Statement of SUE MCBEATH

RFS-TAS-073

Name Susan Lee McBeath

Address Royal Hobart Hospital

C/- Liverpool St Hobart in Tasmania

Position Nursing and Midwifery Director – Women's and Children's Services, Tasmanian Health Service -South

This statement is made by me in response to RFS-TAS-073 ('RFS'), issued on 09 June 2022 by the President of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (the Commission), the Honourable Marcia Neave AO.

My name is Sue McBeath, and I am employed as a Nursing and Midwifery Director – Women's, Adolescent and Children's Services at the Department of Health ('the Department'). The additional roles I have held with the Department are outlined in response to Q2.

1. When did you start working at the Department and/or Tasmanian Health Service?

1.1. I commenced employment at the Department as a registered Midwife in 1987.

2. Outline the role(s) you have held at the Department and/or Tasmanian Health Service, including in respect of each role a brief description of:

(a) the duties and responsibilities of the role

(b) the period in which you held the role

(c) whether the role still exists

(d) which area/department of the Launceston General Hospital or Royal Hobart Hospital the role operated or operates in

(e) who reported to you and to whom you reported

(f) whether you had any personal performance measures, key performance indicators or financial outcomes in relation to how you or your team responded to child sexual abuse, safeguarded children or kept children safe, and

(g) whether you held or were required as part of those roles to hold any qualification or credentials (including any registration to work with vulnerable people).

2.1. In response to questions 2. (a), (b), (c), (d) and (e). I have continued to be permanently employed undertaking various roles to the current time. These roles have included clinical and

non-clinical positions at both the Launceston General Hospital (LGH), the Royal Hobart Hospital (RHH), and Family and Child Health Services.

2.2. During my employment as the Assistant Director of Nursing (ADON) at the LGH I had operational, financial, and clinical responsibility for nursing and midwifery. The role has now been converted to a Director of Nursing role. In this role I had Nurse Unit Mangers (NUMs) and Clinical Nurse Consultants (CNCs) as my direct reports with all nursing, midwifery and hospital aids employed in a clinical unit reporting to the NUM. Medical staff reported via a medical structure to Heads of Department the medical director and the overarching executive Medical Director for the LGH.

2.3. Any professional breaches were escalated and managed by the Director of Nursing (DON) this was considered the operate mechanism by the hospital at the time to protect confidentiality and was replicated across the hospital. It would not be uncommon not to be aware of a Nursing Board review as it was known at the time and communication only occurring between the head of Human Recourses (HR) and the DON. The DONs during this period were [redacted] and Helen Bryan unless they were on leave, then it would be an ADONs such as myself acting under a higher duty. The DON position was restricted and is now referred to as the Executive Director of Nursing and Midwifery (EDONM). A similar structure occurred the RHH were professional practice reports to the Nurses Registration Board and subsequently APHRA were centralized through the (EDONM) who [redacted] was.

2.4. In 2013, I commenced employment as a Group Manager/Director of Nursing and Midwifery for Women's and Children's Services at the Royal Hobart Hospital (RHH).

2.5. Between 2015 and 2017 I also had responsibility at the RHH for Acute Medicine, the Emergency Department and Intensive Care as well as Women's and Children's Services whilst the Tasmanian Health Service underwent a review and restructure. These areas now have 6 medical and nursing clinical and professional leads and I remain as the Nursing and Midwifery Lead for Women's and Children's Services with [redacted]. In 2021 was also employed in fixed term contract covering the EDONM THS -South for 6 months which had professional responsibility for Nursing and Midwifery.

2.6. In 2021, I was employed on a 6 month fixed term contract as the Executive Director of Nursing.

2.7. In response to question 2(f) at no time has there been a key performance indicator, or any financial outcome required in relation to allegations of Child Sexual abuse, safeguarding children, or keeping children safe.

2.8. In 2009 I qualified as a forensic Nurse examiner and participated on an on call roster at the LGH providing sexual assault medical and forensic examinations

2.9. In response to question 2(g) In 2016 working with Children's Checks became an essential requirement for all staff employed under any cost Centre attached to Women's and Children's Services. This later became known as the Working with Vulnerable Peoples Registration and is still an essential requirement for all positions in Women's and Children's Services.

3. Outline any qualifications and credentials (including but not limited to any registration to work with vulnerable people) you hold that are relevant to the role(s) you have held at Launceston General Hospital or Royal Hobart Hospital.

3.1. 1985 Registered Nurse Certificate, St Joseph's Auburn Hospital NSW

3.2. 1987 Registered Midwife Certificate, Westmead Hospital NSW

3.3. 1992 Bachelor of Applied Science Nursing with Family and Child Health endorsement. University of Tasmania.

3.4. 2002 Master of Health Science (Nursing), Deakin University Melbourne.

3.5. 2009 Graduate Certificate of Nursing (Forensic), Monash University Melbourne

4. ***If you continue to work within the Tasmanian Health Service or the Department, please state your current role and provide a brief description of the duties and responsibilities in that role.***

4.1. Please see annexed copy of my current Statement of Duties outlining my current role, duties and responsibilities

Incident Management Systems

5. For any part of the Relevant Period during which you worked at Launceston General Hospital, outline your understanding of the incident management systems that were in place, with particular reference to how incidents were reported, recorded and investigated. In your answer, please explain:

(a) the period for which each system applied

(b) the relevant reporting lines and processes

(c) internal notifications processes (for example, which Officials would be notified of an incident and when and how they would be notified)

(d) the relevant decision-making processes, including by whom and by what means it was determined that an incident should be:

(i) dealt with by an Official of a certain level (for example, at ward level, executive level or Head of Agency level)

(ii) referred or reported to an external body (for example, Tasmania Police, Child Safety Services, the Registrar under the Registration to Work With Vulnerable People Act 2013 (Tas) or relevant professional bodies), and

(e) the information and support (if any) were provided to a complainant once an incident was reported?

5.1. I recall a carbonated paper-based reporting system which then was replaced by an electron

system called *Risk Man between 2000-2010*. The reporting system followed the Manager pathway as detailed in the earlier response. I do not recall a policy on how incidents were reported, however the incidents generally were of a clinical nature i.e. medication errors, patient falls or from a Work Health and Safety perspective i.e. needle stick injuries Musculo skeletal injuries, trips and falls. As the ADON risk were escalated to me that impacted on service delivery, work health and safety or of a clinical nature. If I received any professional risk issues relating to nursing or midwifery staff these would be escalated to the DON.

