Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

WITNESS STATEMENT OF CATHERINE EMMA TURNBULL

I, Catherine Emma Turnbull of [redacted], in the State of South Australia, Chief Child Protection Officer, SA Health Department for Health and Wellbeing, do solemnly and sincerely declare that:

1. I am authorised by SA Health, Department for Health and Wellbeing, to make this statement on its behalf.

2. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Background and qualifications

3. I am currently employed by the Department for Health and Wellbeing (**DHW**), which is also known as SA Health, in the position of Chief Child Protection Officer. I commenced in this role in May 2021.

4. Prior to commencing this role, I worked in the following roles at the following organisations:

   (a) Chief Allied and Scientific Health Officer, SA Health, 2009 to 2021;

   (b) SA Health Education Lead, SA Health, 2017 to 2021;

   (c) Transforming Health Education Lead, Department for Health and Ageing, SA Health, 2015 to 2017;

   (d) Manager ClinEdSA and Better Placed, SA Health, 2013 to 2015;

   (e) International Recruitment for Health Professionals, SA Health, September 2008 to February 2009;

   (f) Acting Director Safety and Quality, SA Health, June 2008 to September 2008;

   (g) Acting Director Clinical Systems, SA Health, July 2007 to September 2008;

   (h) Principal Allied Health Advisor, SA Health, October 2006 to March 2009;

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(i) Deputy Executive Director Allied Health, Sydney South West Area Health Service, 2006;

(j) Director Social Work (with reports including the Physical Abuse and Neglect of Children Service and the Forensic Medicine Counselling Service), Central Sydney Area Health Service and then including Sydney South West Area Health Service, 2000 to 2006;

(k) Head of Department of Social Work (with reports including Manager, Child Protection Unit), the New Children's Hospital Westmead, 1997-2000;

(l) Deputy Head of Department of Social Work (with reports including Manager, Child Protection Unit), Camperdown Children's Hospital, 1995 to 1997;

(m) Team Leader, Paediatric Social Work Team, Westmead Hospital, 1993 to 1995; and

(n) Social Worker – Paediatric Unit, Westmead Hospital, 1991 to 1993.

5. I have the following qualifications:

(a) Bachelor of Social Work, University of Sydney, 1986 to 1991;

(b) Post Graduate Certificate in Public Sector Management, Flinders University, 2003;

(c) Executive Masters in Public Administration, Sydney and Monash Universities, 2007; and

(d) Office of the Commissioner for Public Sector Employment Executive Leaders Program, South Australia, 2021.

6. Attached to this statement marked **CET-1** is a copy of my curriculum vitae.

Current Role - Overview

7. In my current role as Chief Child Protection Officer, I am responsible for leading the governance, models of care and practice reforms occurring in child protection services across SA Health. I report to the Acting Chief Executive of DHW [redacted] through the Deputy Chief Executive (System Leadership & Design), [redacted]

[redacted]

8. My role sits within the Child Protection & Policy Unit of DHW. This falls under the System Leadership & Design division. This role was created in 2021 in response to the ZED Management Consulting's report on the SA Health Child Protection Services. **Attachment CET-2** is an extract of the Executive Summary of this report.

9. As part of my role:

   (a) I am engaged in active consultation with clinicians, consumers, government and non-government agencies, professional associations and registration boards and key stakeholders such as the Commissioner for Children and Young People, the Guardian for Children and Young People in Care and the Commissioner for Aboriginal Children and Young People in South Australia.

   (b) I consider and address the strategic needs, issues and recommendations raised during consultations, to ensure SA Health is implementing a robust, best practice child safeguarding model.

   (c) My focus is on ensuring we can effectively prevent, identify, address and report alleged child abuse and neglect arising in the health context. This includes all types of child abuse and neglect which may present to emergency departments or other health services.

10. My previous role as Chief Allied and Scientific Health Officer also focused on identifying and managing policies to prevent offences being perpetrated against children and young people while receiving care from health professionals.

11. Some of my prior roles have included managing staff who had allegedly committed inappropriate professional conduct or offences against children or young people.

12. In my statement, when I refer to a "child" or "children" I am referring to persons under the age of 12, and when I refer to "young people" I am referring to persons aged between 13 and 18 years of age.

SA Health's approach to consent for children and young people

13. I am advised by SA Health's Legal and Legislative Policy unit that in South Australia, consent to medical treatment is codified in the *Consent to Medical*

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Treatment and Palliative Care Act 1995 (SA) (**Consent Act**). SA Health's approach to consent for children and young people complies with these legislative requirements.

14. Section 12 of the Consent Act deals with the administration of medical treatment "children" – that is, persons under 16 years of age. A parent or guardian of a patient under 16 can provide consent to medical treatment.

15. However, the Consent Act also provides that a patient under 16 can provide his or her own consent if the medical practitioner is of the opinion that they understand the nature, consequences, and risks of the proposed treatment. This opinion must be supported by the written opinion of at least one other medical practitioner who has personally examined the patient.

