TRANSCRIPT OF PROCEEDINGS

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

At Kannenner Room, Mövenpick Hotel
28 Elizabeth Street, Hobart

BEFORE:

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

On 9 September 2022 at 10.12am

(Day 34)

1 PRESIDENT NEAVE: Thank you, Ms Bennett.
2
3 MS BENNETT: Please the Commissioners.
4
5 **<PETER RENSHAW** **[10.12am]**
6
7 **<EXAMINATION BY MS BENNETT, continued:**
8
9 MS BENNETT: Q. Dr Renshaw, we were speaking yesterday
10 about the time period following the time that I understand
11 you first met Mr Griffin on 31 July and then the period
12 following that?
13 A. Not I met Mr Griffin, but the first I heard of
14 Mr Griffin.
15
16 PRESIDENT NEAVE: I should just remind you, you are still
17 under oath from yesterday.
18 A. Thank you, yes, sorry.
19
20 MS BENNETT: Q. The first you heard of Mr Griffin was
21 31 July, your notification to AHPRA the following day and
22 the following sequence of events and the corridor rumour
23 that took place during that period.
24
25 Can I ask you now about 29 October 2019 in which we
26 understand you had a meeting with Mr Hindle of Tasmania
27 Police; do you recall that meeting?
28 A. I had several meetings with Mr Hindle, I'm not sure I
29 recall the exact, but I'm sure you'll remind me.
30
31 Q. Okay, I'll put up the statement of Mr Hindle which is
32 found at TPOL.0004.0001.0001 at paragraph 8. His evidence
33 is that he had a meeting with you on the date of
34 29 October, and that would have been one of a number of
35 meetings you had with him; is that right?
36 A. Yes. Yes, that's true.
37
38 Q. He says there:
39
40 *I along with supervising officers met with*
41 *Dr Renshaw at his office. During this*
42 *meeting the disclosure as outlined by the*
43 *witness Pearn was outlined to Dr Renshaw.*
44
45 A. Okay.
46
47 Q.

1 *That same day I emailed a summary of the*
2 *meeting to the involved parties and*
3 *attached a copy to the working file (refer*
4 *Annexure 6, copy of meeting email dated*
5 *29 October) ...*
6
7 Dr Renshaw, I can show you a copy of the file note but
8 I can assist you by saying that it doesn't refer to the
9 Pearn disclosure.
10 A. No.
11
12 Q. Do you recall the discussion of the Pearn disclosure
13 in that meeting?
14 A. Actually, I do not, no.
15
16 Q. Do you have any reason to doubt Mr Hindle's memory of
17 having discussed it with you?
18 A. No, none whatsoever.
19
20 Q. You'd accept, would you, that it's likely he did
21 discuss it with you?
22 A. Yes, I have no idea in what depth, but yes, he would
23 have.
24
25 Q. Can I ask the operator to bring that down. Are you
26 able to say whether at that stage you'd already had that
27 corridor rumour, I understand?
28 A. Yes, that's true.
29
30 Q. And then you had this, can I suggest to you, a more
31 formal notification from a member of Tasmania Police about
32 that disclosure; is that fair?
33 A. That is true, yes.
34
35 Q. So that's on 29 October 2019. So, what did you do
36 then with what is by this stage a notification from
37 Tasmania Police about that issue?
38 A. Well, once again, I can't recall the exact context in
39 which it was given to me. However, I think I probably
40 would have assumed that, because it would be told to me by
41 Tasmania Police, that Tasmania Police were actually taking
42 action over that. I doubt that I would have thought that I
43 was required to take any further action at that time. I
44 just assume when police tell me something that it's
45 actually under their purview.
46
47 Q. So, is it your practice as the police - you're

1 effectively the police liaison with the hospital; isn't
2 that right?
3 A. I became that. In this particular matter, yes, the
4 Griffin matter, I was the liaison with ...
5
6 Q. And as the medico-legal officer that's a role you
7 carried out?
8 A. Yes.
9
10 Q. And you're effectively the conduit, are you not,
11 between the Tasmania Police and the hospital?
12 A. Yes.
13
14 Q. And so, as the conduit between Tasmania Police and the
15 hospital, isn't part of your job to identify information
16 relevant to the safety of the hospital?
17 A. Yes.
18
19 Q. From what Tasmania Police tell you?
20 A. Yes.
21
22 Q. And wasn't this something that went directly to the
23 heart of what was safe at Launceston General Hospital and
24 what was not?
25 A. Yes.
26
27 Q. And, wasn't it your responsibility therefore to do
28 something with that information?
29 A. Yes.
30
31 Q. And you didn't do anything with that information; is
32 that right?
33 A. No, I did not.
34
35 Q. Why did you not do anything with that information?
36 A. Once again, because I believed, wrongly, that it was a
37 police matter and they were informing me as part of the
38 general information that we were sharing at that time
39 regarding the progress of the case.
40
41 Q. Do you accept now that that ought to have triggered a
42 more substantial response from you?
43 A. Yes, I'm not clear what that substantial response
44 might be, but yes.
45
46 Q. Perhaps an investigation into how it was that a
47 paedophile operated on a Children's Ward for 18 years; is

1 that fair?
2 A. The institution of inquiries would be the result - I
3 think what I should have done is actually informed the
4 Chief Executive because I did not have the power or the
5 authority to institute an investigation off my own bat.
6
7 Q. And that was Mr Daniels?
8 A. That was Mr Daniels.
9
10 Q. And he has given evidence to this Commission; are you
11 aware of that?
12 A. I'm not across the detail, I am aware he has given
13 evidence.
14
15 Q. As I recall his evidence, and I hope I'm not doing an
16 injustice to his evidence, he says he felt misled by the
17 fact that he was not informed of certain matters about
18 Mr Griffin; would you accept that he would be entitled to
19 feel misled by not being told about this issue?
20 A. I can't speak for him, of course, but I can understand
21 why he might feel that way.
22
23 Q. And you accept, I take it, that it would have been
24 appropriate for him to institute an enquiry had he been
25 aware of that?
26 A. I believe so, yes.
27
28 Q. And it would have been appropriate for him to do that?
29 A. Yes.
30
31 Q. And he was deprived of the information he needed to do
32 that because you didn't tell him about it?
33 A. That's true.
34
35 Q. And it was part of your job to tell him?
36 A. As I said, I wasn't clear that it was - it was an
37 ongoing police matter, and I can't recall the context in
38 which the information was given, but yes.
39
40 Q. Returning to that meeting. I'll ask the operator now
41 to bring up photographs of patients - sorry, withdraw that
42 - the reference in the file note to the photographs of
43 patients that was at issue. So, that is at
44 TDOH.0003.0006.00067. This is an email which I understand
45 records the file note; is that right?
46 A. Yes.
47

1 Q. So I'll just ask the operator to come down. At the
2 first dot point, I'll ask the operator to pause. I draw
3 your attention, this is again, 29 October, where it is
4 recorded that:
5
6 *The photographs directly relate to the*
7 *confines of the LGH ...*
8
9 I won't read further and ask that the document come
10 down.
11
12 That was criminal activity directly connected with the
13 hospital that you discussed with Mr Hindle?
14 A. Yes, it was. And, in addition, it was criminal
15 activity that had been disclosed to me immediately after
16 the notification of James Griffin; in fact, it was the bulk
17 of the discussion with police on 31 July.
18
19 Q. And we discussed yesterday that there was also a
20 reference to the child under the age of 12, so it was both
21 of those issues were discussed with you on 31 July?
22 A. Yes.
23
24 Q. And on that date, as I understand it, the focus was on
25 the Child Exploitation Material?
26 A. That is correct.
27
28 Q. Then you provided to, in the fifth dot point, and I'll
29 ask the operator to focus in on the fifth dot point only
30 before bringing it up on screen of that same document,
31 where you provide an overview of known reported internal
32 concern raised as previously outlined. I'll just ask that
33 you be shown that.
34
35 I need not show that to you. Would you accept that
36 you provided an overview of what you knew of the internal
37 concerns that had been identified at the hospital?
38 A. This is on, which date are we talking?
39
40 Q. On the 29 October meeting, it says - there's the dot
41 point there:
42
43 *Dr Renshaw provided an overview of known*
44 *(reported) internal concerns raised as*
45 *previously outlined in email.*
46
47 Is that right?

1 A. Yes.
2
3 Q. Can you tell the Commissioners what enquiries you
4 carried out - thank you to the operator - what enquiries
5 you carried out in order to be able to provide that
6 overview?
7 A. That was primarily the search of the SRLS which I had
8 access to. I did not have access to Human Resources
9 records, but I believe I did make enquiries of Human
10 Resources whether they had any information at that time.
11
12 Q. Who did you make those enquiries of at Human
13 Resources?
14 A. They would have either been to Mr Bellinger or
15 Mr Harvey.
16
17 Q. Did they provide you with any information in addition
18 to the SRLS materials?
19 A. Not that I can recall, no.
20
21 Q. You say in that file note as well, I can take you to
22 it if you need, you say that you might need to initiate
23 legal assistance. Do you recall giving consideration to
24 that?
25 A. This was in relation to the open disclosure to victims
26 identified through the - it was in that context that --
27
28 Q. What did you think you might need legal assistance
29 with at that stage?
30 A. Well, the context would be that, we had given an
31 assurance to Tasmania Police that we would, for any victim
32 identified in the Child Exploitation Material, we would
33 offer them open disclosure and as part of that we would - I
34 would normally arrange for legal advice going into an open
35 disclosure, remembering that the open disclosure process
36 itself is not a legal process, and it would just simply be
37 receiving the advice about the conduct in such a sensitive
38 issue.
39
40 Q. Six or seven days later there's the 5 November file
41 note which I'll ask the operator to return to - so, not a
42 file note, minute to the Secretary. This appears at
43 TRFS.0059.0080.0065-0001. We looked at this
44 document yesterday and I think as I understand your
45 evidence yesterday, you were involved in drafting this
46 minute to the Secretary?
47 A. I was involved in drafting it, yes.

Q. And at the time of drafting it you were aware that it was going to the Secretary and that it was an important document; is that right?
A. Yes, I was.

Q. Have a look at the start to familiarise yourself with that document.
A. Yes.

Q. If I could ask the operator to scroll down, at the third dot point.
A. Yes.

Q. Sorry, first of all, the second dot point:

> *At that time, Tasmania Police were investigating a complaint external to the hospital pertaining to his alleged relationship with a young person ...*

Can you indicate if in that reference to "a young person" is the child under 12 that you notified to AHPRA or a different young person?
A. I cannot confirm that because that was information I received from Tasmania Police.

Q. At that stage, you had been told, as I understand your evidence, about the child under 12; is that right?
A. Yes.

Q. Did you know at that stage about Ms Skeggs's complaint?
A. No, I believe I did not, no.

Q. And did you know at that stage if there was a complaint from Ms Pearn to the police?
A. No, I did not.

Q. So that's likely to be a reference to the child under 12?
A. That is likely to be a reference to the child under 12.

Q. And you refer there to an alleged relationship with a young person, and you mean there a child under the age of 12?

1 A. Yes. That's - because that was what Tasmania - I'm
2 just repeating what Tasmanian Police advised me back on
3 31 July.
4
5 Q. Does it cause any concern the use of the language,
6 "relationship with a young child", and we're talking about
7 a child under the age of 12 and substantially under the age
8 of 12?
9 A. Well, of course it does, and because the police were
10 obviously investigating it at the time, that was - that was
11 the advice we received from police.
12
13 Q. Then, looking further at that:
14
15 *At that time, Tasmania Police advised that*
16 *there was no evidence to suggest that any*
17 *criminal activity had taken place within,*
18 *or connected to, the LGH.*
19
20 Dr Renshaw, this occurs a week after the conversation
21 with Mr Hindle that we've just been to the file note about.
22 A. No, no, the paragraph refers to "at that time", which
23 is at 31 July.
24
25 Q. Well --
26 A. At that time. This was giving a background to the
27 Secretary about what was there on 31 July. "At that time",
28 it says.
29
30 Q. Well, can I suggest to you that's an overly technical
31 reading of that paragraph and that a reasonable reader of
32 that paragraph would come away believing that there was no
33 evidence to suggest that any criminal activity had taken
34 place within or connected to the LGH?
35 A. Once again, at that time; Tasmania Police advised
36 that.
37
38 Q. Well --
39 A. I am reporting the advice from Tasmania Police.
40
41 Q. My question to you is different. My question to you
42 is, would a reasonable reader, if you put yourself in the
43 position of a reasonable reader - and I'll ask
44 Ms Morgan-Wicks this afternoon how she read this - would
45 you expect a reasonable reader to understand that what you
46 were saying was that you didn't have any evidence to
47 suggest that any criminal activity had taken place within

1 or connected to the LGH?
2 A. No, I did not think a reasonable reader would form
3 that view.
4
5 Q. You don't anywhere else - well, sorry, moving on, the
6 LGH --
7
8 COMMISSIONER BROMFIELD: Sorry, Ms Bennett.
9
10 MS BENNETT: Yes.
11
12 COMMISSIONER BROMFIELD: Q. I am still somewhat confused
13 by that sentence, because I understood that on 31 July you
14 were aware of the child under 12 who was a former patient,
15 and you were aware of the Child Exploitation Material with
16 background images of the ward.
17 A. The paragraph there, on 31 July after the notification
18 and after the standing down of Griffin, we attended
19 Tasmania Police headquarters and were given a briefing;
20 that paragraph summarises what was in that briefing at the
21 time. So, the important thing is that Tasmania Police
22 advised that there was no evidence that they had to suggest
23 that any criminal activity had taken place within or
24 connected to the LGH.
25
26 MS BENNETT: Q. But, Dr Renshaw, I think what the
27 Commissioner is asking you, if I could be so bold, is that,
28 did you not know on 31 July that there was at least the
29 potential that the Child Exploitation Material was taken at
30 the hospital?
31 A. If you're asking, did I assume that there was nothing
32 else going on, the answer is certainly not, I did not
33 assume that. And, yes, I did have, once again, very
34 informal knowledge of the situation which I understood was
35 somewhat between 10 and 15 years earlier.
36
37 PRESIDENT NEAVE: Q. Can I just ask a further question
38 to follow up on that. You were aware that Child
39 Exploitation Material, that that involved a criminal
40 activity?
41 A. Absolutely.
42
43 Q. And you were aware, from the police, that that's what
44 they were investigating?
45 A. That's what was told to me, yes.
46
47 Q. So is your point that, although the police had said

1 that there was a background that suggested it might be the
2 hospital, you still found yourself able to say that there
3 was no evidence - that you were told by Tasmania Police
4 that there was no evidence that the criminal activity, and
5 you've conceded it was criminal activity, had taken place
6 at LGH?
7 A. Which was Tasmania Police opinion at that time.
8
9 Q. Even though, even though the background to the
10 photographs suggest some of them might have been taken in
11 the hospital?
12 A. Oh, no, absolutely, the Child Exploitation Material is
13 absolutely - what I was shown was clearly photographed in
14 the hospital and was a criminal activity.
15
16 PRESIDENT NEAVE: I'm sorry, I'm puzzled by that.
17
18 MS BENNETT: Q. Let me assist. Let's go to 31 July.
19 You went and visited the police station?
20 A. Yes.
21
22 Q. And you spoke to the police then?
23 A. Yes.
24
25 Q. And they told you about two categories of offending,
26 can I suggest to you?
27 A. Yes.
28
29 Q. One was a sexual relationship with a child under the
30 age of 12 who had been a patient at Launceston General
31 Hospital?
32 A. That's right.
33
34 Q. Right. Now, so that is on 31 July. I want to be very
35 clear about this, on 31 July the police told you they were
36 investigating sexual abuse of a child under the age of 12
37 who had been a patient at Launceston. Leave aside that
38 document, I'm asking you about 31 July.
39 A. Yes, 31st, yes.
40
41 Q. That's right, you were told that then?
42 A. They were - they were investigating - well, the
43 relationship with the hospital wasn't clear; it was a young
44 person in the community, in a community group. I can't
45 remember whether they actually said whether the individual
46 that they were investigating the complaint from had been a
47 patient at the LGH; I think that's separate from the

1 12-year-old.
2
3 Q. The following day you advised AHPRA that, their file
4 note records:
5
6 *A complaint was made to Tas Police in*
7 *relation to an alleged inappropriate sexual*
8 *relationship with a child under the age of*
9 *12. This child's advised to be a former*
10 *patient.*
11
12 That was what you said to AHPRA?
13 A. A former patient, yes, yes.
14
15 Q. Yes, on 1 August, so that reflects what you knew on
16 31 July, doesn't it?
17 A. Yes.
18
19 Q. You didn't know anything different from 31 July and
20 1 August?
21 A. No.
22
23 Q. So, on 31 July you knew that there was a former
24 patient, a child, a former patient of the LGH who might
25 have been sexually abused by Griffin?
26 A. Yes.
27
28 Q. And that was a matter that was under investigation by
29 the police on 31 July?
30 A. Yes.
31
32 Q. Just to pause at that point, and look at the dot point
33 that we have been talking about: at that time, Tasmania
34 Police were investigating a complaint external to the
35 hospital pertaining to his alleged relationship to a young
36 person and possession of Child Exploitation Material. At
37 that time you tell the Secretary:
38
39 *Tasmania Police advised that there was no*
40 *evidence to suggest that any criminal*
41 *activity had take place within, or*
42 *connected to, the LGH.*
43
44 Now, Dr Renshaw, I'd like to suggest to you that that
45 is not true?
46 A. I acknowledge that it should have been worded better
47 than that. Obviously, the criminal activity - the Child

1 Exploitation Material was clearly criminal activity. It
2 should have read that the relationship with the young
3 person, although that young person had been a patient at
4 the LGH, that any illegal activity apart from the Child
5 Exploitation Material had not - I'm trying to - basically,
6 the message from Tasmania Police was that they had a lot of
7 photographs from Griffin that were obviously taken in the
8 hospital. They were also separately investigating - which
9 they'd found in the process of investigating the
10 relationship, his relationship with a young person at that
11 time, and they were two separate parts of this.
12
13 Q. Understanding that, let's return to my question --
14 A. And I think the "or connected to" is an error; that
15 the phrase "or connected" --
16
17 Q. And I suggest to you, it is a lie?
18 A. No, it is not a lie.
19
20 Q. It is wrong?
21 A. It is wrong.
22
23 Q. It is misleading?
24 A. It is misleading because it --
25
26 MR COX: I have an objection.
27
28 PRESIDENT NEAVE: Yes.
29
30 MR COX: This is all proceeding on the basis of the
31 report - an update of the police's position. The premise
32 is that this is a memo updating his superiors about a
33 police investigation. My friend's conflating what the
34 police are saying with what he might believe and it's
35 unfair.
36
37 MS BENNETT: I'm not sure if that is an objection to me
38 asking a question or a submission, but I'll ask perhaps the
39 Commissioners --
40
41 MR COX: An objection with the submission.
42
43 MS BENNETT: I don't understand if I'm being asked not to
44 ask a question or not.
45
46 PRESIDENT NEAVE: Are you requesting that the Commission
47 not permit that question to be put?

