TRANSCRIPT OF PROCEEDINGS

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

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

BEFORE:

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

On 27 June 2022 at 10.04am

(Day 15)

PRESIDENT NEAVE: Good morning, everybody. I'd like to take this opportunity to acknowledge and pay our respects to the Tasmanian Aboriginal people as the traditional and original owners and continuing custodians of this land and acknowledge Elders past and present. We celebrate the stories, culture and traditions of Aboriginal and Torres Strait Islander elders of all communities who live and work on this land.

We also want to acknowledge all victim-survivors of child sexual abuse. We recognise the profound and lasting harm caused by the sexual violation of a child and the hurt and sense of betrayal that is experienced by children and their families when child sexual abuse is not adequately or appropriately prevented, recognised and responded to with action and empathy. We acknowledge the strength and determination of those parents in seeking to make the world a safer place for all children.

This Commission of Inquiry is seeking to investigate the experiences of child sexual abuse in institutional contexts across Tasmania. Today marks the start of two weeks of hearings in Launceston. The Commissioners welcome the opportunity to learn more about the experiences, challenges and opportunities for positive change for the institutions and the people within this community.

We acknowledge with gratitude all those from this community who have come forward, shared their experiences, provided information and sought to assist the Commission.

We will now take appearances.

MS BENNETT: I appear with Ms Norton and Ms Rhodes as Counsel Assisting.

PRESIDENT NEAVE: Thank you, Ms Bennett.

MR GUNSON: May it please the Commission, my name is Gunson, I appear for the State of Tasmania together with Mr Mackie.

PRESIDENT NEAVE: Thank you, Mr Gunson. During previous hearings I explained that sometimes it will be necessary for the Commission to make an order which restricts the publication of certain information. The Commission is committed to being open and transparent, respecting the

preferences of victim-survivors and considering the impact that evidence from these hearings may have on other investigations, legal proceedings and the wider community.

This week the hearings are focused on a particular institutional setting, namely, the health system. During this week the evidence will explore the conduct of a range of people. In order to ensure the fairness of our inquiry and ensure that any further investigations are not prejudiced, the Commission has decided to make a restricted publication order. The Commission makes this order because it is satisfied that the public interest in the reporting on the identities of particular people who may be discussed during this hearing is outweighed by relevant legal and privacy considerations.

I'll now briefly explain how the order will work. The order will apply for the duration of the hearing this week. The order contemplates the use of pseudonyms in relation to a number of people. Any information in relation to the identity of those people must be kept confidential. This means that anyone who watches or reads the information given by witnesses this week must not share any information which may identify the people who will be referred to as: "Arthur, George and Ray". This information is not limited to their real names and may include other information which may identify them such as where they live or work.

I make the order which will now be published. I encourage any journalists present who wish to report on this hearing to discuss the scope of the order with the Commission's media liaison officer. A copy of the order will be placed outside the hearing room and is available to anyone who needs a copy.

Yes, Ms Bennett.

MS BENNETT: If the Commission pleases. I would also like to take this opportunity to acknowledge the deep history and culture of this island and to acknowledge and pay my respects to the traditional owners of the land upon which we gather. We acknowledge and pay respects to all Tasmanian Aboriginal communities, all of whom who have survived invasion and dispossession and continue to maintain their identity, culture and Aboriginal rights.

I would also like to acknowledge all victim-survivors

of child sexual abuse, their families and supporters, including people in the hearing room today.

Before I call the first witness I'd like to outline in some detail the key themes and issues to be explored this week which concern the Department of Health and the Tasmanian Health Service's response to child sexual abuse.

We will take the unusual step, Commissioners, of outlining what appear to be some of the uncontroversial facts that underpin and form part of this week's hearing. The vulnerability of children under the care of any hospital is clear. Not only are these children in need of medical care, they are also often away from their families and support networks, sometimes for long periods of time and hospitals can be frightening and overwhelming places, particularly for a young child.

As part of the research into safety in Tasmanian institutions that has been commissioned by you, Commissioners, researchers spoke to a range of children and young people who have spent time in hospital. They reported that they sometimes didn't feel safe or confident and relied heavily on parents to advocate for them.

One said:

If I needed something I would ask my mum to ask them because I was too scared to talk to nurses. I was a real timid little kid, I just felt really little and I would just get my mum to do it.

Family members and other loved ones cannot necessarily keep a bedside vigil at all times. When children are left in the care of hospital staff families and carers trust, very reasonably, that they will suffer no harm at the hands of those responsible for their care. In the vast majority of cases, Commissioners, including at the Tasmanian Health Service, that trust is well-placed; doctors, nurses and other hospital staff who provide healthcare in a professional manner more than fulfil their duty of care to patients.

Tragically, however, that is not always the case and, Commissioners, in the course of this week you will hear evidence in relation to three case studies each involving

allegations of child sexual abuse, the Launceston General Hospital, or LGH as it's commonly referred to.

The abuse spans almost the entire 20-year period under examination by this Commission. In one case the abuse occurred before that time period, in 1989, but was again brought to the hospital's attention in the period of interest when the victim-survivors sought their medical records and an acknowledgment of what had happened. While much time has passed since then, we will be examining whether there are similarities in the tone and approach of Launceston General Hospital and others then and more recently.

Commissioners, as in previous weeks, your task is not to make findings about whether the abuse alleged actually occurred; the hearings this week are not a criminal prosecution in that sense. Where appropriate, the identity of those persons will be withheld; instead your role, Commissioners, is to examine the state's response to complaints of child sexual abuse made by or on behalf of patients in the care of Launceston General Hospital and ultimately the Department of Health in the context of the systems and processes that ought to be in place to keep children safe.

And this week, Commissioners, is genuinely inquisitorial and may assist you, Commissioners, and perhaps the Launceston community to understand what has occurred over many years. We will be asking what decisions were made, what actions were taken, what information was shared. It may be that some things people believe occurred did not, while other things occurred that are not well-known.

Because of this inquisitorial approach, Commissioners, we cannot indicate at this stage what findings may be open to you. However, as we indicated in the opening hearing last year, this week may raise uncomfortable questions of whether the response of persons in institutions to alleged allegations of child sexual abuse might have involved serious failings.

At this stage we cannot rule out the possibility that the evidence might support findings of misconduct in relation to individuals and under your Act, Commissioners, misconduct is defined is:

Conduct by a person that could reasonably be considered likely to result in criminal charge, civil liability, disciplinary proceedings or other legal proceedings.

On the other hand, we also cannot advise you at this stage that misconduct will be open for you to find. We will carry out a rigorous and fair examination of the evidence that is available to us.

One fundamental question this hearing asks is whether the safeguarding of children is at the forefront of health services entrusted with their care. Do the systems allow for patterns of behaviour to be detected? Do people feel empowered to speak up? Are they listened to when they do? Are appropriate actions taken to investigate and respond to concerns? Is the leadership team at LGH visibly and proactively trying to improve the systems and processes in place? Are people open to learning from their mistakes?

We will explore these questions through real life examples and you will hear from those who have had experiences of abuse and I'm going to outline some of the details of those case studies to highlight the ways in which the systems have responded to allegations of abuse, behaviours of concern and the aftermath of such matters.

Mr Felton will give evidence later this morning, Commissioners, and so I will not summarise his evidence in any detail. Broadly, however, you will hear that in 1989 he was subject to abuse by a nurse and we will refer to him as "George".

Mr Felton was 13 years old and you will hear of the lasting impact, not just of that day, but of all that followed: how he felt dismissed and his experienced minimised. It appears that investigation followed his report of abuse and George was moved away from the Children's Ward, albeit there was apparently no finding of misconduct at the time. He remained employed by the Tasmanian Health Service.

Ben's experience was talked about for some years. One nurse, Maria Unwin, who we will hear from this week, recalls being told about this in general terms when she started working at the LGH in 1993. She said she felt

shocked and sick and observed that staff at the time were still traumatised by the incident and concerned that the sanction for George was inadequate.

In 2013, as an adult, Mr Felton sought answers and as you will hear, he approached LGH for help and information; he wanted an acknowledgment of what had happened to him, an apology, and assistance accessing support for his mental health. He also, quite reasonably, wanted assurances that George had been punished for what he had done and wasn't in a position where he could abuse others. Mr Felton was provided with some information but not, he felt, all the information that he needed. He continued to feel dismissed and belittled.

He will give evidence he continued to call and attend LGH to seek help and his calls were left unsatisfied. He was told, in his words, it was too late and he simply needed to move on.

The actions that have been taken since and the extent to which Mr Felton was or was not included in that response will be further considered to explore whether the hospital's approach was trauma-informed and provided support to possible victims of abuse.

Our second case study concerns Zoe Duncan. Tragically, Zoe died in 2017. Her parents, Anne and Craig Duncan, will give evidence this afternoon about the events that followed 11-year-old Zoe's admission to the LGH emergency department in May 2001. Since her infancy, Zoe had suffered from a range of health issues, including epilepsy and chronic asthma. She was a frequent patient at LGH. Despite these challenges her father describes her in the following terms:

> *Prior to May 2001 Zoe was a carefree child. She had a well-developed sense of humour and laughed often. Zoe could see the funny side of life even when unwell. She enjoyed playing sport and played hockey and basketball and football. Zoe was extremely honest, bright, well-mannered and delightful company; a gentle, kind, caring person who was grateful for and content with life's smallest pleasures.*

Contrast those words with the words Zoe's father used to describe the daughter he brought home following her short stay in LGH in May 2001:

> *Anne and I didn't have the same daughter anymore. The girl who went into the hospital was not the same girl who returned home. Zoe withdrew for many months. She had been hurt by a man and found it difficult to be around men and boys. She would stay in her bedroom crying, she was withdrawn, angry and had a lack of energy and interest in life. I would describe Zoe as having a complete change of personality.*

So, what happened to Zoe Duncan during her short admission to LGH in 2001? Mr and Mrs Duncan will this afternoon give evidence concerning these events.

Briefly, Commissioners, it appears on 19 May 2001, 11-year-old Zoe attended the LGH emergency department with asthma, she was treated by a doctor we will refer to as "Dr Tim". Zoe's parents say they trusted the hospital and left her in its care while they went home to collect things she needed for an overnight stay.

Mr Duncan returned to the hospital around two hours later, he found Zoe curled up on the bed in the foetal position. She said words to the following effect:

> *Dad, dad, get that man away from me, he's dangerous, he's a mad man.*

She told him that Dr Tim said he loved her and wanted to marry her. He had been touching her all over and she said that he brushed her hands down her chest and over her tracksuit pants. She said he had squeezed her breast, tugged her ears and put his finger in her mouth, and this was Zoe's first disclosure of abuse by Dr Tim.

Mr Duncan raised the issue with other staff who were on duty that night and he was careful not to make false accusations against Dr Tim and hoped there might have been some misunderstanding on Zoe's part. The Night Nurse Manager reassured him that Zoe would shortly be transferred to Ward 4K and that Dr Tim will be directed not to visit Zoe there.

An hour or so later Zoe was transferred to Ward 4K and Mr Duncan went briefly to the car to collect Zoe's bag. When he got to Ward 4K Zoe told him Dr Tim had been to see her. The doctor asked Zoe where her dad was and said he hoped she was okay and to remember, "This is our little secret".

Mr Duncan reported this to the nurse manager the following morning who suggested that he spoke to the Director of Medical Services, Dr Peter Renshaw. The next day, Monday, 21 May, Dr Renshaw met with Mr and Mrs Duncan and later Zoe. At that meeting Zoe made disclosures about Dr Tim. A further meeting took place with Dr Renshaw the following day. Mr and Mrs Duncan will give evidence this afternoon about what was said at those meetings and why they were left feeling Zoe's disclosures had been minimised or dismissed.

In the days and weeks that followed her initial disclosures Zoe made a series of further and more serious disclosures. The Commissioners will recall evidence from the first week of hearings about the way in which children will sometimes disclose incrementally as a way to test their safety or the safety of their disclosures.

In this instance, Zoe's disclosures can be summarised in the following way. On Sunday, 20 May, she told her mother that Dr Tim had put his front bottom on her front bottom. At the time Mrs Duncan did not appreciate the significance of what Zoe said, thinking it was a reference to Dr Tim leaning over Zoe and nothing more.

In an end of term reflection in late may or early June Zoe wrote:

> *I'm having trouble with a man that I was uncomfortable with. He was telling me he loved me and wanted to marry me. He kissed my hand, smothered me and felt me all around the top half. He stuck his fingers in my mouth and felt my tongue and he kept saying sick things. There's more but it's just horrible.*

On 25 June Zoe told her mother that Dr Tim had done more than just touch her breast. He put his hands inside

her pants and put his finger inside her front bottom. On 27 June, Zoe told Anne that she had been raped. She asked mum, "Will I be pregnant?", explaining, "He put his thing in there".

Zoe's parents will give evidence about the impact that her abuse had over the course of her lifetime, including the significance of Zoe's loss of faith in LGH in terms of her ability to access appropriate healthcare.

Commissioners, Zoe can't give evidence before this Commission but her parents have kept meticulous records of her own descriptions of the impact of her abuse, including this account:

> *The hospital experience with the man has changed me in ways I don't want it to; my thoughts, my dreams and the way I feel about things. I find this all too much and what people might think about me. I feel so terrible but it keeps getting worse. People say I'll get over it but I don't think I will. I'm falling apart and I'm struggling to keep my head above the water. I'm trapped, scared, nowhere to go. I can't go on like this. I'm trying to do my best but I'm being held down and I just want to wither away.*

Commissioners, given the gravity of Zoe's allegations, prompt action may reasonably have been expected to investigate the allegations and to ensure her safety and the safety of other patients. There are very real questions about the response of the various state agencies following Zoe's disclosures. We will examine a range of matters in connection with Zoe's case study: for example, was there any consideration given to undertaking a forensic examination following Zoe's disclosure of sexual assault on 19 May? Was there a protocol in place? Was it followed? If not, why not?

Was Dr Tim's conduct in attending to Zoe alone in a closed cubicle contrary to any chaperone policy in place at the time? Did LGH take appropriate steps to investigate Zoe's disclosure as they were made? Were all relevant people interviewed? What, if any, disciplinary action was taken against Dr Tim? Was it appropriate that Zoe's

interviewed by Dr Renshaw when she first made the disclosures?

Why did it take over a week for the LGH to make a mandatory report to Child and Family Services? Why, in spite of Zoe's consistent and escalating disclosures, was there no report made to police by LGH or CFS? What protocols were in place regarding the reporting of child sexual abuse allegations made against hospital and staff and were they followed? And fundamentally, Commissioners, was child safety at the heart of the response by the hospital? Over 20 years later these and other questions haunt the Duncan family.

In 2002, a 12-year-old, Zoe, detailed her abuse in a letter addressed, "To whom it may concern ..." That letter ended as follows:

I just thought I'd write this letter. I know you've probably heard a lot about this but I just wanted to tell you my side of things. I was also hoping if you'd write to me and explain what you're doing because I've heard a lot of things but I don't really understand what's going on. Thank you for reading my letter.

And, Commissioners, we hope the evidence to be called this week will go some way to finally telling Zoe Duncan's side of things and to understand the response.

Commissioners, the case of James Griffin is one of notoriety, rumour and fear and our task this week is to examine the evidence available at present to understand how he could offend as he did.

You have been directed, Commissioners, to inquire into Tasmanian Government institutions; this means the focus this week is on Launceston General Hospital, although we acknowledge that Griffin had contact with children in other ways, including in the Ashley Youth Detention Centre. He was also a volunteer paramedic, participated in netball, in the Spirit of Tasmania and in his personal life.

What you will hear over this week reflects only part of the evidence that we have received. Some people have chosen to provide information in confidence and, while we

have respected that confidence, we have also greatly benefitted by the information provided.

We acknowledge that some people have chosen not to speak to the Commission and we respect their decision and acknowledge that parts of the story may remain untold.

To understand the evidence that you will hear over the course of this week it is necessary to outline the facts which we take to be uncontroversial; that is because the scope and length of Griffin's offending is so significant that each individual witness tells only a part of the story and, in order to see how each part fits, it is necessary to understand the parameters of that evidence.

I emphasise, the outline I am about to give concerns matters which we understand to be uncontroversial and is largely based on evidence from LGH witnesses and documents. There is much more evidence, some of which you will hear this week, which I have not included in this initial outline, not least so the Commissioners can hear about those experiences directly.

Griffin was born in August 1950 and he appears to have been an outgoing person who was popular with many people that he met. One person this week described Griffin as follows:

He would pump you up so you would feel good after spending time with him. I can't recall many people ever speaking badly of Jim and, if they did, others around him would always jump to his defence.

One of the themes to be explored in evidence this week is the extent to which Griffin groomed not only the children he abused, but also their families and colleagues.

Commissioners, you will recall the evidence of Kim from week 1 that Griffin was a volunteer ambulance officers, a role he had from at least 1992. In the late 1990s, 98 or 99, Griffin was a student nurse. He sold his computer to a person who then moved interstate.

It was not until the year 2000 that the person connected that computer to the internet and when they did he found child exploitation material and links to child

pornography websites. The person made a complaint to Tasmania Police in September 2000. We've been unable to determine the outcome of that complaint. This is an issue that will properly be ventilated through our examination of representatives of Tasmania Police in coming weeks when we have the benefit of their full evidence.

However, I will read to you from one of the emails from the concerned citizen who purchased this computer and this is an email from March 2001, and I quote:

> *I wrote to you a number of months ago regarding a registered nurse named Jim Griffin in the Launceston area who I believe is linked with internet pornography involving minors based on the contents of the computer he owned and sold to me. I find it very distressing that I have heard nothing about any enquiries. I do not want to think he is working in a kids' ward somewhere in Tasmania unsupervised given what I have found.*

That email was sent in March 2001 and Griffin started working at LGH in February 2001 as a registered nurse, and on 11 September 2001 he started working on ward 4K at LGH in the paediatric ward. He remained working on that ward with some limited exceptions over the next 18 years. He was sent on assignment at Ashley Youth Detention Centre between 12 September 2017 and 9 October 2017.

We have heard evidence that there was some concerns about culture on Ward 4K and LGH more generally. We will examine whether this culture served to discourage staff from speaking up about matters that concerned them or from taking appropriate disciplinary or other action.

One of the witnesses you will hear from tomorrow, Ms Maria Unwin, a nurse on Ward 4K, told the Commission:

> *People who ask questions and make complaints at LGH are punished for doing so and treated as troublemakers. There's a very strong practice of choosing and promoting people who say "yes".*

Another nurse from Ward 4K has told the Commission

about the culture of nepotism and mistreatment of staff who came from the outside.

Colleagues have described Griffin in positive terms. One described him in the following way:

> *He was very popular on the ward with his colleagues and some parents of patients. He was friendly with everyone and other staff would confide in him. If any of the less experienced nurses had a concern or issue, he would be there to help out. He wanted to be the go-to guy.*

During this time Griffin was also a well-known member of the Launceston community. In addition to his volunteer work with the Ambulance Service, Griffin volunteered with local netball clubs as a masseuse or sports trainer, strapping ankles. He was a familiar face to many who attended LGH because of his profile in the community. His helpful persona and his familiar face endeared him to many patients and their families.

You may recall from the evidence of Kim in week 1 that she was reassured to see Griffin at LGH when her daughter was admitted, saying:

> *Jim was always a very friendly, outgoing, caring person. He just had that way about him that made you feel you could trust him and he was going to look after your child.*

However, some staff still felt uneasy about Griffin and made reports to the Nurse Unit Manager about their unease. You will hear tomorrow from Ms Unwin about the concerns she raised when she worked on Ward 4K. Others also made reports, both formally and informally.

In 2004 we find the first written warning available to the Commission of a boundary breach by Griffin, an incident where he inappropriately greeted an adolescent patient by hugging her. Griffin was asked not to repeat the breach. We do not know if this is the first such breach by him and the state of record-keeping in the hospital will be a key area of concern.

In 2005 Griffin kissed an 11-year-old patient on the

forehead in what was described as a "wet kiss". When confronted with his conduct, Griffin said he did this to establish a level of friendship.

There was an outcome letter to Griffin in November 2005 in which he was directed to have an appointment with a staff member to further discuss issues around associations, care provision and boundaries relating to gender issues and the workplace. The outcome letter was combined with a 2004 letter and forwarded to HR.

In 2009 a further boundary breach was identified when Griffin offered to stay overnight with a young female patient. Shortly after, Griffin was seen cuddling a preteen girl in a recliner chair at LGH. There were documented reports around this time that Griffin had given his phone number to a young girl and told her to contact him outside the hospital.

Griffin's conduct continued and in mid-2009 a doctor complained that Griffin had undermined a patient's treatment by coming off his leave to comfort the patient and giving his phone number to her. Griffin was counselled on professional boundaries and warned that if a similar complaint was lodged in the future the matter would be raised with the Director of Nursing which may result in the complaint being referred to the Nursing Board of Tasmania.

The next month it became apparent that Griffin planned to give away a former nurse at her wedding. He was told this was inappropriate and then invited to contribute to a new policy on professional boundaries.

PRESIDENT NEAVE: Ms Bennett, you said "a former nurse", I think you meant "a former patient".

MS BENNETT: I'm sorry, Commissioners, yes, thank you, it was a former patient.

He was told this was inappropriate and invited to contribute to a new policy on professional boundaries. It's not clear what the product of that work was or whether Griffin was able to shape a policy around professional boundaries after his history of failures to observe professional boundaries and to correct his behaviour.

In March 2009, Tasmania Police received a report that

Griffin had up-skirted young girls; that is, he'd taken photographs up their skirts while he was working as a medic on the Spirit of Tasmania. A search of Griffin's house was carried out and the police report records that he cleared his browser history daily and had a large number of photos of young girls. Griffin declined an interview and the matter was filed for intelligence. Once again, we will return to the Criminal Justice System at a later stage, however, there is no record of a formal notification by Tasmania Police to LGH at this time.

Back at the hospital, there were further instances of inappropriate contact. He was again counselled about his professional boundaries in April 2009 in relation to deviating a patient's care plan, and in May 2009 he was told to stop sending emails to former patients.

We will explore whether there was any escalation from issue to issue or whether the LGH's response to each complaint simply reinforced to Griffin that more serious consequences were unlikely.

In November 2009, there was a complaint from the mother of a patient that she was uncomfortable about him being around her child as the other staff were saying he was a womaniser and a sleaze. The matter appeared to have not been progressed and the patient was discharged shortly after the complaint was made.