16. In the case of emergency treatment, section 13(5) of the Consent Act states that if the parent or guardian of the patient is available, consent must be sought. If the parent or guardian refuses consent or is not available, but the treatment is deemed to be in the best interests of the patient's health and wellbeing, then a medical practitioner may administer the treatment, despite the refusal or absence of the parent or guardian. This opinion must be supported by the opinion of at least one other medical practitioner who personally examines the patient before the treatment commences.

17. SA Health has published the "Consent to Medical Treatment and Health Care Policy Guideline" which provides guidance on obtaining consent for the provision of medical, surgical and dental treatments and other related medical practices. **Attachment CET-3** is a copy of this document.

Risks faced by children in hospital settings

18. Children and young people may be at risk of abuse or neglect perpetrated by adult patients, visitors, health practitioners or other children and young people in hospital settings. By "child abuse" I mean exposure to physical, sexual, or emotional abuse or neglect. This may result in psychological and/or physical injury.

19. My experience at Westmead Hospital. the new Children's Hospital Westmead, Royal Prince Alfred Hospital, Camperdown, Canterbury Hospital and within SA

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Health has assisted me in identifying the following features which may make children or young people more vulnerable in a hospital setting.

Individual room formats

20. If a child is placed in an individual room on the ward and there is no CCTV camera in the room, the child may be left alone for periods of time unsupervised. Nurses are required to work on wards, which may comprise of 23 to 25 single rooms. This means that the nurses cannot monitor all the rooms at one time.

21. Subject to appropriate consent measures, visible cameras may reduce this risk by deterring prospective offenders and enabling ongoing monitoring. In various hospitals where I have worked, visible cameras have been used to enable staff to monitor patients in rooms that are not close to the nurse's station.

Group room formats

22. Where there are multiple bed bays in a room, thought needs to be given to the age and mix of children. At SA Health, children are grouped in particular ages, such as neonates or adolescents. These procedures are addressed in the SA Health's Same Gender Accommodation Policy Directive. A copy of this policy directive is attached to this statement marked **CET-4**.

Mixed wards of children and adults

23. In the early 2000s, NSW Health directed that mixed wards of adults and children should not be permitted because of the risk to child safety.

24. In South Australia, if a young person is placed in an adult ward they are kept separate from adult patients and monitored. The room may have 24-hour CCTV monitoring depending on the level of care required (e.g. intensive care). These cameras function as a protective mechanism as their presence should be very obvious on entry to the room. A one-on-one nurse is able to be allocated to stay with the child or young person, subject to appropriate risk assessments. Attached to this statement marked **CET-5** is a copy of the Children and Adolescents in Adult Health Services Guideline.

Practice of staff working solo on a ward

25. Healthcare practitioners may at times attend to children or young people alone in their room. Children or young people may be more vulnerable to abuse

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where professionals routinely attend to patients or clients on their own. It is important that children or young people feel comfortable, and this may involve a parent, carer or support person attending or staying with the child or young person. Where this is not possible, the staff should ensure that there is either regular or constant monitoring of the child or young person, with strategies such as observational supervision of practitioners attending to children or team-based approaches to care.

26. The most important aspect of health care is observational supervision or team care. This is where a professional sees a client and has either a team member attend with them or has team members who may enter the room to assist from time to time or can observe the treatment session, either in person in the room or through a one-way mirror. It is important that the team-based approach is evident on the ward or within the service.

27. I have dealt with cases in NSW and SA where health professionals have allegedly perpetrated abuse in circumstances where there was no team-based care or regular monitoring of the situation.

Gender concordance of treating health professional

28. It is not always possible to accommodate a client's preference as to the gender of the health professional performing the medical procedure. Sometimes the care that is required by the client is only available from a specialist of a particular gender.

29. For these reasons, offering gender choice, even for intimate medical procedures, is not something I would not recommend generally. I acknowledge that this can be difficult for some clients, but there are ways to work through this with them. At the Women's and Children's Health Network (**WCHN**), which is South Australia's leading provider of health services for children, young people and women, chaperones are always offered to patients during intimate procedures, including when there is gender concordance. Attached to this statement marked **CET-6** is a copy of the WCHN Clinical Procedure on Chaperone use in Paediatric and Young Person Services approved on 18 February 2019.

[redacted]

30. Each Local Health Network (**LHN**) has its own procedures regarding the use of chaperones. The standard process is to offer chaperones where more than one gender is present for an intimate medical examination or procedure.

Length of visit and level of familiarity between child and practitioners

31. When thinking through the risk to children, it is vital to consider the length of time the child has been or will be in hospital, and whether the child attends regularly. If the child is in hospital for less than 24 hours, they are generally considered less at risk as they would usually have a carer with them for this short period and there would likely be a team of staff attending to the child if it was an emergency.

32. If a child is in hospital for a longer period of time, the risk may be elevated because the child will become well known on the ward and may develop trusted relationships with staff members. They may be in a room by themselves for longer periods without family or carers present. This may increase their vulnerability to grooming by an adult, or inappropriate sexualised behaviour from another patient. The same risks may arise if a child or young person regularly comes in and out of hospital for treatment of a condition, such as uncontrolled asthma, chemotherapy, or mental health concerns and becomes well known to staff members by virtue of this.