1
2 MR COX: I'm saying, the line of questioning is unfair
3 unless it's established whether it's his opinion about
4 something or he's reporting Tasmania Police's opinion about
5 something.
6
7 PRESIDENT NEAVE: Well, he's giving his evidence, which
8 we're perfectly capable of hearing, that he was simply
9 reporting what the police activity was. This is in the
10 context of a briefing to the Secretary which he signed and
11 my view, and I would like to consult my colleagues for a
12 moment, my view at the moment is that that is absolutely
13 relevant to the work of the Commission.
14
15 MR COX: I'm not saying it's not relevant. What I'm
16 saying is, if it's put to him that it's a lie, that's
17 unfair because it's being suggested that he's lying in
18 circumstances where it might be a misreport by police.
19 That's what's unfair.
20
21 COMMISSIONER BENJAMIN: I don't understand the nature of
22 the objection. Your client gave evidence, as I understand
23 it, that he was given certain information from police on or
24 about 31 July. He then quite properly the next day, or
25 that day, I'm not sure, reported that information that he
26 received to AHPRA, and we've got the AHPRA report.
27
28 My understanding was, and the doctor might be able to
29 assist me, that by 29 October or early November Mr Griffin
30 had passed away, had he not?
31 A. That is correct.
32
33 Q. And by that time the police investigation into his
34 crimes had come to an end because he had passed away?
35 A. That is correct.
36
37 Q. And you were reporting with others to the Secretary as
38 to what was happening given the circumstances of this
39 paedophile, this sex abuser, working at the hospital for so
40 long?
41 A. That is correct.
42
43 Q. So, I can't understand the nature of your complaint in
44 relation to the questions in that regard, because isn't it
45 this witness's responsibility to inform the Secretary as
46 clearly and as frankly and as fulsomely as possible so that
47 the hospital could take steps to protect children?

1
2 MR COX: Indeed, and that's what he was doing.
3
4 PRESIDENT NEAVE: And that's the import.
5
6 COMMISSIONER BENJAMIN: And that's the import of the
7 question.
8
9 PRESIDENT NEAVE: And that's the import of the line of
10 questioning which Ms Bennett is pursuing, in my view.
11
12 MR COX: But when she puts to him that it's a lie it
13 suggests, I would submit, that he's lying, and he's not.
14 As the Commission quite right says, he's simply frankly
15 reporting back as to the police investigation.
16
17 COMMISSIONER BENJAMIN: Ms Bennett's entitled to put those
18 propositions and he's entitled to answer it as he has.
19 Thank you, Ms Bennett.
20
21 MS BENNETT: If it please the Commission.
22
23 Q. To be very clear, the dot point there that we have
24 been referring to does not reflect, I suggest to you, what
25 you were told about the state of the police investigation
26 accurately at 31 July?
27 A. I believe it is accurate as to what I --
28
29 Q. Right, and --
30 A. Noticing that the first - the first five or six dot
31 points in that document are actually reporting a
32 chronological information leading up to what was pertinent
33 at 29 October; it was background.
34
35 Q. I want to suggest to you that the words, "As at
36 31 July Tasmania Police advised there was no evidence to
37 suggest that any criminal activity had taken place within
38 or connected to the LGH", is wrong. You accept that, I
39 think?
40 A. I accept that the words "and/or connect to the LGH",
41 but they were quite explicit, at that stage they had no
42 complaint about the sexual activity apart from the Child
43 Exploitation Material occurring in the hospital.
44
45 Q. That is sexual activity, isn't it?
46 A. Well, it is, but the police themselves drew the
47 distinction between the Child Exploitation Material and the

1 investigation of other complaints against Griffin.
2
3 Q. The creation of Child Exploitation Material is a
4 serious sexual offence against children, is it not?
5 A. Yes, it is.
6
7 Q. And it is, at the time of 31 July, you were told that
8 there was a prospect that it had taken place within the
9 Launceston General Hospital, had you not?
10 A. Yes.
11
12 Q. And yet, you told the Secretary that as at 31 July
13 there was no evidence to suggest that any criminal activity
14 had taken place within or connected to the LGH; the whole
15 sentence is wrong, isn't it, Dr Renshaw?
16 A. It's poorly worded.
17
18 Q. It is wrong, is it not?
19 A. It is poorly worded.
20
21 Q. I just want to be very clear as a matter of fairness
22 to you. So, you reject the proposition that that sentence
23 is wrong?
24 A. Once again, it does not convey what I was trying to
25 convey, you are correct, but I'm not saying - it was
26 basically a recollection of what we were advised by
27 Tasmania Police at the time.
28
29 Q. And it is on the material and the evidence you've
30 given to this Commission, it is an incorrect recollection,
31 isn't it?
32 A. The police drew a distinction between the Child
33 Exploitation Material which had clearly been generated in
34 the LGH and, if you like, physical sexual assault or
35 physical relationships within the bounds of the LGH.
36
37 PRESIDENT NEAVE: Q. Did you draw such a distinction?
38 A. I don't think I --
39
40 Q. Well, if it's only child exploitation, that's not as
41 serious or?
42 A. No, I certainly did not, in fact I was actually --
43
44 Q. So why was the distinction relevant to your advice to
45 the Secretary?
46 A. Well, I was reporting what Tasmania Police had as part
47 of my briefing.

1
2 MS BENNETT: Q. I don't mean to repeat the point, I want
3 to be very clear about what your evidence is. I think you
4 accept that - you're resisting the proposition from me that
5 that advice was wrong and I just want to understand why and
6 what the distinction is between what you say is conveyed
7 and why it is not wrong; or do you accept that it is wrong?
8 A. No, I accept that it's poorly worded. It did not -
9 yeah. I accept that it was poorly worded but it was
10 certainly not - it was not a deliberate mistake or, um
11 and --
12
13 Q. I haven't come anywhere near deliberate yet. I'm
14 asking you whether it was correct or incorrect, that
15 sentence, that paragraph?
16 A. I would say, if you remove the three words "or
17 connected to", that sentence is as accurate as I knew it at
18 the time.
19
20 Q. Given that those three words appear, would you accept
21 that that is not accurate? I just want to understand it.
22 So, your position is that, are you happy with that briefing
23 note? You think it was as good as was expected of you of a
24 person in your position at that time?
25 A. I believe I was doing it to the best of my ability,
26 yes.
27
28 Q. Do you think you discharged your duties properly
29 providing that briefing note to the Secretary?
30 A. I believe I did discharge my - I may not have done it
31 perfectly, but I discharged --
32
33 Q. And as you sit here today are you satisfied with that
34 standard of your conduct?
35 A. Yes, I have no reason not to be; everybody makes
36 mistakes and everybody - it's that none of us is perfect.
37
38 Q. You don't have any regret about this pretty
39 significant failure, can I suggest to you?
40 A. I don't regret that briefing.
41
42 Q. Looking at the next dot point, again:
43
44 *The LGH had not received any complaint from*
45 *patients or their families regarding*
46 *inappropriate behaviour by Mr Griffin that*
47 *would warrant a Code of Conduct*

1 *investigation, AHPRA notification or*
2 *Tasmania Police notification.*
3
4 Now, do you consider that to be accurate as at
5 31 July?
6 A. As of 31 July and to the best of my knowledge, yes,
7 that was accurate.
8
9 Q. You were aware, though, that there had in fact been
10 the Pearn disclosure before 31 July, were you not?
11 A. No, I was not aware before 31 July.
12
13 Q. Sorry, I phrase that badly. As at the date you did
14 this note, at the time you were doing this note, which is
15 5 November is the date it goes up, you were aware from at
16 least two sources of the disclosure of Ms Pearn. Do you
17 accept that?
18 A. Yes.
19
20 Q. There's the corridor rumour and there's the discussion
21 with Mr Hindle on 29 October.
22 A. I'm assuming that the corridor rumour involved
23 Ms Pearn but as far as I can recall there was no mention of
24 individual names in that corridor conversation.
25
26 Q. Well, you knew from Mr Hindle on 29 October about the
27 Pearn disclosure, didn't you?
28 A. Yes.
29
30 Q. And that means you knew that Ms Pearn had complained
31 to Human Resources some years earlier that Griffin had
32 engaged in child sexual assault; do you accept that?
33 A. Yes.
34
35 Q. Do you accept that Griffin engaging in child sexual
36 assault is something that ought to be notified to AHPRA?
37 A. Yes.
38
39 Q. And Tasmania Police?
40 A. Yes.
41
42 Q. And it would have been a Code of Conduct
43 investigation?
44 A. Yes.
45
46 Q. So you accept that - do you accept that the LGH had
47 received from Ms Pearn a report of inappropriate behaviour

1 by Griffin that would warrant all three of those reports?
2 A. I did not know that on 31 July and this is an
3 historical - this is - the briefing is to give a sequence
4 of events and a chronology as we knew it at the time. So,
5 yes, by 5 November, yes, I was aware, but that is - the
6 LGH, and it should be "at that time had not".
7
8 Q. What I'm suggesting to you is, the way that that reads
9 is that, as at 31 July, the hospital had not been notified
10 of any of those things; do you understand that?
11 A. I was certainly not aware of any concerns that had
12 been, yep.
13
14 Q. I know that but as at the time you wrote this note you
15 had by that stage become aware that the LGH had some years
16 previous received that complaint; do you accept that?
17 A. Yes.
18
19 Q. So at the time you told the Secretary that there was
20 no such complaint that you were aware of that had occurred
21 before 31 July, you knew that to be false, didn't you?
22 A. Once again, this was a chronology of what we knew and
23 when we knew it.
24
25 Q. So again, can I ask you to reflect on this - first of
26 all I'd like to suggest to you, that paragraph is false.
27 Do you accept that as you sit here now?
28 A. With the benefit of hindsight, yes.
29
30 Q. What benefit to you derive from hindsight about the
31 accurateness or otherwise of that paragraph?
32 A. In informing the Secretary the purpose of the minute
33 was to brief her on the chronology of events which led up
34 to Griffin's death and beyond, and that is why the dot
35 points read in chronological order. So, the next dot point
36 refers to 3 August; the fourth dot point to 8 August and so
37 on. The chronology is there --
38
39 Q. So --
40 A. Of course we didn't - that second dot point which
41 should be "at that time", we did not - I personally had no
42 knowledge despite the interrogation of the SRLS which, of
43 course, is not particularly helpful and we've noted that,
44 but this was a full chronology leading up to 5 November.
45
46 Q. This was a full chronology, was it?
47 A. Well, as it is supposed to be a briefing and it - yes.

1
2 Q. It omits any reference to the Pearn disclosure at all,
3 doesn't it?
4 A. The Pearn disclosure - yeah, well, you'll need to go
5 down to the - if it's not at the bottom - if the Pearn
6 disclosure is not there, it should have been.
7
8 Q. Should have been the first dot point on your evidence,
9 shouldn't it?
10 A. No, because it came - to me the evidence came - the
11 notification or the suggestion came at the end of October.
12 This is a chronological document and it starts at day zero
13 and it works through.
14
15 Q. And is it designed to reflect only your state of
16 knowledge?
17 A. It is - well, as the medico-legal - it's - it would
18 reflect my state of knowledge.
19
20 Q. Is it designed to reflect the hospital's state of
21 knowledge?
22 A. Well, it is - it is supposed to, yes.
23
24 Q. You made enquiries to create this note, didn't you?
25 A. I made enquiries.
26
27 Q. Because you wanted to gather a full picture of what
28 the hospital knew at the time you were briefing the
29 Secretary; isn't that right?
30 A. Yes.
31
32 Q. And, as part of those enquiries, you became aware of
33 the Pearn disclosure some eight, maybe 10 years earlier;
34 isn't that right?
35 A. My enquiries in the hospital, my enquiries - it was
36 revealed to me by Mr Hindle from Tasmania Police, and I
37 don't remember that that was actually part of my enquiries
38 but it was provided at that time.
39
40 Q. What I'm trying to suggest to you is that you didn't
41 simply set out what you knew to be the case at 5 November,
42 you set out what you understood to be what the hospital
43 knew at that time?
44 A. That's right.
45
46 Q. And you were aware at that time the hospital was aware
47 for years --

1 A. Well, no, I didn't know it was for years, I just knew
2 that there had been - it was confirmed that there had been
3 a complaint.
4
5 Q. In the past?
6 A. And it might have been 10 to 15 years previously, yes.
7
8 Q. So you knew that at the time and that appears nowhere
9 in this note?
10 A. Um, no.
11
12 Q. And as a matter of fairness to you, I'd like to just
13 suggest to you that, first, that dot point which refers
14 specifically to the state of complaints received by the
15 LGH, the hospital, that that is materially misleading;
16 leaving aside your intention or otherwise to mislead, I
17 would like to suggest to you that that dot point is
18 materially misleading; do you accept that?
19 A. No, I don't, because it was the state of my knowledge
20 on 31 July and that paragraph means nothing more than that.
21
22 Q. And again, can I suggest to you or can I ask you to
23 reflect on whether or not you perhaps ought to have
24 included additional detail - looking at it now, do you have
25 any regrets about the way you worded that paragraph?
26 A. I would concede - no, not that paragraph, but I would
27 concede that there should have been a mention towards the
28 bottom of the chronology regarding the most recent
29 information from Tas Police.
30
31 Q. That is because it was, the Pearn disclosure was a
32 significant - it highlighted a significant or at least
33 potentially significant failure in the systems and
34 processes at LGH?
35 A. Yes.
36
37 Q. And it warranted an immediate response from the
38 leaders at LGH, didn't it?
39 A. Yes.
40
41 Q. And you were a leader at LGH?
42 A. Yes.
43
44 Q. And you took no steps in response?
45 A. Specifically with Pearn, no.
46
47 Q. And you did not equip anyone senior to you to take any

1 steps?
2 A. Not at that time, no.
3
4 Q. And do you regret that, Dr Renshaw?
5 A. Yes.
6
7 Q. Can I take you to your statement to this Commission at
8 paragraph 48. The pinpoint reference is -0031 of your
9 statement, if you have it in front of you. The question
10 that you were being asked by this Commission was:
11
12 *Where concerns or reports in relation to*
13 *Mr Griffin's behaviour were referred to*
14 *you, were you directed formally or*
15 *informally to take particular actions that*
16 *you did not agree with? If so, please*
17 *detail.*
18
19 And your response, if I can read:
20
21 *There were no concerns or reports in*
22 *relation to Griffin referred to me prior to*
23 *31 July and I have not been directed to*
24 *take any action since with which I*
25 *disagree.*
26
27 I'm sorry, what's your response to that? Do you
28 consider that to continue to be accurate?
29 A. Well, at no time before 31 July was any matter
30 referring to Griffin referred to me personally, no.
31
32 Q. Can I direct your attention then to the Question 54 in
33 your statement to this Commission:
34
35 *To your knowledge, what communications were*
36 *had with Ward 4K patients to their families*
37 *in relation to allegations about*
38 *Mr Griffin, detail the nature of*
39 *communications ...*
40
41 Et cetera:
42
43 *As stated above, the initial advice from*
44 *Tasmania Police was that Griffin was in*
45 *possession of child exploitation materials*
46 *and that there was no evidence (at that*
47 *time) of physical abuse or other criminal*

1 *activity occurring at the LGH/Ward 4K.*
2
3 Again, do you see any difficulties with that
4 paragraph of your evidence?
5 A. Sorry, what paragraph are you referring to?
6
7 Q. It's in response to Question 54 at -0034.
8 A. So, you're saying, do I see any problem with that?
9
10 Q. Yes, do you see any problems with that?
11 A. No.
12
13 Q. Returning then to the chronology as we were with it.
14 Overall I just want to confirm with you that the 5 November
15 briefing that we have been discussing, I think you've
16 accepted from me that it was misleading; is that right?
17 A. Yes.
18
19 Q. And I think your evidence is that it was misleading
20 due to your error; is that right?
21 A. Yes, my oversight, yes.
22
23 Q. And, to be clear, that oversight relates to a number
24 of things: it is the Pearn disclosure as told to you in
25 both the corridor rumour and by Mr Hindle; is that right?
26 A. Yes.
27
28 Q. And it makes little to no mention of the fact that the
29 child under 12 was a former - makes no mention of the fact
30 that a child under 12 was a patient at LGH; is that right?
31 A. That is right.
32
33 Q. And they are all material omissions?
34 A. Yes.
35
36 Q. And they are all significant omissions?
37 A. Yes.
38
39 MS BENNETT: I think Commissioner Bromfield would like to
40 ask something.
41
42 COMMISSIONER BROMFIELD: Q. Yes. Commissioner Neave did
43 ask this earlier but I just wanted to confirm: do you
44 understand that the creation of Child Exploitation Material
45 on the ward is a criminal activity?
46 A. Absolutely, I have no doubt about that at all.
47