5.2. Generally, any medico legal or police matter was escalated to the Director of Medical Services Peter Renshaw who would liaise directly with Police, HR or provide a medical opinion for medico legal matters.

5.3. For concerns of a Child Protection nature in relation to a patient these were made by the relevant treating medical clinician who head responsibility for the patients care.

6. Please answer question 5 again in relation to Royal Hobart Hospital.

6.1. On commencement at RHH the Risk Man management system was in place being a state-based system. This transitioned approximately 2015-2016 to the Safety Learning Reporting System (SLRS system). Following internal restructuring the management and monitoring of risks across the hospital was the responsibility of the Quality and Patient Safety Unit who reported to the CEO. Individual clinicians and managers were able to raise a risk and escalated to the streams in severity rating system of 4-1 with SAC 1's being of greatest significance. Risks were able to put on the risk registered which was a component of the SLRS reporting system and assigned a file owner and regularly reviewed with action plans initiated. Staff who enter risks are required to be kept informed by their direct line manager of the risk progress and resolution

6.2. Individual clinicians and managers were able to raise a risk and escalated to the clinical streams or the various departments within the RHH with a severity rating system of 4-1 with SAC 1's being of greatest significance. Risks were able to put on the risk registered which was a component of the SLRS reporting system and assigned a file owner and regularly reviewed with action plans initiated. Staff who enter risks are required to be kept informed by their direct line manager of the risk progress and resolution.

Risk management at Launceston General Hospital

7. For any part of the Relevant Period during which you worked at Launceston General Hospital, outline the risk management framework or structure in place and the role of the Nursing and Midwifery Director - Women's, Adolescent and Children's Services (or similar) within it. Include in your answer any significant changes that occurred during the Relevant Period and the role of the Launceston General Hospital executive management team and/or its committees.

7.1. During my employment as the Assistant Director of Nursing (ADON) at the LGH I had operational, financial, and clinical responsibility for nursing and midwifery. The role has now been converted to a Director of Nursing role. In this role I had Nurse Unit Mangers (NUMs) and Clinical Nurse Consultants (CNCs) as my direct reports with all nursing, midwifery and hospital aids employed in a clinical unit reporting to the NUM. Medical staff reported via a

medical structure to Heads of Department the medical director and the overarching executive Medical Director for the LGH.

8. Explain how this framework was implemented in relation to the following matters:

(a) professional boundary breaches

(b) professional misconduct, and

(c) child safety

Include in your response your expectations as to when concerns in relation to the above matters would be escalated to you as the Nursing and Midwifery Director - Women's, Adolescent and Children's Services (or similar), how these expectations were communicated to ward staff, and the circumstances in which you would report concerns to the Executive Director (or another member of the Launceston General Hospital executive management).

8.1. During my employment as the ADON I had operational, financial and clinical responsibility for Nursing and Midwifery. Any risks identified that may impact on service delivery or the financial position of the Women's and Children's Service were escalated to the CEO. Any professional breaches were escalated as detailed in question 5.

8.2. Any professional breaches were escalated and managed by the Director of Nursing. It was not uncommon not to be aware of a Nursing Board review as it was known at the time and communication only occurring between the head of Human Recourses and the Director of Nursing. The Directors of Nursing during this period 2000 to June 2013 were [redacted] and Helen Bryan unless they were on leave, then it would be an assistant Director of Nursing such as myself acting with a higher duty.

8.3. Any medical, legal or police matter was escalated to the Executive Director of Medicine Peter Renshaw, who would liaise directly with Police Human Resources or provide a medical opinion for medical legal matters. Child Protection concerns regarding patients, are raised by the relevant treating medical clinician who have responsibility for the patients care.

8.4. This reporting requirement of any concerns is now imbedded in professional training and the relevant clinical guidelines and policies. In July 2014 the *Registration to Work with Vulnerable People Act* commenced in Tasmania.

8.5. Initially the registration focussed on working with children with the aim of improving safeguards to help keep children safe from harm. In 2021, the legislation extended its coverage to include worker screening requirements under the National Disability Insurance Scheme (NDIS), aiming to keep people with disability safe when accessing NDIS services.

8.6. This means some employees will need this registration. In the Department it is collectively known as Working with Vulnerable People Registration (WWVPR) and has two categories:

- Working with Children Registration – WWCR (see TRFS.0073.0058.0001)
- Working with Vulnerable People Registration NDIS - WWVPR (NDIS) (see TRFS.0073.0058.0002)

- WWVPR (NDIS) can only be obtained by people who deliver NDIS services/supports for one of the Department's registered NDIS providers.

9. During the Relevant Period, did you hold any concern that matters referred to in paragraph 8(a) to (c) above were not being escalated to you as Nursing and Midwifery Director - Women's, Adolescent and Children's Services (or similar) in circumstances where they should have been? If yes, explain the timing and nature of your concerns and any action you took in response, including whether you raised your concerns with anyone else and, if so, what the response was.

9.1. During my employment as the DONM-Women's, Children's Services, RHH I have held no concerns that issues were not being escalated.

10. During the Relevant Period, where you raised matters referred to in paragraph 8(a) to (c) above to the Executive Director (or another member of the Launceston General Hospital's executive management), did you have any concerns about the response you received? If yes, explain the timing and nature of your concerns and any action you took in relation to them, including whether you raised your concerns with anyone else and, if so, what the response was.

10.1. I was provided with a document TDOH.0003.0006.0012 on the 20th of June 2022 which I had not previously remembered. The document appeared to be a file note from [redacted] documenting a meeting held between [redacted] and myself on the 21st of January. As I was unable to recall more information on the issues outlined at the meeting of the 20th June 2009 I requested if any other documents could be provided to me to see if this could refresh my memory which are attached.

10.2. I then made contacted IT services who attempted to recall my 2009 emails which unfortunately have not been archived, so I was not able to ascertain more background to the document provided to me in relation to the HR file note from 21 January 2009. I also do not have access to any of my hard copy documents from that time.

10.3. On review of the documents provided, the CAMHS registrar [redacted] sent a letter to Sonia Leonard which was subsequently I assume was handed over to [redacted] covering Sonia Leonard's planned leave which I was also informed of as having occurred.

10.4. I vaguely recalled the issue being raised, and obviously based on the information in the file note a meeting was held to discuss the concerns with myself [redacted] acting NUM and [redacted]. Meetings at that time were often not minuted and [redacted] has obviously taken a file note which was often the practice at the time.