Commissioners, tomorrow you will hear from a former employee of the Department of Health who was abused by Griffin as a child. As an adult employee at the hospital, she was very concerned when she saw Griffin working on Ward 4K. She made a disclosure to her Line Manager and you will hear evidence from both her and her Line Manager. Their evidence is that they contacted HR to disclose the issue; that is, the abuse. We will explore with witnesses how this disclosure should have been received and dealt with, as well as how it was in fact received and dealt with.

At a similar time community services received a notification from a school alleging that two parents at the school had disclosed historical child abuse by Griffin. There was a communication with police but CSS declined to provide access to information about the notifier to police and this refusal to disclose information is an issue we

will explore in due course. Throughout it all Griffin continued to work on Ward 4K.

In 2013, a patient's mother asked that Griffin not be permitted to visit her child citing family issues, and later a family member of the patient received a call from LGH questioning why the request was made. Griffin was counselled about this apparent breach of patient confidentiality and told again there could be disciplinary action if there were further such breaches.

Separately, around May 2013, Ms Tanya Skeggs reported to police that she was concerned about Griffin's behaviour towards her daughter, Tiffany Skeggs.

In March 2015, Tasmania Police were provided with credible information that Griffin was discussing child abuse and exploitation online. The police said they would await the receipt of further information from this source before taking any further steps. The source provided that information to Tasmania Police in April 2015. It appears the information was not accessed and no further action was taken. Once again, we will explore why this was so in due course.

Later, in 2015, a further concern was raised about Griffin overstepping boundaries at LGH, this time with a psychiatric patient. Griffin was again spoken to and directed not to sit on patients' beds or hug them.

In that same year Griffin was messaging a young patient at LGH, Kirsty Neilley, a witness the Commissioners will hear from next week. She will tell you that he provided his number to her, called her and texted her. At one point Griffin explained to her that his boss had said he could not look after her anymore because he was getting too close to her. She will tell you about how Griffin behaved towards her, including how he carried her semi-naked down the hall in the hospital between the shower and her bed.

In March 2017, a young female patient expressed discomfort with male nursing staff at night, including Griffin. Her concerns were recorded in hospital notes as being:

Being touched and called pet names such as

"baby" or "sweetheart."

Leading to a re-allocation of staff.

Griffin once again received a letter about his "professional boundaries". The letter stated:

I would appreciate working together to find a suitable provider of education and training in this area to address the behaviours raised through this complaint and support a positive change in your behaviour.

Again, the letter noted:

If there was no change in behaviour it may be necessary to refer the matter to the Director of Nursing or to an external forum for further investigation.

Commissioners, this was the third warning that Griffin received about escalating matters if his behaviours continued over a number of years.

Not long after, in August 2017, Griffin engaged in a discussion with a group of young female patients on the ward. This afternoon you will hear evidence about this conversation with Mr Gordon, another nurse on the ward. You will hear of his alarm, the inappropriate communications which caused him to make a report on the system known as "SRLS". The SRLS system is a means of incident management and the way in which it is used and how people were educated about it will be the subject of some inquiry this week.

Commissioners, Mr Gordon will tell you how alarmed he was when the teenagers told him that Griffin had told them about, he wanted to "Shag a nurse" Griffin called "Titsy" and talk to them about "what boys liked".

Griffin was spoken to about this issue but none of the girls were asked what happened. The allegations were found to be unsubstantiated and no further action was taken, despite the awareness of staff and HR of Griffin's history of similar complaints.

It was in May 2019 when Ms Tiffany Skeggs reported her abuse to Tasmania Police, and, Commissioners, you will hear from Ms Skeggs on Thursday morning. She will tell you about how Griffin operated and how she was groomed by him and abused by him.

The police at that stage undertook a full investigation. At that time, in 2019, the credible information previously provided to Tasmania Police in April 2015 was finally accessed and it was found, Commissioners, to contain child exploitation material.

On 31 July 2019, following the execution of a search warrant, Tasmania Police informed LGH that child exploitation material had been found at his house, including photographs that appeared to have been taken at LGH. Griffin was immediately suspended from his work and his registration to work with vulnerable people was also suspended. Griffin never returned to work at LGH.

On 3 September 2019, he was arrested and interviewed. Further victims came forward to police and in the end Griffin was charged with one charge of sexual intercourse with a young person, eight charges of indecent assault, and three child exploitation material offences. He was subsequently granted bail on 3 October 2019. On 18 October 2019, Griffin died at LGH as a result of an overdose of prescription medication.

The most significant impact of the arrest and death of Griffin has been on the victims of his crimes, both known and unknown, who have not seen Griffin brought to justice. The question that is undoubtedly asked by many patients of Ward 4K and their families and loved ones is, was I or someone I know a victim of the nurse I called Jim?

We acknowledge that this uncertainty is very painful and we will examine what actions the LGH executive and police took to support patients and their families and to identify potential victims within the patient cohort. We will also examine LGH's dealings with staff in the aftermath of Griffin's death and witnesses will give evidence they felt silenced and unsupported by LGH.

You will hear from staff about the impact the events had on them, including learning of the allegations, the response of the LGH executive, and the need for

truth-telling and healing.

The impact on staff will be explored with senior management and the LGH executive witnesses. Consideration will be given to what further supports are needed for the LGH Ward 4K staff.

Most witnesses, Commissioners, have already provided a written statement, many of which were provided on the basis that the systems and processes - and I should say, these are statements given by staff who worked at LGH and in senior positions in the Department of Health, and many proceed on the basis that the systems and processes at LGH worked as they should.

For example, Ms Sonja Leonard said in her statement:

It was my understanding that at first instance complaints could be dealt with informally rather than always making a formal report; this would involve discussing the matter with the complainant and the person being complained of, providing adequate directions and further education.

Mr Bellinger said:

Each matter was dealt with at the time and it is my understanding that it was dealt with consistent with the practice or procedures and the department's expectations that existed at the time.

Mr Bellinger being an HR Manager. We'll invite the staff to reflect constructively on the systems and processes that were in place at LGH, the Tasmanian Health Service and the Department of Health at the relevant time, and whether systems and processes that produced these outcomes could be operating as intended.

One staff member who will give evidence this afternoon took his concerns about management of the situation to the Integrity Commission which ultimately referred the complaint to the Department of Health for further investigation. That investigation was carried out by those who had some responsibility for the various systems and

processes that were in issue. The appropriateness of these investigations and outcomes will be explored towards the end of the week with Mr Easton, the CEO of the Integrity Commission and the Secretary of the Department of Health, Ms Kathrine Morgan-Wicks.

As part of this hearing we will seek to understand barriers to identifying and acting on improper conduct, including whether the safety and concerns of young people are central and taken seriously.

One young person who had a negative experience in a Tasmanian hospital told researchers engaged by the Commission:

> *Socially often children aren't believed when they say something. Their opinions aren't valued because they're young. A lack of life experience. I also think because I was unwell mentally, physically, but regardless, if I am unwell I should still be treated with compassionate decency.*

We want every child and young person to be safe, to feel safe when receiving treatment and care in Tasmanian hospitals. We want their patients and carers to have confidence in health professionals who are overwhelmingly professional and motivated to help their patients.

While we must examine what happened within LGH, we will maintain a strong focus on practical changes and improvements that will ensure children are not harmed in the future. This includes examining ways that damage to public trust in LGH can be restored.

Commissioners, it's going to be a gruelling week for the victim-survivors and other witnesses who have come forward to speak about their experiences; for their families, friends and supporters; for senior staff who will be asked to account for their actions and for many members of the Launceston community whose lives have been impacted by these case studies, and for the Tasmanian community more generally.

We also acknowledge that those who knew and liked Griffin may find the evidence this week painful. We

encourage everyone who finds evidence from these hearings difficult to look after their wellbeing and reach out for assistance. Support services are listed on the Commission's website and access to counselling is available for all those witnesses who give evidence this week.

The lines of inquiry to be pursued this week are not intended to seek headlines or grandstand. This is not a witch-hunt. We are genuinely seeking to understand what happened, what went wrong and what can be done better.

The Counsel Assisting team will seek to ask questions of all witnesses in a fair manner and, where potential findings concern individuals, we will afford them procedural fairness. Where appropriate, we will put difficult questions to witnesses on behalf of other relevant individuals. These hearings are intended to involve an examination of events and responses and to understand the systems and how they may have failed the community they serve.

Commissioners, we want to make sure these systems are fit for purpose in the future.

Commissioners, to assist with this latter objective and to inform your recommendations on system redesign, on Monday and Tuesday of next week we will turn our attention to regulatory bodies and other experts. We'll hear how health organisations can best protect against and respond to child sexual abuse allegations, including by fostering a culture that encourages people to speak up and a system that listens to them and acts when they do speak up.

We will also hear from experts in trauma recovery about the ways in which the Launceston community has been affected, particularly by the conduct of Griffin and their responses to it and the steps that can be taken now to start rebuilding trust in LGH, a vital community institution.

With that introduction, Commissioners, we request a short adjournment before calling our first witness.

PRESIDENT NEAVE: Thank you, Ms Bennett. A short adjournment.

SHORT ADJOURNMENT

MS BENNETT: Commissioners, the next witness is Mr Ben Felton and I ask that he take his place in the witness stand.

<BEN FELTON, sworn: [11.17am]

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. Mr Felton, you've made a statement to assist the Commission; is that right?
A. That's correct.

Q. Are the contents of that statement true and correct to the best of your knowledge?
A. Yes.

Q. Thank you, Commissioners, you should have a copy of that statement before you.

PRESIDENT NEAVE: Thank you.

MS BENNETT: Q. Mr Felton, I'd like to speak to you about the evidence that you've given to the Commissioners, but I'd like to start by asking you about your family life and your childhood before 1989. Can you tell us what your life was like growing up a little bit?
A. It was definitely interesting. Both parents were in the military. We lived in and out of army bases all over Australia. My father served with the training team, the Australian Army training team in Vietnam, did 20 years service, my mother did 16 years service. We travelled around a lot; they were a loving and caring family. We had our ups and downs like every other family. I wouldn't change it if I could, it was turmoil but it was ups and downs, but it was always support with my parents.

Q. In 1988 your dad left the army and you moved to Tasmania and you started high school there; is that right?
A. That's correct, yes.

Q. So, roughly how old were you around that time?
A. I would have been 12 years old, I think, when we moved down here, yep.

Q. And it was the following year when you were staying with a friend in about November 1989 - this is coming from your statement at about paragraph 5 - do you remember you

started to feel unwell?
A. Yes.

Q. Can you tell the Commissioners about what happened?
A. I had a lot of chest pains, stomach pains, coughing, which later turned out to be pneumonia.

Q. You were taken to the hospital; where were you taken?
A. Launceston General Hospital by my father.

Q. And you were 13 at this stage?
A. Yes.

Q. Were you admitted to the hospital?
A. Yes.

Q. And, where did you go once you were admitted?
A. Straight up to Ward 4K.

Q. Do you remember much about Ward 4K?
A. It was a very big open room, there was no single cubicles or anything like that. Thinking back, there would have been possibly 15, 20 beds in there. There were a number of other children in there as well; it certainly wasn't packed when I was there, so the other children were around the same age as myself.

Q. You later got your medical records and they told you that you were admitted on about 19 November 1989; is that correct?
A. That's correct, yes.

Q. You were discharged on 22 November.
A. That's correct.

Q. And something happened on the night of 21 November; is that right?
A. That's correct, yes.

Q. Can you take us back to the night of 21 November 1989?
A. Yes. I'd been admitted and I was staying there by myself without my parents or siblings or anything else, so I was under the care of the hospital.

At approximately 11.30 at night I asked for a drink of water. The male nurse asked me to follow him to the kitchen: very helpful, hand on my shoulder, walked me

through a series of corridors, which was very confusing, and then into a kitchen. Now, the kitchen was - it had been cleaned obviously, all you could smell was methylated spirits and bleach. He then gave me the glass of water and proceeded to pull my pants down and started asking me a whole lot of questions about sexuality and erections and things like this, and then he proceeded to go ahead and did what he did. He touched me very inappropriately and other gestures that he was intending to do things, and I pushed him away. When he was doing this he was down on one knee and it started off with touching my stomach and he worked his way further down. And then there was the incident, what he did, and I'm not going to go into that. It wasn't nice and nobody should ever have to feel like that.

He then moved - motioned forward with his mouth open, and he was sweating and jittery, hyper-excited I guess you could say, and then I slapped his hands because he had both hands on me at the time, I slapped his hands, and I ran to the nearest door, which that door led directly into a hallway and in about three or four metres down directly into the Children's Ward. So, he'd taken me on this rabbit warren search to get to this kitchen.

He did what he did. I didn't see him again for the continuation of that night or the next morning. My parents then came in and I --

Q. Just let me pause you there before you go to the next morning. I'm going to assume it's roughly around midnight by this stage, it's late at night?
A. Yes.

Q. No-one else around, you found your way back to your bed. Is that right?
A. That's correct, yes.

Q. How did you react then? What did you do then?
A. I was in shock, I was in horror. I laid there, I didn't sleep, I kept waiting for him to come back and I'm thinking, you know, this person's done something, and if I speak, you know, it's - he may come back to try to silence me or to continue doing what he did or try to justify what he did, but I never seen him again; but I remember lying there shaking, crying all night.

My parents arrived in the morning and I told my mum

and dad exactly what happened and my father's eyes went black and he went down the hallway. My mother burst into tears.

Q. Can I just pause you there. Your father went down the hallway and he went off and met and spoke with people, you weren't a part of those conversations?
A. No.

Q. Go on, your mother was by your bedside, what was her reaction?
A. Absolute devastation that somebody's done this to her child. My mother was my rock, God rest her soul. I can remember every little detail of that night, and that night changed my life.

Q. Why do you say that? Tell the Commissioners the way in which it changed your life, just that night?
A. I've got three kids. I won't allow them to have sleepovers. I never bath my eldest child. I'm certainly on a hyperalert status all the time, especially in public. When I take my kids to the park I sit there and I can work out, you know, this child to that family, to this person to that person, and sadly this goes on and these people don't wear red flags.

It has certainly had a major impact on my family: my father, my brother and sister, cousins, and my children, and myself in regards to relationships; relationship with my children, relationships of the past, friendships.

It just crushed me, but at the time I was 13 years old and my father had done everything he could possibly do at the time and sadly that fell on deaf ears, even though we had a meeting with these people face-to-face.

Q. Well, let's go to that meeting if we could pause there. So, you say you went to a meeting, so this is the same day that your parents came, so 22 November?
A. Yes.

Q. Tell us what you remember about that meeting?
A. Myself and my mother and father were - after my father had spoken to somebody in the nursing area I was then classed as discharged and we had a meeting with my mother and father and myself where I had to sit down and tell - there was four people in that room: there was two nurses,

Peter Renshaw and a bloke who we were informed was a detective. Now, nobody knows who this bloke's name was. The only documentation I got from that day is a one-paged handwritten account of what happened and that was through one of the nurses who wrote that down.

I remember Mr Renshaw confirming with my father that - I remember him mentioning his own father's service and that my father, with his service, that this would be a matter that would be taken care of. My father asked this to go right through and have this man charged and investigated and a full investigation to be put through.

Mr Renshaw, as we walked out the door, put his hand on my father's shoulder and said, "Ian, this will be a full investigation and I hope your son doesn't remember". From there we were walked out of that room into a hallway and I remember, as we were being escorted out of the hospital I looked over my shoulder and I was seeing the perpetrator being walked into that room.

I believe after that my father had a meeting with some detectives at a police station, but that's as far as it was for me. After that, life just went on.

Q. You just said that Mr Renshaw had said he hoped you wouldn't remember.
A. Yes.

Q. What did you understand by that remark? What did you understand him to be referring to?
A. I didn't understand at the time the impact that it would have later on in life but for someone to say that - I mean, he dismissed it, in other words, he didn't even acknowledge it, and that showed up with the paperwork as well.

Q. You say in your statement, at paragraph 15, that words were said:

Look, we'll deal with this and we don't need to take it any further. We will 100 per cent guarantee this person will be reprimanded.

A. That is correct.

Q. Was that how the matter was left as far as you were concerned?
A. Yes.

Q. Do you remember how long the meeting went for? It's hard to remember at this distance?
A. It would have been lucky to have been, not even 10 minutes.

Q. You went home after that; what happened when you went home?
A. I got home, my parents consoled me and we discussed the matter and my father then reassured me that Mr Renshaw was going to follow the procedures right the way through to have this man removed, possibly charged, but a full investigation.

Q. I wanted to, as a matter of fairness, say to you: Mr Renshaw says that that meeting never happened?
A. Oh, I've got some paperwork if he wants to read it.

Q. No, I just wanted to get your reaction to that as a matter of fairness. Is there any doubt in your mind about that meeting?
A. Hell, no.

Q. Did you receive an offer of counselling or support after that?
A. No. No, nothing like that.

Q. You spoke before about the impact of the assault on you. Can you tell the Commissioners about the impact of what happened afterwards, the way in which that meeting was handled; did that contribute to your distress?
A. It certainly did.

Q. Can you tell us about that?
A. It certainly did, I was just wiped as if nothing had happened, it was a minor incident and get over it, get on with your life, hope your son doesn't remember.

Q. You understood that the nurse, though, would be reprimanded?
A. My father was informed by Peter Renshaw and myself as I was sitting there with my mother and father, that this man would be taken from the Children's Ward, the paediatric ward, Ward 4K, he would be removed from working with

children, disabled or vulnerable, and that this would be a full investigation that would go right through to a police investigation. That's what Mr Renshaw said to us.

Q. Did you receive any updates about what happened after that from the hospital?
A. Nothing; nothing at all.

Q. Were you expecting something?
A. Well, I was hoping to get some counselling and some help for that. That never happened through the hospital.

Q. And so, you didn't forget, did you, Mr Felton --
A. No.

Q. -- about what happened?
A. I live it every day.

Q. And it had a mark on your life as it carried on from that time?
A. It's had an extreme fallout from that.

Q. And so, in 2003, as an adult you felt you needed to go back to LGH; is that right?
A. That's correct, yeah.

Q. Tell the Commissioners about what you needed to do at that stage?
A. Okay, so I flew over from Adelaide to here and I walked into Peter Renshaw's office and I stood in front of him, in his office. He was typing at the time and he just looked up at me and said, "Yes, what do you want?" And I just said to him, "I'm the little boy that wouldn't remember", and in that moment I had his full attention. And he then asked me what I wanted and I said, "I would like to see the outcome of the investigation. I would like to know where this perpetrator is, if this perpetrator's been charged, if this perpetrator has been through the Justice System, and to find out whether that perpetrator was still working".

Mr Renshaw refused to tell me anything in regards to the perpetrator or where he was or if there was a following investigation. The conversation got heated, I was very emotional. From there, after a heated conversation and being, just pass the buck and blown off again, I then went down to the records department where I received a copy of

my records, in which they wanted to charge me for it and I just said to the woman, I said, "No, you can charge Peter Renshaw". She then rung Peter Renshaw and Peter Renshaw said, "Look, just give him the paperwork, we need to get him out of here".

So I then took that paperwork and I was here for a week at the time, and I kept contacting Mr Renshaw in regards to receiving some information and some counselling and some help. They knew I was only here for four days. From that point they emailed backwards and forwards between themselves, which I have all the emails of that. And I've even got on a piece of paper there a statement written by Mr Renshaw that there are no protocols in place for this.

So, they passed it around to Steve Ayre and [redacted], [redacted]. This email went round and round [redacted], and that was the end of it, nothing happened. I flew back to [redacted]. I subsequently then took off to England and spent some time over there trying to piece together what had happened, and then I came back to Australia.

In that meeting with Peter Renshaw in his office, he handed me his business card with his name on it and so forth.

Q. His business card, was it?
A. His business card, yes. On the back of that business card he wrote Steve Ayre's phone number and said, "Look, if you've got any questions you need to contact him, don't contact me anymore". I've held onto that card and when I got back to [redacted] I consistently rang Steve Ayre, who I've never met, and I explained to Steve Ayre the situation and that Mr Renshaw had passed his number on to me to do a follow-up of this. Steve Ayre, in the first couple of phone calls said, look, I'm sorry this has happened to you but there's nothing we can do, and after a considerable number of phone calls I was making to him I finally got to the point that it's falling on deaf ears, there's no point in making any more calls.

Q. You say phone calls, were you calling him regularly?
A. Yes.

Q. How regularly?
A. Oh, once, twice a week for a period of a couple

of months, so he definitely knows who I am.

Q. Just to pause. In 2003 you went back and you tried to get your records. What else were you after? Did you want an apology, did you want recognition? What were you after?
A. I would have loved to have got an apology. I went there wholly and solely to find out the outcome of that incident and if that perpetrator is still working amongst children.

Q. Is it fair to say you wanted an apology?
A. I wanted help.

Q. You wanted help, and you wanted to know if there'd been an investigation and what happened?
A. I wanted help so I went to the top of the Medical Board of Tasmania to get fobbed off for the third time.

Q. And, after 2003, you took the business card that you still have?
A. Yes.

Q. You phoned Mr Ayre on a regular basis?
A. Yes.

Q. And for how long, when do you think you stopped making those phone calls?
A. So, that would have been 2003 for a period of about three months I was ringing, after coming over here to see Renshaw.

Q. And, what happened after that? So, by the end of 2003 you'd made phone calls. Was there an outcome from your point of view?
A. No, nothing, nothing at all: not an email, not a phone call, not a text message, not a letter - nothing.

Q. Again, as a matter of fairness, there's a letter in the records from Mr Ayre dated 9 September 2005 addressed to you. Did you ever receive a letter around that date?
A. No.

Q. I've shown that letter to you before today.
A. You have, yes. No, I've never seen that letter, I've never heard of that letter. Steve Ayre has never been in contact with me, neither has Mr Renshaw, apart from emails with Mr Renshaw, but nothing from Steve Ayre at all. So,

if an investigation has happened, they certainly didn't inform the victim: myself.

Q. The letter had the correct address on it for you at the time, however?
A. Yes, that's correct, yep.

Q. After that it's, let's say, 2004 after you finished phone calling. What happened for you after that time?
A. I went completely off the rails. I sold everything I owned and I went and lived homeless on the streets of London for a year.

Q. So, you were homeless on the streets of London for a year?
A. Yes.

Q. Do you see that as being connected in some way to how you were treated here?
A. I think - well, I know - if I'd received the help when I asked for it in 89 and when I asked for it in 2003, I don't think I would be this broken person. Luckily for my parents' service with the military I've been able to access Open Arms which was formerly known as Veterans Affairs, and they have been an absolutely amazing support for me. If it wasn't for them I probably wouldn't be here right now.