Psychosocial characteristics of children hospitalised repeatedly or for long periods

33. In addition, all hospital patients, whether children, young people or adults, are vulnerable. Someone may be highly competent in their regular life, but in a hospital bed, in a hospital gown, they can suddenly become very disempowered. Being required to spend long periods of time lying flat on your back, and being reliant on others for food, toileting, and pain relief, can produce feelings of dependency.

34. For this reason, hospitals work very hard to get patients up and out of bed as soon as possible. We see better psychological outcomes for patients where we can encourage them to spend time upright and moving around.

35. For example, children who spend an extended period (e.g. 12 weeks) in traction often become depressed and introverted. Once these patients are upright and mobile (which may take longer for some than others, depending on

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their injury), their confidence and sociability tends to improve fairly quickly from that point but it is also dependent upon their adjustment to long term injuries.

36. This dynamic is important to understand as it goes directly to whether a child or young person who experiences sexual abuse in a hospital setting would feel able to make a disclosure or seek support. Less mobile patients may feel or be disempowered and unable to voice what has occurred.

37. Where the alleged perpetrator is the healthcare professional responsible for administering the patient's pain relief, the situation becomes even more complex given the clear power dynamic that exists. Children or young people might become afraid of speaking up, believing the practitioner may refuse to administer them pain relief.

38. In terms of acting on this awareness, at SA Health we have implemented a number of policy directives and guidelines which discuss the need to listen to children and young people, and to ensure that children and young people know they have rights and are able to speak up. For example:

(a) the Child Safe Environments (Child Protection) Policy Directive (**Child Safe Environments Directive**) requires all staff to encourage and respect the views of children and young people who access our services by listening to and acting upon any concerns that they raise with us and proactively ensuring children and young people know their rights and have access to the complaints process. Attached to this statement marked **CET-7** is a copy of the Child Safe Environments Directive; and

(b) the Responding to Suspected or Alleged Offences against a Child or Young Person Occurring at a SA Health Facility or Service Policy Guideline (**Child Offence Response Guideline**) recognises the importance of give an effective voice to children and young people in healthcare settings, having regard to their vulnerabilities and potential feelings of disempowerment. Attached to this statement marked **CET-8** is a copy of the Child Offence Response Guideline.

Adult services

39. Adult services sometimes need to ask questions about children and young people in the presenting adult's household or family, particularly where adults

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are seeking mental health, drug and alcohol or emergency services. This is necessary to ensure that someone is caring for the children if they are left at home while the adult is seeking medical care and also to assess the level of risk that the child is living with day to day.

CREATING A CHILD SAFE ENVIRONMENT

40. An institution's effectiveness in responding to complaints raised by or on behalf of children and young people hinges on the creation of a child safe environment.

41. Essential features of a child safe environment include:

(a) credentialing and supervision of health professionals;

(b) awareness and training around conflicts of interest;

(c) child safeguarding and mandatory reporting policy initiatives;

(d) audits;

(e) training and support for staff and volunteers to recognise, report and respond to children or young people who may be at risk of harm;

(f) protective steps in one-to-one interactions;

(g) a robust complaints mechanism; and

(h) strong leadership and culture.

42. Each of these features are discussed in more detail below.

Credentials and supervision

43. A key component to the safeguarding of children and young people and the provision of quality healthcare is ensuring all practitioners are appropriately credentialed and supervised.

44. In my experience, where a practitioner is resistant to supervision, issues of potential unethical practice are often uncovered. Incorporating appropriate credentialing and supervision requirements may assist in preventing and detecting unethical practice early and reducing the exposure of children and young people to risk.

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45. In my previous position as Chief Allied and Scientific Health Officer between 2006 and 2021, I introduced state-wide policy directives and guidelines focussed on ensuring appropriate credentialing and supervision for allied and scientific health professionals. The corresponding directives and guidelines were already in place for medical and dental practitioners.

46. Copies of the current policy directives and guidelines relating to credentialing and supervision are attached to this statement and marked as follows:

(a) **CET-9:** "Credentialing for Allied & Scientific Health Professionals Policy Directive" dated 21 February 2020;

(b) **CET-10:** "Credentialing and Defining the Scope of Clinical Practice for Medical and Dental Practitioners Policy Directive" (DO208) dated 6 August 2018;

(c) **CET-11:** "Credentialing and Defining the Scope of Clinical Practice for Medical and Dental Practitioners Policy Guideline" (GO190) dated 6 August 2018;

(d) **CET-12**: "Health Practitioner Registration – Recording and Ongoing Verification";

(e) **CET-13:** "Criminal and Relevant History Screening" dated 12 July 2021; and

(f) **CET-14:** "Registration of Health Practitioner - Recording and Monitoring Policy Directive" last updated in 8 January 2014.

47. These policies, which are reviewed every 1 to 5 years, were established in response to serious negligence cases such as *R v Patel* [2012] QSCPR 6, which concerned a doctor who was charged with manslaughter, grievous bodily harm, negligence and fraud in respect of surgeries performed on patients.

