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

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 6: Children in health services
Book 1

August 2023

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

Volume 6
Children in health services (Book 1)

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Introduction to Volume 6

This volume—Volume 6—focuses on children in Tasmania's health system and how the Department of Health prevents and responds to child sexual abuse. The terms of reference for our Commission of Inquiry specifically require us to have regard to:

> The adequacy and appropriateness of the responses of the Tasmanian Health Service and the Department of Health to allegations of child sexual abuse, particularly in the matter of James Geoffrey Griffin (deceased 18 October 2020).[1]

Health services, particularly hospitals, are often assumed to be inherently safe places for children and young people. They are imagined as busy places, humming with staff who have been professionally trained and rigorously screened by oversight bodies to confirm their suitability to work with children and young people. The public naturally assumes that those working in health services will place the best interests of patients at the centre of what they do.

There has been limited research to test the assumption that hospitals are inherently safe for children and young people, and there is little evidence available about the risks of child sexual abuse in health services. However, based on the available research and the limited evidence we heard, there *are* inherent risks posed to children and young people in health services.

Health workers can have intimate contact with children, sometimes without supervision. Children and young people who seek treatment often feel unwell or may have disabilities or mental health concerns that create a dependency on health workers for their care. Children and young people often have less social power than adults and are therefore less able to advocate for themselves. Parents and carers typically take for granted that they can safely leave their children unsupervised in the care of a health worker and that any intimate procedures are warranted or necessary.

The overwhelming majority of health workers do an outstanding job in providing safe, empathetic and high-quality care to children and young people. We met many such health workers across Tasmania during our Commission of Inquiry. We consider the trust and goodwill extended to health workers to be well founded. However, a significant reason that our Commission of Inquiry was established was the shocking and devastating revelations that James Griffin, who was a paediatric nurse on Ward 4K at Launceston General Hospital for nearly 20 years, perpetrated child sexual abuse inside and outside the hospital. Sadly, these revelations were not so shocking to those who knew of Mr Griffin's abuses first-hand or had tried, with little success, to raise the alarm about his concerning behaviour over the years.

While it may be tempting to view Mr Griffin's abuses as an anomaly, they are not. The risk of child sexual abuse in health services must be recognised and addressed. We heard from several people who had reported allegations of abuse within, or connected to, health services across Tasmania, including at Royal Hobart Hospital.[2]

However, our Commission of Inquiry received a substantial amount of evidence about allegations of child sexual abuse connected to Launceston General Hospital. For this reason, we focus primarily on Launceston General Hospital in this volume.

As part of our examination of Launceston General Hospital, we focused on three case studies—those of Mr Griffin and two other individuals who were accused of child sexual abuse at Launceston General Hospital prior to Mr Griffin's employment there or before there were complaints about his conduct. Launceston General Hospital's failure to identify and respond to the red flags raised about Mr Griffin over his long tenure at the hospital are indicative of an institution that did not learn from its previous experience in responding to allegations of child sexual abuse.

We do not discuss the first case study in our report because it is subject to a restricted publication order, which means it will not be made available to the public or media. We are committed to being open and transparent and have sought to examine the prevention, identification, reporting of and responses to child sexual abuse. During our Inquiry, we heard evidence that, too often, people, including victim-survivors, have felt silenced or unable to come forward and be heard. At the same time, we have sought to avoid prejudicing any current investigation or proceedings. Not only was this required by our terms of reference, but we are acutely aware of ensuring we did not prejudice the ability of victim-survivors to seek justice and ongoing attempts to keep children safe. It is in this context that we made a restricted publication order in relation to the first case study. We made this order because we were satisfied that the public interest in the publishing of evidence contained in the first case study is outweighed by relevant legal considerations, including avoiding prejudicing current investigations and proceedings.

Zoe Duncan (now deceased) alleged that she was sexually abused by Dr Tim (a pseudonym) as an 11-year-old in 2001.[3] Her incremental disclosures were met with scepticism and disbelief from the hospital, which set in train a sequence of wrongful assumptions that neither she nor her parents could overturn, despite their best efforts. Zoe remains deeply loved and missed by her family, who were generous in giving us an insight into her life and the abuse she suffered, as well as the disbelieving responses to her allegations by the hospital and other investigatory agencies. The agreement of Zoe's parents to allow us to consider her experience in more detail reflects their desire for Zoe's legacy to be one of protecting other children and young people from abuse and ensuring they are believed when they report concerns. We document the case study relating to Dr Tim in Chapter 14.

Because previous matters, such as Dr Tim, did not act as 'wake-up calls' to the hospital and broader Department of Health, Mr Griffin tested and overstepped boundaries early in his tenure at the hospital and continued to do so until a victim-survivor eventually reported him to police in 2019.

We were overwhelmed by the extent of Mr Griffin's abuse. In line with our terms of reference, we considered in detail the history of complaints and concerns raised about this nurse at Launceston General Hospital. The length of the case study about Mr Griffin reflects the volume of material we received and evidence we heard, much of which was already available to the hospital and other agencies and had been for some time. The amount of information about Mr Griffin's offending points to numerous missed opportunities—by Launceston General Hospital, Tasmania Police and Child Safety Services—to intervene earlier.

We heard from many victim-survivors, former patients and current and former hospital staff, some of whom shared their anguish and frustration that their reports and concerns about Mr Griffin had been ignored. We are indebted to all the victim-survivors, former patients and current and former staff who shared information with us. Without the public participation of some of these witnesses, particularly victim-survivors Kylee Pearn and Tiffany Skeggs and whistleblower Will Gordon, we would not have been able to make the findings we have. These witnesses went to extraordinary lengths to draw attention to systemic failures to protect children and young people from Mr Griffin. We were humbled by their actions, their generous assistance to our Inquiry and their unwavering commitment to children's safety.

We document the case study of Mr Griffin in Chapter 14.

Some of the witnesses who gave evidence to us were wary of doing so. The Tasmanian Government encouraged witnesses to provide information to our Commission of Inquiry. In particular, the Premier, the Honourable Jeremy Rockliff MP, stated that the Government sought to 'reassure all Tasmanians that we absolutely encourage people to come forward'.[4]

In August 2022, the Tasmanian Government also recognised the contribution of victim-survivors and state servants who had provided information to our Commission of Inquiry. The Premier stated:

> I want to once again thank victims and survivors for having the courage to share their experiences, along with State Servants who have come forward in an effort to make things better for children and young people in Tasmania. I want to again reiterate today that all State Servants have my full support to come forward and shine a light on these matters.[5]

The *Commissions of Inquiry Act 1995* also reflects the importance of protecting those who provide information to a commission.

We note the statement of Kathrine Morgan-Wicks PSM, Secretary, Department of Health, in our hearings, who welcomed the courage of some current and former staff in giving evidence to our Commission of Inquiry:

> To our employees, to Will Gordon, to Maria Unwin and Stewart Millar, to Annette Whitemore, and may I also include Amanda Duncan as an employee that has spoken out for her sister: thank you for your bravery in coming forward as whistleblowers and for your continued efforts to try to alert the department to serious misconduct by other Health employees.
>
> I am sorry that it has taken a Commission of Inquiry for you to be believed or for your complaints and our lack of action to be publicly known.[6]

We consider the commitment of these individuals, who were vulnerable in their own reflections about their past actions (some of which were described with some regret), should be viewed within the context of their broader actions at the time and subsequently. We agree with the Premier and the Secretary that they should be commended for coming forward and sharing their experiences.