I have had well over 100, 200 sessions with psychiatrists, psychologists, counsellors and so forth, and I've been continually receiving counselling.

Q. We've been speaking about the hospital response. You also went to the Launceston Police Station, is that right, around the time you came back to Launceston?
A. It was that four days that I was in Launceston.

Q. Yes, can you tell the Commissioners about that?
A. First of all, Mr Renshaw turned around to me in that office and said, "You had three years to make your claim. If you haven't made your claim there's nothing we can do, so move on with your life and just get over it".

I then took by paperwork from the hospital, which includes the one-paged statement of the incident that happened, I took that to the Launceston Police Station here and I met a lady at the front desk and I sat down and I explained the situation to her, and I showed her the

paperwork and the evidence and the documentation and everything that was in there, and her response was, "Well, you had three years, so you're past that now, you can't make any claim, there's nothing we can do for you, so move on with your life and hopefully you won't remember this".

Q. As a matter of fairness I should make clear that Mr Renshaw denies that meeting took place. Is there any doubt in your mind about that?
A. I've got the paperwork if he wants to read it.

Q. I just wanted to test it --
A. He knows exactly what he's done.

Q. No, I'm not seeking to ventilate those matters now, I'm just wanting to explore your recollection of events. So, there was the police station then, and I'm sorry, I've taken things out of sequence so let's go back. We've got the Launceston Police Station and there was someone on the counter there and they said that there weren't records available that far back?
A. That's what they said, yes, and as I pointed out to the police that day, that I said to them, I said, "There was a detective or somebody of hierarchy within the Tasmania Police who was sitting in on that meeting as I was informed". But, in fairness, it could have been anybody. I was just told that it was a detective.

PRESIDENT NEAVE: Q. Sorry, can I just clarify that. Sitting in on the 1989 meeting?
A. That's correct, yes.

PRESIDENT NEAVE: Thank you.

MS BENNETT: Q. So you returned to [redacted], you made the phone calls we've talked about and then you went to London where you were homeless for a year, and what happened after that?
A. I then came back to Australia. I couch-surfed for quite some time and I ended up picking up work in the drilling industry in the mining industry, and just travelled and worked in remote areas for quite some time.

Q. Then you heard about a podcast about the LGH; is that right?
A. I seen a - you know, from living here I follow what goes on in Tasmania very closely and there was a post put

up regarding paedophiles in the hospital, paedophiles in the schools, paedophiles all over the place, and I just wrote a comment regarding the paedophile that not only attacked myself but other people as well. I then responded to that, and from there it opened up avenues to bring my evidence forward.

Q. I think you told us earlier that you received some reports from LGH in 2003 when they said "just hand them over"?
A. That's correct, yep.

Q. What happened to those records?
A. I have a very close friend, a very good mentor; I gave the documentation to him. At the time the business that I was working in was shutting down and that paperwork got filed with the rest of the business's paperwork and we weren't able to find where that paperwork had gone. He was going to show that to his lawyers in Sydney. So, that paperwork we could not find.

I then, in 2001, contacted the hospital again and received a mailed copy of my entire medical records, and when that came through the post I went through it and I then contacted the lady who was running the records department at the LGH and said, "Hey, there's five pages missing here", and her words were, "I've been instructed not to send that paperwork". And I said to her that, "This is regarding child sexual abuse in that hospital by a staff member", and I said, "I need that paperwork sent to me". She then emailed those five pieces of paper to me straight away. I then received an email from Mr Renshaw stating that, "It has all been approved", and that word is in there, at his end as to the upcoming Commission of Inquiry.

Q. That is, the documents could be released to you because of the upcoming Commission --
A. Yeah, so Mr Renshaw feels that he's got the right to hold my documentation back.

Q. I should say, I earlier suggested to you that Mr Renshaw denied the meeting in 2013, that was my error. He says that there was a meeting but he doesn't have any information as to what was said?

COMMISSIONER BROMFIELD: That was 2003, was that?

MS BENNETT: No, 2003, so I've misread the note, I'm sorry, in 2003.

Q. None of that changes your recollection of events, I take it?
A. I stood in front of him.

Q. No, I understand.
A. I watched him squirm in that chair when he worked out who I was. He knows exactly I was there.

COMMISSIONER BENJAMIN: Q. Mr Felton, you indicated the second lot of documents was 2001. Did you mean it was a bit later than that? The first event was 1989?
A. Correct.

Q. The second was 2003 when you went back?
A. Correct.

Q. And then you said you lost the documents?
A. That's correct, yes.

Q. And then I think you said 2001; do you mean it was a later date than - was it 2021 you were talking about?
A. 2021 I contacted the hospital, they gave me another copy of my records apart from those five pages because those five pages hadn't been approved by Peter Renshaw and sent to me.

Q. And that's when you got those five pages, in 2021?
A. That's correct.

PRESIDENT NEAVE: Q. And they were the papers that were lost when you gave them to your friend?
A. And I also (indistinct) --

COMMISSIONER BENJAMIN: No, no, the three pages were lost, I think.

PRESIDENT NEAVE: Q. The three pages were lost?
A. No, the first lot of records I received in 03. That entire file had been misplaced, it hasn't been able to be found, so I then got the social media saying what was going on. I then contacted the hospital again and I asked for another copy of my records, which they sent me everything via mail except for those five documents.

Q. Yes.
A. I then had to ring the hospital and I spoke to the lady in the records department there, who then got clearance from Peter Renshaw to have them sent to me.

PRESIDENT NEAVE: Thank you.

COMMISSIONER BROMFIELD: Q. Can I just check, Mr Felton. Those documents, that was your patient file; was that right?
A. That's correct, yes.

COMMISSIONER BROMFIELD: Thank you.

MS BENNETT: And, I think, Commissioners will find that account of the sequence of events in paragraphs 29 to 35 of Mr Felton's statement.

PRESIDENT NEAVE: Thank you, yes.

MS BENNETT: Q. You received a phone call from a representative of AHPRA in August 2021; do you remember that?
A. Yes, I do.

Q. Can you tell us about that conversation?
A. That bloke rang me at 10 in the morning, and he was straight away, like, "I need to know who was in this meeting in 1989, I need names, I need dates, I need times, I need everything else". Now, I don't know who this guy is and, as I said to him, I said, "I'm not passing any information on to anybody until I know exactly who I'm speaking to". He then subsequently emailed me, apologising for the phone call, being so abrupt in regards to the push for information, and that was the end of that, I never heard from him again.

Q. What about the police in 2021; you heard from them?
A. Yes, I have. I've had a phone call with the detective who is now following through on this. He has been very supportive and I am hoping that they can get to the bottom of all of this?

Q. Have you been contacted more recently by any representative of the Health Department about a subsequent investigation of this person?

A. No.

Q. Has anyone ever asked for your account of events that happened when you were 13?
A. The only people who have asked for those accounts was the bloke who worked for AHPRA and the detective.

Q. Have you been made aware that there has been a subsequent - before today were you aware that there has been an investigation carried out?
A. No, I've never heard anything, and they had all means of contacting me: they've got my email address, phone number and everything else, there's no reason they couldn't have contacted me about it, or informed me at least.

Q. I just want to read to you from a finding. This is a Department of Health investigation report of 2021, I want to read to you a finding. It says:

> *In my view the evidence does not establish on the balance of probabilities that George ...*

That's the name we're giving to this perpetrator, this person --
A. That works for me, "George", yep.

Q.

> *In my view the evidence does not establish on the balance of probabilities that George touched Benjamin's genitals. This is strongly denied and is not supported by the only contemporaneous evidence. It is, however, more likely than not that Benjamin felt uncomfortable by this situation and genuinely believed that George was going to touch his genitals and pushed him away.*

A. Okay, first of all, that perpetrator did touch me; that perpetrator did make gestures of more, he asked a number of very disturbing questions, and I and that perpetrator were in that room. So, if anybody else wants to make judgment on that, they're only guessing because they weren't there.

Q. Did anyone ask you?
A. No.

Q. What do you say to the notion that you were only 13 and you couldn't have a reliable memory of those events?
A. I could draw this out minute-by-minute of that day, the recollection, the smell, the room, the colours on the wall, every little piece, even the deodorant that that paedophile was wearing.

Q. What if somebody suggested to you, "Well, we heard what was said on the podcast, that's enough". Is that enough?
A. No, there needs to be help. There needs to be acknowledgement, to start with, because nobody has acknowledged that this has happened. And I'm pretty sure that anybody involved is going to be jumping up and down and trying to get out of this situation as quick as they can.

Q. As you sit here today, has there ever been any apology or compensation or assistance offered about your connection with anything about this matter?
A. No. Not even a counselling session with the Sexual Assault Unit, nothing, not even a referral. The best I got from Peter Renshaw was, "Oh, maybe you should give Beyond Blue a call", were his magic words.

Q. Mr Felton, what would you like to see different for the future, for young people who might find themselves in a hospital alone at night, what do you want the Commissioners to know about what you want their experience to be?
A. No child should ever have to be put through any traumatic experience like this, and sadly there's some really dirty and nasty people in this world and some of those people work in very high up positions in government and medical centres and hospitals and everywhere else as well. Those people are looking at their pay check and their superannuation and they don't care who they've got to steamroll over to get it.

That man in 89 could have helped me, Mr Renshaw that is: they could have offered support, they could have offered counselling. They should have followed through with, as he said, a full investigation. At the moment there are a lot of vulnerable kids out there, and when you take a child to a doctor or to a medical centre or to wherever, sports club or whatever, we've got QR codes on every place because of this pandemic, why can't we have QR

codes on their name tags that we can scan as a parent to find out who this person is that's going to inject my son with a needle? Why can't we find out on-the-spot, is there anything standing against this person?

[redacted]

Q. Commissioners, those are the matters that I'd like to ask Mr Felton today but perhaps the Commissioners have questions for him?

COMMISSIONER BENJAMIN: No, I have no questions but I thank you for telling us your story. I've read your statement, I've heard your evidence, so thank you for being so brave.

MR FELTON: I just want to know that every other victim out there, if we all come forward we can steamroll these bastards out of our community and get them locked up and get a register so we know who these people are and where they are and where they're volunteering, because with the government staying silent and the whole state staying silent, all it does is harbours victims and puts them in a box where they've got no help, and puts these paedophiles in a box where they can do what they want, and the standard that they walk past is a standard that they accept.

I could have gotten help all the way along, and I reached out for it, and at every turn I got slapped. And every victim out there needs to come forward because we need to weed out every one of these filthy parasites, and the person who covers it up is just as good as the parasite who's offending himself.

COMMISSIONER BROMFIELD: Thank you, Mr Felton. I don't have any questions but I wanted to echo Commissioner Benjamin's thanks and also just acknowledge the way that this has impacted you and your family throughout your life and acknowledge all that you're doing to try and protect other children. Thank you.

MR FELTON: If this saves one kid from getting hurt, it's worth everything: every ounce of pain and anger, if this saves one kid from getting hurt, then it's worth everything, it's worth all of it, because every single

individual child has a soul, and I had my soul torn out along with other victims by somebody who was trying to justify their own gratification and they used a child to do it. That doesn't stand. We need to clean out and weed out these filthy rock spiders. This has got to stop because we're going to have another generation of broken people with broken souls and I don't want that for any kid. Every kid has got a fair chance, but as soon as a paedophile steps in and as soon as the bloke who covers it up, there's no hope because they're all watching each other. And in this state, 500,000 people, I'm pretty sure all these rock spiders know each other some way or another, but that's only my own personal view.

PRESIDENT NEAVE: Mr Felton, thank you very, very much indeed and I agree and I echo the comments made by my fellow Commissioners. We're very grateful to you for coming forward. We hope very much that children will be protected from abuse in the future and your participation in this process will help us achieve that goal. So, thank you very much indeed and for your great courage and for the difficulties you have experienced, we're very sorry.

MR FELTON: Thank you. I want to thank yourselves and the detectives and everybody else who's been involved in this, and the victims, because that's the hardest part, is to stand up. But you guys have got the power to change this, we've got the power to change this, and if we don't change this it's just going to be another homeless kid, broken drug addict, dependent problem, because of an incident that was never helped to start with and if we can fix or if we can help in the first situation it's gonna stop.

PRESIDENT NEAVE: Yes.

MR FELTON: You know, it's gonna stop the further follow on to Ashley Youth Detention Centre, to Risdon, and all the rest of it, because everybody starts with an incident.

PRESIDENT NEAVE: Thank you, Mr Felton, thank you very, very much indeed for your great courage.

MS BENNETT: We might take a lunch adjournment, if it please the Commission.

PRESIDENT NEAVE: Yes, we will now. Could you adjourn, please?

LUNCHEON ADJOURNMENT

PRESIDENT NEAVE: Thank you, Ms Norton.

MS NORTON: Yes, thank you, President Neave. Our next witnesses are Anne and Craig Duncan and I'd ask that they come up to the witness box.

<CRAIG DUNCAN, sworn: [1.12pm]

<ANNE MARIE DUNCAN, sworn:

<EXAMINATION BY MS NORTON:

MS NORTON: Q. If you'd both like to take a seat, please. Mr Duncan, I'll begin with you, could you state again for the transcript your full name and occupation?

MR DUNCAN: Craig Frederick Duncan, teacher.

MS NORTON: Thank you. And Mrs Duncan?

MRS DUNCAN: Anne Marie Duncan and I'm a retired teacher.

MS NORTON: Mr Duncan, you've prepared a statement for the Commission of Inquiry dated 8 June 2022; is that correct?

MR DUNCAN: That's correct.

MS NORTON: That statement has 37 attachments?

MR DUNCAN: That's correct.

MS NORTON: Have you reviewed your statement recently?

MR DUNCAN: I have.

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

MR DUNCAN: Yes.

MS NORTON: Mr and Mrs Duncan, you have two daughters, one of them is Amanda and she's sitting with us here today, and the other is her older sister, Zoe. We can't have Zoe here today because, very sadly, she died in 2017. You have a

picture of Zoe there and I'd like to call up onto the screen the following document: COM.2000.0001.2044. Is this a picture of Zoe?

MRS DUNCAN: Yes, it is.

MS NORTON: Can you remember when this picture was taken?

MR DUNCAN: It was on her 18th birthday.

MS NORTON: Thank you. The Commissioners have already heard this morning in Ms Bennett's opening some of your descriptions of the sort of child that Zoe was. I'd like to just give you the opportunity now to speak about her personality and what she was interested in before a trip to the Launceston General Hospital in May 2001.

MR DUNCAN: Well, before May 2001 Zoe was a very happy, carefree child. There used to be a lot of laughter in our house between her sister Amanda and Zoe, and we often joked and laughed as a family, and Zoe had this beautiful, beautiful laugh, it reminded me of my mum, it was just gorgeous. She was a person who could see the funny side of life even when she was unwell and she often left both Anne and I in awe because she'd be really, really crook and she just thought everyone was sick or had issues, but she didn't see them as problems herself, she would just rise to the occasion, laugh it off and away she'd go again. So, that was an amazing character trait of Zoe's.

MS NORTON: Yes, she sounds resilient.

MR DUNCAN: Absolutely resilient. As a child she enjoyed her sport, she loved playing hockey, basketball, football, which was a great joy to me, and she was also a prolific reader and she loved writing. She would enjoy dancing as well, jazz and national dancing.

MRS DUNCAN: And could I add just something briefly in there?

MS NORTON: Yes.

MRS DUNCAN: She was amazing when she played sport because quite often afterwards she would have to duck behind the sheds or we would have to open both side doors on the car because she'd be vomiting, that was from the pain --

MS NORTON: Can I ask you a bit about that? You've both referred to the fact that Zoe had some health issues, could you just tell the Commissioners and the people listening here today, in general terms, the health challenges that Zoe faced in her life?

MR DUNCAN: Prior to 2001 basically Zoe, she suffered from chronic asthma and epilepsy from aged 13 months, and she had juvenile arthritis diagnosed in Melbourne from about the age of 10. But as a general rule these issues were quite well managed. There were flare-ups from time to time, she would often visit hospital, that was just routine for Zoe, never caused her any great drama.

MRS DUNCAN: And could I also add in that she also had asthma, so epilepsy, asthma and juvenile arthritis; I didn't know whether you'd said that or not.

MS NORTON: You've made reference there to visits to hospital. I think you say in your statement that she first attended the LGH following an epileptic fit when she was about 13 months old. Was she a fairly frequent returnee to the hospital following that?

MR DUNCAN: Yeah, she was.

MRS DUNCAN: Very much so.

MR DUNCAN: I can't put a figure on it, but some winters in particular she'd be there almost on a monthly basis, I guess, and other times things were relatively controlled, so it depended on year-on-year, but she was a regular visitor, there's no doubt.

MRS DUNCAN: She used to call herself a "frequent flyer".

MS NORTON: And I'm sure that, given her age, that that meant that not only was she a frequent visitor to the hospital, but so too were you?

MRS DUNCAN: Yes, as was her sister, Amanda, because we needed to be all there, otherwise someone would have been at home, and usually it meant that Zoe went in the ambulance, one of us would go in the ambulance with her and then the other would go in the car behind.

MS NORTON: I'd like to ask you some questions about a particular weekend in May of 2001 when you made two visits to the Launceston General Hospital and earlier you referred to visits to hospital following an asthma attack, and this was one occasion as I understand it. Zoe played hockey on a Friday afternoon and you had to attend the hospital after that. Can you tell the Commissioners what you remember about that visit?

MRS DUNCAN: Me?

MS NORTON: Either one.

MRS DUNCAN: Well, yes, she was virtually taken from school into the LGH after the hockey game, and she was there till after midnight, so it was quite a lengthy period of time in A&E. And, because her asthma wasn't easy to settle, quite often she had to have very large intravenous doses of cortisone, and so, I went home --

MS NORTON: Can I just stop you there? I'd just like to ask you before you go on to talk about that: I believe at this time Zoe was 11 and Amanda was 6; is that right?

MRS DUNCAN: Yes.

MS NORTON: I want to ask you about a particular doctor who you came across in Accident & Emergency on the Friday night, and we'll refer to him as "Dr Tim". As I understand it, Dr Tim was not Zoe's treating doctor but you had a conversation with him that night about Zoe. Mr Duncan, can you recall that conversation and what was said?

MR DUNCAN: Yes, I remember that Dr Tim came up to me and Anne and said, you know, "You've got a very beautiful daughter", and he said that we should go and live in his country of origin where he said there's no asthma, and he also said to us that he could arrange teaching jobs for us there and this sort of thing, so he seemed to be being very friendly. And I remember him saying that - I asked about, you know, safety where he came from, and he said, "There's no crime in the country from where I'm from, not like Australia, the laws here are very lax and you can get away with anything in Australia", I remember him saying that to me.

MS NORTON: Can I just go back to the comment that he made

about Zoe being very beautiful. Was that the sort of observation that medical staff commonly made when you attended the LGH?

MR DUNCAN: That's the only time I can recall someone saying that, apart from when she was born, Dr Grove said she was a beautiful baby, but apart from that, that was it.

MS NORTON: Par for the course. I'm sure she was a beautiful baby. You were discharged in the early hours of Saturday morning, so it was probably a long and pretty exhausting night for you as a family, would you agree?

MR DUNCAN: It was, yes.

MS NORTON: And it wasn't long before you arrived back at the A&E because Zoe had had a further asthma attack on the Saturday. Now this time Dr Tim was Zoe's treating doctor. What was his response when you arrived and he was to treat Zoe?

MR DUNCAN: Well, it was a very unusual response because he came up to me and very excitedly said - and he was tapping his chest like this saying (demonstrating), "I'll be treating Zoe today, I'll be treating Zoe today", and I thought that was really odd, an unusual response, a bit over-the-top, but I also at the same time considered, well, this fellow's taking an interest in Zoe and in one respect I thought that was reassuring because we've got someone here that's going to look after her and take an interest in her medically.

MS NORTON: In your statement you talk about the fact that at about 4 o'clock or 5 o'clock that afternoon Dr Tim said that Zoe would need to be admitted overnight to Ward 4K, the paediatric ward, and you had a conversation at that point where he suggested that you as a family go home, perhaps to get some rest and also to collect some things for Zoe that she would need overnight including medication. Is that your recollection?

MR DUNCAN: That's true, yes.

MS NORTON: And I think he commented that Amanda, who was 6 at the time, looked quite tired and as a result of that the three of you did go home and you left Zoe at the hospital for a period of a couple of hours.

MRS DUNCAN: Yes.

MS NORTON: Did you have any concerns when you went home that evening about Zoe's welfare and safety while she was left at the hospital?

MR DUNCAN: Well, it was the first time we'd ever left Zoe. I remember, going back to what you asked previously, spending many a night at 4K staying overnight and then going to work from 4K the next morning and back after work, so that was the first time we'd left. But, no, we trusted the hospital, we trusted the doctor and the situation, and we asked Zoe before we left if she was happy for us to go home, and she was very tired at the time and, you know, wanted to sleep, so we thought a couple of hours shouldn't be too much of an issue.

MS NORTON: Yes. Can I ask you, there's a statement in your witness statement at paragraph 12 and I'll just read it to you, it's in relation to some matters that Dr Tim said to you just before you left to go home. You say:

> *I recall Dr Tim asking me how far away we lived and how long it would take us to drive home and collect our things. I told him it would take about an hour to an hour and a half.*

Did that question strike you as odd at the time or does it strike you as odd now?

MR DUNCAN: I probably didn't take it in at the time, but it certainly strikes me as odd in retrospect, because no-one has ever asked that question of us before or since and, you know, in retrospect I'm not too sure that it was relevant.

MS NORTON: So the three of you went home and, Mrs Duncan, you and Amanda stayed home that evening to get some rest and Mr Duncan, you came back to the hospital and I think you say in your statement you came back about an hour and a half to two hours later.

MR DUNCAN: M'hmm.

MS NORTON: And on the way you received a call from Dr Tim

on the phone. What did Dr Tim say in that call?

MR DUNCAN: He simply said Zoe was upset and would like to speak to me, and so I pulled over and, just after he finished saying that I expected to hear from Zoe but the phone went dead, it disconnected. So, I contacted Anne and asked her to ring the hospital to find out what the issue was. Anne tried to contact the hospital herself but couldn't get through, so from that point I went as quickly as I could to the hospital to see what was happening.

MS NORTON: What did you discover when you returned to the hospital? I should clarify, at this point Zoe is still in Accident & Emergency; is that correct?

MR DUNCAN: That's correct.

MS NORTON: What did you discover when you returned?

