS NORTON: Thank you. Do any of those programs that you've just mentioned deal with matters such as governance within hospital administrations?

MS TURNBULL: They would because often the questions that learning managers and developing managers are asking are around governance, safety, quality, risk, audit.

MS NORTON: Thank you. I'd like to begin by asking you both some particular questions in relation to particular vulnerabilities of children and young people in healthcare settings. The Commission has heard evidence, particularly in the first week, about the vulnerabilities of children generally to child sexual abuse but I'd like to hear from you about - and I might start with you, Ms Turnbull, you speak about this in your statement from about paragraph 22, about the reasons why children and young people in hospital are particularly vulnerable.

MS TURNBULL: Yes, certainly. So, the information in my witness statement is drawn from about 15 years clinical experience working in various hospitals across New South Wales before I moved to South Australia, and my role initially was as a clinician and seeing women and working with children, and then I moved into team leader and then in the director roles for social work departments. So, during that time I came across a lot - not a lot, a few examples of where children needed to have some extra safety measures put in place.

So, my observation around vulnerability of children in healthcare settings would be the following: there was a case where a press person pretended to be a relative and came in to try and take pictures with the child for media purposes. There were a few times when non-custodial parents tried to access the child while in hospital giving

false information to staff.

There was a time when a social worker moved from one hospital to another hospital and a client, a young person, followed that social worker because they had started allegedly a relationship in the Emergency Department of both hospitals.

Then there have been times where hospitals that I've worked at, they've had to work through policies to do with not placing adults in paediatric wards, (indistinct) hospitals where it's not a purely paediatric hospital but there's a mixture, so there's been policies drawn up to ensure that children are not placed in the same (indistinct) or the same room with an adult due to the vulnerability of the child while sick in hospital. So, they're some of the examples.

MS NORTON: Thank you. You speak in your statement about the psychosocial characteristics of children who are hospitalised for long periods or repeatedly.

MS TURNBULL: Yes.

MS NORTON: Can you address the Commissioners on that as a vulnerability?

MS TURNBULL: My observation when working in paediatric oncology, so kids with cancer, was they became very, very withdrawn, and very limited in their ability to advocate for themselves, so they would start off before treatment as quite gregarious, outgoing kids, and they would just really shut down and withdraw, and I was very aware that it was those children who appeared to be more vulnerable because they didn't speak up if they didn't like something that was happening to them because they had to have treatment that they didn't like and they were being told that they just had to have it. So, I saw a switch in their affect and I had to do work with them around trying to re-empower them and get them to understand that they had power, choice over what was happening to their bodies, so that was just one example with oncology.

The same thing with rehab, long-term rehab kids, particularly ones with nasty broken legs who would be in traction in bed for six to 12 weeks and they became very disempowered as well, so they were much more vulnerable to

things happening to them that they didn't want and not being able to differentiate necessarily between what they didn't want that was wrong versus what they didn't want that was required because of the condition that they were in.

MS NORTON: You referred before to actively working with some of those patients to re-empower them in relation to their bodily integrity; how did you approach that task?

MS TURNBULL: So that was through really doing play therapy with them and ensuring that I was listening to where they were at, and then working withdrawing them along the pathway to gaining that confidence around decision-making for themselves, and I did a lot of work with needle phobia in particular as they were children. I remember one in particular would get to the hospital and vomit outside the hospital because they couldn't even get in the door.

So, I worked with him and he worked out a way that he would think of his favourite place to go, which was a Kentucky Fried Chicken planet, and that it had escalators up and down going to different Kentucky Fried Chicken places, and so, that was the head space that he would think about in coming to the hospital and he was able to have his chemotherapy, and he did really well actually, but it was very much about doing that play therapy with them in this thing and helping them work through what it was that was really distressing them and giving them power back into, you know, what arm are they going to have the needle in, what are they going to do before they have the needle (indistinct) and for them to count, not the adult, so just little things that make a huge difference for kids and give them some control back.

MS NORTON: Is providing that control back important? You mentioned before it's important to distinguish between touching they don't like which is therapeutically necessary and touching they don't like which is non-therapeutic. Is empowering them also important to enabling them to make a complaint or to raise a concern when they're the subject of touching that is non-therapeutic?

MS TURNBULL: Correct, absolutely, and what is okay, correct, absolutely and what is okay and what is not okay.

MS NORTON: One other thing you mention in terms of --

MS TURNBULL: A lot of the work that I --

MS NORTON: I'm sorry, Ms Turnbull, we're having some problems with your internet connection, I didn't mean to cut you off, please continue.

MS TURNBULL: That's okay. The other area that I worked in was the Emergency Department and intensive care and did a lot of work with siblings of children who either came in deceased or died shortly afterwards. And again, a lot of my work was done sitting with the child on the floor with the parents in the room with the agreement with the parents that, if the child asked a direct question about their sibling and I'd answer truthfully. So, part of what I was modelling was for the parents, that their children know what's going on and that their children, if they're given the space to ask the questions, will ask the questions. But if their children are shut down they won't talk and they won't ask the question.

100 per cent of parents agreed and said, yes, I could do the work, and 100 per cent they would not ask, is their brother deceased, 100 per cent of the kids were asked in front of their parents. So, it was really educational for the parents and part of what I was trying to mirror or model was, listen to your children and allow them to ask questions because they will have insight and knowledge that you don't think that they have.

MS NORTON: And how would you apply what you learned through that process to the possibility of child sexual abuse and the need to encourage children to speak up about concerns?

MS TURNBULL: Well, the same, it's about giving them a safe place and space where they're listened to and that somebody will then respond to what they have said rather than shut them down or dismiss them, or have them in an environment where they're picking up on it's not okay to say what they want to say.

MS NORTON: We'll come shortly to the importance of complaints mechanisms for staff, but what you seem to be saying here is that it's also very important in a healthcare environment, indeed in any environment, to

create a safe space for children to speak up about things that happened to them that they don't like?

MS TURNBULL: Yes, very important.

MS NORTON: Before I move on to some of those other matters, you mention in respect of the significance of the length of a hospital visit in creating additional vulnerability for a patient, you talk about children with long stays in hospital developing a familiarity with particular practitioners and that that can create an elevated risk. Are you able to elaborate on that risk?

MS TURNBULL: So that really was reflecting back on my practice with the rehab, rehabilitation clients who are in hospital for long periods of time and who can be in a very vulnerable position of being stuck in bed, and having people that are around them that become familiar.

I was never so worried about the children in the Emergency Department because there were so many staff around, they were there for, you know, an hour to four hours, so the opportunity for anybody to establish a relationship with that child was very minimal.

MS NORTON: And, would you agree that establishing longer term relationships with health professionals would potentially make those patients more vulnerable to grooming, if grooming were present?

MS TURNBULL: I didn't ever experience that, but that was always my thinking and, therefore, throughout my career I have always implemented strong supervision arrangements and observed practice arrangements for social workers who have been within my remit.

MS NORTON: Yes, I'd like to come to some of those practices shortly. Before I address some questions to Professor Picone, you've talked about long stay patients in a few different situations. Are patients with eating disorders, do they fall into a similar category of vulnerability in terms of long stay, being removed from social environments, et cetera?

MS TURNBULL: Yeah, and (internet unstable) ...

MS NORTON: I'm sorry, Ms Turnbull, you've just broken up

there.

MS TURNBULL: Sure, it's unstable.

MS NORTON: I'm about to address some questions to Professor Picone, so you might want to try and log off and come back in perhaps. No? I'm being told by the IT gurus, camera off.

MS TURNBULL: Okay. So, I've turned the camera off, is that any better?

MS NORTON: It is.

MS TURNBULL: Okay, all right. Then, yeah, so any troubled young person with a mental health issue as well or drug and alcohol problem.

MS NORTON: Thank you. Professor Picone, you've been nodding through Ms Turnbull's evidence there, have you got anything you would like to add to her observations about the vulnerability of those cohorts of patients?

ADJUNCT PROF PICONE: Children are extremely vulnerable, and when I was at the Children's Hospital I was Director of Nursing there for five years. The way I'd try and teach new staff about children was I'd say that, "They're not mini adults. They're the furthest thing from a mini adult that you'll ever meet", you know, emotionally, in terms of their physical, mental and every other ability, and people that haven't had exposure to children in other settings such as families and elsewhere, they take a little bit longer to get that connection. I think it's very important that right from the get-go that we're teaching people about children.

The only other comment I'd make, just following on from Catherine, is that the vast majority of children attending Health Services in this country are attending them not in a specialist Children's Hospital environment, so nearly every, you know, district hospital, Regional Hospital has a Children's Ward, for example, but it's not a Children's Hospital.

The children come to the Emergency Department and after many years we've now got almost all the Emergency Departments have to have separate areas and play areas for

children in those EDs, but that's the principal message to get across to people about, you know, children, toddlers and also adolescents as well. People just think, because someone's an adolescent, suddenly, you know, they're a young adult: they're not, they've got a way to go yet.

MS NORTON: In the context of hospitals that are not specialist Children's Hospital, what are the particular challenges that those hospitals might face in embedding - in, first, appreciating the need for Child Safe Principles or to create a Child Safe environment, and two, in actually embedding Child Safety Principles into the culture within the hospital?

ADJUNCT PROF PICONE: It's more difficult for them, for obvious reasons, because when you're working in a stand-alone Children's Hospital or, say, one that's attached to a Women's Hospital, the whole emphasis, the whole culture and ethos of the place is about the safe care of the child. It's a lot more difficult when you're working in a predominantly adult environment, but I have to say that I know I've been around for a while, for a long time, but from - I really have noticed improvements.

Like, there would have been back in the 90s an argument about why do we have to do special things for children, why do they need to have segregated areas; there's six empty beds in that ward, why can't I move adults in there? Those conversations just don't take place anymore, so we have come a long way, we've learnt a lot, but I'm certainly learning from this special Commission of Inquiry: we've still got a lot more to do around creating Child Safe organisations.

MS NORTON: I'd like to pick up that thread shortly. Before I do, can I invite you to address the Commissioners on the hospital accreditation work that the Safety and Quality Commission undertakes in the industry, and perhaps starting by reference to your National Safety and Quality Health Service Standards.

ADJUNCT PROF PICONE: Right. The Commission was formed to coordinate the development of a set of National Safety and Quality Standards for Australia both in the public and the private sector. So, those standards cover every healthcare provider, public and private, from major teaching hospitals right down to day procedure centres.

So, there are eight standards and those health organisations are required to implement all of those standards and that is assessed on a regular basis with an on site assessment every three years.

MS NORTON: I understand that the LGH is currently undergoing an accreditation process, I might come back to that, but can I first ask you, are you familiar with the National Principles for Child Safe Organisations?

ADJUNCT PROF PICONE: Yes, I am.

MS NORTON: Are those principles integrated into or otherwise reflected in your National Standards?

ADJUNCT PROF PICONE: No, they're not, though we had developed, with Children's Healthcare Australasia, a guide; it's called, A User Guide for Acute and Community Health Service Organisations that Provide Care For Children. So, because those standards are universal, so the first standard is a Clinical Governance Standard, the next one is partnering with consumers, infection control.

The standards are based on where the biggest risks to individuals are that are attending care, and then we set up a standard to mitigate that risk, and in that risk mitigation everyone's involved, from the person who's the chairperson of the board right through to admin staff on the ward. So, I think that's it, I might have lost my thought, I was on a roll there but I've lost it.

MS NORTON: And I should point out, Commissioners, that in Professor Picone's statement she does draw out some of the aspects of the standards which correlate.

ADJUNCT PROF PICONE: That's right. So, the children's healthcare, the joint work we did with Children's Healthcare Australasia; that when the assessors are at the Health Service they will use that document to assess any of the child healthcare services.

So, in a typical hospital, so if we go to Launceston General, it has a Children's Ward, as you know; they have children coming through their Emergency Department so they will have a separate entrance and area and required physical environment there, so children are being cared for

there. Children will come back to an outpatients department so they're cared for in a special environment there, and this is where these standards are used and applied.

But the one thing I've learnt from following this special Commission of Inquiry is that, you know, my view is that, while the work that we did with Children's Healthcare Australasia is very good, I think we're going to have to firm it up and make it more specific, and we're actually considering - we can mandate certain things, people must do certain things, it's not an optional extra, and, you know, given some of the evidence that I've seen and the transcripts, we're going to go back and reconsider that.

MS NORTON: And do you mean that you're going to reconsider that in relation to Launceston General Hospital or in relation to your activities more generally?

ADJUNCT PROF PICONE: No, to the nation, yep.

MS NORTON: Thank you. Launceston General is currently going through its tri-annual accreditation, I understand it's relatively early in that process, but are you able to inform the Commissioners about what that process involves and where it's up to presently?

ADJUNCT PROF PICONE: Yes. It's commenced last week but next week the assessors will be on site. I'm not certain how many people will be attending the hospital. A hospital the size of Launy would normally have, you know, maybe five to 10 people. There will be a lead surveyor, he's a highly experienced, generally, administrator. There will be a medical officer and those Allied Health professionals, a consumer representative, and any other specialised people that we need and they would generally spend five days on site. They divide their work up, and so, the administrator, the nurse and the doctor, for example, would do the Clinical Governance Standard and then they proceed to through to examine whether the hospital has implemented the standards.

PRESIDENT NEAVE: Q. Can I just ask a question about that? When was the previous full accreditation of the Launceston General Hospital?

ADJUNCT PROF PICONE: Madam President, I knew that you

would ask me that question and last night I actually wrote it down and now I can't find it, but I'll take that on notice and get that back to you within the hour.

PRESIDENT NEAVE: Thank you.

ADJUNCT PROF PICONE: But it was about three or four years ago. I read the survey report. They did relatively well but they didn't assess all the standards. Now, the key standard that we've got a big interest in here is the governance standard, the clinical governance standard, and that wasn't assessed at that time.

When you commenced your inquiry I did ask that we go back and look at how the complaints management system operated and their incident management system based on some questions from Counsel Assisting about whether you can, you know, change records. And I got very concerned when she raised that because I thought, oh my God, you cannot change records, but fortunately you can't change those records. So, we have got some information on that, but we would be in a position to advise the Commission probably within three months. If there was anything unusual that comes out of this assessment we can advise you earlier.

I'm also sending - we do send our people, as in the people that work here with me at the Safety Commission, we do send them as an observer on these surveys because they're conducted by independent companies, and I'm sending my most senior person, our Chief Operating Officer, [redacted] will be attending that entire survey so I feel confident about what we would be able to advise you about when that's done.

PRESIDENT NEAVE: Thank you. I think I recall from the witness statement, but I may have this wrong, that you do a survey against particular standards on some occasions --

ADJUNCT PROF PICONE: That's right.

PRESIDENT NEAVE: -- as opposed to the full accreditation. Is that right? Have I understood that correctly?

ADJUNCT PROF PICONE: Yes. People can have a mid-term assessment and just do three, which is always clinical governance partnering with consumers and infection control, but at the three-year mark, unless there's very good

reasons, they have to go up against the eight standards.

PRESIDENT NEAVE: I see, thank you.

ADJUNCT PROF PICONE: And what it is, is we're going in to assess independently that the standards have been implemented.

MS NORTON: Can I ask you a follow-on question, Professor Picone. In paragraph 53 of your statement you summarise some of the assessments that were conducted, and this may save you from taking that question on notice; it looks like the last organisation-wide assessment was May 2018 for the LGH. That's paragraph 52 of your statement.

ADJUNCT PROF PICONE: Thank you, Counsel Assisting, that's excellent. I knew it was 2018 but I just wasn't going to quote it. That's quite correct.

MS NORTON: You say in the next paragraph of your statement that one of the standards that was assessed was in relation to incident reporting and complaint handling and in 2018 those systems were assessed as effective.

I know you've been following the evidence in the hearings in the last week or so. Have you been able to review the evidence of Mr Eric Daniels, the Chief Executive of Launceston General Hospital, and don't be at all embarrassed if you haven't?

ADJUNCT PROF PICONE: I've skimmed that evidence but not in detail, but I'm very happy to go back and to look at that.

MS NORTON: No need, I'll summarise for you the particular aspect of the evidence that I'll invite you to comment on, and I'll give a transcript reference for the benefit of others: it's transcript page 2019.

I think it's accurate to summarise Mr Daniel's evidence there as having involved an acceptance that the hospital's systems and processes had failed to ensure that records of complaints and grievances against James Griffin were maintained and monitored with a view to identifying patterns of behaviour.

Does that evidence, that concession on the part of the

Chief Executive hospital about failures of systems and processes to record complaints and monitor them cause you any concerns in terms of complaints handling?

ADJUNCT PROF PICONE: Yes, it does. Look, the purpose of the complaints handling is to resolve the issue that the person's brought to you, and the most effective complaints handling is to try and get (indistinct). You know, so I'm a patient in a ward or I'm a little one in the ward and there's some issues that I'm concerned about and I go either to my nurse or doctor or nursing unit manager and we should try and get it resolved then. That complaint should still be entered into the system.

So, it's clear to me, and when you read the history of this whole issue, that there was a pattern there, that the hospital, as they say themselves now, failed to pick up and this has been a feature of incident reporting systems for quite some time; it's getting better now but I could give you example after example of information being entered into an incident reporting system or the complaints handling system where there was a definite trend showing - Bacchus Marsh is the sort of classic example, I did the review of that, and if they had looked at that information they would have seen a trend of neonatal deaths but they didn't pick that up. So, we've added additional requirements that these systems are also treated as surveillance or intelligence systems, that you just don't collect the data but you look at, you know, are there patterns emerging here, is there a higher infection rate on this ward than that ward; are there more complaints coming out of this unit than that unit?

The systems are definitely improving but, you know, if I was to compare it to a system, for example, the worker health and safety legislation system and the incident reporting arrangements there. Now, admittedly that's been running for a lot longer; it's got superb intelligence and in turn our complaints management system has got a way to go yet for that.

MS NORTON: Can I ask you another question about that. You talk in your statement and I think you made reference to it before that you've done some further investigations into the safety reporting and learning system which is the incident management system that's used at the LGH. Is that a system that you're familiar with in (indistinct) terms?

ADJUNCT PROF PICONE: Yes, I can, and in many respects the system itself in Tasmania and also South Australia, because they collaborated building this system, is a leading edge system, so that's a good thing but it's, what are they then doing with the information as it comes out the other side?

So you've got two things going on here: what's happening between us and the individual, you know, where something's gone wrong or there's been a complaint made, but then there's the broader surveillance information that's coming out of the system, and that's what we've been concentrating a lot of our efforts on over the last two or three years.

