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 29 June 2022 at 10.05am

(Day 17)

Transcript produced by Epiq

PRESIDENT NEAVE: Thank you, Ms Norton.

MS NORTON: Thank you, Commissioners. Our first two witnesses today are Keelie McMahon and Annette Whitemore, I ask that they come up to the witness box.

<KEELIE MAY MCMAHON, affirmed: [10.06am]

<ANNETTE WHITEMORE, affirmed:

<EXAMINATION BY MS NORTON:

MS NORTON: Ms Whitemore, I'll begin with you and I want to ask at the beginning, am I pronouncing your surname correctly?

MS WHITEMORE: Whitemore, yes.

MS NORTON: Yes, thank you. Can you state your full name and occupation for the Commissioners, please?

MS WHITEMORE: Annette Whitemore, Registered Nurse.

MS NORTON: Ms Whitemore, you've provided a statement for the benefit of the Commission dated 20 June. Have you recently reviewed that statement?

MS WHITEMORE: Yes, I have.

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

MS WHITEMORE: Yes, it is.

MS NORTON: Thank you. Ms McMahon, could you again state your full name and occupation for the Commissioners?

MS MCMAHON: Keelie May McMahon and I am a student.

MS NORTON: You've also sworn a statement that's dated 9 May 2022, have you looked at that recently?

MS MCMAHON: Yes, I have.

MS NORTON: Is it also true and correct to the best of your knowledge?

MS MCMAHON: Yes, it is.

MS NORTON: Ms McMahon, you are here this morning giving evidence as someone who has been sexually abused by James Griffin as a child; is that right?

MS MCMAHON: Yes.

MS NORTON: Ms Whitemore, you're Ms McMahon's mother and you're a former colleague and friend of Griffin's; is that correct?

MS WHITEMORE: Yes, that's correct.

MS NORTON: And you met him through work; is that the case?

MS WHITEMORE: Yes.

MS NORTON: Ms McMahon, I'd like to just start with you. In your statement you say that you recall meeting Griffin when you were about 7 or 8. How was it that you came to know him.

MS MCMAHON: The first memory I have of meeting him was at a Christmas party that 4K quite often held at the end of the year. I can just - when I picture this party I can just hear his voice just booming over the top of everyone. I remember at that age I started showing my love for young children. [redacted], and I think I can remember just playing with them and just feeling very welcome in what I assume was his home or - yeah, so that's how I first remember meeting him.

MS NORTON: You say in your statement that you came to regard him as a close family friend; is that accurate?

MS MCMAHON: Yes.

MS NORTON: You said you had that first recollection of meeting him and him being the loud personality; what else do you remember about his personality?

MS MCMAHON: He was always a friend to everyone; I never heard a bad word come out of anyone's mouth about Jim, they were always saying how he is - like, he was always there for a chat, he was always talking to everyone. He'd find a

way to connect with people on a level that was personal to them, if that makes sense. So, he would find one of their interests and then just talk to them about it, and I think that's kind of how I described him to everyone, he was just a really friendly person.

MS NORTON: Ms Whitemore, what was he like? You initially had a relationship with him as a colleague and, as I understand it, it developed into a friendship outside of work.

MS WHITEMORE: Yeah.

MS NORTON: What was he like as a colleague?

MS WHITEMORE: As a colleague, he was - right from when I first met him he was, sort of would put himself at the centre of attention. He would, like Keelie said, want to be helpful to people when they weren't at work as well. He would put his hand up to - or not put his hand up but, if something happened on the ward, he'd be there front and centre wanting to help. I remember saying to a family once that, "If you wanted anyone to look after your sick child overnight, he was probably one of the best nurses to look after your child". He was caring to his patients, which is - and a lot of the time he would step close to the professional boundaries. On many occasions I'd say to him, "You can't say that, Jim", and he'd sort of step back and amend his behaviour or just chuckle and think it was funny.

Working with him: he was a hard worker, he wasn't one of the ones that would sit and do nothing, yeah.

MS NORTON: You met him through work, but as I understand it you came to have a friendship with him and his family outside of work.

MS WHITEMORE: Yeah.

MS NORTON: How is it that that relationship developed?

MS WHITEMORE: So, when I first started on the ward at 4K, [redacted] we started going camping with family, and that's continued

since we get a report every January for two weeks; that was, you know, Jim got the family into camping, and camping without power, and moaning about no data left on our phones and things like that, so that was one of - and I know that's still one of Keelie's best memories, is camping at [redacted], so that's carried on for 12 years.

MS NORTON: Do you mean, that's carried on since Griffin's death?

MS WHITEMORE: The camping went on from [redacted], so every year since we've been to [redacted]. And the first couple of years we camped with him and his family, I think it was about three years we did that, and then after that we had our own camp site and him and his family were on a different one and we sort of just went to his or he'd come to ours and, yeah.

MS NORTON: And you enjoyed spending time together as families?

MS WHITEMORE: Yeah. Like, it was more as a whole group of family, like, Jim and I weren't friends - like, best friends or anything, it was a family friendship.

MS NORTON: I understand. Ms McMahon, we don't need to go into very much detail about this, but I'd just like to ask you a few questions about the abuse that you suffered as a child, and you were abused by Griffin as a child?

MS MCMAHON: M'hmm.

MS NORTON: If you could just answer for the transcript.

MS MCMAHON: Yes.

MS NORTON: And that abuse took place in about 2011, 2012?

MS MCMAHON: Yes, towards the end of 2011 and the start of 2012.

MS NORTON: And, how old were you at that time?

MS MCMAHON: I was 14, nearly 15.

MS NORTON: And, where did the abuse occur?

MS MCMAHON: The first time was at his house and the second time was camping at the Bay of Fires.

MS NORTON: That's a separate camping trip to the ones your mum has just described?

MS MCMAHON: Yeah, so he used to take us on four-wheel drive trips; mum and dad weren't four-wheel drivers, they didn't have any interest in that, so I think that's one of the things that set him aside from my family, yeah.

MS NORTON: I want to come back to that. You provided a video recorded interview to police in 2019 and you provided full details of the abuse you suffered in that interview; is that correct?

MS MCMAHON: Yes.

MS NORTON: And it's your preference not to go into those details here today?

MS MCMAHON: Yes.

MS NORTON: So, I don't need any further information about the offending, but I would like you to talk a bit more about the circumstances that led up to it and how it was that Griffin gained your trust.

MS MCMAHON: So, as I said before, he would find an interest that you had and roll with it to get close to you. I think he - well, I'm pretty sure everyone noticed from a young age that I was more country, so to say, than my family; I wanted to grow up on a farm, I enjoyed going camping and four-wheel driving, and I think that's where he picked up our similar interests and just kind of rolled with it.

So, he'd quite often invite me to come along with them. Obviously, [redacted], so they were often together, and I think that was just his way of getting me involved, yeah.

MS NORTON: And you say in your statement that at a certain point you started staying at his house the night before those four-wheel driving trips?

MS MCMAHON: Yeah. Yeah, so I can only remember a handful

of times that I ever actually had to stay there, and most of them were because we were going four-wheel driving the next day. I know that there was just a couple of, just random ones; like, I can't remember the details of them but I can remember being there. Yeah, there was only a couple that weren't related to four-wheel driving.

MS NORTON: And is it fair to say that up to a point in time you felt safe with him and you trusted him?

MS MCMAHON: Yeah.

MS NORTON: You say in your statement that in recent years you've come to know other people who were abused by Mr Griffin and you point out that you're a bit different to them in terms of vulnerability. Would you like to reflect on that to the Commissioners?

MS MCMAHON: Yeah. So, obviously, this isn't a dig at other victim-survivors, but there was a real consistency between the people that he abused and they were quite often from broken homes or they were sick a lot in the hospital; whereas I didn't come from a broken home, I had two loving parents, there was really no reason for him to abuse me, but I think where he picked it up, he noticed that I was different to people my age; I was bullied quite severely through my schooling years, and I think he picked up on that vibe, that I just didn't get the attention from anyone other than obviously my family and, yeah, he kind of just ran with that.

MS NORTON: You say in your statement that he, perhaps picking up on that vulnerability, he made you feel special and important?

MS MCMAHON: Yeah. He'd quite often call me his "special girl", which obviously looking back on it is weird, but when you're a teenager any sort of praise is appreciated.

MS NORTON: It felt good at the time?

MS MCMAHON: Yeah.

MS NORTON: You also talk in your statement about the impact that the abuse had on you. What would you like to share with the Commissioners and the people listening today about the impact of the abuse?

MS MCMAHON: I think at the time I didn't feel like it was impacting me, but when you look at my track record you can see that it quite clearly was. I kind of flew under the radar with schooling, I didn't very often do my actual school work; would exclude myself from my friends, was abused by boys my age for quite some years; severe depression and anxiety throughout pretty much my whole teenage years.

And obviously, into adulthood it's affected me: I don't trust people, I don't like being around people. I'm very cautious with my own children, which I think is starting to rub off on them and they're noticing, "Okay, mum acts a little bit weird around situations like this", so yeah, it has had a very big impact on my life.

MS NORTON: Thank you. Ms Whitemore, while the events that Keelie's just been talking about were going on, and unbeknownst to you, I should add, you were a colleague of Griffin's on Ward 4K. Do you have any reflections, now looking back, on whether you were groomed by him at work or as a friend?

MS WHITEMORE: Looking back, yep, definitely groomed. I remember him saying once about Keelie, "She's such a sweetheart", and he said something else as well and I thought, just a split-second I thought that that was a bit too familiar but, um, yeah, I just - because of everything he did out of work, the support he gave, like, [redacted], take them to sport.

There was an incident where Keelie dislocated her shoulder at [redacted] and we had to - I went with her in the ambulance to the hospital in Launceston, and at 2 o'clock in the morning they said, "Okay, we can't do anything, we'll send her for this scan as an outpatient", but he came from [redacted] and picked us up and took us back to camp. Things like that, he'd go out of his way to help.

So, it was like the good stuff he did overshadowed the weird stuff, and even looking back now I can see people that met him once or twice, they said - they would say at the time, "Oh, he's a bit creepy", and you'd say, "That's just Jim", because we believed and trusted that he was decent, a decent person, a decent grandfather, grandfatherly figure.

So, yeah, looking back now it's like I was in a box, it's weird, I was thinking of this yesterday, it was like I was in a box, he was in there with this puppeteer-type thing and now that I'm out of that box I can see little things that he did.

I remember, we had - it was the year 2019 because it was just before he finished work - it was around about the time of the "Me Too" movement and things like that and he said, "People who are sexually abused should report it when it happens", and I just - I was doing something else in the tearoom and I said, "Jim, that is so not true. I said, it doesn't matter when it happens, they can report it whenever, whenever they are able to report it", and he sort of shrunk down and changed the subject.

And it was weird at that last year, his behaviour became a little bit more erratic - not his offending behaviour that we can see from now, but just different things on the ward; yeah, he just became a little bit more erratic.

MS NORTON: You say in your statement at paragraph 39 that:

The culture on Ward 4K made it easier for Griffin to do what he did. He saw the cracks and put himself in there.

Would you like to elaborate on what you mean by that statement?

MS WHITEMORE: So this goes to when Sonja Leonard first became NUM and there was a vote of no confidence, and so, at the time I didn't vote as not confident because I felt that she needed time to prove herself as a manager, but that sort of put, like, cracks in the culture on the ward as far as, some people really disliked Sonja, some people - I sat on the fence - other people really liked her, so there was - and he would, I feel, get into those cracks and communicate with people so that they thought they had his support in the whole three areas, and then he'd - what I've heard, I'm not sure, is he would go back to Sonja and report. And, like, he had this close friendship with her on the ward, yeah, so a lot of mistrust, and so, 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.

MS NORTON: Looking back now, do you think that he, whether with Ms Leonard or others on the ward, tried to build loyalty with them as a protective screen around his behaviour?

MS WHITEMORE: He tried to build loyalty?

MS NORTON: You may not agree with that proposition.

MS WHITEMORE: Maybe, "He tried to build loyalty". In his grooming ways, yes. So, like I've just said, I knew he - I've had that feeling he was odd but I trusted he wasn't, I've trusted he was decent, so yeah, that is that wall he's sort of built around him to get me on side or, if that makes sense?

MS NORTON: Yes. You've referred to some things occurring on the ward that were a bit weird at the time; are there any particular examples that you'd like to offer to the Commissioners?

MS WHITEMORE: Can I talk about the one I --

MS NORTON: Whatever you'd like to talk about, yes.

MS WHITEMORE: So there is one that isn't in my statement but I've looked back on over and over. When I first started on Ward 4K Jim had been there a little while before I started. I was a grad, we were in the room of a [redacted], and we were washing her and we used to put moisturiser on her [redacted], but he moisturised over her chest, and that just keeps coming back, that I - I think I told somebody but I didn't put a complaint in, but it made me feel, "Is that what we do?" But I knew that I wouldn't do that, I wouldn't - if I was a male, I wouldn't do that to a [redacted]. So I sort of regret that I never took that further.

COMMISSIONER BENJAMIN: Was this in about 2002, 2003, around that time?

MS WHITEMORE: Yeah, about 2002.

COMMISSIONER BENJAMIN: I think you said you started

in March of that year?

MS WHITEMORE: I started in February 2002.

COMMISSIONER BENJAMIN: And I think your [redacted] --

MS WHITEMORE: [redacted], so it was a busy year.

COMMISSIONER BENJAMIN: Very busy year.

MS WHITEMORE: I got married in the March, yeah. Started on 4K, got married, [redacted].

MS NORTON: You said just now, Ms Whitemore, that you think you may have said something to someone at the time but you didn't put in a formal complaint; is that right?

MS WHITEMORE: Yeah.

MS NORTON: Was the culture on Ward 4K one that encouraged staff to make complaints about inappropriate conduct?

MS WHITEMORE: There was talk about, like, mandatory reporting, but generalised talk. We all knew we were mandatory reporters, and I don't think we were deliberately not told this, but until 2019 when all this happened, came out, I never knew I could go straight to AHPRA. It was never a formal education to say, if you don't think your manager's taking it any further, you can go to AHPRA, anyone can go to AHPRA, and it's like a build-up of complaints; whether they're minor. So, we could go to the management and complain. I don't think I - I think I did on one or two occasions where, you know, he had got close to that professional boundary, and it would be, "That's just Jim".

I do remember on a couple of occasions we'd have education around professional boundaries because of something he did, and I just thought that was a managerial thing, you educate the whole to try and get the one person to realise, "Okay, I've done the wrong thing".

MS NORTON: Was it your impression, or looking back now do you think that sitting behind that was a lack of willingness to take appropriate disciplinary action against the one?

MS WHITEMORE: I think so, because it'd be like - I don't know, could it be seen as bullying if you're pointing at one person rather than saying as a group, "This is what you should be doing", when 99.9% of the people know and comply to what we should be doing. I always thought, why wouldn't you take it to the one person and escalate it as needed and have a list of what is done or what had been reported and maybe get to, I don't know, the end of the first report and start thinking, "Okay, we need to keep an eye on him". Not, "Oh, we'll keep an eye on him for 12, 20 years. Oh, okay, we should have done this earlier".

MS NORTON: You mentioned, Ms Leonard who was the Nurse Unit Manager on Ward 4K, and in your evidence just now you've said that she was popular with some staff, unpopular with others, and you sat on the fence, you tried to give her the benefit of the doubt. Are there any other reflections you'd like to offer about Ms Leonard's management style or otherwise?

MS WHITEMORE: So, because I worked with Sonja as a nurse on the ward before she became NUM, so there was a friendship there, and she was a decent person. But as a manager, I can't believe that she may not have known how unpopular she was. The amount of maybe disgruntled - or not "disgruntled", that's not a very good word - staff that were unhappy with the way she did things. And I was always in there saying, "Well, maybe she made this decision because of this", and but, like, in the last couple of years I was like, "I'm off the fence".

MS NORTON: And just for clarity, which side of the fence did you land on?

MS WHITEMORE: I landed on the side where I thought, "You need to know how unpopular you are as a manager".

MS NORTON: During your time on Ward 4K I believe Janette Tonks was the Nursing Director at Women's and Children's Services; is that correct?

MS WHITEMORE: Yes.

MS NORTON: And Helen Bryan was the Executive Director of Nursing?

MS WHITEMORE: Yes.

MS NORTON: Do you have any reflections on whether one or either of those women were particularly present on Ward 4K?

MS WHITEMORE: Helen Bryan I probably saw half a dozen times in 18 years on the ward. If she was sitting in the room I wouldn't know who she was, but that's part of my condition: I can't remember faces.

Janette Tonks: Sonja reported to her a lot, they had meetings obviously - I think it was every day they'd have, like, a staffing meeting and - but it wasn't until the last few years from, you know, 2019, maybe a bit before, that she started coming to the ward more. She'd come to our unit meetings, yeah.

MS NORTON: Have you worked on other wards at the Launceston General Hospital or in other health organisations?

MS WHITEMORE: I've only ever worked as a student on the surgical ward, 5A. I worked in the Holman Clinic for a little while as a student. But working, I've worked in the Sexual Assault Forensic Examiner's Unit, and that was also - Janette was my manager in that unit as well.

But I haven't been to - because I was pregnant in my grad year the Nurse Unit Manager at the time asked me would I like to stay on 4K for the whole grad year, and I said, yes, I would because that's what I always wanted to do.

MS NORTON: And so, having regard to that experience are you in a position, and it sounds like you might not be but I'll ask you anyway, are you in a position to comment on whether that sort of lack of involvement on the part of the Nursing Director of WACS and the EDON with the goings-on in the ward was normal or whether in other circumstances you've seen a more hands-on approach?

MS WHITEMORE: From what I know, I think it was normal. I know - well, I assume Janette, as Sonja's manager, was her - was guiding her on how to do the job. Obviously, when she first started the job she was still learning. Yeah, I'm not sure - I think on medical wards maybe the same person in Janette's position has got a little bit more to do with - but I'm only going on what friends have said

from the wards they work on.

MS NORTON: Yes, secondhand.

MS WHITEMORE: Yeah.

MS NORTON: You're familiar with Dr Peter Renshaw?

MS WHITEMORE: Yep.

MS NORTON: Was he a presence on the ward at all?

MS WHITEMORE: Probably saw him on the ward three times in 18 years.

MS NORTON: How long did you work on Ward 4K?

MS WHITEMORE: 18 years.

MS NORTON: Do you have any other reflections that you'd like to offer about Dr Renshaw?

MS WHITEMORE: Dr Renshaw --

MS NORTON: And I might clarify the question. Do you have any other reflections to offer on his management style or approachability?

MS WHITEMORE: So, before all this occurred - actually I would remember what he looked like - but I would not have needed to approach him or wouldn't have thought I needed to approach him. Once this occurred and it changed from, "We'll support you, we'll support the nursing staff with whatever they need", to, "You all should have been mandatory reporting": no respect, no respect. Emails from other people that weren't answered, no respect for him.

MS NORTON: Thank you. I'd like to come back to the hospital's management in the aftermath of Griffin's death, but before I do, Ms McMahon, you made the decision to report your abuse to police in September 2019; is that correct?

MS MCMAHON: Yes.

MS NORTON: What was it that caused you to report the abuse at that time?

MS MCMAHON: So, I was at Mum's house with her and she said to me, "Oh, someone's come forward and made a statement in regards to Jim", and I kind of - I wasn't - I wasn't surprised, I'm not going to lie, I wasn't surprised at all. My first thought went to, "People aren't going to believe her". There's a real culture around people coming forward about abuse, and no-one believing them. It's quite common for people to actually go to the police and make complaints and nothing be done about it, so I automatically went, "I can't keep this to myself anymore, I need to be there to support these people who are now coming forward, and that's when I disclosed to mum what had happened.

The rest of the day is kind of a blur, there's not really any part of it that I remember after that. I had a 1-year-old at the time, so I kind of just got distracted by him, and yeah, we kind of just left it at that for the day because I didn't - it was a weekend, so my dad was home and I didn't want to talk about him about - to it, like, about it yet. So, yeah, from there it kind of just, we didn't mention it again for a couple of days, I think, before mum spoke to someone that she worked with at SAFE to see what my options were. To begin with I didn't want to make a formal statement, but then I thought about it and I thought, "No, I need to do this for the other people more so than myself".

MS NORTON: I'd like to ask you about the experience of making that complaint but before I do I'm conscious that would have been a very significant moment for you, Ms Whitemore, and I want to give you the opportunity, if you wish to take it, to share with the Commissioners what that disclosure was like for you.

MS WHITEMORE: I think I went into work mode, working in SAFE.

MS NORTON: I might just ask you, for the benefit of those who aren't familiar with SAFE, just to explain what SAFE is.

MS WHITEMORE: So, SAFE is a sexual assault forensic examiners area in the hospital. If a sexual assault is being reported me as an examiner would go down, find out what had happened and take swabs and - but the very first step is to support the person who's reporting and let them

know that whatever happens from now on is in their control, so we give control back.

So, when Keelie spoke to me it was like, okay: she cried, I don't think I cried for about a week, but it was like, "What do you want to do? What can we do? It's completely up to you what we do. Just let me know when you've decided what you want to do", and then I went to work. I think I was numb, because Keelie was going to go home or wasn't going to be there for the whole day so I thought I'll go to work. I parked at work and I rang a close friend and said, "This is what's happened", and she said, "What are you doing at work?" I said, "I don't know" but I worked, and then I think it was - I can't even remember the timeframes but ...

MS MCMAHON: Yeah, the timeline's all over the place, I think.

MS NORTON: I think you say in your statement that it was about five days later you fell in a heap?