10.5. I am assuming that the meeting was required to determine the best way of managing the concerns raised and to ensure that staff expectations of behaviour were clearly articulated to both Mr Griffin and all staff in the paediatric area. Hence the plan to develop a guideline on professional boundaries and therapeutic touch in the paediatric area with Mr Griffins and other staff being involvement which was detailed in the letter sent from [redacted] to Mr Griffin.

10.6. In addition, I think the strategy to use this collaborative approach was a way to ensure staff

engagement in the development of the solution. It would have also been recommended as an opportunity to develop awareness of the concerns and perceptions which may have been generated from the issue. From memory this was often an approach utilised at the time it was called 'workshopping'. I was not involved in the development of the protocol. I believe this would have been generated from the unit level with the Nurse educator Michael Sherring and the NUM.

10.7. I am unable to recall knowledge of the documents being provided to me with my request for further information which were obviously generated following receipt of [redacted] letter, and so cannot comment. [redacted] may have referred to other concerns, but I cannot recall being provided with the documents at the meeting.

10.8. The reference to the letter to be written by Gino and my review is obviously attached. In hindsight and having my memory refreshed I vaguely recall this letter having only been a reviewer and not the author of the letter and being required to approve the letter prior to it being sent to Mr Griffin from [redacted] in Sonja Leonard's absence.

10.9. In terms of a Nursing Board of Tasmanian report, the issue was obviously viewed as a professional role confusion/professional boundary issue and the first time it emerged with Mr Griffin. It is also worth noting that there were occasions of other staff allowing patients to use their mobile phones who were on bed rest use and so a ward-based mobile was made available to take into patient's room and then lately a cordless phone or the other way around a can't recall as all rooms children's rooms had no landline.

10.10. From my recollection of the issue which is vague it was obviously thought at the time that to address the concerns raised and to ensure that Mr Griffin had a clear expectations around behaviours, the advice was to develop of a protocol and to communicate the expectations clearly to Mr Griffin which I believe were evident in the letter. I believe it was also thought that the lack of a protocol would make it difficult to manage further breaches of behaviour.

10.11. In this instance and I can't recall whether it was or was not escalated to the DON, however the letter refers to the fact that if similar issues arose that there would be no option but to refer the matter to the Director of Nursing which could potentially be an Nursing Board of Tasmania report now APHRA so can only assume that it was viewed as the first of such a complaint and the letter was seen as more of a warning.

10.12. During my employment as ADON, Adolescent and Children's Services, I had no concerns about the responses I received.

Professional Misconduct

11. For any part of the Relevant Period during which you worked at Launceston General Hospital, outline the circumstances in which a nurse or other staff member at Launceston General Hospital would be investigated under the ED4, ED5 or ED6 processes.

11.1. To the best of my knowledge, any allegation or issue were escalated to the DON and managed through Human Resource guided process. A situation in which I was involved in related to staff with cognitive inability and alcohol addiction leading to an inability for him to perform his role as a registered nurse. He was found lying in a darkened room with significant

jaundice and a concern for his health. The issue was escalated to me by [redacted] the Children's ward NUM. I then escalated the issue to Helen Bryan DON as per our reporting structure. He was subsequently diagnosed with alcohol induced liver failure. The reporting to the Nurses Registration board the NRB was then managed as previously detailed in question 2 and 5 by the office of the DON.

12. In relation to the ED4, ED5 and ED6 processes, explain:

(a) whether, when and how the Nursing and Midwifery Director – Women's, Adolescent and Children's Services (or similar) would be involved

(b) whether, when and how others would be involved, and

(c) the relevant reporting lines (and associating timing), including reporting to the Head of Agency.

12.1. As detailed above the ADON may be involved at the discretion of the DON, however it is my understanding that the ED4, ED5 and ED6 processes are matters dealt with by the Department's HR branch. Other staff may be involved if witness statements were required. The CEO was the delegate for these processes and would be required to be informed and approve the commencement of any such investigation.

13. Explain whether the commencement of an ED4, ED5 or ED6 process at Launceston General Hospital requires reporting to an external body (for example, Tasmania Police, Child Safety Services, the Registrar under the Registration to Work with Vulnerable People Act 2013 (Tas) or relevant professional bodies). In your answer, refer to any relevant policies, procedures, codes or guidelines and explain whether this position has changed during the Relevant Period.

13.1. As detailed in question 5 in relation to Police matters these were escalated to the Director of Medical Services Peter Renshaw. For example, if we needed a restraining order or if there was a coroner's case that required reporting.

13.2. Believed that during this period at the LGH the CEOs could also be contacted by the Police for staff related issues or the DON.

14. Please answer questions 11 to 13 again in relation to Royal Hobart Hospital.

14.1. During my employment at the RHH EDONM [redacted] also led the investigation relating to any issues of professional misconduct and Aphra reporting under HR advice similar to the process at the LGH, outlined in question 13, other staff would be involved as guided by the EDON and Human Resources depending on the circumstances.

Mandatory reporting

15. For any part of the Relevant Period during which you worked at the Department and/or Tasmanian Health Service, what was your understanding of when and how to report a concern of child sexual abuse or other child abuse to Child Safety Services? Who did you understand was responsible for making that report?

15.1. In response to questions 15-17. As previously stated, when the mandatory reporting for Health Professional was enacted, policies and procedures reflected this requirement. Staff also were provided with professional development opportunities to understand their responsibilities.

15.2. Concerns from a patient perspective were escalated to the lead medical clinician. Concerns in relation to Nursing and other staff would be escalated to the relevant manager who would then escalate either to their line manager or seek clarification from a HR adviser in relation to the direction required and the significance of the issue.

15.3. In relation to any Nursing allegations that I became aware of I would be required to escalate to the DON at the LGH or the EDON at the RHH.

16. For any part of the Relevant Period during which you worked at the Department and/or Tasmanian Health Service, what was your understanding of when and how to report a concern about a practitioner's conduct to a professional or regulatory body (including the Australian Health Practitioner Regulation Agency). Who did you understand was responsible for making that report?

16.1. Please see my response to question 15.

17. For any part of the Relevant Period during which you worked at the Department and/or Tasmanian Health Service, what was your understanding of when and how to make a complaint under the Health Practitioner Regulation National Law (Tasmania) Act 2010 (Tas) and the Health Complaints Act 1995 (Tas). Who did you understand was responsible for making that report?

17.1. Please see my response to question 15.

18. For any part of the Relevant Period during which you worked at the Department and/or Tasmanian Health Service, what was your understanding of when and how to report a concern about inappropriate conduct to Tasmania Police? Who didyou understand was responsible for making that report?