MS NORTON: What are the key ways that those surveillance activities can be undertaken in a hospital environment? Is it an IT fix, is it a human review or a bit of both?

ADJUNCT PROF PICONE: Yeah, excellent. It's an IT fix. So, the Health Service has to invest in purchasing these IT systems, because they've got to be easy to use. You know, if the nurses are putting it in - the systems were so bad five or six years ago the nurses would say to me, "I just got it all in and then the screen would refresh and I lost the whole thing, so I just couldn't stand it", so then they'd only put in one line. So, they've certainly done that in Tasmania, they've really invested in it there.

When the entire system is not doing as well as we would want it to do is then what I call the surveillance; you know, when you group all this data over a quarter or a year, what's coming out at you, what is it telling you? Have you got high infection rates, have you got a lot of the patient forms? You know, is there a particular issue in one ward? And that's generally done probably from the Nursing Unit Manager, department head, head of Allied Health, and going up into the management group and then going right up to the board, and the board should be questioning those data, in my view, every couple of months.

MS NORTON: Thank you, Professor Picone. You've just given some examples about the types of incidents that might be reported in SRLS or an equivalent system and you've referred I think to infection - some clinical events. Is it your evidence that the SRLS system is also appropriate for reporting concerns about inappropriate behaviour of a

colleague?

ADJUNCT PROF PICONE: Absolutely.

MS NORTON: Grooming behaviours, for example?

ADJUNCT PROF PICONE: Yes, everything should be recorded in that single system, and it is there, but in places where there's been a major failure where we've really let the community down, the Commission's often invited in to look at these issues. We find two things have gone wrong: (1) they're not interrogating those systems enough, they're not picking up the trends. They might know this information for two years but for some reason or other they haven't put the governance systems in to do that analysis, or they haven't picked up the risk.

Now, I know people find this hard to believe, I still do after all these years, it's beyond my comprehension, but it does happen. It's unacceptable, it's a complete failure really, because you do have the information now and it is telling you that something is going on, so certainly those - as I read that history, those, you know, numerous reports about the nurse, that was a trend; even though it might have been over a long period of time, it was still a trend, and what I don't understand is why it wasn't either picked up in that system or its predecessor or just in the basic HR system.

COMMISSIONER BROMFIELD: Professor Picone, on the HR system, we did see in this event a number of allegations of boundary breaches in patient care being recorded and handled in the HR system. Would it be best practice for any boundary breaches in relation to patient care that are handled by HR to be recorded in both the personnel file and the SRLS system?

ADJUNCT PROF PICONE: It should be recorded in the - it's an incident, it's a clinical incident; in this case, you know, criminal, affecting the welfare of a child, it should have been recorded in there.

Now, this is also one of the other problems, I'll just give you another example. With the Bacchus Marsh issue, for some reason or other on their protocols, you know, their policy statements, they didn't include the unexpected death of a neonate in all the things you were meant to

enter in, and so, they weren't entering the unexpected deaths of neonates, we had to pick it up through another data collection system. So, this is where that initial policy becomes very important. It's also important that it's updated at least annually. So, you're quite correct, that information should have been entered into the learning system and its predecessor.

PRESIDENT NEAVE: And into the personnel file as well?

ADJUNCT PROF PICONE: Oh, absolutely. Absolutely.

PRESIDENT NEAVE: Can I just understand one thing, because you're looking at incidents and trends in this system, in the SRLS system it looks at, but can you search by an individual in the current systems that are being used? So, if you had a suspicion about a particular individual, can you search by that person's name or can you only search by incidents of a particular kind: grooming, for example?

ADJUNCT PROF PICONE: They've got very good search functionality, but I doubt if a person's name is actually listed in the report.

COMMISSIONER BROMFIELD: I believe Ms Turnbull would know as she works in South Australia with the same system.

MS TURNBULL: Yes, thank you. So, in South Australia in my new role that's one of the areas I'm just investigating in at the moment, is the Safety Learning System, and I've asked a whole lot of questions. It is possible to draw out any of the data, and I'm pretty certain and can check and come back to you, that that would include the name of that person and across the state if it's come up again.

And, it is a complex reporting program that they have to write in the back end, so it's not a simple, can you just pull this out, but I am pushing forward with, I want certain reports out of that SLS system, because at the moment there's nobody that I can ascertain in South Australia that gets a routine quarterly report on the SLS to do with anything to do with Child Protection or matters to do with vulnerable children

ADJUNCT PROF PICONE: Well, that's concerning.

PRESIDENT NEAVE: Thank you.

MS NORTON: So it sounds from that evidence, Ms Turnbull, that it's important to have the IT system into which the data can be inputted, but then to also create the reports and the necessary data on a regular basis and have somebody whose responsibility it is to then monitor those reports. Is that a fair summary?

MS TURNBULL: Correct because, unless somebody's asking the question, the data will sit in the data system.

MS NORTON: Yes, and would you also agree that, in order for the data entered into the system to be reliable, staff need to understand things like boundary breaches and grooming behaviours so that the data is inputted and trends can be identified if they exist?

MS TURNBULL: Correct, and there's always a bit of confusion between what is an HR issue and what is a clinical issue, and so, it's getting staff to understand, as Deb has articulated, that the report needs to be in both HR and the SLS.

MS NORTON: And that's because boundary breaches, for example, are both an HR issue and a Child Safety issue, a clinical issue?

ADJUNCT PROF PICONE: Yes, absolutely.

MS TURNBULL: And sometimes the focus becomes AHPRA and registration and that pathway of enquiry rather than the clinical event and what's happened, so I have seen that happen as well.

MS NORTON: I want to come back to you briefly --

COMMISSIONER BENJAMIN: Before you go on, the evidence as I understand it, and I could be wrong, is that the HR department at Launceston General Hospital only have access to the system by consent. Have I misunderstood that?

MS NORTON: I think that's correct, I think they don't necessarily have routine access to complaints, Commissioner.

COMMISSIONER BENJAMIN: Do either of you see that as a problem in any way?

ADJUNCT PROF PICONE: Commissioner, I see that as an absolute problem because the data is collected, it's then, you know, pulled together; there would be a safety and quality group at the facility looking at it. It then goes up to the management team and then it goes to the board. So, why would we be excluding, say, the HR Manager having access to that information?

I'm very pleased that you've raised that because we'll have to get on top of that if that's going on, that's just ludicrous.

COMMISSIONER BROMFIELD: I believe it was at HR for the individual HR consultants did not have routine access to --

ADJUNCT PROF PICONE: I see, so they're contractors to the hospital --

COMMISSIONER BROMFIELD: No, no, their inner staff.

ADJUNCT PROF PICONE: There's some misunderstanding there about sharing of information then, Commissioner.

PRESIDENT NEAVE: I'm sorry, I should have said that they're probably employees of the Health Service rather than the hospital; I can't remember what, but they're certainly not external, completely external to the system.

ADJUNCT PROF PICONE: All right, well then, there's no impediment to them participating in the reviews of those data, none whatsoever, so, say, privacy or other concerns.

COMMISSIONER BROMFIELD: I wanted to pick up on the point, and I can't remember which of you made it now, it might have been Ms Turnbull - and I'm looking at the wrong camera, sorry. It's about, it sometimes ends up going down the AHPRA line rather than being seen as a clinical incident. I just wanted either of you to give a reflection on whether, when it goes down that employment line or the AHPRA line about registration or employment, is there a risk then that the needs of the patient and any impact on them is not addressed?

ADJUNCT PROF PICONE: There shouldn't be because the purpose of all of the boards are to protect the public from harm, just as, you know, that's the purpose of our

organisation and it's standard. But Catherine's quite correct, sometimes people use the AHPRA process as a, you know, I've now put it in that box and I'll let them sort it out. Now, that is not what it is meant for at all.

And we do have examples of some institutions that simply refer all performance concerns off to AHPRA instead of dealing with them themselves, and I have raised this - we're working very closely with AHPRA now to sort out this complaints management side, plus all of the healthcare complaints Commissioners and Ombudsmans, so that, where an institution is not carrying out its obligation to do performance reviews of staff, and the easiest way for them is to pass it on to AHPRA; that is just simply not acceptable.

We're also improving - AHPRA, in my view, are improving their processes as well. So, instead of, you know, lengthy delays for getting an issue resolved, they'll very quickly get things back.

Just to let you know that across the Australian Health System, both public and private, the performance review which is critical, often it's one of the first signs, you know, that there's something wrong in the performance of this individual. Performance reviews come up regularly as not done in about 30 per cent of institutions, and so, as I say to people, "How can you allow - I don't care how senior the doctor or the nurse is or, you know, the social worker is, how can they do their job properly if you're not giving them an annual performance review and feeding it back to them?" So, the performance reviews are either not being done because the system doesn't work, so no-one sees the benefit to it so they don't rush to it to get it done, and we think it's probably that's one of the issues, and then they start to use AHPRA as a place to send poor performing individuals

MS TURNBULL: And then, if I may, the other part to that is, the role of the manager is really important and how a manager manages the incident, and certainly in New South Wales and South Australia where I've been in charge of staff I've brought in a supervision framework document and that is to ensure that all staff are being supervised and have a supervisory arrangement in place for Allied Health, because that's been my remit in my roles, and that has been based on my clinical experience that observed clinical

practice is the safest way to ensure that there is safe clinical practice occurring because the peers or the seniors that are observing the clinical practice can comment on it.

And so, that's the work underpinning of the supervision arrangements, and as part of the supervision, of course, there is the annual performance review. However, throughout the years of my management practice it's been through those supervision monthly arrangements that incidences or poor practice or bad practice has been able to be addressed with the individual in most circumstances, not all. And, there are two or three cases I can think of where staff have ended up resigning because they've not been able to cope with having supervised practice because their practice has been inappropriate.

MS NORTON: Ms Turnbull, don't mute yourself, I've got a question for you. On the topic of training, in paragraph 67 of your statement you say that:

> *SA Health delivers two days of training each year to paediatric medicine practitioners and nurses.*

What sort of topics relevant to the matters we're discussing does that training cover?

MS TURNBULL: Well, that's around Child Protection and what their requirements are under the legislation and what they need to do in reporting.

MS NORTON: And, Professor Picone, would you agree that training of that nature, that specialist training in Child Safe Principles in paediatric wards or paediatric professionals is particularly important where you have a Paediatric Ward within a larger generalist hospital?

ADJUNCT PROF PICONE: It's absolutely essential, and not just to the paediatric staff. Just to let you know, you would be aware that there are shortages and there certainly are shortages of paediatricians and then nurses in Allied Health with paediatric qualifications, so often in these secondary units you might be lucky to have one or two nurses that actually have a formal paediatric qualification, so that's why you have to, you know, continuously do these sorts of continuing education

programs.

But it's not just designed at that unit because you've also got a Health Service whose mindset is not around children, it's around general Health Services, and you've got to keep reminding them of just how vulnerable children are. You know, people understand about vulnerable older people and frail people; I mean, we do a huge amount of work on that here, but I think people don't understand just how vulnerable children can be in an institutional setting. It's a foreign place with foreign people where we've got certain checks and balances like, you know, the Working With Children and all of that, but it's a place, you know, where these predators know that, you know, there's opportunities for them, I have no doubt about it: I've seen it.

COMMISSIONER BENJAMIN: Could I ask both of you to raise another issue which crossed my mind. Over the last week or so we've heard evidence of some senior nurses and/or senior social workers often with many years experience leaving the system because they found or they said they found it impossible to work in and there were never any exit interviews. Is that a general practice and is that best practice, do you think?

ADJUNCT PROF PICONE: It's worst practice that you could possibly imagine, sir, and you would expect an exit interview; many organisations have them very structured and then others have it by way of a conversation, you know, "Is there anything that you want to say to us?"

We have to remember that the last few years have been the most difficult that we've ever experienced in the Health System because of the pandemic, and regardless of what we don't read in the newspapers anymore, it is still extraordinarily difficult out there and it's just got too much for a lot of people. These are extraordinarily demanding jobs and roles that require highly skilled people doing, you know, the most complex work. So, for us to let such a valued person and someone who's made such a contribution leave the place without just hearing back from them is very poor management practice: very poor.

MS TURNBULL: And I would like to add to that, that I've often wondered about the exit interviews and the reason why they don't get done, and I have landed on the thought that

a survey or something that is a bit more removed from the one-on-one conversation between the manager and the person who's leaving, because it may well be that they're leaving because they don't like the environment, they don't like the team, they don't like individuals but they don't want to say anything because they work in such a small field and that it may limit their opportunities elsewhere.

Whereas, if there was a mechanism for an exit interview to be, you know, uploaded into an SLS system, for example, where there were set fields that could actually have data drawn from them, then perhaps we'd get more people doing exit interviews and doing them more honestly.

COMMISSIONER BROMFIELD: Ms Turnbull, just reflecting on your experience, is that concern about future opportunity and giving honest feedback something that you felt was more pronounced in South Australia as a small jurisdiction than in New South Wales?

MS TURNBULL: No, it's usually profession-based within Allied Health at least and I suspect probably Medicine, because you are part of a cohort that is usually pretty well-known to each other, at least at a senior level, so if you're a newer graduate coming up through the ranks then the people above you all know each other. I wouldn't like to comment for nursing, I'm not as familiar, but perhaps Deb could comment.

ADJUNCT PROF PICONE: Exactly the same, exactly the same views for nursing. There is one thing that we've done over the last three or four years, and that's required the introduction of what are called Safety Climate Surveys and, you know, I always used to be highly amused when I was at a board meeting, that we'd be chattering away and we were either doing very well or very bad based on those shocking KPIs that we were given, and quite meaningless really to an individual patient, but anyway that's life, I did it myself when I was Director General so I shouldn't complain. So, I used to always say, if we had the staff in the room they'd just crack up laughing.

So what the Safety Climate Surveys do is, it does give the staff an opportunity to anonymously, you know, give a view, there's about 12 key questions on what they really think is going on.

Now, an organisation that is strong is one where there's not a big difference between what the governance group is saying and thinking and what the staff on the shop floor are saying and thinking. Where there's a really wide gap, that is one of your early signs that there is an issue in this organisation with culture and governance generally.

MS NORTON: Professor Picone, can I pick up on your reference there to the governance group. What's your experience about governance groups within hospital organisations in this country and what are the governance structures that you consider to be important to accountability in hospitals? Is a separate board necessary? What are the models and what works best?

ADJUNCT PROF PICONE: So, our governance, you know, which is just simply sort of the rules and the systems that you have in place to ensure good patient care, and obviously clinical governance is a subsection of that, is quite leading edge compared to, say, the US.

So, in the United States you never hear the word "patient safety or quality", I'm told, mentioned at a board meeting because they've got a bottom line issue there, it's a private system and they've got to keep the system operating.

We also have a very big private system in this country, it's an outstanding system, but there is not a board or a governance group in this country that does not discuss at their board meeting, because we've required it, but many of them were doing it before, they must have a discussion about safety and quality and they must have a sub-committee that just concentrates on that.

Now, the question of boards themselves: I used to be concerned that we would get a group of highly qualified, well-meaning citizens, form them into a board and give them - put them in charge of a technically insolvent organisation, and then we would apply private sector principles to the running of that board. You can almost see the craziness of it, because a lot of the public sector organisations are hanging on, you know, sometimes by a margin of 1 per cent but often are actually experiencing financial difficulty. That becomes a real issue in public administration, in my view.

I'm not a fan of boards for every small hospital; I think that creates very serious governance and clinical governance issues. I think the boards and the legislation that we've got around the operation of our boards in this country at the moment is probably as good as it's going to get, but it is far from a perfect system, if I can say that to you.

I am a very big fan of community-governed boards that are concentrating on patient care and other matters; it's the financial and fiduciary risk in other areas that are extraordinarily difficult.

So I've worked under two systems. I was Director General at - New South Wales had the very first board at Sydney Hospital, and it continued on for years, God bless them, and they were very experienced and knew how to terrorise the Minister and the head office, they were very effective at it. And then there was a period where we lost confidence in boards mainly because of the Campbelltown issue and then we removed all boards and replaced them with community councils and then boards were reintroduced.

So, when I was Director-General everything came, the whole 140,000 people in the 230 Health Services came directly into the department. I think that was too much centralisation, so it's just a matter of getting a fine balance. When you've got Parliamentary counsel drafting the legislation you've got to be sensible and you can't give these boards undoable jobs, and at times they are given undoable jobs.

MS NORTON: Professor Picone, you said in your response a short time ago that you're not convinced that a board is necessary in all cases for a small hospital. What do you think are the alternative structures that can facilitate good governance in a smaller hospital in the absence of a board?

ADJUNCT PROF PICONE: Victoria has maintained all of its boards, so every single little hospital has a board, so that's one extreme, and they seem happy with that system, and I can't really - I've never been asked to review it or look at it so I can't comment any more than that.

In New South Wales the boards were created so that there was a group of hospitals and Health Services,

community health, primary healthcare all grouped in under one board and then there was a series of clinical networks established.

So, I think in Tasmania we originally had three, and then I think we're back to one, and the idea is, it's the clinical networks that you're working on, it's the services that you're providing. If you take it from, what does the community need, then you can take it up the food chain to decide what should the governance look like. So, in that case one board would be quite, in my view, for Tasmania would be quite sufficient. And then you would have a local community council and also a clinical council.

MS NORTON: Thank you. I'd like to ask you both some questions about practices on the ward floor that can help make children safer. Firstly, I'd like to ask you about chaperone policies and I understand they are one measure that can enhance child safety in hospital environments.

Professor Picone, you referred earlier to workforce pressures presently and in particular in the last two years. I'd be interested to hear from you both in terms of your views on chaperone policies, when you think a chaperone is essential, and what can be done in circumstances where as a matter of practicality workforce constraints just don't allow for chaperones in all circumstances?

ADJUNCT PROF PICONE: So, I have never been a fan of a chaperone service to manage a clinician that has known to have some form of aberrant behaviour, so they've already been reported to the board or they've been before a tribunal and the way they deal with it is, they say then, "This doctor or nurse must have a chaperone with them", it doesn't work, I've never been a fan of it, I think it's a real cop-out in any event. It's interesting, when you put more community members on these tribunals, they never recommend a chaperone.