MS WHITEMORE: Yeah, I fell in a heap. I messaged Griffin and I said, "How dare you, how f'ing dare you. My daughter trusted you, I trusted you. She didn't want to ruin your life because you were such a nice man", and he came back with, "Thank you for your past friendship. I'm sorry". So, then I just fell in a heap and it was like that - I think I said on the podcast, that primal scream; I rang my husband and he said, "Do you want me to come home?" I said, "No, I'm okay", I just needed to drop it all out, and then I messaged work and told my manager - well, Sonya and Janette, I think I'm going a bit forward of your question.

MS NORTON: That's okay.

MS WHITEMORE: Told Sonja and Janette what had happened, I said to them, "It's not a secret, my colleagues have been very supportive", I need to take - because I think I already had two weeks off annual leave, "I need to take some extra time, I won't be back until this date". They were shocked and supportive as they could be over email and said they were very sorry this had happened, take as much time as you need. Yep.

MS NORTON: Is there anything else you'd like to add?

MS WHITEMORE: No, I don't think so.

MS NORTON: I will come back, I'd like to ask you some more questions generally about the hospital's management of communication following Griffin's death. But before I do, Ms McMahon you say in your statement you made a complaint to police and that your initial dealings with police were positive; would you like to elaborate on that at all?

MS MCMAHON: Yeah. I didn't have - well, I suppose going into it I wasn't really - I was quite numb to the situation. I went in, the Detective that I spoke to was really - he just had a welcoming nature about him. So, he was --

MS NORTON: I'm sorry, can you just repeat that, I missed it?

MS WHITEMORE: A welcoming nature, so he was supportive in a way that wasn't unprofessional, if that makes sense. So, he explained the whole process to me, he said that if I needed to take a break through making my statement, that I was more than welcome to. He explained that it would all be filmed and, yeah, so he was - it was overall good in the moment, but then once I made my statement that's kind of where it all kind of fell off the bandwagon, so to say.

MS NORTON: And this was Detective Hindle; is that correct?

MS MCMAHON: Yes.

MS NORTON: Where did it go downhill, why did it go downhill in terms of an interaction?

MS MCMAHON: So, once I finished my statement he explained what happened next, I can't remember the exact steps, but they were very basic, like, "We will charge him with the abuse", and so on and kind of just shuffled me out of the building, so to say. I remember him briefly saying something about, "Oh, you can get a monetary payment for this, there's a Victims of Crime payment", and I remember thinking, why would I want money for this, that's not going to help the situation?" And then that was kind of it, he kind of just said, "See you later", and I went back out and I was just like, okay, I've just spoken about something I haven't spoken about in 10 years and I've got no support,

obviously other than mum and my partner and the rest of my family, but like, no professional support.

I think I called him a few days later and said, "Look, is there anyone that I can talk to?", and at that point he recommended Laurel House who I got into contact with, and unfortunately they couldn't provide me with an appointment just due to the masses amount of work that they had. So, I think it was about two weeks that I kind of just sat with no support, like, I just made a massive statement and kind of, like, just had to deal with it on my own.

MS NORTON: Can I ask you about that? You say in your statement, and this is in relation to your approach to Laurel House and their books being full effectively and not being able to fit you in at the time, you say:

They offered a one-off emergency appointment but I was reluctant to do this. You don't want to open up that can of worms without the opportunity to see it through.

Would you like to elaborate on that statement at all?

MS MCMAHON: Yeah, so obviously, what I'd just done was massive, and to have a one-hour appointment with no guarantee of a follow-up, I feel like would have just caused more problems than good; so, yeah, I did decline that just purely because I knew that I wouldn't cope after one appointment. And then, yeah, I think weeks went by. And Laurel House did do all they could, they called me and they'd have a quick chat to me to see how I was going, obviously I was distressed, I still hadn't spoken to anyone about it.

And I think after the first or second check-up from Laurel House it'd be the same every time, they'd said, "Sorry, we can't fit you in, there's just not enough staff", that was when I got back in contact with the detective and said, "Look, I need something else, this isn't working, I can't keep dealing with this by myself", and that's when they gave me the contact details for Victims of Crime.

MS NORTON: And that was a counsellor at Victims of Crime; is that right?

MS MCMAHON: Yeah.

MS NORTON: And up until that point you hadn't been aware that you could access counselling services?

MS MCMAHON: No, he didn't specify to me that it was an actual counselling service. The way he described it to me was, like, they'll take your details and give you money, yeah, that was how brief it was the way he described what it was, so yeah, I wasn't aware that that was an option.

MS NORTON: But you ultimately did receive counselling support from them, and you talk in your statement about that being a positive experience for you?

MS MCMAHON: Yeah, and I still receive counselling through them to this day, and it's been one of the most beneficial things for the whole process.

MS NORTON: Now, Griffin was released on bail for a period before his death and he, as I understand it, lived quite close to you. You talk in your statement about the experience of knowing he was out on bail for that period, would you like to elaborate on that at all?

MS MCMAHON: Yeah, so I found out that he was let out on bail because he was a "first time offender", even though he'd been offending for near three decades, and as far as I was aware he was allowed to go back to his house [redacted] from where I lived. We shopped at the same supermarket, I'd quite often run into him or his children at the supermarket. This kind of put a blanket of anxiety straight over the top of me. I don't think I left the house for about three weeks, if I'm honest, just out of fear of running into him even though logically I could tell myself the likelihood was slim, but in that period of time I knew that it was a possibility that he'd be able to --

PRESIDENT NEAVE: Can I just ask how you found out he'd been bailed? Did the police tell you that or?

MS MCMAHON: I'm assuming it would have been the police that told me; I don't think that was mentioned.

MS WHITEMORE: I can't remember how we found that out.

MS MCMAHON: Yeah, I can only remember being told, I can't

specifically remember, sorry.

PRESIDENT NEAVE: Thank you.

MS MCMAHON: Yeah, so that impacted my life quite a bit from that moment on.

PRESIDENT NEAVE: Yes.

MS WHITEMORE: Actually, Marcia, I do remember, because I made a statement with Detective Hindle as well and he said that he was on bail because they couldn't keep him because he wasn't a career criminal.

PRESIDENT NEAVE: Right, thank you.

MS NORTON: Griffin died in October 2019, and you say in your statement, Ms McMahon, that:

Once Jim died everything just shut down.

Now, that's an observation you make by reference to your interaction with the police. Would you like to share/elaborate on what you mean by that "shutting down"?

MS MCMAHON: Yeah. So, I think from the moment I found out that he'd been let out on bail, I just - I had this feeling, I can't describe it, it was just this inward feeling of, "He's gonna die, there's no ifs or buts about it", I just internally knew that there was no way he would end up in jail.

So, I think, obviously because mum was still involved at the hospital, I knew that he was in ICU and I messaged the detective about it and asked, like, what was going on, and obviously because it was - even though I knew from people at the hospital, it was confidentiality, he couldn't speak to me about it. And then, once I found out that he had passed away I messaged the detective again and I said, "What happens from here? Like, what do we do now?", and I specifically remember him saying, "That's it, there's nothing we can do", and that was one of the last messages I received from him. There was no follow-up to see how I was going. I think I messaged him a few weeks later and got a response from a different detective to say that he'd gone on leave or something for a couple of weeks, and then that was it, I never heard from the police again.

MS NORTON: What did that feel like for you?

MS MCMAHON: Well, it felt like I'd just put my trauma on the table and they'd picked it up and thrown it in a cupboard. Like, there was no, "We're so sorry for this, we're going to do everything we can to investigate how this happened". It was basically like they just signed off on the paperwork and chucked it in a cupboard and they didn't want to deal with it anymore, and from that point on that's exactly how everybody handled the situation. There was no contact from the police, there was no contact from the hospital, there was no public announcement of what had happened to myself and multiple other victims. Even though quite often these kind of cases were followed through the media, it was just radio silence, there was nothing.

MS NORTON: I want to come back to ask you some questions about the hospital's response publicly to what's come to be known about Griffin, but before I do, Mrs Whitemore, I said I would come back to you to offer any reflections you have as somebody who was not only the mother of someone abused by Griffin, but also a colleague on Ward 4K: are there any reflections you'd like to offer about the way that management dealt with communication with staff in the aftermath of Griffin's death?

MS WHITEMORE: Yep. So, when Griffin died, and prior to him, when he left the ward end of July, we were sent an email to say that "Jim had retired, he will let us know when he wants a celebration, can we please respect his privacy, and he'll contact us when he feels like he's able to".

I thought the bit in the email, "respect his privacy", was a little bit odd, and staff that had worked with him for 20 - or 18 years-plus, we sent him messages to see how he was, and the answers to the messages were very generic, "I'm just taking one day at a time. I thought he had a bad back. I hope you're okay. It's hard to retire because of an injury". And then it all came out. We were given the email, "Please respect his privacy".

And then when he died, I knew that he'd died because I knew someone in ICU, but there was another email sent out to say that, "A colleague had passed away over the weekend", I think he died on Friday, there was no mention

of who it was, and then it went straight into, "Confidentiality as nurses. Please don't talk about it", and so, there was a feeling of, we couldn't talk about someone that we'd known for upward of 15, 20 years that had passed away.

And, even though he'd done all these vile things, some people were really close to him on the ward, we were close as family, and there were so many mixed emotions around finding out what he'd been accused of, finding out what he'd done to my daughter, and finding out that a colleague had died, so there was all these emotions that staff were dealing with and we weren't allowed to talk about it.

MS NORTON: What could the hospital have done differently to better grapple with those very complex emotions that you were experiencing within the workplace?

MS WHITEMORE: So, I know when he first died Peter Renshaw was in the UK. Sonja and Janette were trying to keep a lid on things, so they were, you know, telling us not to talk about it. We had a meeting when Peter Renshaw came back, and that was the one where he was supportive and they said, "What do you want us to do? We will gauge what we do by how you as nurses react", and then it changed through those three meetings. Sorry, I forgot the question.

MS NORTON: The question is what the hospital could have done differently to better support you during that complex time?

MS WHITEMORE: To get professionals in straight away, straight away as soon as it happened; not pussyfoot around, "Oh, maybe if we do this, if we tell them not to talk about it, it'll all go away". The feeling was, it was being swept under the carpet, and the fact that it hadn't come out in public either was another layer that was swept under the carpet.

MS NORTON: Did that sense that you had that it was being swept under the carpet and that you were being silenced and asked not to talk about it, did that make the experience more traumatic for you?

MS WHITEMORE: Yes, and looking back, yes, it's still traumatic to think, you know, we were told not to talk about it. I mean, that is not how you treat trauma.

MS NORTON: You ultimately spoke with journalist Camille Bianchi who produced The Nurse, or created The Nurse podcast; why did you take that step.

MS WHITEMORE: I took that step because, this was probably early 2020? I took that step because nothing had been reported on, nothing had been talked about. Keelie wanted to tell her story and initially that was the reason I got Camille's number. I can't remember really remember if I called her - I know she didn't call me, but I can't remember if I gave the number to Keelie or if I called Camille first and sort of got an idea of what she wanted to do, and then talked to Keelie about it and then Keelie called Camille.

Initially it was just going to be Keelie's story, but as the time went on and nothing had been said about any of it, and we were still being told not to talk about it, I thought, "Okay, I need to do something; I need to do something so that kids that five years down the track think, why did that old man touch me, why did this happen?", because we know trauma can be blocked and come out many years later, "Why did this happen and why didn't these nurses do anything post it happening?"

So, I was well prepared to lose my job - not that anyone had said to me "you're going to lose your job". I was prepared to lose my job, I found another job to go to. I decreased my hours on 4K to zero, because I had two positions, I was allowed to do that, I thought I'd work in SAFE and [redacted].

MS NORTON: I want to ask you a few questions about your work with SAFE as a forensic examiner, and then I'll invite you both to offer any closing reflections.

You worked as a part-time forensic examiner for about five years; is that correct, Ms Whitemore?

MS WHITEMORE: Yes.

MS NORTON: And that was at LGH?

MS WHITEMORE: Yes.

MS NORTON: And what did that role involve?

MS WHITEMORE: That role was, I did a year of study to be educated around forensics, and that role was, if a sexual assault occurred the person could report to police, or the hospital, or Laurel House, and that would then come to Laurel House social workers that would work 24/7, would call us and say, "This is what has happened, can we bring this person in for a forensic examination?"

We would have a little bit of a talk to the social worker prior to meeting the person and then we would meet them at the hospital. We would go in first and the social worker and the person would stay in their relatives' room. We would go in first and clean the room completely of all DNA. It was cleaned before the procedure and after the procedure. And then I would go out and meet the person that was reporting the sexual assault and, as I said before, the first thing I would say is, "I'm sorry this has happened to you. Anything we do from now on depends on what you want to do. If you want to stop at any time, we can stop".

We would go back to the sexual assault suite, which was locked all the time, we had to use our keys to get in, our swipe card. We would have a small interview, not counselling, but just to determine what had happened, what parts of the body had been touched with what fluids or other skin or - so, just to determine which swabs we needed to take.

MS NORTON: What were the options for the different types of examinations that you could undertake as appropriate?

MS WHITEMORE: So, there was - as in, like a forensic examination or a medical examination?

MS NORTON: Yes.

MS WHITEMORE: So, it was up to the person whether they wanted a forensic examination where we took swabs, intimate swabs, and photos, not intimate photos but photos of any bruises or anything like that, or if it was a medical examination we would just look at their body to look for bruises or any sort of injury that they had reported, and everything was documented. If they told me that the perpetrator had licked them on the cheek, I could swab the cheek to get DNA.

MS NORTON: Are there particular timeframes beyond which those sorts of tests, forensic tests, are no longer reliable?

MS WHITEMORE: Yes. I can't remember the timeframes but there is a pro forma that we follow and it's got all the timeframes. I know - I've had a look at it last night - grabbing of skin, 12 hours. There was one where, if it's reported seven days later and there's been a shower or a bath, we can still take swabs but it's a less likely a chance to get swabs. If there's, like, bodily fluids internally that's, I think, five to seven days, so there's a lot of different timeframes.

MS NORTON: Different timeframes.

MS WHITEMORE: Yeah.

MS NORTON: Would you agree that, subject to consent of the relevant patient, that it's best to act with speed to undertake those tests?

MS WHITEMORE: Yes, and that's one of the questions we ask when Laurel House call us; we say, "When did it happen, what are the timeframes?"

MS NORTON: When you were operating as a forensic examiner, and I think, am I right to think that the time period was probably 2016 to 2021; does that sound right?

MS WHITEMORE: Yes.

MS NORTON: You've talked about the patient needing to give consent to the procedure. Is the procedure different at all where the person who is alleging that they've been sexually assaulted is a child or a young person?

MS WHITEMORE: It's very different as a child or a young person. The paediatrician will be involved, they will do all the examination and swabs if needed. There needs to be a police report before the paediatrician will become involved, because - yep, there needs to be that. There needs to - us as forensic examiners, we are there to assist the paediatrician. There's a - like, photos aren't taken but there is a colposcope that is a recording, like, they use the little SD cards, they make a recording, there's

processes put in place so that those SD cards are kept under lock and key.

MS NORTON: And so, just to make sure I understand that process: based on your experience in 2016 to 2021, is the correct process as follows. If you have a child or young person in the hospital who's made an allegation of sexual assault, is the first step to notify the police?

MS WHITEMORE: Yes; to either notify the police or notify Laurel House or the social worker in the area, or someone who's trained in speaking to young people about these things to talk to the young person to determine - not to determine - to listen and then they would need a police statement before - well, or alongside a paediatrician being involved. Prior to the paediatrician, if they think there's a chance of DNA, they would ask for a forensic examination to happen, so depending on the report would depend on ...

MS NORTON: And you would expect, tell me if you disagree, but you would expect that a paediatrician would become involved in the examination of the child fairly soon after disclosure?

MS WHITEMORE: Yes, or at least, at the very least contact with the paediatrician to talk it through with the emergency doctor or wherever the doctors are that are involved in the first instance.

MS NORTON: That process that you've just described, would it be different - it strikes me that you could have a patient in the hospital who was making an allegation of abuse that they suffered outside the hospital?

MS WHITEMORE: Yep.

MS NORTON: Or you might have someone in the hospital who was alleging that they'd been abused while they were in the hospital?

MS WHITEMORE: Yes.

MS NORTON: Is the process different in those situations?

MS WHITEMORE: The only difference is, if the person in the hospital can't be moved out of, say, an emergency bed

or a cubicle, we will do the examination in that cubicle; we would clean it as best we could to keep that DNA secure. And in our report we would write, "This is where we did the examination, this is what we did to clean the room before we did it". If the person in the hospital was well enough we would bring them to the sexual assault suite.

MS NORTON: Thank you, Ms Whitemore. I'm conscious of the time but I do want to ask you for some closing reflections, and in particular, Ms McMahon. In your statement, you weren't abused on Ward 4K but you talk in your statement about going back to Ward 4K with your own child and that being a particularly difficult experience; would you like to reflect on that with the Commissioners?

MS MCMAHON: Yeah. So, when my second son was [redacted] we took a fall and he fractured his skull. I went straight to the hospital and I was in the Emergency Department for - it wasn't very long, it was probably a couple of hours while they did scans and stuff, and they admitted him to Ward 4K just for observation; they didn't find anything apart from the fracture, they just wanted to make sure he was okay.

I was moved to the ward, it was quite late, about 10 o'clock at night, and it was during COVID times, so I was by myself with him, and the ward was under construction, so there was still part of the old ward and then the other side of it was blocked off and then the new part had also been opened. And where I was put with my son was one of the old rooms quite close to the entrance to the hospital. It was a four-bed room but it was just me and my son, and then the nurses were obviously at the nurse station in the new department which was - it was ages away, like, you couldn't even see it from the door of my room at the time.

There was no support for me. I know that a lot of the nurses on the ward did know about what had happened, and this is through no fault of their own, there was no trauma-informed care. It was, "You've come to the ward with your son, we're just going to put you in this room and leave". They'd come back every two or three hours for observations, but there was no support offered until my mum contacted whoever was working at the time and said, "Look, Keelie's on the ward, she's really struggling", it was just the atmosphere: I knew that he'd worked there, I knew that

he'd hurt a lot of people in this ward, and that was when the next morning a social worker came up to chat to me, but still wasn't checking on me, she was making sure that my son was okay and was reassuring me that I wasn't going to get in trouble for what had happened.

I was quite - I was nervous about that just purely for the fact that my [redacted] had a fractured skull; like, I thought Child Protective Services or someone was going to be called on me, even though I knew I'd done nothing wrong, but she still didn't ask me as a person how I was going, how I was coping with being in a setting that was really triggering for me. And that really put even more of a dampener on that whole experience and even now [redacted], and just the thought of it gives me anxiety.

Like, my kids are healthy, I've got no need to worry about them going to hospital, but it's, like, it's constant, constant worry about, oh, if this happens I'm going to have to go to the hospital. We've just gotten over influenza and every single day I just thought I can't go to that hospital, I can't take them to the hospital, and I shouldn't feel like that, I shouldn't be putting my children's health on the line purely because I can't step foot in that hospital.

MS NORTON: Is there anything that the hospital could do to lessen the difficulty associated with attending with your children in future?

MS MCMAHON: I think the first step is getting rid of all the bad seeds. We've seen over this week how many people are still in positions in that hospital of power, and they also need to be more - there needs to be more trauma-informed care. There's a whole generation of people who have been abused by Jim who now could possibly be going on to have their own kids: how are they going to feel when they go to the hospital and people don't even acknowledge the trauma that they're carrying around?

And the staff as well who are now still working on a ward where all of this has happened: they need to be supported as well. There's a whole, a whole generation of people who are now affected by this and the fact that the

hospital are still not doing anything to help anyone is unbelievable.

MS NORTON: Ms Whitemore, have you got anything that you'd like to add in terms of what the hospital could and should do now to rebuild community trust?

MS WHITEMORE: I think education around grooming as was offered in the hospital after I - or just before I left, but have education at induction, have it every 12 months. We have mandatory education around handwashing every 12 months; let's have mandatory education around grooming, paedophiles, what is the worst-case scenario. Have posters on the walls that say, "You can report if you feel uncomfortable. You can go to AHPRA, you can go to the manager. You can go to anyone in the hospital and say, 'This happened'".

MS NORTON: I've just been asked to ask you one clarifying question, Ms Whitemore. You referred earlier to the fact that you now work for [redacted]. Are you able to confirm that's a non-government organisation?

MS WHITEMORE: Yes.

MS NORTON: Thank you. I have no further questions, Commissioners.

PRESIDENT NEAVE: Thank you.

COMMISSIONER BROMFIELD: I had one, actually, and I wanted to thank you both for your evidence and your efforts to make survivors aware that they can come and get help and that they were not the only ones.

Ms Whitemore, I do understand you're now working at [redacted], I wondered if you could tell me why it is you no longer work at SAFE?

MS WHITEMORE: Why I'm not working at SAFE?

COMMISSIONER BROMFIELD: M'mm.

MS WHITEMORE: Do we have time?

COMMISSIONER BROMFIELD: Do we have time?

MS NORTON: I'm in your hands, Commissioners.

PRESIDENT NEAVE: Yes.

MS WHITEMORE: Okay, so I think I alluded to the fact before that I dropped my hours on 4K and I thought I - well, in my mind I was ready to lose about my job, so I got this job at [redacted]. Around about that same time I was asked to come in to speak to Janette Tonks about my mental well-being working in SAFE; this was the week after the podcast came out.

In that meeting we talked about the impact that the podcast would have on the public view, or the view of me if I had to follow a sexual assault case through to court. Words that were said were around vicarious trauma, which I knew about vicarious trauma. We'd never been educated in the six years before, five years before, and to my knowledge since I left SAFE they've never had education around vicarious trauma; it's been mentioned but it wasn't formal education.