18.1. At the RHH, during the relevant period, if any incident or investigation commenced which identified any evidence of a criminal matter it was reported to the police via Medicolegal Adviser or Human Resources. For example, whilst I was covering the responsibilities of the Acute Medical stream when I became aware of an incident which was reported to the After-Hours Nurse Manage by a direct care registered Nurse of an allegation from a female adult patient of an alleged sexual assault. This of course did not involve a child but I have used the example to demonstrate the process involved in addressing an allegation of a serious breach.

18.2. I escalated the incident to the Human Resources Manager and the Head of Security, being the direct line manager for the staff member involved in the allegation. A ED 5 or 6 was commenced, and the staff member was required to not attend work for the duration of the investigation. An external investigator was appointed to examine the issue who provided a report which was directed to the Tasmanian Police to investigate.

18.3. During my employment at the LGH I was not made aware of or involved in any report of

concern in relation to any inappropriate conduct made to the police. However, it is my understanding that if a report was raised, it would have been escalated to the EDMS, DON and CEO with HR involvement.

19. For any part of the Relevant Period during which you worked at the Department and/or Tasmanian Health Service, were there other notifications you were aware of that are relevant and required to be made in your role?

19.1. During my employment at the Department, I have escalated two complaints in relation to [redacted] who are currently employed permanently on the [redacted] Both staff have been required to remain away from the workplace on full pay pending the outcome of the ED 5 investigations.

19.2. The first allegation relates to conduct by [redacted]. This information has been submitted to the Department investigation. The second allegation relates to hospital aide [redacted] received anomalously via a text message to a Nurse unit Manager, who I escalated to the CEO [redacted] which I received on the [redacted] April 2022. At the date of this statement, the outcome of these investigations are still pending.

Handling, storing and dispensing controlled drugs and prescription medication

These questions relate to your knowledge of how controlled drugs and some prescription medications were stored, handled and dispensed at the Launceston General Hospital during the time of your employment. When answering these questions please indicate whether these processes changed over time, and how.

20. Where were controlled drugs stored in Ward 4K and how were they secured?

20.1. To the best of my knowledge, controlled drugs were stored in a secure drug cupboard as per the requirements outlined in the *Poisons Act* 1974,

20.2. The Pharmacy department regularly stocked the cupboard. A drug register was required to be checked with the oncoming shift and the outgoing shift. A red key to the Drug Dispensary cupboard was held by the in-charge Nurse and each drug cupboard had several blue keys but only one red key. No staff member was permitted to hold both the blue key and the red key simultaneously. If the red key was inadvertently taken home by a staff member the whole red key lock was changed, and the incident reported. The lock change was initiated by the head of pharmacy. I recall this occurring only once.

20.3. Dispensing of drugs is only permitted by a medical practitioner or a pharmacist, nurses administer. Dispensing is giving drugs to a patient in a specified manner on discharge or on day leave. Nurses can administer drugs however, they are required to sign out the drug checked against a medication order and with another staff member, administer the drug to the patient. However, before administration, a second check is required to insure that it is the correct drug, dose and patient.

21. How were controlled drugs dispensed in and around Ward 4K?

21.1. I am unaware how controlled drugs were dispensed in and around Ward 4K as I never

worked on the ward.

22. Was there any system in place to record when drugs were removed from storage or dispensed in Ward 4K? How were these records maintained and reconciled?

22.1. I am unaware of any system in place that recorded when drugs were removed form storage or dispensed in Ward 4K.

23. Was it possible for nurses to remove controlled drugs from other parts of Launceston General Hospital premises into ward 4K? If so, how?

23.1. I have no knowledge as to whether it was possible for nurses to remove controlled drugs from other parts of the LGH.

24. Was there any system in place to record when drugs were removed from storage or dispensed from other parts of Launceston General Hospital premises to Ward 4? How were these records maintained and reconciled?

24.1. I have not worked at the Launceston General Hospital since 2013. Whilst I was there all drugs were dealt with in accordance with the standards set out in my response to question 20.

25. Was it possible for nurses to remove controlled drugs from Launceston General Hospital premises without detection?

(a) If yes, explain how this was possible.

(b) If no, explain the process in place to ensure that this did not occur.

25.1. I have not worked at the Launceston General Hospital since 2013. Whilst I was there all drugs were dealt with in accordance with the standards set out in my response to question 20. As such I am unable to comment on this hypothetical.

26. Please answer paragraphs 20 to 25 again, but with reference to the storage, handling and dispensing of antihistamines, antibiotics, sedatives and pain killers.

26.1. I have not worked at the Launceston General Hospital since 2013. Whilst I was there all medications such antihistamines, antibiotics, sedatives and pain killers, were all kept in secured areas within Ward 4k. Further, it was standard practice for nurses, when administering any drugs, to do so in pairs to moderate the dispensing of drugs, often provided in dosages for adults, in an appropriate form to children (i.e. to dispense relative to their size etc.).

James Griffin

27. During your employment at the Department and/or Tasmanian Health Service did you ever work with Mr Griffin? If so, for how long (including date ranges) and in what capacity?

27.1. During my employment at the LGH, I never worked with Mr. Griffin directly. To the best of my knowledge. Whilst I had oversight of the clinical areas involving care standards, models of care workforce development working with industry partners and other organisations for the

delivery of services for of Women's and Children's my role was not a direct care role. As such I did not directly intersected with Mr Griffin to observe any of the behaviours described in Question 30 (a), (b),(c),(d),(e), (f),(g),(l),or(j).

27.2. Mr Griffin was a direct care nurse who worked with a group other nurses and enrolled nurses, hospital aides and ward clerks, medical staff and allied health professionals as part of the multidisciplinary team. Direct care nurses were allocated a patient cohort who they were responsible for on a shift-by-shift basis. As a direct care nurse, he reported to the NUM or the After Hours Nurse Manager (AHNM) or the In Charge Nurse of the ward which was allocated on a shift by shift basis. On occasions in the absence of the NUM the registered nurse in charge of the shift would escalate issues to me that needed immediate action or approval. For example, approving overtime, or if there was a clinical deterioration of a patient needing to be transferred to Melbourne or Hobart were the usual examples. Mr Griffin would have been in charge and possibly escalated an occurrence such as those described, but I can't recall anything of significance.

27.3. In my occasional interactions with him in the work environment Mr Griffin always communicated with me in a professional manner and seemed friendly and approachable with other staff members.