MR DUNCAN: When I walked into A&E I walked over to Zoe's cubicle and just as I arrived Dr Tim walked out from behind the curtains and said he'd rung me because Zoe was upset, and I thanked him and --

MS NORTON: Could I just stop you at that point. When he came out of the cubicle, had he been in the cubicle alone with Zoe?

MR DUNCAN: That's correct, yes.

MS NORTON: Thank you.

MR DUNCAN: And so, I thanked him for contacting me and he left, and then I walked into Zoe's cubicle.

MS NORTON: And, how was Zoe when you walked in?

MR DUNCAN: Well, she was curled up in the foetal position on the bed, she was really agitated, and she said to me, "Dad, dad, get that man away from me, get that man away from me, he's a mad man, he's dangerous", and I said to Zoe, "What do you mean?" And she said, "Oh, he's been saying things to me like he loved me, he wanted to marry me" and all this sort of bizarre stuff. And I said to Zoe, "You might have perhaps misunderstood what he was saying" because his language - his English was not good, and she said, "Dad, it wasn't like that", and she said, "He touched

me", and she pointed to her breast (demonstrates), and then she flicked her hands down her tracksuit bottoms and said, yes, he was touching her and feeling her, and she mentioned that he'd tugged at her ears and squeezed her breast and put his fingers in her mouth and, yep, it was pretty confronting, I have to say.

MS NORTON: Absolutely. Had Zoe ever made disclosures like that to you before?

MR DUNCAN: No, this was - this was totally, totally not Zoe, she was not one to speak ill of anyone, she wouldn't ever - I would never ever come across her speaking like that, and she certainly wouldn't speak ill of anyone, and so, in my mind at the time it was racing, I just didn't understand, it was really hard to compute what was happening, and so, I --

MS NORTON: Before you go on, I think you say in your statement also that she expressed a fear to you that he would follow her toward 4K, which was where she was to be transferred to; is that correct?

MR DUNCAN: That's correct, yes.

MS NORTON: And so, what did you do? Understandably you're finding it difficult to process this information, but what steps did you take at that point?

MR DUNCAN: Yeah, so at that time I walked out, I wanted to report what Zoe had said to someone, and when I walked out of the cubicle - and Zoe's cubicle was opposite the nurse's station, the doctor's station - there was no-one there and I literally walked around the whole ward looking for someone to speak to and there was no-one. It's really hard to believe, this is - particularly in what we see today, but back then I recall that day there was a man two cubicles to the left who was, he was severely drug-induced I would think and there was an elderly lady across the other side of the nurses' station and she was not really with it either. And so, I rang Anne to tell her what had happened and Anne said to me, "Go and report it", and I said, "I'm trying to but there's literally no-one here", and I was walking around phoning Anne at the time.

MS NORTON: Now, can I just ask you a question about that. You described there being three other patients in the ward

at that time that you --

MR DUNCAN: Two.

MS NORTON: Sorry, two others, three including Zoe. That's a matter of some significance, isn't it, because as we'll come to, subsequent investigations found - or people who subsequently investigated Zoe's report found that it was implausible that someone would do what she accused Dr Tim of doing in a busy Accident & Emergency ward. What's your reaction to the idea that it was a busy ward?

MR DUNCAN: Absolutely not, no. That was astounding to have heard that comment because it was simply not; it was dead quiet.

MS NORTON: And you presumably at that point had seen a busy Accident & Emergency ward because you'd been in and out of hospital frequently.

MRS DUNCAN: Many times. And it corroborates with Zoe's - when we asked Zoe later, "Why didn't you go and get someone, Zoe, why didn't you seek some help?" She said, "There was no-one, I couldn't find anyone to get any help", so her statement matches that as well.

MS NORTON: Mr Duncan, you eventually did come across a nurse; what conversation did you have with the nurse at that time?

MR DUNCAN: I reported to the nurse what Zoe had said and I asked her what Dr Tim was like, and she told me that he was new and she didn't know much about him. I made the comment at the time to her, "Look, I don't want this to go any further" because I just hoped at that stage that Zoe had misunderstood, you know, what was going on and I didn't want to accuse someone of wrongdoing without knowing all the facts. But this nurse quite rightly immediately reported to the other staff members on duty at the time and within five or 10 minutes I was in a meeting room with those other people.

MS NORTON: And so, can I just pause there. That nurse, even though you had expressed a desire not to make a formal complaint at that point, it sounds as though that nurse took it upon herself to escalate the matter regardless of your wishes?

MR DUNCAN: Correct.

MS NORTON: Are you glad she did that in hindsight?

MR DUNCAN: Absolutely, she did the right thing.

MS NORTON: Thank you. What happened next?

MR DUNCAN: At the meeting I went through again what Zoe had disclosed to me.

MS NORTON: Now, just for the transcript, this is a meeting, as I understand it, that's attended by four staff members: two nurses, a Night Nurse Manager and a registrar about; is that correct?

MR DUNCAN: That's correct, yes. The thing I distinctly remember from that meeting was the registrar who made the comment, "The doctor's a very nice man and he wouldn't have meant any harm". That was a thing that sticks in my mind. The Night Nurse Manager also assured me after I said to her about Zoe being fearful that Dr Tim would follow her to 4K, she assured me that she would speak to Dr Tim and under no circumstances would he visit her in 4K on her subsequent admission.

MS NORTON: You say in your statement that about an hour or so later Zoe was transferred to Ward 4K, and I think it was around that time that you popped out to the car, Mr Duncan, to grab her bag.

MR DUNCAN: Yes.

MS NORTON: And you think you were gone for about 10 or 15 minutes. What did Zoe say to you when you returned to Ward 4K where she now was?

MR DUNCAN: When I got back to 4K Zoe said Dr Tim had been back in very briefly to see her again, and she told me that he'd asked her, "Where's your dad?" And Zoe cleverly just pointed to the corridor and said, "Oh he's just out there", I was still out in [redacted] getting these things but that's what she said, and Dr Tim just said to her that, he hoped she was okay and to remember, "This is our little secret", so she said he was there for probably 30 seconds all up.

MS NORTON: And this is in circumstances where you assumed he had been directed not to attend because that's what the night manager said she would do.

MR DUNCAN: Yes, it was.

MS NORTON: You spoke to the night manager again the next day and what did she suggest to you on that occasion?

MR DUNCAN: She suggested I go and see Peter Renshaw who I believe was Director of Medical Services at the time.

MS NORTON: Yes.

MR DUNCAN: And she said she would make the appointment for, I think it was Monday; this was on the Sunday morning.

MS NORTON: For the following day. Now, you mention in your statement that on the Sunday you got into a lift with the registrar who had been at the meeting on the Saturday night. What did the registrar say to you on that occasion?

MR DUNCAN: She enquired after Zoe, you know, how is she, and then she told me that she'd been to Dr Tim's house in the early hours of Sunday morning and she said that his wife was deeply distressed and she had suggested that the little girl's probably misunderstood what Dr Tim had said, and then she went on to say, "The doctor's a very nice man, you'd better hurry up and decide what you're going to do. I don't think the doctor will take it any further and see his lawyer as he's not that sort of person".

MS NORTON: What was the message that that conveyed to you at the time?

MR DUNCAN: Well, it was clearly a thinly veiled threat that, you know, don't go and pursue this matter any further. I suspect she was protecting a colleague or a friend, I'm not sure what, but that's how it came over to me.

MS NORTON: Mr Duncan, you went home that afternoon to get some rest and, among other things, you took some washing home to do, some of Zoe's washing. Can you tell the Commissioners what you discovered when you were doing the washing?

MR DUNCAN: Yes. Well, there wasn't much in the way of washing; there was some knickers of Zoe's, some socks and the tracksuit bottom, but as I was throwing them in the machine I noticed there was blood on Zoe's knickers and I thought, oh gee, she's got her period as well, she just started to menstruate infrequently and inconsistently prior to her admission, so I did actually contact Anne later and say, "Has Zoe got all her sanitary requirements for the stay?", and Anne later on asked Zoe whether she had her period and Zoe said she hadn't.

MS NORTON: Can I ask you, when that report was made on the Saturday night, and bearing in mind - and I'll just emphasise that it was a report that Dr Tim had squeezed her breast, pulled on her ear and put his fingers inside her mouth. Was Zoe examined at all by a paediatrician or a forensic examiner from the hospital?

MR DUNCAN: No-one. No-one came near her.

MS NORTON: Did anyone talk to you, ask you whether you would like to have her examined in an appropriate way?

MR DUNCAN: No.

MRS DUNCAN: No.

MS NORTON: I know she was subsequently examined and we'll come to that in due course. Now, Mrs Duncan, we're on the Sunday night now and Zoe had a conversation with you on the Sunday night where she told - well, I'll ask you to recall what she told you on that Sunday evening, and it's paragraph 24 of Mr Duncan's statement if that assists you.

MRS DUNCAN: Yes, it was quite late at night and she was lying in the bed just thinking about things, and I was sitting next to her and she said, "Mum, he put his front bottom on my front bottom". I thought, when she said that, that she meant he'd leant - when with the tugging of the ears, the fingers in the mouth, I thought he'd leaned over her to do that, but that's not what Zoe meant.

MS NORTON: What do you now understand Zoe meant by that comment?

MRS DUNCAN: I think she was trying to tell me very

clearly that - I don't think she had the words to tell me, to be honest, but I think she was trying to say "much more happened than I've revealed", yeah.

MS NORTON: Thank you. I know that Zoe made a number of subsequent disclosures and we'll come to those shortly, but before we do I'd like to talk to you about the hospital's response and in particular the meeting that you had with Dr Renshaw on the Monday morning.

What do you recall about that meeting? As I understand, you were both at the meeting?

MRS DUNCAN: Yes.

MR DUNCAN: Well, when I told Peter Renshaw what Zoe had disclosed to me, the first thing he said was, "Well, this is the third case of similar complaints against doctors in that department". He told me, "One's been deregistered and one's under a cloud. The name that you mentioned isn't the name I thought you were going to give me". He told me he was very surprised with that name stating, "He's my protege".

MS NORTON: Can I stop you at that point. Did that concern you at the time or does it concern you now the reference to Dr Tim being his protege, does that suggest to you that he might not particularly have been independent, Dr Renshaw, in the way he approached Zoe's complaint?

MR DUNCAN: I would think so, I think subliminally he's trying to tell me that, again, there's nothing to see here, this bloke's a good doctor and wouldn't do anything like that.

MS NORTON: I think he said by reference, and this is in your statement at paragraph 25, that the Night Nurse Manager tended to sensationalise things, this is the Nurse Unit Manager who had suggested you'd speak to him.

MR DUNCAN: Yeah, and said she'd make a good reporter, she tended to sensationalise things.

MS NORTON: Yes, and you say in your statement that you responded by saying that you weren't here to accuse someone of wrongdoing or ruin their career but nevertheless these were disturbing allegations Zoe had made and she wasn't one

to make things up. We had always found Zoe to be exceptionally honest".

MR DUNCAN: That's correct.

MS NORTON: At this point or shortly after this meeting Dr Renshaw interviewed Zoe himself or met with her.

MR DUNCAN: Uh-huh.

MS NORTON: Who else attended that meeting?

MR DUNCAN: Dr Renshaw's Secretary and it was just Peter Renshaw, his Secretary and myself and Zoe.

MS NORTON: You go into detail about that meeting in your statement, would it be accurate to say that in that meeting Zoe gave a consistent account of what had happened on the Saturday night, that is, consistent with what she had told you on the Saturday night?

MR DUNCAN: Yes, it was pretty much exactly as she told me, and I just stood back, I didn't prompt her or, you know, coach her in any way, I just stood back and let Peter and Zoe have a conversation. And I remember Peter Renshaw, after Zoe explained what had happened to her, saying that, you know, she had a right to have another person present when she was being examined and she had a right to be safe and that sort of thing.

MS NORTON: Was that right ever conveyed to Zoe or to you in advance of the abuse?

MR DUNCAN: No.

MS NORTON: It strikes me that it's asking a lot of an 11-year-old child to have the wherewithal to insist on a Chaperone Policy being observed.

MR DUNCAN: I'd agree with that.

MS NORTON: After the meeting Dr Renshaw spoke to you about Zoe's demeanour during it; what did he say to you at that point?

MR DUNCAN: Well, as we were walking down the corridor with Peter Renshaw and his secretary I asked him what did

he think of what Zoe said, and he simply said, "Zoe wasn't upset enough for sexual assault of any nature to have occurred".

MS NORTON: What was your response to that when you heard that?

MR DUNCAN: I just thought he was instantly dismissive and just - you know, just totally ignoring what Zoe had to say.

MRS DUNCAN: But Craig did note and he passed this on to me, the rather surprised and horrified look on the secretary's face in response to Peter Renshaw's statement.

MS NORTON: Yes. Did you feel at that point that Zoe's disclosure was being taken seriously by the hospital - or by Dr Renshaw, I should say?

MR DUNCAN: No, not at all.

MRS DUNCAN: No.

MS NORTON: Looking back now, do you have any regrets about the fact that it was Dr Renshaw and not somebody trained in interviewing child witnesses or child complainants? Do you have any regrets about the fact that he was the initial interviewer?

MR DUNCAN: Yes. Well, at the time I didn't know who to turn to for help, and that's why I asked Peter, to be fair to him but, you know, I've subsequently found out that there should have been someone who was experienced in paediatric issues and forensic sexual assault evidence-gathering; there are such people around and I was unaware at the time.

MS NORTON: I'd like to ask you now, Craig, I think this was on your own, you had a second meeting with Dr Renshaw the following day and you talk about this at paragraph 27 of your statement. It is it fair to describe that meeting as one in which you put to Dr Renshaw various components of Zoe's complaint or her report for him to respond to?

MR DUNCAN: M'hmm.

MS NORTON: What I might do is put each of those components to you and if you'd like to tell me what

Dr Renshaw said in response. So, you referred to Dr Tim having touched Zoe's breast?

MR DUNCAN: He said - to that he said, Dr Tim was probably trying to locate the heart, and that was the excuse given for touching Zoe's breast, but I don't think doctors need to do that, personally.

MS NORTON: What did he say to the allegation that Dr Tim had put his fingers in Zoe's mouth?

MR DUNCAN: He said, well, Zoe may have been checking for ulcers - Dr Renshaw may have been checking for ulcers, but he said, normally you would look in the mouth with a torch.

MS NORTON: Yes, and what about the fact that Dr Tim followed Zoe to Ward 4K against an express direction not to?

MR DUNCAN: He didn't really address that directly. He said that he encouraged doctors to follow through with their patients and he thought that was good practice, that Dr Tim followed Zoe to 4K.

MS NORTON: And then, the final component was Dr Tim's reference, "This is our little secret".

MR DUNCAN: Yes.

MS NORTON: And what possible explanation did Dr Renshaw offer for that?

MR DUNCAN: He just said, "That was a silly thing to say and the standard of English spoken by foreign doctors is something which needs to be addressed".

MS NORTON: Mr Duncan, the Commission has a file note that Dr Renshaw prepared around that time, I know you haven't seen that document, but he says of that meeting on 22 May that you appeared satisfied with the monitoring plan that was in place. Would you describe yourself as satisfied following that meeting?

MR DUNCAN: Not at all, no.

MS NORTON: Did you feel that Zoe's distress and her allegations were being treated for the very serious matters

that they were?

MR DUNCAN: No, I don't.

MRS DUNCAN: Something that Craig said to Peter Renshaw is:

> *One of the parties concerned here has been tragically aggrieved but nevertheless I'm troubled by the nature of Zoe's allegations and the tenuous responses to them.*

MS NORTON: Yes. Mr Duncan, you comment in your statement, looking back, that you were very careful to be very fair to Dr Tim at the time and you didn't want to jump to any conclusions. I anticipate that Dr Renshaw may give evidence later this week that you wanted this matter to be dealt with quietly and discreetly. Is that a fair reading of your intentions?

MR DUNCAN: Initially that would be fair. I didn't want to accuse someone of wrongdoing without having all the evidence in hand, but in retrospect I shouldn't have been the one making those calls I don't believe, and I would hope, if the roles were reversed, I would hope that I would have said, if I was Peter Renshaw, having listened to what was being said to me, that I would have said, "Look, there's something untoward here; whether you're happy with this or not, I'm going to explore what has happened by the appropriate channels". As a teacher that's what I would do.

I can tell you that at the time my mind was in turmoil, I wasn't sure what to do, and I think that I was taken advantage of in a sense because my conservative cautious nature I think was played upon; not only played upon, but it also - and this annoys me to the nth degree - it caused Zoe irreparable harm, both immediately and long-term because I was overly cautious, I should have - and this is my fault - I should have insisted, you know, that action be taken and it be investigated more fully at the time.

MS NORTON: Can I test that with you? Was that really your job or do you think it was a reasonable thing for you to assume, if you did assume, and tell me if I'm wrong about this, but is it a reasonable thing to assume that the

hospital would have policies and procedures in place to appropriately respond when an allegation of this kind was made?

MR DUNCAN: I would hope that that was the case, yeah. I feel responsibility as a dad, but I let her down badly, but yeah, I would have hoped the institution would back me up and have the policies and procedures there ready to face situations like this.

MS NORTON: Because, would you agree that it ought not be your responsibility as Zoe's parent to design the investigation and the hospital's response into her allegations?

MR DUNCAN: Well, that would be helpful.

MS NORTON: On a similar note I'd like to ask you about mandatory reporting. You're both teachers, or a retired teacher in your case, Mrs Duncan, so you're both familiar with mandatory reporting obligations. I don't think there's any controversy that Zoe's allegation, and again remembering it's an allegation among other things that she was touched on the breast and Dr Tim's fingers were in her mouth, that report wasn't reported to Child and Family Services until, I think it was nine days after she disclosed.

Based on what was known to the hospital on the weekend that she was abused and having regard to your experience as mandatory reporters, do you think that's a matter that ought to have been reported at the time?

MRS DUNCAN: Most definitely.

MS NORTON: Do you have any sense of why it wasn't immediately reported by the hospital?

MRS DUNCAN: I felt there was a charm offensive going on that was intended to derail any further reporting; also, as Craig has already said, playing on his very good nature, but yes, you're right, mandatory reporting has to be within 24 hours.

MS NORTON: Out of fairness I should just put to you, and would you agree, that at the time you yourselves were hesitant about having this matter reported to Child and

Family Services; is that correct?

MRS DUNCAN: Well, I think we didn't - we didn't really know what was going to be reported because it had been sort of derailed by the comments that Peter Renshaw had made, and so - and I guess something else that comes into play here is that we were often very extremely tired parents because there were many nights that we sat up with Zoe due to her asthma, and that's no excuse, but we did and so we felt it really did take us some time to get our head round all this, yeah.

MS NORTON: Yes.

MR DUNCAN: I could probably further add too that in the back of our minds, in answering that question, you know, the comment in the lift by the registrar and then Peter Renshaw sort of downplaying everything that was being said to us, made me question myself, you know, what are we doing here? So we felt sort of - were made to feel, I think, to be frank - guilty about trying to pursue anything.

MRS DUNCAN: Yes.

MS NORTON: I'm going to read to you from Dr Renshaw's note at the time, and this is in response to a contact that was made by somebody from Laurel House, who said that they hadn't been provided with full details of what Zoe had reported because they'd been told that, well, you were reluctant to provide full details because they said they would then need to report to Child Protection.

He goes on to say:

I advised at the meeting the hospital would be willing to proceed to report to Child Protection if you so desired.

That suggests, on a plain reading, that it was up to you whether or not the matter was reported to Child and Family Services. Do you believe that to be the case?

MR DUNCAN: I can't honestly remember that, yeah.

MRS DUNCAN: I got the - yes, I - yes, and I eventually did have to make that contact, yes, because it wasn't going to happen any - it was us totally.

MS NORTON: Can I ask you the question a different way. Even if you said, "No, I don't want this to be reported to Child and Family Services", did the mandatory reporting obligation apply regardless?

MRS DUNCAN: Absolutely, yes.

COMMISSIONER BROMFIELD: Mr and Mrs Duncan, did Dr Renshaw or anybody else at LGH specifically say to you clearly like that, "Would you like us to make a report to the police" or "would you like us to make a report to Child Protection?"

MR DUNCAN: No.

MRS DUNCAN: No.

COMMISSIONER BROMFIELD: Thank you.

MS NORTON: Dr Renshaw did ultimately make the report to Child and Family Services on 29 May and that was after a conversation, I think, that you, Mrs Duncan, had had with him on 25 May. What do you recall about that conversation?

MRS DUNCAN: Oh, that really came about because we felt we needed some support with all this, and we visited a psychologist who's mentioned in the statement, and she said to me, "I cannot - I will - I cannot and I will not see Zoe until Peter Renshaw has reported this to the police", and I got the feeling she was doing that quite deliberately.

MS NORTON: And you then had a conversation with Dr Renshaw about that?

MRS DUNCAN: Yes, and he was extremely cross about it. He said - asked me, "How many other people have you told about this? Who else knows about this?", and I explained that the psychologist knew and the GP had been made aware of it.

MS NORTON: Yes. Dr Renshaw in a statement that he has provided to the Commission now accepts - well, he said this:

> *The Duncans have been reluctant to proceed to notification.*
>
> But he accepts that, in hindsight, he should have

proceeded to mandatorily report despite your reluctance, and he goes on to say:

> *I believed that at the time Dr Tim's behaviour was a professional boundary issue which did not necessarily meet the criteria for a mandatory report. I accept that this was wrong and I would like to take this opportunity to apologise to the Duncan family for the seven day delay in my notification of the incident.*

What's your response to that apology now? Have you received an apology to that effect prior to now?

MRS DUNCAN: No, we haven't. Did you want to respond? I'll start.

MR DUNCAN: Yeah, you go.

MRS DUNCAN: I am sort of saddened to hear that - no, I am saddened to hear that because, if it had been said four, five years earlier, our daughter - we could have passed that on to our daughter who was still alive at that time, and that, while that wouldn't have really solved all the problems, it at least would - she would have passed away knowing that.

MS NORTON: I'd like to ask you some questions now about - sorry, before I come to that. In your statement you refer to a series of further disclosures. Given the time available I'm not going to go through those in detail, the Commissioners have already been taken through those this morning in Ms Bennett's opening, but if I can just say this, and tell me if you agree with this characterisation, that in addition to the disclosure the following night to you, Mrs Duncan, that Dr Tim touched his front bottom to her front bottom, there was a reflection at the end of term - this is late May or early June - the reflection has been read out already today but would you like to just summarise that reflection in your own words?