Now, as far as clinical practice is concerned it is essential if you're doing intimate procedures, particularly on children, and also in my view older cognitively impaired people or people that may have an intellectual or some other disability, you must have two people there: that's the end of it. There are very good safety reasons for it. Now, often the nurses will complain and they have

complained to me bitterly over the years that it's ludicrous. You know, "Deb, why do we need to do that? You know, we're just doing a dressing around the thigh, or we're putting a catheter in or doing something else". You need to do it to protect that child. So, those policies are very well enunciated by the hospital; once you work them in the work practice they go in. Do people do workarounds when they're really flat out and, you know, two people call in sick and you haven't been able to get relief or the ward's on its ear? I would hope that they think twice before they decide to do the workaround, which is, I'll just nick in and put this catheter in because the place is really busy. We've got to explain to them why it's very important to have two people there: (1) it's a complex procedure anyway, but (2) there's the safety of a child or an older or cognitively impaired or disabled person; I feel very strongly that there's a policy statement.

Do I need two people every time I pull a screen around, you know, when I'm washing somebody? Yes, I think you do. How do you get around it when you're really busy? Those are the arguments that I've had with nurses and doctors over the years. You know, someone can still check in and have a look, but you've got to have it in your mind. Clinicians will do things that make sense that will improve health outcomes for their patients, so if you can give them the logical reason for why you're asking them to do it, they'll do it. But it's difficult, it's extra work, it's another process.

MS NORTON: Thank you. Ms Turnbull, can I just ask you, staying on the ward floor, to comment on the features of the built environment that can enhance child safety within hospitals, and to the extent you're able to comment on child safe architectural design; what makes ward environments safer?

MS TURNBULL: Again, observation, so where there is the opportunity for observation, and it may even be observation of staff walking past so that room doors are kept open. As Deb refers to, you know, if screens are drawn across, sometimes you have to draw screens across, but there's auditory opportunity, you can hear the people talking through the curtain.

Where I've worked previously there have been cameras

in rooms and that's been because the staff haven't had direct line of sight, particularly in intensive care units where they're needing to see the patient all the time, and, I've never known a family complain about that or say that they want the camera turned off.

In regards to the chaperone issue, I agree with Deb, it's about having two clinicians there where it's required, where it's required both for the patient but also for the clinician. One of the services I was responsible for in New South Wales was the Pennock Services in Central Sydney or Sydney Southwest, and that service was a home visiting service for physically abused or neglected children, and always we had two go out to the home, and that really was a chaperone-type mechanism and that was to make sure that both the staff were safe and also that the children were not on their own with a staff member in their home, that there was always somebody else there as a witness.

So, I think it's just really important for safety on both sides and from a clinical point of view interestingly the Pennock mechanism turned out to be beneficial from a therapeutic point of view because one of the staff would work with the parents or parent and the other staff would work with the child. If there had only been one person going out they wouldn't have been able to do that.

MS NORTON: Can I ask a follow-up question, Ms Turnbull, you said chaperones would be available where required. Is it the obligation of the child or young person to request a chaperone or is that something that should be determined by clinicians or according to policy?

MS TURNBULL: I think, from a clinical practice point of view, most clinicians I've worked with will already have that in the back of their heads, to make sure it's safe practice. Now, that is more complicated in rural and remote areas and may not be possible, so then you need to go back to your built environment, so keeping the door open, having a privacy screen across like a curtain but having other people around who are able to, you know, at least be able to assist with this problem, and having environments that are open and friendly or different as well; not dark, closed-in dim environments.

MS NORTON: Commissioners, I'm mindful of the time. I was hoping to ask our witnesses some questions about open

disclosure before we finish. I think we have scope in our day if you're content to sit on?

PRESIDENT NEAVE: Yes, we're happy to do that.

MS NORTON: I should clarify, are you both available for another five or 10 minutes?

MS TURNBULL: Yes.

ADJUNCT PROF PICONE: Yes, Assisting Counsel.

MS NORTON: Thank you both. Professor Picone, I might invite you to talk about the importance of open disclosure as a process where something goes wrong in a hospital environment.

ADJUNCT PROF PICONE: Now, it may seem remarkable to the general community that we've even got a thing called open disclosure and that we've had to have a policy, because it does go back into the history of medicine and the other professions as well, that we often just didn't tell people what was going on.

I mean, there was a time when I used to do ward rounds after surgery and everyone would know that a person had cancer except the person who had cancer, particularly if they were a woman. So, we've come a long way, as I want to say, in the last 40 or so years that I've been working in Health.

But open disclosure is where we say to a person, something's gone wrong, something has happened that we didn't expect to happen. The best providers tell the patient immediately. So, we've all made mistakes, I'm made mistakes. I made a doozy of a mistake on a night duty shift once where I gave five people the wrong dose of subcutaneous heparin before they went into theatre. Fortunately it was a lower dose and the poor patients had to have another injection, but I just went around and told them all what I'd done, and they sort of looked at me and probably wanted another nurse. But that's an open disclosure.

But frequently in the past, it's getting better, open disclosure didn't occur or, if it did occur, it was a sort of a forced thing.

Now, every healthcare provider in the country is required, not only by our National Safety Standards but also by their own Codes of Conduct in their register to engage in open disclosure. We spend a lot of time and energy in training people in open disclosure. We're meant to provide an apology, we're meant to tell the person what actually went wrong. We must provide an opportunity for the family or the patient to ask questions, to have additional information provided to them, and then we talk about what the consequences are and how we're going to respond.

Every time I've seen a failure in the system or been asked to go in and investigate a failure the one principal feature of it is a failure to do open disclosure at the time the event's occurred. Had they done open disclosure, it would never have got into the difficulty, so there is still a small proportion of people of clinicians, and often unfortunately very senior clinicians who think they don't need to do open disclosure: it is unforgivable.

I had a very senior person in another state, we were doing a review with a very serious chemotherapy mistake, and I said to him, "I can't understand why" - there were four incidences, I said, "I cannot understand why you didn't have that entered into the clinical incident reporting system", though the nurses did, and I can't understand why he just didn't simply tell the patients, and his response to me was that, "The incident reporting system was just a system for nurses to dob on doctors". Now, seriously, if you're that regressed that far into your career and that's really your attitude, that's probably time to pull up stumps and get another job.

But open disclosure has been difficult in Health. When I first started in this job about 10 years ago - I'm retiring soon, so you'll be pleased to know there will be some fresh blood soon - I was told by the private sector and the public sector that they would not be able to meet our standards on open disclosure and now, you know, it's working extremely well. So, it's just, we sit down and we say, something's gone wrong, we didn't expect it to go wrong.

MS NORTON: One of the concerns that I understand, or the reason why practitioners might be reticent to apologise

sometimes is out of concern for medico-legal consequences.

ADJUNCT PROF PICONE: Absolutely.

MS NORTON: How do practitioners or hospital staff give an apology in a way that doesn't give the lawyers cause for concern?

ADJUNCT PROF PICONE: Well, first of all, we've worked with all the medical defence unions and they're all completely supportive of open disclosure and encourage, you know, their people to participate in it, and so, it's just a matter of sitting down and saying, "We did this". Look, some mistakes are quite catastrophic, I have no doubt about it, and at that stage everyone will be there, with no offence to the company, with lawyers queued up; but if that person who was involved in the mistake, and it's often not just one person, it's often multiple people, then the hospital should take that over and still do the open disclosure.

PRESIDENT NEAVE: Can I just follow up on that? So that's a change in the attitude, isn't it, that used to exist where the medical defence bodies would tell people not to apologise?

ADJUNCT PROF PICONE: Oh, absolutely, not to apologise and not to admit to anything.

PRESIDENT NEAVE: So the last 10 years, would you say?

ADJUNCT PROF PICONE: I'd say, when we did our last update of the open disclosure policy, which was last year, we had the medical defence unions writing to us supporting us; we obviously went and had meetings with them, and it is a complete change, and the reason for that is, it shows that the individual - people are profoundly affected by these mistakes.

I can still remember all my mistakes; you would think I would get over it, but you just can't. And so, also, we've also learnt to care for people more when the person's made a mistake; we don't - you know, we try and look after their emotional health as well where everyone's quite distressed. I've only ever met a few sociopaths in my time, you know, we don't --

PRESIDENT NEAVE: There is some legislative protection now, isn't there? Do you know about that?

ADJUNCT PROF PICONE: Yes, there is, and there's also, for many of the registries and things that we run we've got qualified privilege.

PRESIDENT NEAVE: Right, thank you.

MS NORTON: Ms Turnbull, I see you've had your hand up there, would you like to add something?

MS TURNBULL: Yes, to just maybe reflect on a few things with that question. I realise that professional social work in hospitals actually work on the premise of open disclosure in working in paediatrics, because nobody wants to see this social worker, and so, you have to start off by saying, "I am part of the team and as part of the team we're coming to speak with you". And part of what I would always have as that opening speech was informing the parents that under legislation I would need to report to the Department For Child Protection if certain information came to my attention, and that, if that happened I would inform them and let them know and we would talk through the consequences and the response and the support that they will be offered.

So, it was really that up-front disclaimer of a pre-warning, so it was being really open about, things might happen along this pathway that you don't like, but we will be open with you about it, we will talk with you about it, and we will work our way through it. So, consent is really important and I don't know that consent always improves talking through open disclosure that, if something goes wrong there is a process and that we will go through that with you, so that might be something that the Commission likes to consider.

And I certainly do reflect upon a case in the 1990s where a cardiac child got an adult cardiac dose of medication and unfortunately died, and that was in the early 1990s and that doctor forbade anybody to talk to the parent about what had actually happened, but things have changed --

ADJUNCT PROF PICONE: (Inaudible.)

MS TURNBULL: -- (indistinct words) significantly since then, thank goodness.

MS NORTON: Thank you, I'd like to invite one final reflection --

COMMISSIONER BROMFIELD: Sorry, Ms Norton.

MS NORTON: I'm sorry. No.

COMMISSIONER BROMFIELD: On the open disclosure I just wanted to check with Professor Picone: we had an instance in one of the case studies that we're looking at where there was a boundary breach, inappropriate discussion with four vulnerable adolescent patients, and that boundary breach was never verified or discussed with the adolescent patients because there was a concern that it would affect the therapeutic relationship. I just wanted to get your reflection on that.

ADJUNCT PROF PICONE: So, child sexual assault and, you know, grooming is on that spectrum, it would depend on where you had it in the system. You know, had the hospital reported it to the police and the police were dealing with it, then you've got to coordinate --

COMMISSIONER BROMFIELD: I can be more specific. It was an incident reported in the SRLS system, the allegation was that a patient had reported to one nurse that another nurse had discussed with these patients what boys would like in the context of the girls using Snapchat, and also a comment that this nurse would like to "shag Titsy the nurse from downstairs".

ADJUNCT PROF PICONE: No, I read that in the transcript. Look, I don't know if there was, in terms of an evidentiary trial, preclusion from including the parents and keeping them fully informed, I don't know enough about it, but it seems to me that, unless - it's really the police.

So, if there was a reason that it could interfere with that evidence being collected or in some way it could contaminate it later on, and you're being asked not to discuss the details with the parents, then the hospital (indistinct words). But, unless that request has been made there should be a complete open disclosure with the parents or the guardians in relation to that matter. A complete

open disclosure: this is what we've been told, this is where it's been reported, this is what we've done so far, is there anything else that you want to add to it?

The most important thing I've learnt over the years is to find out from the family, you know, the parents or guardians, what questions they've got. Often their questions and their line of enquiry is quite different to ours, and so, I always ask that at the beginning of one of those conversations, you know, "What is it that you want us to look into, what is it that you're concerned about?" And so, unless you're told not to have those discussions, you should be having them.

MS TURNBULL: Yeah, and the other thing with this question, Deb, is that there was worry about the therapeutic relationship if it was brought up with the board.

ADJUNCT PROF PICONE: Well, that's where your social worker is the expert and you'd have to get an opinion from them, but that sounds pretty Dodgy Brothers to me.

MS TURNBULL: Yeah, because certainly in my clinical experience you have to be open about those things, those poor adolescents (indistinct) --

ADJUNCT PROF PICONE: The holding of that is going to affect the therapeutic - there won't be a therapeutic relationship because the family will think you're not being honest with them; this is what causes often the first breakdown, is this withholding of information.

MS TURNBULL: Yeah.

MS NORTON: Thank you both for those reflections, I just have one final question. We've been talking about open disclosure as between a hospital and a patient. In circumstances where something has gone terribly wrong within a hospital and it causes a loss of trust within the community more generally, is there a place for a process along the lines of open disclosure on a public level?

ADJUNCT PROF PICONE: Absolutely, and it's expected, it's expected from you. So, you're often unfortunately - no, I shouldn't say that, but you're often doing it through the media but you have to stand up and say, "This has happened,

it wasn't expected, it has hurt this person, and this is now what we're going to be doing about it", and with the permission - you always have to have the permission of the patient and the family, you can't go off and do these things without their permission, "We will keep you up-to-date".

The most important thing, though, is never to assure people that it will never happen again; you just have to assure them that you're now going to put in stronger systems. But it's very hard, once you've lost community confidence, it's very hard to pull it back and it takes a lot of time. So, the best way not to lose community confidence is to be very honest from the beginning. And there's a public interest to be served: the public Health Service is there funding them, so there's a public interest in you being honest with your local community.

MS NORTON: Thank you, Professor Picone. Ms Turnbull, have you got anything you'd like to add on that reflection?

MS TURNBULL: Yes, I agree with what Deb has just articulated and, if it is in a paediatric setting, then thinking about how messaging can get through to (indistinct words) a referral.

MS NORTON: Thank you both for your time. Commissioners, I would just like to clarify one matter that, Professor Picone, you gave evidence about some time ago. You referred to being asked some questions about whether records in an incident reporting system could be altered, and I just wanted to clarify that evidence.

As I understand it, your evidence was that you'd looked into the SRLS system and whether it was possible to edit entries in that system in a way that the edits didn't show up or couldn't be seen, and can I just clarify what the outcome of that research was?

ADJUNCT PROF PICONE: The outcome of that is, yes, the records can be altered and are frequently altered from what was first recorded, but there's a record of those alterations and the original entry is never obliterated. So, then you can see the trail, because as I used to try and train new Ministers, that what you're told on the first occasion of what was the event will completely change within 48 hours, so that there are always changes, but

you've got to keep that paper trail in that system in Tasmania, which I said, as I've said to you is really one of the - probably the best in the country, that and South Australia, allows you to do that.

MS NORTON: Thank you, Professor Picone, thank you Ms Turnbull. Commissioners, I have no further questions.

COMMISSIONER BROMFIELD: I had one. Ms Turnbull, you're the Chief Child Protection Officer for South Australia for Health. I just wanted to get some reflection from you on what the benefit is in having a Chief Child Protection Officer in Health?

MS TURNBULL: Yes, thank you for that question. It is the only position that I'm aware of out of the jurisdictions across Australia and it's been in place for one year, and I'm the inaugural person in the position.

One of the major benefits has been the governance structure now within Health has an executive lead position that anybody across the Health System can come to if the systems are not working well where they sit, and Health is an extremely complex organisation.

I have had one case a month on average, and I've been keeping record of them, come to my attention because they haven't been able to be solved or resolved at the local level, and working with the Chief Executive officers and their executives for the relevant Local Health Network I then work across government and NGOs and pull together the services that are helping or need to be helping the child or young person and their families and resolve what those barriers, issues or problems might be, so that's been a major change for South Australia.

The other component is having a key person that the other agencies can come to. So, if the Department For Child Protection have a problem, they haven't really known where to go or it's been quite complex; we've got 10 local health networks, so do they go to all 10 CEOs, do they go to two of them? So, I've made it quite clear then the message has been, come to me in my role and I will help them navigate the complex Health System.

The other component that I'm very clear about is highlighting the need for Aboriginal children and young

people because we have about 35 per cent in care are Aboriginal in South Australia and the population, I think, is about 2 per cent. So, that's part of or a very strong part of my role is working with the Health Services in making sure that they are prioritising their care because, of course, there's waiting lists, there's pressure, and making sure that those children are getting a prioritised level of care because we know the long-term effects of children being either in out-of-home care or in having been part of the Child Protection System that down the track when they're in their teens and their 20s and their 30s, they have much poorer outcomes. So, my role is, I look to advocate on behalf of those children and make sure that they don't get lost in a very complex Health System.

COMMISSIONER BROMFIELD: And, Ms Turnbull, are you the person within SA Health with the responsibility for considering policies, training and looking at data with a child safety lens?

MS TURNBULL: Correct, that is right. We've just gone live today with a data system that will collect information across the three Health Child Protection Service units and we'll be able to look at that data and partner with other government agencies around that data, and then also we're looking at what the education and training program is for both the staff working in the Child Protection Service unit, and then also all staff who are seeing children who may be vulnerable or at risk across the Health System, and particularly making sure that we have succession planning as we don't have a good pipeline, and as Deb mentioned earlier on, that we're very thin on doctors and psychologists, social workers working in this space, and that we need to be making sure that we have trainees coming through and people who are interested having the opportunity to do professional development and further education to move into those specialist roles.

COMMISSIONER BROMFIELD: Thank you.

PRESIDENT NEAVE: Thank you very much, Professor Picone and Ms Turnbull, you've given us some very important information and also a lot of important things for us to think about. So, thank you very much indeed.

ADJUNCT PROF PICONE: Thank you.

MS TURNBULL: Thank you.

LUNCHEON ADJOURNMENT

MS ELLYARD: Good afternoon, Commissioners, the next session is a panel comprising Dr Kate Brady and Dr Rob Gordon, they both appear remotely and I ask that they be sworn in.

<KATE JOANNA BRADY, affirmed: **[1.51pm]**

<PETER ROB GORDON, sworn:

<EXAMINATION BY MS ELLYARD:

MS ELLYARD: Thank you. May I turn first please to Dr Brady; could you tell the Commission your full name?

DR BRADY: My name is Kate Joanna Brady.

MS ELLYARD: And your profession?

DR BRADY: I'm a researcher at the University of Melbourne where I have a PhD from the School of Population and Global Health. My research there and my PhD focus was on the impacts of disasters and what's helpful and unhelpful after disasters. I'm also the Technical Advisor for Diaster Recovery at the Australian Red Cross Emergency Services where I headed up the disaster recovery program for more than a decade.

MS ELLYARD: Thank you, Dr Brady. You have made a statement to assist the work of the Commission which is signed by you and dated 4 July 2022?

DR BRADY: Yes.

MS ELLYARD: Are the contents of that statement true and correct?

DR BRADY: Yes.

MS ELLYARD: Thank you. May I turn to you, please, Dr Gordon, and ask you for your full name?

DR GORDON: My name is Peter Rob Gordon.

MS ELLYARD: And you are, by profession, a clinical psychologist?