Taken together, the case studies show a fundamental failure of leadership at Launceston General Hospital to respond to potential risks to child safety over more than three decades, contributed to by the associated failures of Tasmania Police and Child Safety Services. The accounts in these case studies cannot be categorised as 'one-off' or 'rare instances' of inappropriate responses by the hospital to allegations of unprofessional behaviour.

We heard about the absence of effective protocols to protect children and young people at the hospital, the poor attitudes of managers to complainants and the inadequate responses of the hospital to disclosures.

These systemic failures at Launceston General Hospital have existed for decades and are likely endemic to the Tasmanian health system. Our recommendations—which we summarise below—are therefore relevant to all health services.

This volume comprises three chapters; Chapter 13—Background and context: Children in health services, Chapter 14—Case studies: Children in health services, and Chapter 15—The way forward: Children in health services.

In Chapter 13 we provide the context for our case studies. We outline Tasmania's health system (particularly as it relates to child safety) and summarise previous reviews of the health system that identified some of the same problems we discovered through our Commission of Inquiry. As previously noted, Chapter 14 focuses on our case studies—those of Dr Tim and Mr Griffin. In these case studies we identify systemic and individual failings within Launceston General Hospital relevant to the hospital's response to these allegations.

In holding individuals to account, we have tried to be fair and balanced, recognising that none of us are immune from imperfect responses and that we hold the benefit of knowledge that was not available to some at that time. We are also mindful that people operated in a broader context and that it was, in part, the hospital's lack of leadership and protocols, as described in the case studies, that enabled the unsatisfactory response of some to concerns and complaints about misconduct.

We are also conscious that some people were subject to greater scrutiny than others because of their roles in responding to complaints about Dr Tim and Mr Griffin, or because these people were more prominent in the information we received. We acknowledge that we may have not identified the relevant conduct of others because we were not made aware of it or did not have enough evidence to substantiate it. In considering the actions of individuals, we carefully considered their relative roles and responsibilities, and whether we considered their conduct justified our particular focus.

In these case studies we identify individual and systemic failings. These inform our understanding of the broader problems that need to be addressed in health services to protect children and young people from sexual abuse in the future, and to ensure health services respond better when abuse does occur.

In Chapter 15 we make recommendations for reform.

We recommend that the Department of Health develops and publicly communicates a policy framework and implementation plan for reforms to improve responses to child sexual abuse in health services. This policy and plan should explain the purpose and need for the reforms; the role, responsibilities and interactions of bodies established by the Department of Health as part of the reforms; how the reforms will work together to provide a system-wide response to child sexual abuse in health services; how the reforms are being prioritised for implementation; who is responsible for their implementation; and the expected timeframes for implementation.

Of national significance, recognising the risks we have identified of child sexual abuse in health settings, we recommend that the National Principles for Child Safe Organisations should be a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards under the Australian Health Service Safety and Quality Accreditation Scheme, and the Tasmanian Government should advocate for this reform at the national level.

We recommend that the Department of Health's cultural improvement strategy ensures clear organisational values, has strong governance, and ensures accountability of senior managers and executives. We recommend the Department of Health establishes processes and forums to facilitate the participation of children and young people in decisions affecting the delivery of health services, including a health services advisory group. The advisory group should comprise young people of varying ages and backgrounds, but who share significant experience with health services. Through the advisory group young people should have a say in departmental strategies, policies, procedures and protocols that affect them.

We recommend that the Department of Health develops a professional conduct policy for staff who have contact with children and young people in health services. The policy should provide examples of behaviour that is inappropriate in clinical and non-clinical contexts, such as engaging with children through online social networks and having unnecessary contact with children outside the professional relationship. It should also reference existing professional and ethical obligations held by registered health practitioners.

The development and implementation of a clear complaints management, escalation and investigation process is critical. Noting the specialised context in which health workers operate, the Department of Health may choose to establish a standalone Health Services Child-Related Incident Management Directorate or to partner with the Child-Related Incident Management Directorate we recommend in Volume 6 (Recommendation 6.6).

The Department of Health, Launceston General Hospital and Tasmania Police must ensure ongoing assistance to known and as yet unknown victim-survivors of child sexual abuse by Mr Griffin. The Department of Health should also develop and implement a critical incident response plan to ensure that measures are in place to communicate with clarity and consistency, and to support the affected members of the community, in the event of a future critical incident, such as a serious breach to children's safety within the public health system. The plan should identify who is responsible for leading the response to the critical incident, facilitate psychological first aid, support and critical incident debriefing and provide for a review of how the Department of Health responded to the critical incident.

Further, the Tasmanian Government should ensure a review of the *Health Complaints Act 1995* is completed and considers the role of the Health Complaints Commissioner in relation to addressing systemic issues within health services related to child safety.

Although the case studies in Chapter 14 focus on conduct that occurred at Launceston General Hospital, the aim of our report and recommendations is to prompt and facilitate change across the broader Tasmanian Health Service, the Department and agencies that work alongside those services, such as Tasmania Police and Child Safety Services.

Although most health services are places of healing and safety for children, our Commission of Inquiry has identified the high cost of complacency about the risks of child sexual abuse in these settings. The issues at Launceston General Hospital can and doubtlessly do occur within other health services. Services beyond the immediate remit of our Inquiry are encouraged to reflect on their own understanding and decision making about child safety and to take steps to make their organisation safe for children and young people. We trust the evidence presented in this volume of our report provides compelling reasons to do so.

13 Background and context: Children in health services

1 Introduction

In this chapter we summarise what is known about child sexual abuse in international and Australian health services, including through the Royal Commission into Institutional Responses to Child Sexual Abuse ('National Royal Commission') and our own research into children and young people's perceptions of safety in government health institutions in Tasmania. We briefly describe the Tasmanian health system and the key regulatory bodies that play a role in overseeing health services and the people who work within them. We also summarise four key reviews that have examined aspects of the Tasmanian health system relevant to our Commission of Inquiry, including organisational culture, governance arrangements and the reporting and management of misconduct.
We conclude the chapter by highlighting what we heard about the organisational culture at Launceston General Hospital, which as noted earlier is the primary focus of the remainder of this volume, including our case studies in Chapter 14.

2 Understanding the health context

Health services and health workers have a duty of care to patients, including children and young people, that extends to keeping them safe from harm while they are under their care.

Because people often assume health services are highly controlled, supervised and public environments, the risk of sexual abuse to children in these settings can be underestimated. People rightly expect that health workers will act in the best interests of patients and according to their professional obligations.

We reviewed a key report examining child sexual abuse in healthcare contexts published in the United Kingdom (discussed in Section 2.1.1), as well as research we commissioned into the experiences of Tasmanian children (discussed in Section 2.1.2), to learn more about the vulnerability of children and young people in health services. We also learned from the lived experience of victim-survivors and people working in these settings about the specific factors that can increase the risks of abuse to children in health services.

2.1 Research into child sexual abuse in health services

Unlike other government or government funded institutions of interest to our Commission of Inquiry, child sexual abuse within health services has not been the subject of significant research. There is limited data on the prevalence and incidence of child sexual abuse perpetrated within health services.[7] Consequently, the extent and nature of child sexual abuse that occurs in these institutions is not well understood.