48. The above policies apply to all professionals irrespective of employment status, and covers registered, self-regulated or unregulated professions. Examples of professions within each category are:

(a) **registered professions**, being professions required to register through the relevant National Board of Australian Health Practitioner Regulation Agency (**AHPRA**), such as medical practitioners, dentists, dental therapists, medical radiation professionals, occupational

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therapists, psychologists, podiatrists, physiotherapists, optometrists and pharmacists;

(b) **self-regulated professions**, being professions where individuals will be eligible for membership with their respective professional association following completion of a minimum standard of accredited training, such as audiologists, dieticians and nutritionists, orthoptists, social workers and speech pathologists; and

(c) **unregulated professions**, being any profession that is not registered or self-regulated but provides allied health-related clinical services, such as naturopaths, Bowen therapists and complementary health practitioners or maybe an emerging new profession such as cardiac perfusionists.

Credentials

49. The credentialing policy directives and guidelines require staff members to provide a range of documentation at the time of their appointment, which is then reviewed at least every three years. Such documentation includes:

    (a) evidence of tertiary qualifications;

    (b) National Police Clearance;

    (c) Working With Children Check;

    (d) evidence of their registration with AHPRA or eligibility for membership with the relevant Professional Association;

    (e) most recent performance review and development plan; and

    (f) evidence of fulfilment of Continuing Professional Development requirements.

50. The intervals for credential reviews during employment are determined based on a risk assessment. For example, those working independently in regional areas will be required to undergo checks more frequently (and may be subject to annual credential reviews), compared to those working in large hospitals where there is plenty of observed practice and incidental observational supervision.

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51. Referee checks are undertaken on appointment as per human resource policy and procedures. It is always important to speak with the previous direct line manager of the applicant and also to check that they don't have a conflict of interest in giving a referee report.

52. Non-clinical staff have to follow the relevant LHN policies for their workplace in relation to pre-employment checks, such as police checks or Working With Children Checks.

53. Continuing Professional Development is legally required for practitioners in registered and self-regulated professions. However, SA Health requires this of all of its practitioners, including those in unregulated professions.

54. SA Health reviews the content of a practitioner's Continuing Professional Development plan and modules to ensure that they are completing ongoing training in the practice areas relevant to the clinical work they perform for SA Health.

Supervision

55. Another key component of the credentialing policies is that they require practitioners to participate in supervised practice. Clinical supervision is a formal process of professional support and learning, focussed on facilitating a proactive and reflective approach to clinical practice. Individuals work with a nominated clinical supervisor, who will develop and implement a supervision plan including:

    (a) periods of observed clinical practice;

    (b) reflective practice and mentoring discussions, focussed on provision of regular and specific feedback to reinforce learning; and

    (c) workshops and opportunities for skill development, focussed on promoting evidence-based practice.

56. The SA Health Allied Health Clinical Supervision Framework dated March 2014 also contains specific supervision requirements for allied health professionals. Attached to this statement marked **CET-15** is a copy of this framework.

57. Since the implementation of the credentialing and supervision policies during my time as Chief Allied and Scientific Health Officer, I received fewer reports of alleged incidents involving staff and patients. For me, this reduction in reports

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suggests that there were a number of professionals within the system who have improved their clinical practice as a result of increased supervision.

58. Some practitioners have resigned since the supervised practice requirement came into place. The introduction of stringent observation and supervision requirements has the potential to weed out practitioners who know they are contravening applicable ethics codes and professional requirements and do not welcome increased scrutiny. For example, a social worker employed by SA Health resigned following the implementation of this requirement because that social worker admitted to having a relationship with an adult client.

59. Similar credential and supervision policies were in place in NSW during my time working in that jurisdiction. As a result of these policies it was standard practice in NSW that all staff would be required to obtain a Working with Children Check, National Police Clearance, and engage in regular supervision and performance reviews. I am aware that a social worker in NSW, who was alleged to have been in a relationship with a young person in the emergency department at two different hospitals, resigned from their employment after the introduction of supervision requirements.

60. Supervision requirements are also treated as a key aspect of reflective practice. Reflective practice is a strategy endorsed by AHPRA and the registration boards of Professional Associations as best practice for practitioners. It is focussed on engaging in planned, deliberate self-reflection and self-appraisal. Practitioners review challenging situations and assess the following:

(a) Description – what happened?

(b) Insight – what were you thinking and feeling?

(c) Evaluation – what was good and/or bad about the experience?

(d) Analysis – what sense can you make of the situation?

(e) Conclusion – what could you have done differently?

(f) Action plan – what will you do differently next time?

61. Engaging in this process can assist practitioners in creating a logical order to thoughts and feelings related to working with other staff and with patients. It can also help practitioners and their clinical supervisors to identify learning

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needs and areas where skill development is required. These also tie in processes to assist in recovery from trauma among health professionals.