DR GORDON: Yes, I'm a clinical psychologist and a member of the Board of Clinical Psychologists of the Australian Psychological Society.

MS ELLYARD: You have specialised, as I understand it, in the areas of trauma emergencies and disasters?

DR GORDON: Yes, I had a role as a consultant to the Victorian Government since 1983 and to the Red Cross for emergency recovery.

MS ELLYARD: You've also done some work in Tasmania, is that right, arising from traumatic events occurring in this state?

DR GORDON: Yes. Yes, from the Port Arthur shootings and various bushfires, and the more recent ones a couple of years ago.

MS ELLYARD: Thank you, Dr Gordon. You've made a statement to assist the work of the Commission signed by you and dated 23 June 2022. Are the contents of that statement true and correct?

DR GORDON: They are, yes.

MS ELLYARD: May I start with you, Dr Gordon. Both of you are giving evidence today in the context of a week and a half of evidence about events occurring in the Launceston General Hospital which have had a profound effect on not just those most immediately affected but perhaps on the whole community, and there's been a lot of use of the word "trauma".

At paragraph 13 of your statement, Dr Gordon, you identify what we mean most precisely when we speak about trauma; could you tell us about that?

DR GORDON: Yes. The word really comes from the Greek word meaning "wound" or "injury" or "damage" and this is brought across from physical medicine where trauma medicine really relates to the medical care of people with externally caused injuries. So, by contrast, in psychology we use that to describe the damage caused by extreme events

impinging on otherwise healthy individuals, and so, it's quite different in people who have a mental disorder of some description.

MS ELLYARD: Dr Brady, you identify the term "collective trauma" as a term that might be relevant to the work of this Commission at paragraphs 9 and following of your statement. What do we mean when we speak of collective trauma?

DR BRADY: The term 'collective trauma events' is a term that's used in different types of research and practice. Collective trauma events refer to the type of events that are characterised by a shift in a community's understanding of how the world works, so there's a shift in sort of that understanding of what they understood to be true.

In 2018 the Australian Red Cross developed collective trauma event guidelines and that was based on the idea that there had been a number of incidents in a short period of time in Australia such as the events that happened in Bourke Street in 2017 in both January and December and other events that had happened around that time to provide some guidance to organisations working in them. In that set of guidelines we drew on a definition from an American sociologist, Kai Erikson, who is very well regarded in disaster research, and his definition:

> *A collective trauma event is an event, irrespective of the hazard, which results in a blow to the basic tissues of social life that damages the bonds between people and impairs the prevailing sense of community. Such events may impact things that we previously took for granted about public locations, routines and values.*

It's worth noting in the context of this that Rob was also a part of the group of people who developed these guidelines so we sort of have an agreement I think generally on these things.

MS ELLYARD: And not every event that might be regarded as a disaster or traumatic will lead to community trauma; is that right, Dr Brady?

DR BRADY: Yes, the difference between a collective trauma

event and another type of disaster, so not all disasters are collective trauma events. So, collective trauma events are those ones that they really shift something fundamentally in what you understood to be true or reasonable or predictable in the community. Some of the characteristics that we noted in those guidelines were the commonly occurring elements of collective trauma events included things like witness violence, horror, public grief, a strong sense of injustice, intense media coverage, a highly politicised aftermath, judicial or public inquiry processes and identifications with victims and locations.

But I suppose one of the key elements of that was that understanding that in some disaster events it's expectable. So, for example, if you live in a community that experiences a bushfire threat every year, that has recurrent bushfires throughout their history, when a bushfire occurs in that community it's not such a shocking thing usually; sometimes it can be, but it rarely exceeds expectations or behaves in a way that is not predictable; it might be.

But for communities who experience an event that is either unprecedented or exceeds the imagination of that community because it's not something they would reasonably expect, that's when it can become one of these.

MS ELLYARD: Thank you, Dr Brady. Dr Gordon, at paragraphs 13 and following of your statement you identify the potential differences where trauma arises from a human-caused event rather than from a natural disaster, can you tell us about the significance in that distinction?

DR GORDON: Yes, if we go back for a moment one of the defining characteristics as Dr Bradley was saying --

MS ELLYARD: I'm sorry, Dr Gordon, I'm just going to ask you to pause. I'm told that the audio has dropped out on the live stream, Commissioners, and I've been invited to pause while we see if it can be fixed. I'm in the Commissioners --

PRESIDENT NEAVE: We'll stay here for a minute, we'll see how we go.

MS ELLYARD: Pause there, Dr Gordon, hold that thought, I just don't want --

DR GORDON: You're hearing me?

MS ELLYARD: Yes. It's the live stream out to those watching.

PRESIDENT NEAVE: Any guidance on whether we should leave the Bench?

MS ELLYARD: Please bear with us, Dr Brady and Dr Gordon, about one minute more.

PRESIDENT NEAVE: Thank you.

(Pause taken.)

PRESIDENT NEAVE: I'm sorry witnesses, this hasn't happened to us before.

DR GORDON: That's all right.

MS ELLYARD: I understand the fix may take a few more minutes, Commissioners, may I invite you to stand down?

PRESIDENT NEAVE: Yes, we will, thank you.

MS ELLYARD: May I ask the witnesses, if you don't mind just holding on for five minutes, we'll see if we can get the technical issue at our end fixed.

PRESIDENT NEAVE: Thank you very much, witnesses.

SHORT ADJOURNMENT

MS ELLYARD: Thank you, Commissioners.

Thank you very much, Dr Brady and Dr Gordon, for your patience. Dr Gordon, when the sound went down I was inviting you by reference to paragraphs 13 and following of your statement to speak about the significance of traumas arising from human-caused events as opposed to natural disasters.

DR GORDON: Yes, if we just go back to the basic idea that trauma involves damage or injury. Psychological trauma involves injury to the fabric of assumptions and beliefs

and accepted sense of reality that people have.

When we have a natural disaster what's thrown in question is, it seems like the weather and nature and what is likely to happen, and these are things outside ourselves that we can prepare ourselves for and gain a sense of control even if we evacuate and so on.

When it comes to human-caused events there's a lot of research to show the traumatic effect of human-caused events are often more complex, long-standing and have a more debilitating effect on those involved because what's damaged really is the sense of other people and when we come to collective trauma it's not only other people but institutions and organisations and social values and all the things that are constitutive of our normal everyday environment, and so, the question arises, what can I trust, who can I trust, and this of course undermines the very fundamental basis for recovery, which is to be amongst trusting people with whom I can re-establish my sense of confidence.

MS ELLYARD: Thank you. Dr Brady, at paragraph 13 of your statement you observe that in your experience it's not common for organisations to know how to respond to the impacts of collective trauma; can you tell us how you've come to that view?

DR BRADY: In my experience of working with different organisations and communities after collective trauma events one of the things that I've observed is that it's not usually a core competency of leaders within organisations have these particular skillsets. You know, considering we're talking about the Commission, if you looked at, say, law firms who's probably the head of most law firms they would be very good lawyers. The people who are, you know, the head of ASX 100 companies are usually CFOs. You know, it's not a skill that's required for you to be in a leadership position, and so, one of the things that I've observed is there is a real variation in how leaders within organisations respond to these sort of events but it's very unusual when I've been asked to come and assist in my professional capacity for people that I meet to say, "I knew exactly what to do".

Now, one of the examples that I gave in the interviews that I've had with the team for the Commission was that

following the 2017 - the event in Bourke Street in January I was asked to go and speak to a number of workplaces that had either had people who were from their workplaces directly involved in the event or had witnessed the event or in some way they were caught up in it, maybe people had come into their businesses to seek shelter during it, and the variation I saw was quite stark: at one end you had people in management who were so convinced that everyone would be completely paralysed by a form of trauma that, you know, they would have to be sort of coddled, that they would be very ill, that they would be taken out on stretchers or something, all the way through to the other end where in some workplaces people were banned from talking about the event, managers were instructed to tell their team members not to talk about it if they were heard talking about it in things like common rooms, lunchrooms, were told that they had to take it outside the workplace.

And when I asked why, their response was usually that they were fearful that it would sort of trigger some sort of WorkCover claim, that it would be considered a workplace injury, and so, they wanted to keep it outside the workplace.

And what I found quite interesting was that there was this real stretch of those, you know, different experiences. There was some people who sat sort of in the middle in a more probably, I suppose - the term common sense isn't that helpful - but like in a more sort of reasonable end, but people who sat at both ends as well.

MS ELLYARD: Dr Gordon, at paragraph 18 and 19 of your statement you identify based on research that there can be some predictions made about what percentage of people might be more likely to experience severe effects of trauma and how they might be identified?

DR GORDON: Yes, that's correct. We would normally say that probably about 20 per cent of people in a natural disaster are likely to have significant trauma responses, but in a human-caused event, particularly something of the nature of sexual assault, the proportion of people directly affected who are likely to be traumatised is going to be much higher and it can be up to 100% if recovery support is not provided, that's a crucial variable in the incidents.

MS ELLYARD: And so, turning then to the question of

recovery support, each of you in your statements have given evidence about what can be understood to be best practice or the essential elements of a response to a collective trauma event.

Starting with you, Dr Brady, at paragraph 16 of your statement you identify what are the five essential elements of intervening to assist people who have been subjected to trauma; can you summarise those for us, please?

DR BRADY: Yeah, it's both just making sure that the Commissioners are aware, I don't come from a clinical background, so Rob and I are varied in our backgrounds here. But in 2007 there was a fairly seminal piece of research that was published that was referred to as the five essential elements of mass trauma, support and intervention, and those intervention points are evidence-informed and basically the point of these principles are that so many events were happening around the time of 2007 that these researchers felt that, if there was some guiding principles that underpinned different types of interventions, whether they were one-on-one interventions or whether they were large-scale sort of mass communication interventions, that they would be helpful.

Those interventions are promoting a sense of safety, calming, a sense of self and collective efficacy, a sense of connectedness and a sense of hope.

Did you want me to speak to the other principles that I referred to?

MS ELLYARD: No, that's okay, thank you for that. I might look, noting what you have identified that it's Dr Gordon with the clinical background, you identify, Dr Brady, the importance of Psychological First Aid but I might turn to you, Dr Gordon, to invite you to speak about what Psychological First Aid is and the role that it plays in assisting people after a trauma.

DR GORDON: It's a very crucial role because the state that a person goes into when they are subjected to extreme and highly threatening and disturbing events is what we call a state of high arousal. Just really, arousal refers to the overall state of energy of our mind, brain, body, emotions on so on, and in that state we know that people function out of much deeper more instinctive part of

themselves and it's in being in that state that we move into a very specialised state which is totally focused on immediate survival here and now, and it's in that state that perceptions and sensations and so on are registered very intensely, and this becomes the core of the key symptom of post-traumatic stress which is the intrusive re-experiencing as though it's happening now versus a memory of something in the past. And, as long as the person remains in arousal they will continue in this state of re-experiencing and therefore consolidating the very disturbing experiences and not feeling the fact that it's over and they're in a safe place and they're supported.

In my clinical experience I think one of the main predictors of those people, and it's considered to be about a third now in recent studies, a third of the people who get a diagnosis of post-traumatic stress are at risk of having chronic post-traumatic stress that doesn't recover, it just really adjusts.

One of the key factors in my experience is that people don't get early support. They'll often leave the situation, won't talk to anyone and they'll spend a long time trying to get control of their minds. Now, that's not recovery and that sets them up for chronic illness. So, the idea of Psychological First Aid is to have a very simple procedure that anyone can do, with a bit of training and common sense, to actually bring the arousal down and when we do that we actually bring the person out of that instinctive re-experiencing state into a more thoughtful, emotionally controlled state where they are not available to receive the emotional support of caring people around them and thereby feel it's over, I'm safe, I'm back with good people now, and that's what limits the effect of being damaged to the assumptions of what human beings are, to just those people in that situation. Whereas we see people who have a whole series of problems that go on and on, just don't know who they can trust in the whole world and this is a very essential part to sexual abuse because of the difficulty anyone has in talking about it.

MS ELLYARD: Thank you, Dr Gordon. One of the things that you say, Dr Gordon, and you mention it as well in your statement, Dr Brady, is the importance of communication. You talk about effective and timely management, Dr Gordon; you talk more specifically, Dr Brady, about the importance of communication, and you gave an example a little while

ago in your evidence about the different views that were taken in response to the Bourke Street tragedy about what should or shouldn't be talked about.

What's the significance of open communication for a community that has experienced a trauma?

DR BRADY: Are you referring to me or?

MS ELLYARD: To you, Dr Brady.

DR BRADY: Yes. So, open and transparent communication is a really essential part of making sure that people can trust the information that they are receiving and also feel like nothing further is being hidden from them.

There are a number of crisis communication models that exist, there's hundreds of them, but the one that I referred to in my statement is a commonly used one after the crises and one of the reasons I like it is, it's very simple, and it basically follows a process of organisations or people or figureheads making statements based on the idea of, this is what we know, this is what we don't know, this is what we're doing, and this is what we need you to do; and being able to repeat information as often as new information comes to light or at regular time intervals so that people who are listening to the information feel like they're getting everything that's there at the time.

Traditionally, I suppose organisations have been more in favour of saying, this is what we know and this is what we're doing, but the importance of being able to say, this is what we don't know, helps the audience basically feel like nothing's been withheld from them and that further work is being done. So, it's okay to say, there are things that we don't know at the moment but this is what we're doing about it.

The fourth step in that is around directing people to useful action. Most people during or following a crisis want to help, they want to help other people they want to help themselves, they want to help their loved ones, they want to do something productive, and so, by giving people useful direction as to what they can be doing that's helpful can help guide that energy that people want to sort of direct into helping.

One of the reasons it's really important, I suppose, to be continuously repeating information and providing as much transparency as possible is because, if you don't do that, if people feel like they're missing information, there's more information out there, that there's something being withheld, they'll still go and try to find the information; they are not going to pause and wait for you as an organisation or as a leader or as a figurehead to say, just wait for us, they're going to try and get information from all different sources, so if you can say, this is the whole picture of what we're looking at and we're going to make sure that we keep you as up-to-date as possible, it establishes some trust and rapport and it means people can feel like they can keep on coming back to you for reasonable, accurate information.

MS ELLYARD: Thank you, Dr Brady. Dr Gordon, at paragraph 30 of your statement you identify that if communication's done well then one of the things it can engender is a sense that people are being supported and that a sense of feeling supported is very significant?

DR GORDON: Yes, because in a sense the human reality of communication is connectedness; and we don't mean by communication that simple transmission of information, we mean that communication, that information is given out and that it's understood and been received, and that usually requires feedback, "Yes, I get the message", and it's that that creates that sense of connection, and this is one of the most severe areas of injury when a person is traumatised, is that they feel in a different world to everyone else. They'll say, "I feel as though I dropped in from another planet, no-one understands me". Even disaster-affected people feel that anyone who didn't go through it says things that made it clear they had no idea what they went through, so it's a very isolating situation, and we know that isolation is one of the worst prognostic features for recovery. Conversely, social connectedness is one of the greatest assets.

So, social connectedness is really directly a product of communication, the quality of the communication and also, taking up the points that Kate's mentioned, you're creating these situations where people can come together first of all from a formal situation, the management structure, and police and whoever is involved, openly communicating. I've many examples of good and bad

communication from authorities making such a profound difference in people's recovery. And then, of course, that has spread right through to helping those present and loved ones and so on to communicate with each other, which really means we've got to - and picking up Kate's earlier points about the variety of views, we've got to get it out of people's own personal prejudice or past experience, and a lot of people are frightened and reacted by closing down and, dare I even say, lawyers I think get very frightened of the danger that their clients are under and institute a system that is purely designed to protect the financial concerns of the organisation, and that usually - that means don't acknowledge anything, don't say anything, and definitely don't apologise, and these are totally at odds with the recovery priorities, but of course it (indistinct) by other groups.

MS ELLYARD: One of the pieces of --

PRESIDENT NEAVE: Commissioner Benjamin.

COMMISSIONER BENJAMIN: Some people have told us that after James Griffin died - you were going to ask that question, were you?

MS ELLYARD: I wouldn't presume to know, Commissioner, I'll defer to you.

COMMISSIONER BENJAMIN: That after James Griffin died following his arrest and charging, that members of staff at the Launceston General Hospital wanted to have a debriefing session, and in fact from time to time had some sessions but in those sessions perception of some witnesses was that they were told not to discuss, they were told they were not fully informed, there was a sense of blame for some and there was a sense that it was being covered up. Is that the antithesis of the response that you would anticipate would be the best practice?

DR GORDON: Yes, absolutely, but look, for 18 years I was the Clinical Director of the Critical Incident Stress Program for the Department of Human Services in Victoria, and we dealt with many incidents and I was responsible for organising and providing debriefings and consulting to managers, and amongst those were incidents where staff had sexually abused clients and these reactions are quite typical and characteristic of people in positions of

authority, as Kate mentioned, had never had it presented to them but part of their responsibility is their management of the collective trauma.

And anyone who works for an organisation and cares about their work has an attachment to that organisation and carries within it the values of that organisation, and therefore if a colleague acts in this way it's a direct trauma to them and their collective values, so they have a profound need to have support for healing, and we know there's a lot of research now that shows that the severity of the impact is not accurately defined by how closely involved you are. In other words, some people would be very involved, as some of us colleagues and staff members and are not severely affected and others are maybe at remote parts of the hospital and feel profoundly affected, it has to do with all sorts of personal factors.

So, I think there's a lot of misunderstanding about the nature of debriefing and the kinds of interventions that should be provided, and I think it often gets tangled up with this anxiety about legal liability, which sort of seems to dominate any large public institution. And, it'll be like telling people you can't wash your hands after there's been a toxic spill or an infection because washing your hands might be acknowledging that there's a problem. But of course, you know, we must wash our hands to actually start the recovery process. And so, the debriefing is really just to clarify the facts, bring you out of our - and help people form a framework for how they're going to work this through. So, that's very familiar, those responses that you've reported.

MS ELLYARD: Dr Gordon, there's some suggestion in the evidence that those who were resistant to the idea of group debriefings or group discussions did so because of a concern about vicarious trauma and that it might actually be a traumatising experience for people to meet together and discuss what has happened. I take it from what you've said that you wouldn't agree with that, but are you familiar with that as a suggestion?

DR GORDON: Absolutely. I would agree with it but I think it's often taken as a very knee-jerk anxiety rather than an assessment, and my first step in managing an event like this would be to sit down with the managers and other informants and find out exactly what's happened, who's been

exposed to what.