Although the National Royal Commission heard evidence from some people who had experienced child sexual abuse in health services, child sexual abuse in health institutions was not a specific focus of the National Royal Commission.[8] Nonetheless, the National Royal Commission made the following general observations about child sexual abuse in health contexts:

> Medical practitioners, health professionals and hospitals are responsible for improving and maintaining the health of their patients. Patients, who are in a vulnerable state of illness, place their trust in health care providers. Patients, and the parents of child patients, place such trust in medical practitioners that they permit those medical practitioners to view and touch intimate parts of the patient's anatomy. Patients permit these acts because of the close nature of the health practitioner–patient relationship and because they believe that a health practitioner is acting in pursuit of a higher purpose of assisting the patient with his or her illness or injury and not out of personal sexual gratification.
>
> Children often follow instructions from health care providers without question and the private one-on-one nature of therapy places children in a vulnerable position.[9]

This observation extends beyond medical practitioners—it applies to all health workers within the health system, some of whom will use their position to abuse or manipulate children and young people.[10]

2.1.1 Truth Project thematic report into child sexual abuse in healthcare contexts

In 2020, as part of the Independent Inquiry into Child Sexual Abuse in the United Kingdom, the Truth Project published a thematic report that included findings about the experiences of victim-survivors of child sexual abuse in healthcare contexts.[11] The report described the research into health workers as sexual abusers of children as 'dated and sparse'.[12] The report also stated that it is difficult to estimate the prevalence of health workers breaching sexual boundaries, particularly in relation to children, because most child sexual abuse is hidden.[13]

The Truth Project report considered power dynamics that exist between health workers and patients, including the power dynamics between children and the health workers upon whom they rely to treat them.[14] The report described health services (particularly mental health facilities) as 'strong institutions'; that is, the power imbalance between patients and staff, coupled with the depersonalisation of patients that can occur in such institutions, creates an environment that enables abuse to occur.[15] This can be exacerbated when there is a workplace culture that prevents people from speaking up about wrongdoing.[16] We found similar problems through our Inquiry.

Key qualitative findings from the Truth Project report included:

- The vulnerability of patients in health settings was heightened because of patients being alone and without chaperones, and due to the 'unique nature of the position of trust and authority' held by health practitioners.[17]
- Although there were examples of children, their parents and staff being manipulated by abusers, overall, there was little evidence of grooming from health workers, which was attributed to the fact that such workers often did not need 'special' explanations to perpetrate their abuse.[18]
- Abusers were most commonly men with routine access to children, with many abusing children under the guise of medical procedures or examinations, sometimes involving medication.[19]
- Many (but not all) abused children had experienced abuse and neglect at the hands of family members and had experienced other difficulties (for example, bullying) that contributed to their health problems and made them particularly vulnerable to abuse within health services.[20]
- Only a quarter of the children who were abused felt they could disclose their abuse. Those who did disclose were often not believed, particularly if they were experiencing mental health problems at the time of their treatment. There were also limited processes or pathways for young people to disclose sexual abuse, particularly if they were inpatients.[21]
- For victim-survivors, abuse in a health setting sometimes contributed to a lifelong fear and mistrust of health workers.[22]

2.1.2 Commission of Inquiry's research into children and young people's perceptions of safety in government health institutions in Tasmania

As part of our Commission of Inquiry, we commissioned research that explored children and young people's perceptions of safety in government organisations in Tasmania, including hospitals.[23] This research enabled us to learn directly from the views and experiences of children and young people.

As part of this research, children and young people described two factors that contributed to making a health institution or hospital feel safe. The first was the presence of an adult who was 'friendly and kind', who 'showed interest' and who asked children and young people what they needed.[24] The second was the protective role parents or carers play in a child or young person's home life and engagement with institutions. For example, one young person reported feeling a lot more at ease in hospital knowing that his parents were there to make sure he was getting the care he needed, as well as to help him raise concerns and to advocate on his behalf.[25] Other children and young people who had spent time in hospital held a similar view:

> When there were issues, my mother had to go to the front counter, the main hub desk of the paediatric unit, and voice her frustration on behalf of not only my parents, but also me.[26]

Another participant in the research said:

> It does help to have someone to talk to. They said parents could sleep on a couch in the room. If I needed something I would ask my mum to ask them because I was too scared to talk to nurses. I was a real timid little kid. I just felt really little and [I would] just get Mum to do it.[27]

Several young people who had experienced a stay in hospital reported not feeling safe due to the physical characteristics of the hospital environment. They talked about how hospitals could feel 'creepy' and 'sterile'. One young person described the hospital environment in the following way:

> My room was dark. I didn't have access to a window. It felt like solitary confinement. It was quite horrible: that situation, I didn't feel safe. I didn't feel like I could flourish in an area like that. I didn't feel like I could get better in an area like that. It really wasn't useful until I was moved into a room where there were three windows and where I had different nurses, where I felt like, 'okay, I'm starting to get better. I can do this. I can get out of here'.[28]

Another young person talked about how having their own space in hospital was important:

> I've had a few surgeries and sometimes I am in a room by myself, sometimes I am in a room with someone else and that doesn't feel comfortable being in a room with someone you don't know. It's being in a room with strangers.[29]

One young person discussed the experience of being Aboriginal and having contact with a health institution. This person said the hospital made no attempts to acknowledge their culture or to support them to stay connected to their culture while they were in hospital:

> I didn't really feel represented or supported in terms of my cultural identity. I wasn't even asked if this was something I wanted, or if this was something that I valued about myself. It wasn't until I had been mentioning parts of my culture to nurses that that was a topic of conversation.
>
> [Question (from researcher): So, you would've been able to tell if it was culturally safe for you. In what way? How would it have been culturally safe for you?]
>
> If I had an Aboriginal youth worker come over. I didn't feel support in that aspect. And also, even whether there was access to national indigenous TV on the television, whether there was an Aboriginal mural in the hospital or things like that.[30]

These views from children and young people show how hospitals can feel unsafe and unwelcoming for many and how difficult it can be to raise concerns with staff, particularly if a young person does not have protective family or carers to advocate for them. The views referenced above reinforced for us the importance of hearing directly from children and young people about what is needed to facilitate and enhance their safety.[31] We discuss empowering children and young people in health services in Chapter 15.