28. How would you describe your relationship with Mr Griffin?

28.1. As mentioned in my response to question 27, to the best of my knowledge, I only encountered Mr Griffin in passing.

29. Describe any contact you had with Mr Griffin outside of work.

29.1. To the best of my knowledge, I had no contact with Mr. Griffin outside of work.

30. Do you have any knowledge of occasions where Mr Griffin did any of the following:

(a) engaging in any misconduct (including child sexual abuse)

(b) overstepping professional boundaries (hugging and non-care related touching) with paediatric patients

(c) calling paediatric patients "baby", 'babe', "princess" or similar

(d) having inappropriate conversations with paediatric patients, their families or visitors

(e) not following best practice or expected standards or procedures involving intimate engagement with paediatric patients

(f) using his mobile phone while on shift

(g) giving his mobile phone number to paediatric patients

(h) telling paediatric patients they could contact him after hours or when off-duty

(i) having contact with paediatric patients after hours or when off-duty, or

(j) having ongoing contact with paediatric patients after they were discharged from hospital.

30.1. Please refer to response in question 10. Other than the issues raised in question 10 I had no recollection of Mr Griffin engaging in any of the above behaviours during my employment at the LGH. I have reviewed documents that suggest I was cc'd into correspondence between NUM [redacted] and [redacted] in November 2005. I am not able to recall any additional information about that correspondence for the Commission.

31. If your response to paragraph 30 is yes, detail:

(a) whether the concern was your own or was reported to you

(b) the nature of the behaviours

(c) when the behaviours occurred

(d) how you became aware of the behaviours

(e) when you became aware of the behaviours

(f) whether you were concerned by any of the behaviours (giving reasons why/why not)

(g) what role (if any) you had in dealing with the behaviours, and

(h) how the behaviours were addressed.

31.1. Please refer to my response in question 10.

32. Do you have knowledge of, or did you observe anything else about Mr Griffin that concerned you, including in relation to his interactions with paediatric patients and/or children and young people generally? Please explain your answer.

32.1. Please refer to my response in question 10. Due to the non-clinical nature of my role I did not observe him directly in practice.

33. In relation to any concern you did hold about Mr Griffin, did you report those concerns to anyone at the Launceston General Hospital?

(a) If yes, explain:

(i) the nature of your concerns, and

(ii) the process you undertook to report your concern (i.e. who did you report to and was your concern reported orally or in writing or via an incident management system).

(b) If no, explain why you did not report the concern, the nature of concerns and identify any barriers to you making a report.

33.1. Please refer to my response in question 10. However, when the media stories identified Mr

Griffin by name, I recalled a patient complaint verbally discussed with myself and the then NUM [redacted] in relation to a new male nurse who had kissed the forehead of a young female patient in the presence of the parents. The parents had then made a complaint about his action. At the time I was unaware of who the staff member was, and the explanation provided to me was that he didn't realize it was inappropriate and had apologized to the parents.

33.2. On hearing the media story I thought perhaps this was Jim Griffin and so I contacted Helen Bryan EDON LGH to inform her of my concern. She stated that [redacted] had already rung her to disclose the incident which was in fact Mr. Griffin.

34. In respect of any report made by you to anyone at the Launceston General Hospital, what process was followed after you made your report? In your answer, explain:

(a) how was your report recorded

(b) what conversations were had about the report, when and with whom

(c) what actions were taken by your supervisor and/or the Launceston General Hospital management

(d) whether you are aware of any actions taken against Mr Griffin, and if so, what those actions were and who they were taken by (including if those actions were taken by you)

(e) how the Launceston General Hospital executives responded (if at all)

(f) whether you have any concerns or complaints about how your report was responded to by your supervisor and/or the Launceston General Hospital's management and/or the executives. If so, the detail of those concerns or complaints, and

(g) whether the process that followed consistent with your understanding of the relevant complaints and grievance process?

34.1. In regards to the disclosure I mentioned in question 33 I am unaware if it was recorded or what (if any) actions were taken.

35. Are you aware of any reports concerning Mr Griffin's behaviour being made to any of the following:

(a) Department of Health and/or the Secretary of the Department of Health

(b) a Minister of Ministerial Office

(c) a professional or regulatory body (including the Australian Health Practitioner Regulation Agency)

(d) Child Safety Services

(e) The Department of Justice and/or the Registrar under the Registration to Work With Vulnerable People Act 2013 (Tas) and/or the Consumer, Building and Occupational Services business unit within the Department of Justice

(f) Tasmania Police

(g) any other office, agency, organisation, authority or regulator, and/or

(h) any union or representative body for nursing and medical staff employed at the Launceston General Hospital.

35.1. In February 2021 whilst acting as the Executive Director of Nursing and Midwifery at the RHH I raised with Dr Stephen Ayre the current Executive Director of Medical Services the issues that had reached the media with the Pod cast in relation to Mr. Griffin. As Dr Ayre had been the CEO at the LGH during this period I shared with him my shock at the disclosures. During this discussion Dr Ayre stated that the Police had been in contact with him in relation to allegations between 2009-2011 whilst he was the CEO and that he had been advised by Human Resources to allow the Police investigation to proceed and that any industrial process would follow pending the outcome of the criminal investigation.

36. If reports were made to any organisation listed in paragraph 35 please detail:

(a) who made the report

(b) how the report was made

(c) when the report was made

(d) any responses received to the report (including when those responses were received), and

(e) what was the outcome of the report?

36.1. I am unaware of any reports concerning Mr. Griffin being made to any of the agencies listed in question 35.

Other people's concerns

37. Did anyone raise concern about Mr Griffin with you, including the behaviours outlined in paragraph 30? If yes, please detail in respect of each concern:

(a) the nature of the concern

(b) when and how the concern was raised

(c) the action you took in response to the concern (and when you took this action)

(d) whether you reported the concern to your supervisor

(e) the response of your supervisor and/or the Launceston General Hospital

management and/or the Launceston General Hospital executives to the concern

(f) whether the concern was reported to the organisations listed in paragraph 35 (and if so, please answer paragraph 36 in respect of those reports), and

(g) whether the concern was resolved , and if so how?

37.1. Please refer to my response in question 10.

38. Was the process that followed the raising of the concern consistent with your understanding of the relevant policies, procedures, codes and guidelines? If no, identify the relevant policy, procedure, code or guideline and explain the inconsistency.