They said that my objectivity may be questioned in a court of law. I said, "But DNA is DNA. If it's not there, then you can't argue that it is". I was asked how I could separate myself from a case, and myself, my life from a case. I said, "I've been separating myself from my patients since I started on 4K and for the last 12 months with my daughter I've worked in SAFE separating myself from what I do in the SAFE service". So, it put this seed in my mind that I couldn't work there anymore and I left the meeting - I did ask at the time, "Are you trying to push me sideways?" And they said, "No". They, as in, Janette Tonks and [redacted], she was on the phone, she's a medical in charge of the service. So, yeah, I left the meeting thinking, "I can't do this job" and I loved - I really liked that job.

PRESIDENT NEAVE: Could I just ask you: so, Sonja Leonard was at that meeting. I'm sorry, who did you say was --

MS WHITEMORE: Sonja wasn't there, this was Janette, she was my manager in SAFE, and [redacted] was on the phone because she --

PRESIDENT NEAVE: Thank you.

MS WHITEMORE: So, I put a claim in for workers' compensation, a psychological claim, because it just kept ruminating that I can't do this job, and that's another story. Workers' comp is so belittling. I did the 12 weeks' worth that you're allowed and then the institution can dispute it. I thought, I'm not going to go through this being disputed, and I decided to resign from THS, took my long service, my holidays, and continued working at [redacted].

COMMISSIONER BENJAMIN: When you retired from the hospital, you'd been there pretty close to 18, 19 years, hadn't you?

MS WHITEMORE: Yes.

COMMISSIONER BENJAMIN: Did you have an interview afterwards? Did they ask you about an interview?

MS WHITEMORE: No.

COMMISSIONER BENJAMIN: Did they contact you in any way to ascertain why they've lost a nurse of such experience?

MS WHITEMORE: I had a phone conversation - no, this was before I decided to not work on 4K. So, I had a conversation with Sonja then, I said, "No, I just want to go out of the hospital". After the workers' compensation, no, nothing.

COMMISSIONER BENJAMIN: Thank you.

PRESIDENT NEAVE: Thank you both so much for your evidence, you've both shown great courage and great thoughtfulness in the way you've described what happened and what the response was to your experiences, so thank you very much indeed.

MS WHITEMORE: Thank you all so much, too.

MS NORTON: Can I just ask one more question, Commissioners, and it's arising out of that most recent evidence you've given.

The discussion that you had with management about their concerns about you continuing in your SAFE role; did you consider that to be an act of reprisal for having gone

to the media?

MS WHITEMORE: At the time, I did. Looking back now I can see a little bit of concern for my mental health, but it was veiled in, "We're concerned for all the staff", and yet, I was the only one pulled in for a meeting, so - and since then from my understanding no other SAFE staff have been called in and said, "How are you going since the podcast came out?".

MS NORTON: Thank you, Ms Whitemore. Thank you, Ms McMahon. No further questions.

SHORT ADJOURNMENT

PRESIDENT NEAVE: Before you start, Ms Norton, I think there's somebody else who's going to announce an appearance.

MR PHILLIPS: Yes, if Your Honours please, my name is Phillips and I appear for Ms Emily Shepherd.

PRESIDENT NEAVE: Thank you very much, Mr Phillips.

MS NORTON: Commissioners, I'd like to call our next witness, Ms Emily Shepherd, to the witness box.

<EMILY IRENE SHEPHERD, affirmed: [11.39am]

<EXAMINATION BY MS NORTON:

MS NORTON: Q. Good morning, Ms Shepherd. Would you like to state for the transcript your full name, professional address and occupation?
A. Emily Shepherd. I am a Registered Nurse of 182 Macquarie Street, Hobart.

Q. Sorry, there's a bit of background noise. You've sworn a statement for the benefit of the Commission that's dated 23 June 2022; is that correct?
A. That's correct.

Q. And there are seven attachments to that statement?
A. Yes, that's right.

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

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

Q. Ms Shepherd, your current roles include Tasmanian Branch Secretary of the Australian Nursing and Midwifery Federation; is that correct?
A. Yes, that's correct.

Q. And you also have a background in nursing, including at the Launceston General Hospital?
A. Yes, that's right.

Q. Would you like to briefly outline for the Commissioners that nursing background at LGH?
A. I completed my Bachelor of Nursing in 2006 and completed my transition to practice graduate year at the Launceston General Hospital. I worked in a variety of clinical settings as a Registered Nurse, went on to undertake a role as a clinical facilitator with the University of Tasmania but based within the Launceston General Hospital. Further a position as a clinical nurse educator, a clinical nurse consultant with Safety and Quality Unit, and also later as the Nurse Unit Manager at Ward 5D, which is the medical oncology unit at the Launceston General Hospital.

Q. Thank you. While I will be asking you questions primarily in your current capacity with the ANMF, if you have any reflections to offer in answer to any questions that I ask drawing on your experience as a nurse and in other roles at Launceston General Hospital, then I'd invite you to do so.

I'd like to begin by asking you some questions about James Griffin. Now, Griffin was a union member, a member of the ANMF. I think you say in your statement at paragraph 23 that he was a member for 19 years; is that correct?
A. Yes, that's correct.

Q. And he also held the position of workplace delegate on Ward 4K?
A. Yes.

Q. Do you know for approximately how long he held that

position?
A. It's for around 16 years.

Q. 16 years, thank you. Have you been watching or monitoring the evidence that's been given over the course of this week?
A. Yes, I have.

Q. And you'd be aware then that the evidence that's available to this Commission shows that the first recorded - and I say "recorded" with emphasis - the first recorded complaint to LGH about Griffin was made in 2002, and then complaints were made in at least 2004, 2005, multiple complaints in 2009, 2013, 2015, and again multiple complaints in 2017. I'd like to ask you whether the ANMF was aware of any of those complaints at the time they were made?
A. I can say from my perspective as ANMF Secretary, I've been in the role for four and a half years, I was unaware of any of those complaints, and obviously given the history I have undertaken a review of our membership records, our database, I've spoken with staff who have been employed, some staff, industrial staff who have been with the organisation for almost 20 years, and they're not able to recall any allegations or any concerns that were raised with the ANMF in relation to misconduct or allegations of misconduct or indeed allegations around child sexual assault.

Certainly, the enquiries that we - or assistance we did provide James Griffin of an industrial nature were in relation to queries he'd made in relation to the industrial agreement at the time in relation to penalty rates and that type of thing. Certainly, there's no indication from our perspective that any of those allegations were known about.

Q. And you give that evidence today based on your own personal recollection but also reviews of the union's records and enquiries made of staff?
A. Absolutely. Obviously, we weren't made aware of any of these allegations until after James Griffin's death on 21 October 2019. Certainly at that time we were shocked and horrified and certainly felt it was appropriate to undertake that immediate review to understand if there was any indication that ANMF had any knowledge of these allegations so that we could obviously examine our own systems and processes to make sure that we did address

those allegations appropriately. As I say, we weren't able to identify anything at that time and certainly from my own recollection there's no knowledge until after James Griffin's death.

Q. Did those enquiries that you made go beyond formal notifications? It sounds like you've satisfied yourself there were no formal notifications of concerns about his conduct at work or otherwise. Did you make enquiries about whether any of the staff of the ANMF were aware informally or by reference to rumours they'd heard, that there were allegations that he had behaved inappropriately towards children?
A. Absolutely. As I say, it was absolutely shocking to the ANMF to learn that an ANMF delegate had had these allegations made against him and charges against him, and certainly it was cause for enormous reflection within the ANMF and for many of our staff who had had associations with James Griffin over his time as a delegate. We absolutely felt that it was appropriate to reflect and consider whether there was something that should have raised a red flag that wasn't noticed or should have been acted on.

But certainly, as I say, throughout all of those processes and discussions with staff there were no reports, there were no recollections of, you know, rumours, and for all intents and purposes, as I say, the general feeling among ANMF staff were one of shock and just absolutely - you know, very concerned, not only for our members on Ward 4K but importantly for the victims.

Q. Yes. Griffin was a workplace delegate, you've said, for 16 years; can you just explain briefly to the Commissioners what the role of workplace delegate involves?
A. Obviously as a representative body for nurses, midwives and care workers, we have members working across every sector in Tasmania, in public, private, the aged care sector and in hospitals, community, you know, a whole range of - wherever healthcare services are delivered there are members.

Obviously, we have a membership of over 8,000 and obviously we have staff that work for the ANMF, but importantly as a representative organisation we do acknowledge that it's important to be able to be accurately representing our members and their individual workplaces

and needs.

As a result we do have workplace delegates who we work with closely and are the key contacts of the ANMF Tasmanian Branch who work with us when they're elected to the role and they're generally our conduit into a workplace. They'll come to us to raise concerns on behalf of other members or indeed collectively on behalf of the area in which they're working, so they're essentially, you know, our extension of our operational staff in the workplace.

Q. At the time that Griffin was a workplace delegate, what was the election process to that? I understand it's changed more recently and we'll come to that, but what was the process during the 16 years that he was a delegate?
A. So, the process prior to the change was that a member within a ward or unit would nominate themselves as a workplace delegate or indeed be nominated by one of their colleagues. That nomination process would require two signatures of fee paying members or members of the ANMF to support that nomination; that would come to the ANMF Tasmanian Branch, the nomination would be taken, it would be processed and then obviously correspondence would go back out to that delegate to say that they'd been nominated or their nomination had been received. There's then a 14-day period in which the delegate must advertise, or promotional material is sent to the delegate to be advertised in that ward and unit to say that they have been nominated and that there is a 14-day period in which members could raise concerns or dispute the nomination for the workplace delegate process.

Q. So, is it an accurate summary of that process to say that somebody can self-nominate, they need to receive the endorsement of two other colleagues on the ward, and then in the absence of any objection being raised in that two-week period, they would become the delegate?
A. Yes, that's correct.

Q. I'd like to read to you a quote from a statement that's been provided to the Commission by Ms Janette Tonks who is the Nursing Director of Women's and Children's services. Do you know Ms Tonks?
A. Yes, I do.

Q. She says this, and really it's - well, I'll just read the quote, she says this in her statement:

The fact that Mr Griffin had a current Working with Vulnerable People registration, had an APRA registration, and that he was an active member of the ANMF as a ward union representative gave me confidence that Mr Griffin had the appropriate screening and credentials to work in a paediatric ward.

Do you agree that, read in context, the reference there to Mr Griffin being an ANMF ward union representative is something that Ms Tonks saw as - and you can't speak to her state of mind, I appreciate that - but would you agree that she seems to be saying there that she took comfort from the fact that he was a workplace delegate; that it was some sort of endorsement, if you like, by the ANMF?
A. Well, I think that it goes to the fact that Ms Tonks has taken the fact that James Griffin was a delegate and an ANMF member, mind you of which we have over 8,000, into account in determining, I guess, the appropriate checks and balances for an employee.

But as my understanding, any employer and those that are employing health professionals undertake those checks themselves, and obviously our delegates have to be employed by a health provider or an employer, so those checks are completed obviously when they come to us as a delegate, but certainly from the perspective of indicating that, because a delegate is a member of the ANMF and a representative of the ANMF, that that gives additional weight, I suppose, to a person's professional conduct.

Certainly, we absolutely regard our delegates, as I said, as an extension of the ANMF. We are very keen to ensure that our delegates are always conducting themselves in a professional way. Any concerns that are raised with us by an employer or a manager or indeed another member are immediately dealt with and addressed with a delegate, but certainly from our perspective the ANMF condemns any violence against children in the strongest possible terms, including child sexual assault, and any allegations irrespective of whether it's a member or workplace delegate will be dealt with appropriately and reported through to the appropriate mandatory reporting requirements through to the police.

Q. Would you agree or is it the case that being an ANMF workplace delegate is intended to be, or would you accept that it is an ANMF endorsement of an individual?
A. Yes, I would, and obviously as I mentioned earlier, we have looked at our process around elections of and nominations and ongoing elections of existing workplace delegates and the renomination process to ensure that we are making sure that everybody in a ward or unit, if they have concerns, understands how that can be raised with us, so that communication now goes to everybody within that ward or unit that is listed as a member to ensure that, if they do have concerns about a workplace delegate of any kind, they can raise that with us so that we can understand that from their perspective.

Because clearly our delegates are in a workplace setting, in a health setting, we're not working alongside our delegates, and obviously they have our full support and we offer training and education et cetera, but if there's concerns around the clinical conduct, we obviously aren't in the workplace to witness that ourselves, which is why we made that change to the process to ensure that every member had the opportunity to raise concerns with us.

Q. Yes, and so these recent changes that you have made - and I say recent, I think it's fair to say since --
A. 2019 after we became aware of the allegations that were made against James Griffin we reviewed the workplace delegate process in conjunction with that analysis around whether we were aware of any complaints.

Q. Can I ask you this: aside from perhaps more actively inviting colleagues to raise concerns about a nominee, is there anything else that the ANMF does now to screen nominees as workplace delegates for appropriateness to fill that role?
A. Well, obviously, as I said, we rely on additional information from our members, but we also on occasion have received feedback from members in workplaces who may not necessarily be an ANMF member, and that information is also taken and acted on.

Clearly, as you say, as an ANMF workplace delegate we want to be sure that those that are representing the ANMF are representing us in the professional way in which we expect them to be.

Q. Ms Shepherd, have you, from your discussions with members on Ward 4K and through evidence that you've listened to or otherwise been briefed on this week, are you familiar with concerns about the culture on Ward 4K and in particular staff feeling unable to speak up about concerns they have about colleagues?
A. Yes, I am.

Q. And, in circumstances where a culture like that exists on a ward, do you think that the recent change that you've made, again, inviting staff to raise concerns about a nominee, will necessarily pick up the inappropriateness of a candidate like Griffin?
A. Well, I would like to think so. Certainly, it is a change to our process and, as I say, we never received any complaints about James Griffin. Yes, I acknowledge James Griffin was an ANMF delegate on the ward for a significant period of time, but during his tenure we also have had other workplace delegates on Ward 4K who were delegates alongside James Griffin, and one of those workplace delegates, Will Gordon, was able to come to the ANMF and raise concerns that he had in relation to James Griffin when he felt that pursuing the avenues he had available to him within Ward 4K and LGH management weren't being acted on.

So I do feel that, even with that culture and with additional workplace delegates and those that do feel strongly do feel supported to be able to come to the ANMF and certainly that was the case with our other workplace delegate, Will Gordon, on Ward 4K.

Q. And so, were you seeking there to draw a distinction between staff who may feel uncomfortable reporting concerns to management and that that doesn't necessarily mean that they won't feel comfortable reporting concerns to the ANMF?
A. That's right. Certainly, as I understand it, all attempts - or there have been numerous attempts over time to raise concerns with management in relation to James Griffin from members' accounts and certainly from Will Gordon, and when they weren't able to, I guess, receive the response or support that they were hoping for they did feel comfortable and able to come to the ANMF and be able to speak freely and know that they had our full support.

Q. But that was after the fact, wasn't it, in the sense that it was after the extent - the fact and extent of

Mr Griffin's offending was known?
A. Yes, that's right.

Q. Yes, no-one came to you before then. And the Commissioners heard evidence this week that staff were concerned about Mr Griffin's behaviour and he continued for 16 years to be an ANMF delegate; no-one brought those concerns to you?
A. Well, no, I've been in the role for four and a half years, but to the ANMF.

Q. To the ANMF.
A. It is our recollection that there haven't been any concerns raised and, as I understand it, members have followed the reporting process that they have been instructed to follow within their clinical area to raise those concerns.

Q. Would you accept, Ms Shepherd, that there's a possibility that the recent changes that you've introduced to better encourage staff to raise concerns about nominees might not be enough to draw to your attention the lack of suitability of a nominee like James Griffin? Do you accept that's a possibility?
A. Yes, I do accept that's a possibility and I think the important - in reflecting on our processes and reflecting on the conduct of James Griffin in 2019, which we took extremely seriously, it became evident that the behaviour of that individual and the grooming behaviour that had occurred within Ward 4K potentially wouldn't identify anybody, including an ANMF delegate, and that's why we have certainly looked at additional policies internally as to how we actually consider concerns that are raised with us.

We have implemented a mandatory training policy internally to encourage our staff to raise concerns if any are made in relation to abuse of children, child sexual assault, et cetera. We have nursing staff who work with us, we obviously have annual training recently conducted around reinforcing appropriate mandatory reporting requirements both with AHPRA and the appropriate legislation, and making sure that those that are front-facing positions with our organisers, our member support team that are interacting with members that, if our concerns are raised, that our staff are instructing our members on those reporting avenues and to consider making their voluntary reports themselves if they have had

allegations, you know, levelled against them.

Q. Just to make sure I understand, that policy that you've just referred to, is that the policy that's Exhibit or Attachment ES-2 to your statement; that is, it's a policy entitled, "Requirements of ANMF staff in relation to meeting mandatory reporting requirements"?
A. Yes.

Q. That's what you're referring to. And that's a policy that's dated May 2022. Is that a new policy or an updated version of a policy that was previously in existence?
A. That's a new policy. The policy's been in draft, we've been working on that with staff since obviously 2019 when we have reflected on the events of James Griffin and our support of members on Ward 4K, and we felt that it was important that we needed to be looking at our systems and our processes and understanding that, although we didn't have any knowledge of reports of inappropriate conduct or anything untoward, any disciplinary matters involving James Griffin, we felt that we needed to reflect and look at our systems to make sure that our systems and our policies were absolutely in line with best practice to support our staff in supporting members in these situations.

The May version, we have a draft policy for some time and there's been many changes to that and it was signed off by our executive in May.

Q. Just to be clear, this is a policy that applies to people employed by the ANMF; it's not a policy that is intended to apply to, although it may guide, your members in respect of their obligations?
A. That's right, it's for our staff, internal staff.

Q. And also, I think you said you conduct annual training now in relation to mandatory reporting; is that also a fairly recent addition?
A. Yes, in conjunction with the policy.

Q. Yes.
A. We absolutely feel that it's appropriate to, as I say, we have a number of registered nurses, registered midwives that work with the ANMF who understand their reporting requirements, but it's not only in relation to reiterating those requirements and how we might deal with a complaint if we ever did receive one, particularly if it was a

disclosure by a member that wasn't being acted on by an employer, how would that be handled; but importantly making it clear to staff that they will absolutely be supported if they have any concern.

We made it clear about the time and the resources that would be dedicated to that particular individual if they needed to make a mandatory report and also the counselling assistance that would be provided as well to ensure that we were reflecting a culture that we would like to see in other workplaces in light of the events of a workplace delegate to ensure that our staff felt fully supported.

Q. So, it's a policy that seeks to both guide staff in relation to their obligations, how to report a concern, and also to give them support when they do raise a concern?
A. That's right.

Q. And you see that at the ANMF as a responsibility of an employer to educate employees about those matters?
A. Absolutely, and I think that, you know, the events involving James Griffin have certainly allowed a significant period of reflection within our organisation and looking at how it is that we practice ourselves and how we support our staff in doing that so that they can best support our members, our delegates, and children within our Tasmanian community which we all have a vested interest in.

Q. Thank you, Ms Shepherd. I'd like to now ask you some questions about your understanding of mandatory reporting at the Launceston General Hospital based on the concerns that your members have raised with you.

Your statement refers to various meetings and discussions with members in the aftermath of Griffin's death, during which concerns were raised with you that complaints made about Griffin by colleagues were not appropriately responded to.

Now, I should say, Commissioners, owing to time constraints I'm not going to go into some of the detail in that statement, you have the benefit of that evidence.

I would like to ask you, Ms Shepherd, to speak about - you raise concerns about a lack of clarity and perhaps some confusion among your members as to the proper reporting processes in relation to mandatory reporting. I'll just

quote from paragraph 56 of your statement, and just to orient that in time, this is I think a concern that was raised with you during an initial meeting that you had with Ward 4K members immediately after or shortly after Griffin's death. Do you recall that meeting?
A. Yes, I do.

Q. And you say in your statement that:

Concerns were raised about varied reporting processes when a mandatory report for a child on the ward is required.

Are you able to inform the Commissioners about what those varied processes were?
A. Obviously, that particular meeting was a really difficult meeting with staff on the ward, it was immediately after the death of James Griffin. There were a lot of matters discussed at that time and naturally there was significant distress among our membership, and obviously reflection of, how did this happen, was very much the question among our members at the time.

That led to a discussion in relation to reporting and reports that our members were aware had been made in relation to James Griffin's conduct. There was one report that was quite recent from 2016 which was made by one of our workplace delegates. That information was shared, but then there was also other members indicating they were aware that other reports had been made, both verbally, via email, on paper-based incident reporting some time ago, and there was a collective recognition that there had been a pattern of reporting over a number of years.

That also then led to discussion around mandatory reporting when there was a clinical concern in relation to a paediatric patient on Ward 4K; that led to a discussion in relation to, often concerns were discussed within the treating medical team which would include the treating medical doctor and there might be other Allied Health professionals involved in that discussion, and members indicated that often the medical practitioner would say, "I will make the mandatory report for this child", and often in that instance it was acknowledged that members felt that there was this lack of clarity; is it the medical practitioner's responsibility because they were admitted under that medical practitioner? Others would say, "Well,

medical staff might say that to me but I'll go on to make a mandatory report anyway". But it was obvious to me there wasn't clarity around who was responsible and the acknowledgment that everyone had the obligation to report, and I think that then has also confused reporting around concern around a colleague.