2.2 Evidence of the risk factors for child sexual abuse in hospitals

Catherine Turnbull, Chief Child Protection Officer, SA Health, Department for Health and Wellbeing, told us that children and young people can be at risk of abuse or neglect perpetrated by adult patients, visitors, health workers or other children and young people in hospital settings.[32] She identified several risk factors that can make children and young people more vulnerable to abuse and neglect in hospital settings. These risk factors include:

- children and young people recovering in rooms that are not closely monitored by staff and/or closed-circuit television[33]
- placing children and young people in group rooms without enough regard for their suitability to be placed together[34]
- inpatient services that have a mix of child and adult patients[35]
- health workers treating children and young people without other people present (such as a parent/carer or other staff member)[36]
- failure to offer a chaperone where treatment is provided by a staff member of a different gender[37]

- the length and regularity of children and young people's attendance at hospital, and the degree of familiarity between children and young people and their treating health workers[38]
- feelings of disempowerment and dependency that arise in children and young people who have been hospitalised for long periods (or who have been hospitalised repeatedly), which can affect their ability to disclose concerns.[39]

Kathryn Fordyce, Chief Executive Officer, Laurel House, also described the vulnerability of young people in health services, stating that, '[u]nfortunately, there are social norms that mean we condition children, especially those with disabilities and health conditions, to be compliant and submissive'.[40] She described that trying to empower children to speak up when they are harmed is:

> … even more complicated for a child with a disability or a health condition who has been poked and prodded their whole life, and had their personal space invaded many times for legitimate medical or care reasons. All too often adults ignore a child's attempt to maintain their bodily autonomy, and then those same adults are surprised when children are abused and do not report it.[41]

3 Tasmania's health system

The Tasmanian Government provides a range of healthcare and health support services to the community. These services are delivered through major hospitals, district hospitals and community health services across three service areas—North, North West and South.[42]

The four major government hospitals that service the Tasmanian community are Launceston General Hospital, Mersey Community Hospital, North West Regional Hospital and Royal Hobart Hospital. Launceston General Hospital, North West Regional Hospital and Royal Hobart Hospital each have a paediatric unit and offer outpatient services to children and young people.[43] The smaller Mersey Community Hospital provides emergency paediatric services. District hospitals and community health services also provide healthcare and support services to children and young people.

3.1 Department of Health

The Department of Health is the system-wide administrator of the public health system and its attendant organisations in Tasmania. The Department is one of the largest public sector agencies in Tasmania, employing around 15,500 people who work across approximately 330 sites statewide.[44] The Department's workforce includes medical practitioners and specialists, allied health professionals, dental practitioners, paramedics, nurses and midwives, facilities officers, administration and support staff and contracted locum and agency staff.[45] A large base of volunteers also contribute their time and efforts across health services.[46]

The Department of Health has undergone several 'machinery of government' changes since the late 1990s.[47] These have resulted in substantial modifications to the Department's organisational structure and governance arrangements.[48] The recent *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (discussed in Chapter 15) found that this restructuring has contributed to 'some confusion around management roles, responsibilities and accountabilities' and a level of 'restructuring "fatigue"'.[49]

As noted, Secretary Morgan-Wicks leads the Department of Health. Secretary Morgan-Wicks started in the role on 2 September 2019.[50] The Secretary has a range of duties including planning health services and overseeing the performance of executive and senior staff.[51] The Secretary is also responsible for the performance of the Tasmanian Health Service and the Health Executive.[52]

A note on language

Unless otherwise stated, further references to 'the Department' in this volume are to the Tasmanian government department responsible for 'hospitals, ambulances, community health, and related areas such as primary healthcare'.[53] During the period under examination by our Commission of Inquiry (that is, responses to reports of child sexual abuse since 1 January 2000) this Department has been called the Department of Health and Human Services and the Department of Health.

3.2 Tasmanian Health Service

In line with the *Tasmanian Health Service Act 2018*, the Tasmanian Health Service is a statutory entity responsible for delivering health services to the community. Its functions are:

- to manage the operations of health services, including at public hospitals
- service planning
- budget management
- ensuring the Minister for Health's policies are implemented.[54]

3.3 Health Executive

The purpose of the Health Executive is to 'lead the strategic direction and provide oversight of the Department's key responsibilities'.[55] It includes the Secretary as well as a range of other senior roles, including the chief executives of Tasmania's hospitals, the Chief People Officer, the Chief Medical Officer and the Chief Nurse and Midwife.[56]

The functions of the Health Executive are to:

- administer and manage the Tasmanian Health Service
- perform and exercise the functions and powers of the Tasmanian Health Service
- ensure the services the Tasmanian Health Service provides are delivered in line with Tasmanian Health Service standards and within budget
- manage and monitor, and report to the Secretary on, the administration and financial performance of the Tasmanian Health Service
- monitor and report to the Secretary on the outcomes, for people, of providing health services to those people
- set up appropriate management and administrative structures for the Tasmanian Health Service
- perform any other functions specified by the Secretary.[57]

Various subcommittees and local health service managers across the State support the Health Executive.[58]

Some of the members of the Health Executive also serve on the Tasmanian Health Service Executive, which is responsible to the Secretary for administering and managing the Tasmanian Health Service.[59]

4 Oversight of the Tasmanian health system

As in other states and territories, external agencies oversee aspects of Tasmania's health system. These agencies are:

- the Office of the Health Complaints Commissioner Tasmania, which responds to systemic complaints about Tasmanian health services
- the Australian Health Practitioner Regulation Agency ('Ahpra') and the National Health Practitioner Boards, which respond to notifications about registered health practitioners, including those in Tasmania
- the Australian Commission on Safety and Quality in Health Care ('Safety and Quality Commission'), which accredits Tasmanian health service organisations against the National Safety and Quality Health Service Standards.

A core function of these oversight bodies is ensuring the safety of patients, including children and young people, who receive healthcare or health support services.

We briefly outline below the role of these bodies in overseeing aspects of Tasmania's health system.

4.1 Office of the Health Complaints Commissioner Tasmania

The Office of the Health Complaints Commissioner Tasmania was established in 1997 under the *Health Complaints Act 1995*. The Health Complaints Commissioner (at the time of writing) is Richard Connock, who was appointed to the role in July 2014.[60]

The functions of the Health Complaints Commissioner include to receive, assess and resolve complaints and to enquire into and report on matters relating to health services, at their discretion or as directed by the Minister for Health.[61]

The Health Complaints Commissioner performs their functions independently, impartially and in the public interest.[62] The Commissioner is not subject to the direction of any person about the way their functions are performed.[63]

4.2 Australian Health Practitioner Regulation Agency and National Health Practitioner Boards

In 2008, Australian states and territories agreed to develop a National Registration and Accreditation Scheme for health practitioners. This scheme replaced individual practitioner regulation in each jurisdiction.[64] The *Health Practitioner Regulation National Law Act 2009* ('National Law') began in all states and territories in 2010. Tasmania adopted the National Law through the *Health Practitioner Regulation National Law (Tasmania) Act 2010*.[65] The National Law established Ahpra and 15 National Health Practitioner Boards ('National Boards') for 16 health professions.[66] The National Law applies to all health practitioners who are registered in any one of these 16 health professions.[67]

Ahpra is the national organisation responsible for administering the National Registration and Accreditation Scheme.[68] Ahpra has a range of functions, but it primarily provides administrative support to the National Boards in performing their functions under the National Law.[69] Ahpra also establishes procedures for receiving and assessing applications for registration and notifications about registered health practitioners and maintains the national register of registered health practitioners.[70] This register, which can be searched on Ahpra's website, contains information about registered health practitioners, including information about current restrictions that apply to their registration.[71] An Agency Management Committee oversees Ahpra's work.[72]

The National Boards for the 16 health professions have a range of functions including:

- determining requirements for registration within the health professions
- approving accredited programs of study for registration in the health professions
- registering suitably qualified people in the health professions

- working with Ahpra to ensure the national register of health practitioners is up to date
- developing standards, codes and guidelines for the health professions
- overseeing notifications about people who are or were registered in the health professions
- overseeing the management of health practitioners registered in the health professions
- referring matters about people who were or are registered in the health professions to a relevant tribunal.[73]