What you don't want is people who were not directly exposed to say the most visual, disturbing elements of the experience to be in a room with people who were, where that's the load they're carrying, that's what they need to talk about, that's what they need to process. So, you often have to do debriefings with different groups, but it's very important also to have open information sessions where you get everyone together and you create this structure of common understandings and all the things that Kate was mentioning.

But, no, there is a risk of vicarious trauma, it has to be assessed, but it's often overstated. Often the people who are less involved want to know exactly what happened, but of course they don't need all the really sordid details.

MS ELLYARD: Dr Brady, you touch on this at paragraph 31 and following of your statement; firstly, the significance of peer support, but also the fact that there might need to be different forms of support or different groups of people with different levels of connectedness to what's happened?

DR BRADY: Yeah, one of the examples that I offer of types of interventions are things like psychoeducation that Rob's just referred to but also support groups are another type of intervention that's pretty common after these sort of events, with the idea that you would need different ones for different types of experiences.

So, for example, people who have been bereaved in an event, for example, might need a group that is different to people who are at a workplace or who are witnesses.

I just wanted to offer, I suppose, a non-clinical perspective of what Rob was just talking about because one of the things that I hear really often around concerns around debriefing is that debriefing is used in both a lay term and a clinical term, and so, that there is I suppose confusion from non-clinicians around the appropriateness of debriefing when sometimes it's used in the clinical sense and sometimes it's used just to refer to - for an opportunity for people to get together and sort of get an understanding of what's happened and be able to say, this is what's happened to me and this is the type of support

that I need. It's one of the conflicts that we hear quite often with, I suppose, people who want to offer support but are quite worried if they've read around clinical interventions around any concerns that come up there, that use of the term "debrief" is used to mean lots of different things and I think that's where some of the confusion comes sometimes as well.

MS ELLYARD: Thank you. Dr Brady, you identify at paragraph 38 of your statement particular concerns that might be raised about small communities, and Launceston counts as a smaller community and the community of those associated with the hospital is smaller still, and certainly the evidence suggests that there's been in one sense a great deal of talk and a great deal of knowledge or perhaps assumed knowledge about what happened, and that could be a good thing or a bad thing, could it, if it's discussed broadly in a small community?

DR BRADY: Yeah, one of the things about hyper-connection is that information travels really fast and so we see that in small communities a lot, and a lot of the time it's referred to as gossip, right, and so gossip can be considered a really negative thing a lot of the time but in my experience if the information source is open and honest and transparent and robust and providing accurate, relevant information, that information can spread very fast and that's a good thing.

So, as long as there's not a vacuum of information so that that hyper-connection means that all sorts of myths and rumours are spreading but instead there is really good transparent, robust information that's coming out it means that information gets to people really quickly, and that's a good thing I think.

There are lots of examples of sort of larger more disparate less connected communities where it becomes very difficult to get information to some people in the community because they don't have formal connections into organisations or to social media or to news media, however the information is travelling. Whereas, if you have groups that are very well connected, as long as you can give good information and have a reliable source for people to come back to and that information is repeated, it's helpful.

MS ELLYARD: Dr Gordon, can I turn to you and addressing

paragraph 52 and following of your statement. One of the themes that emerges in the evidence this week and in the information the Commission's received about James Griffin and the impact that he's had on the Launceston community and the Launceston General Hospital in particular is that there's a clear sense of concern about the fact that many people were around him, didn't know what he was doing who might now feel themselves to be tainted by association or implicated in some way in the fact that the person that they knew and that the organisation that they worked for permitted these terrible things to happen.

You refer in your statement to the concept of a moral injury; can I ask you to talk a bit about that?

DR GORDON: Yes. Particularly people like nurses or other staff working in a hospital are very, of course, sort of the sense of their moral identity is the wish to care for and help people. When somebody exploits patients, particularly when they're helpless, this is totally at odds. Now, the core idea of moral injury came from work with veterans in the United States where they actually found themselves doing things, and maybe even wanting to do things that were actually at odds with their moral values, and so there was a, if you like, a trauma or a damage to their own moral sense of themselves, and this has in recent times been named by others and identified as a particular value.

But I've certainly seen this in workplaces where a colleague acts - and I'm thinking of various examples - acts, particularly in relation to sexual exploitation of clients. And, previous to this the relationships that the colleagues had with the perpetrator is usually a collegial one where they assume they're working on the basis of shared values and, I'm not sure about Mr Griffin, but in the cases that I've dealt with, that the personalities of these people is often very keen to ingratiate themselves with everybody and to draw them into a collusive sort of relationship so that they feel that they're a very good friend and so on.

And, of course, when you find out about this, then the moral injury is, how could I allow this totally aberrant behaviour against one of the principals to be happening, so to speak, under my watch or under my nose? The fact is, of course, that the people doing it would only be detected if

you didn't give them any trust at all and you skeptically scrutinised everything they did and said; but, of course, that's not the basis on which we can live and work together, we have to give trust, and that means we're liable to betrayal. The only way you can avoid that is to be, in colloquial terms, paranoid all the time and suspecting everybody.

So, this is a point that I've worked on with many people over the years in debriefings from these kinds of events, that you have to accept that the price of trust is that, if someone really intends to deceive you, they can. It doesn't mean, however, that the organisation shouldn't have robust procedures to maintain the quality of care and to fix up things that go wrong much earlier.

MS ELLYARD: The Commission's heard from a number of witnesses, including a witness today who reflected on the level of fear that they have or the loss of trust and confidence they have going into hospital or even being out in public because of the sense that their boundaries have previously been violated.

So the question then comes, and it's an important question for this Commission, of how does one rebuild community trust if, as appears to be the case here, there's been a profound loss of community faith and confidence in an important community institution?

Can I turn first to you, please, Dr Brady, you make the point that it's never too late to start that work. If, as appears to be the case here, there has been a delay and important work to rebuild trust hasn't happened straight away, what could an organisation do starting from today to begin that process of rebuilding community trust?

DR BRADY: Thanks. One of the reasons I talk about it's never too late is because I think sometimes when there has been a delay from efforts to rebuild trust from when an incident or incidents have occurred there's a sense of, oh well, it's too late now, there's nothing we can do about it we've got to move on, and I suppose one of the points I really wanted to emphasise was, that distrust will stay until we make efforts to repair it. Part of that is acknowledging that there has been a failing and acknowledging the impacts that that failing has caused and that breach of trust has caused and it's got to be quite

explicit; you know, we did something wrong, we did these things wrong, here's how we failed you, here's how we have heard that this has impacted you.

I think there has to be a willingness to ask and to be open to being asked very difficult questions and being transparent in those responses. There has to be a demonstration that the lessons that have been learned have been learned, that this is not going to be repeated, that this isn't something that's just going to keep happening. That, I suppose, the efforts of the people who have put up their hand to say, this is how it has impacted me, that the profound burden that these people carry hasn't been wasted, that there has been changes that have been made that will impact into the future.

There has to be an ongoing dialogue and it has to be acknowledged, and I suppose that will be slow. There's not one single action that an organisation is going to take that's going to change these things, it has to be a constant demonstration that change has happened and that trust is being earned again, and that's a long - it's a long, slow road and it's going to take an organisation like the hospital to be very open and very transparent and willing to, I suppose, be asked a lot of questions.

MS ELLYARD: Dr Gordon, at paragraph 56 of your statement and continuing this original medical idea of trauma as a wound, you say that one way to think about it is to think about a recovery process from an injury.

DR GORDON: Yes, and, if you like, healing of what has to be healed; what has to be healed is those assumptions that we have about a hospital and its staff, and I think it would be very important - I mean, I think the provision of a Commission of Inquiry such as this, or Royal Commission is incredibly important, that it is seen that issues are to be opened up, but at some point the community needs to have some clear statement of why this happened, what kind of changes have been made to protect patients in the future, and I think to engage the community in a process of exchange and allowing people to give expression. Now, how you do that is, of course, another matter; maybe there are various ways in which that can be thought about, but you know, it's incredibly healing for people to be able to express their anger and you don't need to do anything with the anger accept receive it, because actually the anger is

motivated by society and the fear that I can't trust the place I might need to safe my life or my children's life. And so, just receiving it and then operationalising the issues within the anger; not just responding to the emotion, sort of responding to the issues.

I would say it's going to be very important to allow the community to hear from the staff, the good staff, the people that have devoted their lives, who take care of people to the best of their ability day in and day out, because what's in line with the ideas I've said about trauma performance is that what has been imprinted is all a bad experience and the good experience doesn't create arousal, so it needs to be organised and presented.

And then the values of these staff, you know, how committed they are, and maybe have to be done carefully, not to be sort of a public relations exercise but maybe patients who have been well cared for and really value their time. To complicate the simplistic notion that it was good or bad; no, it was a bad person but we've basically got a good institution. I would also emphasise the profound roles of symbols and symbolic events. In some sense the Commission is a symbolic event, a symbol that the government is willing to have it all out, but to consider symbolic events which have to be constructed according to what is meaningful to the people involved, like getting people together even to construct a, I don't know, a memorial garden or a plaque or a piece of artwork somewhere. This has been done, I know, in Victoria in some of the schools that were places in which sexual traumas were perpetrated and where they've had various different approaches of having an artwork or a garden or something of that sort and then having an unveiling of it and then some kind of process. These are very, I think, crucial symbolic events. Not everybody one has to go to them but just has to know that they're happening.

And I think we see in disasters in a very unique way how institutions are built into the core of the fabric of the community and a very local example is Dunalley. When the Dunalley fires occurred and the community was asked, what did they want, they said, "We want our Primary School to be rebuilt and opened", and of course many of the people that were saying that no longer had children there and won't have children there but had been there as a child themselves, so we see a place like a Primary School as

having an emotional symbolic value for people that goes right into history, and this is I think even more so with hospitals, and, you know, the smaller the community the more profound the emotional meaning of the hospital and place of carers

And so, allowing the community in some managed way, probably a representative way, to participate in this recovery process is an acknowledgment that actually the hospital doesn't belong to the board, it belongs to the community and the board are administering it for the community; that would go to the core of our democratic philosophy, wouldn't it? The government is managing our community on our behalf, for instance, and these are moments where these ideas can be enacted or become the basis for the way we design a social process of recovery.

MS ELLYARD: Thank you, Dr Gordon. Can I look to you, Dr Brady, I saw you nodding during some of that. It seems to me that, without doing justice to what's being said, there's a role for truth-telling in the initial stages, perhaps also telling the good stories as well as the bad stories and then creating ongoing opportunities for people to take control of the story and be heard about what's important to them and about how they want to move forward.

DR BRADY: Yeah, I think one of the challenges that some institutions face is how, how will we do this, what will be meaningful in there, and there's sometimes a bit of a stall or a paralysis in that, and the good news is that what you have to do is ask, you have to find ways to ask what people need, ask what people are going to need from you to regain that trust and ask what sort of things are going to be helpful.

So, Rob's touched on some of the elements of symbolism and ritual and acknowledgment and bringing into that cultural fabric, but there's also other ways of doing it. In some cases it'll be things like transparency of complaints processes or, you know, how action has been taken to change and public transparent ways of being able to acknowledge that, so there's all different ways; it's not up to an organisation to determine them solely themselves, they can have some ideas about things that they could do or improve or change early on, but to ask and have that ongoing two-way dialogue knowing that this is not something that's going to be fixed in six months or

12 months or two years or five years even, that this is something that's going to have to be built on and built on and built on and it's around changing a culture of transparency.

MS ELLYARD: And presumably it's no one size fits all, there's different cohorts of people in the community.

DR BRADY: Definitely not.

MS ELLYARD: Impacted in different ways either as direct victims or as colleagues or as members of the community who once went to the hospital and each of them will have separate levels of need and separate ways in which their own trauma needs to be addressed?

DR BRADY: Absolutely, and acknowledging that something like this can be intergenerational, you know it can be people who haven't been directly caught up in these events can still be concerned about going to the hospital or taking their children to the hospital. So, it's even new people to the community, people who weren't there at the time, so understanding - you know, one of the ways that we describe it sometimes is the ripple effect of disaster. Like, you plop the stone in the middle and all of those ripple go out and out and out, so getting a good sense of what those ripples are.

MS ELLYARD: Dr Gordon, can I come back to you on that last point about the need for what I'll call a differentiated response reflecting the fact that different parts of the community have experienced the trauma of Mr Griffin and his conduct in different ways?

DR GORDON: Yes. The first thing that strikes me about that is to collect the information; probably the Commission has a lot of information about how people have experienced it, and that would be the first point around which one might start thinking about how to design a recovery process. Of course, nowadays with things like Facebook groups and so on, we've got the capacity to bring people into communication with each other around particular aspects of it, and then, as Kate mentioned, to ask "What would you find helpful?", and then, of course, then you begin to work with that but making no assumptions as to who's affected and which groups they might need to go to.

MS ELLYARD: The final message is that it can be done; the rebuilding of trust and confidence in the institution, it can be done?

DR GORDON: Any attempt to do it would be enormously important to those who have been injured and to those whose trust in public institutions have been damaged.

MS ELLYARD: Thank you, Dr Gordon; thank you, Dr Brady. Commissioners, those are my questions.

PRESIDENT NEAVE: Thank you very much that was very enlightening, very helpful, and we hope it will be helpful to the Tasmanian community and the Launceston community too, thank you.

We'll go on straight away, we won't take a break, I think?

MS ELLYARD: Perhaps I'll invite you just to stand down for five minutes, Commissioners, we'll take a change of personnel at the Bar table, but we won't take a long break, if that's convenient?

PRESIDENT NEAVE: Yes, thank you.

SHORT ADJOURNMENT

PRESIDENT NEAVE: Ms Norton.

MS NORTON: Commissioners, the final witness for this block of Health hearings is the current Secretary of the Department of Health, Ms Kathrine Morgan-Wicks. Before I call Ms Morgan-Wicks into the witness box I would like to briefly explain the approach to be taken in this session.

Following the unexpected adjournment of hearings on Friday, Ms Morgan-Wicks's substantive evidence in relation to the Health case studies has been deferred to the final week of hearings in August.

As a result, our victim-survivor and direct experience witnesses will need to wait a bit longer to hear the evidence of Ms Morgan-Wicks along with Dr Renshaw and possibly others as well.

The Counsel Assisting team made the application for an

adjournment to ensure we could obtain the best possible evidence to support your conclusions.

In recognition of the courage and determination that witnesses have already demonstrated before the Commission, as well as their contribution to these hearings and also the fact that Ms Morgan-Wicks has been present during each of the seven days of Health hearings, your Counsel Assisting team has decided to call Ms Morgan-Wicks to give evidence this afternoon by way of reflection on the Health hearings to date.

My examination of Ms Morgan-Wicks this afternoon will not be forensic in nature. Difficult questions as to Responses to Child Sexual Abuse within her department are for another day. Instead, I will invite Ms Morgan-Wicks to reflect on the evidence that she has heard and the things she has learned over the past seven days.

Following Ms Morgan-Wicks's evidence I will give a short closing summarising the key themes arising from our evidence, including concessions given by witnesses from the LGH as to the systems that failed to protect children in the care of the Tasmanian Health Service. I will also foreshadow matters that will be the subject of further investigation over coming weeks.

I'd now like to call Ms Morgan-Wicks into the witness box.

<KATHRINE LOUISE MORGAN-WICKS, sworn: [3.14pm]

<EXAMINATION BY MS NORTON:

MS NORTON: Q. Ms Morgan-Wicks, if I could just ask you to state your full name, professional address and occupation, please?
A. So, Kathrine Louise Morgan-Wicks, Secretary, I'm a lawyer by trade but Secretary of the Department of Health, and my professional address is 22 Elizabeth Street, Hobart.

Q. You're the current Secretary of the Department of Health and is it correct that you've held that role since 1 September 2019?
A. Yes. By memory I thought it was 2 September, but 2 September 2019.

Q. The 2nd of September, and prior to that it was Mr Michael Pervan who was in the role for over five years?
A. Yes, it was Mr Michael Pervan; I would need to check his exact, but that is my understanding.

Q. Thank you. Ms Morgan-Wicks, you've prepared a number of statements in response to requests from the Commission of Inquiry and most recently you prepared a supplementary statement dated 30 June 2022; is that correct?
A. That's correct.

Q. And, have you recently reviewed that statement?
A. Yes, I have.

Q. And, to the best of your knowledge and belief, is it true and correct?
A. Yes, it is.

Q. Thank you. I think you swore or prepared that statement after the first four days of hearings - sorry, first four days of evidence, and you've attended the hearings for the following three days; is that right?
A. Yes, that's correct.

Q. The evidence provided to the Commission over the past week and a half has been confronting in the extreme. I'd like to begin by asking what hearing that evidence has been like for you as the Secretary of the Department since 2019?
A. And at this point am I able to make a general reflection?

Q. I'd invite you, yes, a general reflection, thank you.
A. So, I have been asked as Secretary and head of the Department of Health to provide a general reflection but a personal reflection to the Commission of the evidence presented in the Commission of Inquiry Health hearings, and I have recorded this in writing as it's too important to me to simply speak off-the-cuff.

I am a lawyer by trade and to me the written word has deep meaning. I've thought long and hard about how I can express my reflection and apology and have done my best to do this, which is from my heart, and as a human being that has heard all that has been said in this room.

I have also committed my apology to writing so that it can be shared with the victim-survivors that are not here

and are yet to be heard.

I am personally horrified by the lack of empathy, humanity, and often a lack of trauma-informed approach by the department and the Tasmanian Health Service to such devastating accounts of abuse from the victim-survivors who have shown immense courage to come forward.

In addition to these victim-survivors I also acknowledge the victim-survivors that have made submissions to the inquiry that have not been called, those that have chosen to remain silent, and those that are wracked with uncertainty unaware if they or their children had been patient victims of James Geoffrey Griffin or other as yet unnamed perpetrators within our Health System.

While I've read the file notes, complaints and transcripts of podcasts, nothing can replace the significant impact of hearing directly from the victim-survivors and the staff involved, which is why I committed to attend every day of the Health hearings in person.

PRESIDENT NEAVE: Would you like a slight pause? Yes.

MS NORTON: Take your time, Ms Morgan-Wicks.
A. Sorry ... to hear it firsthand.

Often the role of Secretary is seen as one that is all knowing, with knowledge deep into many layers of complex and hierarchical systems and people or across multiple agencies. While I wish this was true, the fact is that I have learned a tremendous amount by simply sitting and listening this week to our victim-survivors, to our brave staff that have come forward to report their concerns and to the staff that I have had many dealings with, that perhaps I did not ask the right questions or provide the right guidance to, to ensure that a matter was properly dealt with.