38.1. As mentioned in my response to question Q10 and 37, to the best of my knowledge these concerns were guided by HR in relation to current policies, procedures, codes or guidelines at the time.

39. Did the fact that Mr Griffin was the delegate of the Australian Nursing & Midwifery Federation impact your response to concerns raised in relation to him? If yes, explain how and why this was the case.

39.1. The complaints raised in response to Q 10 and Q37, were to the best of my knowledge the only complaints raised concerning Mr Griffin's behaviour during the period of my employment as the ADON at LGH. The fact that he was the delegate for the ANMF would not have had any impact on how the issues were managed as HR guided the process in accordance with current policies, protocols, guidelines and codes.

40. Do you consider the action you took in response to concerns raised by others in relation to Mr Griffin was adequate? Please provide reasons. To the extent that you consider your actions to have been inadequate, state what action you would take now and why.

40.1. As raised in response to Q's 10 and 37, to the best of my knowledge I cannot recall anyone raising any further concerns to me regarding Mr Griffin's behaviour. The first concern in 2005 and the subsequent concern in 2009 were supported and guided by HR. The plan for protocol development was to ensure that boundaries were clear and communicated with staff. A mobile phone/cordless phone was made available so that staff did not feel compelled to use their private mobiles when patients were on bed rest. With the benefit of hindsight if I had been made aware of the police reports made to HR and the CEO I may have acted differently especially with my knowledge of sexual assault and predatory type behaviours. As stated in Q 35 I only became aware of the presence of an allegation to Police in 2021.

41. In your role as Nursing and Midwifery Director - Women's, Adolescent and Children's Services (or similar) did you receive any formal reports in relation to Mr Griffin's conduct during the Relevant Period, including in relation to the behaviours outlined in paragraph 30? If yes, how did you respond to the reports?

41.1. As raised in response to Q10 and 37, to the best of my knowledge I cannot recall another concern raised to me regarding Mr Griffin's behaviour. I did not receive any formal reports in relation to his conduct.

42. In the event that a person raised concerns on the ward about Mr Griffin in relation to the behaviours outlined in paragraph 30, would these concerns automatically be escalated to you as Nursing and Midwifery Director - Women's, Adolescent and Children's Services (or similar)? If no, who was responsible for determining whether concerns would/wouldn't be referred to you?

42. During my employment as the Assistant Director of Nursing (ADON) at the LGH I had Nurse Unit Mangers (NUMs) and Clinical Nurse Consultants (CNCs) as my direct reports. Direct care nursing, and midwifery staff and hospital aids in a clinical unit report to the NUM. Medical staff reported via a medical structure to Heads of Department the medical director and the overarching executive Medical Director for the LGH. The examples provide in Q 10 and 37 outlined how concerns were raised at the time from the NUM to my role with HR advice. Any professional breaches were escalated and managed by the Director of Nursing (DON) to the Nurses Registration Board and subsequently APHRA. See attached organizational chart (TRFS.0073.0058.0004).

43. Are you now aware of any concern(s) or formal report(s) in relation to Mr Griffin's conduct, including in relation to the behaviours outlined in paragraph 30, that were not escalated to you at the time but should have been? If yes, explain the nature of the concern/report and the action you would have taken, had the concern/report been escalated to you.

43.1. As raised in response to question 37, to the best of my knowledge I cannot recall anyone raising a concern to me regarding Mr Griffin's behaviour.

44. Do you have any other concerns or complaints about how staff, patient or family concerns in relation to Mr Griffin's conduct toward paediatric patients (including the behaviours listed in paragraph 30 above) were responded to by ward staff, Launceston General Hospital management or executives during the Relevant Period? If yes, please explain your concerns.

44.1. As raised in response to question 37, to the best of my knowledge I cannot recall anyone raising a concern to me regarding Mr Griffin's behaviour.

45. Where concern(s) or formal report(s) in relation to Mr Griffin's behaviour were referred to you, were you directed (formally or informally) to take particular actions that you did not agree with? If so, please detail.

45.1. As raised in response to question 37, to the best of my knowledge I cannot recall anyone raising a concern to me regarding Mr Griffin's behaviour.

46. Prior to 31 July 2019, were you aware of any allegation that Mr Griffin had engaged in child sexual abuse of, or had had an inappropriate relationship with, a child or young person (whether or not a paediatric patient of Launceston General Hospital)? If yes, state the nature of each such allegation and when and how you became aware of it.

46.1. As raised in response to question 37, to the best of my knowledge I cannot recall anyone raising a concern to me regarding Mr Griffin's behaviour.

Other people of concern

47. During the Relevant Period, did you have any concerns about any conduct similar to that described in paragraph 30 in relation to other staff members at Launceston General Hospital or staff members at Royal Hobart Hospital? If yes, answer paragraphs 31 to 36 in relation to each staff member of concern.

47.1. Please refer to question 19 in relation to staff members reported at RHH.

47.2. The information in relation to [redacted] was provided to the Departments Commission of inquiry. I am unaware of where this investigation is at or the outcome of the only to say that I was interviewed and a second investigation under a second ED 5 as new information had been received which I was not aware of in the first ED 5.

47.3. In relation to [redacted] the issue was escalated to CEO [redacted] and [redacted] who I believe was the Acting People Culture Director and a ED 5 initiated. I was responsible for contacting [redacted] and informing him of the allegations and of his requirement to not attend the workplace for the duration of the investigation. I also provided him verbally with information on the nature and process of the investigation and informed him of his right to reply and offered him the opportunity for Employee Assistance for support. It is my understanding that he also received a registered mail document detailing the process and this information.

47.4. I was concerned that he was rostered to work and that timeliness for HR to respond to phone calls and provide guidance from experience was not great. So because of the content and seriousness of the issues raised anonymously in the text with patient names which I recognised, I rang [redacted] to raise my concerns around the issue and timeliness.

47.5. She suggested I call [redacted] which I did but she did not return my call.

47.6. I then contact [redacted] again who contacted [redacted] who contacted the HR to escalate the response directly to Kathrine Morgan-Wicks was the required delegate to approve the investigation. The response from Kathrine Morgan-Wicks and to provide approval for HR to commence the ED 5 he remains on paid leave and has not return to the [redacted] with the investigation ongoing.

48. During the Relevant Period, did anyone raise with you concerns about any conduct similar to that described in paragraph 30 in relation to other staff members at Launceston General Hospital or staff members at Royal Hobart Hospital? If yes, answer paragraphs 37 to 45 in relation to each staff member of concern.