In Tasmania, the relevant tribunal is the Tasmanian Civil and Administrative Tribunal.[74]

4.3 Australian Commission on Safety and Quality in Health Care

The Safety and Quality Commission was established by the former Council of Australian Governments in 2006 and is jointly funded by the Commonwealth and states and territories.[75] It started as an independent statutory authority on 1 July 2011.[76] The objectives of the Safety and Quality Commission are to 'contribute to better health outcomes and experiences for all patients and consumers and improve value and sustainability in the health system by leading and coordinating national improvements in the safety and quality of health care'.[77]

The Safety and Quality Commission has a range of functions in relation to healthcare safety and quality, which are set out in the *National Health Reform Act 2011* (Cth).[78] As part of its role, the Safety and Quality Commission develops the National Safety and Quality Health Service Standards ('National Standards').[79] The National Standards 'provide a nationally consistent statement on the level of care that consumers can expect to receive from health service organisations'.[80]

There are eight National Standards, including a Clinical Governance Standard, a Partnering with Consumers Standard and a Communicating for Safety Standard.[81] The primary aims of the National Standards are to protect the public from harm and to improve the quality of health service delivery.[82] We consider how the National Standards should relate to child safety (including the National Principles for Child Safe Organisations) in Chapter 15.

5 Previous reviews examining the Tasmanian health system

Over the past two decades the Tasmanian health system has been the subject of several reviews and investigations. These reviews and investigations have considered issues of performance, efficiency, organisational culture and misconduct committed by State Service employees. Although none of the reviews have specifically examined child sexual abuse in health services, many have identified some of the same problems that we found through our Commission of Inquiry as exacerbating the risks of child sexual abuse.

These problems include:

- ineffective governance arrangements and a lack of clarity about roles and responsibilities among staff in health services
- an absence of scrutiny over staff conduct and decision making and a lack of accountability for senior managers and executives
- organisational cultures characterised by poor leadership and toxic behaviour, including misconduct by State Service employees in relation to conflicts of interest, underperformance and mistreatment of staff
- failures to report misconduct due to fear of retribution
- instability because of changes in organisational and governance structures.

These reviews are relevant to our Inquiry because the available research into the risks of child sexual abuse in health services shows that workplaces with dysfunctional cultures—particularly those that allow poor conduct to go unaddressed—contribute to, or at least hinder, the identification of child sexual abuse.[83] These reviews also show that problems with governance, culture and misconduct within the Tasmanian health system are longstanding.

5.1 Report of an Investigation into Ward 1E and Mental Health Services in Northern Tasmania (March 2005)

In March 2004, the then Minister for Health and Human Services directed the then Health Complaints Commissioner to investigate Ward 1E at Launceston General Hospital and its associated Oldaker and Spencer clinics. At the time of the investigation, Ward 1E and its associated clinics were managed by Mental Health Services as part of the Community, Population and Rural Health Division of the Department of Health and Human Services and was not managed through the Launceston General Hospital.[84]

The investigation was prompted by several complaints to the Health Complaints Commissioner and Nursing Board of Tasmania about the treatment of patients in these units.[85] The complaints raised serious concerns about the standard of care and treatment provided to patients and alleged sexual misconduct by two nurses and a ward attendant against highly vulnerable adult patients.[86]

The Health Complaints Commissioner was tasked with examining the incidents and the Department's response to these complaints.[87] The Health Complaints Commissioner was also tasked with making recommendations for improvement, including in relation to complaints management, governance and risk management, performance oversight and the protection of patients.[88]

Two investigations addressed the terms of reference—one into the specific complaints about the behaviour of individual staff (which included sensitive information about patients) and the other into the broader systemic issues highlighted in the complaints.[89] We summarise the findings of the latter investigation below, noting that many of the problems identified are similar to those we heard about nearly 20 years later through our Commission of Inquiry.

5.1.1 Investigation into systemic issues

The Health Complaints Commissioner's investigation explored how reported incidents were managed, whether the individual performance of staff members was monitored, whether standards set by regulatory bodies were complied with, and whether systemic problems were identified and addressed.[90]

The report found that Ward 1E and its associated clinics did not, in many respects, provide an appropriate model of care for mental health patients nor foster an environment consistent with best practice.[91] The report also described serious sexual misconduct by staff at the facilities.[92]

The Health Complaints Commissioner made 26 recommendations, all aimed at improving the standard of care at the facilities.[93] These recommendations related to nursing practice, governance and incident reporting within a safety and quality framework, and the importance of spelling out appropriate professional conduct and accountability.[94]

Key recommendations included:

> **1. Ethical and appropriate workplace conduct**
>
> That Area Management, HR [Human Resources] and non-nursing personnel receive education and training in relation to the State Service Code of Conduct and its operation, with particular reference to the sort of conduct that could constitute a breach of its terms.

2. Appropriate professional conduct

That guidelines, educational units and protocols be developed and implemented in relation to professional boundaries for MHS [Mental Health Service] health professionals, and operate in conjunction with a governance and professional mentorship model.

3. Training — incident reporting, complaints and grievances

That all ward staff and area management officers receive education and training in relation to the procedures for the reporting of incidents, concerns and complaints and their investigation and resolution; with particular reference to the need to have regard to any clinical and clinical risk management issues raised by incidents, concerns or complaints.

4. Clinical supervision and mentorship

4.1 That if feasible, clinical supervision be delivered by both internal and external supervisors.

4.2 That the model of care formulated clearly articulate[s] the governance arrangements for the service. These governance arrangements need to incorporate both the unit specific governance and the broader hospital or health service governance arrangements. Clear lines of accountability and minimal duplication should be established.

4.3 Clinical leadership should be reflected in the governance arrangements and the role of clinical leaders determined by the model of care implemented.

4.4 Any amendments to clinical leadership should be implemented as an interim measure until a model of care is agreed.

4.5 That a Ward Management committee be part of the governance model.

...

20. Complaints

20.1 Implementation of policy and procedures for a continuum that addresses information notification of complaints through to sentinel events. The policy should cover resources required, governance arrangements, legislative requirements, staff development, timeframes and quality improvement cycles.

20.2 Any complaints [about] sentinel events and associated investigations or responses should be recorded on a database to allow trend analysis to occur and corrective action implemented.