1 Q. Can you read your paragraph again with that knowledge
2 in mind?
3 A. The --
4
5 Q. Paragraph 54, I think it was that Ms Bennett --
6
7 MS BENNETT: It was paragraph 54, response to 54, I think.
8 A. And I'm referring to the initial advice from Tasmania
9 Police.
10
11 COMMISSIONER BROMFIELD: Yes?
12 A. It was that Griffin was in possession of Child
13 Exploitation Materials and there was no evidence at that
14 time or - at that stage police were not certain where the
15 photographs had been taken, and it was only confirmed after
16 my return when we met with police, but at that stage all
17 they knew was, there was a significant amount of Child
18 Exploitation Material on Griffin's personal phone and
19 laptop.
20
21 So, once again, I'm repeating exactly what the police
22 told us: yes, Griffin had Child Exploitation Material; at
23 that stage they had not confirmed where the Child
24 Exploitation Material had been generated. They also at
25 that stage said that there had been no complaints referred
26 to them of sexual activity - sexual child abuse activity
27 apart - within the LGH itself, but they did say that an
28 employee of the LGH had been found with Child Exploitation
29 Material.
30
31 PRESIDENT NEAVE: Q. But the question relates to your
32 own knowledge rather than to the knowledge of the police,
33 what the police told you, I thought.
34 A. The question is - well, it was actually to give - that
35 was to give context to the question, which is, "What
36 communications had been had with Ward 4K patients and their
37 family?"
38
39 Q. Yes.
40 A. So, it was ... at the time when that first paragraph -
41 this is 31 July - that at that time, yes, we were briefed
42 by police, the briefing was that there was Child
43 Exploitation Material on Griffin's thing; I think they may
44 have even said, look, it may be that it was generated at
45 the hospital, but they - they - their investigations hadn't
46 proceeded that far.
47

1 MS BENNETT: Q. So, to be clear, Dr Renshaw, it was the
2 live possibility at that point that the photograph - the
3 Child Exploitation Material was generated at the hospital?
4 A. That's right, which is confirmed in my second
5 paragraph.
6
7 Q. Yes. So, just to be clear, you understood there was
8 at least the prospect as at 31 July that serious child sex
9 offending had occurred at Launceston General Hospital?
10 A. Yes.
11
12 Q. And you didn't put that in your note to the Secretary?
13 A. I put it in my note to the Secretary of 3 August or
14 2 August; my initial briefing to the Secretary did contain
15 that.
16
17 Q. Sorry, but in this note you're saying directly to the
18 contrary, aren't you? In the note of 5 November you're
19 saying directly to the contrary, are you not?
20 A. I don't believe so, no.
21
22 Q. Let's go back to it, if I could ask the operator to
23 bring it up. You say:
24
25 *At that time, Tasmania Police were*
26 *investigating a complaint ... [et cetera].*
27 *At that time, Tasmania Police advised that*
28 *there was no evidence to suggest that any*
29 *criminal activity had taken place within,*
30 *or connected to, the LGH.*
31
32 That's not right, is it?
33 A. The police said that there was no evidence at that
34 time. I'm only repeating what the police said and advised.
35
36 Q. Well, I think your evidence to this Commission has
37 been that they were actively considering the evidence that
38 they had to determine if it disclosed serious child sexual
39 offending --
40 A. Yes.
41
42 Q. -- on Ward 4K on 31 July. So, they had some evidence
43 that they were analysing to determine whether or not
44 criminal activity had taken place within or connected to
45 the LGH?
46 A. There was certainly a significant possibility that 4K
47 would be involved, yes.

1
2 Q. So, where you say "there was no evidence to suggest",
3 there was indeed evidence to suggest that and it was being
4 considered on that basis; is that right?
5 A. The police said they had no evidence at that time.
6
7 PRESIDENT NEAVE: Ms Bennett, I think we might move on to
8 our next point.
9
10 MS BENNETT: Please the Commission, yes.
11
12 Q. At the time of that note that went to the Secretary,
13 Griffin had died?
14 A. Yes.
15
16 Q. And so, you were aware that the police investigation -
17 or what was the status of the police investigation from
18 that time?
19 A. I wasn't certain until my meeting with Glenn Hindle,
20 when he said that at that stage the police investigation
21 would perforce finish because of the death of the
22 perpetrator.
23
24 Q. So, were you then involved in a review or
25 investigation that took place following October?
26 A. Was I personally involved? No, I was not.
27
28 Q. Was anyone who was carrying out that review - or who
29 was carrying out the review?
30 A. Well, at that stage my understanding was, it was
31 departmental level that steps had been taken, certainly -
32 the chronology is difficult - certainly not in November, or
33 we were - in November we were involved in some briefings
34 for staff and we had already offered - the Tasmania Police
35 were going to provide us with copies of appropriate
36 photographs that we could - to try and identify any of the
37 victims and we assured the police, and I - the commitment
38 was given to the police that we would conduct open
39 disclosure to all the victims and their families as
40 required.
41
42 Q. So, were you involved in any investigation into - were
43 you involved in any interrogation of Griffin's conduct on
44 the ward?
45 A. No.
46
47 Q. Were you aware that there was an internal review being

1 carried out?
2 A. No.
3
4 Q. I think the evidence of Mr Bellinger is that he was
5 carrying out what he talked about as an internal review or
6 a desktop review; were you aware of that?
7 A. No, I was not.
8
9 Q. Did you have any involvement in that?
10 A. No.
11
12 Q. I'll ask my learned junior to double-check the
13 transcript, but I recall that Mr Bellinger's evidence was
14 to the effect that you involved; can I ask you for your
15 response to that?
16 A. I don't recall at what level. He may well have asked
17 me about matters I'd discussed or was able to discuss
18 through my connection with Tasmania Police, but I can't
19 recall anything about the specific behaviour on the wards
20 or anywhere in the LGH, it was more the consultation with
21 me about what I knew or what I - what information I had
22 from police.
23
24 Q. So, were you aware that Mr Bellinger was carrying out
25 a review?
26 A. Yes. Sorry, yes, I was.
27
28 Q. Tell the Commissioners what you recall about the
29 review that you knew was being carried out?
30 A. I just knew that a review was being carried out.
31
32 Q. What was the nature and scope of the review?
33 A. I do not know.
34
35 Q. Your responsibilities were, you were a Senior
36 Executive at the hospital, you remain a Senior Executive at
37 the hospital?
38 A. Yes.
39
40 Q. And you had a medico-legal role which included
41 oversight of, broadly, the legal and regulatory matters
42 connected with the operation of the hospital; is that
43 right?
44 A. Well, yes.
45
46 Q. And, Griffin operating on a Children's Ward for
47 18 years presented significant legal and regulatory

1 concerns for the hospital, didn't it?
2 A. Yes.
3
4 Q. So, what was your role in relation to responding to or
5 addressing those concerns?
6 A. With the regulatory? My mandatory notification to
7 AHPRA, that was my regulatory role. With regard to the
8 criminal activity, my liaison with the Tasmanian Police was
9 the role. Other parts of the work were at the province of
10 Human Resources, so they were my two roles, were the
11 regulatory and the police liaison.
12
13 Q. And, in relation to Human Resources, what was your
14 role?
15 A. They are their own entity, they were - I was just
16 available to consult with them if they required.
17
18 Q. So, Human Resources didn't report to the Executives at
19 the hospital?
20 A. They did not report to me, they reported directly to
21 Mr Daniels.
22
23 Q. So, can you tell us whether or not you discussed with
24 Mr Bellinger the Pearn disclosure?
25 A. No, I did not.
26
27 Q. And, did you make any enquiries about whether or not
28 there was going to be a response to - well, sorry. Did you
29 consider that Griffin's offending unmasked substantial
30 system failures at the hospital?
31 A. Yes.
32
33 Q. And those failures were directly connected with the
34 safety of children at the hospital?
35 A. Yes.
36
37 Q. And that it, therefore, called for a prompt and
38 energetic response?
39 A. Yes.
40
41 Q. Can I ask what steps you took to promptly and
42 energetically respond to those risk?
43 A. This is a corporate responsibility and all Executives
44 were in the same position as I was with regard to this
45 matter.
46
47 Q. Yes, and I'm asking you about the steps you took in

1 response to your responsibility?
2 A. My responsibility was: report to AHPRA, standing down
3 Mr Griffin, and the liaison with the police.
4
5 Q. So, do you not accept the proposition that you had a
6 responsibility to take proactive steps in response to
7 obvious system failures?
8 A. I believe that those were - I was proactive in what I
9 did, but I am just one of the Executives, there were six or
10 seven other Executives; we couldn't possibly be all doing
11 every aspect of what you're asking.
12
13 Q. I'm only asking for your understanding of your
14 obligations. So, you understood you had obligations to
15 respond; is that right?
16 A. My obligation was to provide the advice on request
17 from whoever was doing the review.
18
19 Q. The Executive Director of Nursing gave evidence to
20 this Commission; do you recall who that was at the time?
21 A. Helen Bryan.
22
23 Q. And her evidence was to the effect that you
24 effectively pushed her out of the response. I hope I'm not
25 being unfair to her, I'll check the transcript.
26 A. No.
27
28 Q. Do you think that's an accurate --
29 A. No, I do not. I do not.
30
31 Q. You were certainly a visible figure in the response;
32 would you accept that?
33 A. Yes.
34
35 Q. And people had an expectation, would you accept
36 that --
37 A. Yes.
38
39 Q. -- you were intimately involved in the response?
40 A. Yes.
41
42 Q. And people, other Executives, might have considered
43 that you were centrally involved in responding to the
44 offending of Griffin --
45 A. Yes.
46
47 Q. -- would that be a fair assumption by them?

1 A. That would be a fair assumption by them.
2
3 Q. When we're talking about the response, that includes a
4 response that identifies and responds to the systemic
5 difficulties uncovered or the systemic failings uncovered
6 by Griffin's offending; would you accept that?
7 A. Yes.
8
9 Q. Would you accept that there was a general expectation
10 upon you, given your role and the length of your service,
11 that you would take some initiative to respond to those
12 systemic issues?
13 A. By "respond"?
14
15 Q. Take some steps to fix the problems?
16 A. Yes, but on my own?
17
18 Q. At all?
19 A. I'm part of a team. It's the team responsibility and
20 my responsibility is to be part of the team and to exert my
21 role. Now, my role was slightly unusual, in that, I did
22 step up and took responsibility that probably normally
23 would have been the Executive Director of Nursing, but
24 because of my relationship with Tasmania Police I was the
25 one who had the information - primarily when I returned
26 from leave, obviously the hospital was in turmoil, there
27 were, as was said yesterday, rumours flying everywhere. My
28 role which I took was to actually provide the information
29 that I was allowed to by Tasmania Police in order to
30 provide some single point information to staff. The
31 reviews of what had happened in the past were in the very
32 early days, I wasn't directly involved in those, they were
33 an HR matter.
34
35 PRESIDENT NEAVE: Q. Can I just ask: did you have a
36 responsibility to keep children in the hospital safe in the
37 future?
38 A. Yes.
39
40 Q. And, how did you discharge that responsibility?
41 A. I discharged my - that responsibility by doing my job.
42
43 PRESIDENT NEAVE: Thank you.
44
45 MS BENNETT: Q. Is there anything you'd like to add to
46 that?
47 A. Well, doing my job to the best of my ability. And,

1 well, I'll say, and by assuming some sort of leadership
2 where there was some sort of leadership vacuum.
3
4 Q. So, you stepped into a leadership role in responding
5 to Griffin and, in doing that, did you try to inform
6 yourself about how Griffin had operated on a Children's
7 Ward for 18 years without detection?
8 A. Yes.
9
10 Q. And did you review all of the complaints made about
11 him in the course of that work?
12 A. Well, at that stage I had not been provided with any -
13 I mean, the timeframe for this sort of information that
14 you're asking, did I do this or did I do that, is really,
15 given the amount of material that was available and the
16 time span; normally the - I'm not sure who commissioned the
17 internal review, but I presume it was at Chief Executive
18 level, and that would have been primarily the HR
19 responsibility to start gathering the information together,
20 they would refer matters to me if they felt that my
21 medico-legal input was required, but it would not be - that
22 would be me doing my job, as it were.
23
24 Q. I'll put to you the response from Mr Bellinger in the
25 last hearing some weeks ago. I asked him about the desktop
26 review in 2019, he said:
27
28 *Yes, I was involved in the desktop review*
29 *from 2019, I was not solely responsible for*
30 *it.*
31
32 And I said:
33
34 *Who was senior to you that was responsible*
35 *for it?*
36
37 He said:
38
39 *Senior to me, if I can clarify the*
40 *expression "senior", there was also the*
41 *Executive Director of Nursing, the*
42 *Executive Director of Medical Services;*
43 *they are senior in experience in their*
44 *field, I don't report to them in an*
45 *operational sense.*
46
47 So, what do you say to the suggestion that you were

1 involved in the review in that sense?
2 A. Well, I think I've already accepted that I was
3 involved in the review, yeah, within my role as Executive
4 Director of Medical Services.
5
6 Q. And, to understand that role, your evidence is, that
7 role was to provide information to Mr Bellinger, not to
8 review the information provided to Mr Bellinger as a whole;
9 is that right?
10 A. If Mr Bellinger had provided me with information to
11 review, I would have reviewed it.
12
13 Q. Did he provide you with information to review?
14 A. Not that I recall, no.
15
16 Q. You reviewed the SRLS, didn't you?
17 A. Well, first of all, yes, on 31 July we did a - I asked
18 for a very quick scan of it because I had never heard of
19 Griffin before and I asked them to do a search and SRLS
20 were using the word "Griffin" and that of course showed no
21 evidence of complaint; using that particular search word.
22
23 Q. You were aware, were you not, of a 2017 complaint put
24 forward by Mr Will Gordon on the SRLS about inappropriate
25 conversations of a sexualised nature?
26 A. I became aware of that later but it was not shown up
27 on that initial.
28
29 Q. So, on the initial SRLS?
30 A. Yes.
31
32 Q. What about the HR file, when did you review that?
33 A. I never received or reviewed the HR file.
34
35 Q. So, did you ever see any final document that recorded
36 the review?
37 A. Not to my knowledge, I can't recall it.
38
39 Q. Were there any action items or next steps to change
40 the systems and processes arising from Griffin's crimes?
41 A. I'm not sure I - action items generated by the report?
42
43 Q. Did the hospital learn anything from the experience of
44 having Griffin operating on a Children's Ward for 18 years?
45 A. Yes.
46
47 Q. And, where do we find those learnings reflected?

1 A. I can't answer that question, I don't know where. I
2 certainly know that the experience has been a great
3 teacher, yeah. You see, as I say, at that stage the focus
4 of the enquiry had moved to departmental level rather than
5 hospital local level, and the learnings, I don't believe
6 we've - we certainly haven't completed the, I suppose, the
7 wash-up but, I mean, the Commission's work is actually part
8 of that. From our point of view, you know, there will be
9 learnings that we get from the Commission that we will be
10 able to use.
11
12 Q. So, what were the changes to the systems and processes
13 at LGH that followed from the offending of Griffin?
14 A. I'm not certain that we've - I'm not certain that
15 there have been any marked changes. The --
16
17 Q. Can I ask, Dr Renshaw, how you can be sure that it is
18 safe in light of that observation?
19 A. As I'm not aware of any formal action items and what
20 they would be intended to achieve, I really can't answer
21 that.
22
23 Q. Yes, thank you, Dr Renshaw. There was an Integrity
24 Commissioner request that was made in late 2019, it was not
25 communicated to anyone in the hospital until sometime
26 after. Were you aware of the Integrity Commissioner
27 request?
28 A. No, I was not.
29
30 Q. Were you aware of any steps made to respond to the
31 Integrity Commissioner request?
32 A. I was not - I did not.
33
34 Q. Do you have any involvement in putting together the
35 material for the Integrity Commissioner request?
36 A. I don't believe so, no.
37
38 Q. Did you ever see any drafts?
39 A. No, I did not.
40
41 Q. Understanding that to be so, can I ask you your view
42 about the accuracy or otherwise of this paragraph. The
43 operator might show it to you to be clear and I don't
44 suggest to you that you wrote this page, I'd like your
45 impression of it. TDOH.0003.0006.0046. I'll read it out
46 while the operator brings it up:
47

1
2 *The THS [and that's the hospital] has*
3 *reviewed all available records and*
4 *determined that all matters that were*
5 *raised with the Agency were addressed in a*
6 *manner that was reasonable in the*
7 *circumstances that existed at that time.*
8 *The decisions made over the past 15 years*
9 *were without the benefit of the information*
10 *that now exists as a result...*
11
12 I'm reading I think from the last page.
13 A. Thanks.
14
15 Q.
16 *... without the benefit of the information*
17 *that now exists as a result of the Police*
18 *investigation and the management actions*
19 *cannot be judged with that in mind.*
20
21 So that's that first paragraph under the words "In
22 conclusion".
23 A. Yes.
24
25 Q. I'm not suggesting to you that you wrote this, I'd
26 just like your reflections on whether or not that is -
27 that's your view. Is that accurate in your view?
28 A. I think it's a big call to say "reviewed all available
29 records", because there would have been thousands of
30 records, one would have thought. But overall, I can see
31 that that would be a fair assessment.
32
33 Q. Can I ask whether or not you say that with the Pearn
34 disclosure in mind?
35 A. Oh, of course: no, there should have been. You're
36 right, yes, so ...
37
38 Q. So that's, had you seen that document, you would have
39 been concerned it was not accurate?
40 A. Yes, I would have been.
41
42 Q. I'll ask the operator to bring that document down.
43
44 PRESIDENT NEAVE: Q. So can I just follow up on that?
45
46 MS BENNETT: Yes.
47