And often, as I say, a lot of the discussion was centred around, "How do we report concerns for a child?", but is that the same when we're talking about reporting a concern for a colleague who is a staff member in an organisation, and we've been told we must follow this appropriate reporting process around, any concerns must go through our Nurse Unit Manager.

So, obviously ANMF in that very initial meeting with members on 21 October 2019 took the legislative Act, so Children, Young Persons and Their Families Act and we highlighted the relevant section around mandatory reporting, and we also had discussions with members around AHPRA mandatory reporting as well, but also voluntary notifications to AHPRA if there was a concern, and also making concerns in a confidential way if they had concerns.

But certainly, it was clear to me that there was confusion, lack of clarity, and there was a myriad of different reporting systems, in fact, where staff had asked management, when they had concerns about conduct of James Griffin, how they should report that. Some of the reports even within that room were different: some were via email, some were, "Speak to your Nurse Unit Manager", some were, after speaking with a Nurse Unit Manager, "Speak to Jim Griffin about it yourself", and others were reported through SRLS.

And certainly that concern and that confusion was something ANMF were advocating on behalf of members while we're meeting with the Chief Executive of Hospitals, that this confusion, lack of clarity and the culture of not supporting staff to be able to speak up and make these reports was of a great concern of members when they were reflecting of the events and what they could see was a pattern of reporting over a significant period of time.

PRESIDENT NEAVE: Q. I've got a question there. This is an issue, we're talking about LGH, but was this an issue that has been raised in relation to other hospitals in

Tasmania?
A. Certainly not in relation to child sexual abuse.

Q. No.
A. But certainly in terms of our advocacy, we have had repeated concerns raised with us from members that there's a continuous repetitive instruction to members that any concern within your workplace must first go through you're Nurse Unit Manager, and certainly I think in an attachment to my witness statement there was communication from an Acting Executive Director of Nursing at the Royal Hobart Hospital that sent a memo out to staff, even with a flowchart that states, "Any concern must first be raised with your Nurse Unit Manager".

So, I think there's this continuation and embedding of a culture that all concerns, irrespective of what they might be, must first be raised through a Nurse Unit Manager. However, I must say, obviously, members will be very clear if they were to witness instances of child sexual abuse, et cetera, but this was more around those concerns that members might have witnessed something else that might be unprofessional, not necessarily in relation to (indistinct) --

Q. So it could theoretically be a concern about medical competence, for example?
A. Yes.

Q. Something that happened to an adult or a child?
A. Yes.

Q. But was observed by nurses and they weren't quite sure what to do about it?
A. Yes, that's right.

Q. Is that fair?
A. Yes, that's fair.

PRESIDENT NEAVE: Thank you.

MS NORTON: Q. The evidence that you've given to the Commission is, you've certainly given evidence that your members at that meeting shortly after Griffin's death conveyed to you that they were confused about their options for reporting directly to AHPRA, and that there were mixed messages, if you like, about what the correct approach was.

Would you go so far as to say that your members, or some of your members, felt constrained by hospital policy in terms of their ability to report concerns about a colleague directly to AHPRA?
A. I think that's a fair account, and I think that in the case of our delegate, Will Gordon, obviously had raised his concerns as instructed and as processed through the SRLS reporting system and via email.

It was also evident during that meeting with members that outside of their Nurse Unit Manager and perhaps the Nursing Director they were unclear on the governance process and the governance chain, if you like, of escalation of concerns and they weren't actually clear on who they would actually escalate a concern to outside of their immediate Nurse Unit Manager or perhaps their Nursing Director.

So, that was obviously an added issue, but certainly in terms of constraint, I think our members absolutely felt that way and certainly the individual accounts that many members provided - and, I must say, some of those accounts might not necessarily have been reasonable grounds to make a mandatory report, but their concern was that there was this what appeared to be a pattern of incidents that, you know, was bordering on unprofessional behaviour, and I think that that was really a concern about, well, how is it that that is captured over time and how is that escalated?

MS NORTON: Q. I want to come back and ask you some questions about patterns of behaviour, but before I do you've referred a few times now to Will Gordon and you will, of course, be aware that Mr Gordon gave evidence earlier this week and he ultimately raised his concerns about management's response to staff concerns about Griffin with the Integrity Commission.

You also refer in your statement to having suggested to members that they raise concerns with the Integrity Commission. Why did you make that recommendation or that suggestion?
A. The suggestion to members to make a report to the Integrity Commission was following conversations with management and culminating with a meeting with the Chief Executive of Hospitals, Eric Daniels, following correspondence that were sent to the Nurse Unit Manager in relation to our members' concerns. They weren't a surprise

to the Nurse Unit Manager. I'd met with the Nurse Unit Manager and the Nursing Director around those concerns.

Q. I'm reluctant to cut you off, but I'm just conscious of the time and I'm conscious that we have your evidence and we have evidence from other witnesses about the events leading to Mr Gordon's concern or his complaint. Can I ask the question a different way.

In suggesting to staff that they go to the Integrity Commission what did you think might be gained by having the Integrity Commission look at a complaint?
A. Sure. Obviously, we'd pursued every avenue that we felt we could and our members had, too, internally within the organisation. Going to the Integrity Commission and recommending our members to go to Integrity Commission we had hoped that there would be an independent and objective assessment of our members' concerns that might bring about a fresh set of eyes and analysis of the concerns that our members had raised and an independent objective review of complaints that perhaps might paint a different picture for an independent person outside of the organisation.

Q. And, did you consider that such independent oversight was necessary in circumstances where your members had not been satisfied with the oversight, for want of a better word, that was provided within the hospital?
A. In this instance, I did; I felt that that was really important. I did have the opportunity to speak with the Secretary of the Department of Health in relation to the Integrity Commission report and the fact that it was made on a confidential basis made it difficult for any further follow-up with the reporter to seek further details and clarification, so that did make it difficult, but in my mind the fact that our members didn't - no longer had confidence in the organisation within the Tasmanian Health Service it was important to have a completely objective assessment so that, not only was it an objective assessment, it was also giving confidence to our members about the way in which the investigation was carried out.

Q. Was that suggestion, that your members consider going to the Integrity Commission, one that you made lightly or a suggestion that you make often to your members?
A. Well, look, obviously we will always advise members on their options and at the end of the day we don't know our members' level of depth of concern, but certainly it's not

a suggestion that we would actually suggest to a member, "I think that this is where you need to go with your concerns", and that was actually direct advice, that "I think this is the avenue you now need to take to have this issue addressed for you".

Q. Was that because you felt that your members had exhausted their options for review of the hospital's actions internally within the Department of Health?
A. Yes, I had, and after following the meeting with the Chief Executive of Hospitals, to be frank, I felt that the ANMF had exhausted all of our avenues of enquiry as well, and I felt that that was an appropriate avenue to escalate these concerns to have them addressed.

Q. I'm sure you're aware prior to this week, but certainly following Mr Gordon's evidence this week, that that complaint that he made to the Integrity Commission was ultimately referred back to the Secretary of the Department of Health for investigation. I think it's fair to characterise the evidence that was given yesterday by Mr Bellinger, an HR Manager - he's now a manager, he may have been an advisor at the time - but he was ultimately charged with that re-investigation, in conjunction with some other colleagues, but it was referred back to the HR Department. And I think it's fair to describe him as having given evidence or accepted the proposition that the review he undertook at that point was really a desktop review of reviews that had already been undertaken by the hospital.

Does that sort of process accord with the kind of independent oversight and independent investigation that you expected to occur following a complaint to the Integrity Commission?
A. No, it doesn't, and that's why we supported our members previously. Even in 2019 our members had wanted to go to the media, and certainly as advised by the Chief Executive of Hospitals that would indicate that under the State Service Act they'd be putting their employment at stake if they did that, which is why we pursued every other avenue, but ultimately that's why we went public with our workplace delegate in calling for a Commission of Inquiry because we didn't have confidence in the processes, even through the Integrity Commission, to bring to light the - you know, the systemic changes that were required to ensure that the events that had transpired with James Griffin

never happen again.

Q. Thank you.

COMMISSIONER BROMFIELD: Q. Ms Shepherd, did any of your members express any concerns about - that there was any conflict of interest for Mr Bellinger to be involved, or the HR Department to be involved in that investigation?
A. Well, at the time our members, and certainly the ANMF weren't aware that Mr Bellinger was involved in that investigation; we were only aware that the report to the Integrity Commission had been made, and also, that the response to our workplace delegate, Will Gordon, to say that it had been referred to the Secretary of the Department of Health; so, they weren't aware that there was any further action even occurring, so wouldn't have had the opportunity to raise a conflict of interest at that point.

Q. Do you have any concerns knowing that now?
A. Yes, I do have concerns. Obviously, the fact we'd advised our member to go to the Integrity Commission was simply to have an independent and objective person outside of the organisation undertake that investigation and analysis, someone removed from relationships, environments and cultures within the organisation, and it is concerning that it has ended up back with, you know, the organisation, I suppose, in which we'd wanted it to step outside of.

Although, as I say, privy to that further discussion with the Secretary of the Department of Health I do understand that, because it was an anonymous report, it was difficult for them to make further enquiries, but certainly an appointment of an independent investigator perhaps may have been or would have been a preferable option than returning it back to the organisation in which the complaint arose out of.

COMMISSIONER BROMFIELD: Thank you.

MS BENNETT: Q. Can I just clarify, Ms Shepherd, you referred a short time ago to having had a conversation with the Secretary of the Department of Health in relation to the Integrity Commission report. Can I just clarify, was that a conversation in response to the referral of the complaint back to the Department of Health or in relation to some other matter?
A. So, the conversation with the Secretary of the

Department of Health occurred after the podcast, The Nurse, by Camille Bianchi was released and the internal investigation by the Tasmanian Health Service was announced, and the Secretary and I had a conversation; obviously, the Secretary was then privy to the correspondence between the ANMF and the Chief Executive of Hospitals, Eric Daniels, and obviously the advocacy that we'd been undertaking for some time, so that conversation occurred after the concerns of members were made public.

Q. I just want to ask you a further question about evidence given by Mr Bellinger yesterday. Now, you may have seen or otherwise read about evidence given by Ms Kylee Pearn yesterday to the effect that she and her manager at the time, Stewart Millar, who also gave evidence, went to HR in 2011 and she disclosed there that Griffin had sexually abused her as a child.

Ms Bennett asked Mr Bellinger a question yesterday about - no, I'll withdraw that. Mr Bellinger was asked a question yesterday about what should happen when HR are notified that an employee of the hospital, and indeed an employee on the Children's Ward, had previously sexually abused a child and he said his first step would be to get Solicitor-General advice. I'd just like to invite you to comment on whether you would expect that to be the first step upon receiving notification of that kind and, if not, what you would say ought be the first step?
A. My first step would be reporting it to the police.

Q. Thank you. You mentioned before patterns of behaviour and I know you speak in your witness statement about the fact that management is better placed to pick up patterns of behaviour; you might have individual colleagues who report concerns here and there, but management is able to have a bird's eye view and identify patterns in behaviour. Would you agree that that's an important process and that patterns ought be looked for, including by HR departments?
A. Absolutely, and I think one of the challenges that has become evident is the myriad of reporting lines by which members raise concerns in relation to James Griffin. As I say, some of them were verbal conversations, some of them were via email, some of them were via SRLS, and as I understand it they were on the paper copy of incident reports in years gone by, but I would like to think that those reports, irrespective of how they are reported, are kept and collected, because I think it's one thing to look

at a concern that might be raised about an individual in a clinical environment around a clinical practice concern, for instance, legibility of documentation, for instance, versus looking at a pattern of behaviour through the lens of protecting children, and I think that they're two very different things and I think that the myriad of reporting systems that were in place and the fact that SRLS or Safety Reporting Learning System has been used at times to make those complaints doesn't lend itself to being able to collect those complaints in a central repository or in a collective way to allow for that analysis of patterns of behaviour.

Q. You drew a distinction there between concerns about child sexual abuse or inappropriate behaviour and other disciplinary matters. Would you agree that, by virtue of that distinction, HR ought take a different approach to managing concerns or responding to concerns where they put at issue child safety?
A. Absolutely, and I think that goes to the training and education; members raised that they had never obviously - well, some of them didn't recall, some vaguely recalled education around mandatory training, but certainly not around grooming-type behaviours and that was certainly something that they had raised that they wished that they had had because that certainly would have allowed them in their clinical context when looking at a behaviour that they thought was a bit weird or a bit odd might have actually empowered them to be able to raise their concern and escalate it, rather than just thinking, well, that's a bit odd. When you look at it through the lens of grooming behaviour it gives an entirely different context to an individual or collective series of complaints.

Q. We're just been talking about the importance of HR or management, if I can put it more generally, identifying patterns in behaviour, and would you agree that it's important not only to identify them but also to act on them when they emerge?
A. Absolutely. Absolutely, it must be acted upon, and certainly that's the advice that, you know, we've provided to our members when we met with them immediately after James Griffin's death; it doesn't matter what you might be told by your manager, you have an obligation if you've got concerns, then report it.

Q. And I should clarify, my reference to patterns being

acted on, I meant acted on by management; you'd agree with that?
A. Yes.

Q. One of the difficulties that Mr Harvey identified yesterday - he's an HR advisor within the Department of Health - is a difficulty that HR face in dealing with unsubstantiated complaints. I think the evidence was by reference to Mr Gordon's 2017 SRLS report, which I think you're familiar with. There was a component of that report that was found to be unsubstantiated and this is in relation to whether or not Griffin said on the paediatric ward to adolescent patients that he "wanted to shag Titsy the nurse". Are you familiar with that allegation?
A. Yes, I am.

Q. That was put to Mr Griffin and he said that he'd made that comment outside of the workplace and it had been overheard by a patient. Are you familiar with that evidence or that --
A. Yes, I am familiar with the evidence. I wasn't aware until earlier this week that that was the outcome of the investigation though.

Q. The outcome of the investigation was that that allegation was found to be unsubstantiated, and I think it's a fair summary to say that Mr Gordon gave one account of what the girls on the ward said and Mr Griffin gave a different account, so it's a he said/she said, if you like. And Mr Griffin's account was preferred without there being any further investigation, including of the girls who were on the ward or the mother to whom Mr Griffin said he'd made the comment outside of work.

Mr Harvey gave evidence that HR are constrained in their ability to refer back to unsubstantiated complaints of that nature if in future another similar complaint comes up, and I'd like to invite you to respond to whether the ANMF is of the opinion that HR ought be constrained in that way in circumstances where child safety is concerned?
A. Well, first and foremost in relation to child safety, I don't think they should be constrained at all. I think there absolutely should be assessment of previous complaints through the lens of protecting children. And I would also say that, in terms of the investigation, that a more fulsome investigation and interviewing of the patients, the girls in the scenario and the incident that

Mr Gordon reported should have been fully investigated. And I think from an ANMF perspective, of course we support the principles of natural justice and without undertaking a fulsome investigation it's actually not serving anybody: it's not serving the person making the complaint, it's not serving the person who's had the complaint made against them, and it's certainly not serving vulnerable children in a paediatric ward.

And yes, I did hear the evidence provided that, of course, we have to be conscious of paediatric patients with their own set of clinical circumstances, but there are ways in which those interviews can be conducted sensitively, and I don't think there's anything that's more important than ensuring the safety of the children on a paediatric ward and that should be the absolutely priority in that situation and in that investigation.

Q. Having regard to what you've just said about child safety needing to be the absolute priority, how does that impact on the approach that the ANMF takes or would take if a member of the union was accused of inappropriate behaviour or child sexual abuse and came to the union for support?
A. Sure. Well, obviously, again, as I say, we subscribe to principles of natural justice and we advise our members of process. If there are criminal charges that have been laid we advise members to get independent legal advice; we don't support members who have criminal charges against them. But certainly in the event if allegations are raised we support our members through the process.

And certainly reflecting on the incident that you referred to in the SRLS made by Will Gordon, in that instance we would actually be suggesting that a more fulsome investigation be carried out because they are serious allegations, which is also another reason to fully investigate to ensure that every party is equally represented and that there is an outcome and an outcome can be determined wherever possible; that can't be done without fulfilling the benefit of having all parties interviewed that were involved, making sure that all the evidence is before you to come to a determination.

Q. And in that circumstance, while investigations are being undertaken, would you oppose a member being stood down in order to ensure child safety during the

investigation phase?
A. No, certainly, obviously we'd advise our members around the process, what's available to their employer to be able to do that. In fact, we advise our members in those circumstances to make their own voluntary report to AHPRA if they haven't already done so, and we advise the member to trust in the process, trust in the investigation and follow the process, engage and be reflective.

MS NORTON: Thank you Ms Shepherd, I have no further questions.

COMMISSIONER BENJAMIN: Q. Yes, I have one which may be a series. I note in your submission that the ANMF have concerns about the efficacy of Working with Children Checks. I think you've set that out. Can you assist me: are you aware as to whether all nurses in children's wards in hospitals in Tasmania are required to have that check?
A. To the best of my knowledge, yes.

Q. Do all nurses have to have that check?
A. Not all nurses, no.

Q. And, who normally pays for that check, because they're not inexpensive, are they?
A. I believe it's the individual, but I think that there are various - depending on the employer, whether it's public, private, et cetera, there are often instances where the employer might cover the cost of the check.

COMMISSIONER BENJAMIN: Thank you.

PRESIDENT NEAVE: Any questions?

COMMISSIONER BROMFIELD: No, thank you.

PRESIDENT NEAVE: I don't think we have any further questions, thank you very much.

MS BENNETT: Thank you, President Neave. If that witness can be excused, the next witness is Mr Gino Fratangelo.

While that witness swaps and position is taken over I'll just explain the current plan for the rest of the afternoon. I will endeavour to start Mr Sherring's evidence before the lunch break, but obviously we'll need to pause his evidence, perhaps break for lunch and then

return with him after lunch and make a few cascading changes to the afternoon which I'll raise with the witnesses in the afternoon during the break.

If that's convenient and if that small interlude has filled the time necessary to obtain the next witness, I could ask Mr Fratangelo to come into the witness stand.

PRESIDENT NEAVE: And I believe Mr Fratangelo is represented.

MS BENNETT: Perhaps his lawyer could also come to the Bar table.

PRESIDENT NEAVE: I'm sorry, do we have an appearance?

MR SULLIVAN: Mr Sullivan for Mr Fratangelo.

PRESIDENT NEAVE: Thank you.

MS BENNETT: I'm sorry, I've mispronounced your name, it's "Fratangelo", is it?

MR FRATANGELO: "Fratangelo".

PRESIDENT NEAVE: You can remove your mask, Mr Fratangelo, if you're happy to. Thank you.

<LUIGINO (GINO) FRATANGELO, sworn: [12.37pm]

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. You've made a statement to assist this Commission in response to a notice; is that right?
A. That's correct, yes.

Q. And, have you reviewed your statement recently?
A. Yes, yes.

Q. Are its contents true and correct?
A. Yes.

Q. You say at the end of your statement that you spoke to no-one but your lawyers in preparing your statement; is that right?
A. In preparing the statement, yes, that's right, yes.

Q. Have you spoken to anyone since preparing your statement other than your lawyers?
A. Not in regarding to my statement. I did speak to Mr Bellinger but it was more the, "Are you okay" type exchange.

Q. When did you speak to Mr Bellinger?
A. Oh, it would have been emailed yesterday and this morning as well.

Q. Can you tell us what you spoke with him about?
A. Yeah, "Are you okay?" Ah, yeah, I've probably got the emails probably at home if you want to look at them?

Q. Yeah, we would. Will you be able to provide them to the Commission?
A. Yeah, I should be able to, yeah.

Q. How long did you speak with him for before giving your evidence today?
A. Five minutes, if that, two minutes maybe.

Q. Did he talk to you about the evidence that he gave?
A. No.

Q. Did you talk to him about the evidence you propose to give?
A. No, no, no, we - I've been quite, um, conscious of the not talking to anybody, not seeing anything, not reading anything, not watching anything up until I had my hearing appearance, then I'll talk to somebody.

Q. So, have you watched the hearings this week?
A. No.

Q. So, are you aware of the evidence of Ms Kylee Pearn this week?
A. No.

Q. Perhaps you might know her as Kylee Bannon?
A. Ah, yeah, probably more Kylee Bannon I think.

Q. Are you aware of her evidence this week?
A. I haven't read it, no.

Q. Have you heard anything about it?
A. No, I - I've seen her statement.

Q. Yes.
A. But no, I haven't got media reports or anything like that, no.

Q. And you didn't watch the evidence?
A. No.

Q. And the evidence of Mr Stewart Millar, have you watched that evidence?
A. No.

Q. Do you know the evidence of Mr Stewart Millar?
A. I've seen his - I think it was two documents?

Q. Yes?
A. Yeah, I've seen those two.

Q. Those statements that he made?
A. Yes.

Q. You know Mr Stewart Millar?
A. Yeah, I remember him as, um, the manager of the social work department.

Q. Yes. Did he have an assigned HR contact as the manager of the social work department?
A. We would have had - we were a small team, there was only two or three of us at any one time, so if he may - he wouldn't have been allocated a person, put it that way, but he could have rung whoever he wanted to and I guess if he was comfortable with that person over a period of time, then probably his first point of call probably would have been to contact that person first.

Q. So, it would have been, he elects who he's comfortable calling within the HR group without a specific designation; is that fair?
A. Yeah, I think that's fair.

Q. Is it fair that a small group meant that it was flexible in its operation? There were no strict delineations in who took what call, for example?
A. No.

Q. So, anyone might receive the call at first instance and then take the steps they deem to be appropriate and

necessary; is that fair?
A. Yes.

Q. And so, do I understand then that there wasn't a formal allocation of an HR person to a particular department?
A. No, not that I can recall.