20.3 That the skills base of managers and HR staff in relation to complaint handling be strengthened through the provision of additional training, with a focus on the importance of timeliness in responding to these types of matters.[95]

The Health Complaints Commissioner concluded that systemic failures can create a workplace culture that is conducive to misconduct or unprofessional conduct. This in turn has the potential to have an adverse effect on clinical practice and professional workplace relationships.[96]

5.1.2 Implementation

In April 2005, the then Minister for Health and Human Services established a taskforce to oversee implementation of the 26 recommendations.[97] The taskforce submitted a final report to the Minister in November 2006, which stated that 22 of the 26 recommendations had been implemented.[98] The report noted that the four outstanding recommendations were to be implemented over the following year by senior mental health service staff on Ward 1E as part of the broader *Mental Health Services Strategic Plan 2006–2011*.[99]

In June 2007, following more allegations about staff behaviour on Ward 1E, an external reviewer was engaged to undertake an audit. The purpose of the audit was to assess whether the Health Complaints Commissioner's 26 recommendations had, in fact, been implemented.[100] The external reviewer found that the recommendations had been implemented and that actions beyond the recommendations were taken.[101] However, the external reviewer identified that a persistent negative culture within the service and failures to adequately change this culture were having an ongoing adverse impact on practice.[102]

The external reviewer made a further 38 recommendations with respect to leadership, clinical governance, practice development, human resources management, partnership development, mental health promotion and information management.[103] The Department of Health and Human Services undertook a range of actions in response to the external reviewer's report.[104]

In December 2008, the external reviewer was invited to evaluate the progress the Department had made in implementing the 38 recommendations.[105] A final report, which was not publicly released, noted significant progress. However, the external reviewer also made another seven recommendations, some of which were addressed as part of a workforce review of Mental Health Services in 2009.[106]

5.1.3 Parallels between the 2005 investigation and evidence before our Commission of Inquiry

At our hearings, Mr Connock, current Health Complaints Commissioner, told us it was 'concerning' that very similar issues to those identified in the investigation of Ward 1E had emerged before our Inquiry.[107] He said there were 'very strong parallels' between the circumstances giving rise to the investigation into Ward 1E and the evidence that had emerged at our hearings, particularly about the nature of the misconduct, inadequate record keeping of complaints, poor communications about what had occurred, and inadequate support for those affected.[108]

5.2 Report to the Australian Government and Tasmanian Government Health Ministers, Commission on Delivery of Health Services in Tasmania (April 2014)

In September 2012, the Australian and Tasmanian governments set up the Commission on Delivery of Health Services in Tasmania ('Delivery of Health Services Commission'). The purpose of the Delivery of Health Services Commission was 'to investigate health service delivery in Tasmania, identify inefficiencies, and make recommendations on opportunities for lasting improvements in quality, efficacy, and system sustainability'.[109]

The Delivery of Health Services Commission's report documented far-reaching problems and called for a 'fundamental reform and redesign' of the Tasmanian health system.[110] The report noted that the health system had been the subject of several previous reviews, including *Tasmania's Health Plan 2007* and *The Tasmanian Hospital System: Reforms for the 21st Century* (2004), and that many of the issues identified in these previous reviews had not been rectified.[111]

The report also documented deficiencies in the clarity of roles and responsibilities between the Department of Health and Human Services (as it was then) and the former Tasmanian Health Organisations, finding that these deficiencies had negatively affected performance management, clinical governance, safety and quality, service planning, integration, engagement with the community and leadership and culture.[112]

Comments in the report on the culture of the health system were particularly concerning. The report described a 'deeply engrained culture of resistance to change, evidenced by the system's inertia in the face of several reviews recommending reform'.[113] The culture, as described, was characterised by varying degrees of denial about the problems within the health system and cynicism about the ability to implement initiatives designed to improve efficiency and sustainability.[114] The report stated that decisions made by some health practitioners or administrators appeared to be based on political convenience and self-interest rather than what was in the best interests of patients.[115]

Further, the report expressed serious concerns about the conduct of some staff within the health system:

> We have observed a lack of respect amongst key stakeholders, competition and a lack of cooperation, and resistance to routine performance measures. While there are capable and committed individuals within the health system, there are administrators and clinicians in leadership positions who behave in an unduly territorial manner. Personal animosities appear to override professional considerations and what should be universally accepted codes of conduct.[116]

We are particularly concerned about the reference to territorial disputes because such disputes can lead to problems being concealed to protect the reputation of a division or staff contingent.

The Delivery of Health Services Commission further noted in its report that the lack of leadership and accountability mechanisms within the Tasmanian Health Organisations had created 'a culture where behaviour that falls far outside acceptable professional conduct' was tolerated without consequence and was therefore allowed to thrive.[117] The Delivery of Health Services Commission also found that the Tasmanian Health Organisation model, whereby staff misconduct was the responsibility of local governing councils, shielded misconduct and the response to it from broader scrutiny by the then Department of Health and Human Services.[118]

The report concluded that 'poor leadership and bad behaviour [was] at the heart of Tasmania's inability to achieve both effective governance and sustainable change in its health system'.[119] The report stated that cultural problems needed to be addressed before any system reform or clinical redesign could be effectively undertaken.[120]

The Delivery of Health Services Commission made six recommendations, focusing on:

- governance arrangements, including positive leadership and collaboration
- requiring leadership roles to be performed according to a code of conduct
- making cultural change and leadership a top priority
- delivering whole of system leadership training to managers within the health system
- requiring leaders within the Tasmanian Health Organisations to take part in performance management
- implementing a change management process informed through staff consultation.[121]

The website that housed the Delivery of Health Services Commission's report has been decommissioned. The extent to which the Tasmanian Government accepted the Delivery of Health Services Commission's recommendations is unclear because no formal response to the recommendations is publicly available.

Subsequent reforms to the health system appear to have at least partially responded to the Delivery of Health Services Commission's report and prior reports. However, we note that the culture of leaving unprofessional conduct unaddressed and unscrutinised was evident in all our case studies, in particular our case study of Mr Griffin, which we discuss in Chapter 14.

5.3 An Investigation into Allegations of Nepotism and Conflict of Interest by Senior Health Managers (2014)

The Integrity Commission investigated senior health managers in 2014 following a complaint from a member of the public. The complaint alleged that two senior officers at the North West Area Health Service (as it was then) had used their positions to employ family members and associates.[122]

The Board of the Integrity Commission found that the two officers had not disclosed significant conflicts of interest and had failed to comply with the applicable policies for employment.[123] Significant gaps were also found in record keeping relevant to the recruitment of these roles.[124]

A key issue the Board of the Integrity Commission considered was how the organisational culture at North West Area Health Service had influenced attitudes and responses to inappropriate behaviour. The Board commented that:

> A good workplace culture which promotes the values, code of conduct and principles of the State Service can improve morale, boost productivity, and improve an organisation's reputation with the community, suppliers and its own employees. Equally, an organisation whose leaders consistently breach the principles, code of conduct and applicable policies, and who demonstrate inappropriate and improper conduct, risks producing a workplace culture that fails to implement or even understand the principles.[125]

The Integrity Commission observed that the improper conduct had been instigated by senior officers, who should have known that such conduct was improper and contributed to an unhealthy culture that discouraged staff from raising concerns.[126] The Integrity Commission noted it was significant that a member of the public had to complain about the conduct before any action was taken.[127]

The Integrity Commission's report, which had 11 recommendations to prevent future misconduct, was referred to the then Premier and Auditor-General for action. Broadly, these recommendations were about keeping health service staff accountable for their recruitment practices.[128]

The Integrity Commission also noted that as part of a 2013 investigation into allegations of misconduct in recruitment within the Department of Health and Human Services, it had recommended to the Department of Premier and Cabinet that a mandated process of declaration of knowledge or association be established in State Service selection processes.[129]

In a media release issued in response to the 2014 Integrity Commission report, the Premier stated that the Government had acted on the recommendations.[130] In 2020, the Integrity Commission again inquired into the misconduct of public officers in the Tasmanian Health Service, North West Region.[131] The report noted that management

can dictate culture. It highlighted that a similar culture existed in 2020 to that which it had identified in its 2014 report, noting that employees failed to report conduct even though they had significant concerns about the integrity of management's actions.[132]

5.4 Performance of Tasmania's Four Major Hospitals in the Delivery of Emergency Department Services (May 2019)

In 2019, the Tasmanian Auditor-General reported on the findings of an assessment of the efficacy of emergency departments in Tasmania's four major hospitals, from the perspective of patients.[133] These four hospitals were the Launceston General Hospital, Mersey Community Hospital, North West Regional Hospital and Royal Hobart Hospital.[134]

In his report, the Auditor-General concluded that the Tasmanian hospital system was not working effectively to meet the growing demand for emergency department care, inpatient beds and performance obligations in relation to emergency department access and patient flow, as required by the *Tasmanian Health Service Plan*.[135] This failure was found to be due to capacity constraints and longstanding cultural and process weaknesses within the hospitals, which impeded effective discharge planning, bed management and coordination between emergency departments and inpatient areas.[136] The Auditor-General made 10 recommendations.