1 PRESIDENT NEAVE: Q. The tone of that letter is, this
2 was a bad apple in a sense.
3 A. Yes.
4
5 Q. This was a problem employee who unfortunately was not
6 picked up?
7 A. Yeah.
8
9 Q. Do you accept that characterisation or do you see this
10 as a systemic issue?
11 A. I think it's both: predators function best in a system
12 that allows them to function, so yes.
13
14 MS BENNETT: Q. So, you met with staff after these
15 events that we've been talking about. So, it was in
16 12 December 2019 and over further meetings the
17 following year; is that right?
18 A. That's correct.
19
20 Q. And that's what you've described as open disclosure?
21 A. No.
22
23 Q. Sorry, what were those about?
24 A. I was asked by, I believe it was the Nursing Director
25 of Women's and Children's. When I returned from leave,
26 because she was concerned about the issues with staff and
27 divisions within staff, and the obvious shock and anger and
28 the mixture of emotions, I was asked whether I'd be willing
29 to provide basically a fact-based session on information
30 that the police were able to provide me to give them some
31 information because the chief complaint at that time was
32 that nobody knew what was going on, there were allegations
33 that we were keeping things from staff, and so on and so
34 forth, so the primary function of the sessions was to
35 provide facts to the staff.
36
37 Q. Did staff at those sessions express to you concerns
38 that there had been issues about Griffin raised in
39 the nature of boundary breaches that hadn't been acted
40 upon?
41 A. Yes.
42
43 Q. So, what kind of issues were raised by staff at that
44 stage?
45 A. There was the Will Gordon concern about the 2017
46 issue. There were a number of other staff who - I think it
47 was three staff who actually emailed me with individual

1 issues that were passed on to HR for their processing and
2 so on. There was the other general staff desire - not
3 general staff desire, a few members of staff were very keen
4 on a group debriefing or counselling session.
5
6 Q. So, in terms of the issues that had been raised, was
7 it your understanding from the flavour of those matters
8 that there had been a number of boundary breaches involving
9 Griffin and that there were questions over whether they had
10 been responded to properly; is that fair?
11 A. Yes.
12
13 Q. So, did you have an operational response to that in
14 terms of clarifying, you know, boundary breach protocols or
15 anything along those lines?
16 A. No, my view was that was an HR issue and I referred
17 those matters to HR.
18
19 Q. You referred them to HR?
20 A. Yes.
21
22 Q. Did you give them instruction that they needed to
23 provide additional training, resources or policies around
24 those issues?
25 A. No, they were to come up with a plan about how they
26 would address those issues.
27
28 Q. So you instructed them to create a plan to address
29 boundary breach issues?
30 A. No, I didn't. I provided the context of the concerns
31 to HR.
32
33 Q. Sorry, my learned junior reminds me, and sorry to
34 return to it, it's a matter I should put to you as a matter
35 of fairness from the evidence of Mr Daniels, just to take
36 you back to the question of a review.
37
38 He said, in the context of a discussion about the
39 internal review that we've been discussing, I asked, "Who
40 told you that?", that a review was being carried out and he
41 said:
42
43 *It would have been a combination of*
44 *Mr Bellinger and Mr Harvey, I understand,*
45 *and probably the Chief People Officer at*
46 *the time who was their direct operational*
47 *manager.*

1
2 I asked:
3
4 *Question: And what about Dr Renshaw, did*
5 *he provide you with any assurances that he*
6 *had carried out a review?*
7
8 *Answer: He did.*
9
10 *Question: And what did he tell you about*
11 *the outcome of that review?*
12
13 *Answer: He told me he'd had a number of*
14 *meetings with the staff on the ward and*
15 *that was part of the counselling and*
16 *debriefing for them, and he indicated that*
17 *the outcomes of those were that he felt*
18 *that people were aware of their*
19 *responsibilities and that they would*
20 *require further training going forward.*
21
22 A. I disagree with Mr Daniels on that.
23
24 Q. So, did you tell him that you carried out a review?
25 A. No, I did not.
26
27 Q. Did you tell him that you indicated that the outcomes
28 of your meetings were that people were aware of their
29 responsibilities and that they would require further
30 training going forward?
31 A. In the context of mandatory reporting, I believe I
32 probably mentioned that to him because obviously Mr Gordon
33 identified that as an issue in his submission, but beyond
34 that it was that the meetings with staff were not part of a
35 review, they were part of an information-giving session.
36
37 Q. Again, I believe it to be the evidence of Mr Gordon
38 that it is suggested that at one of those meeting you, in
39 an accusing manner, suggested that other nurses or medical
40 staff could have and should have mandatorily reported
41 Mr Griffin; is that right?
42 A. No, I didn't say that. What I did say was that, as
43 registered health professionals we all have a
44 responsibility. Now, I know Mr Gordon said I shook my
45 finger, and I possibly did, but I'm also aware that
46 Mr Gordon said, "And he was right"; it was under his breath
47 after he said that "He shook his finger", and he's right

1 that I shouldn't have shaken my finger but, in fact, I was
2 right, it is actually the responsibility of every
3 registered health professional who becomes aware of matters
4 affecting community safety from registered health
5 professionals that they do submit a mandatory report or a
6 report to AHPRA, and I was actually very surprised that
7 nobody seemed to understand that, which would give context
8 to my saying, "We really need to do some work about
9 educating our health professionals as to their
10 responsibilities under the National Law".
11
12 Q. So you felt that the staff at the hospital weren't
13 aware of their obligations as mandatory reporters?
14 A. I think it was clear that they weren't.
15
16 Q. And what was the training that the Executive team were
17 providing to the staff to make sure - before this happened
18 to make sure --
19 A. There was no training in the National Law.
20
21 Q. What about boundary breaches? Was there training
22 around boundary breaches?
23 A. No.
24
25 Q. What is a boundary breach?
26 A. Boundary breach - well, the definition in the AHPRA
27 document is quite long, but basically it's where you act
28 outside your - the normal, in terms of social interactions,
29 financial interactions with other - with the community.
30
31 Q. And, is that something that you had concerns that
32 there was not sufficient training about?
33 A. I must admit, it hadn't - it hadn't crossed my mind
34 until the Griffin issue.
35
36 Q. Yes, and from the Griffin issue?
37 A. My assumption, which was wrong, was that the various
38 registration boards around nurses, medical and so on have
39 their own individual Code of Conducts and the professional
40 responsibility for every registered professional is to be
41 actually aware of those Codes of Conduct and to act within
42 them.
43
44 Q. So there was - for example, there was a boundary
45 breach by Griffin in 2005 where he was said to have kissed
46 child on the forehead; it was described as a "wet kiss".
47 Did you hear about that at the time?

1 A. No.
2
3 Q. Do you think that is a boundary breach as you
4 understand it?
5 A. Yes.
6
7 Q. In his response, and I don't suggest that this
8 response was provided to you, Griffin was counselled about
9 that and he was told that was inappropriate. That happened
10 in writing. He provided a written response, and I'll read
11 to you from it. He said:
12
13 *It was a spontaneous action and happened*
14 *while I was squatting down beside the child*
15 *asking her to go to bed, which she did not*
16 *want to do. In retrospect, I believe I did*
17 *this as a way of establishing a level of*
18 *friendship rather than being seen as some*
19 *kind of authoritarian figure. While this*
20 *may have been seen by a parent in her*
21 *context as an inappropriate act, giving a*
22 *child a kiss as a show of caring is*
23 *something that is done often on the ward by*
24 *many nursing and other staff. I do,*
25 *however, accept that this may not be seen*
26 *as appropriate.*
27
28 Now, Dr Renshaw, you're a longstanding member of staff at
29 the LGH: is kissing patients or their family members part
30 of the usual conduct or culture at LGH?
31 A. No.
32
33 Q. Is it something that you would expect staff at the LGH
34 would hug or kiss patients or members of their family in
35 the performance of their professional duties?
36 A. Not in the performance of their professional duties,
37 no.
38
39 Q. I'm now going to put a document to you, and my learned
40 friend may have an objection about it.
41
42 While my learned friend is looking at that, would you
43 have expected something like that to have been escalated
44 beyond the level that it was at the time in 2005?
45 A. I don't think so, no.
46
47 Q. You've written a letter dated 19 January 2022 in which

1 you've said, and I'll quote, and you can tell me if this is
2 not accurate:
3
4 *It is normally my practice at the end of an*
5 *emotional and distressing meetings where a*
6 *clear rapport has been established with the*
7 *family that I confer my sympathy and*
8 *support for the family with a hug. Almost*
9 *invariably I will say during the goodbyes*
10 *"may I give you a hug?" I have never had*
11 *any negative response to this and I believe*
12 *that it helped to humanise the hospital*
13 *response to very sad clinical incidents.*
14
15 A. Yes.
16
17 Q. So, can I suggest to you that it is part of your
18 practice to offer hugs to the family members of patients?
19 A. It is, with permission. That's the important
20 distinction there, it is with permission. I do not impose
21 it, but given the emotional nature of a lot of the things
22 that we do, especially long and involved conversations with
23 patient deaths and so on, it is something I offer; it is
24 not something I impose.
25
26 Q. So, returning to my question: it is part of your
27 practice to hug patients and their families?
28 A. With permission.
29
30 Q. Yes. Yes, with that acceptance, that's your practice?
31 A. Yes.
32
33 Q. And that is known in the hospital?
34 A. I don't think so. I don't believe so.
35
36 Q. You don't hide it, though?
37 A. No.
38
39 Q. Would a person who had concerns about hugging on the
40 ward be entitled to think it was a normal part of practice
41 at LGH to do that?
42 A. I'm not sure how they would know.
43
44 Q. Well, assuming people saw you?
45 A. But context is everything.
46
47 Q. Yes. Well, assuming people have seen you.

1 A. Yes.
2
3 Q. You've been at this hospital for 35 years, so you have
4 hugged - it's part of your normal practice over those
5 35 years, where you believe that there is a rapport, that
6 you would say, "May I give you a hug?"
7 A. To put it in context, it probably has occurred 10 or
8 11 times in the 35 years.
9
10 Q. Sure.
11 A. So, it is not a regular occurrence, it is usually done
12 on one-on-four or one-in-five meetings, like open
13 disclosures. It is never done alone, and it is always done
14 with permission.
15
16 Q. There's been evidence before this Commission that
17 Griffin was observed hugging patients, child patients
18 often, but patients also above the age of a child, and that
19 the reason that it did not cause concern to those who
20 observed that behaviour was because it occurred in a group
21 and there didn't appear to be any problems from the person
22 in receipt of the physical contact.
23
24 So, I just want to test with you if, in hindsight, you
25 have any concerns that people at the hospital might not
26 have seen that contact as any sort of a problem because it
27 was part of the cultural norms at the hospital?
28 A. With respect, I do not think so, no.
29
30 Q. And, what about kissing patients or their family
31 members?
32 A. Kissing them?
33
34 Q. On the forehead, on the head?
35 A. Once again, it would only be with permission. These
36 are all adult patients, I should say, most of them elderly,
37 most of them distressed. And the offer was, "Can I give
38 you a hug?"
39
40 Q. And what about a kiss on the head?
41 A. That would not be normally - no, that would not
42 normally be part of my - no.
43
44 Q. That would be inappropriate?
45 A. Yes.
46
47 Q. And the hug you see as being appropriate in some

1 circumstances?
2 A. With permission.
3
4 Q. Permission, yes. I want to return to the meetings.
5 I've just been informed by my junior that I have gone over
6 time. I am very close to being finished, unless someone is
7 going to tell me I am not close to being finished. It
8 might be best that we can finish now, if the learned
9 stenographer --
10
11 PRESIDENT NEAVE: Thank you.
12
13 COMMISSIONER BROMFIELD: Q. Are you okay?
14 A. Me? Yes. Thank you. Yes, yes, I'm fine. Thank you.
15
16 MS BENNETT: Q. Did Ms Pearn call you in 2020 or at any
17 stage?
18 A. I must admit, I've heard that. I honestly have no
19 recollection of that phone call.
20
21 Q. Do you dispute that it took place?
22 A. No.
23
24 Q. It was after the podcast, my junior reminds me, was
25 alleged to have occurred.
26 A. I really can't remember.
27
28 Q. She says she felt dismissed when she tried to tell you
29 about her disclosure; do you have a response to that?
30 A. I'm sorry that she felt dismissed. Often it's when
31 you actually - it is sometimes difficult to meet people's
32 expectations. Look, I really don't have a clear
33 recollection of that call and I'm very sorry if she felt
34 dismissed, because I certainly don't feel - I do try to be
35 kind and listening as a part of ...
36
37 Q. Ms Knight gave evidence that she raised issues and
38 felt dismissed and like a number in her discussions with
39 you. Can I ask for your response to that?
40 A. I had not only a couple of phone calls from Ms Knight,
41 but also some emails and I certainly tried to help her as
42 far as I could, and one of those of course was the
43 recommendation of support agencies and so on, but there
44 wasn't very much else I could offer at the time beyond
45 listening; I certainly didn't dismiss her concerns.
46
47 Q. The evidence of - I just want to check there's no

1 pseudonym - the evidence of Ms Unwin was that you tended to
2 be dismissive of complaints. Do you have a response to
3 that?
4 A. I'm very surprised with Ms Unwin about that; I
5 understood that she was reporting what she - not her
6 experience, but the experience of others in the ward, and
7 this was back in the early 2000s where I'm certain that it
8 wouldn't have been an issue. I'm not quite sure where she
9 got it from, but it should be - it could be a conflation of
10 previous issues. But, no, I do disagree and I was quite
11 disappointed.
12
13 Q. I want to briefly touch on the process of open
14 disclosure with the police photographs. Can you tell the
15 Commissioners very briefly what that involved?
16 A. We had a number of - the police brought a number of
17 heavily redacted photographs in which - approximately seven
18 or eight heavily redacted photographs which provided some
19 identifying either faces or identifying marks, which
20 experienced paediatric nurses might be able to identify the
21 individuals.
22
23 We were told that police had had a lot of trouble
24 trying to get the dates and times of the child exploitation
25 photographs, and so we had no basic date range in which to
26 try and consider, so we actually had three or four of our
27 senior paediatric nurses and one of our paediatricians to
28 examine those photographs. That occurred, I believe it
29 was December. Yeah, it was certainly then. It was
30 obviously quite a confronting - even with the heavily
31 redacted photos.
32
33 The police explained that the majority of the child
34 exploitation photographs were of very poor technical
35 quality, obviously taken at night or under bed covers and
36 so on. And --
37
38 Q. I don't need detail.
39 A. Yeah. No, no, no. That's - sorry, I apologise. And
40 so, that's why there were so few.
41
42 Q. Perhaps I'll pause there. I might ask you some more
43 pointed questions rather than that.
44 A. Yes. Okay.
45
46 Q. What follow-up did you offer to those who availed
47 themselves of the open disclosure?

1 A. We had a single open disclosure process, and that was
2 the mother and father of a victim.
3
4 Q. And, what support was offered to them?
5 A. We had a psychologist present, we had the police
6 present, we had an experienced paediatric social worker
7 present and myself.
8
9 Q. Do you think the open disclosure process was done well
10 or would you change anything with the benefit of hindsight?
11 A. I believe that it went well, the family concerned
12 appeared to be very thankful for it, and quite
13 extraordinarily they, at the end when they said, "Look,
14 we're quite understanding, but you need to know that our
15 daughter wouldn't be alive today if it wasn't for Griffin",
16 and that was --
17
18 Q. I'll just pause there. I'm just asking you if there's
19 anything you would do differently today if you were doing
20 the process --
21 A. Absolutely not.
22
23 Q. I have three further questions. I'd like to return to
24 the question of Mr Felton, just matters that I missed
25 yesterday, very briefly. I want to know, do you remember
26 the matter of Mr Felton and George?
27 A. Yes.
28
29 Q. Just taking you back there, do you know if anything
30 was done do determine George 's whereabouts or work status
31 in 2005?
32 A. I don't believe so, but I really don't know for
33 certain.
34
35 Q. That's fine. Did you give any consideration to a new
36 investigation in 2005 in relation to George?
37 A. Me personally? Well, I was working with Dr Ayre at
38 that stage. Dr Ayre ...
39
40 Q. I'm sorry?
41 A. Personally, no. But obviously in discussions with
42 Dr Ayre over the Freedom of Information requests and so on
43 there was obviously a suggestion at that point that a
44 review be done.
45
46 Q. So, there was a suggestion at that point?
47 A. There was a suggestion at that time.