Conflict of interest in smaller professional communities

62. In South Australia, the professional community is smaller and a lot of practitioners are known to one another. This means that if a professional conduct or malpractice issue arises, people may be more hesitant to address or report the problem because there are interpersonal consequences which make the situation more complicated for the individuals involved. This also means that when practitioners are interviewed for roles, they are often already known to members of the interview panel. This has the potential to result in complacency when assessing the practitioner's background credentials – interviewers may assume they know an applicant's character, and not carry out background and credentials checks properly.

63. It is therefore important that HR undertake random audits to ensure that processes have been followed. It is also important for all interview panel members to undertake training prior to being on the panel and then annual refresher training on interviewing applicants and conducting credential checks.

Training provided to staff regarding child safety

64. The above policies are accompanied by internal training programs that seek to equip practitioners to view the clinical practice and behaviour of other professionals through a child safety lens.

65. The WCHN has a Workforce Development Framework to guide the provision of appropriate learning and development to support health care staff, volunteers and students in developing the attitudes, knowledge and skills they need to contribute to a child safe environment. Attached to this statement marked **CET-16** is a copy of the WCHN Child Safe Environments Workforce Development Framework.

66. The Child Safe Environments Directive directs child safe environment (CSE) training requirements for all SA Health staff. The DHW is in the process of developing a whole of SA Health Mandatory Training Framework and this will include CSE training obligations.

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67. SA Health delivers two days of training each year to paediatric medicine practitioners and nurses, looking at risk factors for child safety and identification and responding to safety risks. Similar training is provided to non-medical staff at services working directly with children and young people and their families across SA Health.

68. In paediatric medicine departments, a focus of this training is on talking through the concerns that practitioners have had in relation to the behaviour of colleagues. A key part of this is reflecting and reframing – for example, asking practitioners, "if you didn't know them [the other practitioner], would you view the behaviour differently?".

69. In my view, the most effective format for training of staff is through facilitated scenarios and examples in interactive workshops with other clinicians, designed specifically to their work/role with written, visual and spoken information.

70. For staff who rarely have access to children in their role, it remains important that they complete online training on topics such as mandatory reporting and duty of care organisational requirements. In my opinion, this is sufficient alongside the child safety history checks and the recruitment processes.

Protective steps in one-to-one interactions

71. One-to-one interactions between children and young people, and professionals within health care environments present an increased child safety risk. It is important to look at the environment and consider the protective steps that can be put into place to make it more open from a safety perspective. The Child Safe Environments Directive is aimed at addressing these risks.

72. Emergency Departments and home visits are examples of environments in which practitioners may be required to interact one-to-one with children or young people. The Child Safe Environments Directive sets out key children's rights principles and risk management strategies which practitioners are required to uphold in all settings. These include:

    (a) listening to and acting upon any concerns that children, young people or their families raise;

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(b) seeking consent to provide treatment to children and young people engaged with the health care system;

(c) ensuring the privacy and dignity of children and young people as consumers of SA Health is respected at all times during their health care experience;

(d) provision of appropriate safe and secure physical environments, that are responsive to the clinical need, age and stage of development of the individual; and

(e) ensuring that appropriate, immediate and consistent action is taken to report any actual or suspected intentional harm to a child or young person in line with mandatory reporting requirements.

73. In terms of the operational functioning of Emergency Departments, SA Health has implemented protective steps to improve child safety. These steps are included in the following annexures:

(a) **CET-17:** National Safety and Quality Health Service Standards User Guide for Acute and Community Health Service Organisations that Provide Care for Children; and

(b) **CET-18:** Clinical Services Capability Framework Emergency Services – Children.

74. These documents establish specific service requirements and standards for SA Health to ensure children and young people receive safe and high-quality health care. Our compliance with the National Safety and Quality Standards (**Standards**) is independently assessed by external National health practitioners and all LHNs and SA Ambulance Service (**SASS**) provide evidence of the systems in place and provided with comprehensive evaluation and recommendations to meet the Standards. The Standards are implemented by SA Health's Safety and Quality Unit in consultation with each service unit and management across SA Health.

75. Home visits also present a risk, as they often involve a single practitioner attending the home of the child or young person. Protective steps should be put in place to ensure the safety of the child or young person as the patient, and also to protect the practitioner. By way of example, when I was Deputy

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Executive Director Allied Health for the Sydney South West Area Health Service, I was responsible for managing the Physical Abuse and Neglect of Children service, which was a home visit service. We implemented an observed practice requirement to ensure that two staff members attended each home visit. This worked well from a safeguarding perspective, as there were never any one-to-one interactions between the child and a practitioner. It also resulted in better service provision, as it enabled practitioners to better work with the adult and child present at the home visit simultaneously.

76. Similar requirements exist for home visits under the WCHN Chaperone Procedure (**CET-6**).

Complaints made about practitioners or ancillary staff members

77. Where a complaint regarding alleged child maltreatment or other misconduct is made about a staff member, SA Health must balance the need to listen to the child or young person and the need to robustly investigate allegations and ensure procedural fairness is afforded to the practitioner. In this regard, the Child Offence Response Guideline prescribes a range of reporting and response actions to be taken depending on the nature and circumstances of the allegation. This includes communication and follow-up to the child or young person involved, including offering counselling services.