MRS DUNCAN: Zoe spoke originally about, you know, subjects, reflected on her subjects, then on the second page she talks about a nasty incident that occurred to her at the hospital with a man touching her, saying marriage-type things to her - I think that's --

MS NORTON: Yes.

MRS DUNCAN: -- and then said, "But the rest is too horrible to write about".

MS NORTON: And then on 25 June, I think again this is a disclosure she made to you, Mrs Duncan, she told you that Dr Tim had done more than just touch her breast, she said, "He'd put his finger inside her front bottom". Do you recall that?

MRS DUNCAN: Yes. There were three disclosures, three written disclosures, and then there were verbal disclosures, yes.

MS NORTON: And then, as I understand it, the final verbal disclosure was two days later, on 27 June, so this is about five weeks after the event but after a string of escalating disclosures she disclosed that she'd been raped and she said to you, "Mum, will I be pregnant? He put his thing in there".

MRS DUNCAN: Yes, that's correct.

MS NORTON: I'm sure it's very difficult to put into words as parents what it feels like to be told that by your child, but I'd like to give you an opportunity to describe that moment.

MRS DUNCAN: I don't think I handled that very well, in that, I kind of became - I froze and I walked out of the bedroom to the study where Craig was and said - well, I can't say what I said, I just said, "I think he's raped her", and then we both went into Zoe together to just talk that through a little bit more and get a little bit more information. Is there anything you want to say?

MR DUNCAN: It was just certainly numb, shock, bewilderment, I don't know what to say really.

MS NORTON: Can you describe Zoe's level of distress at this point and the physical and psychological impact that the sexual assault she'd suffered was having on her?

MR DUNCAN: Look, immediately she was just crying all the time, you know, she couldn't go to sleep, she hated going

to bed, Anne would take her trundle mattress and lay on the floor next to her to try and calm her down. She began wetting the bed.

MRS DUNCAN: She was very hypervigilant all the time, so the fight or flight was really highly exacerbated. She had suicidal thoughts which eventually, the wonderful people at Laurel House alerted us to, they actually rang while I was at work one day and said, "I need to tell you that Zoe's having some very realistic suicidal thoughts", they were obviously concerned she would act on that. Quite often she actually wouldn't go to bed because she - a bed - this had occurred in a bed, so a bed was a nasty place for Zoe, so sometimes she would lie on the couch and we would just put blankets over her. She developed further down the track severe agoraphobia, she didn't want to leave the house, she self-isolated from friends eventually; that started to occur a little bit in high school, and very heightened sensory issues. I mentioned hypervigilance, but she developed a really heightened sense, had heightened sensory issues.

MR DUNCAN: I'd like to add that, as far as her health's concerned, you know, prior to 2001 she had asthma, epilepsy and juvenile arthritis and they flared from time to time and we tended to cope with it. After this her anxiety and her stress levels were just off the charts and that precipitated a whole range of other illnesses. By the time she passed away she had a collection. I remember one GP saying, "Zoe, we haven't got enough room on my computer to fill up the space", and I put it all down to this. It's just the stress and the hurt and whatever, it just literally killed her.

MRS DUNCAN: She had very severe chronic fatigue towards the end, extremely severe. She couldn't sit up in the chair.

MS NORTON: I'd like to come back to the end of Zoe's life, but before we move on can I just ask you, Mr Duncan, you say in your statement at paragraph 93 that Zoe withdrew from you for many months. She'd been hurt by a man and found it difficult to be around men and boys. Is there anything you'd like to add to that in terms of the abuse she suffered on your relationship with her?

MR DUNCAN: It was really - I understood why she did it,

but it was nevertheless gut-wrenching. Zoe and I had a really close relationship and later on that came back, but there was a long period of time where, yeah, she just didn't want to have much to do with males. We used to have visitors, we used to have regular visitors to our house but Zoe didn't want anyone there. So, yeah, it impacted her, her life a bit, it impacted her social life and certainly impacted my relationship with her for a long period.

MRS DUNCAN: And it impacted her sister, Amanda's life, yes.

MS NORTON: I'm conscious that Amanda's in the room but she's not giving evidence today, I'd like to invite you if you'd like to speak on Amanda's behalf about the impact of what had happened to Zoe has had on her, if you'd like to.

MRS DUNCAN: Well, for the first three years Amanda had a sister physically but not mentally and emotionally. She had a playmate, someone who loved playing with her and play fighting, playing outside, and that just completely ceased. Amanda would sit at Zoe's bedroom door and say, "Are you coming out to play today, Zoe?" And Zoe would answer, "Not today Panda", and Amanda even understood at 6 years of age that Zoe would have liked to have come out and play but she just couldn't manage it psychologically, mentally, emotionally.

I think long-term, if you asked Amanda directly has it had an impact, I think Amanda would say, "Yes, it has". There's a reticence to be involved romantically and I hope that I'm hitting the nail on the head there, but it makes her wary, very wary.

MS NORTON: Understandably. I'd like to ask you about two more things that happened around this time and then I'd like to speak briefly about the investigations that other agencies undertook. The first event is, shortly after the disclosure of rape you say in your statement at paragraph 44, Mr Duncan, that Zoe also disclosed to you that the registrar had walked into the cubicle when Dr Tim was there, she looked up the wall and walked straight out. Now, is that the same registrar in your understanding that you had a conversation in the lift with and who attended the meeting on the night of the initial disclosure?

MR DUNCAN: That's correct.

MS NORTON: Do you know if that registrar was ever interviewed as a potential witness to what occurred?

MR DUNCAN: As far as I'm aware, the only time she was ever interviewed was, I think, in May 2003 by the Medical Council of Tasmania.

MS NORTON: Okay, I'll come to that. I asked before whether or not there'd been a forensic examination or any kind of medical examination of Zoe after her initial disclosure and there hadn't been, but you talk in your statement at paragraph 41 about a GP performing a forensic examination, I think it's about five weeks after the event.

MR DUNCAN: M'hmm.

MS NORTON: And I think I'm correct in summarising the outcome of that examination as being inconclusive, the GP reported there was no evidence of trauma and the hymen was intact. You talk about conversations you've had since and your current understanding about the procedure that ought be adopted following a disclosure of abuse. What do you now understand ought to have happened when Zoe disclosed?

MR DUNCAN: My understanding is that a paediatrician or someone trained in forensic sexual assault should have examined Zoe and, if that had have happened at the outset, then I know there would have been an entirely different outcome.

MRS DUNCAN: Can I just add to that, that an obstetrics and gynaecology doctor told us that the Royal College of General Practitioners state that:

> *The condition of the hymen is not indicative of sexual activity and is irrelevant in assessing whether sexual assault has occurred.*

MS NORTON: Was that report of the GP following forensic examination treated as irrelevant in subsequent investigations or was it treated as being very relevant to those investigations?

MR DUNCAN: Sorry, was her finding that --

MS NORTON: The finding that the examination was inconclusive and not indicative of trauma.

MRS DUNCAN: It had a great bearing on the information that went to the police and I think also to Child and Family Services.

MS NORTON: And would you agree that this was one of a number of features of the hospital's early response or the early response to Zoe's disclosure which affected the subsequent course of investigations? And I'm referring there to the failure to conduct a forensic examination soon after the disclosure, the delay in notifying Child and Family Services, and the fact that Zoe was not promptly interviewed by somebody who had experience in interviewing child complainants?

MR DUNCAN: Absolutely, all of those things impacted greatly because the CFS and the police relied upon all those reports later on.

MRS DUNCAN: And went on to say that, because she had been interviewed by a number of people, that is, the psychologist, the GP, I'm not sure, was there anyone else? But because she had disclosed to those people that therefore she was well rehearsed and perhaps her evidence was tainted.

MS NORTON: So those early decisions had a marked bearing on subsequent investigations?

MRS DUNCAN: Very much so, yes.

MR DUNCAN: Yes.

MS NORTON: Ultimately, and I should ask you, did the hospital or Child and Family Services inform the police of Zoe's allegation which, by the end of June, was an allegation of rape?

MR DUNCAN: No.

MRS DUNCAN: No.

MR DUNCAN: They didn't inform until - the police weren't informed until a week after we'd actually informed the police ourselves.

MS NORTON: So, you informed the police?

MR DUNCAN: M'mm.

MS NORTON: And as I understand it, you did that at the beginning of October 2001?

MR DUNCAN: Yeah, that was --

MS NORTON: What motivated you to report to the police at that point?

MRS DUNCAN: Actually, we went on holiday and we were all sitting together and we thought, they're not going to report this, because we had by this stage written a lot of - we had a lot of written documentation and we thought, it's not going to happen, and someone - I think she was a nurse at the hospital who was designated to liaise with us - actually said, "Health and Human Services are not going to report on themselves". So, we went on holiday, we talked this through and then as soon as we came back we went to the police.

MS NORTON: So again, the onus is on you to make the decision about notifying authorities?

MRS DUNCAN: Yes, absolutely.

MS NORTON: You talk in your statement about some deficiencies in your view in the reports or the investigations of Child and Family Services and the police. Now, the Commissioners have copies of those reports, I won't go to them in detail. One of the criticisms that you make is that part of the reasoning behind the findings of both of those agencies, that the allegations were unfounded, was that it was implausible that Zoe could have been assaulted in a busy A&E. And I think, Craig, we've already heard your evidence about that; that is, in your view it was not a busy A&E that evening. Is that correct?

MR DUNCAN: That's correct.

MS NORTON: Another feature of those reports is, the police I think say that Zoe was in full view of staff at all times with the curtains open. Now, you've already said that Dr Tim was in the cubicle with her alone when you

arrived back at A&E. Were there any other indications to you that she may have been left alone with him in the cubicle; that is, not in plain sight?

MR DUNCAN: Yeah, well, I came across him immediately after the meeting I had with the four medical staff on that Saturday night, and when that meeting finished I went back to Zoe's cubicle and he was there with the curtains shut again, and as soon as I arrived he just bolted.

MS NORTON: Would you agree with this statement: that the authorities seem to have gone to some effort to give Dr Tim the benefit of the doubt in relation to Zoe's allegations; would you agree with that?

MR DUNCAN: Absolutely.

MRS DUNCAN: Yes. I guess something that's crossed my mind is that sometimes in all the reports there was a lack of an imagination, you know, how could this happen in a busy A&E ward, but the perpetrator didn't have any lack of imagination.

MR DUNCAN: The reports really annoyed me, to be frank, because we had asked, and so had the psychologist, asked before the report was presented by Child and Family Services for them to have it checked over by both ourselves and the psychologist for accuracy, and that didn't occur, and then when we read that, you know, the curtains were shut, it was a busy A&E, it just painted a picture that was completely divorced from reality.

MS NORTON: It was factually inaccurate?

MRS DUNCAN: Actually I think they were saying at all times the curtains were open, and Craig can testify to the fact that that was not the case.

MS NORTON: I'd like to ask you about a meeting that you had, and I'm conscious of the time but I'd like to give you an opportunity to talk about this, it's a meeting in November 2001 with senior hospital executives and DHHS staff. Can you recall who was at that meeting? It's paragraph 66 of your statement.

MRS DUNCAN: Okay, thank you.

MS NORTON: Liz Stackhouse?

MR DUNCAN: Liz Stackhouse, [redacted].

MRS DUNCAN: There was also a secretary from Child and Family Services taking notes.

MS NORTON: Yes. And you talk in your statement, and again I won't go to the detail, but you talk in your statement about concerns you raised in that meeting about the delay that Child and Family Services had taken in completing its report, concerns about a Chaperone Policy being implied rather than formalised, and you say there was "a gentle criticism of Zoe for not initially reporting the allegation of rape". What was your feeling coming out of that meeting? Did you feel that Ms Stackhouse and the other senior people who attended were fully grappling with Zoe's complaint?

MRS DUNCAN: I felt they were doing their best to answer the less important aspects of questions, so by that I mean I wanted to know whether Dr Tim had been screened for AIDS, for example, and so I was given a long explanation about how that occurs as you come into the country. Where they could they spoke about protocols and processes which I later discovered were not really enacted or were only implied, they were not - so, where they could, they tended to go off to a legalistic kind of component.

MS NORTON: Did you feel in that meeting, again, that they were grappling with, well, on the one hand there were these reports that cleared Dr Tim and we've spoken about problems with those reports, but did you feel again that senior members of the hospital were grappling with what Zoe was experiencing?

MR DUNCAN: I'm not sure whether they, again, were just dismissive of Zoe's allegations; I'm not sure that they were 100 per cent concerned with them either, to be honest. I just think they were more interested in protecting their institutional representations or individual representations, that's the sense I get.

MRS DUNCAN: And they were not really focused on Zoe, that was not mentioned - she wasn't mentioned much.

MS NORTON: Putting to one side the fact that these

allegations had been found to be unsubstantiated, was there any acknowledgment or apology for the fact that, for whatever reason, following the trip to the LGH, Zoe was extremely traumatised?

MR DUNCAN: No.

MRS DUNCAN: No.

MR DUNCAN: I would love to know what Zoe has alleged didn't occur: well, what did occur? What caused her from going from this happy, bubbly little child to someone who was completely different for the rest of her life? I'd love an explanation.

MS NORTON: Is that a question that the representatives of the hospital and the department that you dealt with grappled with in your view?

MRS DUNCAN: No.

MR DUNCAN: No.

MS NORTON: I'd like to fast-forward now to the end of Zoe's life, and I want to recognise that you've spoken, Mr Duncan, that she in your view continued to experience the impact of her abuse throughout her life, but you also talk about the fact that that resilience started to show through again, she ultimately went on to university, and you must have been proud when, unfortunately posthumously, but she was awarded a degree.

MR DUNCAN: M'hmm.

MS NORTON: And she studied behavioural science.

MR DUNCAN: M'hmm.

MS NORTON: And what motivated her to pursue that course of study?

MRS DUNCAN: Zoe, when she was 19, sought - she asked me, could she - could we visit Minds & Hearts in Brisbane because she felt - she had studied The Curious Incident of the Dog in the Night-Time, in Year 11 and she said, "Mum, I have some of those sensory issues". And I said to her, "Well, if you ever want to explore that further come back

to me on it", and at 18 she did. And we knew the diagnosis of girls, because it's very subtle in girls, is not - there was no-one really with the skills in Tasmania to do it. So, we contacted Minds & Hearts, we sent information prior to that, we arrived and she had a day's testing, and at the end of that day she - they said - well, she said to them that she understood they were trying to be diplomatic, and she said, "You don't have to beat about the bush, I know I've got it", and so, I'm sorry, I've forgotten your question.

MS NORTON: That's all right. I was asking why she pursued study in behavioural science.

MRS DUNCAN: So that was, she wanted to be able to make a difference for people, particularly for girls on the autism spectrum.

MS NORTON: You talk in your statement about the fact that by about April 2015 Zoe had lost all faith in the Launceston General Hospital and I want to be fair and acknowledge that there are complex reasons for that which we won't go into today, but would it be fair to say that the loss of trust following the hospital's handling of her allegation back in 2001 was, in part - was a factor that ultimately led to her not feeling comfortable seeking medical care from the Launceston General Hospital?

MR DUNCAN: Yeah, it was absolutely, and as parents we, subsequent to her decision in 2015 never to go back, we tried to get her to go back but as parents we couldn't cope with all the epilepsy in particular at the time, it was escalating, but she, you know, for those reasons you've mentioned just didn't want to go back, she said, "No-one believes me, no-one, I can't trust what goes on there, I can't go back".

MS NORTON: It sounds as though a loss of trust in the only hospital in town is a significant thing for any person, but was it a particularly significant thing for someone with Zoe's health challenges?

MR DUNCAN: Yeah, there was nowhere else to go.

MRS DUNCAN: And we knew once she had made that decision, we knew we'd lose her. We were going to do our best in conjunction with the GP, but we knew that it was just a

matter of time before we would lose her.

MS NORTON: And you did lose her, very sadly.

MRS DUNCAN: Yes.

MS NORTON: That was in 2017, she ultimately died at home alone, and I understand that your belief based on discussions that you've had with experienced doctors, is that her death was in some way a complication related to her epilepsy; is that accurate?

MRS DUNCAN: Yes. SUDEP, yes.

MS NORTON: I know you've spoken in your statement about things you'd like to see improved and the Commission's had the benefit of those contributions. I'd like to invite you each to offer any closing reflections and in particular I'm conscious that we have focused today on the ways in which the system let you down, but that along the way you did feel supported at times and I wanted to give you an opportunity if you'd like to acknowledge the support that you did receive.

MR DUNCAN: Oh look, there's some wonderful people at the LGH and some wonderful nurses and doctors, so we're not - we don't want to disparage the entire hospital community, that's for sure, but there are certainly things that need addressing. If you've got time, could I address some things?

MS NORTON: Sure.

MRS DUNCAN: Just before Craig starts, I would like to say that culture starts at the top and you have to have someone at the top who's morally and ethically sound because all decisions - well, not all decisions, but a lot of decisions flow from the decisions that person makes, and I think that the community of Launceston deserve better.

MR DUNCAN: So, if you'd just bear with me a number of points here. Amanda's informed me, and Amanda works currently at the LGH, that the system for internally reporting issues at the hospital is called the Safety Reporting Learning System, and she's told me that SRLS reports are able to be edited, de-escalated or rejected by management as per written LGH policy.

Amanda has said staff across many departments have been advised not to submit reports and furthermore there's no way of reviewing reports to see if they have been edited. There's no transparency in the reporting process and people making the reports are rarely given feedback.

Amanda further reported to us a number of people within the hospital are now going directly to her with their issues because they know she will advocate on their behalf as they are uncomfortable following the formal lines of reporting. She said staff need to be safeguarded in order to feel comfortable making those formal reports.

Another area which needs to be reviewed is the hospital Chaperone Policy. Just before I go on, at the November 2014 meeting I remember [redacted] saying there was a delay in CFS reporting and seeing Zoe because the Chaperone Policy had been reinforced at the hospital and she was safe and home with us, and so, cases are looked at on a risk basis. On the same meeting we were told that the Chaperone Policy's implied, so I'm not sure how you have an implied policy and one that's being reinforced all at once, but anyway, that's ...

So I think a Chaperone Policy needs to be part and parcel for any admission, particularly when it comes to treating children and vulnerable patients. A chaperone needs to be offered to anyone over 18 but made mandatory during the treatment of a child or vulnerable patient when a parent/carer is not present. Both nurses and doctors need to be chaperoned, this would help to protect not only patients but medical staff as well.

Zoe wanted this after her abuse, she didn't want her friends to be placed at risk. The hospital - oh, I won't go into that, that's enough.

Perhaps there needs to be some sort of psychometric testing and screening in relation to ethical standards in order to determine suitability of all health workers to practice, and I think the standard of English at times has been an issue which prevented effective communication and treatment.

One of the major ones though is, we were concerned at the time of Zoe's abuse that the policy outlined to us

around investigation and reporting was, if the hospital became aware of a sexual assault outside the hospital, then management would report directly to the police, but because Zoe's abuse was committed by an employee of the Department of Health the procedure required the hospital conduct its own internal investigation for possible reporting to the Secretary who is then responsible for reporting the matter to police if he or she deemed appropriate. While we are unsure if this policy is still in existence, it defies belief a policy could exist whereby there's one system for the public and a disparate one for the institution itself.

Amanda's told us that the LGH policy for reporting concerns on maltreatment of children is only in relation to domestic maltreatment; there is nothing in the policy which directs staff on how to respond and report child abuse occurring within the hospital. We also believe mandatory training on trauma-informed practice should be implemented for all staff at the hospital to help prevent re-traumatisation. Ideally this training could be offered to all staff of all government agencies.

MRS DUNCAN: Could I just add to that, that the Child and Family Services seem to have, back in 2001, a very immature understanding of the mindset of perpetrators and possibly the GP did as well, but certainly they've got social work backgrounds, and so, yeah, I hope they have trauma-informed training as well.

MR DUNCAN: Could I just, a closing statement?

MS NORTON: Of course.

MR DUNCAN: I'd just like to say, upon reflection I cannot fathom why the key players involved throughout Zoe's ordeals were unable or unwilling to provide her with the support, understanding, and ultimately the justice she deserved. I ponder were they protecting individual and/or institutional reputations or was it simply prejudice and an inability to comprehend sexual assault could occur within a hospital setting?

Alternatively, was it due to incompetence in investigating sexual assault, coupled with an unwieldy and poorly understood system of reporting; or worse, was Zoe's truth deliberately covered up?

It's impossible to summarise what happened to Zoe 21 years ago in this statement and the impact it had on her family but I would like to say how immensely proud I am of our girls Zoe and Amanda and my wife, Anne, for trying to shed light on this abhorrent situation.

We attempted to effect change back in 2001 so this would not happen to any child again. It's clearly evident from recent revelations this attempt was futile. Hopefully in the current climate people, and that includes health professionals, will be more open to understanding that abuse can and does occur in our public institutions.

The Tasmanian community as a whole need to come together and ensure mechanisms are put in place to ensure the safety of those who work within and those who rely upon our public institutions. Updating policies and procedures is fine, but unless a culture exists in which staff and patients feel comfortable reporting without fear of reprisal, then the potential for dangerous situations to arise will continue. It is generally held that responsibility for establishing and maintaining a positive culture in any organisation primarily falls to those in senior management. It's absolutely imperative that when reports are made within the hospitals those allegations are not investigated internally.

Furthermore, there needs to be a process which provides honest, timely and transparent feedback regarding the progress and ultimate outcome from any report. Thank you.

MS NORTON: Thank you, Mr and Mrs Duncan. Commissioners, I have no further questions.

COMMISSIONER BENJAMIN: I have no questions. I simply want to acknowledge that each of you have spoken eloquently for Zoe and for Amanda in dealing with this unimaginable tragedy which was inflicted on Zoe and her family in May 2001 and which has continued to this very day, so thank you.

MR DUNCAN: Thank you.

MRS DUNCAN: Thank you very much. Would it be all right? I just wondered if we could briefly thank some people.

I would like to thank Zoe's very dear friend, Rebecca Moore who's in the gallery today. It was Rebecca who initiated - contacted Camille Bianchi and I'd like to thank Camille. I'd also like to thank Emily Baker, Amber Wilson and Sebastian Buscemi for their support and for the other people who have come forward as well. I would like to acknowledge Ben in particular - is it, Ben?

MR DUNCAN: Yes.

MRS DUNCAN: I'd like to acknowledge Ben because after Ben reported his abuse, we decided we wanted to support him and we came forward. So thank you to all those people.

MR DUNCAN: Could I also add my thanks on behalf of my family to the Commission and all those working in the background for all the work that you have done and continue to do.

MRS DUNCAN: Thank you very much.