Q. But, if Mr Millar felt comfortable calling you, he might call you; is that right?
A. That's right.

Q. And if he felt comfortable calling Mr Bellinger, he would call Mr Bellinger?
A. That's right.

Q. And that's consistent with your understanding?
A. That's how I remember it, yes.

Q. You worked across a number of parts of the Department of Health over the years: you've worked in the Human Resources Department since 1980 and you finished in 2019; is that right?
A. Ah, not quite. Yeah, 1980 I started as a pay clerk.

Q. Yes.
A. And I don't think payroll was part of Human Resources then. I think we had that many restructures, to be honest, I really can't think when actually Human Resources became Human Resources if that makes any sense.

Q. Yes, so you, from 2004 to 2019, you say in your statement you worked as a Human Resources consultant; is that right?
A. Yeah, that sounds right.

Q. So from that period you were working in Human Resources?
A. Yes.

Q. And you were involved, you say in your statement, as part of the Department of Community and Health Services, the Hospital and Ambulance Services, the Tasmanian Health Organisation and the Tasmanian Health Service. Now, were they all separate parts of the Department of Health?
A. I think when I first started it was the Department of Health but it had so many restructures and so on, so at any

given point between 2004 and 2019 it would have been a restructuring and then it was called the Tasmanian Health Services, or and then it was called the Tasmanian Health Service North. I can't really remember what the structure or the name of the department was at any particular time.

Q. Did it change your experience - withdraw that. Did it change your practice what part of the structure you were in?
A. I'm not sure I quite get that.

Q. You were sitting in the same building throughout the - in the same area; is that right?
A. Yes.

Q. So physically located in the same place between 2004 and 2019, roughly?
A. Yeah, roughly, there might have been office changes, yeah.

Q. And roughly with the same team over that period?
A. No, I don't think so.

Q. Or people came in and out?
A. Yes.

Q. But you stayed in your place?
A. Yeah, from 2004, yes.

Q. And your reporting lines changed somewhat over that period of time?
A. Oh, they would have done, yes, what I remember, yes.

Q. But so far as you're concerned your duties remained reasonably the same over that period of time?
A. I think - well, I can't really remember to be sure. I would say the majority would have stayed the same all the way through, but maybe some - some new duties may have been added as the years went by, but I'd say the crux of it would have been about the same if I had to think about it.

Q. And the practice you described of people with whom you had a relationship contacting you remained constant over the time?
A. Sorry?

Q. The practice you described, where people would contact

you directly for Human Resources assistance, remained consistent over the time?
A. Yes, I remember it, yes.

Q. You had some responsibility for assisting. As you describe it, your duties included providing advice to employees and managers in the north of the state, and that's advice concerning Human Resources issues?
A. That's right.

Q. And that could include, despite that as I understand your evidence, you say you have no understanding of when and how to report a concern of child sexual abuse or other child abuse to Child Safety Services; is that right?
A. That's right.

Q. So, if someone came to you with a question about that, you wouldn't know how to answer?
A. No.

Q. You wouldn't --
A. I mean, yeah.

Q. -- have expertise - sorry?
A. Yeah, I was trying to say - yes, going to your second question, I would not have the expertise, yes.

Q. You would not have the expertise?
A. I would not have the expertise, yes.

Q. And you would not have any expertise or training in how to identify issues of child sexual abuse?
A. No, I wouldn't have had.

Q. You worked with Mr James Bellinger. Do you remember the period of time where you worked with Mr Bellinger?
A. No, I can't remember when he started, to be honest. I don't know, maybe a decade, I don't know, maybe --

Q. Did you work --
A. Sorry? Yeah, no, I can't really remember when he started.

Q. Was there a specific time where you met him for the first time or was he somebody who was around before he worked with you?
A. I think, I might have met him when he worked in the

pay personnel department.

Q. That's where you started in 1980?
A. No, no, I think that's when I met him, because I think Mr Bellinger might have actually worked in the pay personnel department at one point, so I think that's when I first met him.

Q. You knew him over a number of years?
A. Oh, not knew him, knew him; knew that he worked in the pay - I think it was the pay personnel area at the time, yeah.

Q. You knew he worked in HR?
A. I'm trying to remember. Yes, I think actually, I think he - from pay personnel I think he also moved to HR but I think it was a different area of HR to - when I say "different area", there was a Hospital and Ambulance Services which I can remember, but then there were other areas as well and I think he worked for one of those other areas, but I can't remember a time period or anything like that.

Q. Did you have contact with him when he worked in those other areas?
A. I say no, but bumping in a corridor or something like that, yes.

Q. I asked you before about Mr Millar. Do you remember any meetings with Mr Stewart Millar?
A. Yeah, I do remember meetings with Mr Millar.

Q. Do you remember, why would you have meetings with Mr Millar?
A. The one I remember clearly, it related to a matter that was lodged in the Anti-Discrimination Commission, so I can remember speaking to Mr Millar about that. When I say speaking, meeting with Mr Millar about that.

Q. Do you remember roughly when that was?
A. No, but there'd be a file somewhere on that.

Q. And so, in 2011 did you have a meeting with Mr Millar and Kylee Bannon or Kylee Pearn?
A. I can't remember, um, that meeting, being at that meeting or of that meeting, but there's nothing - I mean, I may have been there from what I've read from Mr Millar's

two documents and Ms Bannon's document, so maybe I was there but I can't remember it.

Q. What makes you say "maybe I was there"?
A. Only because - well, I've got no reason to doubt Mr Millar because - and I've got no reason to doubt Ms Bannon, and so where they say I may have been there, then I've just got no reason to say that, no, I definitely wasn't there; maybe I was and I just can't remember it.

Q. In fairness to you, Mr Millar gives evidence that he's 99 per cent sure that you were present at a meeting and that at that meeting Ms Bannon told you, and perhaps somebody else, that she had been sexually abused by Griffin as a child. Do you remember that?
A. No.

Q. And Ms Bannon says that in that meeting she felt fobbed off and that she was told to go and get a conviction against him and that nothing could really be done. Do you remember that?
A. No, and I don't think I would have used those words if I was there.

Q. I'm paraphrasing.
A. Sorry.

Q. Did you consider an ANMF delegate to be a problem if you needed to raise a disciplinary concern against them?
A. No.

Q. You had no concerns at all that they were a union rep?
A. No.

Q. Did you think it was a significant matter if somebody had come to you to say that they had been subject to child sexual abuse by a nurse? Your understanding of the process, what should your response have been?
A. What was the question again, sorry?

Q. If someone came, if Kylee Bannon and Stewart Millar had a meeting with you in which Kylee Bannon said, "I was sexually abused by a nurse on the paediatric ward when I was a child", what should you have done?
A. I would have told her to go to the police, because she would have described a criminal - a criminal act.

Q. Would you have told her - I'm sorry, I interrupted you, go on.
A. No, no, you're right.

Q. You would have told her to go to the police; would you have gone to the police?
A. I don't know whether I would.

Q. Would you have taken any steps to have that nurse removed from the ward?
A. I'd have to go back and think that, if it was a criminal act - yeah, if I went back I think the State Service Act had a Code of Conduct and one of the sections on it was "an employee must abide by Australian law". We also had an employment direction that talked about, or it described rather how to investigate potential breaches of the code. And one of the - so, to investigate whether someone had breached that section of the code, that is, they didn't abide by Australian law because they broke a law, one of the key pieces of evidence is that the person was convicted. But we'd step back as well, because there was also another employment direction that talked about the suspension of employees that was subject to an investigation, and I've forgot what that said as well. I'll say what I think it says because I don't know if it's changed since, but I'm sure what it said at the time was that, if someone was charged then you could move the person if that was practical to do so, or if it wasn't practical to do so or it wasn't in the public interest to do so you could suspend the person, so that would have covered the period from being charged right through to the conviction. That's how I remember it.

Q. So, if Ms Bannon's evidence is that, upon disclosing this, she was told by a member of HR that she needed to have Griffin charged before anything could be done about his employment, that would be consistent with your understanding of the way the process should work?
A. Well, I don't think it'd be that she should get - sorry, Ms Bannon should get Mr Griffin charged; I think it's more, she needs to go to the police, yeah.

Q. So, if her evidence were, and it was, that she was told by somebody in HR that she needed to go to the police about her allegation against Griffin before HR could take a step, that would be consistent with what you would understand the correct process to be at the time?

A. What I understand the process was at the time, that under those two Employment Directions, to determine whether someone had breached the code by not abiding with Australian law they had to initially be charged. That's how I understand it or remember it, yeah.

Q. And so, if I can suggest to you that that's precisely what happened in 2011, what would be your response?
A. Sorry, if that was?

Q. I'd like to suggest to you that that is precisely what happened in 2011 and I'd like to get your response to that?
A. That he was charged?

Q. No, I'm sorry. That Ms Bannon came to you in 2011 and said that she had been abused by Griffin and that you said, "You need to go to the police before I can do anything"?
A. I would have - I wouldn't have said it like that, if - like I said, I've got no recollection of the meeting, but I would have explained that process, obviously in a different set of words, but I would explain that process.

Q. But in essence that's what you would have done?
A. In essence I would have said, "These are the two provisions that we've got and this is where it fits if he's charged", yes.

Q. And I'd like to be really clear that I'm suggesting to you that that's what you did do, albeit that you cannot presently recollect?
A. Well, look, I can't comment on that; honestly, it surprises me that I have no memory of it, to be honest.

Q. Yes, it's the sort of thing, it's a significant matter, isn't it?
A. It is, because I - you know, I can remember clearly some things, many things, but for whatever reason I can't remember this.

Q. Do you remember any other gossip or discussion about Griffin?
A. No.

Q. Did you talk about, do you ever remember discussing Griffin with Mr Bellinger or any of your other colleagues?
A. No.

Q. Was it your practice to take file notes at any time?
A. Yes, we used to make file notes.

Q. Would you have made a file note of this disclosure?
A. I think I would have made a note back on the computer, just typed up a note, "Met with", if I met with, whoever - yeah, I would have thought so.

Q. Do you know where that note might be?
A. Oh, if I made a file note it'd be on the computer somewhere.

Q. The computer at work?
A. Yeah, my computer at work.

Q. Would you have emailed anyone with it?
A. I don't think so, I don't think I would have, would have made my own notes, I guess. When I say "I guess", I think that's what I would have done if I was taking file notes.

Q. We might have our solicitors ask you about the search parameters for that document after your evidence.
A. Yes.

Q. Was there any catastrophic IT failures that you recall around the HR systems?
A. Not that I --

Q. Do you remember your emails being lost at any stage?
A. No, I don't, to be honest.

Q. Do you remember anyone else's emails being lost at any stage?
A. Yes, I think one of my colleagues did. Um, yes - yes, I can.

Q. Would you not have met with one of you're superiors after a meeting like that with Ms Bannon?
A. Well, I'd like to - under normal events, yes, but I just can't remember whether I did or I didn't, but I'd like to think that I did.

Q. Yes, and it would have been your usual practice to have such a meeting?
A. Yeah, because we're such a small unit we used to meet informally as a small unit and just discuss what we were

doing, who was doing what and where they were at with what.

Q. So there would have been informal communication about the goings-on of the day; is that fair?
A. Yes, that's correct.

Q. And there are no meeting notes or records of those conversations?
A. I can't recall there being so.

Q. Just one moment. I just want to make very clear that I've covered this with you as a matter of fairness and I just want to give you the opportunity: did anyone from Tasmania Police ever contact you about any concerns about Griffin?
A. No, not that I - no.

Q. Did you ever contact Tasmania Police with any concerns about Griffin?
A. No.

Q. Did anyone within the hospital hierarchy, anyone else at all other than Ms Pearn and Mr Millar, and Ms Bannon and Mr Millar, ever come to you with any suggestion whatsoever that Mr Griffin had engaged in inappropriate conduct or child sexual abuse?
A. I can't recall the meeting, but - so when I say I can't recall the meeting, so I can't recall - so I don't think they would have come to me at any other time. Like I said, I can't - I just have no recollection of that meeting.

Q. No, I'm asking you now about any other meeting --
A. Oh, any other.

Q. -- any other phone call, any other?
A. Yeah, sorry, I misinterpreted. No.

Q. Would you have expected that there be a note of the disclosure kept with Mr Griffin's file?
A. I'm trying - ah - yeah, I guess it's fair to say I would have expected a note to be made of the meeting, and equally would have expected - well, I would have expected that I would have spoken to my manager about the meeting, if I was there, and equally I suppose I expect that Mr Millar would have spoken to his manager as well.

Q. Yes, and do you remember who your manager was in 2011?
A. It would have been either one of two people.

Q. Yes.
A. There was [redacted] and [redacted].

Q. Yes.
A. I can't think if there was anyone else back then.

Q. Did anyone ask you about this conversation before this Commission of Inquiry?
A. Yes, I met with Mr Bellinger late - I think it was either late 2020 or early 2021, um, and he said, "Can you recall being at a meeting with Mr Millar, Ms Bannon, in which you said words to the effect, 'Oh look, the person needs to go to the police'". And I thought about it and in all honesty I've been thinking about it ever since. I said, "No, I can't remember it at all", so that is basically it - the conversation, that is.

MS BENNETT: Commissioners, I think I have nothing further, unless my learned instructors remind me of a matter that I need to put as a matter of fairness, but those are the matters that I seek to examine this witness on at present.

PRESIDENT NEAVE: Thank you. We'll just break.

MS BENNETT: Yes, I apologise for running over time, Commissioners, thank you.

PRESIDENT NEAVE: Thank you, yes.

LUNCHEON ADJOURNMENT

MS BENNETT: Please the Commissioners, the next witness is Mr Michael Sherring.

<MICHAEL ANTHONY SHERRING, affirmed: [1.51pm]

PRESIDENT NEAVE: Q. You can remove your mask, yes.
A. Thank you.

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. Mr Sherring, please tell the Commissioners your full name and professional address?

A. Michael Anthony Sherring, Launceston General Hospital.

Q. Mr Sherring, you have worked at the LGH since about 1990; is that right?
A. Yes.

Q. Between 2003 and 2008, you were responsible for clinical education, professional development for staff in the Paediatric Unit, right?
A. From 2000 until October last year I still have a one day a week role in the Paediatric Ward.

Q. Thank you. You acted as a Nurse Unit Manager for a period of time; what period of time was that at 4K?
A. Recently I job shared with Sonja Leonard, I think it was early 2018. I did a stint in the 1990s. I can't recall another stint during that period.

Q. So, you job shared with Ms Leonard for a period of time?
A. Yeah.

Q. When was that?
A. I think it was either early 2017 or early 2018.

Q. Mr Sherring, I'd like to start by speaking to you about Mr Griffin. You knew him since 2001 or 2002; is that right?
A. 2001 when he commenced the Graduate Certificate in Nursing in Paediatrics.

Q. You were aware of a number of issues with Mr Griffin over the years; is that right?
A. Yep, professional boundary issues mainly.

Q. Can I ask you what you understand to be a professional boundary issue?
A. Professional boundaries determine the therapeutic relationship between nurses and clients, it should have a start and an end point with a therapeutic relationship. In smaller communities like Launceston you can run into people from the community, family members, and those should be identified and managed. It does officially preclude things like sexual conduct with patients and it would also - there are elements of that where nurses are required to reflect on and examine their own practice and determine whether or not they're having boundary violations as part of that.

Q. In relation to children, drawing on the knowledge that you now have, there is significant overlap, is there not, between what you might call professional boundary issues and potential grooming?
A. Absolutely.

Q. Those two things might be the same thing; is that fair?
A. Yes.

Q. Is it fair that in your pre-2019 experience at LGH matters that you might now describe as grooming were previously described as "professional boundary issues"?
A. Yes.

Q. When was your first concern with Griffin raised?
A. I don't recall the exact details, but when the 2009 incident regarding the Child and Adolescent Mental Health patient came up I was requested to document some professional boundary discussions I had had with Mr Griffin in 2002; I don't recall the exact nature of that, they would have been submitted probably as a written document at the time and I'm not --

Q. Let me pause and break it down. So, did you say there were issues in 2002?
A. I reflected on issues that I'd discussed with him in 2002 at the 2009 incident.

Q. That's right and so in 2002 you had discussions with him concerning professional boundaries, centring around overly friendly behaviour regarding children and young people exhibited by Jim. This includes hugging on greeting and other non-care related touching. I'm reading now from your file note. Is that your file note?
A. Yes.

Q. That's a file note you wrote in 2009?
A. Yes.

Q. And it concerned discussions you had in 2002?
A. Yes.

Q. What were the issues that gave rise to those 2002 discussions?
A. I can't remember specifically.

Q. Save to say that there was hugging on greeting and non-care related touching?
A. Yes.

Q. Can you assist the Commissioners to know what you mean by non-care related touching?
A. It would be cuddling, touching on the arm, yep.

PRESIDENT NEAVE: Q. Conversations?
A. Not specifically if I was referring to touching.

PRESIDENT NEAVE: Okay, thank you.

MS BENNETT: Q. I'll ask the operator to show the document as a matter of fairness, it's at TDOH.0003.0006.0008_PA at -0001. You will see this document here, that's your file note, isn't it?
A. Yes.

Q. I've just read the first sentence of paragraph 2 and I'll read again from the second part of paragraph 2:

I identified the inappropriateness of this and the potential risk of people misinterpreting such behaviour.

A. Sorry, where are we?

Q. Second paragraph?
A. Yes.

Q. "The 2002 discussion", you see those words?
A. Yes.

Q. And you can see that after the words "non-care related touching" it starts with the words, "I identified the inappropriateness of this". Do you see that?
A. Yes.

Q. You identified the inappropriateness to Griffin; is that right?
A. Yes.

Q.

... and the potential risk of people misinterpreting such behaviour.

Were you warning Griffin that people might think he was grooming children?
A. I did not have that conscious thought at the time I don't think, my knowledge of grooming has expanded considerably in the last three years.

Q. Is it fair, though, that you were giving him a warning at that stage that his behaviour might be misinterpreted?
A. Absolutely.

Q. Are you giving him the benefit of the doubt? Are you assuming that people are misinterpreting his behaviour?
A. I think I would have given him the benefit of the doubt at that point, I'd only known him a short period of time.

Q. Is it fair that that's the basis on which the hospital then proceeded, you and your colleagues then proceeded, was that he was apt to be misinterpreted?
A. I can't speak for my colleagues, and I don't believe I followed through in that way.

Q. Do you think that he was at a greater risk of being misinterpreted, as in behaving inappropriately, because he was a man?
A. I think there was a certain perception in the profession, in professions when men are working were children there is a greater risk of that, yes.

Q. It goes on to say:

Jim did not appear to identify anything wrong with his behaviour despite advice from myself that it was inappropriate and, however innocent, would be considered unprofessional.

Do you see that?
A. Yes.

Q. So is it fair that in the conversation you had with him in 2002, he demonstrated to you a lack of insight into the impropriety of his behaviour?
A. Yep.

Q. Why was he permitted to continue working with

children?
A. I can't answer that.

Q. Do you think that a minimum pre-requisite was that he understand that what he did was inappropriate?
A. Yes.

Q. What were the processes for escalating concerns about a person whose behaviour was inappropriate where they failed to appreciate it?
A. That those details would have gone to the Nurse Unit Manager at the time and they as the performance managers would have been the people to pursue that in that first instance.

Q. I've been unable to locate any documents reflecting those 2002 issues. Is it your evidence that there should be some?
A. Yes.

Q. Where would they have been stored?
A. To the best of my knowledge, there were personnel files kept on the ward at that time, in two D-ring folders in the Nurse Unit Manager's office, and my understanding would have been that any documentation related to nurses, whether it was employment records or other file notes, would have been kept in those.

Q. You go on to say:

I cannot remember at this time whether we also discussed his exchanging his mobile phone number with the young people he was working with or whether this is an issue that I have become aware of subsequent to that discussion.

To the best of your knowledge, when did the exchange of his personal phone number with patients become an issue?
A. To be accurate, probably about the 2009 incident.

Q. And again, did he demonstrate any understanding of the reason that that was inappropriate?
A. I cannot remember.

Q. He kept doing it, didn't he?
A. He, allegedly, yes.

Q. You go on to say in the penultimate paragraph:

I am aware of one formal incident regarding a parent complaint that they had seen Jim kissing a young parent on the head when they were upset ...

Just to pause there, and you say:

I am not aware of the specific outcome of this conversation.

So, as at the time that you dealt with the "wet kiss" allegation, if I can call it that, you were aware that he had a history of non-care related touching; is that right?
A. From the 2002 incident, yes.

Q. And that he had demonstrated a lack of insight into the impropriety of that non-care related touching; is that right?
A. Yes.

Q. And then, in two thousand and - I think it's said here as "2004", there was a "wet kiss" allegation?
A. Yes.

Q. On the forehead of an [redacted]-year-old child?
A. Yes.

Q. You talk about that in your statement at paragraph 74, and you say that that was unacceptable conduct. I'll ask the operator to bring that document down now.
A. 74?

Q. Yes.
A. Okay, yes.

Q. You said that it was unacceptable?
A. Whereabouts?

Q. In your statement?
A. But, which point, sorry?

Q. Good question.
A. There's two incidents described in paragraph 74.

Q. Well, let me just ask you this: did you consider his conduct in kissing an [redacted]-year-old child on the forehead as inappropriate?
A. Yes.

Q. I think you say it's in October 2005. You said there that you were:

> *... requested by the Nurse Unit Manager to discuss professional boundaries and behaviour with Griffin including associations, care provision and boundaries related to gender issues.*

What were the boundaries related to gender issues you were asked to discuss with Griffin?
A. I can't remember the specific details, but I think it was around the fact of males and - male nurses and female patients.