1
2 Q. And what happened to that suggestion?
3 A. I don't know.
4
5 Q. Did you think a new review should be done, new
6 investigation should be done?
7 A. Yes.
8
9 Q. And, you thought you had enough information then to do
10 that investigation?
11 A. I didn't personally know where George was at that
12 time, but ...
13
14 Q. And reflecting on the way that that matter --
15 A. May I add that we had arranged for reports from the
16 senior nurse and the deputy senior nurse who actually
17 conducted the original review, because the actual papers of
18 the review could not be located at that time, so we got
19 statements from both those individuals which did cause me
20 some concern when I read them.
21
22 Q. So, you wanted to carry out an investigation; is that
23 right?
24 A. Yes.
25
26 Q. Do you know what happened, whether there was an
27 investigation?
28 A. No, I don't know.
29
30 Q. Do you know who made the decision about whether to
31 have one?
32 A. I don't know.
33
34 Q. Reflecting now on the matters connected with
35 Mr Felton, is there anything that you think could have been
36 done differently?
37 A. I think that George should have been stood down at the
38 time, based on the evidence that I have before me, and
39 I believe it should have been referred to Child Protection
40 at that time.
41
42 Q. Dr Renshaw, those are the questions that I have for
43 you. I'd like to give you - we've ranged across a broad
44 matter and it's perhaps not a matter for me, but whether or
45 not Dr Renshaw have the opportunity to offer any apology he
46 might think appropriate. But it's a matter for you,
47 Dr Renshaw, if you think there's anything you'd like to

1 say; I'd like to give you that fair opportunity.
2 A. Look, I believe that I've given a fair --
3
4 Q. If you don't have any to add, then please don't
5 feel --
6 A. No; no, no, no. But I just think from yesterday the
7 information that you provided to me regarding the Child
8 Safety Services re-evaluation of the Zoe Duncan case did -
9 was a surprise to me, and my evidence to that point was on
10 the assumption of what I knew in 2003 or whenever.
11
12 I regret not knowing that information and I know the
13 suggestion caused additional grief to the Duncan family,
14 and for that I apologise. I should have known about the
15 re-evaluation of the case, and my evidence was predicated
16 on my knowledge at the time that it was not believed that a
17 rape had taken place. However, I conceded that was wrong
18 and I sincerely apologise to the family and to the
19 Commission.
20
21 MS BENNETT: I have nothing further for this witness,
22 Commissioners.
23
24 COMMISSIONER BENJAMIN: Q. Yes, I have a couple of
25 questions. Given your evidence in relation to Mr Felton a
26 moment ago where I think you said that there should have
27 been another review at that time in 2005 --
28 A. Five, yes.
29
30 Q. -- and it didn't happen and you didn't know why, would
31 you agree that at that time there was a failure of
32 leadership of the hospital in its administration?
33 A. I believe the failure was shared between the hospital
34 and the --
35
36 Q. I'm not trying to point to anybody else.
37 A. No, no, no, but.
38
39 Q. I'm talking about the hospital in general?
40 A. I am aware that the hospital's Ambulance Service at
41 that time was also involved in the decision-making, but
42 accepting responsibility on behalf of the hospital, yes, I
43 think it should have been.
44
45 Q. Then you also gave evidence a little while ago in
46 relation to the difference, in your understanding, of the
47 circumstances following the events of 2019 and the

1 difference in evidence between your evidence and
2 Ms Bryan's, your evidence and the CEO's, your evidence and
3 Mr Bellinger. Would you believe it's open for us to find,
4 at best, that the leadership at that time was dysfunctional
5 as it had no clear focus on providing care for children and
6 protecting them from sexual abuse?
7 A. I would not agree with that. In my view, this was an
8 absolutely unprecedented situation that none of it - nobody
9 had had any experience in, and yes, we muddled through, but
10 it was not ideal. Probably what we could be criticised,
11 not being dysfunctional, but being not resilient or not
12 flexible enough to try and work out better ways of ensuring
13 the safety of the children in the hospital as a result of
14 this experience.
15
16 Q. Could you really say that you had no experience?
17 Because we have evidence before us of what happened to
18 Mr Felton in 1989, what happened to Zoe Duncan in 2001, and
19 what happened with Mr Griffin between 2000 and 2019; do you
20 still adhere to your evidence that it's not open for us to
21 find that the leadership was dysfunctional following the
22 death of Mr Griffin?
23 A. It would be presumptuous of me to say it is not within
24 your purview to do so, and certainly it is open for you to
25 find that.
26
27 COMMISSIONER BENJAMIN: Thank you.
28
29 MS BENNETT: Commissioners, if there's nothing further,
30 perhaps we might allow the witness to withdraw before we
31 adjourn.
32
33 PRESIDENT NEAVE: Yes. Yes, thank you. Thank you,
34 Dr Renshaw.
35
36 MS BENNETT: With Dr Renshaw's counsel withdrawing at the
37 same time perhaps.
38
39 PRESIDENT NEAVE: Yes.
40
41 MS BENNETT: Commissioners, I apologise for running over
42 time again. Perhaps we might now take a break and
43 recommence when it's convenient to the Commission.
44
45 PRESIDENT NEAVE: Certainly. We'll just check whether we
46 take a full break, check with our next witness.
47

1 MS BENNETT: Please the Commissioners, that's convenient.
2 If we break now for the longer break which some might
3 characterise as a lunch break, and we'll return at
4 1 o'clock and complete the evidence, please the
5 Commissioner.
6
7 **LUNCHEON ADJOURNMENT**
8
9 MS BENNETT: Commissioners, the next witness is
10 Ms Morgan-Wicks. I ask that she be sworn.
11
12 <**KATHRINE LOUISE MORGAN-WICKS**, **sworn**: **[1.04pm]**
13
14 <**EXAMINATION BY MS BENNETT**:
15
16 MS BENNETT: Q. Ms Morgan-Wicks, would you please tell
17 the Commissioners your full name and professional address?
18 A. Kathrine Louise Morgan-Wicks, and 22 Elizabeth Street,
19 Hobart.
20
21 Q. Thank you. You've provided five statements to the
22 Commission in response to various requests for information:
23 they are dated 24 May of this year, 22 June - indeed, there
24 are two dated 22 June; one dated 30 June which is said to
25 be supplementary to your statement to one of your 22 June
26 statements, and a further statement dated around 25 July,
27 and another undated in response to an RFS, a request for
28 statement, dated 28 July. So, that is six statements; have
29 you had the opportunity to review your six statements?
30 A. Yes, I have.
31
32 Q. Is it the case, Ms Morgan-Wicks, that the latest
33 statements are to be read as taking the place of the
34 earlier to the extent of any inconsistencies?
35 A. Yes. So, certainly my statements are accurate as at
36 the date that I swore those statements, but noting that
37 they have occurred over a period of time.
38
39 Q. So, if read in that way, are you happy that those
40 statements are true and correct to the best of your
41 knowledge and belief?
42 A. Yes, I am.
43
44 Q. And just so the Commissioners are clear, if the
45 Commissioners were to read your first statement of 24 May,
46 they would not see a full picture of your view of events if
47 they didn't read it in combination with your latest

1 statements; is that right?
2 A. That's correct.
3
4 Q. Thank you, Ms Morgan-Wicks. Ms Morgan-Wicks, you've
5 given evidence in the past, and in that evidence you
6 expressed your apologies and regrets that relate to the
7 case studies presented before this Commission. So, I'm not
8 going to repeat those matters, I'm now going to move to
9 some of the operational or systemic matters.
10
11 Have you been briefed on the evidence that has
12 occurred since you last appeared before this Commission in
13 relation to Health?
14 A. Yes, I have and I've also watched the evidence as it
15 relates to Health as best as I could.
16
17 Q. I see, so you've watched - and I understand that
18 you've had other obligations over the last few days, so I
19 make no criticism if you haven't watched it all, but have
20 you watched most of the evidence over the last day and a
21 half?
22 A. Yes, I have because I was able to access a recording
23 of the evidence of Dr Peter Renshaw, so I watched that last
24 night.
25
26 Q. I see, thank you. I'd like to start by asking you
27 about the material that the Commission has heard in
28 relation to George. Do you know who I'm referring to when
29 I use the pseudonym "George"?
30 A. Yes, I do.
31
32 Q. That is a matter which concerns primarily the abuse
33 perpetrated by George upon Mr Ben Felton in 1989 and the
34 response to that abuse as it followed over the years; is
35 that a fair summary?
36 A. Yes.
37
38 Q. We heard evidence from Dr Ayre yesterday that he
39 believed that Mr Felton had been abused as a child by a
40 nurse we refer to as George, but that the matter was not
41 investigated afresh in 2005. Were you aware of that
42 evidence?
43 A. Yes, I heard that evidence.
44
45 Q. Dr Renshaw gave similar evidence today, that there was
46 no further investigation in 2005; is that right?
47 A. Yes, that's right.

1
2 Q. In your view as the present Secretary, accepting you
3 were not the Secretary at the time in 2005, in your view
4 should there have been an investigation in 2005?
5 A. Yes.
6
7 Q. Why do you say that, Ms Morgan-Wicks?
8 A. Because I have caused an investigation to be carried
9 out in relation to that matter.
10
11 Q. So, is there anything about the age of the allegations
12 that means that that's not possible?
13 A. No, I do not believe so.
14
15 Q. You'd accept then as a general proposition that there
16 ought to have been an investigation in 2005?
17 A. Yes.
18
19 Q. The other matters that were explored - would you
20 accept from me, Ms Morgan-Wicks, or would you accept that
21 any failure to investigate child sexual abuse in the
22 hospital context potentially gives rise to the risk of
23 further abuse in that context?
24 A. Yes, I do.
25
26 Q. And you approach your role in that way?
27 A. Yes, I do.
28
29 Q. There was a briefing that went to the Secretary at the
30 time in 2005, and again, I don't suggest that you had any
31 involvement in that briefing, I'd just like your impression
32 of it as the current Secretary. That briefing is found at
33 TDOH.0003.0017.0042. It might be I haven't properly cued
34 that document, but in any event, that is a briefing to the
35 then Secretary, and in summary it said that there was -
36 have you seen that before, Ms Morgan-Wicks?
37 A. Sorry, I'm just trying to see. Yes, I have.
38
39 Q. And, is it fair to say that that summary repeats the
40 legal advice that there was no liability?
41 A. Sorry, if it scrolls up.
42
43 Q. If the operator could scroll up, at the fourth dot
44 point, "advice has been received from [blank] ... advising
45 that the limitation period has expired on any view of the
46 matter and no action is maintainable", et cetera?
47 A. Yes, I see that.

1
2 Q. Just to pause there. What's the position today, if
3 you receive advice that there is no liability, is that a
4 barrier to making a claim in respect of a child sexual
5 abuse allegation?
6 A. No, I don't believe that's a barrier.
7
8 Q. So, you'd be entitled to make a payment if you
9 considered it appropriate, even in the face of legal advice
10 that there was no liability?
11 A. And I'm just trying to, in terms of the briefing
12 document, if I comment: so, in relation to the likelihood
13 of liability and noting that I wasn't there in 2005 --
14
15 Q. Of course.
16 A. -- so I'm not quite sure in terms of what question was
17 asked, but certainly as Secretary of the Department it is
18 open, firstly, to conduct enquiries or an investigation in
19 relation to an employee, so under our Employment
20 Directions, though I'm not quite sure in 2005 whether ED4,
21 5, 6 et cetera applied at that time, but for the sake of
22 today I assume that they do, so that is certainly open.
23
24 In terms of, there would be criminal liability to be
25 explored, there's also civil liability that could be
26 explored in relation to a matter. But in terms of the
27 ability to make a payment of compensation, usually it does
28 require a settlement agreement to be negotiated with a
29 claimant, and I make that statement in relation to
30 particularly a payment that is made by a public
31 organisation or institution.
32
33 For example, the LGH is not a private hospital, it's
34 not run by a private board and they can't make that type of
35 financial decision necessarily, particularly where it's the
36 expenditure of public funds. So, usually we need to make
37 sure that we're complying with the financial management
38 legislation and parameters as they apply at that time. So,
39 for example, if it was today under the Financial Management
40 Act and legislation, and for an ex gratia payment to be
41 made outside of the realm of a legal settlement or
42 contract, et cetera, usually you would need to apply to the
43 Treasurer or seek some other type of approval to make that
44 type of ex gratia payment.
45
46 Q. So, as things stand today, would legal advice to the
47 effect that there was no civil liability be a barrier to

1 you as the Secretary deciding to make a payment of that
2 kind?
3 A. No, because I believe that you could enter into a
4 conversation in relation to settlement, and I believe that
5 I would have - if it had been me today, so speaking in a
6 hypothetical, I would have had further conversations with
7 the officer - Office of the Solicitor-General in relation
8 to the matter and I would have pursued whether a settlement
9 option or a legally drawn up agreement could be reached,
10 noting the concern and issue that had been raised.
11
12 Q. And so, who's the final decision - where does the
13 final decision lie?
14 A. If there is a legal mechanism by which a Secretary can
15 make a payment, the Secretary can make that decision.
16
17 Q. In that instance, the Secretary agreed only to an
18 appropriately worded letter. There was a recommendation
19 from the staff at LGH from Dr Ayre that there be a written
20 apology, counselling and $5,000. The Secretary agreed only
21 to an appropriately worded letter according to the
22 documents, and we haven't heard from the Secretary who
23 received that briefing. Can I ask your reflections on
24 whether or not a decision of that kind would be made now?
25 A. And I don't wish to cast any kind of aspersion in
26 relation to the decision of a past Secretary, so I cannot
27 speak to what was in their mind, I can only speak to my own
28 actions, where for some reason no criminal prosecution had
29 been pursued, where there may be the application of
30 compensation in a criminal sense, where there's no civil
31 case that had been pursued. Certainly if there was civil
32 litigation I would be asking the question of the Office of
33 the Solicitor-General about settlement and compensation to
34 be, you know, considered and payable, and certainly I do
35 that in relation to legal matters that have come up to me
36 as Secretary.
37
38 So, certainly I am a lawyer, I understand the process
39 in terms of litigation; I also understand the pain and
40 suffering that occurs through long and drawn out
41 litigation, and certainly from my perspective I would
42 rather see a faster resolution of a matter and a settlement
43 and compensation payable wherever it's fair.
44
45 PRESIDENT NEAVE: Q. Can I just clarify that. So, it's
46 not technically a settlement because there's no cause of
47 action because the time has expired. Would you, in those

1 circumstances, explore the possibility of an ex gratia
2 payment being made, not technically a settlement, no legal
3 liability, but you might consider it appropriate to make
4 some payment in acknowledgement of the suffering that the
5 person has had as a result of the events; is that what
6 you're saying?
7 A. Yes, Commissioner, and in the past I have explored the
8 payment of ex gratia payments.
9
10 PRESIDENT NEAVE: Good. Thank you.
11
12 MS BENNETT: Q. In 2021 there was an investigation into
13 the allegations about George and he was then subject to an
14 ED5 process; is that right?
15 A. That's correct.
16
17 Q. So, does that mean that he was an employee of the
18 Public Service at that stage?
19 A. Yes, he was.
20
21 Q. Are you able to tell the Commissioners whether there
22 was any flag against his name in the system before your ED5
23 in 2021 referring back to his conduct in 1989?
24 A. Would it be possible for me to go to that part of my
25 statement that refers to [redacted]; I don't know if you
26 could flag where I am?
27
28 Q. We'll cut the live stream. I'll just remind you, use
29 pseudonyms.
30 A. Oh.
31
32 Q. It'll be in the first statement which is dated 24 May
33 2022.
34 A. Sorry, is this a section in the statement that
35 you're --
36
37 Q. The proposition that I'd like to explore with you, to
38 be clear, is that there had not been an ED5 process in the
39 past in relation to Mr Felton's complaints, had there?
40 A. No, there was no.
41
42 Q. To the extent that he was employed in the
43 Public Service, he was employed without an ED5 having been
44 completed and without the benefit of that investigation?
45 A. Yes, that's correct.
46
47 Q. And is that a matter of concern?

1 A. Yes, I believe it is a matter of concern.
2
3 Q. And, in what way does that concern you?
4 A. It concerns me, and I have to note in relation to the
5 systems that we have in place that record our employees and
6 establishment, I think are a matter of public record in
7 relation to their age, their lack of integration, and the
8 silos that appear across our Hospital and Health Services
9 environment which was the basis for a business case that we
10 actually put to government and successfully received some
11 $22 million, I believe it is, and in fact probably more, to
12 actually implement a new Human Resources Information
13 Management System. So, it concerned me the state of our
14 Human Resources Systems, which is why we formed that
15 business case and are in the process of implementing a new
16 one.
17
18 Q. A new ED5 was carried out. Now that ED5, Mr Felton's
19 evidence was that he wasn't interviewed in relation to
20 that. Is that a matter of concern?
21 A. So, in relation to the ED5 --
22
23 Q. In 2021?
24 A. In 2021 that was carried out, certainly my
25 recollection in relation to that matter was that it
26 occurred following a podcast and media reporting that we
27 became alerted to in relation to the incident involving
28 Mr Felton, we commenced the ED5 on the basis of that
29 information, and it was allocated to an independent
30 investigator who then determined the course of that
31 independent investigation. So, they determined who was
32 interviewed, they will reach a view in relation to the
33 evidence that they have collected whether further people
34 need to be spoken to in relation to that investigation, and
35 a recommendation report is put to me as an independent
36 decision-maker.
37
38 Q. As an independent decision-maker, do you review the
39 reports you're provided from the independent investigator?
40 A. Yes, I do.
41
42 Q. If the independent investigation appears to you to be
43 in any way deficient, are you able to take action?
44 A. I am able to ask - raise questions in relation to the
45 report of an investigation; it is also put to the employee
46 and any advisor that they have to raise questions in
47 relation to the report.