78. Under the Child Offence Response Guideline, if the complaint involves an alleged criminal offence, the service must take the following immediate actions:

    (a) ensure the child is safe;

    (b) call SAPOL;

    (c) ensure that the senior manager is aware of the situation;

    (d) contact the Child Abuse Report Line; and

    (e) advise the parent / caregiver of the child what action has been taken and what can be expected.

79. We will then take steps to address any potential risk the practitioner may pose to other children and to ensure a safe environment.

80. Where the alleged offender is a health practitioner (medical practitioner, nurse, allied health practitioner etc.) they will be required to cease all clinical work and

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solely assist on research or policy work (with no client contact) until the investigation has concluded. Where the alleged offender is a member of ancillary staff (porter, cleaner etc.), the process will be led by the human resources department within the hospital.

81. As soon as a complaint is made, the practitioner is removed from the child's or young person's care team. If the child or young person is discharged, the practitioner will not be permitted to be on the child's or young person's care team if they are re-admitted in future. If the child or young person needs to remain in hospital, this often becomes more complex. Questions may arise among staff if a practitioner is at work but not seeing one specific child or young person. In some cases, it may be agreed not to permit the practitioner to attend work at all, depending on the severity of the complaint and the projected length of the investigation.

82. We utilise the Safety Assessment Code (**SAC**) Matrix to determine the SAC score for patient incidents. The SAC score takes into account the type of event, its likelihood of reoccurrence and its consequences. Attached to this statement marked **CET-19** is a copy of the SAC Matrix.

83. The SAC score guides the level of incident investigation or review that is undertaken under the Patient Incident Management and Open Disclosure Policy Directive. Attached to this statement marked **CET-20** is a copy of this policy directive.

84. Conditions and restrictions imposed on the Health Practitioner, following the report and during the investigation, may include:

(a) moving the Health Practitioner to another speciality or area under a regime of close supervision;

(b) specific exclusions to clinical practice or restricting professional practice to agreed areas;

(c) preventing the Health Practitioner from having direct clinical patient contact; and

(d) undertaking audit, research or training.

85. How the complaint is addressed will also depend on whether the practitioner is part of a registered, self-regulated or unregulated profession.

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86. Where the practitioner is registered with AHPRA, AHPRA will also conduct its own investigation.

87. Self-regulated and unregulated practitioners fall within the scope of our credentialing policies, but do not have a registration board. These scenarios are more complex. We rely on managers and executives, assisted by HR units and the Chief Allied and Scientific Health Officer, to investigate the complaint appropriately and make recommendations. The final decision to suspend, restrict or place condition on the practitioner is then made by the Chief Executive of SA Health.

88. When investigating an employee, it is necessary to check whether they are employed at another SA Health site or even another public sector agency, so that relevant work history can be taken into account (e.g. previous warnings). It is also necessary to inform the employee that any suspension with pay will have application across the public sector, and that any disciplinary action will apply to them as an employee per se and be relevant to such other public sector employment. HR units guide the provision of appropriate support, informal counselling or performance management processes in line with the SA Health (Health Care Act) Human Resources Manual. Attached to this statement marked **CET-21** is a copy of this manual.

Investigation and reporting of complaints

89. As soon as a complaint is made an internal investigation is commenced and appropriate reporting practices are followed.

90. From a systems perspective, I believe that it is important that an independent person who is not part of the hospital where the complaint was made is responsible for investigating the complaint. Independence assists in preventing the "halo effect", being a cognitive bias towards making positive judgments of health care professionals.

91. In about 2010, one of the initiatives I implemented while in the role of Chief Allied and Scientific Health Officer at SA Health, was to obtain agreement from each of the Directors of Allied Health across all of the South Australian LHNs that they would call in a Director from another LHN to hear and progress each complaint. The complaint would be heard by the independent Director on a de-

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identified basis, to ensure they did not know the name of the practitioner or the patient involved.

92. The majority of complaints were able to be resolved at the LHN level. Complaints which were escalated to me in my role as Chief Allied and Scientific Health Officer usually involved situations where the practitioner was resistant to work plans or supervision, or where the investigation was being held up by lack of attendance by the practitioner. In these circumstances I was responsible for resolving the complaint and making a determination from a professional practice point of view.

93. General SA Health staff do not interview child complainants. Specialist trained SA Health Child Protection Services or SA Police will undertake assessments and interviews with children as a component of the investigation.

Facilitation of internal complaints

94. SA Health has a Safety Learning System (**SLS**) for reporting incidents that can or has had an adverse effect on a consumer, patient or client. A table listing the key modules within the SLS is attached to this statement and marked **CET-22**.

95. It is vital to facilitate a culture where staff feel safe making complaints. To achieve this, we have implemented a governance system for SLS which makes clear to staff who to share information with, at what level and for what purpose. Attached to this statement and marked **CET-23** is a copy of the SA Information Sharing Guidelines.