Q. And, what about them?
A. I cannot remember the specifics, sorry.

Q. And you were concerned by the behaviour because it was outside professional guidelines?
A. Yes.

Q. And at the time were you able to put it together with the 2002 concerns that you had --
A. I can't remember whether I put the two incidents together.

Q. There's no central repository of the documents that we have been able to find; is that consistent with your understanding of the way records are kept at the hospital?
A. Yes.

Q. And you would agree now that that constitutes a barrier to identifying patterns of troubling behaviour?
A. Yes.

Q. And is that something that you're attempting to correct at the hospital today?
A. Personally, no, I'm not involved in that process. I know with the Child Safe Organisation's project that there is an overarching approach to everything, but I don't know the details as to how that might be restructured so that

documents are more accessible.

Q. You wrote a memo after the wet kiss allegation, and I think it is at TDOH.0004.0052.0034-0004. I'm not entirely sure if I've given that to the operator and if I have not I apologise and I'll simply read you the sentence that I've asked for. No, I haven't, I apologise to the operator.

You said in that memorandum:

Jim recognises that there may be a disproportionate focus on the interactions of males in nursing roles with children in paediatric settings and that there is an increased need for awareness of how nursing behaviours might be viewed by others.

Do you remember writing that?
A. That sounds familiar from the documents.

Q. Is the message that you're conveying there, that the problem is with the perception of others, not with the behaviour of Mr Griffin?
A. It was not my intent.

Q. It wouldn't be appropriate to place the burden there, would it?
A. On others, no.

Q. Is there a risk that Mr Griffin understood that you considered him to be at risk from the perception of others?
A. I can't speak to what he thought.

Q. In January 2009, you speak about this at paragraph 74, 15(b) or 15(a), being awareness of a separate incident of Mr Griffin cuddling a child?
A. Yes, I became aware of that as part of that follow-up of the CAMHS letter. I think it was either an incident, a note or something written by [redacted].

Q. Was that the incident that led to the production of a new professional protocols document?
A. The whole incident together, yes, but primarily driven by the letter from CAMHS.

Q. So, there was a hugging of a child, a cuddling of a child - I wish I could have a different word for that - but

cuddling of a child on [redacted] January 2009, and later in January 2009 there was another incident concerning a complaint by CAMHS as to his interference with the care plan; is that right?
A. The interference with the care plan was the first I recall being aware of any of these incidents. I can't recall whether I was aware at the time of the cuddling of the child or whether that's occurred since I've had the documents in preparation for my statement.

Q. I see. And it was that document that led to the development of a new protocol?
A. The Professional Boundaries Guideline, yes.

Q. Was Mr Griffin involved in developing that protocol?
A. I can't remember exactly how that protocol came about. The only extant copy I've got is a 2012 to 2015 version which is version 2 replacing the 2009 document. I cannot recall the original development of that. The letter - the directions that were given as a result of the meeting with - I think it was someone from HR, the co-director of nursing and [redacted] who was the acting NUM, specified that as part of it and that would have been consistent with the professional boundaries reflection aspect of it, but I suspect I probably did most of the drafting of the document, it would have been reviewed by a number of people.

Q. Is it fair to say, Mr Sherring, that at this stage Griffin has not necessarily responded in the way you would have hoped to the repeated warnings about boundary violations?
A. Yes.

Q. Does it make you think that he was not going to respond to the boundary violations warning?
A. I can't recall whether I thought that, but on reflection, yes.

Q. On reflection it was reasonably futile to continue to give warnings; is that right?
A. Yep.

Q. He was threatened with escalation on a number of occasions?
A. Yep, and certainly on that occasion he was threatened with escalation to, I think it was the Nursing Board.

Q. And none of those escalations took place?
A. Not that I'm aware of.

Q. In your experience, does that send a negative message to a person that they can continue to violate protocol with impunity?
A. I suspect it would.

Q. Indeed, is it possible that you're educating Griffin about how to get away with these things?
A. It could be inferred.

Q. There was a confidentiality breach in 2013 which is referred to in the statement of Ms Leonard; that concerned a request by Griffin - sorry, I withdraw that: a request by a family that Griffin not visit a child in their room because of a family issue, and Griffin had subsequently called a member of the family to ask why he'd been excluded from the room. Do you recall being involved in that process?
A. Only to the extent that I was invited to a meeting with Mr Griffin and Sonja Leonard where she communicated the inappropriateness of that, that patient confidentiality breaches are a significant issue, and I believe there are a number of attachments given with that letter that accompanied that related to Nursing Board Guidelines and breaches.

Q. Do you recall anyone having any concerns about the reason that the parent wanted Griffin excluded from the room?
A. No, I don't actually recall being aware of the reasons for the - or the background of the patient confidentiality thing at the time.

Q. In March 2017, I think you tell us in your statement again at paragraph 74 or 75, that a patient had reported discomfort with Griffin, including being called "babe" and "sweetheart" by him and he was given a further direction to amend his behaviour; is that right?
A. Yes.

Q. So this is after you've drafted an entire protocol with him in mind; is that right?
A. Yes.

Q. And you've had training sessions with the entire ward of 4K around professional boundaries?
A. Yes.

Q. That training session was because of Griffin's boundary breaches?
A. Primarily, yes.

Q. He's still continuing to breach boundaries?
A. Yes.

Q. He's never moved from the ward?
A. No.

Q. Was any consideration given to moving him from the ward?
A. Not that I'm aware of.

Q. What would it have taken to have him removed from the ward?
A. Ultimately, we know why he was removed from the ward, I can't specify why.

Q. Do you have any awareness of his secondment to Ashley Youth Detention Centre?
A. I'm aware that he went; I have very little knowledge of why, I'd presumed he'd asked to go but I have no background knowledge whatsoever. I remember being in email exchanges around the instrument of appointment attached to that but that is all.

Q. Who authorised his secondment?
A. I don't know. I don't know whether it was a request or whether it was um, yeah, I don't know.

Q. You said you assumed it was a request by Griffin himself; is that right?
A. Yes.

Q. What makes you make that assumption?
A. Memory, I have no obvious grounds for saying that.

Q. You have a foggy recollection that he might have asked?
A. Basically, yes.

Q. And, would it be fair, and I'll ask your colleague

shortly, would it be fair that he would have needed to have been released from his roster to attend?
A. Yes - oh, depending on the timeframe for the transfer and the planning process for that. I cannot recall how long that was; rostering usually takes six to eight weeks to clear, yep.

Q. Are you aware whether or not his transfer or secondment was in any way connected with disciplinary proceedings or concerns?
A. I am not aware.

Q. Did you have any involvement in the 2017 SRLS that we've been discussing over the last few days?
A. Not that I recall.

Q. Do you recall discussing it with any of your colleagues?
A. I don't, no.

Q. The reason I ask, I believe that some of your notes were made available to Mr Harvey for review; you don't know if he checked with you about them?
A. I haven't spoken with Mat Harvey, no.

Q. In your time on Ward 4K, how often would the Nurse Unit Manager, and I include in this you when you were in that role, have meetings with Ms Tonks?
A. It would vary. We have a number of formats where we would meet with her. Most mornings we will meet for staffing. There would be various group meetings. Nursing had Midwifery Executive Group, which is the senior nursing staff from the women's and children's program. There would have been paediatric management meetings, and possibly other meetings which would usually have been on a monthly basis. We would have had other meetings ad hoc as necessary.

Q. And are these meetings documented?
A. The executive group, the peak management, yes, they're all minuted.

Q. And the daily meetings around staffing, they're just --
A. They're just discussions and the outcomes of those would be recorded with allocators and rostering records.

Q. And those discussion, I think you said they were about staffing, are they also about issues of the day, any matters?
A. They may develop into that was well.

Q. Any serious issue on the ward which you chatted about?
A. Yes, that's the opportunity.

Q. Do you recall any discussions being had at those meetings concerning Griffin?
A. Not specifically, no.

Q. You have a general recollection but you can't recall a time?
A. No, I - no.

Q. Isn't that the time to talk about concerns you might have around staff members?
A. It's an opportunity, yes.

Q. Are you able to offer any explanation as to why that didn't occur, if it didn't occur?
A. At which point?

Q. Well, in the time that you were the Nurse Unit Manager or acting part-time as the Nurse Unit Manager, do I understand your evidence to be that there were no concerns with Griffin at that time?
A. Not that I can recall, no.

Q. Do you recall having any discussions with Ms Tonks or Ms Bryan concerning Griffin in that time?
A. I can't remember any.

Q. What about with Ms Leonard? Save for those specific incidents we've talked about, are there other incidents concerning Griffin that we haven't got any record of?
A. I'm - I can't recall any, no.

Q. We have the generalised 2002 issues that are referred to in your file note and the other documentary matters. Ms Leonard says that Griffin had a habit - well, I don't want to put words in her mouth - that he would often greet patients with a hug. Was that your observation?
A. I can't say I can recall seeing it, but I have seen records where that's been the case, yes.

Q. What would you say the culture on Ward 4K was like when you were the Nurse Unit Manager?
A. I'm not sure how to respond, sorry.

Q. Was it a collegiate environment?
A. I have felt so, but I'm aware that there were concerns between some staff members and Mrs Leonard.

Q. We've heard some evidence about complaint escalation processes, can I summarise my understanding and tell me if I've misunderstood. If there were grievances between staff they would attempt to deal with the issue locally with the other person?
A. Yes.

Q. If they could not resolve it they would escalate it to the Nurse Unit Manager; is that right?
A. Yes.

Q. It was then within the discretion of the Nurse Unit Manager to escalate it further?
A. In short, yes.

Q. And, there was not necessarily any written record of any of those steps?
A. Possibly not, no.

Q. There was no protocol that required a written record of any of those steps?
A. No that I'm aware of.

Q. That may include boundary breaches of what we now understand to be grooming?
A. Possibly, yes.

Q. Separately, patients could initiate a complaints process by lodging a patient complaint form to the Patient Liaison office; is that right?
A. Yes.

Q. And those are not necessarily cross-checked to the grievance complaint process on the ward?
A. I'm not fully aware of whether they do or don't cross-reference there.

Q. And then finally, there's SRLS, which is an electronic process for recording information?

A. Yes.

Q. Is that primarily concerned with capturing complaints and grievance data or clinical data?
A. Clinical data in its primary function.

Q. Was it - yep.
A. And workers' compensation data was well.

Q. Mr Sherring, would you accept that the various complaints by Griffin were inappropriately dealt with upon escalation? Well, let me withdraw that.

We've talked about a number of complaints, there are a couple of others. Would you accept that as a general proposition Griffin's various boundary breaches were not properly handled at the time?
A. Yes, I think I would.

Q. Yes, thank you.

MS BENNETT: Those are the matters, Commissioners.

PRESIDENT NEAVE: No questions, thank you very much, Mr Sherring.

MS BENNETT: Thank you, Mr Sherring, for your evidence.

Commissioners, I'd ask that Ms Sonja Leonard now be called.

PRESIDENT NEAVE: And I think Ms Leonard has counsel?

MR HILLIARD: If the Commissioners please, my name is Hilliard, I appear for Ms Leonard.

PRESIDENT NEAVE: Thank you very much.

<SONJA RUTH LEONARD, affirmed: [2.17pm]

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. Ms Leonard, please tell the Commissioners your full name and professional address?
A. Sonja Ruth Leonard. COVID Clinic, 63 Dowling Street, Launceston.

Q. Ms Leonard, I'm going to ask you to speak up and lean forward or just bring the microphone towards you?
A. Is that better?

Q. Yes. Well, let's try this question: you've made a statement to assist the Commission; is that right?
A. Yes, I have.

Q. Is that statement true and correct?
A. Yes.

Q. I am going to ask you to speak up a little bit more?
A. Okay, sorry.

Q. No, that's okay.

PRESIDENT NEAVE: Perhaps you could even move the other mic a little bit closer to you too. Thank you.

COMMISSIONER BENJAMIN: Ms Leonard, can you pour yourself a glass of water. We acknowledge that this is hard, giving evidence, so take your time, listen carefully to the questions and answer them as best you can. Okay?
A. Thank you.

Q. Because we really want to hear your answers.
A. Thank you.

MS BENNETT: Q. Ms Leonard, you were registered as a nurse in March 1989; is that right?
A. Yes, that's correct.

Q. And you've worked on Ward 4K since about 1991; is that right?
A. Yes, I think maybe December of 1990 or December 91.

Q. Yes, and you were a nurse on that ward until 2008, at which time you became the Nurse Unit Manager; is that right?
A. That's correct.

Q. When you became the Nurse Unit Manager, you take responsibility for the management of the unit itself, for the ward; is that right?
A. Yes.

Q. So, the nurses on the ward report to you from that

time?
A. Yes.

Q. Did you continue with nursing duties?
A. No, it's a very administrative and managerial position, so not really - not really directly involved in patient care.

Q. You're involved in recruitment, management, rosters, HR, strategic development, and other related duties; is that right?
A. Yes, that's correct.

Q. Did you receive any training in any of those tasks before you took up your role as Nurse Unit Manager?
A. Recruitment: I don't recall if selection panel training existed at that time. Rostering was more experiential through acting in the Nurse Unit Manager at various times over those years. Sorry, what were the other points that you raised?

Q. What about for Human Resources and strategic development, were you given any training, did you have any training when you made the transition from being a nurse on the ward to being a Nurse Unit Manager?
A. I'd undertaken some training modules externally which are documented in my resumé.

Q. I see, and is it fair to say though that there was no formal transition process for you at the hospital to go from being a ward nurse to being --
A. That's a fair comment, yes.

Q. And so, there were processes around, for example, resource management, human resource management, which you were expected to know because of your length of time on the ward; is that right?
A. Potentially, yes, but there was no training.

Q. Let me put this another way. When you became the Nurse Unit Manager you became responsible for all of the nurses on the ward; is that right?
A. Yes.

Q. You were their first point of call for any grievance or complaint; is that right?
A. Yes.

Q. And your responsibility was to ensure a safe, harmonious working environment; is that right?
A. Yes.

Q. It's a complex task?
A. Yes.

Q. It involves the management of a number of different personalities in a high-stress environment; is that right?
A. Yes.

Q. What training were you given to undertake those tasks at the time you were promoted?
A. None.

Q. Do you consider now that you - withdraw that. What about SRLS? At the time you were promoted in 2008, that system was not yet in operation as I recall; is that right?
A. Yes.

Q. There was a system called EIMS; is that right?
A. Yes.

Q. That process was to similar effect?
A. Yes.

Q. Did it operate in precisely the same way or just a similar way?
A. Not exactly the same way, but similar and my recollections of that are - are not strong.

Q. We have heard evidence that there were effectively three processes for complaints to be raised and escalated: there was what I will call the SRLS pathway but I will incorporate with that EIMS for the 2014 period.
A. Yes.

Q. There was a direct grievance process, that is, any person on the ward might come to you, and there was a Patient Liaison complaint form; is that right?
A. Yes.

Q. Did you ever receive the Patient Liaison complaint form feedback?
A. No, no, I didn't receive it directly. So, it would be sent to the Patient Liaison address staff and, if they

investigated the complaint and needed information, they would come to me and ask for me to address it on points but I didn't receive it directly.

Q. When issues were escalated to you directly, how did you decide when to escalate it to your manager? I pause there. Who was your manager - sorry, I withdraw that. What was the title of your manager, generally speaking?
A. Nursing Director of Women's and Children's Services.

Q. We'll use that title, we'll speak about the Nursing Director for now because I understand that was a different person at different times. Is that clear enough?
A. Yes.

Q. How would you know when to escalate a concern with a member of staff to the Nursing Director?
A. I think it - we had very transparent communication and I was clearly new in the role, so I was discussing most feedback with her at the time, so --

Q. That's in 2008 your general practice was to discuss most issues that came up most of the time; is that right?
A. Yes.

Q. As time went on, when you were no longer so new, what was your practice then?
A. So, it was still to advise them of any issues that were arising in the ward in relation to complaints or staff grievances.

Q. Were there any complaints or concerns that were not escalated in that way?
A. Yes, perhaps, like, what I'd call low level complaints.

Q. And do you consider boundary breaches to be low level complaints?
A. Not now, no. No.

Q. At the time, did you consider boundary violations, professional boundary violations, to be low level?
A. What I did think was, it was an opportunity for education and redirection at the time.

Q. I see. Is that the sort of thing that you would have raised or did raise with your Nursing Director?

A. I can't recall.

Q. Was there any documentation around any matters that you escalated? Save what you've referred to in your statement, which we'll come to, was there an expectation that you would document concerns or grievances that you were escalating?
A. There was an expectation - sorry, can you say the question?

Q. That you would document any concerns or grievances that you might have had?
A. So, there's probably a variety of ways to document that, whether they were diary notes or file notes to HR, or there would be a formal grievance process.

Q. And so, was it the expectation that each matter would be documented in one of those ways?
A. I don't think so, no; I think there was times that maybe things weren't documented, yes.

Q. You tell us in your statement that in your view mandatory reporting was not well understood on the ward; you say that at paragraph 61 of your statement. Why do you say that?
A. Because, even in the period up to and including 2020 there were still patients that staff had concerns over that hadn't been directly reported to Child Protection Services.

Q. What kind of concerns?
A. Around potential, like, care and neglect and --

Q. Child safety concerns?
A. Yes.

Q. That weren't being reported?
A. So, there was a pattern of behaviour where staff might have felt, if they reported that to the social worker, that that had been reported to Child Protection, and so, I would find no evidence in the notes that that had been reported and I had discussions with the staff that, when they held those concerns they needed to report them directly, they couldn't delegate that.

Q. When did you have that discussion?
A. We had - I remember having that in the year of 2020.

Q. In 2020?
A. Yes.

Q. So, after Griffin's conduct was known and he had died it was still your experience that people on the ward weren't aware of mandatory reporting?
A. They weren't following through on their mandatory reporting to Child Protection when they had concerns.

Q. What training was there about mandatory reporting?
A. I can't recall.

Q. And, what did you do when those concerns arose for you? What positive steps did you take in response to those concerns?
A. So, in 2020 I discussed it with the staff, I kept clarifying that the report hadn't been reported because I wasn't confident that it had been reported, and I went back through the notes and couldn't find any documentation where it had been reported, and so I again - then I called the social worker who the staff had discussed these concerns with and I asked them to clarify, and I believe at the time there was perhaps a crossover with some social work staff as well that made it more difficult.

Q. Did you escalate your concerns to somebody more senior than you?
A. I raised it with the paediatrician at the time.

Q. A paediatrician at the time?
A. Yes, that was caring for the child.

Q. But the systemic issue, that there are nurses who are unaware of their mandatory reporting obligations in 2020, is that an issue that has been escalated by you to somebody more senior?
A. I discussed it with my Nursing Director of Women's and Children's Services.

Q. Can you tell the Commissioners what you understand your mandatory reporting obligations to be?
A. Insofar as child and safety and concerns of care and neglect, that the person that receives that information should be calling Child Protection Services and take all the Child Safety liaison to make that information known to them as much as - as much as you have.

Q. I think I understand from your evidence at paragraph 74 you tell us that prior to 2006 there was a paper system for reporting complaints; is that right?
A. Yes.

Q. And, after that, was the EIMS system that we've talked about, and after that in 2014 was the SRLS system?
A. Yes.

Q. Do you know whether the paper system, the paper records, were transferred to the electronic records?
A. I don't have any knowledge of that.

Q. Do you know if the paper records from that time remained on Ward 4K?
A. I don't - I don't know.

Q. Returning to SRLS, the system in place following 2014, you received notifications of all SRLS matters concerning patients on Ward 4K; is that right?
A. Yes.

Q. Does the SRLS system notify you by reference to the staff member about whom there is a concern or about the patient about whom there is a concern?
A. So, the initial notification would tell you the class - like, the category.

Q. Yes.
A. And then when you go to access that file it will give you the patient.

Q. Yes.
A. It doesn't tell you the staff member.

Q. Well, if I wanted to look up an incident on SRLS and I didn't know the SRLS number I would search the name of the patient; is that right?
A. Yes.

Q. Could you search the name of the staff member involved?
A. I don't have any experience in that search, so I couldn't say, but --

Q. So, is it fair to say that's not a search you ever carried out?

A. Correct.

Q. And so, was it your understanding that the SRLS system was not primarily there to capture inappropriate conduct or inappropriate staff conduct?
A. Correct.

Q. You were dependent upon the direct reference from staff; is that right?
A. Yes.

Q. And that, in turn, depended upon you having a strong relationship with staff; is that right?
A. Yes.

Q. They needed to have trust and confidence in you in order to report to you; is that right?
A. That - yes.

Q. Well, would you accept that people would be unwilling to escalate complaints to you if they held a concern that you --
A. Yes.

Q. -- might not deal with it appropriately?
A. Yes.

Q. And you would accept, wouldn't you, that people would be reluctant to raise a concern with you if there was a perception that you would not deal with it in a way that was transparent and fair?
A. Yes, they would have other avenues to explore if they didn't choose to report to me.

Q. And what are those avenues?
A. They could report to any of the other senior nursing staff or to the Director of Women's and Children's Services.

Q. So, the protocol is to go to you, isn't it?
A. Yes.

Q. And if not to you, then to someone - your Line Manager; is that right?
A. Yes.

Q. And that's a reasonably senior person?

A. Yes.

Q. And that's not a person with whom they'd have day-to-day contact?
A. Not day-to-day contact, no, but regular contact.

Q. Regular contact?
A. Yes.

Q. But you would accept that, in a ward that was working in the way it was meant to work, people would feel they could come to you?
A. Yes, definitely.