I have had many, "I wish" moments this week: I wish I had done, I wish I had asked more, I wish I had dived deeper, I wish I had known X detail and acted earlier, and I'll take these learnings with me for the rest of my life.

I am personally devastated by the lack of care or supports offered to victim-survivors at the time they

reported abuse, the lack of proper procedure or protocol to record the account or keep records, and the lack of relevant training on interviewing and investigation and detection of grooming and the abuse of a child.

From the evidence and from my conversations with several witnesses, including staff that have come forward to report, they all share a common story of feeling fobbed off, their abuse minimalised, or their complaint ignored and they did not feel supported in relation to the serious harms or incidents they reported.

This is wrong and an absolute failure by our Health System for which I am deeply sorry. I am personally so very sorry to hear these accounts, for the failure by the Launceston General Hospital and department to properly respond at the time, and for our inability to detect indicators of abuse by reason of human error, a lack of training, a lack of leadership or accountability, a reported lack of knowledge or awareness of even the most basic signs of grooming behaviour made worse by unconnected or siloed systems despite the red flags or signs.

I apologise for the failures of the Department of Health, in particular by the Launceston General Hospital and the Tasmanian Health Service, and I commit to making large-scale change to ensure any complaint of child sexual abuse or other such serious misconduct by an employee, volunteer or contractor, is independently reviewed and acted upon in a trauma-informed and proper investigatory manner, and all prior complaints, substantiated or unsubstantiated, are reviewed each time a new complaint is received.

I have spoken with each victim-survivor or their family representatives that attended the hearings to provide their brave accounts to provide my personal apology on behalf of the Department of Health and I asked our victim-survivors, should they wish to be involved in implementing this large-scale and long-term change. Should any other Health victim-survivor wish to speak to me or to be involved, please contact me.

While my words alone will not heal the hurt of all those who have suffered, nor will words alone comfort those who will never know if their children were victims, I'll do my very best to lead Health to right the wrongs of the past

so that no one in Health now or our employees of the future will ever forget the reasons why we must place the safeguarding of children and vulnerable people at the centre of our care.

Q. Thank you, Ms Morgan-Wicks.

PRESIDENT NEAVE: Thank you, Ms Morgan-Wicks.

MS NORTON: Q. I'd now like to provide a brief précis of the evidence of each of the victim-survivor witnesses, focusing on their experience of abuse and the impact that it has had on them. While the paths of all these witnesses have intersected with the LGH, I do acknowledge that not all victim-survivors were patients of the hospital.

I'll begin with Mr Ben Felton, our first victim-survivor in this block of hearings. Mr Felton was sexually abused by a nurse at the LGH in 1989. He disclosed the abuse to his parents the next day and describes the disclosure as having shattered his family.

Mr Felton gave powerful evidence about his unsuccessful attempts to raise his abuse with the LGH both at the time it occurred and in more recent years. Despite the passage of time, the abuse he suffered has stayed with him in graphic detail, and I'll quote directly from Mr Felton's evidence:

I could draw this out minute-by-minute of the day: the recollection, the smell, the room, the colours on the wall, every little piece, even the deodorant that that paedophile was wearing.

You would also have heard how painful and damaging Mr Felton's subsequent interactions were with the department as an adult. He said:

If I received the help when I asked for it in 89 and when I asked for it again in 2003 I don't think I would be this broken person.

I'd like at this point to invite you to offer any reflection that you have on the impact that Mr Felton's abuse has had on his life and the importance of supporting

patients who make disclosures of abuse.
A. To Ben Felton, the terrible hurt that you suffered as a boy in 1989 and the lasting and devastating impact that this has had on your life and on your family's life will stay with me forever.

You kept coming back to Health to ask for an apology and for help and we failed to provide you with either. On behalf of the Department of Health I thank you for meeting with me and I am so very sorry that we failed you.

Q. Next I'd like to refer to the evidence that Mr and Mrs Duncan gave on behalf of their daughter, Zoe, who has very sadly passed away.

Zoe disclosed that she had been sexually abused by a doctor in the LGH Emergency Department in 2001. She was 11 years old. Despite Zoe's immediate disclosure of her abuse the response of the hospital and other agencies was characterised by delay and a willingness to believe the denial of Dr Tim even in the face of Zoe's incremental but consistent reports of abuse and her evident and escalating distress.

Zoe's father, Craig Duncan, described the impact of her abuse in the following way:

Anne and I didn't have the same daughter anymore. The girl who went into the hospital was not the same girl who returned home. I would describe Zoe as having had a complete change of personality. Zoe died at home in 2017 having vowed never to return to the LGH for care.

I again invite you to reflect on the evidence in relation to Zoe Duncan.
A. To the memory of Zoe Duncan, to Mr and Mrs Duncan, and also to Amanda Duncan, you have waited a long time for Health to believe, and let me say that as the leader of health, I believe. I am very sorry for what you have gone through for so many years to re-tell Zoe's story. I offer my deepest apology to you for our failure to hear what Zoe tried to tell us and which she ultimately revealed through incremental disclosure to her trusted parents and family.

We must ensure that all child victims reporting

assault are sensitively treated in a trauma-informed and expert approach and that there is no defining limit to disclosures. May Zoe rest in peace with her memory living on through the enormous effort that you've each gone to right the wrong done to her, and I'll never forget Zoe's story.

Q. Next we received evidence from Kirsty Neilley. Ms Neilley was a frequent patient on Ward 4K as a teenager. James Griffin cultivated a relationship with her, sending her text messages, being attentive and calling her "baby-girl". At the time she thought it was nice to have his attention and to feel like someone loved her. As an adult, however, she has come to see that the relationship that Griffin cultivated with her was inappropriate and wrong. She wonders why the adults around her did not pick up on the signs and notes comments that he had photos of her - I withdraw that. She also gave evidence that Griffin's comments that he had photos of her, though they seemed innocuous at the time, now concerned her greatly.

She said in her evidence:

I feel like there are a lot of red flags that people could have picked up on. Obviously, something was picked up on because there was a complaint. I feel like I was really let down but nothing actually happened.

What reflection would you like to offer in respect of Ms Neilley's evidence?
A. To Kirsty Neilley: Kirsty, while I did not have the chance to talk to you in person yesterday, may I say that you had tremendous courage to tell your story of grooming within the hospital ward, and again the red flags that should have been obvious to us and acted upon.

I apologise for what happened to you and that you are now forced to look back and question what might have occurred given the escalation in grooming behaviours perpetrated by Griffin. What he did was wrong and we should have done more to escalate our concerns and take action against him and, for this, I am very sorry.

Q. This morning the Commission heard evidence from Angelique Knight. Ms Knight was a patient of Ward 4K from

the age of 4 until she was 21. She first met Mr Griffin at aged 14. He would regularly touch her, hug and kiss her, wash her, have sexual conversations with her, invite her on trips away, and ultimately he sexually abused her.

During her time on the ward she said:

Staff would say things about Griffin's behaviour but nobody did anything about it.

She talked about how she felt shamed and unheard, that there was no support offered to her. She also spoke of the importance of speaking up about child abuse and what happened on Ward 4K.

A. To Angelique Knight, as I spoke to you, Angelique, this morning I reconfirm my deepest apology to you for the harm you have suffered that started inside the walls of our hospital and continued outside.

I am so very sorry that you have felt like a number in our system and not supported by my department to help you to report Griffin's offending. I absolutely agree that all victim-survivors should have the right to report the offending regardless of whether the perpetrator is alive or dead and that, by trying to silence victim-survivors, we do not know the full extent of what has happened.

You have been so brave to come forward, particularly with your serious health issues, and I'm committed to working with you to find a better way to support you to attend the LGH or elsewhere to receive the care that you need. I welcome the input of all victim-survivors known to me in relation to that in supporting receiving the healthcare that they require.

Q. I'm now going to summarise the evidence given by two witnesses in week 1, and I do so mindful of the fact that Ms Morgan-Wicks was not present when these witnesses gave evidence. I'll summarise their evidence which does relate to the LGH and then invite any reflection you may have on it.

Beginning with Kim and Paula. You may have been briefed in relation to an account that was heard in that first week of hearings from a mother, Kim, regarding her daughter Paula. I should note that those are pseudonyms.

Kim told us that Paula had experienced abuse while at school from a teacher. Struggling with anxiety and an eating disorder, she was admitted to Ward 4K and cared for by a familiar face to her family, Mr Griffin. Paula struggled for many years and passed away far too young.

After her death, Kim read about Mr Griffin's abuse in the paper. She told the Commission:

> *Oh, it just made me feel so ill and then I - all these thoughts raced through my head that maybe these things, these terrible things, had happened to Paula and she'd never spoken about them, and maybe this attributed to all of the issues that she had through her life.*

Kim is left not knowing, never knowing, if James Griffin harmed Paula.

The second witness in week 1 who I'll refer to was Tammy Donohue who spoke about the experience of her daughter, Lillian. Ms Donohue is someone who is reliant on the Tasmanian Health Services as a single mother of three children, including Lillian, a young woman with quadriplegic cerebral palsy.

Lillian was admitted to 4K. She has challenges communicating with people but is generally able to do so via gestures. Her attentive mother is able to read her needs and emotions closely, although she told the Commission that doctors and nurses at LGH made little effort to do so.

She described observing an injury on Lillian's vagina under thick layers of cream despite this not forming part of her treatment. Ms Donohue observed Lillian's escalating distress. She raised concern at the time and asked that male nurses not attend to Lillian. She gave evidence that her concerns were not taken seriously.

She told us that Lillian does not like going to the LGH and starts yelling as soon as they go through the doors. She added:

> *That's why she'd rather go to Hobart now than LGH despite the distance and*

inconvenience.

Now again, mindful of the fact that you weren't present for that evidence, I'll nonetheless invite you to offer any reflection you have on it.

A. And I note that I reviewed the transcripts of the evidence.

To Kim first and to the memory of your daughter, Paula: your bravery in coming forward to tell your daughter's story of being a long-term patient in the LGH Ward 4K is significant. You are the voice of the parents in Launceston and surrounds who simply do not know.

I am so very sorry that you now live with this uncertainty and, if there was any way that I could try on behalf of the Department of Health to offer comfort for this, I would.

I apologise to Paula and to you, Kim, for having to carry this trauma on stop of your grief for the loss of your daughter.

To Tammy Donohue and her daughter, Lillian: as Lillian's mother you knew that something was wrong and that Lillian was significantly distressed in attending the LGH Ward 4K. You tried to tell staff of your concerns and that you and your daughter were not treated with dignity or respect and these concerns were not acted upon.

I apologise to Lillian for the harm you have experienced and continue to do so for these visits and your personal bravery and effort to communicate this harm to your mother.

I also sincerely apologise to Tammy and I thank her for sharing her story with us so that we can directly learn from our failings to respect the concerns raised by a very vulnerable patient.

I will reach out to you to talk about the additional supports for Lillian in attending a public hospital to receive healthcare.

Q. The Commission also heard evidence from Ms Tiffany Skeggs. Ms Skeggs was abused by Mr Griffin over an extended period. While she was not a patient on Ward 4K at

the time, she would visit James Griffin at work. Other staff had reported seeing her on the ward from time to time.

She gave evidence that Griffin started grooming her when she was 11, and I'll quote again from the transcript of Ms Skeggs's evidence:

> *His grooming processes were textbook perfect. I speak to anyone about his grooming process now, and including experts in their field and others, just whether they're other victims or regular people, and as soon as I say any kind of his behaviour, like even down to just the reassuring touch on the shoulder, it's all - immediately they responded to me and they're, like, "Well, of course he did". And initially when I was having those conversations I was like, "What does that mean?", what does "of course he did" mean? But there was nothing that he did that, if you go and read all the textbooks that have been published on grooming, he did every bit of it and he mastered it.*

I'd invite you to reflect on Ms Skeggs's evidence and what it says about the dangers of grooming behaviours?
A. To Tiffany Skeggs: Tiffany, while I recognise that your trauma began outside the walls of the hospital I apologise to you for the Department of Health's systemic failures to properly act on previous complaints to us regarding James Griffin.

I also apologise for our failures to recognise the signs of grooming and the red flags that were so strongly appearing in our hospital and in the community in not questioning your frequent visits to see Griffin on Ward 4K.

I thank you for your amazing bravery in reporting Griffin and for your central role in exposing the truth of this matter. I admire you, as I believe you are a very strong female leader and, in my view, a warrior in this.

Q. Finally, I'd like to refer to one final victim-survivor witness, Keelie McMahon. Ms McMahon was abused by Griffin as a teenager in his home and on a

camping trip to the Bay of Fires. Although the abuse did not occur at the LGH, she found it very difficult to stay at the hospital with her youngest child during an admission to Ward 4K. She fears that other victim-survivors will also find it difficult to take their children to the LGH.

She said as follows in her witness statement to the Commission:

> *A whole generation of girls who were abused by Jim are going to return to the hospital with their own children. Based on my own experience I believe that that would be extremely triggering for anyone who was abused by Jim.*

I'll again invite reflection on Ms McMahon's evidence and in particular the damage done to public trust in LGH following the events surrounding Mr Griffin.

A. To Keelie McMahon and also to her mum, Annette Whitemore: Keelie, I am truly sorry for the pain and suffering that you have experienced which I heard for the first time through The Nurse podcast.

And to your mum, Annette, one of our nurses on 4K: I am so very sorry that after years of service you discovered this terrible truth and were forced to try to reconcile, without proper support from the department, your memories of Griffin as a former colleague and a friend with the reality of what he was and what he had done to your daughter.

Keelie, I want you to know that your story has made a long lasting impression on me. In particular, I will not forget your account of being on Ward 4K in 2021 with your baby son without support and without trauma-informed care. Through you, I recognise that we have to do so much more to support our victim-survivors to continue to access healthcare for themselves and for their families in a safe and supported way.

Q. That concludes my summary of the victim-survivor witness evidence. I'd now like to summarise the evidence given by current or former employees of the LGH, including employees who sought to raise concerns about Griffin with the hospital, and I'll begin with Ms Kylee Pearn.

Ms Pearn gave evidence both as a person who was sexually abused by Griffin and as someone who had tried to warn LGH that he presented a risk to children. Ms Pearn worked in 2011 as a social worker at the LGH. At that time she and her manager, Stewart Millar, according to the evidence they've given to the Commission, gave evidence that they attended a meeting with HR in around 2011 and at that meeting Ms Pearn disclosed that Griffin had sexually abused her and a friend when they were children. Ms Pearn was a social worker at the time in the hospital and was concerned about the risk that Griffin posed to patients on Ward 4K.

Despite Ms Pearn's shocking disclosure, it appears that HR took no steps in response. Mr Griffin remained on Ward 4K with unfettered access to children. Ultimately, Ms Pearn left a job she loved at the hospital just so she didn't have to interact with Griffin at work.

I'll invite your reflection on that, but in doing so I'd just like to acknowledge that, while it seems on the evidence that the meeting with HR occurred, I acknowledge that there are unanswered questions about who attended that meeting, so I'll just invite you to offer a response generally in relation to Ms Pearn's evidence and the possibility that a disclosure was made to the hospital as early as 2011.

A. To Kylee Pearn: it was devastating to hear your story and I make a sincere and deep apology for the systemic failures of the Department of Health and all agencies to properly refer and act on your 2011 complaint which you told us as one of our own employees and supported by your manager, Mr Millar.

No victim of child sexual abuse should ever feel that the onus is back on them or that they are responsible for obtaining a criminal conviction of a perpetrator before protective action can be taken to remove a reported offender from the workplace.

I want to assure you, the fact of your 2011 report was central to my recommendation for an Independent Inquiry into the Griffin matter, noting the systemic failures of the Tasmanian Health Service and the department to properly record and deal with this complaint and the fact that other agencies also appeared to be aware.

I am personally so very sorry for the way that your very first disclosure of the terrible trauma you suffered was treated by the Department of Health.

Q. I'll now summarise the evidence given by three witnesses who were former or current staff on Ward 4K.

Ms Pearn was not alone in raising her concerns about Griffin with the LGH. We also heard evidence last week from current and former nurses on Ward 4K about their experience of James Griffin as a colleague, their attempts to raise concerns over his conduct, and the lack of support from LGH management following his death.

Beginning with Ms Annette Whitemore who you've already referred to in your apology in respect of Ms McMahon: Ms Whitemore is the mother of Ms McMahon and a long-term - was a long-term colleague of Mr Griffin. She described the culture on Ward 4K as characterised by mistrust and toxicity; a culture which Griffin used to his advantage.

She described being groomed by Griffin at work in the following way:

It was like I was in a box. He was in there with this puppeteer-type thing, and now that I'm out of the box I can see little things that he did.

It's hard to imagine the betrayal she would have felt upon hearing her daughter's disclosure of abuse. This, we heard, was compounded by what she felt to be undue concern about her capacity to be impartial in her role as a forensic nurse for SAFE, a concern expressed by her manager at the hospital which ultimately led to her ceasing to do that work that she enjoyed.

The Commission also heard from Ms Maria Unwin. She said she always had an uneasy feeling about Mr Griffin and noticed his preference to care for teenage girls with chronic illnesses. In early 2000 Ms Unwin reported her concerns to her Nurse Unit Manager but was told, "Everyone has something to offer". At the time Ms Unwin believed she could not do anything because she did not have any evidence. Instead, she tried to ensure that teenage girls were not allocated to Mr Griffin.

Finally, we heard from Mr Will Gordon. Mr Gordon also raised complaints with LGH management, including via the hospital's Safety Reporting and Learning System in 2017. He did not receive a satisfactory response to that report.

Following Griffin's death he remained dissatisfied with the response of management and ultimately filed a complaint with the Integrity Commission. Of his considerable efforts to publicly expose LGH's mismanagement of complaints about Griffin, Mr Gordon said the following:

> *You know, this isn't a minor thing to be swept under the rug, this is the sexual abuse of children. At what point do we as healthcare workers, and this includes all levels of management, at what point do we brush aside our ethics and morals to cover this sort of thing up? It's just despicable, it's deplorable.*

And I'll invite you to comment again on the evidence of those three nurses and their accounts of feeling silenced and unsupported, and their role also in bringing to light the story of Griffin.

A. To our employees, to Will Gordon, to Maria Unwin and Stewart Millar, to Annette Whitemore, and may I also include Amanda Duncan as an employee that has spoken out for her sister: thank you for your bravery in coming forward as whistleblowers and for your continued efforts to try to alert the department to serious misconduct by other Health employees.