96. The information sharing process is very clear and linear, with different groups of people responsible for dealing with different types of complaints. There is a specific notification section within the SLS that deals with child sexual abuse complaints.

97. Any staff member of SA Health can record an incident into SLS.

98. Staff use SLS in a variety of ways depending on their role and responsibilities. There are guides and training to assist users who:

(a) are recording an incident or near miss into SLS (notifiers);

(b) have responsibility for review of reported incidents (managers or supervisors will need user/login access); and

[redacted]

(c) have responsibility to create reports and use them for quality improvement and monitoring trends.

99. Details of incidents recorded on the SLS can be changed by managers, and records of any changes are retained in the system. Managers are required to document information arising from the review, investigation, and analysis phases in the managers' section of SLS.

100. Earlier this year, audits of the SLS identified instances where reviewers (manager-level and above) have rejected incidents that have required further investigation. This potentially could result in incidents not being appropriately managed, lost opportunities for clinical and operational improvements, as well as exclusion from trended data. To reduce this occurrence, SA introduced a system change from 30 March 2022 that only SLS Administrators and Nominated individuals have the ability to reject incidents.

101. The Notifications Module within SLS provides a mechanism for nominated SA Health managers to record the following categories of notifiable incidents:

(a) any death that is reportable to the State Coroner;

(b) possible medical malpractice;

(c) alleged sexual assault or sexual misconduct; and

(d) employee disciplinary matters.

102. Each LHN will nominate senior staff who have the responsibility to record notifiable incidents in SLS and securely store documents relating to the investigation of incidents. Requests for login access to any of the notification sections within the Notifications Module of SLS must be approved by the relevant DHW or LHN Director of Safety and Quality and CEO.

Leadership and culture

103. Strong leadership and a culture that encourages open, transparent disclosure is vital to ensuing that concerns are reported and acted on. It is critically important for staff to know that they can go to their direct line manager and make a report, and that they will be treated respectfully.

104. One aspect of clinical practice which I observed to make a big difference in NSW was case consultation. It is important for professionals to meet and

[redacted]

discuss cases. In my view, face to face training (or in person or virtual) is the most valuable opportunity to discuss any concerns practitioners may have, and to clarify what their responsibilities are.

105. It is also critically important to have a child rights and safeguarding champion in the hospital — often this is a member of the Social Work Department or Child Protection Unit within the hospital. SA Health sites have Champions for the Rights of Children in Care who are champions of child protection training and are an important port of call for other professionals when incidents occur on the ground. Their role is to consult staff on child safety issues and provide training to staff with the Learning and Development Units.

106. To that end, it is also vital we take steps to protect and retain quality practitioners. When health professionals are burnt out or suffering from vicarious trauma as a result of their caseload and adverse experiences in the hospital, this results in high turnover. It is imperative that staff feel supported, and able to decompress sufficiently so that they can make effective decisions when at work. In order to encourage this, at SA Health we ask the clinical management team to ideally maximise a 75% / 25% (new graduates) or 80%/20% (more experienced staff) split of clinical work and “fill up” time. “Fill up” time is time spent focussing on engaging in mentoring, research, supervision, and cross-disciplinary work. It is time that is not direct patient time. The goal is to encourage thinking, curiosity and ongoing learning. We find that staff who are maintaining research engagement and actively participating in learning activities are more alert, more aware and detect issues more readily.

Child safeguarding and mandatory reporting policy directives

107. SA Health has in place a number of policy guidelines and directives which specifically address safeguarding children and young people in the health care system, including responding to suspected or alleged offences against children or young people in SA Health facilities and mandatory reporting requirements.

108. The SA Health policy governance applies to all policies and guidelines development, management, and the process and templates required for policy development and approvals. SA Health policies are underpinned by the legislative and strategic context within which SA Health operates. Policy

[redacted]

documents align the work of SA Health to new or amended government policy or legislation. The underpinning legislation is complex and the policy documents minimises the risk that compliance obligations will be missed or inconsistently applied.

109. It is a requirement for any system-wide policy or guideline that appropriate consultation and engagement (at the right time and with the right people across SA Health, and with external stakeholders where relevant) has been undertaken throughout the process. This includes ensuring sufficient time is allowed for meaningful engagement and consultation, and the provision of feedback.

110. All approved SA Health policies and guidelines must be published on the SA Health intranet and website (except in instances where a policy or guideline contains sensitive or contentious information that is not for public disclosure, and approval is given for it to be published on the intranet only). All SA Health staff must be notified via a Policy Update when the following occurs:

(a) new system-wide policies and guidelines become available and their commencement date;

(b) significant amendments are introduced to existing policies and guidelines; and

(c) policies and guidelines have been rescinded.

111. Copies of the key policy guidelines and directives which seek to address these issues are attached to this statement and marked:

(a) **CET-7:** "Child Safe Environments Directive";

(b) **CET-8:** "Child Offence Response Guideline"; and

(c) **CET-24:** "Child Protection – Mandatory Reporting of Suspicion that a Child or Young Person (0 – under 18 years) is or may be at Risk of Harm Policy Directive" dated 4 November 2020.