1
2 Q. So, is it a matter of any concern to you that
3 Mr Felton wasn't interviewed in relation to that
4 investigation?
5 A. If I may reflect --
6
7 Q. Please?
8 A. -- following the evidence of Mr Felton, and I have
9 also had discussions with Mr Felton, that I believe that he
10 should have been interviewed in relation to that
11 investigation, but in reading the report I also understand
12 that the investigator had formed the view that there was
13 enough material to make a recommendation in relation to
14 that investigation which has ultimately resulted in
15 termination.
16
17 Q. Yes.
18 A. So, certainly, and I have spoken to Mr Felton in
19 relation to the incident and the abuse and I have also
20 apologised to Mr Felton.
21
22 Q. Are there any guidelines that go to the investigators
23 about, for example, adopting a therapeutic approach or a
24 trauma-informed approach when carrying out investigations
25 that concern child sexual abuse?
26 A. I can answer in relation to recent ED5s in terms of,
27 we have started to issue the instruction to ensure that
28 there is a trauma-informed approach to the ED5, and
29 I believe that, where it involves a victim of abuse or any
30 type of action that we are investigating, that they should
31 be spoken to wherever appropriate; and I say that, for
32 example, if that particular victim is experiencing a
33 medical episode and we're unable to speak to them or
34 they've refused to speak or declined to speak, but I think
35 that the offer or opportunity should be put to them.
36
37 Q. When did you become Secretary to the Department of
38 Health?
39 A. 2 September 2019.
40
41 Q. And you went on leave, again not being critical of
42 that, you went on leave in October 2019; is that right?
43 A. Yes, I had a pre-arranged family holiday.
44
45 Q. Understood. There were some briefings in relation to
46 Griffin on 14 October, and I can take you to it, it's at
47 TDOH.0003.0006.0079. That was approved by your Acting

1 Secretary at the time. Was that provided to you as a
2 matter of update? Or were you provided with that document?
3 A. So, I have seen this document, but I do not recall,
4 and I think I have detailed that in my statement, actually
5 receiving that from Mr Smith at the time, but I do recall
6 on the return from leave having a briefing with him as to
7 matters that had occurred during the period of my leave.
8
9 Q. Pausing for a moment on this briefing note, and I'd
10 ask the operator to scroll through it to give you the
11 opportunity to refresh your memory as to which briefing
12 note this is.
13
14 The analysis of the issue says - really focuses on
15 media attention, "It's reasonable to assume there will be
16 some media attention in the future". Just to pause:
17
18 *To date, there has been no notification*
19 *that the offences are linked to*
20 *Mr Griffin's employment as a Paediatric*
21 *Nurse with the THS.*
22
23 And then, if we keep going down, just down to the
24 bottom to show the dates and the clearances. So, again,
25 that's 9 October 2019; 8 and 9 October appear to be the
26 drafting dates.
27
28 So, having regard to that document and the evidence
29 you've heard - could I ask the operator to bring the
30 document down - do you consider that to be an accurate
31 briefing based on what you now know to be the case?
32 A. No, I do not.
33
34 Q. Do you consider it to have been a misleading briefing?
35 A. Yes, I do.
36
37 Q. What is the impact of receiving a misleading briefing
38 in the circumstances of this case?
39 A. As the Secretary of a department that has some close
40 to 16,000 employees, I rely on the accuracy of information
41 that comes up to me. It's certainly impossible for me to
42 dive in to every single issue that actually crosses a
43 Secretary's desk on any day of the week, so certainly I
44 absolutely do rely on the information that comes to me.
45
46 Q. I understand you rely on a briefing, perhaps I'll be
47 more specific. As at October 2019, as I understand the

1 evidence of Dr Renshaw this morning, Dr Renshaw - I trust
2 my recollection is fair - gave evidence that he was aware
3 that there were allegations that Child Exploitation
4 Material had potentially been produced in connection with
5 LGH and that there was an allegation that a child under the
6 age of 12 had been sexually abused by Griffin and that
7 child was a former patient of the hospital.
8
9 So, that is the matters that were disclosed by the
10 police at the very least on 31 July as the evidence this
11 morning came out. Would you expect those to be matters
12 that were included in that briefing of October 2019?
13 A. Yes, I would, and noting that I was not Secretary as
14 at 31 July and I don't know what has been told to the
15 previous Secretary in relation to that.
16
17 Q. No. So no-one told you anything about - did you
18 receive any briefing before this October briefing?
19 A. So on my return from leave I do recall having a
20 briefing from Mr Ross Smith who had been Acting Secretary
21 during that period, and my recollection from that briefing,
22 and it wasn't written, so I don't recall receiving any
23 written briefing, was that it focused on the death of
24 Mr James Griffin and the impact of that on the hospital and
25 the support; my concern was that support had been offered
26 to staff.
27
28 Q. Then again, the evidence that has fallen this morning,
29 which I understand you heard, was that there was both a
30 corridor rumour and a report from the police concerning the
31 Pearn disclosure, what we have been referring to as the
32 Pearn disclosure; you know what I mean by that, do you?
33 A. Yes, I do.
34
35 Q. And then, following awareness of that disclosure in
36 addition to the other two matters I've just identified,
37 there was a briefing of 5 November. And I'll ask the
38 operator to return to that briefing, it's
39 TRFS.0059.0080.0065. You recall, this briefing did go to
40 you at the time, didn't it?
41 A. Yes, it did and I can recognise my handwriting,
42 apologies if that's hard to read.
43
44 Q. Not at all. Can I ask you to have a look at the dot
45 points under, "Summary of Key Issues". You're familiar
46 with this note if I ask you questions about it?
47 A. Yes, I am.

1
2 Q. From reading this note, did you learn anything about
3 the Pearn disclosure?
4 A. No, I did not.
5
6 Q. From reading this note, did you become aware that
7 there was an investigation into whether Child Exploitation
8 Material had been produced at Launceston General Hospital?
9 A. No, I did not.
10
11 Q. And from reading this note, were you aware that there
12 was an investigation being carried out as to whether or not
13 a former patient at LGH under the age of 12 had been
14 sexually abused by Griffin?
15 A. No, I certainly did not.
16
17 Q. Are those matters that you would expect to be briefed
18 to you if they were known to any person providing you with
19 this briefing?
20 A. Absolutely.
21
22 Q. Now, I take it you heard the evidence of Dr Renshaw
23 this morning about his interpretation, particularly dot
24 points 2 and 3 there present on the screen. Do you see
25 those, 3 and 4?
26 A. I see those dot points, but I can't say that I
27 understand Dr Renshaw's interpretation of them.
28
29 Q. What's your interpretation? I'm sorry, my learned
30 junior reminds me how to count, it's 2 and 3. What's your
31 interpretation of those dot points?
32 A. So, in relation to dot point 2, my interpretation was
33 that the Tasmanian Police were investigating a complaint
34 relating to a person that was not connected in any way with
35 the hospital. So, by the word "external to the hospital"
36 indicated to me that it wasn't a patient, and certainly
37 that the words "at that time", Tasmania Police advising
38 there was no evidence to suggest that any criminal activity
39 had taken place within the LGH were, I feel, designed to
40 reassure me that there was nothing to see here in terms of
41 the LGH.
42
43 And certainly, I think if you look at my handwritten
44 note, I asked whether there's been any patient that has
45 been impacted by the conduct of Griffin. And certainly,
46 from my experience in handling employee investigations,
47 there can often be matters where, you know, perpetrators so

1 carefully hide things that they are absolutely outside the
2 course of their employment, and I've seen that in the past,
3 and certainly my concern in reading this was to try and
4 work out what had happened in the hospital.
5
6 Q. And your impression reading this was that nothing had
7 happened in the hospital?
8 A. Absolutely, and in terms of the third dot point so:
9
10 *The LGH had not received any complaints*
11 *from patients or their families regarding*
12 *inappropriate behaviour by Mr Griffin that*
13 *would warrant [any] Code of Conduct*
14 *investigation ...*
15
16 So, that is informing me as a Secretary that there is
17 no recommendation that an ED5 or any other type of
18 investigation is required by the Secretary, or a
19 notification to AHPRA or a referral to Tasmania Police.
20
21 Q. So, assuming that this note - I'd ask the operator to
22 bring it down now. I think I've asked you if you felt
23 misled by this and you said that you did - perhaps I'm
24 putting words in your mouth; is that correct?
25 A. And I'm not hesitating about saying the word
26 "misleading", I'm absolutely horrified, to be honest, that
27 I haven't received the information as at that date, and I
28 question myself what I could have done better to try and
29 find out that information, to be honest. So, I do believe
30 that it is misleading and I have accepted that note as I do
31 in relation to minutes that come up to the Secretary. I
32 often ask questions and I asked the question by writing on
33 that actual minute to try and determine that, if Tasmania
34 Police at any point in time discovered that there has been
35 a patient involved in relation to the offending, that we
36 are informed so that action can be taken.
37
38 Q. I think Commissioner Neave might have a question.
39
40 PRESIDENT NEAVE: I have a question.
41
42 Q. And I understand the terms of the State Service Code
43 of Conduct which may not cover, at least arguably doesn't
44 always cover, activities that occur outside the workplace.
45 Do you have a view about the adequacy of that provision?
46 Just assume for the sake of argument that all of this
47 behaviour occurred outside the hospital, it had absolutely

1 nothing to do with the hospital at all, what would your
2 view be about the employment suitability of a person who
3 had allegedly offended against children outside the
4 hospital but had been very careful to have ensured that it
5 was kept outside the hospital?
6 A. Thank you, Commissioner, and I have had matters
7 notified to me as Secretary relating to allegations against
8 an employee that are entirely outside the course of
9 employment, and I have suspended - so I've stood down and
10 suspended those employees while an investigation could be
11 undertaken.
12
13 Q. And is that because of the possible risk that that
14 behaviour outside the course of employment could
15 conceivably in the future pose to children within the scope
16 of the person's employment: is that why?
17 A. Yes, so it is placing child safety absolutely at the
18 centre.
19
20 PRESIDENT NEAVE: Thank you.
21
22 MS BENNETT: Q. Ms Morgan-Wicks, you said a moment ago
23 you're horrified to hear of the additional disclosures.
24 A. Yes, I am.
25
26 Q. This might be a difficult question to answer, but what
27 is it that horrifies you? Why use that word? What
28 horrifies you about this? And I'm speaking now in
29 relation, perhaps I can be clear in my question. Does your
30 horrified response arise from the evidence you've heard in
31 the last day and a half or from other matters?
32 A. I think it's actually a culmination from all of the
33 days of evidence that we've heard in Health week, or
34 weeks - feels like months.
35
36 And I use the word "horrified". I think, for example,
37 yesterday at lunchtime I did have to leave to attend to
38 another matter that I had sought permission to do so from
39 the Commission, and I did sit in my car for a long time
40 before I actually went, because reflecting in relation to
41 the evidence that I had heard.
42
43 In terms of the jobs we do and the decisions that
44 we're required to make every day, and we make many every
45 day, we absolutely have to rely on the judgment of the
46 people that work for us and the information that is
47 provided to us, and it is on the basis of the best

1 information that you can then make a decision in relation
2 to a matter. And, from my perspective, my trade, I am a
3 lawyer, I am trained to search for detail and to understand
4 the facts and, as my staff will probably say to me, I ask
5 for a lot of information and a lot of detail that perhaps
6 others don't but I do that to try and make the best
7 decision that I can.
8
9 So, my horror is, and I was horrified from October
10 2020 when this information started to appear, so from
11 The Nurse podcast and from the media reporting and as each
12 piece of information came forward, and that is why I took
13 the steps that I did in October 2020 to start the first
14 internal investigation, and then, as evidence and
15 information came in and awaited an independent
16 investigation that ultimately led to this Commission of
17 Inquiry.
18
19 Q. Would you agree that the Pearn disclosure, the
20 evidence that this Commission has heard about the Pearn
21 disclosure and those who knew of it, that that disclosure
22 did not trigger the kind of energetic and proactive and
23 horrified response that it ought to have triggered?
24 A. So, it did trigger that response when I became aware
25 of the Pearn disclosure.
26
27 Q. I'm sorry, I mean from those who heard about it in
28 2019?
29 A. I can judge only by the actions that I took. I became
30 aware of the Pearn disclosure when Ms Pearn actually
31 contacted the office of the Secretary in October 2020
32 following our callout for information in relation to
33 Mr Griffin, and within 24 hours we had commenced the
34 independent investigation in relation to that matter. So,
35 I can only judge by my own actions that it was of such
36 critical nature that it had to be investigated.
37
38 Q. And so, what's your reaction to the response of those
39 working in the hospital who appear to have taken a
40 different view or to have not responded in that way?
41 A. I do not understand their response.
42
43 Q. What should they have done at the time? What's your
44 expectation of your staff at the time? How should staff
45 respond?
46 A. In relation to the initial disclosure?
47

1 Q. Yes, to the Pearn disclosure as it was. Leaving aside
2 any disputes of any kind, let's look at the undisputed
3 email from Mr Bellinger in 2019 in which he discusses the
4 Pearn disclosure with Mr Hindle; what should have happened
5 then, in 2019?
6 A. So, in 2019, when there is - so, Mr Hindle has
7 indicated that this disclosure occurred at the earlier
8 time, I understand between 2010/2012. The immediate
9 question should have been asked, why action hadn't been
10 taken in relation to that disclosure at that time. So,
11 that would have caused an immediate review of our systems
12 and procedures to determine why that had not been acted
13 upon and what action there needed to be taken, what support
14 needed to be provided in relation to Ms Pearn, what support
15 needed to be provided to any employee that was involved in
16 relation to that disclosure, including Mr Millar.
17
18 Q. So let's return to the 5 November briefing, I won't
19 ask that it be brought back onto the screen, but at that
20 stage, so taking yourself back to November 2019, you were
21 aware that there was an investigation of a complaint which
22 you were told was external to the hospital pertaining to
23 Griffin's alleged relationship with a young person and
24 possession of Child Exploitation Material. That's correct,
25 isn't it?
26 A. Yes, it is.
27
28 Q. I can bring the note back up if you prefer to look at
29 it.
30 A. No, I accept that.
31
32 Q. So at that point you were aware that police were
33 investigating Griffin for photos and sexual offending which
34 you were told was external to the hospital, but you knew
35 that the offending was against children. Is that fair?
36 A. Yes, that's fair.
37
38 Q. Accepting that you didn't know the extent of the
39 allegation, was that enough to have triggered an
40 investigation at the hospital level at that stage into what
41 may have been Griffin's conduct on the ward?
42 A. Yes, it could have.
43
44 Q. Should it have, Ms Morgan-Wicks?
45 A. And I'm just trying to - so, if you could just repeat
46 the question. So, it started with the November?
47

1 Q. So, just pausing at 5 November, the briefing we'd just
2 been looking it, as at that date you were aware of, I
3 think, the following: there was potential Child
4 Exploitation Material in Griffin's possession; is that
5 right?
6 A. Yes, that's correct.
7
8 Q. And you knew that there was sexual offending which you
9 were told was external to the hospital, but it was against
10 a child; is that right?
11 A. Yes, that's correct.
12
13 Q. And you knew that Griffin was a nurse at the hospital?
14 A. Yes; not at 5 November, but yes. Yes.
15
16 Q. Sorry, of course; yep, no. That he had been a nurse
17 at the hospital for many years?
18 A. Yes, that's correct.
19
20 Q. And that he'd been stood down, was no longer working
21 at that point, and you knew he was a nurse on the
22 Children's Ward?
23 A. Yes.
24
25 Q. So, at that point, knowing that someone who was at
26 least potentially a child sex offender had worked for
27 many years on a Children's Ward, is that not enough to
28 trigger an investigation into what may have taken place on
29 the ward?
30 A. And, from my briefing on 5 November, you know, I've
31 been informed that that enquiry has been undertaken in
32 relation to previous complaints in relation to Mr Griffin.
33
34 Q. Complaints, but what about a proactive investigation
35 into whether there is any undisclosed conduct? I think
36 your evidence earlier was that you would expect that
37 Griffin's conduct would be concealed; is that right?
38 A. Well, that was my expectation having been told that it
39 was external to the hospital, but certainly the 5 November
40 briefing indicates to me - and by using the words and
41 underlining "not received any complaints", indicates to me
42 that they have undertaken enquiries to determine whether
43 there had been previous reports and that there was an
44 active Tasmania Police investigation on at the same time.
45
46 Q. And so, should you at that stage, though, have carried
47 out an investigation into whether there might have been any

1 undisclosed - as yet undisclosed offending by Griffin over
2 the many years that he had been a paediatric nurse?
3 A. So, at that point I was unable to undertake any
4 employment direction investigation given that Mr Griffin
5 was deceased, so it wouldn't have been an employment
6 matter. I was aware that Tasmania Police were continuing
7 to investigate, but I will accept that certainly at that
8 point I could have undertaken an additional investigation
9 in relation to Tasmania Police, but I did not at that
10 point.
11
12 Q. Well, not in relation to Tasmania Police, in relation
13 to Griffin's conduct while a paediatric nurse at the
14 hospital?
15 A. Yes, sorry, I meant in relation to his activities at
16 the hospital.
17
18 Q. Because you understood that, with the death of
19 Griffin, that might well reduce the prominence of a police
20 investigation, mightn't it?
21 A. I don't know that I would be aware of that.
22 Certainly, I had not received a copy of the charge sheet or
23 any information from Tasmania Police, nor was I not aware
24 that he was a sole offender, for example, so I wasn't aware
25 if Tasmania Police were continuing investigations in
26 relation to other people, and I'm not saying that that is
27 what has occurred, but if it's about assumptions that you
28 can form on the basis of information, you know, I was aware
29 that Tasmania Police had an investigation in relation to
30 Mr Griffin, I don't know what evidence they had or what
31 witnesses they'd spoken to.
32
33 Q. So it's fair you didn't know the extent of his
34 offending at all at that point?
35 A. That is fair, and certainly I hadn't received a copy
36 of the charges or charge sheet and that I would need to
37 apply to a Magistrate to actually receive a copy of that.
38
39 Q. You'd be aware, though, that dead people aren't
40 charged, wouldn't you?
41 A. I was aware that he had been charged prior to his
42 death.
43
44 Q. Yes. So, there'd been no completed police
45 investigation, had there?
46 A. Not to my knowledge.
47