I am sorry that it has taken a Commission of Inquiry for you to be believed or for your complaints and our lack of action to be publicly known.

And to the staff of 4K, past and present, I am very sorry that as leaders and managers we did not truly appreciate the depth of your suffering in late 2019. Your efforts to talk about past complaints against Griffin and the toxicity of the culture that has permeated that ward for so long.

I hope that the steps that we have taken since October 2020 to improve your ward culture and continuing education and training will help to ensure that such a toxic environment and the cracks it creates for perpetrators and

predators to thrive in will not exist again.

We will take steps, I hope with your assistance, to embed a culture at the LGH where staff are empowered to speak up for safety and have independent mechanisms to report serious misconduct.

Q. Ms Morgan-Wicks, that concludes my summary of the direct experience evidence. I'd like to turn to the task ahead and ask you a few questions about that, if I may?
A. Yes.

Q. My first question is to ask how the experience of hearing the evidence over the last seven days will influence the way you approach the task in front of you and your department in terms of effecting systems change and building trust within the community?
A. So, the experience of the last seven days, and certainly it was incredibly important for me to be here to actually hear firsthand the evidence of the victim-survivors, of each of our whistleblowing employees, and also from my staff in relation to the way in which they handled it and in terms of the systems and the complete breakdown in terms of procedural protocol really has demonstrated the significant work that we have to do ahead of us.

And certainly for me, I will never forget these last seven days, and many people will talk to me about, you know, what I've learned in this time and in the same way that I dedicated myself to COVID and trying to protect the lives of Tasmanians from that insidious virus, I absolutely commit to trying to right the wrongs.

I don't think anything I can do can ever fix or try to repair the harm that has been suffered. Certainly, I can try my hardest to lead the department and to continuously remind our employees of why this is important. If there is an employee in Health today that hasn't heard the last few days, I wonder if you are an employee that actually wants to be a part of our future Department of Health.

If you are an employee or a member of a sports association that have heard the evidence that has happened this week, if you're an employee in any other state sector agency, I don't know how you could look past the information that has been brought forward, so we all have

our part to play, and I'm absolutely determined that we are going to try to address the wrongs that have been raised and it is going to take an incredible amount of time to do that and I absolutely acknowledge that because there is no magical switch that I can pull as a Health agency and it's going to take a significant effort right across the 15,000-odd employees that currently work for us and also out into the rest of Tasmanian Health. Because, if it's happening in terms of a public sector, I have no doubt that it is also occurring potentially for our vulnerable people in aged care, for example, and I discussed that this morning, for example, with Angelique.

Q. Ms Morgan-Wicks, you initiated a governance review that was announced and you stood alongside the Premier on Sunday. Are you able to provide an outline of what is envisioned with this review and how you will ensure that it is appropriately independent and that all relevant parties, including yourself, are held accountable for that governance review?

A. And certainly, if I had been given the opportunity to provide evidence last Friday, which unfortunately I understand could not occur, I was going to speak to my intention which I had spoken to the Premier about in the nights preceding Friday, to immediately launch a governance review of the Launceston General Hospital and of Human Resources.

And, once we got through the events of last week and also Friday morning, which I am sorry had a significant impact certainly on me to see that occur, it was very important that we did not wait any longer before announcing that governance review.

So, it's very clear to me that this is not a matter for tweaking around the edges or, if there's individual positions that need to change, for example in the LGH, this is right across the organisational structure of the LGH and any learnings that we actually obtain by talking to experts, experts in child safety, hospital administration, experts in governance and in Human Resources, that is what we need to apply and I want to focus on the Launceston General Hospital as the very first priority but I will apply those learnings also across the Royal Hobart Hospital, the North West Regional Hospital and the Mersey Community Hospital, statewide Mental Health Services and any other Health Service to which that type of

organisational review through a child safety lens applies.

It is very important to emphasise that this Child Safe Governance Review is not about picking through the past or all of the accounts that we've heard; that is absolutely the role for the Commission of Inquiry, which is why I did recommend an Independent Inquiry back in October 2020. This review is about structure and it is about the very first Child Safe Organisation's principle of embedding child safety and wellbeing right into our culture and our leadership and our governance and that this is going to be led from the top.

In terms of the independence, and I note that I thought that I was going to provide my evidence on Friday, last Friday which has now been adjourned until a date in August to be set, I actually had a conversation with Emily Shepherd, the Secretary of the ANMF last night and Emily reported to me concerns about the fact that I had not yet provided my evidence and that that was due in August and about to make sure that we do have independence in the way that this governance advisory panel conducts itself and prepares the advice to me under section 13 of the THS Act.

So, I agreed with Emily, noting that I also had to have a conversation with the Premier and my Minister that an independent facilitator and chair will lead that panel, because I haven't yet provided my evidence, and I note that, and so that that advice can be independently facilitated through meetings of that expert advisory panel which will also include staff representation and a member of each of the unions who I have spoken to and whom I understand support the fact of this governance review.

COMMISSIONER BROMFIELD: Q. Just for clarification and not to provide any indication of you, can I just confirm, will you be a member of that group still?
A. Commissioner, I would really like to be a member of that group, and I'd like to attend the meetings, and I make that because this is not a review about what has happened in the past; this is about setting up an organisational structure for our hospitals that will report directly to me under the Act. And I feel, if I cannot have an opportunity to participate in that to truly understand the wide sweeping scale of the changes that are going to be implemented, I think it just makes it that one step harder to then try and make sure that that is implemented properly

and works.

But from my perspective, if I feel that the integrity of the process or the result that they're trying to get to an advice has been impinged in any way, particularly prior to me giving evidence, you know, I'm happy to step back from that.

But certainly I have spoken to the unions about the fact of me being a member and they were supportive of that.

Q. Thank you for explaining your reasons for wanting to be a member and it does sound like, if I can confirm, it really is about wanting to be a part of that process; be embedded within it?
A. Yes, Commissioner, and if I can say it in a respectful way, that I feel that as a leader of Health I need to be part of the solution, and I don't see this as a matter where I get to sit at my desk and sign a section 13 order and hand it off to someone else to try and fix this. But if I feel I'm impinging on it I'm happy to step back from it, but I really do want to be part of that solution.

COMMISSIONER BROMFIELD: Thanks for clarifying that.

MS NORTON: Q. Can I ask another point of clarification. Will victim-survivor representatives be invited to be part of the consultation group as well?
A. Yes, and apologies for omitting that fact, and I have spoken with each of the victim-survivors after they provided evidence this week that attended here in person - I was unable to speak to Kirsty who was actually on the video link. And certainly I'm very happy to meet, and I put out the invitation to meet, in terms of talking through our intention with the governance review and for them, if they're minded to - and I understand that for some they may be done by actually coming forward and participating in the inquiry, but I would be very, very grateful for their assistance as part of an expert reference group to make sure that, despite every expert in the world that we might invite to participate, and we've heard some excellent ones here over the last couple of days who have already actually reached out, a couple of them to me so I'll be very pleased to speak to them, it needs to be reality tested and reality tested by people that have actually experienced this and people that actually know the LGH very well from having spent so many nights there at the LGH.

As an example of that reality testing hearing Angelique this morning, for example, in her suggestion of an independent person that can visit each patient at night on the wards to debrief and just check in, which I think is an excellent suggestion and certainly one that, when I've been a mum, for example, and had my daughter in hospital, it can be hours between when a nurse might come in to check on you, and I know in the old days that might have been a role that, for example, a chaplain in a religious hospital or a sister might have also done. So, certainly the suggestions that I've heard throughout the last seven days I'm very keen to talk to victim-survivors about and will be inviting them to participate in the review.

PRESIDENT NEAVE: Q. I have one question. Are you intending to include people with expertise from other parts of Australia in the review perhaps?
A. Yes, I am, Commissioner, and President, I should say. I would be very keen for us to be able to do an inter-jurisdictional comparison to find a modern and contemporary hospital that we can compare to the LGH.

I know that the LGH's structure, for example - and I spoke to the LGH Executive about this yesterday morning - has been in place for an incredibly long time. We have tinkered around the edges, particularly in COVID, for example, in trying to insert additional roles, and I really do believe that it is time for the LGH to have that complete reset, so certainly we will look to interstate comparisons and I'm hoping that our governance expert will come from interstate but I wouldn't rule out internationally, because certainly a lot of our staff I'm hoping will also come forward with their views and ideas having worked in other hospitals so that we can take that into account.

This is only going to work if they are involved also in the solution to try and reset the LGH and to restore the public's confidence to attend there.

PRESIDENT NEAVE: Thank you very much.

MS NORTON: Sorry, I do have one final question, if I may, President Neave, and that is a question really by reference to the evidence in the previous session from Drs Gordon and Brady, and that is to ask you what you think is necessary

or what you propose to do to begin, in addition to the governance review but in a more immediate sense to try and rebuild the trust in the Launceston community in such a vital public institution?

A. So, in addition to the Child Safe Governance Review, and I note that as part of that review we will be implementing a centralised complaints management unit which is separate from the hospitals and our Health Services, we will be taking the governance review, we will also consider all of our mandatory training and make recommendations although noting that our Child Safe framework and the mandatory training relating to grooming and other behaviours is already underway, so I'm not going to stop that occurring because I think it's absolutely critical but I'm happy to take suggestions from that review in relation to that training which has been developed by Child Safe.

But certainly in terms of the experts, and I have to say that I didn't hear all of the evidence of the two previous experts because I was preparing for now, but certainly I will view the transcript and I think that certainly the independent expertise to be able to evaluate, not just the governance of our hospitals, not just the training and the mandatory education that is required, their views, for example on the systems that we currently have in place; the connection that that has with accreditation and what is checked across our hospitals.

And certainly I note from some of the evidence this morning in relation to SRLS, over the last few years we have done a lot of work to be able to successfully get close to half a billion dollars to invest in our systems, so that expertise will also assist to make sure that we are going to try to eradicate those silos of information and to actually get that information and to speak also to other agencies about how we connect to their relevant systems.

I think we can also learn from experts in relation to, particularly in Tasmania, the Memorandums of Understanding, for example, that we don't have between various agencies. We have several, but certainly I have learned from this week in relation to other MOUs or other agreements about the sharing of information between agencies and I think a lot of work has to be done in relation to that.

COMMISSIONER BROMFIELD: Q. Ms Morgan-Wicks, I appreciate you didn't see the last two witnesses. One of

the things that Drs Gordon and Brady - well, they mostly spoke about - was really about the collective trauma of critical incidents and they spoke through processes for supporting community recovery as part of rebuilding trust in public institutions, particularly when trauma was caused by human behaviour rather than a natural event?
A. I thank you Commissioner for aiding me and I will review the full transcript of their evidence.

And I note in relation to a trauma-informed approach, that will be part of the training and education that we will provide in our leadership and management training, and our Health Executive, for example, has already booked into receive a trauma-informed approach in terms of education and training.

We have several staff that, as part of their own professional development, do receive that training. I think I heard snippets in relation to trauma, for example, that is suffered in a bushfire or in, for example, the terrible flooding that's occurring in New South Wales at the moment and I think systems like that swing into action, but we need to recognise that this is a critical incident, that we need to work with the community, and certainly I've had members of the community come forward to me this week to offer suggestions on how we can engage in the community.

I can't sit here now and say that I have 100 per cent of the solution, but I am very aware that there are members of the community and parents that are very, very worried that their children were impacted by Griffin, so it's about trying to restore that confidence in saying that we will reset the LGH, but I will also call for the engagement of the community in trying to restore that confidence and work with them. So, whether it's about piloting, for example, gender choice in carers that are provided to you within our hospital, or if there are other suggestions that come forward from the community, that will try to lessen the anxiety of members attending, particularly for victim-survivors. And there will be victim-survivors out there that we don't know so I need to make sure that the team at the LGH are aware of that, are alive to that and can try and support people who may feel tremendous anxiety and we want to try to reduce that going forward in the future.

MS NORTON: Thank you, Ms Morgan-Wicks. Commissioners,

that concludes the questions I have for Ms Morgan-Wicks.

PRESIDENT NEAVE: Thank you very much for your evidence, Ms Morgan-Wicks. I think that both I and the other Commissioners would agree that it was very important for you to attend these seven days of hearings and to hear firsthand from both victim-survivors and the staff of Ward 4K and the staff of the hospital generally.

We're glad to hear of your intention to focus on the future and how these terrible events can be prevented from happening again. I acknowledge that you said that this was not simply going to be a tweaking review but will look at Health Services right across Tasmania, won't focus solely on LGH but will look at other Health Service providers as well.

I was also just going to briefly refer to the evidence that you weren't able to hear, the evidence of Dr Brady and Dr Gordon about how to respond to human-caused events that have caused terrible collective trauma. It seems to me that the acknowledgments and apologies that you made in your response to counsel's reference to the various victim-survivor accounts of what had happened to them, that that acknowledgment is a step towards the notion that a symbolic recognition of what has occurred and acknowledgment of what's gone wrong and acknowledgment of what needs to be done in the future, it's a step towards that process so we're glad to hear that, so thank you.
A. Thank you.

MS NORTON: Thank you, and I'll just ask if the witness can be excused.

COMMISSIONER BROMFIELD: Sorry, I have one.

PRESIDENT NEAVE: Yes.

COMMISSIONER BROMFIELD: Q. One final question. We heard in the very first week of our struggles in being a small jurisdiction, but we also heard from one of our victim-survivors about how tight-knit small communities are also a strength and they offer real opportunity for doing things differently. And, in light of that aspiration and hope for one of our victim-survivors, I wondered if you wanted to say anything about your hopes to both the Launceston community and the staff at the LGH?

A. Thank you, Commissioner, for that opportunity. And I think we should have a lot of hope about what we can achieve. I know just from speaking to members of the community that have come forward, or to my own staff, that many have many frustrations about the way in which that hospital, whether it's the LGH, might work and in fact others. The fact that hospitals are like this, that they are handling hundreds of patients a day and doing amazing things every day, and I just say that to absolutely reflect the amazing work that a lot of our staff have done over the last couple of years in a global pandemic and to continue to provide healthcare, that they should take from that amazing work the fact that we can actually change this and that we can rebuild that relationship with the community.

We know we can do good things, I know that our Health professionals do amazing things every day, and when I make my observations today and the apology, I want them to take that into each of their hearts to reflect on it but to know that we are absolutely proud of the fantastic work they do, but we just need to do this better, and each and every single individual has to have their role to play in this. So, I'm happy to be there to help guide them to do it, but every single individual in Health has to be responsible for this.

PRESIDENT NEAVE: Thank you.
A. Thank you.

MS NORTON: The witness can be excused.

PRESIDENT NEAVE: We're going to run straight on, aren't we?

MS NORTON: We will, if that pleases the Commissioners.

Commissioners, Ms Morgan-Wicks' evidence concludes this part of the hearings concerning Responses to Child Sexual Abuse at the Launceston General Hospital, the Department of Health and the Tasmanian Health Service.

We opened the hearings by observing that it would be a genuinely inquisitorial process. We have discovered much over the course of the past week and a half but we do not yet have all the answers.

The evidence you have heard points squarely towards

catastrophic failures in the response to allegations of child sexual abuse at the Launceston General Hospital. We now propose, or I on behalf of the Counsel Assisting team, will make some high-level observations about key aspects of the evidence that you have heard over the past seven days. These observations are not exhaustive. They are made noting that our enquiries are not complete. Some witnesses are yet to provide their substantive oral evidence, other witnesses may need to be called to appear or to reappear before the Commission.

Commissioners, you have heard evidence from victim-survivors and family members of victim-survivors who have generously come forward and told their truth about deeply personal matters.

In addition, you have heard from employees at LGH who, despite fears of reprisals against themselves and their families, came forward to share their experience of a toxic culture on Ward 4K.

All of these witnesses came forward, not for themselves, but for others; for their children and other people's children to ensure that all children who seek medical care can do so without fear of sexual abuse. To these witnesses we express our thanks for their courage, integrity and tenacity.

The three case studies considered by the Commission spanned 30 years. Ben Felton and Zoe Duncan were abused by a nurse and a doctor respectively. We also have heard much of the conduct of James Griffin and the impact of that conduct on many victim-survivors in the Launceston community. Each case study covered a different period of time and involved different people and different factual circumstances. However, each raised systemic issues which showcased astonishing similarities.

First, the evidence from the executive level staff indicates that issues of concern raised by staff, including allegations of sexual assault and other inappropriate behaviour, were viewed through a clinical or disciplinary lens rather than through a child safety lens. It appears that in none of the case studies that you have heard evidence about were the interests of children the primary concern of those called upon to respond.

The second observation I would make is that executive level staff were slow to respond to issues that had been raised, that is, if those issues were escalated to the executive which is an open question. To the extent that issues were raised with the executive, they have displayed an apparent reluctance to involve external bodies and agencies.

In relation to both Ben Felton and Zoe Duncan you have heard that children were not listened to or believed, matters were not investigated appropriately, apologies were not forthcoming, and the health professionals in question continued to work and to present a risk to children right until recent times.

We will return to the specifics of these matters, however, it is clear that the responses of the hospital have exacerbated the impacts of the original offending on Mr Felton, Ms Duncan and her family - and their families, I should say. The impacts on Zoe Duncan and her family and on Ben Felton are almost unimaginable.

People might say that these matters are in the past, however, similarities in more recent experiences suggest a failure on the part of the LGH to learn from and meaningfully improve responses to child sexual abuse over time.

What happened to Mr Felton in 1989 does not seem to have led to an improved response to the Duncan family just over 10 years later. In turn, the failings in response to Zoe Duncan's disclosures and her subsequent distress does not appear to have led to strengthened trauma-informed practices at the LGH. Such practices would have led to a more empathetic response to Mr Felton when he returned to the hospital in 2003 seeking support, an apology and an explanation of what happened to the nurse who harmed him.

In both instances there were clear opportunities for the LGH to make things right but it didn't. The Duncans and Mr Felton have had to wait many years to finally receive acknowledgment that they were wronged and it's a tragedy that Zoe Duncan is not here with us to hear for herself the apology offered by Ms Lovell yesterday and by Ms Morgan-Wicks just now.

Taken together, their experiences also do not appear

to have led to the sort of improved Child Safe practices that would have enabled Mr Griffin's behaviour, inappropriate behaviour, to be identified and acted upon at the earliest opportunity.