Q. Did people feel they could come to you?
A. So, there was a complicated culture in 4K, and some people were very comfortable to come to me and others were not.

Q. Was Griffin very comfortable to come to you?
A. Yes; yes, he was comfortable to come to me.

Q. And, he was a friend of yours?
A. No, he wasn't a friend of mine. So, we had a friendly work relationship, but I have very clear boundaries about work friendships when I'm a manager, so I don't consider him a friend.

Q. So, when you became the Nurse Unit Manager in 2008, you transitioned from being friends with your colleagues on the ward.
A. (Witness nods.)

Q. Did you dispense with friendships at that time?
A. Yes.

Q. How did you do that?
A. So, in the beginning of 2009 I felt that I needed to be - have objectivity around staff relationships and I felt that, if I had friendships, that that was going to be difficult to maintain, so I ceased social media connections with staff at that time, anyone that I managed.

Q. Before that time, did you have social relationships with Griffin?
A. I don't recall so, no.

Q. There was no barrier to you having such a relationship at that time?
A. No.

Q. I think you said there was a - I think you used the word "complex culture on Ward 4K", can you elaborate what you mean by that "complex culture"?
A. So, the transition to the Nurse Unit Manager probably really started in the earlier part of 2008 when the manager went on long-term leave and four staff expressed an interest in filling that role, and there were four people that undertook that period, so it was a protracted period of management for the ward which was difficult with four people all having a different approach. And then I was appointed in November 2008 and it's fair to say that that was difficult for the staff because my management style was quite significantly different from the previous manager, and so, that arose quite a difficult period where the staff raised grievances around the changes in the management in the ward.

Q. You say in your statement you found it very challenging to obtain information from Ward 4K staff as it related to poor conduct or poor performance. You will find that at paragraph 62, Commissioners?
A. Do you mind if I just read my notes?

Q. Please.
A. So, paragraph 62?

Q. Second 62 you say in the second line:

I found it very challenging to obtain information from Ward 4K staff as it related to poor conduct or poor performance.

Do you see that?
A. Yes.

Q.

In my view the staff who worked on Ward 4K were protective with their long-term friendships and they tended to respect the decisions of certain more senior members of staff. Ward 4K had a culture of bullying that made staff reluctant to report poor

conduct or performance due to the impact that would have on their personal and professional relationship with colleagues.

That was your experience at 4K?

A. Yes.

Q. And you had come from 4K?

A. Yes.

Q. Did you have long-term friendships on the ward when you started as a Nurse Unit Manager?

A. Long-term working relationships.

Q. So, were you aware at the time you became the Nurse Unit Manager that there were barriers that the culture of bullying existed?

A. Was I aware of that?

Q. Culture of bullying?

A. When I went into the position?

Q. Yes.

A. No.

Q. When did that understanding develop?

A. I experienced that over the early months of 2009.

Q. You said it made it difficult to get reports concerning conduct of poor performance?

A. Yes.

Q. Difficult for people to escalate grievances to you?

A. Yes.

Q. And you were aware of that in 2009?

A. Yes, I was shut out of communications.

Q. And you considered it was necessary and important that you have communications with your staff?

A. Yes.

Q. You needed to have the capacity to manage the staff and for that the entire system, it seems to me, depended upon people reporting to you any concerns they might have; is that right?

A. Yes, or to escalate it to the Nursing Director.

Q. Yes, but there was a barrier to that happening in an immediate sense and that was this culture at the time?
A. (Witness nods.)

Q. Did you report to your manager that this culture existed?
A. She was very aware of it as was the Executive Director of Nursing, Helen Bryan, as these grievances were all being raised with those positions.

Q. So, was it well understood at the hospital that there was a dysfunctional culture on Ward 4K?
A. I think that's fair to say.

Q. And, in your view, that dysfunctional culture impeded reporting of concerns or issues that people had?
A. Yes.

Q. What steps did you take to allow people to report their concerns or culture?
A. Sorry, can you say that again?

Q. What steps did you take to fix the reporting lines for your staff, to make it so that they could safely and easily report concerns they might have?
A. I think it's important for you to understand that I was continually trying to build relationships, and positive relationship with the staff in 4K, but their willingness to meet me and to continue with that wasn't always reciprocated.

Q. Was Griffin willing to meet with you?
A. I don't recall that.

Q. Was he someone who was willing to give you the benefit of the doubt, so to speak?
A. I don't recall his - his role in those early years.

Q. Was he someone that you spoke to about - or sorry, let me withdraw that. So, you don't recall where he stood on these issues at the time?
A. No.

Q. Did you have a positive relationship with Griffin at that time?
A. I don't recall.

Q. Did you have a negative relationship with Griffin at that time?
A. No.

Q. So, at the very least you had a neutral relationship with Griffin?
A. Yes.

Q. At the time you had a negative relationship with a lot of staff on the ward; is that right?
A. Yes.

Q. Is it fair to say you didn't want to make any more enemies on the ward?
A. That wasn't a conscious decision of mine, no.

Q. Well, conscious or unconscious, is it fair that it was a difficult environment; that's right, isn't it?
A. Yes.

Q. Griffin was not one of the voices raised against you, was he?
A. Yes, he did actually sign the vote of no confidence, I think you'll be able to find that.

Q. He signed it?
A. Yep.

Q. When issues were escalated to you in 2009, was it a matter of concern to you that you might increase the number of people arrayed against you on the ward?
A. No.

Q. That wasn't something that occurred to you?
A. No.

Q. Let's go through some of the issues that were escalated to you or that came to your attention. I first wanted to ask as a general matter that, as I understand your evidence, at about paragraph 138 you tell us that you:

> *... frequently [saw Griffin] greet familiar patients with a hug, including standing side by side with patients and hugging them.*

Is that right?
A. Yes, 138.

Q. Are we to understand from your evidence that that was your frequent observation of Griffin up until you told him to stop in about 2015?
A. Sorry, can you repeat the question?

Q. Are we to understand from your evidence that that was your frequent observation of Griffin up until you told him to stop in 2015?
A. I don't recall.

Q. Did you frequently see Griffin greet familiar patients with a hug, including standing side-by-side with patients and hugging them?
A. Yes.

Q. And that was your observation of him over a number of years?
A. Yes.

Q. And that is separate to any of the documented reports that you have included in your materials? You're not referring there to a single incident that is otherwise recorded in a complaint or grievance?
A. Oh, sorry. No.

Q. You're speaking about his general mode of operating on the Ward 4K?
A. Yes.

Q. Patients on Ward 4K are generally children, are they not?
A. Yes.

Q. So when you say that "he'd frequently greet familiar patients with a hug", you're talking about him hugging children?
A. Yes.

Q. Is that inappropriate, Ms Leonard?
A. I consider it to be inappropriate, yes.

Q. Did you consider it to be inappropriate then?
A. Yes.

Q. How many years did it go on for before you said anything to Griffin about that inappropriate conduct?
A. I don't recall.

Q. Was it a number of years?
A. I don't recall, I'm sorry.

Q. And I suggest to you it was a number of years before you raised that issue with Mr Griffin at all?
A. When I observed Mr Griffin, these hugs were in public, in open ward areas, with staff present, with parents present, and all of those people responded positively, you know, not negatively around those hugs, and so, whilst I consider it to be inappropriate and unprofessional, it seemed to be well received by those people.

Q. Why is it relevant how it was received? Isn't it relevant what is proper and professional?
A. Yes.

Q. So, can I ask you again, Ms Leonard why - it went on for a number of years; is that right?
A. Yes.

Q. And you took no steps over those years?
A. No.

Q. Are you able to explain to the Commissioners why that was the case?
A. Some of the complications were these pre-existing relationships that Mr Griffin had; Mr Griffin was well-known in the community and knew a lot of - knew a lot of people, and so, sometimes it was difficult to separate what were those pre-existing close relationships, and the fact that these greetings were in public areas within the ward, that the parents responded positively, the staff responded positively, that I felt that perhaps that I was not reading the situation.

Q. I think you've talked about the negativity on the ward that was directed to you by some staff; was that negativity directed to Ms Tonks as well?
A. Ms Tonks took on the Nursing Director role in 2013?

Q. M'hmm.
A. I'm not aware of any negativity towards Ms Tonks.

Q. Was it directed to the Nursing Director that preceded Ms Tonks?
A. I'm unable - I don't know, I don't have any evidence of that.

Q. So, as far as you understand, it was limited to 4K itself?
A. The negativity?

Q. The negativity?
A. Yes.

Q. Yes, I see. Did the culture improve over time?
A. Yes, it did.

Q. By what stage do you think the cultural issues had resolved?
A. The cultural issues improved when a number of very powerful and vocal staff moved on from the ward.

Q. It was improved, not resolved, I guess; is that right?
A. Yes.

Q. Roughly when was that?
A. I've lost track of time, I'm sorry, I don't recall.

Q. There was the hugging that you speak about at paragraph 138 or so. There's also evidence about Griffin using words like "baby, babe, princess" and that's the subject of some of the specific complaints. Are you aware of that kind of language being used by Griffin in a more general way as well?
A. Yes.

Q. And that appears more frequently than is in the written record; is that right?
A. Yes.

Q. Indeed, it was a practice of his that wasn't captured in all of the complaints; is that right?
A. Yes.

Q. And again, that's conduct of his that continued in combination with his tendency to hug patients, and I should interpolate, hug children. Would he also refer to them as "baby, babe, princess" or similar?
A. Yes.

Q. Did you see that as inappropriate?
A. Yes.

Q. And that went on for years as well, didn't it?
A. Yes.

Q. And you didn't do anything to stop that conduct over years?
A. I think that we've mentioned those specific incidents where we've talked about it.

Q. So, in 2017 a patient raised discomfort with being called "babe and sweetheart", came to your attention and you coordinated with Mr Sherring about a response; is that right?
A. Yes.

Q. Before that time was there any negative response with Griffin referring to patients as "baby, babe, princess" or similar?
A. I don't recall.

Q. Well, is it possible that the first time you raised it with Griffin was in 2017?
A. It is possible, I don't have any recall.

Q. I want to put this very plainly. Is it the case that from the time that you became the Nurse Unit Manager in 2008, Griffin's everyday conduct, his everyday manner, was to hug children patients and to refer to them in that "baby, babe, princess" or similar kind of a way, that was just Jim; is that right?
A. Yes.

Q. And that was more or less accepted by you on the ward in the sense that you took no steps to prevent it over a number of years?
A. It was accepted by all the staff.

Q. Yes, you included?
A. Yes.

Q. And you accept that you had a heightened responsibility to take steps to stop that kind of behaviour?
A. Yes.

Q. You see it as being inappropriate behaviour now?
A. Yes.

Q. Did you see it as inappropriate behaviour then?
A. Yes.

Q. Why did you not stop inappropriate behaviour on a Children's Ward?
A. I did try, I did address issues when I saw them. I think there's a reference in my statement that I raised issues with Jim and addressed them.

Q. Let's go through the sense. I'm speaking about his general manner, and as I have understood your evidence you accept that he had a general manner that involved the hugging and involved the informal address to patients separate to the incidents that you refer to in your statement as being escalated disciplinary matters; is that right?
A. Yes.

Q. What I'm trying to understand is why you took no steps to prevent that general manner, over a number of years, from 2008 and following? Are you able to explain to the Commissioners why no positive steps were taken over that period?
A. No.

Q. Let's go then to some of the specific complaints. Before we do that, Ms Unwin gave some evidence that Griffin preferred to treat female patients; was that your observation?
A. No, I hadn't made that observation.

Q. Does her evidence surprise you in that respect?
A. I hadn't made that observation or that connection, and staff had often particular skill sets and particular - you know, um, might have tended to gravitate to certain diseases or conditions or treatments because they had skill sets or particular interests, so it doesn't surprise me in retrospect but I hadn't noted that at the time.

Q. Did Griffin have any such interests, medically?
A. I don't recall, no.

Q. Did he have a particular interest in eating disorders?

A. Yes.

Q. It's an issue that predominantly affects young women, is it not?
A. Yes.

Q. Most of the patients on Ward 4K admitted for eating disorders were women, girls?
A. The majority, yes.

Q. And that is a particularly vulnerable cohort, is it not?
A. Yes.

Q. And did he express to you a preference to work with that cohort?
A. No, he didn't express an interest in that, no.

Q. You were aware he had an interest in that area of medical practice?
A. Yes.

Q. How were you aware of that?
A. Because, when the first Maudson Model Training was offered in Launceston before 2008, there were four staff that I believe were offered the training, and I don't know why I think four, but I remember myself, Mr Griffin, I think Michael Sherring and perhaps one other undertook that four-day training, so that's why.

Q. And so, did he for that reason - was he for that reason assigned more often to work with children with an eating disorder?
A. No.

Q. Did he, for that reason, more often work with children with an eating disorder?
A. I think the background to that is, children with eating disorders are in hospital for a prolonged period of time and have high intensity care needs, so staff would often look after these patients because they were in hospital for a long period of time, so --

Q. Yes, did Griffin display any - did he particularly look after that cohort of patients? Did he spend more time with patients of that type than other nurses?
A. I couldn't honestly say that I noted that.

Q. You note in your statement at paragraphs 156 and 157 that it was your practice to attempt appropriate gender allocations, that is, male nurses with male patients where possible; is that right?
A. Yes.

Q. Female nurses with female patients where possible?
A. M'hmm.

Q. Including, in particular, where intimate assistance might be required, so bathing, showering, those sorts of matters; is that fair?
A. Yes.

Q. That's what you mean by that. And as I understand your evidence, you did observe that Griffin didn't correct you if you inadvertently assigned him to an inappropriate patient gender allocation; is that right?
A. No, I don't think that's what I said.

Q. Can you tell us if he did correct you when you inadvertently assigned him to an incorrect gender allocation?
A. I didn't assign.

Q. Sorry?
A. I didn't assign him.

Q. Yes.
A. So, the general allocation would be around trying to match skill sets with the patient's needs.

Q. Yes.
A. So, we'd be looking at, well, who is the most junior, who's got the right skill sets for the right - for the patient's needs, so it was more around skill set allocations, and also offering staff some choice in the matter. So, what I was trying to say in that paragraph is that, if staff had selected an inappropriate allocation, whether it was a gender issue or a skill issue, I would re-assign it and identify it.

Q. So, you say there:

Griffin, as well as other staff, did not always demonstrate an awareness of

procedures involving intimate engagement with paediatric patients.

So, do you mean there, didn't always demonstrate an awareness of procedures where you might need to shower or undertake intimate examinations of patients?
A. What I'm saying is, I wouldn't always - I'd pick that up at the allocation that it wasn't inappropriate and re-assign it and would intervene. That's what I was trying to say.

MS BENNETT: Commissioners, I'm conscious of the time, I'm about to move to a new topic; perhaps we might break now and ask Ms Leonard to return after the break and we'll proceed from there.

PRESIDENT NEAVE: Thank you.

MS BENNETT: Could I ask that Ms Leonard be directed not to discuss her evidence over the break?

PRESIDENT NEAVE: Yes.

MS BENNETT: Please the Commission.

COMMISSIONER BENJAMIN: Q. Just to be clear, you're being asked questions, so if you could not discuss your evidence with your lawyer over the break, and just have a cup of tea, a cup of coffee, and relax and then come back?
A. Yes, Commissioner.

Q. Do you understand that?
A. Yes.

Q. And you can't talk to anyone else?
A. Yes, Commissioner.

SHORT ADJOURNMENT

PRESIDENT NEAVE: Thank you, Ms Bennett.

MS BENNETT: Q. Ms Leonard, we've been speaking about generalised issues of Mr Griffin over the time that you were the Nurse Unit Manager, and we've identified some inappropriate conduct by him that was generalised and ongoing. Did you speak about those matters with your Nursing Director?

A. I can't recall.

Q. Is it the sort of thing that was in your practice or general practice to raise with your supervisor or Nursing Director?
A. I would generally discuss specific concerns.

Q. Yes.
A. I'm not sure about general concerns.

PRESIDENT NEAVE: Ms Leonard, can you speak up as much as you can, please.
A. I'm sorry.

MS BENNETT: Our technical staff seem content. Yes, thank you.

Q. I'm going to go through now some specific instances that are outlined in your statement, I've been through them with a number of witnesses already and so I'll use shorthand. If at any stage you don't know the incident that I'm referring to, please pull me up and we'll go through it in detail; is that okay?
A. Yes.

Q. In 2009, and this is in your statement at paragraph 131, there was an incident where Griffin overstepped boundaries with a child by staying with her against her care plan. Do you recall that?
A. Yes.

Q. That was in early 2009, and it was close in time to the incident you refer to at paragraph 134, which was when he was cuddling a child on a recliner; is that right?
A. Yes.

Q. That child being a patient on Ward 4K; that's right?
A. Yes.

Q. Yes. In the same month, on 11 January, you tell us at paragraph 159, that he had given his phone number to a patient?
A. Yes.

Q. So those incidents --
A. Oh. 159.

Q. Yes, 159 and 161.
A. Yes.

Q. So those were all quite close in time, is that right?
A. Yes.

Q. January 2009, and you involved other people in the management of the issue; is that right?
A. Yes.

Q. Who did you involve?
A. So, I involved [redacted], he was the Nurse Manager, he was going to be taking over from my period of leave, and I believe that I told the Nursing Director and HR when I received that letter on 15 January.

Q. That's a letter you received from a doctor at CAMHS complaining about Griffin's conduct; is that right?
A. (Witness nods.)

Q. So, that you escalated; is that right?
A. Yes.

Q. Who else did you involve in that?
A. Subsequent to that, Human Resources and Sue McBeath, the Nursing Director at the time.

Q. And you include a file note in your statement of a meeting that took place on 21 January 2009, and it says:

> *If you discussed physical touch of patients outside therapeutic boundaries, giving out mobile phone number to patients ...*

And I'm sorry, I don't have a paginated copy of your statement.

PRESIDENT NEAVE: What paragraph are you reading from?

MS BENNETT: I'm reading from file a note that appears as an annexure, and it's roughly Attachment 21.

Q. Do you have access to which attachment is which there?
A. 421?

Q. Yes, is that a file note?
A. It looks to be an email.

Q. No, all right. Just go over to the next - we'll return to that in a moment. What's the date of the email you have there?
A. 17 April 2013.

Q. I see, that's all right, we'll come back to those matters. Nonetheless, what were the steps that you decided to take in response to those boundary violations in 2009?
A. That was the letter that was written to Mr Griffin after the meeting with the Nursing Director and Human Resources.

Q. That was something that - you decided to write a letter and in that letter you identified - sorry: who was responsible for writing the letter?
A. I believe Human Resources and [redacted].

Q. At what stage did you decide to involve Human Resources? Why was Human Resources involved in that complaint or those complaints?
A. Because it was a serious concern raised by Child and Adolescent Mental Health staff.

Q. Was the involvement of an external agency a significant factor?
A. I think that those professional staff having concerns was a significant factor.

Q. Why was that?
A. Because those professional staff had concerns about his behaviour, so that was --

Q. You had concerns about his behaviour, didn't you?
A. Yes.

Q. And your colleagues had concerns about his behaviour in 2009, didn't they?
A. Yes.

Q. Why did it take external notice to elevate the matter to a degree of formality?
A. From my recollections I understand that those concerns were raised subsequent to the letters from CAMHS.

Q. I see. So, before the involvement of an external agency there was less likely to be a formal escalation; is

that right?
A. I'm not sure, given that I was only a few months into the role at that time when I started in November 2008.

Q. Was that an opportunity for you to - let me withdraw that. Did you receive any feedback for the way in which you handled that complaint from HR or anyone else within the hospital?
A. I can't recall.

Q. Do you recall anyone advising you about the next steps if the warning to behave appropriately was not complied with?
A. No, I don't recall.

Q. Who did you go to for guidance at that time?
A. Being new to the role, I was going to the Nursing Director and Human Resources frequently.

Q. And you went to the Nursing Director about this issue?
A. Yes.

Q. In February 2009 you were told that Griffin was going to give away his former patient; you speak about that at paragraph 167 of your statement. Did that concern you given the recent boundary issues that you'd just dealt with in January?
A. Yes.

Q. You told Griffin that he wasn't to give away his former patient; is that right?
A. Yes.

Q. What other steps did you take in response to that?
A. So, the steps I took were to speak with the Executive Director of Nursing as my Nursing Director was away and I was concerned about this, and I spoke with her on the telephone and she said that it was reasonable for him to attend the wedding but not to give him away, and she shared the same view as myself, and we formalised that in a letter, or I formalised that in a letter.

Q. Yes, and that letter in which you said, we're pleased that you have decided not to give away your former patient, please be aware of your boundary obligations; is that right?
A. Yes.

Q. And that followed a month after you had sent a letter about a failure to adhere to boundaries, so there's two in a reasonably short period of time?
A. So again, the complicating consideration here was that I was led to believe that Mr Griffin was friendly with this person's mother and there was pre-existing relationships, so that made it a little bit more less clear.

Q. Is it fair to say, was your antenna up at that point then with Mr Griffin?
A. To be honest, there was a lot going on at 4K in that time with the no confidence.

Q. So, it didn't take on the prominence it perhaps might otherwise have taken; is that right?
A. Yes.

Q. And is it fair that that's a matter upon which you reflect with some regret?
A. Yes.

Q. Later in 2009 you tell us in your statement that you met with the mother of a patient who said that he was a womaniser and a sleaze; do you recall that?
A. Yes.

Q. Did that raise any concerns for you?
A. I found that, like, an unusual conversation to have with a parent because she said that the staff had spoken about their colleague, Mr Griffin, and advised her that he was a womaniser and a sleaze, so I found that an unusual conversation to be having with a parent, so I wasn't quite sure how that conversation would come to pass in a clinical setting.