MS NORTON: Indeed, we couldn't do it without you. Commissioners, I'm conscious that you may have something to say. Can I just ask that when we break we have a five minute break for Counsel Assisting before the next witness.

PRESIDENT NEAVE: I'd like to thank you all on behalf of the Commission. Commissioner Benjamin's words were very eloquent, I don't think I can better them, but thank you so much for your courage. We are so sorry to hear about the terrible things that happened to Zoe, and we are very grateful to you for your persistence in continuing to advocate on behalf of Zoe and Amanda and for all children and particularly those children who end up in Ward 4K. So, thank you very, very much, it must have been a very, very difficult thing for you to do to speak as frankly as you have done to the Commission and we are very, very grateful to you.

COMMISSIONER BROMFIELD: And we have every hope that it will not be futile.

MR DUNCAN: Thank you.

MRS DUNCAN: Thank you.

SHORT ADJOURNMENT

MS BENNETT: Commissioners, I'd now like to ask Ms Elizabeth Stackhouse to give evidence. If she could come into the witness stand.

<ELIZABETH JAYNE STACKHOUSE, affirmed: [2.54pm]

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. Have a seat, Ms Stackhouse.
A. Thank you.

Q. Ms Stackhouse, could you tell the Commissioners your full name?
A. Elizabeth Jayne Stackhouse.

Q. And you're retired?
A. I am.

Q. And you've made a statement to assist the Commission; is that right?
A. I have.

Q. In response to a notice?
A. I have.

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

Q. Thank you. The Commissioners will find that statement before them. Ms Stackhouse, you were the CEO at Launceston General Hospital between 1998 and 2003; is that right?
A. Yes.

Q. Can you broadly tell us what your responsibilities were at the time?
A. I was responsible for the day-to-day management of the hospital, strategic planning, financial planning, appointment of senior staff.

Q. How many people, roughly, reported to you?
A. Directly?

Q. Roughly directly, yes?
A. Probably, at the most, seven.

Q. Let's go through it this way. The LGH executive was

assisting you, you tell us in your statement at paragraph 16, that there was an executive that assisted you in managing the day-to-day operations of the hospital; is that right?
A. Yes.

Q. And so, tell us about what you mean by the day-to-day operations of the hospital?
A. We often looked at bed capacity issues if we were fully - full of patients for the day, what other issues were impacting on how we could provide services, how the surgical program was running, how many aged care patients we would have in the hospital that we needed to move, so very much an operational management issue.

Q. And so, that operational management responsibility operated across that executive; is that right?
A. Yes.

Q. Was there a sense in which that executive worked together in relation to that day-to-day operation or was there strict delineation of responsibilities?
A. There was delineation of responsibilities, but then there were many issues that crossed all departments and all professional services.

Q. And, is child safety one of the things that crosses all departments?
A. Yes.

Q. There were five directors, you tell us this in your statement at paragraph 10, there were five directors that were part of the LGH executive as well as you; is that correct?
A. Yes.

Q. So, there was a Director of Medical Services; is that right?
A. Yes.

Q. Nursing, Medicine, Surgery and Women's and Children's Services; is that right?
A. Yes.

Q. Tell me how those directors divided up responsibility between themselves?
A. Okay, so the Directors of Medicine, Surgery and Women

and Children's Services were the director of the inpatient facilities, so they were the Director of the Wards and what was happening on the wards, and the Director of Nursing had an overarching responsibility for nursing, and the Director of Medical Services had an overarching responsibility for medical staff.

Q. What's the difference between nursing and medical staff?
A. Medical staff is someone that's a registered medical practitioner.

Q. And nurses?
A. And a nurse is someone that is a registered nurse.

PRESIDENT NEAVE: Q. Can I just clarify, what's the difference between the Director of Medical Services and the Director of Medicine?
A. At the Launceston General at the time there were a number of medical wards and there were a number of medical - they'll confuse you, but there were medical services that were provided for --

Q. What would be an example?
A. For example, renal services.

Q. Sorry, I missed what you said?
A. Renal services.

Q. Okay.
A. And the Director of Medical Services was responsible overarching for the medical practitioners.

MS BENNETT: Q. So, Ms Stackhouse, was that organisation for administrative purposes, for disciplinary purposes, what was the purpose of having those five different directors?
A. For organisational purposes so that one person didn't have overall complete responsibility for what was a fairly big organisation.

Q. I see. And so, the way it was divided was by reference to the clinical services being provided in each area?
A. Yes.

Q. So, where did responsibility for child safety lie

within that structure?
A. Child safety was covered by a number of them.

Q. Yes.
A. For child safety within paediatric services, which is part of Women's and Children's Services, Ward 4K, that would have been the responsibility of that ward and the Director of Women's and Children's Services.

Q. But what about children generally in the hospital? Like, from the point of view of not a ward but the hospital's approach to the safeguarding of children, where do we find responsibility for that?
A. Unless they were a patient, they weren't really covered by it.

Q. Let's assume they're a patient in the emergency department, who's got responsibility for their safety?
A. The emergency department at that time was under The Director of Medicine.

Q. Okay, so The Director of Medicine is responsible for child safety if they're in one department and the Director of Women and Children's Services would be responsible in another department if they're in a different ward?
A. Yes.

Q. So, does responsibility move depending on where the child is located?
A. Yes.

Q. And where is this written down?
A. The role and the responsibilities of the directors would have been part of their position description. I cannot recall if it specifically referred to child safety.

Q. Is it fair, though, Ms Stackhouse, that nobody had overall oversight of the hospital from that perspective?
A. From the child safety perspective?

Q. That's right.
A. No.

Q. And there was in fact a clinical lens being applied --
A. There was always a clinical lens applied.

Q. Is it fair to say, the clinical lens came first and

any safeguarding lens came second?
A. Yes, because we were a hospital, it's a clinical lens.

Q. Yes, I understand that. So, matters to do with, for example, mandatory reporting, would they be dealt with depending upon who the ultimate report was in any particular area?
A. Yes.

Q. So, it might be different depending on which ward you landed in?
A. Yes.

Q. And different between nurses and doctors?
A. Yes.

Q. Did ultimate responsibility ever make it to the top of the tree, to the CEO level?
A. For mandatory reporting?

Q. Or at all?
A. Not that I can recall, no.

Q. What about for ensuring that systems and processes were holistically coherent; is that something that was --
A. It's something that would rise to the level of CEO and would be the remit of the executive.

Q. Okay, so at the CEO level you'd be responsible for what aspects of safety?
A. Protocols and policies.

Q. Protocols and policies, okay.

PRESIDENT NEAVE: Q. What's a protocol?
A. A procedure.

Q. How you go about something, I mean --
A. Yes.

Q. I'm still trying to understand. Give me an example of a protocol as opposed to a policy, that would be helpful?
A. I'm sorry, I can't recall one specifically, it's 20 years since I was at the LGH.

COMMISSIONER BROMFIELD: Q. Could I perhaps check my understanding? So, a protocol might be a treatment

protocol; would that be a helpful --
A. We did have treatment protocols, yes.

Q. And were there other types of protocols? Are all protocols in relation to treatment and/or, when you say "procedure", do you mean medical procedure?
A. The protocol would have been a medical procedure, yes.

PRESIDENT NEAVE: Q. But you, I thought, said that you were responsible for protocols and policies and you were not involved in the kind of medical decision-making.
A. My role still covered ensuring that the hospital adopted hospital-wide protocols and procedures that may have been medical by nature.

Q. Okay, thank you. Sorry, I have one further question. I think you said there were seven people in the executive, so that's the five directors that you mentioned?
A. And me.

Q. Sorry?
A. And me.

Q. And you, that's six.
A. And my other direct report was my personal assistant.

PRESIDENT NEAVE: Okay, thank you.

MS BENNETT: Q. So, how do the different directors work together? So let's just say you've got a Director of Nursing and Medicine, you would imagine that doctors and nurses would be working together, so too do the Directors of Nursing and Medicine often work together?
A. Yes.

Q. What about all five, what level of cooperation was there?
A. We met weekly and the cooperation was when we had to manage whole-of-hospital issues or support areas that only perhaps only cross one or two.

Q. Were issues of concern raised at that LGH executive if there was, for example, an allegation of abuse? And we'll come to the example of Ms Duncan in a moment, but if there were allegations of that kind would they be discussed at those weekly meetings?
A. I cannot recall one being discussed at that meeting.

Q. Leaving aside the specific example, was that the sort of thing that you would expect would be discussed at those kinds of meetings?
A. They were much more organisational-wide, what was discussed at that meeting. Like, if we were about to have a nursing strike or - the issues of safety for children did not arise at those meetings.

PRESIDENT NEAVE: Q. Can I just ask another question about that?
A. Yes.

Q. We're talking about abuse that occurred allegedly within the hospital but there are provisions relating to mandatory reporting for children who come to the hospital and show that there may be some evidence of abuse outside and there's a process, I think there's a policy to deal with that issue. I don't remember the date of it. So, would that issue come to the executive or would that be dealt with by a director?
A. Under the mandatory policy for a child that had been abused or alleged abused outside, that would not be discussed at the Director's meeting.

Q. So, it would be dealt with by the --
A. By the Director.

Q. -- whichever Director that was?
A. Yes, and normally that would be the Director of Women's and Children's because the child would have been cared for by Ward 4K.

Q. So, not the Director of Nursing, The Director of Medicine?
A. I would have said normally it would be the women and childrens, yep.

Q. Women and Children's?
A. Yep.

PRESIDENT NEAVE: Okay, thank you.

MS BENNETT: Q. We've seen reference to a Quality Committee, sometimes called a Quality and Safety Committee. Is that a committee you're familiar with?
A. Yes.

Q. How does that committee interact with the Directors' positions or the LGH executive we've been discussing?
A. The Quality and Safety Committee met and reported to - there was a larger management team which included the senior management of areas like pharmacy and pathology, so it was a broader team, and the Quality Committee reported to that group, and that group met monthly.

Q. Was that committee a committee that was concerned with safety issues?
A. Safety would have been on the agenda, yes.

Q. Are they as close as we get to a body that's concerned with safety of children at the hospital?
A. In my time? Yes.

Q. Okay, and it wasn't their primary role or function?
A. It was not their primary role or function, no.

Q. It's simply as close as we get to a body that had that function at that time?
A. Yes.

Q. Who was monitoring complaints that might be made about safety concerns relating to children at LGH while you were the CEO?
A. So, complaints would have gone through the quality office and the quality manager, and they would have - the quality manager would usually determine - sometimes in conjunction with the Director of Medical Services - to whom to send that complaint for response.

Q. And why in conjunction with the Director of Medical Services?
A. Because Quality Office sat underneath the Director of Medical Services.

Q. I see. So, the body which was the most responsible for safety in the hospital reported up the line to the Director of Medical Services; is that right?
A. Can you just say that, sorry?

Q. Sorry. As I understand, the body that was monitoring complaints, is that the same body we were talking a moment ago when we were talking about the Quality Committee?
A. Okay. The body is that Quality and Safety Committee.

The Manager of Quality reported to the Director of Medical Services.

Q. And who was that in the time of your tenure?
A. The Director of Medical Services?

Q. Yes?
A. Dr Peter Renshaw.

Q. Yes, thank you. Can you tell us very briefly how it is that complaints were meant to be dealt with, and let's use the example of Zoe Duncan. What should have happened when Mr Duncan raised the complaint? As far as you're aware at the time, what should have happened?
A. What should have happened?

Q. Yeah?
A. It should have been - there should have been a mandatory notice immediately to Child and Family Services.

Q. And, can you tell the Commissioners why that's your view?
A. Because it's my understanding of the policy that that should have happened.

Q. I want to ask you about that policy and tell me if you need a moment, Ms Stackhouse, if you need a moment, let me know. I'd like to ask you about this policy, it's the Protocol for Hospital Based Medical Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect. I'll ask the operator to bring it on screen so you can see it, it's TRFS.0060.0092.0003_PA at TRFS.0060.0092.0003-0001.

Those numbers sound a lot more significant than they are. I understand it's a long time since you've worked in this space but I'll ask you if you recognise that policy?
A. I have no reason to doubt that it isn't the policy that applied at the time.

Q. And is that the policy you mean - if I could ask the operator to go over the page - that's the policy that you're talking about that tells us that a report should be made straight away; is that right?
A. I haven't seen this policy since 2003.

Q. Okay, that's okay.

A. And I think it was replaced in 2002.

Q. Yes.
A. But I believe that would have been the policy I was referring to, yes.

Q. I'll ask you about a part of this policy and understanding what you say about the period involved, could I ask the operator to go over the page to page 2 of that policy -0003 - and ask the operator to focus in on the, "Essential practice guidelines" in the middle of the page. Can you see there where it says:

> *No decisions or actions in respect of suspected or actual potential child abuse or neglect are to be made by any health worker in isolation unless there is concern for the immediate safety of the child.*
>
> It goes on to say:
>
> *Whenever child abuse is suspected or identified the matter must be given top priority. The most senior medical officer on duty in the unit should be advised at once and the Paediatric Registrar must be contacted immediately as outlined in Item 6 below.*
>
> Is that broadly your recollection of the way that policy operated?

A. That's broadly, yeah.

Q. It goes on to say under 4.2:

> *Information volunteered by the child should be fully and accurately recorded. However, no in-depth interview of a child especially regarding sexual abuse should be attempted.*
>
> That was the hospital policy at the time?

A. Yes.

Q. I'll ask the operator to just hold that there for a moment, I wanted to ask you about the first paragraph I read out to you that:

No decision or actions in respect of suspected actual or potential child abuse or neglect are to be made by any health worker in isolation ...

Just to pause there, is that a direction to staff not to make a report externally before they've spoken to somebody more senior?
A. I wouldn't have inferred that.

Q. You would have?
A. I would not have.

Q. No, okay. So, how do you understand that? The person who suspects potential child abuse or neglect, what should they do?
A. They should not do it in isolation, they needed to discuss with someone else.

Q. Is that not something that could cause delay?
A. Well, it could cause delay, yes, and there's also reference to the Paediatric Registrar being contacted.

Q. Yes.
A. Yes.

Q. I'll ask the operator to bring that page down now. That Paediatric Registrar, do you recall - again, I'm asking you about something a long time ago - but do you recall why the requirement to call the Paediatric Registrar was included?
A. Because you're dealing with a child.

Q. Sorry?
A. Because this referred to dealing with a child.

Q. Yes, and because there's specific skills that are needed to deal with a child?
A. And often - I shouldn't say "often", I'm not sure from my memory how often the abuse was alleged, but in many cases it would also be physical abuse.

Q. I'll take it that sexual abuse is obviously physical abuse as well?
A. Yes, but there would often be instances where there were other physical trauma such as broken arm.

Q. I see, and it's important to have a doctor who has a familiarity with paediatrics to assist the child?
A. Yes.

Q. Was anyone monitoring the operation of this policy at the time? Was there a monitoring mechanism in place at the time that you recall?
A. No, I don't recall a monitoring process that was in place.

Q. You've heard the evidence of the Duncans here today, I take it?
A. Yes.

Q. And in your statement at paragraph 107 you reflect that in the case of Zoe Duncan there should have been an immediate notification: that's right, isn't it?
A. Yes.

Q. There should have been an independent investigation; is that right?
A. Yes.

Q. And there shouldn't have been any investigation by a member of the LGH staff; is that right?
A. Yes.

Q. When did you form the view - when did those reflections come to you? Was it in the course of preparing this statement or are these ideas that you had after the Zoe Duncan case?
A. They are ideas I had after the Zoe Duncan case.

Q. So, around 2001 and 2002?
A. Yes.

Q. So, when were you informed about it?
A. I was - the allegation?

Q. The allegations?
A. A few days after the allegation; the exact date I do not recall.

Q. No, I understand that. And, do you recall what you were told broadly?
A. I was broadly told there was an allegation by a child of sexual assault in Accident & Emergency Department.

Q. And what was the response that that disclosure triggered?
A. The response was, "Well, have we identified - have we notified Child and Family Support Services?"

Q. Is that something that you were asking at the time?
A. Yes.

Q. And had Child Services been notified at the time?
A. I can't recall the exact timing. I can't recall if they had been notified by the time I was told of the allegation, or if there was still concerns raised around the parents not wishing - unclear as to whether they wished to pursue a complaint.

Q. So, there was some suggestion to you that the parents might not want to pursue a complaint?
A. Yes.

Q. And what was the relevance of that in your mind?
A. At the time, I'm not sure.

Q. Is it fair to say now that, if that was causative of any delay, it should not have been?
A. That's fair to say, yes.

Q. Would you accept that the matters that you identify in paragraph 107 of your statement, accepting that they were matters that you reflected upon at the time, can you tell the Commissioners about what you did at the time in response to those reflections?
A. Apart from being advised that Child and Family Services had been advised --

Q. Yes?
A. -- I don't know that I did anything else.

Q. Because you accept, I think, that there should have been an independent investigation and there ought be no involvement by LGH staff. Did you communicate that view to anyone below you at the hospital? Did you tell anyone they'd done the wrong thing when you thought they might have done the wrong thing?
A. I can't recall my exact words but I was not happy that Child and Family Services had not been advised and I'm sure I conveyed that to Dr Peter Renshaw.

Q. Can you tell us what you remember about the conversation with Dr Renshaw?
A. I can't recall the specifics of it.

Q. That's all right, just tell us what you do recall?
A. I can't recall.

Q. You were angry? You weren't happy?
A. I wasn't happy.

Q. Okay, and did you communicate you weren't happy?
A. I can't recall.

Q. Did you leave a note, a file note, a reprimand?
A. I don't believe I left a file note or a rep - I may well have left a file note, but I - when I left the hospital I destroyed all the file notes.

Q. And, was Mr Renshaw reprimanded for the delay in the report?
A. I don't believe so.

Q. Was he offered any further training for the delay in the report?
A. I can't recall.

Q. You heard the evidence that he had interviewed Zoe Duncan about her experiences shortly after it happened and asked her about what occurred whilst still in the hospital. Is that something you would expect to happen at your hospital?
A. No.

Q. And, were you made aware of that at the time?
A. Yes, I was.

Q. What was your reaction to that?
A. That it should not have been, Peter Renshaw interfering - Zoe.

Q. And did you indicate that to him?
A. Yes.

Q. Do you recall what you said to him?
A. No.

Q. Did you leave a reprimand for him?
A. I'm not quite sure what you mean by "reprimand" but --

Q. Was there any disciplinary impact on Mr Renshaw for those, what I understand you to say, breaches or failures?
A. No.

Q. Were they breaches or failures, in your view?
A. In my view?

Q. In your view?
A. 20 years later?

Q. Yes.
A. They were failures.

Q. Should there have been a reprimand?
A. Yes, in hindsight; that's in hindsight.

Q. I understand.

MS BENNETT: Commissioners, I have no further questions. Sorry, I do have one further question, I'm sorry.

Q. I'm sorry, Ms Stackhouse. I just wanted to know if there was any consideration of an apology to the Duncans at the time?
A. Not that I can recall, but I would like to give please --

Q. Please.
A. -- my sincere apologies and say I'm sorry for their loss today, and also, that the LGH collectively let the family down. It's very sad.

MS BENNETT: Thank you, Ms Stackhouse. Commissioners, I have no further questions.

COMMISSIONER BROMFIELD: I have no questions, thank you.

PRESIDENT NEAVE: Thank you, Ms Stackhouse.

MS BENNETT: Sorry, Commissioners, we're running slightly behind time, perhaps I could, at the risk of the stenographer's wrath, ask for a slightly shorter break to 3.30, would that be convenient?

PRESIDENT NEAVE: Yes, that's fine, thank you.

SHORT ADJOURNMENT

PRESIDENT NEAVE: Ms Norton.

MS NORTON: Thank you, Commissioners. I'd like to call our final witness for this afternoon, Mr Will Gordon, and I'll ask Will to come up to the witness box, please.

<WILLIAM EDWARD GORDON, affirmed and examined: [3.39pm]

<EXAMINATION BY MS NORTON:

MS NORTON: Q. Take a seat please, Mr Gordon. Can I just ask you to repeat for the transcript your full name and occupation?
A. My name is William Edward Gordon and I'm a nurse on 4K at the Children's Ward at Launceston General Hospital.

Q. Thank you. Mr Gordon, you swore a statement on 30 March this year; do you recall doing that?
A. I do, yes.

Q. And you have today made some changes to that statement.
A. I have.

Q. Is the copy of the statement that's in front of you the amended statement?
A. It is.

Q. A copy of the recently amended statement has been provided to the state in advance. Mr Gordon, is that amended statement true and correct to the best of your knowledge and belief?
A. It is.

Q. Thank you. You're a registered nurse, Mr Gordon?
A. I am, yes.

Q. But you started working at the LGH before you became a registered nurse, it was 2015 and you worked as a hospital aide; is that correct?
A. I did, yes, on the maternity ward.

Q. What sort of work does working as a hospital aide

involve?
A. I was also a ward clerk, so part of my role was to sort of create patient files on the babies that were born, I was changing beds and cleaning up rooms after deliveries, et cetera, so yeah.

Q. And, were you studying at the time you were working as a ward aide?
A. I was, yes.

Q. I might just ask, stenographer, is that sound okay?

You finished your studies and commenced working in the hospital as a nurse in 2016; is that correct?
A. Yes.

Q. Where did you initially work as a registered nurse?
A. In the day procedure unit.

Q. And in October 2016 you moved to Ward 4K?
A. That's correct.

Q. Had you also wanted to be a paediatric nurse?
A. After working at St Giles with the children I thought that's where I'd like to be, yes.

Q. And perhaps for the benefit of the Commissioners, could you just explain what St Giles is?
A. St Giles is an organisation which focuses on sort of special needs children but also adults as well, and my role at St Giles was, I was in the respite centre looking after special needs children, yeah.

Q. You began working on Ward 4K in 2016 and you continued to work in that ward currently; is that correct?
A. That's correct.

Q. How would you describe the culture on the ward when you started there in 2016?
A. Prior to starting there I was told by several nurses who knew I was going to work there to, "Watch out for the Nurse Unit Manager", and since starting there, originally I found it quite hard because I didn't really - it was a culture of tension, of high anxiety, of - yeah, there's a lot of nurses sort of constantly watching their backs, afraid to make any sort of error whatsoever. There was no trust at all amongst the nurses and the management of the

ward as well, and that sort of stayed - that culture stayed on, was present until - would have been until Sonja Leonard's removal in 2020.

Q. And that's the Nurse Unit Manager that you're referring to?
A. That's the Nurse Unit Manager, yes.

Q. So, you heard about that culture before you started on the ward and then was your experience on the ward consistent with what you'd heard?
A. There were occasions where, yes, it was consistent, yes.