Indeed, despite multiple red flags and a clear report from an adult staff member about abuse she experienced as a child, it was only when a victim-survivor reported to police in 2019 and Mr Griffin's Working with Vulnerable People registration was suspended that Mr Griffin was finally removed from the Children's Ward.

Turning then to the Griffin case study. The simple fact that a paedophile was working on the Children's Ward of the Launceston General Hospital for 18 years is a matter which in and of itself ought to have caused substantial concern and introspection from those in senior leadership positions at the hospital. This does not appear to have been the case, however.

Commissioners, you have heard evidence from staff on Ward 4K about a culture of secrecy, a fear of losing your job if you spoke out, and of only "yes" people being promoted. Ms Whitemore's evidence referred to "cracks in the culture of the ward". She said that Griffin would get into those cracks and communicate with people so that they thought they had his support:

> *... when there are cracks like that from what I've learned looking back, that's where they can get in and do their best grooming.*

The lack of a robust and thorough investigation into the operations of Griffin on Ward 4K over such a prolonged period is also telling of a culture that does not look out for issues, and I should say, does not look out for and then reflect on issues that arise, but is simply content to move on, preferring to talk about good news stories.

Even today, almost three years after Griffin last worked at the LGH, there are questions about the extent to which the hospital has a culture that is reflective and motivated to learn from mistakes in order to prevent their recurrence.

The Commission has heard clear evidence that there

were three pathways at LGH to make a complaint about staff behaviour: staff could make a report to the Nurse Unit Manager, concerns could be reported through a patient grievance process, or by staff logging an issue through the Safety Reporting and Learning System also known as SRLS. It appears from the evidence that none of these three systems operated in a manner that identified or analysed potential patterns of behaviour.

In evidence provided today, Professor Picone of the Australian Commission on Safety and Quality in Healthcare gave evidence that the SRLS system is a suitable system for recording complaints about boundary breaches and grooming behaviours; it is also capable of monitoring for patterns of behaviour provided that complaints dealt with in the moment are subsequently recorded and trend data is analysed.

It also appears from the evidence that there is no single central repository for complaints. This means that, if complaints or concerns were recorded, they were not necessarily consolidated in one place. This makes it very difficult to gain a complete picture of staff behaviour or to identify concerning patterns of behaviour.

Commissioners, the evidence before you suggests that Mr Griffin was the subject of multiple complaints by staff, patients, family members, and other medical service providers. It seems highly likely that the recorded complaints made available to the Commission do not represent all complaints that were made against Griffin during his time at LGH.

Indeed, it was Ms Leonard's evidence that she routinely had concerns over Griffin's physical contact with patients but this was not a matter that she, as his manager, addressed with him for some time.

Looking just at the recorded complaints, Mr Griffin was found to have breached boundaries with patients on a regular basis but he was subject to no real sanction. He was generally asked to undertake re-education, told not to engage in particular behaviour again, or on occasion warned about an escalation in the hospital's response if the behaviour recurred. These responses were taken by Ms Leonard and her predecessor in the role of Nurse Unit Manager in consultation with Human Resources and on

occasion Mr Sherring, the Clinical Nurse Educator.

Mr Griffin's boundary breaches were regular but his recurring conduct, despite the warnings given to him, his recurring conduct was not escalated for appropriate intervention; nor was it reported to regulatory bodies or any other sanction imposed other than a reprimand and re-education.

Ms Leonard stated:

I always thought that education and redirection would change that behaviour.

Despite having held that view since 2008 and having had concerns about Mr Griffin's boundary violations in 2017, Ms Leonard was unable when asked in her evidence to say when it was that Mr Griffin should simply have been removed from having access to children.

There does not appear to be a satisfactory explanation why these matters were not appropriately escalated to the executive or acted on in a more formal way prior to the suspension of Griffin's Working with Vulnerable People registration in July 2019.

Matters were also not escalated to authorities outside the hospital. Ms Leonard noted that there was a reticence to report to external agencies, including regulatory agencies, stating in her evidence:

I think that there was not an openness to engage with those regulatory bodies.

Commissioners, you also heard evidence from ward staff, the NUM and numerous executive level employees about a lack of training and understanding of reporting obligations. There was a disturbing lack of understanding of mandatory reporting requirements under the Children, Young Persons and Their Families Act.

Although it was identified that individuals had a responsibility to report, there was confusion about who from the hospital was responsible for reporting and to whom reports should be made.

Ms Bryan, the Executive Director of Nursing, said in

her evidence that she had not heard of the Strong Families Safe Kids Advice & Referral Line which, as Commissioners you are aware, is the first point of contact for child wellbeing and safety and the place to which mandatory reports ought be made.

The evidence also suggests confusion concerning when to report to professional bodies such as the Australian Health Practitioner Regulation Agency and, despite the recommendations of the National Royal Commission, witnesses spoke of a lack of training on how to identify and respond to child sexual abuse, including grooming behaviours.

Indeed, it might be said that there was a lack of recognition that the National Royal Commission's work was relevant to the hospital and might require reflection and response about its own approach to child sexual abuse.

Commissioners, in relation to record-keeping, it would be open to you to find that the lack of a robust record-keeping system at the LGH constitutes a system failing. This is most clearly demonstrated by the lack of any record of the 2011 meeting between Ms Pearn, Mr Millar and the Human Resources Department at which Ms Pearn disclosed that she had been sexually abused by Griffin who was working on Ward 4K at the time. This was a significant disclosure and there is no written record of it.

The executive staff, Ms Tonks, Ms Bryan and Mr Daniels, all claim that they were unaware of many, if not all, of Mr Griffin's boundary breaches until the podcast, The Nurse, was released. These executive staff members gave evidence that they did not, on reflection, offer proactive or visible leadership, often relying on what they were told by their subordinates, including relying on the advice of Human Resources.

Mr Daniels, the Chief Executive of the hospital, said:

... I rely very heavily on the advice from those people who manage those processes to advise me ...

It is concerning in the extreme that the executive were unaware of Ms Pearn's disclosure to her manager and the Human Resources Department in 2011, and this is particularly so given the extent to which the executive

appear to have relied so heavily on Human Resources' advice.

Prior to giving evidence at the hearings all members of the executive believed that complaints had been properly investigated at the time and they gave evidence in statements submitted to the Commission reflecting that view. However, upon hearing the evidence given at these hearings they all retreated from their original position and accepted that the complaints raised about Griffin were not properly investigated and dealt with at the time or subsequently. For most, this change of view has resulted in significant departures from the evidence that they originally provided in statements to the Commission.

The executive evidence also indicated that at each level there was an astonishing lack of proactive leadership. At no stage did any member of the executive team fully investigate what went wrong and how a paedophile was allowed or enabled to operate within the hospital on the Paediatric Ward for up to 18 years. There was a complete lack of curiosity about what led to this failure in the policies, processes and procedures of the hospital.

Even in the face of increasingly vocal staff members on Ward 4K following the death of Griffin, the executive undertook no rigorous investigation into where the failings were in the system or how to prevent their recurrence.

I will now turn to summarise the evidence of the Human Resources witnesses, beginning with Mr Harvey. Although Mr Harvey, an HR consultant, said that HR are not investigators or decision-makers, he said that they did provide advice in relation to the SRLS that was lodged by Will Gordon in 2017. Mr Harvey consulted with Ms Leonard, Griffin's manager, regarding who to interview, what version of events to accept and what the outcome of the complaint should be. He also drafted critical correspondence.

Mr Griffin's previous boundary breaches were considered by Mr Harvey and Ms Leonard but no pattern of behaviour was identified. In addition, they did not consider making additional enquiries to verify Mr Griffin's account of the conversation that he had had with patients; an account which differed from the account given by those patients to Mr Gordon.

Among the enquiries that could have but were not made include enquiries with the patients involved in the conversation or their patients in a sensitive and trauma-informed way. And, Commissioners, you will recall the evidence given earlier today by Professor Picone about the importance of an open disclosure process in circumstances such as those surrounding the 2017 SRLS report.

Under cross-examination each of Mr Harvey, Ms Leonard and Mr Bellinger, who was the HR Manager, acknowledged that the investigation into the 2017 SRLS report was inadequate.

The evidence of both Mr Harvey and Mr Daniels supports a view that, rather than focusing on child safety, responses to disciplinary matters at the LGH are primarily informed by industrial relations concerns and potential outcomes for the alleged perpetrator and the institution.

Indeed, we heard from Mr Bellinger in Human Resources that, in the face of a disclosure such as Ms Pearn's, which should have signalled an immediate risk to children, he would have sought legal advice from the Office of the Solicitor-General rather than take immediate action to remove Mr Griffin from the Children's Ward pending investigation.

Furthermore, despite the HR team not being investigators or decision-makers on the evidence of Mr Harvey, and also not having the skills or expertise to identify child sexual abuse or grooming, there was a heavy reliance on the opinion and advice of the HR team in responding to concerns of this nature.

For example, in 2019 HR was responsible for an internal review of all complaints held on the files about Griffin. HR provided assessments as to the adequacy of the conduct and outcome of those complaints.

Given that many executive level staff learned key facts from the podcast, it can be assumed that the HR review did not capture the full extent of the concerns and the complaints about Mr Griffin's behaviour.

When asked if he knew what grooming was, Mr Harvey stated that prior to 2019 he was never trained in the identification of red flags of child sexual abuse or

grooming behaviours, and the following is a direct quote from Mr Harvey's evidence:

> *I understand, limited understanding of what child grooming is ...*
>
> *From an outsider who didn't understand and didn't have training in grooming behaviours to know what grooming behaviours were, it did seem like a low level professional breach that he should - a breach of his professional boundaries - that he shouldn't have made any comment to the children at that time ...*

Ultimately the HR review of complaints was adopted by Mr Daniels in his correspondence to the ANMF in late 2019. No-one within the Tasmanian Health System appears to have made the decision to seek an independent investigation of how these complaints were handled prior to the release of the podcast, The Nurse.

In November 2017, as the Commissioners have heard, Will Gordon did make a complaint to the Integrity Commission concerning the hospital's management of complaints about Mr Griffin, among other things. The Integrity Commission determined to refer the matter back to the Department of Health for investigation and action, but the referral only led to a desktop review, again, conducted by HR. The review was undertaken by Mr Bellinger despite the HR Department having provided advice on some of the complaints under review. The review was not a full and fresh investigation, it was merely a desktop review.

Mr Bellinger conceded in his evidence that the internal review he conducted was deficient, it was not carried out in a manner consistent with best practice for a review of a serious incident and serious complaints at a hospital, and that this deficiency infected the investigation that was later requested by the Integrity Commission.

I'll note that, Commissioners, there remains an open question about the circumstances that led to the Integrity Commissioner's complaint having been referred back to the department ultimately ending up with HR, and that will be a matter that is explored in the final week of hearings.

That Mr Easton, current CEO of the Integrity Commission, noted in his evidence that he now does have some concerns about aspects of the investigations conducted by the Department of Health, including the fact that it was Mr Bellinger who conducted those investigations.

Yesterday, Mr Connock gave evidence about a review in 2005 into sexual abuse of vulnerable adults on Ward 1E of the LGH. That review found that the governance of the hospital was lacking and made several recommendations to improve governance and responses to complaints. It's unclear what, if any action, LGH took in response to these allegations.

Mr Connock in his evidence recognised similarities between the issues that he saw as an external consultant to the 2005 review and the evidence that has been provided over the last seven days. He said as follows:

> *... it looks to me from what I've seen that senior management are not being made aware of complaints being made and that was happening then; they weren't engaging internally with it.*
>
> *I should say, there was an interim period where this changed, but yeah, there were some very strong parallels between what was going on ... [in 2005, including] inadequate record-keeping, inadequate communications, inadequate support; yes, quite a few similarities but certainly not to the same degree as the Commission has been hearing in the last week.*

Mr Connock also said that the Integrity Commission complaint in relation to the management of complaints about Griffin should not have ultimately ended up back in the hands of the HR Department for investigation.

I'll turn now to the evidence of the ANMF. Unlike the LGH, the ANMF did undertake a review of its policies and processes to determine where they went wrong and how they allowed a paedophile to be an ANMF workplace representative for a significant period of time.

I'll pause to note that that review was undertaken despite the ANMF not having received any complaints itself raising concerns about Mr Griffin's conduct.

We were told by Ms Shepherd that this review has led to improvements in the nomination system for workplace delegates, training for staff, and improved focus on child safety. Ms Shepherd has also provided evidence about the confusion held by members of Ward 4K about their mandatory reporting obligations, and again, concerns about the Launceston General Hospital's handling of complaints about Mr Griffin.

Ms Shepherd said that she recommended to members that they contact the Integrity Commission because the union had taken the complaints as far as possible with the LGH with no resolution.

Like the ANMF, Tasmania Police has conducted a review of its management of the investigation into Griffin and has since made changes to its approach to child sexual abuse investigations. And, Commissioners, you will hear evidence tomorrow as part of the Justice hearings from Detective Senior Constable Glenn Hindle and Commissioner Hine.

Mr Matthew Hardy, the National Director, Notifications for AHPRA, gave evidence about the regulatory scheme in Tasmania for registered practitioners. His evidence was that any person can make a notification about a health practitioners and that in some cases, including where they form a belief that sexual misconduct has occurred, nurses and doctors are under an obligation to notify the relevant board.

Given his evidence, it is not clear why staff at LGH were not aware of their ability to make a notification directly to the board. Boards can act on notifications, including by taking steps to limit a person's practice while they are under investigation. They can also keep records of past notifications so that, if a pattern of conduct emerges over time, they can act on that pattern.

Mr Hardy said that no notification had been received about Griffin until 1 August 2019. If his behaviour had come to AHPRA's attention sooner, whether from police or a notification from a patient or colleague, the board may have been able to investigate and take action.

Mr Hardy also gave evidence that, with the benefit of the learnings from the National Royal Commission about how children make disclosures and about what the impact of sexual abuse can be, a board receiving a notification from Zoe Duncan may have been better able to investigate the doctor concerned.

Professor Erwin Loh gave evidence before the Commission yesterday afternoon. He has significant experience in clinical governance and the management of complaints and concerns in hospital settings, including in his current role at St Vincent's Hospital in Victoria. He shared his views on best practice governance, including the oversight and scrutiny that an independent board can provide over a hospital's executive team. He was clear in stating that there is no place for boundary breaches in Health and highlighted that quality of care and patient safety were clinical issues as far as he was concerned.

We heard about strategies to shape a "speak up" culture where all staff, including junior staff, feel empowered and supported to raise their concerns in the moment; this includes the Ethos Program which was developed by St Vincent's Health Australia as a messaging service designed to facilitate informal feedback at a peer level and to positively shape future behaviour. He reminded us that such programs cannot stand alone, they are but one tool to effect culture change. Cultural change ultimately requires strong leadership from the top but permeates all levels of a hospital to ensure a shared focus and concern for patient safety and wellbeing.

Your last witness yesterday was Ms Lovell, Executive Director of Children and Family Services. She provided evidence about the role of Child Safety Liaison Officers within hospitals. Their role is not to receive notifications or investigate complaints, but to act as a conduit between Child Safety Services and hospital staff, for example, by advising that a matter should be referred to the Advice & Referral Line. And, as I've already mentioned, at least one member of the LGH Executive has given evidence that, prior to last week, she had not heard of the Advice & Referral Line.

Although Ms Lovell was not the author of the statement that was prepared by the Department of Communities for the

purposes of this hearing, she was able to address questions about the CSS's response to notifications to the service in relation to Zoe Duncan, Tiffany Skeggs and others. Ms Lovell acknowledged that CSS had made mistakes in the past and had not always followed best practice in relation to notifications made to them.

She said at the time that some of those complaints were received policies were inadequate, there was confusion around the role of policies, and it is likely that staff were trying to meet KPIs rather than properly investigate reports. And, in respect of the policies of Child Safety Services, she gave evidence that they are not subject to scheduled audits.

Turning to the evidence of today's expert witnesses, we heard from Catherine Turnbull, Chief Child Protection Officer at SA Health and Professor Debora Picone who I have already mentioned earlier in my closing. They have both worked extensively in the Health sector and provided a realistic assessment of what can be done to protect children, including effective complaints handling processes, critical incident management processes, leadership and governance.

We heard that the SRLS is a good incident system to record child safety concerns and to identify patterns of behaviour. We also heard about the importance of open disclosure in hospitals when any error occurs. Both witnesses stated that open disclosure on a public level is important for the community.

Professor Picone said that:

The most important thing, though, is never to assure people that it will never happen again; you just have to assure them that you're now going to put in place proper systems. But it's very hard, once you've lost community confidence ... the best way not to lose community confidence is to be very honest from the beginning.

Finally, we heard evidence from two experts in the process of helping communities recover from collective trauma: Dr Kate Brady and Dr Rob Gordon. Commissioners, you have received evidence about the ways in which a

human-caused event can shatter an individual's perception of the world and their relationships within it. This requires specialised and effective support for people in order for them to recover. It also requires strong, clear and consistent communication both during the immediate crisis but also in the recovery phase. This is particularly the case when there has been damage to community trust. It requires an institution's representatives to front the community, listen, acknowledge the harm that has been done, and be transparent and accountable in making necessary improvements. And, Commissioners, you will note echoes in that evidence of the benefit that Professor Picone spoke of in terms of open disclosure on a public scale.

We also heard that, while the sooner an institution acts to acknowledge harm and begin repair, the better, however, it is never too late to commence this work.

Commissioners, I'd like to briefly turn to the final week of hearings, noting that there is an intermediate week in relation to Ashley. But in terms of the final week in mid-August, as I've already foreshadowed, we will return to the Health case studies in that week. At that time evidence will be called from Ms Morgan-Wicks and the LGH's Executive Director of Medical Services, Dr Renshaw.

In the meantime, we will continue our investigative efforts. Key questions that remain unresolved at the conclusion of this block of hearings include who from HR attended the 2011 meeting with Ms Pearn and Mr Millar and whether any record of that meeting was kept.

We anticipate issuing further notices to members of the HR Department in relation to these matters. Depending on the outcome of our enquiries, it may be that other witnesses from HR will be called in the final week or that HR witnesses who have already given evidence will be recalled.

Over the balance of this week Ms Ellyard and Ms Rhodes will call evidence in relation to the response of the criminal and civil justice systems to allegations of child sexual abuse in Tasmanian Government institutions.

If the Commission pleases.

PRESIDENT NEAVE: Thank you very much indeed, Ms Norton, and we'll adjourn till tomorrow morning.

AT 4.57PM THE COMMISSION WAS ADJOURNED TO WEDNESDAY, 6 JULY 2022 AT 10.00AM