Q. I see, and she said to you, as I understand your evidence at paragraph 185:

> *"You've got men working here looking after children, and bad things happen we all know that."*

That's your evidence?
A. Yes.

Q. What did you understand she meant by that?

A. So, I guess I'm assuming that she was alluding to paedophilia.

Q. Did that raise an alert in you, Ms Leonard?
A. No, it didn't, because it was a - it was a generalised statement about men and not particularly Mr Griffin; there didn't seem to be the link between the comments of him being a womaniser and a sleaze.

Q. It was in the context of a conversation about a complaint about Griffin; is that right? Just looking at the first line of paragraph 185?
A. Yes.

Q. And then she describes him as a "womaniser and sleaze"; is that right?
A. M'hmm.

Q. And then she goes on to say, to infer that:

You've got men here looking after children and bad things happen and we all know that.

And she would interpolate, you understand, to be a reference to paedophilia. Is that something that raised your concerns about Griffin? Did you link that to Griffin?
A. No, I didn't at the time.

Q. I see. In 2013, Griffin was asked not to visit a family due to family reasons; you talk about that at paragraph 148. Were you curious about what "family reasons" might mean, a nurse should not visit a particular patient?
A. No, not in itself because, having worked with children and families for a long time you know that families take on very different frames and structures and they're complex and there are many blended families and many complicated families and family relationships, so no, that didn't.

Q. That didn't cause you to - there was a family reason for a nurse not to visit a particular child, and that raised no concern for you?
A. No.

Q. We've heard about the incidents of 2017 a number of times. Early in 2017 there was another issue of boundary violation by Griffin, again raised by CAMHS, and this time

concerning calling a patient "babe, sweetheart"; do you recall that?
A. Yes.

Q. That was in March 2017, and again, you invoked HR's assistance at that point; is that right?
A. Yes.

Q. Who at HR did you seek assistance from?
A. I believe it was Mr Harvey.

Q. And you provided him with the materials that you had about Griffin's previous boundary violations?
A. I can't recall that.

Q. What did you expect from his assistance of you in managing that complaint? Why did you ask for HR assistance?
A. To direct me and guide me in the response.

Q. Is that because you had directed Griffin to comply with boundaries a number of times and he had not complied?
A. Yes.

Q. Did you communicate to HR that he had failed to comply with boundary violations a number of times?
A. I don't recall.

Q. Is it fair to say that you had concerns about Griffin's capacity to comply with boundaries at this point?
A. Yes.

Q. It was pretty clear, wasn't it, by this stage that he was not going to comply with professional boundaries with children, was he?
A. I always thought that education and redirection would change that behaviour.

Q. You had had that view since 2008; is that right?
A. Yes.

Q. It is by this stage 2017; is that right?
A. Yes.

Q. At what stage should someone simply be moved away from children? That was a question.
A. Okay, I'm not sure of the answer to that question.

Q. With the assistance of HR you sent a letter to Griffin which you annex at Annexure 14 on 6 March 2017, and in that letter you say - well, I'll ask you in a moment who says it:

This is not the first instance of a complaint of this nature brought forward regarding a patient under care and that external agencies have been made aware of this concern expressed by the patient.

That was in the letter?

A. Is it 14?

Q. 14.

A. 41 or 14?

Q. Second paragraph:

As this is not the first instance of a complaint of this nature.

Do you see that?

A. No, I think I'm looking at a different document.

Q. All right, I'll read to you from this letter and see if it reminds you of a letter you've seen before:

As this is not the first instance of a complaint of this nature brought forward regarding a patient under your care and the external agencies have been made aware of this concern expressed by the patient I feel this is a serious breach of your professional boundaries.

And my learned friend tells me it's Exhibit 16.

A. Okay. Yes.

Q. Do you see that second paragraph? Would you read that to yourself?

A. Yes.

Q. What's the relevance of external agencies being aware of it?

A. I think it's in relation to other health professionals

with experience in child and adolescent mental health that increases the gravity for me.

Q. Yes, and I want to understand why the involvement of external agencies increases the gravity of Griffin's conduct?
A. It shouldn't.

Q. Was there a culture of keeping things in-house at the hospital?
A. Well, I think part of the grievance process is around resolving things at a low level if possible, so --

COMMISSIONER BROMFIELD: Q. Sorry, Ms Leonard, could you slow down and just speak up a little bit for me?
A. Sorry. I think, in following the grievance process and the principles of trying to resolve things at a low level in the first instance.

MS BENNETT: Q. And so far as you observed, that had the effect of keeping things in-house in the hospital rather than escalating to external agencies; is that fair?
A. Yes.

Q. Some of those external agencies are regulators, are they not?
A. Yes.

Q. So AHPRA would be one, and the Nursing Board and other oversight bodies?
A. Yes.

Q. And, would you accept that there was a culture which sought to minimise the extent that contact with those agencies was required or encouraged?
A. I think that there was not an openness to engage in those regulatory bodies, yes.

Q. I'm sorry, I haven't heard you.
A. Sorry. I think there was not an openness that there is today around engaging with those regulatory bodies.

Q. Yes, thank you. There's been extensive discussion over Mr Gordon's SRLS of September 2017. He raised his complaint first with you, you asked him to make an entry in SRLS; is that right?
A. I don't recall that, but Mr Gordon's email to me said

that he didn't have time to enter an SRLS on the night and that he was going to do so.

Q. Would you accept that the allegation as made involved sexualised commentary by Griffin to the girls on the ward?
A. The response that Jim offered was slightly different, but that was the concern that Mr Gordon had.

Q. Yes, it was of sexualised commentary, was it not?
A. Yes.

Q. It was not merely - I withdraw that. It was not a boundary violation, it was sexualised commentary from an old man to a teenaged girl?
A. Yes.

Q. And that should have been escalated as such?
A. Yes.

Q. You sought the assistance from HR again; why did you seek the assistance of HR in that instance? I'm not being critical, I'm just asking.
A. Because it was a concern. It was a concern and I needed some guidance and direction how to resolve it.

Q. Mr Harvey's evidence is that it was your decision not to carry out an interview with the girls who were party to the conversation with Griffin for fear of their therapeutic relationship with the nurses on the ward. Is that your recollection of events?
A. No, I don't have a recollection of that.

Q. Do you recall turning your mind to whether or not the girls on the ward should be interviewed?
A. I don't recall.

Q. Is it your view that asking questions about whether or not a conversation had occurred would have interfered with the therapeutic relationship with nurses?
A. I think what would have been important to do is to have external, skilled interviewers undertake that.

Q. Are you able to offer an explanation as to why that didn't happen?
A. Because the response from Mr Griffin seemed reasonable at the time.

Q. And I take it, that's evidence you, again, give with some regret; is that fair?
A. Deep regret.

Q. You accept that you should have made further enquiries about that?
A. Yes.

Q. Griffin shortly after that went to the Ashley Youth Detention Centre. Can you help us to understand the circumstances of his secondment to Ashley Youth Detention Centre?
A. Well, staff will frequently explore other career options in nursing in different specialities, so that wasn't an uncommon occurrence. So, Mr Griffin - I have no knowledge of this up to the point that Mr Griffin advised me that he was arranging a secondment to Ashley Youth Detention Centre.

Q. How did you find out?
A. That's difficult to recall, but I don't know if Mr Griffin told me directly or I was contacted by the manager at Ashley, but I understand as it was a secondment that the HR team were involved in arranging that secondment.

Q. Are you aware of any screening or checks that are carried out on nurses if they want to go to Ashley Youth Detention Centre?
A. I have no knowledge of how Ashley Youth Detention Centre works and their essential requirements.

Q. The Commission heard in the first week of this inquiry from a witness called Tammy Donohue and her daughter [redacted]. Have you heard that evidence?
A. No.

Q. Ms Donohue gave evidence that her disabled daughter was present on the ward in 2018 and that she raised a complaint about Griffin caring for her daughter. Do you have any recollection of any such complaint in 2018?
A. No, I don't.

PRESIDENT NEAVE: Q. Can I just ask a question, please? You said that he may have organised the transfer to Ashley himself and that you may have been contacted by the manager of Ashley. Did I understand you correctly?

A. Yes.

Q. Were you asked for your view as to whether he was a suitable person to --
A. No; no, I wasn't asked for any reference or recommendation or history, work history at all.

Q. And it didn't occur to you that referring to his violation of professional boundaries in the past could create a problem if he went to Ashley?
A. No, I'm sorry, I didn't.

MS BENNETT: Q. Do you know who was the manager at Ashley Youth Detention Centre at the time?
A. No, I don't recall that.

Q. You tell us in your statement, this is about paragraph 124, in Easter of 2013 or 2014 Griffin was staying at the same seaside town as you, and that he invited himself to your holiday house; is that right?
A. Yes.

Q. There was a girl with him, he introduced her as "Tiff". Can you tell us about what you observed of his conduct with that child?
A. It was unremarkable. She came with him by herself, which was a little unusual, because I did expect [redacted], but he passed that off as, that [redacted]. So, it was unremarkable, they came, had a cup of tea, had a look around the house in the afternoon, and I don't - I have a feeling that it was a wet day, so it kind of maybe broke up the day of camping, but there was nothing that --

Q. Nothing that caused you concern or alarm about that interaction?
A. No.

Q. Had you seen Ms Skeggs or that same girl on the ward at 4K ever?
A. I think subsequent to that, I did, but I have no recollection of her.

Q. You think you saw her on the ward after that, but in what circumstance?
A. That it was around netball training and going to

netball after school and something like that, so it was - it was - what I remember of being told, is that, [redacted].

Q. Did you ever see them alone in a room together on the ward?
A. No.

Q. Would that have raised concern for you if you had seen it?
A. Yes.

Q. You give some evidence about the location of drugs on Ward 4K at paragraph 96 of your statement. You say that when you started on Ward 4K, and I'm going to suggest to you that this is before you were the Nurse Unit Manager, controlled drugs were stored in a double locked cupboard in a secure room; is that right?
A. Yes.

Q. There were red lanyard or red keys?
A. Yes.

Q. And you would need the key from the nurse in charge?
A. Yes.

Q. Whoever had the red keys would give them to the requesting nurse, who would unlock the drugs and return them later; is that right?
A. Yes. That's best practice.

Q. That was best practice. Was that common practice on Ward 4K at that time under that system?
A. Yes, but the practicalities of finding the in-charge Nurse and getting the keys was somewhat challenging at times, so it became more commonly carried by - you know, you would pass them off to another Registered Nurse.

Q. And someone would be running around saying, "Who's got the red keys", and you would give them to the next person; is that fair?
A. Yes.

Q. So for much of the time there was little control over who had the red keys; is that right?
A. Yes.

Q. And whoever had the red keys had access to the drugs on the ward?
A. Yes.

Q. It would have been possible to remove drugs without detection under that system; is that right?
A. Possible.

Q. Ms Skeggs suggests that Griffin told her that it was his practice to remove drugs from the ward; are you able to say whether that was something that could have taken place under that system?
A. It would have been identified in the controlled drugs count every day.

Q. So at the end of each day the drugs in the controlled drugs area were counted?
A. Yes.

Q. How was any discrepancy identified?
A. So, they would usually be counted between - at the late shifts, as two staff would come on the late shift for a daily count at that time and, if there was any discrepancy, that would be identified and reported - should be recorded in an SRLS.

Q. So, when someone is checking drugs out of the cupboard in the secure room they have to record the drugs they're taking and for which patient; is that right?
A. Yes.

Q. Is there any reconciliation - or should I say, was there any reconciliation between that document and the actual drugs administered to the patient?
A. Well, they have to be double-checked.

Q. Yes, so there have to be two signatures?
A. Yes.

Q. And was that checked, so at the time of removal two signatures were always present; is that your evidence?
A. Yes.

Q. And was it necessarily checked at the point of administration to the patient as against the amount that was taken out?

A. It should be checked, it should be double checked at the point of care and administration to the patient.

Q. Thank you. And, in 2014 there was a change to swipe card access; is that right?
A. I believe that's correct.

Q. And the swipe card, was that a more secure process?
A. So, it's - it's a monitored process. So, can you refer me to which paragraph?

Q. Paragraph 108.
A. Thank you.

Q. To 110.
A. So, the activity is traceable. So, it's a single swipe access and it's traceable, so if there was a discrepancy you would be able to go back through and check.

Q. So, individual nurses had their individual cards?
A. Yes.

Q. And so, in order to access controlled drugs, that single nurse's card would be the swipe. Would they still have another person watching the removal of the drugs?
A. Best practice, absolutely.

Q. When you say "best practice", does that mean that it wasn't the common practice?
A. No, I believe that was common practice.

Q. How often was that checked, that practice?
A. Um --

Q. Let me put that another way.
A. Thank you.

Q. At the end of each day with the paper record I can understand there was a reconciliation with the controlled drugs. How did that take place with the swipe card?
A. There is - yes, you're absolutely right, there is no auditing, formal auditing process of the swipe access to the drugs safe.

Q. What about antibiotics and antihistamines; are they in a slightly different category?
A. Yes, they are.

Q. They're not controlled drugs, and so, they're stored quite differently; is that right?
A. Yes.

Q. Can you tell us briefly how they're stored in the post 2014 period?
A. So, they would be in the drug room inside the swipe door access. So, again, like all paediatric medications, need to be double-checked for the calculation and then to the bedside, but there is no reconciliation, from my knowledge, in terms of volumes and stock levels.

Q. Is the storage of drugs something that's been a matter of ongoing review or audit over time at a macro level? When was the last time that storage system was reviewed, do you know?
A. Sorry, which particular storage system?

Q. The antihistamine and other one, the less significant one?
A. I'm not aware of that, but I haven't worked in the area for nearly two years.

Q. After Griffin was arrested you asked for all the records concerning Griffin; is that right?
A. I don't recall that.

Q. Did you gather all of the records concerning Griffin after his arrest?
A. I don't recall that.

Q. Did HR ask for access to all of his records after Griffin's arrest?
A. At some stage they asked for all the records.

Q. And you gathered them for them?
A. Yes.

Q. And you made everything available to HR for review at that stage?
A. Yes.

Q. Did you also provide them with your observations that we've discussed today about his tendency to hug and behave inappropriately?
A. No, I don't recall that.

Q. Do you recall the process after Griffin died; was there a direction given not to discuss the circumstances of his offending?
A. After he passed?

Q. After he - well, sorry: before he died after he was arrested was there a direction not to discuss his offending?
A. Yes, there was.

Q. Who gave that direction?
A. That came from Human Resources.

Q. Do you remember who at Human Resources?
A. I believe it was Mr Harvey.

Q. Do you understand what the purpose of that direction was?
A. That he was providing that recommendation and advice from the Tas Police Force because it was an open investigation and they didn't want to contaminate evidence and witnesses, or potential witnesses.

Q. And, what was the effect of that instruction in your view?
A. It was very, very difficult for all of us.

Q. And, why was that?
A. So, where are we at? At this point he's been --

Q. He's arrested and before he's died.
A. And, been charged?

Q. Yes.
A. So, that was very, very difficult for all of us as we were trying to grapple with the enormity and the gravity of the charges and the deception.

Q. And that was something you felt you needed to discuss with your colleagues?
A. (Witness nods.)

Q. And they wanted to discuss with each other?
A. Yes.

Q. And it caused stress and concern on the ward --

A. Yes.

Q. -- that that wasn't possible?
A. Yes.

Q. After he died, was there a consistent - do you need a moment, Ms Leonard?
A. (Witness shakes head.)

COMMISSIONER BENJAMIN: Q. Ms Leonard, would you like a couple of minutes?
A. No, thank you.

Q. Are you sure?
A. Yes.

MS BENNETT: Q. Did you ask management to attend to speak to staff?
A. Yes.

Q. And, what was the response?
A. So, it was a little bit difficult at that time. So, the Nursing Director was on leave, and I was acting as the Nursing Director at that time and another nurse in 4K was acting as the Nurse Unit Manager. So, I recall when I was Nursing Director in that period I met with the staff with Mr Harvey to talk with them as best we could, as far as we could, and to try and help them with the information that they needed, and then a second time I met with the staff in the Nursing Director role with James Bellinger with the same purpose.

Q. And, what's your assessment of how those meetings went?
A. They were obviously very difficult meetings but everybody - from my observation and assessment, a lot of the staff were coming from very different places and experiences, and so, you couldn't - you couldn't necessarily say that how one person felt, everybody felt, and so, it all depended, as far as I could ascertain was, you know, their relationship with Mr Griffin their own personal private experiences and their own personal, personal experiences, so I think it's very difficult to meet those needs and have an expectation that everybody was feeling the same thing, because not everybody was and not everyone had long-term relationships or friendships with Mr Griffin.

Q. What was Ms Bryan's role at this stage?
A. Executive Director of Nursing.

Q. And, in these meetings, what role did she take?
A. She wasn't attending any meetings.

PRESIDENT NEAVE: Q. I'm sorry, I didn't hear what you said then?
A. Sorry. She didn't attend any meetings to my knowledge.

MS BENNETT: Q. Was she present in the country?
A. Yes.

Q. Would you have liked her to attend those meetings?
A. It would have - I think it would have been helpful for us all.

Q. To have a more senior person present?
A. And to recognise the gravity of the situation.

Q. Did you feel that it wasn't being taken seriously by senior management?
A. No, I'm confident it was taken seriously by senior management.

Q. Perhaps, not by Ms Bryan?
A. I can't - I can't speak for that.

Q. Was that the impression given by her failure to attend, to you?
A. Can you ask me the question again, please?

Q. I'll withdraw the question. After Griffin's death in October 2019 were you involved in - how did you receive notice of his death?
A. I believe it was a Saturday morning and I was sent a text message from the nurse who was acting as the Nurse Unit Manager, and she'd been told through informal channels that Mr Griffin had passed.

Q. Yes.
A. And, I asked one of my paediatric medical colleagues to let the Medical Director of Paediatrics know that Mr Griffin had passed. And then, I think it was perhaps on the Sunday that I was again sent a message that LGH

nursing - well, LGH staff were contacting the ward and asking about what had happened with Mr Griffin and discussing Mr Griffin's passing with the staff, and the staff that were on were having great difficulty with that and weren't sure how to respond and how to communicate with our 4K team as well, and the suggestion was to put a text out to all the 4K staff to let them know that Mr Griffin had passed. And the nurse acting as the Nurse Unit Manager and myself didn't think that that was a reasonable course of action given that the family's confidentiality hadn't been observed and there hadn't been a family notice about his passing.

Q. Was the notice given in any event? Did the notification go out despite --
A. I don't believe so, not to my knowledge, and I didn't receive it.

Q. The direction not to discuss Griffin's death or his conduct, did that continue?
A. So, on the Monday morning, when we were at work for a 7 o'clock handover, I did direct the staff not to discuss Mr Griffin's passing; that we'd had a difficult weekend but if we could just focus on our work and our professionalism. And so, what I was actually trying to do was buy some time until I could talk to my Nursing Director and to HR to get some guidance as to how to manage the situation, so - but knowing how difficult that was, I also followed up with everyone and met them individually and tried to talk with them and discuss it.

Q. And, did you get any guidance from HR or your superiors?
A. I think that what happened was that they concurred that that was the right action at this point in time until we had the family death notice or - but that became difficult because of the relationships within the community and the communication channels, so staff were receiving that information from other sources, so it was a very difficult time for us all.

Q. And so, the direction not to speak about Griffin and his conduct, did that remain in effect so far as you were aware?
A. I don't recall the direction regarding conduct specifically, but around his death I believe so.

Q. It was his death, was it?
A. Yes.

Q. So, as far as you were aware, staff were free to discuss his conduct, what they knew of his conduct, but were asked not to discuss the fact or manner of his death?
A. I don't recall the detail there.

Q. Is it fair to say, do you feel that you got enough direction or leadership around the issues managing the aftermath of Griffin's death?
A. No, I don't think so.

Q. Are you able to elaborate on that?
A. Well, I think it's reasonable that none of us - we were all in very unchartered waters and didn't have any knowledge, or experience, or training in how to deal with this.

Q. I have two further questions for you, Ms Leonard. The first is this: in all of the boundary violations that we've talked about today, did you perceive a risk to children?
A. Not at the time I didn't.

Q. Looking back now?
A. Most definitely.

Q. My final question, Ms Leonard, is this: do you consider that you were groomed by Griffin?
A. Yes.

Q. Can you tell the Commissioners why you think that?

COMMISSIONER BENJAMIN: Q. Ms Leonard, take your time and just look at us, okay, because we'd like to know.
A. I feel the challenges of coming into the Nurse Unit Manager role and learning a new role, and the complexities that presented themselves, and the culture and the conflict and the undermining that was going on in the ward at the time, unfortunately, were a perfect storm for Mr Griffin to take advantage of. In my opinion, I feel that I had no knowledge or training of grooming until 2020 and it's still a very - it's a topic that I find very triggering.

I have a lot to learn, as we all do, and part of the challenge in responding is that I feel deep, deep, deeply that we were deceived, we were manipulated, and we were

sold a version of Mr Griffin that he wanted us to believe; and, unfortunately with all of the distractions and the difficult personalities and difficult situations on the ward, it's - I feel that that might have opened up opportunities for Mr Griffin to take advantage of and to manipulate us.

MS BENNETT: If it please the Commissioners, those are the questions for this witness.

COMMISSIONER BROMFIELD: I don't have any questions. Thank you, Ms Leonard.

PRESIDENT NEAVE: Thank you very much, Ms Leonard. And, we'll adjourn, thank you.

AT 4.06PM THE COMMISSION WAS ADJOURNED TO THURSDAY, 30 JUNE 2022 AT 10.00AM