Q. Was it a place where you and your colleagues felt comfortable speaking up about concerns?
A. No, not at all.

Q. And, why was that, Mr Gordon?
A. We felt like concerns wouldn't be made - wouldn't be heard or followed through. If we made concerns about certain people, in particular James Griffin, we - they would get brushed aside, we'd be told to, "Have you followed up with James himself?" And the nurses would not do that because they felt like they could not do that. Yeah, it was a culture of, if you spoke up there were reprisals for you; if you didn't obey what the Nurse Unit Manager wanted there were consequences as a result, whether it be career stagnation, yeah, it was very much a, "don't speak up, shut up, do your job, say yes", and hopefully get through another day.

Q. Would it be fair to describe the culture as one of fear among your colleagues?
A. Absolutely.

Q. I'd like to come shortly to some examples of some of the times when you or colleagues tried to speak up, but before I do, you've mentioned James Griffin. When did you start working with Mr Griffin on Ward 4K?
A. Would have been October 2016 when I first started.

Q. Whether you arrived. You didn't have any experience of him prior to that?
A. No.

Q. How would you describe Mr Griffin as a colleague and a

personality?
A. Prior to 2017, he was a man who was well-liked among the nurses on the ward, although many of them did find him slightly creepy at times with his actions or what he would say. He was about as tall as myself but he was quite a broad-shouldered man, he could cast an imposing figure when he was upset or frustrated about something; he could be quite intimidating at times, again, if he wanted to be, but generally he was fairly well-liked on the ward, and he would also try to create relationships with the parents of the patients.

Q. By the time you started in 2016 he'd been working on that ward for quite some time; is that correct?
A. I believe so, yes.

Q. You describe him in your statement, at about paragraph 4, as:

A bit of a hero and wanting to be the go-to guy.

A. Yes.

Q. Would you like to elaborate on that?
A. If there were ever - if there was ever a patient that, you know, was deteriorating or if as a junior nurse at the time, if I had ever a concern, he would always step in to, you know, try and be there to make sure this patient was okay. If there were codes on the ward or anything he would have to be at the forefront and centre of it. He had to be almost the centre of attention. Not socially, but more to prove his prowess as a registered nurse looking after these children.

Q. I think you describe him as having a reasonably large ego in your statement?
A. Yeah, yep.

Q. You've said that he was popular with a lot of his colleagues and with some parents of patients, but is it also fair to say that, despite that persona, you had concerns about his behaviour?
A. Sometimes he would say certain things which were, for lack of a better word, quite creepy and that sort of general old man creepiness sort of feel to it, but then certain actions that he did just heightened my suspicion of

him.

Q. You go to some examples in your statement. The first example at paragraph 5 of your statement involves a drug called Midazolam that was being administered to a patient who was 5 or 6 years old, would you like to tell the Commissioners what you overheard Mr Griffin say on that occasion?
A. So, Midazolam is a scheduled drug that requires two people to be present when it's actually administered to the child. When James and I checked out this drug we went to the child and the child's - both the child's parents were there, mum and dad - and James went up and said, "Now, this Midazolam, it's essentially the date rape drug, and the father sort of had a bit of a chuckle, the mum didn't say anything and I was like, "You shouldn't really be applying date rape medications to a child on a paediatric ward", and that is the first example of that and I have heard of a second example of those exact words from another nurse much later on.

Q. Did you do anything in response to that conversation at the time? You obviously were disturbed by it, did you act on your concerns?
A. No, I didn't, because I was quite junior at the time, and I did not have permanency on 4K and, in order to not upset the apple cart, I sort of didn't raise any concerns that I deemed were what I thought weren't minor but would cause tension between myself and the other staff members. I did want to stay there and I thought, if I mentioned - started throwing accusations about James Griffin the other staff members would not take too kindly to it.

Q. Mr Gordon, we've heard evidence from another - a former nurse on Ward 4K who, I think I'm getting this right, said that, in order to be promoted on Ward 4K, you needed to be a "yes" person?
A. Absolutely, and I'm going to go further: in order to be promoted in the THS you needed to be a "yes" person.

Q. And so, were you endeavouring in your early years as a registered nurse to be a "yes" person or at the very least not attract attention for being someone who spoke up?
A. I would not be a - I had limits on what I would say "yes " to, I still had a moral and ethical standard that I believed and that I would hold myself to, but I would not try to speak up and, like I said before, create rifts in

the ward at the time because, like I said, I didn't have permanency on that ward, I was under contract and very easily when my contract was up, if I applied again it could get rejected.

Q. Does the term "speak up culture" mean anything to you, Mr Gordon? Do you understand what that term means, a culture of speaking up?
A. Could you define it for me?

Q. Well, a culture where staff in a particular workplace feel comfortable speaking up about things that concern them. Would you describe Ward 4K as having a speak up culture?
A. Prior to 2020, it did not have a speak up culture, and those who did often it felt like had consequences towards them, and as a result in the four years I was there before the change of the Nurse Unit Manager I did not see many people speak up out of fear of consequences.

Q. You've made a reference now twice to an improvement in culture following the appointment of, is it the current Nurse Unit Manager?
A. So, the Nurse Unit Manager who replaced Sonja Leonard was one from the maternity ward who was an educator from the maternity ward and she has just recently moved on from that position, and it is very, very safe to say that the entire ward pretty much respected her. She took on our concerns, we could go to her with any issues whatsoever. If we did need to speak up about something, she would listen to us without fear of reprisal or anything, she was a complete 180 from the nurses we were used to - to the point that, when she first started it was reported that she was saying that - or she said to other nurses that the nurses were almost too scared to talk to her because they were afraid of - there was such a history of their previous Nurse Unit Manager that they were afraid to talk to her and, you know, she couldn't understand why. And then other nurses were like, "We're not used to this, we're not used to this kindness in general".

Q. And under that Nurse Unit Manager, did you feel able to speak up about your concerns without having regard to the implications that doing so might have on career progression?
A. Absolutely, yes.

Q. So you know what that feels like, that kind of a culture?
A. Yes.

Q. You refer to another example in your statement about a conversation you had with Mr Griffin in about August or September 2017 when you started dating your current partner. Would you like to tell the Commissioners about that conversation?
A. When I started dating my current partner we were talking about it just at the nurses station and James asked me whether she was still in school and it struck me as quite odd.

Q. Can you recall how old you were at the time, Mr Gordon?
A. How old I was?

Q. Yeah, at the time.
A. This was in 2017; I was 28, 29 years old at the time, yeah.

Q. And did that strike you as an unusual question to ask a 27 or 28-year-old man?
A. Absolutely.

Q. How did others on the ward react to Mr Griffin's behaviour? Was he inappropriate or did he have similar sorts of "creepy", to use your word, conversations with other colleagues of yours?
A. I'm not too sure about what other conversations she had with other nurses, but he would sometimes make generalised comments which were a bit inappropriate, but the one thing about James Griffin in this ward was that anything he did or said could be summed up by the phrase, "Jim is Jim", and if you made comments or if anyone commented about comments he made, it'd be, "Jim is Jim".

PRESIDENT NEAVE: Would you mind just speaking up a little and moving your microphone closer to you? Sorry, I missed the last bit.
A. Is that better?

Q. Yes, I think so, just speak up a little bit? Yes.

MS NORTON: Q. So, by that phrase, "Jim is Jim", did that convey to you that there was a general acceptance of

James Griffin's behaviour?
A. I wouldn't say "acceptance", but - because the nurses did find it, you know, quite odd or creepy at times, but it was - it almost felt like an excuse for his behaviour, not an acceptance. But if we reported it, it would be, "Jim is Jim. That's just who he is".

Q. Was there an acceptance by management of Jim's behaviour?
A. Yes, it felt like that, yes.

Q. I think you've already referred to this, but on occasions when you or colleagues did raise a concern regarding Mr Griffin's behaviour with management. I think you said that the response was, "Well, have you spoken to Mr Griffin about the issue?"
A. Yes, yes. I know of one nurse who James Griffin made a comment to her, she took it to Sonja Leonard, Sonja said, "Have you spoken to James about this?", and as far as I'm aware she has been the only nurse on the ward who actually did, and she no longer works on our ward; whether it's her own choice or Sonja's, I do not know, but she did raise it with him and I'm not sure of the response of that, but yeah, not many people did speak to James about his behaviour.

Q. And, did you feel confident speaking to him about his behaviour?
A. I only - in the first instance I witnessed his behaviour with the Midazolam: no. After I made the 2017 complaint against James, I never really got the chance to speak to him about it.

Q. We'll come to that now, Mr Gordon. Would you like to tell the Commissioners about a particularly concerning incident which occurred in August of 2017. Just to orient the Commissioners and you, you were as I understand it, supervising four adolescent girls who had eating disorders and you were supervising them having their dinner; is that correct?
A. Yes.

Q. Can you tell the Commissioners what happened on that occasion?
A. When I was supervising these four girls, it's a fairly open room with people walking by constantly, so I felt fairly safe to supervise them. After they finished their

dinner we had sort of supervising time and they were talking, and they were on Snapchat talking to, you know, teenage boys that they fancied at the time, and the topic of conversation - they were asking me about advice on how to talk to these boys. I said, "No, I'm not going to do that, it's, you know, it's a bit inappropriate, that's something you should talk to your parents about".

One of these patients then stated that, you know, "James gives us advice", I said, "James shouldn't be doing that, that's not his role". And she said, "James tells us everything. James told us of a woman downstairs that he calls Titsy because she's got massive tits and he wants to shag her because of her massive tits", and then she went further and said, "James tells us what boys like", and I shutdown the conversation fairly quickly then and we finished supervision and I left and immediately notified the in Charge Nurses on the ward at the time.

Q. Can I ask you, I want you to speak in more detail about the steps you took after this, but just going back to the content of that conversation, you said there was a reference to James giving them advice about what boys like. Are you able to tell the Commissioners what you understood that to be a reference to?
A. They did not give me any detail on acts per se, but the nature of the conversation and the way they were talking, the tone, some of the other - you know, the way they were talking about the subject matter, it felt highly sexual in nature and it felt sexual of the comments - it felt like the comments that James had made to them were sexual themselves.

Q. And is it fair to say you were quite disturbed by that conversation?
A. Definitely.

Q. You said you immediately spoke to some colleagues on the shift, and you talk in your statement at about paragraphs 10 and 12 - I don't need you to name the people that you spoke to, but is it correct that you spoke to your partner who was also working on the ward?
A. Yes. My partner nurse on the ward, the nurse in charge and the after-hours Nurse Unit Manager, I relayed my concerns to, yes.

Q. And what did they suggest individually or collectively

that you do in response to your concerns?
A. The after-hours Nurse Unit Manager suggested that I email Sonja Leonard.

Q. So that's the Nurse Unit Manager?
A. The Nurse Unit Manager, yes.

Q. You sent an email, I think it's the following day, 27 August, you sent an email to Ms Leonard?
A. I did, yes.

Q. You recounted the conversation that you'd overheard to Ms Leonard in that email?
A. Yes, I did.

Q. What response did you get from Ms Leonard?
A. I got a response asking me for more detail and, when I said I couldn't provide anymore because I've made a fairly detailed email at the start, I believe she said, "Do an SRLS on it", which I did, and then I did not hear a word about it since.

Q. I'm going to ask you more about the SRLS, I just want to go back to the content of the email that you sent. You said earlier that the conversation that you overheard was, in your mind, sexual in nature. Was the conversation as you described it in your email to Ms Leonard sexual in nature?
A. Yes, I believe so.

Q. The SRLS entry that you made, this is in the safety reporting and learning system; is that correct?
A. Yes.

Q. What process did you follow in taking what you put in your email and converting that into a report as requested by Ms Leonard?
A. So, with the Safety Reporting Learning System, I - it's a series of dropboxes and, you know, boxes you just have to type the incident in. I pretty much copied what I had - without copying and pasting I pretty much wrote exactly what had occurred on that day into the SRLS system.

Q. Just going back to the email, is it the case that, in the email which is an exhibit to your statement, you requested that your confidentiality be respected?
A. Yes.

Q. You then made the report in the SRLS, and this is on 29 August, I believe. You say in your statement that you took some photos of the SRLS report at the time you entered it or shortly after?
A. Not at the time I entered it.

Q. Right, when did you do it?
A. It would have been 2019, after the allegations against James Griffin were made.

Q. I see, so it was two years or thereabouts later?
A. It was.

Q. Why did you take photos at that point?
A. There was rumours about documentation around 4K prior to my being there, that documentation had been at one point shredded, altered, changed, deleted, forged, doctored, many, many things. My concern was in 2019 after the allegations of James Griffin, that my SRLS was altered or deleted, so I took photos of it just for my own back-up.

Q. I think you say in your statement that you do harbour concerns that your SRLS report may have been edited; is that the case?
A. I felt like it had, yes.

Q. And why did you feel that?
A. I felt like there was a line that was missing from my SRLS and I thought I'd type in one particular sentence, whether it was in the patient notes or the SRLS but I thought it was in the SRLS.

Q. And what was in that line?
A. "These comments were made in a sexual nature".

Q. And that comment doesn't appear in the SRLS report currently?
A. No, it doesn't.

Q. Out of fairness, Mr Gordon, I should tell you that on documents available to the Commission we have not been able to find evidence that there has been any substantive change to the content that you, or the report that you made in that SRLS. Do you have any response you'd like to make to that?
A. That's fine, but I felt like I - I wrote it down

somewhere whether it was in the patient notes, but I definitely felt like I wrote that particular line down somewhere; whether it was in the SRLS or in the patient notes.

Q. And I think you've said - I can't recall whether this is in your statement or in a complaint you subsequently made to the Integrity Commission which we'll shortly come to, but I think you expressed a concern that there were certain dates where the entry recorded edits of some kind. Is that correct?
A. Yeah. If you do a bit of digging around you can see people who have access - not really access, but had something to do with the SRLS; it doesn't really go into - because I'm a registered nurse and I don't have a higher access to the SRLS system, I can't see what changes were made, I can just see names of people who had something to do with it.

Q. Yes. And I think there was an entry in 2017 where there'd been access granted to another nurse, a project nurse whose name I won't mention - well, [redacted] who's provided a statement, and then there was a further entry some time in 2019. Does that sound --
A. That name does ring a bell, yes, I did see that name on there.

Q. And that's a concern that you've harboured for some time now going back to 2019 or thereabouts; is that correct?
A. Yes, because it felt like the report that I made had possibly been altered somehow, with the severity rating of it might have been downgraded or upgraded to suit the time, or, things were deleted et cetera, yeah.

Q. Now again, out of fairness, we've made inquiries of [redacted] and she's given a statement to the Commission that those changes in 2017, or the points at which she edited the entry were to provide access to a member of HR on one occasion and management on another occasion. Has that explanation ever been given to you by anyone from LGH?
A. No, and that's absolutely, like, you know, that nurse's role and, you know, access in the SRLS is absolutely fine; you know, like I said, I have no access to see what they can do, I can just see that they've done something to it, so yeah, I'm satisfied with that.

Q. Now you said that you made that report and you never got any feedback in response to that report. Did you expect to get feedback or that contact might be made with you to further understand your concerns?
A. Yes and no. I thought some feedback would have been quite nice to see what the result was, but I did not expect to see that. I would have liked some but I did not expect to see that.

Q. I guess it follows but I'll just ask you to confirm: you were never interviewed or asked by anyone who was looking into that report about the content of the conversation you'd had or that you'd overheard that night on 26 August?
A. No. The only - yeah, the only contribution I had to that report was my original email and the SRLS; nothing else after that.

Q. And, had someone asked you whether the content of that - whether you understood that conversation, the reference to conversations that had been had with Mr Griffin to be sexual in nature, what would you have said?
A. I said it would have been - it felt highly like it was sexual in nature, the tone and the way these young patients were discussing this content it did feel sexual in nature. And, going further on that, when I did discuss this incident with other nurses they'd say, "Oh, Jim is Jim", and I'd say, "Yes, but would you like James looking after your daughter?" And only one other actual person said, "Yes". Everyone else said, "Mmm, no, not really".

Q. Mr Griffin continued to work on Ward 4K following your 2017 SRLS report; is that correct?
A. For a brief period of time and then he left to the Ashley Detention Centre.

Q. Was that shortly after the report? Can you estimate how long after the report that was?
A. A couple of weeks, maybe a month or so, I really can't remember the dates I'm sorry.

Q. Were you told why he was moved to Ashley Youth Detention Centre at that time?
A. He told me himself. We heard that he was going to Ashley and I went up to him and I said, "I heard you're going to Ashley, how come you're leaving the ward?" And he

said, he looked at me in the eyes and he said, "There's no-one but fucking dibber-dobbers on this ward", and his tone of voice, his body language, that sort of standing tall, broadening the shoulders and staring me straight in the eye; I knew from that moment that he knew I made that report against him, and he - it almost felt like he wanted me to know that he knew as well.

Q. And this was despite the fact that you'd asked Ms Leonard for your identity as the person who'd made the complaint to be kept confidential?
A. Yes.

Q. I can indicate to you that documents available to the Commission confirm that Mr Griffin was told at the time the report was made that you had made the report. What response do you have in relation to that information?
A. I'm not surprised at --

Q. Do you regard - please, continue.
A. At all, I'm not surprised at all by that. There were - you know, the relationship between Sonja Leonard and James Griffin, you know, I'd heard James talk about his relationship with Sonja Leonard, I knew it of one of trust, James felt quite proud of that fact, and so, the fact that he - the fact that Sonja told him about this does not surprise me at all.

Q. What sort of impact does the - I suppose a resignation to the fact that you'd complained would get back to Mr Griffin, what sort of impact did that have on your confidence in speaking up about concerns on the ward?
A. I felt, because of the lack of feedback, closure, and then the fact that James was told about my submitting of the SRLS and the complaint against him, yeah, there was no confidence whatsoever anymore; it felt like there was no confidence in the process at all.

Q. Now you talk in your statement, at about paragraph 23, about some concerns you had in relation to Mr Griffin's conduct in relation to a particular patient. I don't need you to go into any detail about that patient, but is it fair to say that your concerns centred on Mr Griffin not observing the hospital Chaperone Policy?
A. Yeah, it felt like he was not obeying - not practising by a chaperone practice essentially, yes.

Q. Can I ask you this: does the hospital, does the LGH have a Chaperone Policy that you're aware of?
A. When I first started I was told about a chaperone practice by the nurse educator for the ward. I have not seen a paper copy of that policy at all. And, if I was going to look for one, I'd be able to find it in a matter of minutes, but I have never actually looked for it; yeah, I've never actually looked for it. I've never seen it, it's never been educated to us at all, it's sort of been as something, "This is what we do and that's how I've always done it".

Q. So do you mean by that you've never received training in relation to the Chaperone Policy?
A. No. So, our Chaperone Policy also extends to, if the patients are going up into theatre, if they're going down to x-ray or medical imaging I should say, or if they're going to a day procedure, if there's an attendant who's taking them there, you know, if the parent can't go, depending on, you know, whether the parent can go, the nurse should be going there with them as well for medical and other reasons as well.

Q. And in the absence of training or having looked at a policy put out by the hospital, how do you as a male nurse on a paediatric ward approach patient safety and chaperoning?
A. Okay. As a male on a paediatric ward, you need to realise that from the second I step into a patient's room I am already on the back foot compared to a female nurse, because I'm a male nurse. I am a male working with children. I have to try harder to gain the therapeutic trust of the parents. When I take a patient and, you know, I will ask the patient or the parent, you know, "Are you okay with me looking after you?" Some of them have said, "Well, no, not really". "That's absolutely cool, I understand that, that's fine, I'll get you a female nurse". Yes, it's - sorry, what was the question again?

Q. My question was, if you haven't received training or been schooled in a policy how do you approach chaperoning, do you have your own practices and how have you developed those?
A. Yeah. I do have my own practice of chaperoning from personal experience with St Giles. I try to always do something with - if I were going to do any sort of procedure or, say, change a nappy from a child whose

parents are not there I'll either, and I have done this numerous times, I'll pull in anyone from the student nurse, to the hospital cleaner or someone, just so someone's in the room with me.

If I've got to do an ECG on a teenage girl, I will give it to female nurses to do that unless, you know, it's like in the middle of a medical emergency; there's plenty of other people there and I've got no issues with that.

You know, certain patients who might have been affected by sexual abuse by a male perpetrator, I will, you know, tend not to take those patients out of respect for them, plus they wouldn't feel comfortable with me being in the room with them.

I've always tried to, you know, not put myself into a position where accusations could possibly be made against me because it takes one half-truth to potentially ruin my career, and I learnt that the very early on from, you know, prior - like I said, prior to working in 4K I worked at St Giles and, you know, the clients there would say stuff which, you know, could potentially end your career.

Q. Did you observe or did you hold concerns about Mr Griffin's lack of adherence to the sorts of chaperoning practices that you've referred to on one occasion or on multiple occasions?
A. On multiple occasions I had seen him just go into rooms and, you know, again, change nappies, give medications. He would carry some patients back from the bathroom, and the bathroom was a locked bathroom down the other end of the hallway, so, you know, it wasn't very visible at all. But there was one occasion in particular I saw him changing a young patient's nappy and that concerned me.

Q. You spoke, if I may say, with some emotion about what it's like to be a male nurse on a paediatric ward, and it sounds like you have your own robust practices around chaperoning. What sort of impact did it have on you to observe a colleague, James Griffin, not observing similar practices?
A. What James was doing at the time was, it felt, innocent because he was just changing a child's nappy. She was old enough to stand up and he was just pulling a pull-up on her, that was it. But it still sort of made my

hairs stand on end watching him do that, and this was - I literally saw, it would have been a second as I was walking past the room.

But subsequently as, you know, as a result of all the allegations being made against James later on down the track, I look at that - I replay that, you know, those two seconds, that two second memory, and I feel like that patient, without a shadow of a doubt, was a victim; purely because of the way that he would talk about her as well. The way he would talk to the family, the relationship he had with the parents. He would always try to look after this patient; even if he wasn't allocated, he was there. Yeah, without a doubt, I believe she was a victim.

Q. And you didn't raise concerns about that at the time?
A. No, because it was - there was no - I couldn't raise a concern about it, it was just changing a nappy, that was it. It was just me walking by seeing him pull up a nappy. There was nothing that could have been acted on, and considering the room he was doing it in was an observation room, so it had a big glass window, nurses could see into it. I can't remember whether the blind was up or down; yeah, it's a highly visible room yeah, but it's just, whether an incident happened there, I don't believe an incident happened at that time, but something - yeah, it could very well have been something happen then, yes.