[redacted]

48.1. I was aware of an incident of concern in relation [redacted] a [redacted] on the [redacted] generated through the SLRS system by a staff member Registered Nurse [redacted] who worked permanently on the [redacted] Ward. [redacted] claimed that she was approached by [redacted] in the treatment room, and he showed her an image of a child's penis on a camera used for forensic images which had been left in the treatment room. [redacted] had also made sexually derogatory comments and then had tried to take a photo up

her skirt. The incident occurred in on the [redacted] October 2017 and was reported via the SLRS system to the NUM [redacted]. The incident was handed over to [redacted] CNC and acting NUM as [redacted] was scheduled to commence planned leave. I advised [redacted] to seek support and advice from [redacted] HR. I am aware that the advice from HR was that the complaint be formally presented to [redacted], and he was requested to provide a written response. I am aware that he was advised that his actions were not acceptable nor appropriate and would not be tolerated. I am aware that a written response was received and that he acknowledged that his actions were wrong and not appropriate and regretted that he had made [redacted] feel 'degraded', 'embarrassed' and 'ill at ease'.

48.2. The Camera was a forensic camera that had been used for recording a clinical image of a congenital abnormality which required surgical correction. It was not part of [redacted] responsibility to check the battery of the camera which is how he claimed that the image had been found. Unfortunately, [redacted] had not been informed of the outcome which was normally the responsibility of the NUM hence felt the need to seek support from the ANMF in December 2019 as she was feeling uncomfortable whist working with [redacted]. The ANMF escalated the concern to [redacted] HR. [redacted] HR raised the concern with me some months later and I requested [redacted] to provide a formal response for [redacted] with HR support, which occurred.

48.3. A further concern was raised in relation to [redacted] by [redacted] following a discussion with a teenage girl [redacted] and her mother. The complaint centred around the fact that [redacted] believed [redacted] would stare at her from his workspace which was opposite her room. I understand that the chaplain informed the nursing staff and medical staff and then formalised the concern via the complaints process. I was informed that Staff met with the family and reassured them. [redacted] was advised that he should not enter the room for any reason and that [redacted] could keep her curtain partially drawn to protect her privacy if that made her feel more comfortable. I was aware of this after the event as the complaints process came to me following the event, by a now adult patient about an interaction that she had had encountered with [redacted] whilst a patient receiving care on [redacted]. This was initially managed by the [redacted] the NUM.

48.4. On the 3rd November 2020 I received an email from [redacted] detailing a number of concerns reported to her by the acting CNC [redacted]. [redacted] was the assistant Director of Nursing (ADON) but covered my leave and my Role from December 2020-August 2021. The email was an update outlining the concerns and the advice already provided by [redacted] had escalated the issue to earlier in the morning. [redacted] directed [redacted] to seek advice and guidance from [redacted] as these were additional concerns raised of inappropriate behaviour by [redacted]. The concerns came from [redacted] RN, [redacted] RN and [redacted] RN.

48.5. [redacted] concerns related to what he had observed as [redacted] was unnecessarily following [redacted] RN around the ward and described what he thought was an obsession [redacted] had with her. He also raised that other staff had reported that [redacted] had stated that he found [redacted] attractive. [redacted] also felt concerned that he had observed [redacted] using the computer in [redacted] on multiple occasions and that the screen on the computer was turned away from the door. Also, [redacted] raised a confidential concern in relation to an ex-patient which was made to him several years ago. [redacted]

[redacted] and [redacted] concerns related to inappropriate gesturing [redacted] made with his hands towards [redacted] as she walked past.

48.6. A further update was provided via email from [redacted] at 5pm to [redacted] and [redacted] and myself, that she had been in contact with [redacted] HR and that they were progressing to obtain first-hand information from the staff involved. [redacted] had provided advice that most of the concerns that were raised by staff were not something that were necessarily something that would be proven as it could come down to 'he said / she said' between staff; that [redacted] would be able to explain some of the concerns raised e.g. it would not be seen as an issue for a [redacted] to be sitting in an unoccupied room on a computer as he could be checking staff emails; that it is not something that we would pursue if a staff member makes a comment to a fellow staff member that they found another staff member 'attractive'. With regards to the comment raised by [redacted] that he had spoken with an ex-patient regarding a comment that [redacted] made to her when she was an inpatient many years and that the comment was made to [redacted] about 1 year ago, [redacted] felt that this was not something that we could investigate without more information and that a complaint had not been made by the ex-patient, and also raised concern that [redacted] should have raised the concern at the time. I am aware that statements were obtained from the staff raising complaints and [redacted] and HR formalised the concerns raised of inappropriate workplace behaviour and presented them to [redacted]. Again, [redacted] acknowledged that his behaviour was inappropriate.

48.7. As a risk mitigation strategy all staff were reminded in a face-to-face session with HR present of their obligations in the workplace to adhere to appropriate workplace behaviour, and also the importance of raising concerns under the principle of speaking up for safety.

48.8. In 2021 I am aware that these issues were subsequently regenerated with additional information whilst I was covering the Executive Director of Nursing Role and being managed by the acting DONM for [redacted]. In May whilst still working as the EDON I was requested by [redacted] CEO with support from [redacted] to contact [redacted] and inform him of an ED 5 investigation regarding a potential breech of the code of conducted and that he be suspended with full pay pending the outcome of the investigation which I did. I coverer this responsibility as [redacted] was on leave.

48.9. I am also aware that a second ED 5 investigation has commenced as I have been interviewed in relation to new information that had recently been provided which I was unaware off an informed the investigator to that effect.

48.10. See TRFS.0073.0058.0003, TRFS.0073.0058.0005, TRFS.0073.0058.0006, TRFS.0073.0058.0007, TRFS.0073.0058.0008 & TRFS.0073.0058.0009.

[redacted]

48.11. I received a text message from the NUM of the Maternity unit [redacted] which had sent to her anonymously on the 4th of April 2022. The message described instances and examples of behaviours of concern in relation to child safety and misconduct by a long-standing [redacted] staff member [redacted].

48.12. I escalated the issue and anonymous text message to [redacted] RHH CEO who then escalated the issue to [redacted] who I believe was the acting People and Culture Manager for the THS. Subsequently an ED5 was initiated by Kathrine Morgan-Wicks Health Secretary. I was responsible for contacting [redacted] and informing him of the allegations and of his requirement to not attend the workplace for the duration of the investigation. I also provided him verbally with information on the nature and process of the investigation and informed him of his right to reply and offered him the opportunity for Employee Assistance for support. It is my understanding that he also received a registered mail document detailing the process and this information. The investigation is still ongoing.