1 Q. And what you knew was that there had been a paedophile
2 working on a Children's Ward over a prolonged period of
3 time, and you knew that in the context of your general
4 proposition that his conduct would be concealed; is that
5 right?
6 A. Yes, that's correct.
7
8 Q. And that's more than enough, isn't it, to warrant an
9 investigation into what he did on the ward?
10 A. And it's - well, if I could also say that it's, as
11 Secretary, and relying on a Chief Executive Officer of the
12 hospital also managing that hospital and undertaking the
13 enquiries that are required, an Executive Director of
14 Medical Services, an Executive Director of Nursing, the
15 entire LGH Executive operating to actually enquire as
16 people that worked in that hospital every single day to
17 understand how this has actually occurred and to make
18 recommendations to me as Secretary.
19
20 Q. I think that Mr Daniels was CEO at the time and I
21 think that he's accepted in his evidence that he ought to
22 have carried out such an investigation and that his failure
23 to do so was a catastrophic failure. Would you accept that
24 characterisation of his failure to carry out an
25 investigation?
26 A. I believe so, but I am happy to also take any
27 responsibility in not requesting that that occur.
28
29 Q. Where does the responsibility lie? What I'm trying to
30 understand is: Mr Daniels says, "I didn't do that and I now
31 accept I should have". Where is the locus of
32 responsibility? Who should have done it? Should it have
33 been you, should it have been the CEO?
34 A. I take responsibility as Secretary for the
35 organisation. I am very happy to take responsibility for
36 that and certainly to learn, and I do note that the moment
37 that information came to me in relation to the extent of
38 the offending, the fact that patients were involved, that I
39 took the steps, and I apologise that that was late in the
40 piece, being some months after 2019 and the death of
41 Mr Griffin, and I'm absolutely - since that time and since
42 the community have heard our call to report in relation to
43 child sexual abuse offending within our institution I have
44 taken immediate action in relation to that offending,
45 including suspension and stand down of at least some eight
46 employees at the Department of Health.
47

1 Q. Let's move to the Integrity Commission investigation.
2 There was a complaint that was referred to you around
3 21 November 2019; you refer to that in your statement at
4 145 to 147, that's at your statement 0098. Sorry, that's
5 undated, it's in response to our notice of 28 July 2022.
6 A. Sorry, was it paragraph?
7
8 Q. 145 to 147, and I think you refer to it as well in
9 your statement of 22 June 2022 between paragraphs 133 and
10 142. While you're looking at that I'll ask the operator to
11 bring up the letter which I understand is at
12 TRFS.0059.0080.0067, so this is the referral of the
13 complaint. Just to briefly summarise, a complaint was made
14 by a staff member to the Integrity Commissioner, and the
15 Integrity Commissioner referred it to you; is that right?
16 A. Yes, that's correct.
17
18 Q. If you have a look at the third paragraph there,
19 starting with the words, "I have determined":
20
21 *... to refer these allegations to you, as*
22 *the principal officer of the relevant*
23 *public authority for investigation and*
24 *action ...*
25
26 Do you see that?
27 A. Yes, I do.
28
29 Q. Towards the bottom of that paragraph it says - it
30 makes clear the expectation of the Commissioner:
31
32 *You will make sufficient enquiries to*
33 *satisfy yourself as to whether any act of*
34 *misconduct has occurred and, if so, to*
35 *ensure it is dealt with in an appropriate*
36 *way and an opportunity for policy and*
37 *procedural improvement.*
38
39 So that was what you understood was the purpose of the
40 referral; is that right?
41 A. Yes, that's right, and certainly that's the similar
42 text that we receive in relation to complaints that are
43 referred to us that have been assessed by the Integrity
44 Commission and referred on to us to action.
45
46 Q. That document can come down. The matters that were
47 referred to you related to both the allegations of Griffin

1 and the failure to respond properly to them; is that fair?
2 A. Yes, that's fair.
3
4 Q. So, it was, in part, a request that you investigate
5 the way in which the hospital structures responded to the
6 various matters that had been raised about Griffin over
7 the years; is that right?
8 A. That is correct, albeit that as Secretary I do not
9 independently investigate each of these complaints that are
10 referred by the Integrity Commission, that I rely on my
11 allocation of that complaint; I am then the decision maker
12 in relation to the assessment that occurs and action and
13 report within my department.
14
15 Q. What did you do next? You received this, if you like,
16 instruction to investigate the way in which the management
17 and structures at LGH had responded to Griffin; what did
18 you do next?
19 A. Sorry, and I believe that my statement at paragraph 9
20 onwards, RFS-TAS-075, a supplementary statement, does deal
21 with that, noting that I had heard the evidence of
22 Mr Bellinger at the previous Health hearing. And
23 certainly, in terms of the actual referral coming in, I
24 don't have an actual recollection of that referral coming
25 in, however, I don't doubt, in terms of the process of my
26 office of the Secretary in terms of the usual process for
27 any matter that's referred by the Integrity Commission,
28 that a review is undertaken and that the subjects of the
29 actual Integrity Commission complaint are noted and then a
30 determination made as to the allocation of that complaint
31 within our organisation to investigate to prepare then a
32 briefing to the Secretary so that I can make a decision in
33 relation to that complaint.
34
35 Q. So in this instance the task of responding to the
36 issues raised by the Integrity Commission, and I've
37 summarised them in the broadest possible way, was tasked to
38 the hospital itself, wasn't it?
39 A. So, I don't individually task the handling of the
40 Integrity Commission complaint. So, I had - and noting
41 that I had been in the department since 2 September
42 that year, I had taken advice about the appropriate
43 handling of Integrity Commission complaints within the
44 Department of Health and that the matter was allocated to
45 our Chief People Officer, [redacted], to
46 investigate.
47

1 Q. What happened after it was referred to her?
2 A. So, and as I've laid out in terms of my statement, I
3 understand that that occurred on a date in December - I can
4 find the date if you wish --
5
6 Q. No.
7 A. -- from early - or sorry, I should say from
8 late January, not early February, the COVID-19 pandemic
9 occurred globally, and certainly - and you know, it's my
10 own error, I did not follow up in terms of the allocation
11 of that complaint; I actually diverted my entire
12 secretarial attention to the management of the pandemic and
13 I actually stood up a Secretary delegate to manage
14 non-COVID matters within the department from at
15 least March.
16
17 But my understanding is that follow-ups were sent by
18 my office of the Secretary to the Chief People Officer to
19 respond to the complaint and that the Integrity Commission
20 also wrote to us, as they do, particularly looking for a
21 six-month update in relation to matters that they refer to
22 us.
23
24 Q. The matter was ultimately referred to the hospital to
25 carry out the investigation, wasn't it?
26 A. My understanding of the matter is that it was referred
27 by the Chief People Officer to Mr James Bellinger within
28 Human Resources, not the hospital.
29
30 Q. He was - no, sorry, go on.
31 A. Because it named hospital subjects within the
32 Integrity Commission complaint.
33
34 Q. Mr Bellinger worked very closely with the Launceston
35 General Hospital, didn't he?
36 A. Yes, he did, and I had no knowledge of the allocation
37 of the Integrity Commission complaint beyond its allocation
38 to the Chief People Officer.
39
40 Q. And, how do you now evaluate the allocation to
41 Mr Bellinger?
42 A. It's my expectation that when employees receive
43 matters that they are working on, so whether it's an
44 investigation or whether it's a transaction or other matter
45 that they need to work with, that they need to evaluate
46 their own conflicts of interest in relation to handling of
47 matters. And certainly, I'd be concerned that, should

1 Mr Bellinger believe that he had a conflict in relation to
2 managing a matter, perhaps being involved in a previous
3 review of complaints or perhaps being involved in the
4 investigation of complaints, that he would have a
5 discussion with his supervisor in relation to that
6 allocation.
7
8 Q. I just want to understand your view of what might
9 constitute a conflict. Given the scope of the review that
10 the Integrity Commissioner was asking be carried out, the
11 scope of the investigation, should it have been referred to
12 the Human Resources personnel who were involved or
13 potentially involved in responding to complaints about
14 Griffin?
15 A. At that time I had no reason to question the
16 allocation of this matter to the Chief People Officer or
17 her judgment in the allocation of the matter for
18 investigation.
19
20 Q. I'm just trying to understand - I'm not coming to any
21 contention that you knew about it at the time, I'm just
22 trying to understand your expectations or your
23 understanding of what a conflict is in this context.
24
25 Given the scope of what you know about the scope of
26 the Integrity Commissioner request for an investigation,
27 should that have been given to HR personnel who had been
28 involved in the management of complaints about Griffin?
29 A. I would be concerned to have a matter, or to have an
30 officer receive a complaint to manage or investigate where
31 they had been involved in the prior investigation of
32 complaints that are relevant to that matter, but I had no
33 awareness nor did I --
34
35 Q. I'm not suggesting, I just want to check that - is it
36 clear to you that this was allocated to somebody with a
37 clear and present conflict?
38 A. I believe so, yes.
39
40 Q. So, it should not have been allocated to Mr Bellinger;
41 is that right?
42 A. That is correct.
43
44 Q. And that's because of his position in HR and his
45 connection with the LGH, not because of any conduct or
46 allegations against him, just the perception was enough,
47 wasn't it, to mean that it should go to somebody outside

1 the structure?
2 A. I'm sorry, I'm just trying to think --
3
4 Q. Please.
5 A. -- whether there was any opportunity within the Human
6 Resources team, which is not small in Launceston.
7 Certainly the Human Resources officers handle delicate and
8 sensitive conduct matters on any one day and that they may
9 independently be able to manage a matter that they've not
10 had previous involvement in, and certainly I'd expect an
11 individual to be able to assess their own conflict of
12 interest or, you know, the potential for a conflict of
13 interest to be able to put their hand up and say to their
14 supervisor, "I've already worked on this matter, you will
15 see my name through documents on this matter, I believe it
16 can be or should be allocated to someone else",
17 particularly where, perhaps, that Chief People Officer
18 wasn't aware of the level of involvement of Mr Bellinger in
19 relation to this matter.
20
21 Q. So, you rely upon the Human Resources staff to
22 identify their own conflict; did they receive training and
23 are there policies around the identification of those
24 conflicts?
25 A. We do have department-wide conflict of interest
26 policies, particularly in relation to, for example,
27 recruitment decisions which HR are very well aware of, and
28 in terms of the actual conduct of investigations, I would
29 assume that that awareness would carry over to that.
30
31 Q. Have you made any enquiries as to how that
32 investigation came to be allocated to Mr Bellinger?
33 A. We've certainly attempted to search our systems to see
34 if there's any other material that we can provide to the
35 Commission, and we have not found any.
36
37 Q. So, you're not able to assist the Commission how that
38 allocation was made?
39 A. No, I don't --
40
41 Q. Save for what you've already said?
42 A. That's correct.
43
44 Q. In terms of the expectation that there be an
45 investigation, the evidence of Mr Bellinger has been that
46 he carried out a desktop review that was based largely on
47 his earlier internal review. My learned junior will remind

1 me if I'm being unfair to anyone. But you've heard that
2 evidence, haven't you?
3 A. Yes, I have.
4
5 Q. Is that consistent with what you expected to have been
6 carried out in response to the request for an
7 investigation?
8 A. And, I probably pause to just reflect on when a
9 desktop review might be appropriate. Certainly, every
10 matter of enquiry would start with a desktop review, but
11 depending on, you know, what is revealed through that,
12 whether further people need to be spoken to or whether an
13 independent investigator actually needs to be appointed to
14 conduct the review.
15
16 Q. So, was it your expectation that an investigation
17 would be carried out that was different to a desktop review
18 in this instance?
19 A. I can't say that I formed any expectation at the time.
20 I allocated or was aware of the allocation of the matter to
21 the Chief People Officer, and a Chief People Officer is a
22 Senior Executive; I have my faith in that officer to
23 actually make a correct allocation and also to provide
24 guidance or instructions as to the conduct of that
25 investigation.
26
27 Q. I don't mean to harp on the matter, but in terms of
28 your expectation, to the extent you had an expectation, did
29 you have an expectation of the level of the investigation
30 at all?
31 A. I had an expectation that a thorough review would be
32 undertaken in relation to the matter so that full
33 information could be provided to me as Secretary, and so
34 that I could also respond accurately and truthfully to the
35 Integrity Commission.
36
37 Q. Are you able to assist the Commission in what are the
38 elements of a thorough investigation or review; what are
39 the minimum elements that you would expect as part of such
40 a thorough review?
41 A. Generally or in relation to this matter?
42
43 Q. In relation to a matter of this kind?
44 A. Oh, of this kind?
45
46 Q. Of this magnitude and seriousness?
47 A. And I certainly reflect on - so, a matter of this kind

1 and seriousness, the actions that I myself took in relation
2 to the enquiry by immediately forming a team of legal
3 expertise, but also complaints management, and systems
4 expertise to try and interrogate all of the systems across
5 Health to find whatever information could be found to test
6 the allegations that were actually contained within the
7 complaint.
8
9 I note that the complainant was kept anonymous by the
10 Integrity Commission or through the request of the
11 complainant, I'm not sure, so they couldn't be interviewed,
12 but I'd usually expect that, if they'd been identified,
13 that investigation would involve interviewing that
14 complainant to see if there was any further information
15 that could be provided to us or any officers that were
16 involved in the management of complaints that are
17 identified through that enquiry. I wouldn't think that it
18 was short, I would think that that would be a matter of
19 lengthy enquiry to look into each of the matters that were
20 identified.
21
22 Q. A response was ultimately provided under your hand on
23 10 September 2020; that document is at
24 TRFS.0059.0080.0069-0001. Before we go to the
25 document though, so before we put the document on the
26 screen, what's the process? What did you get back in
27 order to generate this document from the Chief People
28 Officer?
29 A. What I received back from recollection was a minute to
30 the Secretary which would detail the investigation
31 undertaken, together with any prepared correspondence back
32 to the Integrity Commission, and I note that the Integrity
33 Commission were pressing for a response and that we were,
34 similarly, pressing the Chief People Officer for the
35 provision of that response.
36
37 Q. So, it comes to you as a minute, and you review that,
38 and then this document is generated, and I'm not suggesting
39 that you sit down at a computer, but somebody generates
40 this draft for you and you review it; is that right?
41 A. Yes, that's correct.
42
43 Q. Did you have any further questions or concerns when
44 you were reviewing the draft that required clarification or
45 going back for further information?
46 A. I do not recall that I asked any further questions.
47 I believe that I cleared this document and reviewed it late

1 at night, as is my wont amongst, you know, several other
2 matters and minutes. Certainly, in terms of the matters
3 that a Secretary's required to sign off on each and every
4 day, it was one of many.
5
6 Q. I've read this passage out a number of times, I now
7 ask the operator to show the document, you'll have it at
8 Annexure 63 if you prefer to see it in paper. Would you
9 prefer the paper version or would you like to see it on
10 screen? Here it is on screen.
11 A. I'm happy on screen.
12
13 Q. I'm grateful to the operator. I'll just ask the
14 operator to slowly scroll through to give you the
15 opportunity to refresh your memory, but unless you need to
16 read the whole thing I won't ask that you read it in
17 detail.
18 A. Yes, and I note that there were several or many
19 attachments actually to this letter because I remember
20 opening them.
21
22 Q. Yes. Well, you remember opening the attachments; a
23 number of those attachments were - I ask the operator to
24 bring the document down - a number of the attachments were,
25 for example, records of communications with Griffin and his
26 response to various allegations over time. You recall
27 reading those?
28 A. Yes, I do.
29
30 Q. What was your overall impression? At this stage, what
31 was your impression of what you were dealing with here?
32 A. So, obviously, I mean, I had already formed the
33 impression that it was, you know, a concerning and serious
34 matter which I had asked my officers to investigate and to
35 make enquiries and to provide a response for the Integrity
36 Commission.
37
38 Q. I've read to a number of the witnesses and I'll read
39 to you and I'll ask the operator to show you the final
40 page of the letter again under the heading "In conclusion".
41
42 I'll read it out:
43
44 *The THS has reviewed all available records*
45 *and determined that all matters that were*
46 *raised with the Agency were addressed in a*
47 *manner that was reasonable in the*

1 *circumstances that existed at that time.*
2 *The decisions made over the past 15 years*
3 *were without the benefit of the information*
4 *that now exists as a result of the Police*
5 *investigation and the management actions*
6 *cannot be judged with that in mind.*
7
8 *Further, the THS has repeatedly sought to*
9 *particularise and identify any complaints*
10 *that the employees contend were previously*
11 *raised and not addressed. No such*
12 *complaints have been identified.*
13
14 Can I ask you to reflect for the Commissioners upon
15 the accuracy or otherwise, as you presently understand it,
16 of this part of the letter?
17 A. I believe that, so, particularly the second
18 paragraph there is misleading, and I identified as such
19 when I heard the evidence of Mr Bellinger and I provided a
20 supplementary statement to the Commission identifying the
21 misleading nature of that statement, noting the Pearn
22 disclosure, and I also wrote to the Integrity Commission to
23 apologise for not including that information as it was
24 known to officers of mine but not to myself at the time I
25 signed the letter.
26
27 Q. Are you able to assist the Commission in understanding
28 how it is that the processes of the Department of Health,
29 as it was then constituted, caused you to mislead the
30 Integrity Commissioner?
31 A. So, I believe that that has occurred through the
32 allocation of this complaint, firstly, to a staff member
33 that has not declared any conflict or potential for
34 conflict of interest that has been involved, on his own
35 evidence, in relation to matters that were reviewed as part
36 of this complaint. However, and in terms of that failure
37 of our own systems, to be able to undertake a properly and
38 independent review of what had previously been reported to
39 the department, I have taken steps to remove all management
40 of complaints and to centralise that within the office of
41 the Secretary with clear conflict of interest requirements
42 and that they be independently reviewed, triaged, and
43 allocated appropriately.
44
45 Q. Is it correct to say that you were misled as well as
46 the Integrity Commissioner?
47 A. Yes.