112. The above policy guidelines and directives are drafted to reflect the National Framework for Protecting Australia's Children, by emphasising that child protection is everybody's business. They are also designed to reflect and embed the South Australian Health and Community Services Complaints Commissioner's (**HCSCC**) Charter of Health and Community Services Rights

[redacted]

(**HCSCC Charter**). This priority is articulated in the SA Health policy directive entitled "Charter of Health and Community Services Rights Policy Directive" (31 January 2019), which requires that all SA Health employees uphold the rights of health care service consumers set out in the HCSCC Charter. A copy of this policy directive is attached to this statement and marked as **CET-25**.

113. Further, these policy guidelines and directives bring together the legislative reforms undertaken from the findings from two significant Royal Commissions, being the South Australian Child Protection Systems Royal Commission and the Royal Commission into Institutional Responses to Child Sexual Abuse.

114. Within SA Health, different mandatory reporting processes apply, depending on whether the alleged perpetrator is a registered, self-regulated or unregulated health professional or a member of ancillary staff.

115. In terms of registered health professionals, the obligation to make the mandatory report to AHPRA falls on the individual and the organisation. For self-regulated and unregulated health professionals the process is more complex as the organisation is required to notify the HCSCC. For ancillary staff such as porters or cleaners, the report or complaint is made to SA Police (**SAPOL**).

116. Management staff within the hospital will work with the Human Resources team to formalise the report. Part of this process involves working with the staff member who is the subject of the complaint to create a performance plan.

117. If the complaint is very serious, it may be necessary to call SAPOL immediately. Irrespective of which pathway is followed, the responsibility rests on the organisation to take appropriate measures.

118. To my knowledge, South Australia does not have a reportable conduct scheme in place. The mandatory reporting regimes in place are:

(a) reporting obligations to the Department for Child Protection under the *Children and Young People (Safety) Act* 2017 (SA);

(b) notification obligations to AHPRA in respect of conduct of registered health practitioners under the *Health Practitioner Regulation National Law (South Australia) Act* 2010 (SA); and

[redacted]

(c) reporting obligations to the HCSCC in respect of conduct of health care workers (whether registered, self-regulated or unregulated) under the *Health and Community Services Complaints Regulations 2019* (SA).

119. The audit measures discussed below in paragraphs 120 to 123 provide a step towards mandatory reporting suspected child abuse or neglect across the whole of SA Health.

Utility of a reportable conduct scheme

120. It would be helpful to have data to map practitioners who have been the subject of complaints as they move around South Australia or Australia. An ongoing concern for me has always been that self-regulated and unregulated professionals can easily move from state to state. Hospitals and healthcare organisations will likely struggle, or be unable, to access relevant information regarding any prior complaints made about the professional. A reportable conduct scheme that tracks and stores that data would be beneficial in addressing that concern.

Audits

121. In 2018 the policies were audited under the SA Health Child Safety Internal Audit with the operation of the Child Safety Legislative Reforms. The internal audit aimed to consider the adequacy of policy and supporting governance frameworks through the review of documented processes and monitoring and reporting activities to assess the level of compliance to policy requirements to ensure that children under the care of SA Health staff and facilities are being cared for in a safe manner.

122. Specifically, the audit aimed to:

(a) obtain an understanding of the overall governance frameworks in place at DHW, LHNs and SA Ambulance Service (SAAS), through documentation inspection;

(b) obtain an understanding of all services being provided to children across SA Health;

[redacted]

(c) obtain documented procedures and other implemented processes to assess compliance with child safe environment policy and legislative requirements;

(d) from a sample of services, test compliance to controls; such as documented evidence of risk assessments when treating vulnerable patients alone and visiting children at home;

(e) review documentation obtained through a questionnaire and perform walkthroughs of processes as appropriate to verify implemented processes and compliance; and

(f) obtain incident reports and consumer complaints received during the period relating to children and analyse to determine appropriate action taken to address and prevent recurrence and identify any systemic trends.

123. The Child Safety Internal Audit Report made the following recommendations (each was accepted and completed):

(a) the SA Health Legislative Compliance Framework to include a Legislative Compliance Policy Guideline;

(b) implement a Mandatory Notification for Suspected Child Abuse or Neglect form for use across the whole of SA Health; and

(c) develop and implement a Communications Plan for the introduction of the *Children and Young People (Safety) Act 2017*, which includes system-wide communications, LHN and SAAS communications, fact sheets, frequently asked questions and website content about the Act and changes in DCP practice and impacts of this for SA Health.

I make this solemn declaration under the *Oaths Act 2001* (Tas).

This document was signed and witnessed in accordance with the Notice made by the Premier under section 17 of the COVID-19 *Disease Emergency (Miscellaneous Provisions) Act* (Tas) 2020 on 4 September 2021.

[redacted]

Declared at [redacted]
on 23 June 2022

[redacted]
....
Catherine Emma Turnbull

Before me

.......[redacted]

An Australian legal practitioner within the meaning of the Legal Profession Uniform Law (Victoria), Commissioner for Declarations

[redacted]