Commission of Inquiry – Notices to Produce

48.13. As part of the Commission of Inquiry's work, I have been, from time to time, responsible for collating and providing information and documentation to the Department's Commission of Inquiry Response team. During this work I have been provided with information and documentation I was not previously in possession of, or had knowledge of, concerning aspects of the matters of the [redacted] and [redacted] matters which did not directly relate to me, or the roles or responsibilities I had in responding to those matters at the time. As such, my answers to contained in paragraphs 48.1 to 48.11 were those known to me at the time I responded to them.

49. During the Relevant Period, were you aware of past allegations of child sexual abuse at the Launceston General Hospital or the Royal Hobart Hospital and who such allegations have been managed? If yes, did such awareness influence the action you took in response to concerns in relation to Mr Griffin or any other person identified in answer to paragraphs 47 to 48?

49.1. I do not have any recollection of matters relating to child sexual abuse other than those managed through the medical and forensic services. I had a direct report from CNC's for this Service and also participated in an on call roster. I was not involved clinically in cases other than in those cases where I was the examiner. I had a qualification in forensic nursing and an awareness of grooming behaviours however the issues raised at the time in the context that they were provided did not trigger any alarms for me professionally.

What should change and how

50. With the benefit of hindsight, do you consider that you acted appropriately in relation to matters outlined in your statement? If so, why? If not, what would you change or do differently?

50.1. I am aware that the behaviour described in relation James Griffin in questions 10 and 37 were believed to be those of a caring nurse with confusion on professional boundaries. All issues were guided by HR. With the benefit of hindsight and the knowledge that there had been allegations made to police during the same period, and if these had been made available to me at the time, I would have viewed theses to be potentially predatory type behaviours.

51. Given your experiences at the Launceston General Hospital, what do you think needs to change to keep children safer from child sexual abuse whilst patients at the Launceston General Hospital?

51.1. Please refer to my answer to question 52.

52. How do you think the health system's response to allegations of child sexual abuse can be improved?

52.1. I believe the introduction of a National Principles for Child Safe Organisations an initiative of the Council of Australian Governments in response to the Royal Commissions Response to Child Sexual Abuse launched in May by the Tasmanian Government should receive priority status. The strategies to be effective need to be appropriately resourced and imbedded in practice with an external review and accreditation process, to ensure that Tasmanian children are provided with the same protection as children in other jurisdictions. I believe that the HR department and senior managers at THS and the RHH had the ability to reflect on the issues with JG and as such expedited the response in relation to [redacted] and [redacted].

52.2. I believe it is very challenging for all clinical and non-clinical staff to access timely support and assistance in the areas of Information Technology, and Human Resources. This is not a reflection of individual staff members' ability to provide guidance advice or support, it relates to the lack of resources available within those functional areas to assist. The resources needed are both human and technology with unreasonable workloads leading to delays in accessing support or not being able to support at all. For example, the intranet site is outdated technology and software leading to confusion and delays in accessing information for policies and guidelines to guide practice, responsibilities and decision making. I believe that one of the many challenges for particularly Nurse Unit Managers is the broadness of their responsibility and the lack of support and preparation for them as they transition from a clinical to a managerial and leadership role. Investment in leadership development and manager support would provide much needed opportunities which may assist managers in identifying and responding appropriately to complex issues such as the issues under review in this investigation.

53. What steps do you think the Launceston General Hospital should take in an effort to rebuild community trust in the Launceston General Hospital?

53.1. Please refer to my answer to question 52. Also, by ensuring that consumers are involved at every level of planning and decision making helps to create an environment of greater transparency which is also associated with high performing organisations in Health. In addition, the approach required to achieve in Magnet Hospital's and Pathways accreditation also ensures that staff are well supported and have access to appropriate support and professional development. This increase in support would assist in ensuring staff feel comfortable and have contemporary knowledge around emerging issues. Also, part of Magnet accreditation is the implementation of a ward-based nursing council at every level. This currently being implemented at the RHH to ensure that direct care clinical staff have an opportunity to be involved in planning, services management and can provide the lived experience should issue or solutions be generated that may not fix the issue or solve the problem. The implementation of the strategy Speaking Up for Safety provides all staff with ways that they can escalate issues and concerns is also something being implemented at the RHH which would be useful at the LGH if it hasn't occurred already.

The Commission

54. Has anyone in a position of authority (whether or not employed by the Launceston General Hospital) discouraged you from assisting this Commission? If yes, please outline in general terms the form the discouragement took.

54.1. No.

Sources of information for this statement

55. Have you refreshed your memory for the purposes of this statement by reviewing any documents or other records or by speaking to any other person (other than a lawyer assisting you with the statement)? If so:

(a) Pleases give details of each person you spoke to and the matter you discussed; and

(b) Please provide a list of, and attach to your statement a copy of each document which you have used to assist you in making this statement, including but not limited to diary notes, emails, text messages, policy documents, incident reports and correspondence.

55.1. Yes. I have requested access to information previously provided to the Department's Inquiry Team.

Other information

56. Is there further information you would like to provide to the Commission regarding the Launceston General Hospital or the Royal Hobart Hospital?

56.1. No.

57. Is there further information you would like to provide to the Commission regarding the Tasmanian Health Service (including any other hospital within the Tasmanian Health Service) and/or the Department of Health?

57.1. No.

Request for documents

58. Produce a copy of any document referred to in response to any paragraph in this Notice (including any document which you used to refresh your memory referred to in your answer to paragraph 55 above).

57.2. I sought information from the Intranet site on Child Safe Organisations.

57.3. Additionally I was provided the following materials provided to the Commission of Inquiry by the Department of Health:

57.3.1. TDOH.0003.0006.0001;

57.3.2. TDOH.0003.0006.0002;

57.3.3. TDOH.0003.0006.0003;

57.3.4. TDOH.0003.0006.0004;

57.3.5. TDOH.0003.0006.0005;

57.3.6. TDOH.0003.0006.0006;

57.3.7. TDOH.0003.0006.0007;

57.3.8. TDOH.0003.0006.0008;

57.3.9. TDOH.0003.0006.0009;

57.3.10. TDOH.0003.0006.0010;

57.3.11. TDOH.0003.0006.0011;

57.3.12. TDOH.0003.0006.0012;

57.3.13. TDOH.0003.0006.0013; and

57.3.14. TDOH.0003.0006.0014.