1
2 Q. Can you again offer your reflections to the
3 Commissioners about what the effect of that is in respect
4 of what your response would otherwise have been? What
5 would you have done differently had you known the full
6 truth at the time?
7 A. If I had known the truth of - sorry, not the truth -
8 if I had known of the fact of the Pearn disclosure
9 I believe that I would have taken the steps that I did take
10 in October 2020 following learning of the Pearn disclosure,
11 which was to commence immediately an internal
12 investigation, as it then was, in the office of the
13 Secretary which I personally led a team to undertake, and
14 which then ultimately, on the information and evidence that
15 came forward from the public, and noting the involvement of
16 other agencies who were also implicated in the information,
17 I requested that an independent investigation outside of my
18 department be undertaken.
19
20 Q. Looking at the letter itself, it disclosed a
21 concerning pattern of conduct by Mr Griffin over a number
22 of years, did it not?
23 A. Yes, it did.
24
25 Q. Were you satisfied that all of those matters had been
26 appropriately dealt with as they arose?
27 A. I relied upon the information that was provided to me,
28 that they had been independently reviewed, and I relied
29 upon the fact that no recommendation was made to me to take
30 any other course of action as Secretary, and I had no
31 reason at that point in time to doubt the effort or the
32 adequacy of the response that was prepared by Mr Bellinger.
33
34 Q. Just reading from your letter - I'd ask the operator
35 to bring it back - it says here, after the list of matters,
36 on the second page after the dot points:
37
38 *In summary the agency has, over the course*
39 *of 14 years, had several complaints*
40 *pertaining to Mr Griffin that can be*
41 *broadly characterised as professional*
42 *boundary issues. Each matter that the THS*
43 *was made aware of has been investigated and*
44 *addressed with Mr Griffin. It is*
45 *acknowledged that some of the historical*
46 *records are incomplete; this is reflective*
47 *of an area of continuous improvement for*

1 *the State over time and does not reflect an*
2 *absence of preparedness to address such*
3 *matters.*
4
5 Do you continue to be of the view that the list of
6 matters there were - sorry, to go back. Were you aware
7 then about the relationship between boundary breach issues,
8 grooming, child sexual abuse?
9 A. Yes, I was aware.
10
11 Q. And so, did the list, the fairly extensive list of
12 incidents over 14 years cause you to have any concerns
13 there might be more there?
14 A. So, it raised with me in terms of the concerns as to
15 the training and adequacy in terms of a recognition or
16 identification of grooming behaviours; raised with me the
17 concern in relation to mandatory reporting of those
18 behaviours; it raised with me the concern as to the
19 adequacy of our Human Resources information systems that
20 complaints were incomplete or our documentation of
21 complaints historically were incomplete, which is why I
22 caused several matters to occur, including campaigning very
23 strongly for the allocation of some $22 million to
24 implement a new system which will include a conduct module
25 so that each and every record of a complaint against an
26 employee can be held in one place and so that, when a
27 complaint is actually received, you are able to look back
28 over the historical and see and recognise any systemic
29 pattern of behaviour.
30
31 MS BENNETT: Commissioners, I don't have much longer to
32 go. I'd be grateful if we take a brief adjournment now and
33 then conclude shortly thereafter, if that's convenient?
34
35 PRESIDENT NEAVE: Yes.
36
37 MS BENNETT: Please the Commissioners.
38
39 **SHORT ADJOURNMENT**
40
41 MS BENNETT: Q. Ms Morgan-Wicks, this Commission has
42 received evidence from some people who have told the
43 Commission that they feared speaking up for fear of losing
44 their jobs or some other retribution. Are you able to
45 assist the Commission in your position in relation to those
46 fears and whether or not assurances are provided by your
47 office?

1 A. Yes, I can, and certainly I am incredibly grateful to
2 everyone that has come forward to provide evidence to the
3 Commission. I have sent many messages to my staff, I've
4 personally addressed staff to encourage them to come
5 forward, and certainly also said that, if there is any
6 whiff of any type of retribution or other action taken in
7 relation to a staff member who has come forward as a
8 whistleblower or to provide evidence, that that should be
9 immediately reported to my office and that would be a
10 matter of employment investigation.
11
12 Q. Ms Morgan-Wicks, I'd like to now look to the future a
13 little bit and understand what steps your department has
14 taken and will take to ensure the safety of children under
15 the care of the Health System in Tasmania. Can you tell
16 us, without being exhaustive, what are the key steps that
17 you and your department are taking?
18 A. And certainly these are steps that we haven't waited
19 to take, they're steps that have commenced since late 2020,
20 it's taken through most of 2021 and 2022, and there are
21 several pieces of really important work that we have
22 undertaken and will continue to undertake because I do
23 recognise that this is a multi-year journey for a lot of
24 our staff, but certainly in terms of my determination as
25 Secretary to make sure that everything we do at the
26 Department of Health places child safety and wellbeing at
27 the centre.
28
29 We haven't got it right in terms of the years, and
30 obviously all of the evidence that we've heard at these
31 hearings, but now is our opportunity to absolutely
32 prioritise it and to get it right.
33
34 We won't have come up with everything that we think is
35 obviously the comprehensive list and we will obviously look
36 forward to the recommendations of the Commission, but
37 certainly today I have, for example, provided the final
38 copy of our Child Safe Organisation Framework, which I
39 think I've previously spoken about and I've provided that
40 to counsel; it has been extensively consulted on, so both
41 internally and externally.
42
43 Our Child Safety and Wellbeing Framework will require
44 mandatory training by every single employee in the
45 Department of Health in relation to the framework, the
46 importance of the National Principles in terms of Child
47 Safety, and the recommendations of the Royal Commission; it

1 will require mandatory training in relation to indicators
2 of abuse, of grooming behaviours, and it will require
3 mandatory training in relation to mandatory reporting and a
4 trauma-informed approach to receiving reports or complaints
5 or any type of issue raised with a member of the Department
6 of Health.
7
8 Now, this is a significant piece to rollout across
9 16,000 employees, and I recognise that and I am determined
10 that the resources will be applied. We have prioritised
11 that training to occur for our Executive, noting that this
12 has to absolutely be led from the top, and I am determined
13 that I will lead that and that I'll ensure that my
14 Executive are responsible and accountable for Child Safety,
15 and I will also speak about some other items that we have
16 underway and that that may require some change.
17
18 Q. There's a Staff Advisory Panel; is that right?
19 A. Yes, so as part of the framework, so just reflecting
20 at the moment on our Child Safety and Wellbeing Framework,
21 what it does involve is a Child Safety and Wellbeing Panel
22 being implemented, and we are just preparing at the moment
23 to nationally advertise to call for membership of that
24 panel who will consider, on referral from me, all serious
25 allegations of child sexual abuse as they've occurred, both
26 historical or contemporary, within the Department of
27 Health. So, that panel will be established.
28
29 We are also establishing our Child Safety Service that
30 will sit underneath that panel and have dedicated resources
31 that are prepared to audit, to hold officers to account
32 across our organisation, to test all of our policies,
33 procedures and protocols through a Child Safety lens.
34
35 We have also appointed, as announced by the Premier,
36 our Governance Advisory Panel, and the Governance Advisory
37 Panel are conducting a review of the Launceston General
38 Hospital organisation and of Human Resources. That panel,
39 and I've also provided to counsel and submitted to the
40 Commission the two latest updates from the Co-Chairs of
41 that panel, and our Co-Chairs being Professor Debora Picone
42 who provided evidence to the Commission and Adjunct
43 Professor Karen Kershaw, together with other experts that
44 have been appointed to the panel and staff representatives.
45
46 That panel will also be informed by an expert
47 reference group which I have invited each of our lived

1 experience witnesses to provide as best - and through the
2 chairing of Professor Maria Harries who is a Child Safety
3 expert, their contribution and information and testing of
4 the products that we come up with, because we are trying to
5 come up with the best and contemporary structure for the
6 LGH and Human Resources through that Child Safety lens.
7
8 But I note that it's not always the way in terms of
9 just having a meeting, and Maria Harries is exploring that
10 with each lived experience witness as to their willingness,
11 or how they'd like to engage with the panel in that
12 respect.
13
14 Q. What's the current timing for the rollout of the
15 framework that you've provided?
16 A. So, the framework has been formally released and it
17 was released in its final form last week. We have already
18 commenced the mandatory training, we've already had some
19 160 officers through that training, including our members
20 of the Health Executive, the Executive Directors of the
21 Medical Services across our three major hospitals, and
22 Executive Directors of Nursing, together with our Women's
23 and Children's precincts across our hospital and
24 child-related Health Services, so they've been prioritised
25 as the first employees to go through that.
26
27 Q. How are the voices and views of children being fed
28 into this process?
29 A. Certainly, and we've been engaging with the
30 Commissioner for Children in terms of the framework and
31 also child-wise as the best way to hear the voice of the
32 child, and we note that not just in relation to the
33 framework but as we pick up each policy and procedure
34 across the Department of Health to take that expert advice
35 about how to engage with the voice of the child, noting the
36 National Principles and how children need to be engaged to
37 provide that advice.
38
39 Q. So that's work in process?
40 A. Yes, that is work in process.
41
42 Q. Is it fair, Ms Morgan-Wicks, or is it your
43 understanding that the events concerning the Launceston
44 General Hospital have had a substantial impact on the
45 relationship of trust and confidence in the community in
46 Launceston; is that your understanding?
47 A. Yes, that is my understanding, and over the last few

1 weeks we have actually called for expressions of interest
2 to attend community forums in Launceston, because this has
3 been a significant and catastrophic event that has impacted
4 the Launceston community, and not just Launceston, we know
5 that patients travel further than that to attend our
6 hospital, and we've appointed an expert to actually lead
7 some community recovery work, but to hear from the
8 community how best they would like to engage and to rebuild
9 that trust. We note that that will take some time.
10
11 In addition though, to the already immediate steps
12 that we've taken in terms of the people that are working
13 and leading Ward 4K, for example, at the LGH with the
14 appointment of a new Nursing Unit Manager, and we also have
15 a new Acting Director of Nursing in the Women's and
16 Children's precinct.
17
18 So, to immediately build that trust and to ensure - I
19 wish to assure the public that we have been actively taking
20 steps over the last two years to ensure the safety of
21 children that are turning up now; they're turning up now to
22 our Emergency Department, they'll come tomorrow, they'll
23 come Sunday, they will continue to come and we need to
24 provide that safe service and I certainly, if I may --
25
26 Q. Please.
27 A. -- call out to every single staff member, every single
28 volunteer, every single contractor, that if you do not
29 believe that we are absolutely serious about placing child
30 safety and wellbeing at the centre of all we do, and to
31 report any concern that you may have in relation to child
32 safety, I don't know what else we could do across that
33 hospital.
34
35 But certainly I repeat and am prepared to lead from
36 the very top to indicate that, should there be a concern in
37 relation to an employee, that we will take immediate action
38 to stand down and to suspend while there is an
39 investigation carried out.
40
41 Q. And at present, Ms Morgan-Wicks, who receives any
42 notifications about child abuse or concerns of that kind as
43 at today, who would get those concerns?
44 A. So, as at today we have moved to a centralised
45 management of complaints to the office of the Secretary.
46 So, we have already publicly released a form that is
47 actually on our website that encourages people to report

1 any inappropriate behaviour by someone that is working in a
2 Health workplace in Tasmania. So, that is coming to the
3 office of the Secretary, we are already receiving those
4 forms and we are already acting on matters that are
5 reported to us.
6
7 I have also taken the steps to remove all Integrity
8 Commission and conduct matters that will be removed to the
9 office of the Secretary in the south, so to take those
10 investigations or enquiries out of the hands of employees
11 that are already involved and know everyone in these
12 hospitals.
13
14 So, I'm not doubting the very good work that the
15 majority of our staff across our Health System actually
16 undertake, but for those Health professionals to
17 concentrate on being Health professionals, to identify
18 matters and report them up, but to place the management of
19 enquiries and complaints into the hands of experts, so to
20 have those experts, and for child sexual abuse to have that
21 Child Safety Panel that will independently review any
22 allegations, separate from a doctor having to judge a
23 doctor or a nurse having to judge a nurse in relation to
24 those matters.
25
26 Q. And does this apply statewide at present?
27 A. It applies statewide, so in terms of that office. In
28 terms of the movement of the Integrity Commission matters
29 and the employment matters, so ED4, 5 and 6, I have issued
30 that direction last night.
31
32 Q. I can see various of the Commissioners wanting to ask
33 you questions, so perhaps I'll cede to the Commissioners.
34
35 I have nothing further for this witness in any event,
36 save that, is it your intention to keep the Commission
37 updated on the progress of your work in this respect?
38 A. Yes, I'd very much like to keep the Commission
39 updated, noting that this is the very start for us, but we
40 are absolutely determined to get this right.
41
42 COMMISSIONER BENJAMIN: Q. Yes, Ms Morgan-Wicks, we've
43 heard evidence of very dark and traumatic circumstances
44 emanating from the Tasmanian Health System, which I think
45 you've rightly described as "horrific".
46 A. Yes.
47

1 Q. You've given evidence today and in your statements
2 that you're working hard to bring about a change and
3 rebuild trust for both your staff and the community in the
4 Tasmanian Health System, and I think - not "I think" -
5 you're telling us that you put child safety at the
6 forefront of your organisation and of your thinking. I
7 think the Child Safe Framework is but one example of what
8 you're doing. Are you satisfied that you have the broad
9 political support to continue this into the future?
10 A. Yes, I am, Commissioner. And may I say, in terms of,
11 we have the Child Safe Framework, we are moving complaints,
12 we are moving enquiries, but what this all stems from is a
13 significant and positive cultural improvement program that
14 has to be undertaken right across Health.
15
16 So, we're actually placing the finishes touches on
17 that program which I know that my Minister for Health, who
18 is also the Premier, is a significant and passionate
19 believer in because I've had many conversations with him in
20 relation to the positive cultural change that he would like
21 to see across Health.
22
23 He's seen some amazing, I've seen some amazing things
24 that have come from Health, particularly during our
25 management of COVID, the management of a global emergency,
26 but what we need to ensure is that we take that positivity,
27 the ability to work together, the respect that we had from
28 that crisis environment and bring it into the every day,
29 and the crisis of child safety has to come into the
30 everyday, and it's through that cultural improvement and
31 particularly our development of our leaders and managers
32 understanding that they are accountable and that they need
33 to take action; you don't need to wait to be told or be
34 directed by a Secretary to do that, each person can be
35 their own leader in terms of child safety.
36
37 COMMISSIONER BENJAMIN: Thank you.
38
39 COMMISSIONER BROMFIELD: I feel a bit terrible about my
40 question because that would have been a lovely way to
41 finish, and I have a very technical question after it.
42
43 Q. Just in relation to the Child Safety Panel, you said
44 that serious allegations of child sexual abuse were being
45 referred to that panel. I just wanted to understand the
46 eligibility criteria for that and whether it included
47 boundary breaches that aligned with what we understand to

1 be potential grooming behaviours?
2 A. Yes, it would, and certainly - and I should clarify in
3 terms of the panel. So, once information or a complaint is
4 received by a central complaints management unit we will
5 immediately undertake all other referrals: so, a referral
6 to Tasmania Police, to Child Protection, to Working with
7 Vulnerable People.
8
9 And I should note that I neglected to mention before
10 that, you know, some 17 per cent or so of Health at the
11 moment are registered in terms of Working with Vulnerable
12 People registration, and certainly through the support of
13 the Minister for Health, that will be extended across
14 100 per cent, so that's another matter that will continue
15 going forward.
16
17 But in terms of eligibility to that panel, aside from
18 the external and proper investigations that would be
19 undertaken, that panel will also consider what we've talked
20 about today; so that failure of the department to pick up
21 where a particular process or procedure failed to detect or
22 understand that systemic pattern of grooming that has
23 occurred over time. That, together with their assistance
24 on our implementation of our new Human Resource Information
25 Management System and the conduct module to make sure that
26 we can record each and every piece of conduct.
27
28 PRESIDENT NEAVE: Q. Ms Morgan-Wicks, I wanted to thank
29 you very much for your evidence. We've heard some terrible
30 things about the Tasmanian Health System and I think you
31 yourself acknowledged that some of that information, some
32 of that evidence that we've heard is horrifying.
33
34 I think you've given us some hope that things are
35 going to change and it's important not just that we feel
36 that hope as Commissioners, and we will of course look at
37 all of the proposed changes, but that the community in
38 Launceston and in other parts of Tasmania feel that hope as
39 well.
40
41 Now, that won't be an easy task. I'm glad to hear
42 that you identify culture change as one of the elements,
43 because you can have all sorts of lovely policies in place
44 but, if people are not led to follow those policies, don't
45 understand them, are not trained, don't understand their
46 significance, then the policies will not achieve anything.
47

1 So, I was very pleased to hear you mention the issue
2 of culture change, and I think the community should also
3 receive some reassurance, not only from all the different
4 things that you're proposing to put in place or are already
5 being put into place, but also by that focus on bringing
6 about culture change so that children who do need to go to
7 hospital or need help or need treatment are safe in the
8 future. So, thank you very much.
9 A. Thank you.
10
11 MS BENNETT: Commissioners, that concludes the hearing for
12 today. This week of hearings, as the Commissioners will
13 recall, is split across Wednesday, Thursday and Friday of
14 this week and Monday and Tuesday of next week.
15
16 Next week we will call additional witnesses with a
17 future focus on what comes next for Tasmania. I won't at
18 present offer closing reflections because we're really
19 midweek. I did, however, want to acknowledge the
20 victim-survivors who have been present today and yesterday
21 and the day before, and to acknowledge the heaviness of the
22 evidence that has been received by this Commission over
23 that time.
24
25 It's somewhat unusual, Commissioners, but I'd be
26 grateful if I could extend my acknowledgment to the staff
27 of the Commission who have acquitted themselves
28 extraordinarily over the past few days over some quite
29 difficult circumstances, and that goes for all branches of
30 the Commission team, and with those comments I ask that we
31 perhaps adjourn until Monday morning at 10am.
32
33 PRESIDENT NEAVE: Thank you very much, Ms Bennett.
34
35 **AT 2.57PM THE COMMISSION WAS ADJOURNED TO**
36 **MONDAY, 12 SEPTEMBER 2022 AT 10.00AM**
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