Although most of the Auditor-General's report concerned service delivery within emergency departments, it also referenced the culture within the Tasmanian Health Service. The report acknowledged that:

> Successive reviews by the Tasmanian and Australian governments over the last decade have highlighted dysfunctional silos, behaviours, process barriers and resistance to change from some clinicians and administrators within hospitals as major drivers of inefficiencies.[137]

The Auditor-General further observed, while conducting the assessment, that hospital staff had described longstanding cultural and governance challenges as factors contributing to poor coordination between emergency departments and inpatient wards. These challenges included:

- the ongoing presence of dysfunctional operational 'silos'
- the lack of effective whole of hospital leadership and action to drive change
- the effects of disruptive governance role 'churn' at the senior executive level
- perceived inadequate planning, governance and resourcing to implement past reforms
- lack of accountability among staff.[138]

Reference was again made to the findings of the Delivery of Health Services Commission in its 2014 report.[139]

To address the cultural issues raised, the Auditor-General recommended that:

> [The] Tasmanian Health Service and [the Department of Health and Human Services] urgently implement a culture improvement program and initiatives with clearly defined goals, accountabilities and timeframes to:
>
> - eliminate the longstanding dysfunctional silos, attitudes and behaviours within the health system preventing sustained improvements to hospital admission, bed management and discharge practices
> - ensure that all Tasmanian Health Service departments and staff work collaboratively to prioritise the interests of patients by diligently supporting initiatives that seek to optimise patient flow.[140]

A media release from the then Minister for Health indicated that the Tasmanian Government had noted the recommendations and was considering opportunities for reform.[141]

6 Poor culture at Launceston General Hospital

Just as previous reviews have identified a dysfunctional culture across some of Tasmania's health services, we heard from several current and former staff members about a longstanding dysfunctional culture at Launceston General Hospital. Staff members told us of their concerns about entrenched cultural problems at the hospital, including practices of favouritism in recruitment and the manipulation of recruitment processes, and deliberate attempts to suppress or conceal complaints of misconduct.[142] A sample of the evidence we heard in relation to the dysfunctional culture at Launceston General Hospital is summarised below.

One former staff member, who worked at Launceston General Hospital in the late 1990s, described the hospital's culture during their time of employment as 'grotesque' and 'distorted'.[143] They said the culture was:

> Grotesque in that it prioritised reputations and institutional interests over staff and patient safety. Distorted in that it punished those who sought to protect staff, patients and children. I believe that patients are not safe if staff don't feel safe.[144]

Maria Unwin told us of learning about an incident of alleged abuse from her colleagues when she started working at Launceston General Hospital in the 1990s. She said that, in the period she worked in Ward 4K, the response of hospital management to this incident left a clear message for staff:

> I was always shocked that even when someone was caught in the act of child sexual abuse they would only be moved on and that would be covered up.[145]

Ms Unwin also stated that those who spoke up about issues at Launceston General Hospital were considered by management to be 'trouble-makers'.[146]

Another nurse who had worked at Launceston General Hospital since the early 1990s told us she believed Ward 4K had a 'culture of fear and insecurity' that 'allowed staff concerns about Jim Griffin's behaviour to be ignored'.[147]

A current employee of the hospital told us she thought there was a 'distinct cultural lack of regard for clinical governance', resistance to change and narrow-mindedness.[148] This employee also noted what she understood to be a resistance from management to receiving and acting on feedback, and that management had promoted 'a culture of dismissing complaints'.[149]

At our consultation in Launceston, several former and current staff members independently raised concerns about the culture at Launceston General Hospital. These concerns included:

- a poor complaints process that lacked transparency
- management minimising staff concerns when reporting those concerns to senior management or the executive
- preferential treatment for some staff, including disclosing the identity of staff members who had complained about them
- victimising complainants
- managers not responding to complaints causing people to stop raising concerns
- a hierarchical, chauvinistic culture that normalised sexualised bullying of staff
- some staff members bullying, ostracising and intimidating colleagues so they would not make complaints against them
- staff being so fearful of management that they had physical traumatic reactions when management was nearby
- the hospital silencing dissent by 'weaponising the legal system' such that people were scared to speak up for fear that a defamation or breach of confidentiality action, or reprimands for failing to personally make a mandatory report, would be the consequence
- staff feeling as though they could not report poor conduct because they owed their jobs to those people exhibiting the conduct, or the allies of those people
- staff not making complaints due to fear of reprisal

- management being motivated by a desire to protect the reputation of the institution over the needs of children
- rumours that destroying incriminating records was a regular practice within the hospital.[150]

While we have not established that each of these concerns are true, when considered as a whole they paint a picture of a culture that discourages complaints and fails to respond to complaints when they are made and may allow poor conduct to go unaddressed. Such a culture increases the risk of child sexual abuse occurring or being ignored.

The cultural issues described above give context to what we heard about the ways in which Launceston General Hospital, its executive and senior managers responded to complaints about, and the alleged conduct of, staff at the hospital such as Dr Tim and Mr Griffin. We make a range of findings about the collective leadership of Launceston General Hospital in its response to Mr Griffin's abuses within that case study.

In the next chapter—Chapter 14—we present our case studies.

Notes

Introduction to Volume 6

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Chapter 13 — Background and context: Children in health services

7 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 16.

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25 Tim Moore and Morag McArthur, *Take notice, believe us and act! Exploring the safety of children and young people in government run organisations* (Research Report prepared for the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, February 2023) 43.

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14 Case studies: Children in health services

Content warning

Please be aware that the content in this report includes descriptions of child sexual abuse and may be distressing or raise issues of concern for some readers.

We encourage readers to exercise discretion in their engagement with this content and to seek support and care if required.

1 Introduction

In this chapter, we present three case studies relating to allegations against staff in health settings. Our terms of reference specifically required us to have regard to allegations of child sexual abuse against James Griffin.[1] We received evidence about other allegations in health settings and examined some of these more closely. We did this to acknowledge the efforts of the victim-survivors involved and their families to improve the safety of other children and young people, and to bring to light that Mr Griffin's abuse, and the hospital's failures to respond to it appropriately, were not an anomaly.

Case study 1 examines a complaint made by an individual in respect of receiving a health service. We make findings in relation to this case study, but it is subject to a restricted publication order.