COMMISSIONER BROMFIELD: Q. Mr Gordon, you're saying that, while it looked innocent, there was still something about - in that very moment there was something that you said made your hairs stand on end, so something alert - it's not just hindsight. I just wanted to check?
A. At the time, yeah, something really made my hair stand on end because it felt like - just purely because of the way he would be around this young child all the time, it did not feel right at the time, but I can't make a report on feelings alone, and that's the problem. So, yeah.

COMMISSIONER BROMFIELD: Thank you.

MS NORTON: Q. Mr Gordon, I'd like to move forward in time to August of 2019. You'd come back from leave, you'd been on leave for some time, and when you came back James Griffin was no longer working on Ward 4K, and we know now that that was because he was being investigated by police and he had been stood down at the end of July.

Would you like to speak in general terms about how management on Ward 4K handled that very delicate situation, and I'm referring here to the period where Mr Griffin was no longer working on the ward but was still alive?
A. There were rumours about James circulating but we weren't told anything about the reason why he was taken off the ward itself. We were eventually told by HR that some allegations had been made, but there was - still being investigated, but the culture of the ward was essentially, "Keep doing your jobs, don't speak and shut up".

Q. I imagine that at that time on the ward people had a range of different reactions to what they were coming to discover about a long-term colleague. Was it an unsettling and difficult time on the ward?
A. Absolutely. This was a man who had been working with these nurses for the better part of, you know, over a decade and a half for a lot of them, they were quite close to James. So these nurses, it was very obvious that they were grappling with the difficulty of a range of positive emotions with this man of a friendship and then these allegations that were horrific in nature and, you know, just trying to come to terms that, how could it be the same person? It was a very emotionally conflicting time for a lot of nurses on the ward.

Q. You say in your statement that there was a lack of transparency - I'm paraphrasing, tell me if I've got this wrong - but a lack of transparency in management's communications with staff on the ward about what was going on; is that an accurate description?
A. We were trying to keep it to the bare minimum of information that was being released to us. We eventually found out through one nurse was able to find out through external sources - actually, no, a couple of nurses were able to find out through external sources what James was accused of and what was happening externally from the THS in regards to James and, because it's nursing, these things are talked about and, yeah. So, the information we were receiving externally almost seemed more than what we were receiving internally.

Q. Mr Griffin died in about the third week of October in 2019, and you refer in your statement to an email that you received from the Nurse Unit Manager at around that time. You describe it as being very vague, it referred to "a

former employee having recently died" but didn't name Mr Griffin. There was an offer of support through a 1300 phone number, and also an instruction that the matter should not be discussed, and you were reminded of your ethical obligations and obligations under the Code of Conduct. What was your reaction to that email, Mr Gordon?
A. At the time it felt very - the fact that it didn't name James, it felt very almost cold-hearted as if "we don't care what you're feeling, you're here to do a job, don't talk about it amongst yourselves and support each other, just shut up and do your work".

Q. And is it for those reasons that in your statement you described it as the worst shift that you and many others had worked in your careers?
A. Yes, it felt like management were constantly trying to be around us to make sure that we weren't talking about it amongst ourselves or trying to offer each other any support at all. You know these are our colleagues, you know. I could see a couple of them hurting as, like, we can't even say, "Are you okay?", you know, it felt like we couldn't even go up and say that for fear of being reported back to management.

Q. Yes. What could management have done differently, that might have made that a less traumatic shift and indeed time on the ward?
A. The email itself could have been phrased a lot better. There were nurses who had not worked - so, I believe James died on the Friday, the email was sent on the Monday: there were nurses who had not worked all weekend who woke up to that email and, because of James's name not being mentioned, had no idea who it was about, this was the first that they'd heard about someone dying. They had to start messaging other people to find out whether it was James or not and how it happened. The email itself was - was a big one, you know - sorry: the email itself felt quite cold with lack of emotional support for the nurses, so that could have been changed, it might have been a start.

The handover at the very start of the morning, Sonja Leonard pretty much did the exact same thing, "Shut up, do your jobs, go out." No mention of, you know, support or anything, and then throughout the day the constant feeling like we have to watch our backs for fear of, you know, if we asked one of our colleagues, "Are you okay?", we'd be reported and then reprimanded as a result.

Q. Now, one of the things that you were advocating for on behalf of colleagues at the time was some kind of a group counselling or group debrief session; is that correct?
A. Yes.

Q. Now you sent an email to Dr Peter Renshaw on 12 November and you talk about this in paragraph 41 of your statement. As I understand it, Dr Renshaw had already had two meetings with staff which had been generally well received, and there was a third meeting scheduled for the next day, and in that email you requested that that meeting be used for a group debrief process. Is that correct?
A. Yes.

Q. And why was that important to you and colleagues?
A. Because we had not had one. We were - every time we requested one we were denied by senior management from Sonja Leonard all the way up to Eric Daniels. The ANMF were involved at this point, I believe, and they - requested from Eric Daniels as well. A group debrief would have helped the nurses to be able to console each other and talk amongst each other their, you know, conflicting emotions, their issues, their thoughts, their beliefs, everything - what had happened. Because we are a team on that ward, we were all feeling the same thing, a lot of us were feeling the same thing, and a group debrief would have been beneficial, and it wasn't just myself requesting it, it was many of the other nurses on that ward through the ANMF meetings - yeah, through ANMF meetings they were asking for the same thing.

Q. And I should foreshadow that we will be hearing from a representative of the ANMF later this week, so we'll hear more about that process. The meeting took place the following day; did the group debrief take place then?
A. No.

Q. What do you recall about that meeting?
A. Only certain parts of it now, because, you know, they're the parts that stuck out to me the most. One of the parts was that Peter Renshaw mentioned a similar case that had been made against another nurse on 4K, which none of us really knew about at the time, it happened in the early 90s, I believe. I didn't know the exact details - well, back then I didn't know the exact details, not many people knew the exact details, not many nurses on the ward

knew the exact details, sorry, to correct myself, so we didn't really look too far into that.

The other part was Peter Renshaw mentioned that he had gone through all the complaints made against James Griffin and all of them were minor. I asked him if he had seen my complaint against James, he said --

Q. This is your SRLS.
A. My SRLS. Yes. He said, no, he hadn't and I told him about it there and then. I phrased that he wanted to shag this woman because of this massive - et cetera.

Q. Titsy?
A. Titsy, and he stated, "I did not know about that". Jeanette Tonks stated, "Yes you did Peter?
A. He replied, "No, I didn't". She stated, "Yes, you did, Peter", he said, "No, I didn't". She said it one last time and then he changed the topic saying, "Well, you know, can you provide me with a reference number for this?" And because I had taken photos of the SRLS on my phone I was able to pull it up there and give him the reference number.

I then asked him, "Is this a minor incident?" And he said, "No, it's not". So, I was like, "Well, did you actually see it, did you read it?" It felt heavily implied by the contradicting statements of, you know, Jeanette Tonks and Peter Renshaw at the time that one of them wasn't being truthful and it felt heavily like it was Peter Renshaw who was not being truthful at the time.

Q. At the time. Now, in your statement you say that you asked Dr Renshaw at that meeting why the 2017 SRLS complaint had not been reported to AHPRA. Do you recall Dr Renshaw's response?
A. We were asking, you know, why Sonja had not - Sonja Leonard had not reported this to AHPRA, and I can't remember his response prior leading up to the next statement, but the next statement he said, "Well, if you're going to blame Sonja" and he pointed his finger and looked at my general direction, he said, "Why didn't you report him?" And that's when it truly hit me that this was dead in the water, the THS were not going to do anything about it.

It was pretty much passing the buck back to the nurses, and as we walked out of that meeting the nurses

were - some of the nurses mentioned to me they were quite angry and upset because now they felt like all of the incidences with James Griffin, no matter how minor they were, it was now because of them that this had happened.

Q. So, if somebody who had made that SRLS report in 2017 only to receive no feedback and it appears no disciplinary consequences apart from perhaps a move to Ashley for a short time, how did it feel to have the Executive Director of Medical Services point the finger at you and blame you for not reporting it when you had done what your manager had asked you to do?
A. Honestly, I felt amused at the time because that sealed the deal of every subsequent action I took to get this story out to the public: that was it, and I thought, "Well, that's on you now, Peter". It also felt quite personal as if, you know, it was my fault, and the big problem was, is that, he was actually right. Why didn't I? Because I didn't know I could report my own staff members to Working With Childrens. The majority of nurses on that ward, after hearing about this, didn't realise that they could report their colleagues to AHPRA, otherwise we might have done.

Q. And is that, again, because there was no policy or no training? How did you not know?
A. We just did not know, we weren't told about it, there was no education about that sort of complaint process.

Q. Now, you said that this meeting sealed the deal in terms of everything you did next. I'm conscious of the time, but you took some pretty significant steps following on from that meeting, I'd like to take you through them. The first is, you made a complaint to the Integrity Commission; that was November 2019. I don't need to go to the specifics of the allegations, but would it be accurate to summarise them as concerning the failure of past and present LGH management to respond to reports of inappropriate conduct by Mr Griffin?
A. Yes.

Q. And you were also concerned that documents might have been destroyed?
A. Yes.

Q. What did you hope might come out of that complaint?
A. It would be passing to the Secretary of Health,

Kathrine Morgan-Wicks.

Q. And, why did you want that to occur?
A. Because she, apart from Sarah Courtney, the Minister for Health at the time, they were the top bosses; they were the top level of management and, if she knew about it, you know, hopefully something could have been followed up upon. But, as long as she knew about it then, you know, there's no way to say, "Oh, I didn't know about it", when I have an email that states very clearly that she was notified.

Q. Did you have an expectation when you made that complaint that it would be investigated by the Integrity Commission?
A. I was hoping it would, but I did not expect it to because that submission to the Integrity Commission was highly emotive at the time and it was a lot of hearsay without facts, so I did not expect it to be investigated thoroughly but, like I said, the result I wanted I achieved: Kathrine Morgan-Wicks was aware of it.

Q. So, you received a letter from the Integrity Commission, I think it was about 10 days later, to say that it had been referred back to the Secretary, Ms Morgan-Wicks. Did Ms Morgan-Wicks or anyone on her behalf contact you in relation to your concerns?
A. I made that complaint under confidentiality, so no.

Q. I see. Were you aware that the person who was ultimately responsible for reviewing responses to complaints that had been made about Mr Griffin was an HR Manager, Mr James Bellinger?
A. I'd heard his name pop up through discussions with Emily Shepherd, the Secretary of the ANMF, but I was not aware of his actual - I was aware of his involvement but I wasn't, like, privy to what he was actually doing.

Q. Were some of your concerns - you talk, I think, in your letter about concerns about management's response; did that include the response of HR?
A. I can't remember the exact wording of the Integrity Commission report, but yes, I believe I was afraid HR would essentially try and sweep it under the rug.

Q. Did you have concerns about the fact that the complaint made to the Integrity Commission ultimately made its way back to somebody in HR which was at least one of

the units within the department?
A. I did, yes.

Q. Now, at this time you also wrote a letter to the Health Minister, Ms Sarah Courtney, Health Minister at the time; why did you take that step?
A. That would have been early 2020. I had engaged a lawyer in February, a lawyer who was recommended to me by another senior nurse in the hospital. He listened to my concerns and he said the best course of action was to draft a letter to the Secretary - sorry, not the Secretary, the Minister for Health, Sarah Courtney, to relay my concerns about the lack of action and about getting the story of James Griffin out into the public so it could be thoroughly investigated.

Q. Why was that so important to you, that it become publicly known?
A. We're not talking about some nurse giving a medication over to a child or something minor, we're talking about the sexual abuse of children in a paediatric ward under our watch, you know, we heard that, you know, one child, if I'm accurate here, one person who's actually been abused by James ended up losing her life as a result of his actions.

You know, this isn't a minor thing to be swept under the rug, this is the sexual abuse of children. At what point do we as healthcare workers, and this includes all levels of management, brush aside our ethics and morals to cover this sort of thing up? That's just frigging - like, despicable, it's deplorable. For the sake of our own reputations, our egos, our money, you know, finances or whatever, it's just - I just couldn't let that happen, so I pushed as far as I could to Sarah Courtney so that she knew this was happening and so that she could not say she did not know about it.

Q. You said that you requested anonymity when you wrote to the Integrity Commissioner, did you request anonymity when you wrote to Ms Courtney?
A. At the time, yes.

Q. And you received a letter ultimately from her again referring the matter to the Secretary, Ms Morgan-Wicks?
A. I did.

Q. I think the last step in this journey of escalating

complaints was, you went to the media. Would you like to tell the Commissioners about why you went to the media?
A. There were four potential journalists I could have gone to. One of them I hadn't spoken to for a number of years, so she was a no. The other one had quite strong ties to the Liberal Party and she had - you know, this journalist had already talked to a nurse on 4K and that went nowhere, so I didn't go to that journalist.

[redacted], and the fourth one was Camille Bianchi who was my old housemate in 2012, and so I went to Camille Bianchi.

Q. And the result of that approach was ultimately The Nurse podcast. Is it a coincidence that you went to an interstate journalist?
A. Yes, it was.

Q. Could this story, do you think, have been told by a local journalist in the way it has been?
A. Now I, after seeing some of the journalists now, like Emily Baker, possibly. I didn't know of these other journalists at the time, I went to someone who I knew and that was Camille, and I knew that she had worked at Southern Cross previously, she knew the state, she knew the system of the THS from reporting back in 2012, and the fact that she was interstate meant she wouldn't be completely hampered by, you know, what happens in Tasmania.

Q. Following the release of the nurse podcast in October 2020 there were two meetings that you talk about in your statement that were attended by Ms Kathrine Morgan-Wicks and, I believe, one other person on behalf of the department. What would you like to tell the Commissioners about those meetings?
A. On the first meeting which happened probably a day or two after the podcast was released, the ANMF was hosting a meeting, a big group debrief with nurses among the ward, and Katherine Morgan-Wicks, Sonja Leonard, and the Acting Director of WACS, [redacted] were present. There was someone else who was there but I did not know who they were.

I stated to Kathrine Morgan-Wicks that, you know, it was pretty deplorable that we had to go to a media - we had to go to a journalist to get this story out to the public,

when it should have been either through HR or the THS's media personnel themselves. And I stated my concerns to Kathrine, Kathrine stated twice on that day, she said, "If I knew about it", you know, to suggest, "I would have done something about it". The thing is, I actually knew she knew about it because I had a letter from the Integrity Commission and Sarah Courtney saying that she knew about it.

The second time I had a meeting with Kathrine Morgan-Wicks was in the auditorium that, I think - I believe the day before the Commission was actually announced, and it was the day Kathrine told us that Sonja Leonard had been moved aside from her role as the Nurse Unit Manager. Again, during that meeting the THS had already launched their own internal investigation; I stated that this was not appropriate, that it should be - at the time I didn't know what it was - a Royal Commission.

Kathrine asked me, what would a Royal Commission - you know, why would we need a Royal Commission if we have our own internal investigation?" And, I said, "The Royal Commission can compel witnesses to come forward, you know, under threat of prosecution and under oath to actually come up and give evidence at the hearings and the internal investigation doesn't do that". She then didn't talk about that subject anymore, she wanted - it felt like she wanted to avoid any further subject of a Royal Commission or a Commission of Inquiry.

Then later on down she again stated the words, "If I knew about this", you know, "something would have been done", and again, I knew that she knew and I went down to her afterwards and I stated, "I'm the person who put in the Integrity Commission report, and so, I know that you knew". So, yeah.

Q. Out of fairness I'd like to ask you this question, Mr Gordon. The statement that you've referred to Ms Morgan-Wicks making on a few occasions that, had she known about the situation, she would have followed up; it strikes me that that comment is open to potentially two different meanings: that is, on the one hand had she known about the complaints at the time they were made she might have followed up or done things differently, or alternatively, had she known about the situation after Mr Griffin's death she would have followed up. You can't

speak to what she meant, but what did you understand her to mean?
A. Considering the nature of the Integrity Commission report I made and the nature of the letter that his lawyer had written on my behalf to Sarah Courtney, there was no doubt in my mind it was about the allegations of James Griffin on 4K.

Q. Before we close I'd like to ask you about the impact that these events have had on you. I'd like to invite you to speak to the Commissioners about the personal impact and also the professional impact that they've had.
A. During the whole process from 2019 until the Commission of Inquiry being announced, I felt as if my career, my job, was potentially able to be sort of thrown away in a heartbeat. I have had to sacrifice mental, social, physical health in order to pursue this to get to the result where we are now.

I have had during a meeting with Sonja Leonard post a job interview to gain more hours of permanency on the ward, Sonja Leonard's - just briefly, Sonja told one of the other nurses who applied but did not get the job that it was based on merit, and further discussion of that's in my statement. But then, when I had this meeting with Sonja she stated - there was no discussion of my job, my job application or the interview process, she stated that, "We did not have a good working relationship". And I stated, "Why is that?", and she said, "You went to the ANMF about the James Griffin thing instead of going to managers". I said, "Well, we can't really go to the managers when the managers are the problem". And a little bit further into the conversation she said, "Well, James would come to me with these concerns", and I was thinking, "Well, James is the last person I want to emulate at this point in time".

My biggest concern now though, speaking publicly, is that my family are now at risk for their careers as well. My entire family is in Health; literally my parents were and still are, their partners, my siblings, my partner, are all in the THS. Because at the time it felt like I did not get a position - like, I did not get an increase of permanency hours because of my involvement with the James Griffin thing, with the James Griffin situation, I feel like THS, although they may not be able to directly let me go as a result of my actions, for whatever little reason I do something, you know, that may not be 100 per cent

accurate or 100 per cent on point, they'll let me go.

Essentially, I now need to keep a diary of every single colleague I now work with. If the THS comes to me and said, "You did not do this", I need to be able to say, "Well, such and such did not do the same thing on the same date, why are you targeting me?"

I'm afraid that my partner, who has wanted to be a nurse since she knew what it was, her career will - is now sort of dead in the water as a result of this; that they will not hire her purely because of her relationship with me.

I'm afraid that my younger brother, who is now a doctor in the emergency department, I'm afraid that he, when he has to leave the state and then come back for his training, will not be able to get a job in the only hospital in the city that he was born, went to school, grew up in, he would not be able to work here if he wanted to come back because - he looks exactly like me for starters - and he's my brother, and this is now my fear as a result of that.

And, although Kathrine Morgan-Wicks released a document saying that family members wouldn't be targeted: I'm sorry, it's a load of crap, it's not worth the paper it's printed on. Because all they have to do, according to Sonja Leonard, is to just say "It was based on merit", that's all they have to do.

And then, if you want to take that further you then go into the Industrial Commission, which has its own set of problems as well, if you want to pursue, you know, a job claim. So, this is part of the reason that, you know, I am concerned of - like, this is the sort of fear I now have to live with as a result of my actions here today and the repercussions from the THS themselves towards my family.

Q. Mr Gordon, I have just one final question. The answer you've just given indicates very strongly the personal and professional toll that your pursuit of this matter has had on you. What personal factors have driven you to pursue these matters as vigorously as you have?
A. Someone very close to me asked me, "Why are you doing this, it's not your child?" And my response was, "But what if it was? What if it was my child, something happened,

people knew about it, and it wasn't reported on? And then, what happens if, God forbid, my child ended up killing themselves as a result of sexual abuse, and people knew about it and nothing was done? I would not want that on my conscience."

You know, the problem as well is that, being Tasmania, it feels heavily ingrained into the response of the politics as well about this, is that, no-one cares at all about these kids who are abused, we don't care. We see their articles in the paper, online, in the media, everything, thank God it's not my children, it's someone else.

The problem is that everyone is someone else to someone else. So, it may not be your child, but it might be your daughter's girlfriend, it might be your son's footy team mate, it could be anyone indirectly involved with your children, it could be anyone at all. And the fact that we are so readily available to cover it up from what should be one of the three safest places in Tasmania for children, apart from the Royal Hobart Hospital, us, and the North West, is astounding to me.

Morally and ethically I don't know how people can do that, so that was my driving factor. As well as, how could my children come up to me and say, "Dad, I need to talk to you about something, something's happened to me", if they know that, given the opportunity to do something about it when presented with it, in regards to James Griffin, I did nothing? Sorry, that's just not the sort of person who I am.

MS NORTON: Thank you, Mr Gordon. No further questions, Commissioners.

COMMISSIONER BENJAMIN: Q. Yes, I have one question. You've shown fairly deep insights into how the hospital system operated in the past, perhaps operates now; you've shown compassion in terms of your service as a nurse. What insights can you offer us as to what could change from your perspective to bring about a change back to the young man that went into that ward in November or October 2016?
A. A lot more education surrounding this sort of - you know, about the complaints processes and mandatory reporting. We started having some education through a group - I believe they're called Aardvark. They had taught

us, you know, what child abusers, some of the tactics they use to groom patients and families and stuff like this, things like that so we could be aware of these processes and how these people work. Visual: like, the ward - after the rebuild the ward, certainly aspects of it are a lot more visual but some aspects aren't. It would still be quite easy to do something on that ward.

Q. What about engaging with people such as you?
A. Such as me? Could you elaborate, please?

Q. The evidence you've given was that you've been isolated as a whistleblower, essentially; is that essentially what you're saying? Not isolated but minimised. Would it be better if the system engaged with you and learned from you?
A. Yeah, I believe because of all my experiences, yeah, it would help me if the THS was able to work with the nurses so we wouldn't have to go this far and I wouldn't have to, you know, pursue the path I did, what felt like alone at the time until Camille was involved. It felt like every avenue to get this out to the public, we were stonewalled by management of the THS. If they worked with the nurses, furthermore if they listened to the nurse's a bit more, things could have been a lot more different as well. So, yeah.

COMMISSIONER BENJAMIN: Thank you.

MR GORDON: Thank you.

COMMISSIONER BROMFIELD: I don't have any questions, Mr Gordon, but I was reflecting as you were speaking that we often say in this field that "protecting children is everyone's business"; you've certainly made it your business and I wanted to thank you for that.

MR GORDON: Thank you.

PRESIDENT NEAVE: Thank you very much Mr Gordon, your evidence has been really compelling and we are very grateful to you for having come forward at risk to yourself and your family to tell us your story.

So, thank you very much indeed and thank you for all the efforts you have made to protect children in Tasmania. Thank you.

AT 4.57PM THE COMMISSION WAS ADJOURNED TO TUESDAY, 28 JUNE 2022 AT 10.00AM