Case study 2 examines a 2001 complaint by 11-year-old Zoe Duncan (now deceased) and her parents alleging sexual abuse by Dr Tim (a pseudonym), a former doctor at Launceston General Hospital. It outlines a series of wrongful assumptions and inadequate investigations, each infecting the next. We make several findings in relation to this case study.

Case study 3 examines at length the evidence we received about Mr Griffin's abuse throughout his tenure at the hospital. Over the course of Mr Griffin's offending, there were numerous and consequential missed opportunities—by Launceston General Hospital, Tasmania Police and Child Safety Services—to intervene earlier. The number and scale of findings we make in this case study is reflective of the magnitude of the failures to keep children and young people safe from Mr Griffin for almost twenty years, until he was finally suspended from his employment in mid-2019 after losing his registration to work with vulnerable people following a police report. They also reflect a series of response failures—in the systems and processes, and in the conduct of individuals, once Mr Griffin's offending was known. We carefully considered the responsibilities of individuals at the hospital relative to their roles in addressing Mr Griffin's behaviour, and in the context of the dysfunctional environment in which they were operating. In some cases, the conduct and omissions of individuals in response to known risks and incidents of abuse by Mr Griffin were not justified and we make findings accordingly.

In accordance with the Restricted Publication Order of the Commission of Inquiry dated 30 August 2023 and section 10(3) of the *Commissions of Inquiry Act 1995* (Tas), the Governor has omitted Volume 6, Chapter 14, Case Study 1 because the public interest in the disclosure of that part of the report is significantly outweighed by other relevant considerations, namely the right of any person to a fair trial.

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Case study 2: Response to complaint about Dr Tim (a pseudonym)

1 Overview

In a written statement and at our hearings, Anne and Craig Duncan told our Commission of Inquiry about the experiences of their daughter Zoe at Launceston General Hospital. While we refer to Mr Duncan for much of this case study, because the statement is written in his voice, we acknowledge that this was a task Mr and Mrs Duncan undertook together with great care and dignity. We also acknowledge that Zoe's sister, Amanda Duncan, contributed to our understanding of Zoe and her experiences.

Zoe Duncan experienced many health issues as a child, including epilepsy, chronic asthma and juvenile arthritis.[137] Although she was resilient and considered these issues 'just a part of life', they did result in regular visits to Launceston General Hospital.[138]

In 2001, when Zoe was 11 years old, she made allegations about sexual abuse perpetrated against her at Launceston General Hospital by an emergency department doctor who we will refer to as Dr Tim (a pseudonym).[139] Mr Duncan said that these events changed Zoe, describing his daughter prior to her admission to Launceston General Hospital in the following way:

> Prior to May 2001, Zoe was a carefree child. She had a well-developed sense of humour and laughed often. Zoe could see the funny side of life, even when unwell. She enjoyed sport and played hockey, basketball and football. Zoe was a prolific reader and loved writing. She enjoyed jazz and national dancing as well as learning to play the piano. Zoe deeply appreciated and often expressed awe at the beauty of nature. Annual camping holidays at the Mersey Bluff, Devonport were always eagerly anticipated and provided Zoe with many happy and relaxed occasions with family and friends. From a young age Zoe had a deep insight into people and could generally read others extremely well. She was loving and loyal to her family and friends. Zoe was extremely honest, bright, well-mannered and delightful company. A gentle, kind and caring person, who was grateful for, and content with, life's smallest pleasures. We would describe Zoe as an easy child to parent.[140]

This description contrasts significantly with how Mr Duncan described Zoe after she was discharged from Launceston General Hospital in May 2001:

> Following her abuse at [Launceston General Hospital], Anne and I didn't have the same daughter anymore, nor Amanda her sister. The girl who went into hospital was not the same girl who returned home. Zoe withdrew from me for many months. She had been hurt by a man and found it difficult to be around men and boys. She would

> stay in her bedroom crying. She was withdrawn, angry, had a lack of energy and interest in life. I would describe Zoe as having a complete change in personality. She started having suicidal thoughts and suffering from insomnia. Zoe began to wet the bed which had not occurred prior to her admission to [Launceston General Hospital]. She began having periods lasting in excess of 20 days, which her [general practitioner] stated was due to stress. Zoe was prescribed Xanax to help her manage the overwhelming anxiety she experienced. The experience at [Launceston General Hospital] caused significant emotional dulling and stress. In addition to Zoe, every member of the family was in incredible emotional pain.[141]

In 2002, Zoe wrote a letter that described what she said happened at the hospital and how it had affected her:

> The hospital experience with the man, [Dr Tim], has changed me in ways I don't want it to. My thoughts, my dreams and the way I feel about things. I find this all too much and what people might think about me. I feel so terrible but it keeps getting worse. People say I'll get over it but I don't feel I will. I'm falling apart and I'm struggling to keep my head above the water. I'm trapped, scared, nowhere to go. I can't go on like this. I'm trying to do my best but I'm being held down and I just want to wither away.[142]

2 Zoe's admission to Launceston General Hospital in 2001

On 18 May 2001, Zoe was taken to the Launceston General Hospital emergency department after an asthma attack.[143] Mr Duncan told our Commission of Inquiry that at the hospital he and Mrs Duncan met Dr Tim, who said they 'had a very beautiful daughter'.[144]

On 19 May 2001, Zoe was again taken to the emergency department after another asthma attack.[145] This time, Dr Tim was assigned as Zoe's treating doctor.[146] Late that afternoon, Dr Tim told Mr and Mrs Duncan that Zoe would need to remain under observation in the emergency department for a few hours and then stay overnight in the paediatric ward, Ward 4K.[147] Mr Duncan recalled that Dr Tim commented that Zoe's younger sister, Amanda, looked tired and suggested the family go home and collect some personal items for Zoe's stay.[148] Mr Duncan also recalled that before leaving the hospital Dr Tim asked how far away they lived and how long it would take for them to drive home to collect the items.[149]

While Mr Duncan was driving back to the hospital with the items, he got a phone call from Dr Tim, who said Zoe was upset and wanted to speak with her dad.[150] The call disconnected before Mr Duncan could speak with Zoe so he contacted Mrs Duncan and asked her to find out what was going on before he continued the drive to the hospital.[151]

When Mr Duncan arrived at the emergency department, he saw Dr Tim emerging from behind the curtains of Zoe's cubicle.[152] Mr Duncan recalled that Dr Tim reiterated that he had called because Zoe was upset.[153] On entering the cubicle, Mr Duncan saw Zoe 'curled up on the bed in the foetal position'.[154] Mr Duncan told us that Zoe said: 'Dad, Dad get that man away from me, he's dangerous, he's a madman'.[155] Zoe told him that Dr Tim had said he loved her, wanted to marry her and had been touching her all over.[156] Mr Duncan told us Zoe also said Dr Tim had squeezed her breast, tugged her ears and put his fingers in her mouth.[157] He said Zoe also reported fearing Dr Tim would follow her to Ward 4K.[158]

Mr Duncan told us that he reported what Zoe had said to a nurse on duty. Not wanting to falsely accuse Dr Tim of wrongdoing, and hoping that there had been a misunderstanding, Mr Duncan indicated at that stage he did not want to take things further.[159] Despite his reservations, Mr Duncan said the nurse reported Zoe's allegations and set up a meeting between Mr Duncan and four members of staff, including the after-hours nurse coordinator and the registrar on duty.[160] Mr Duncan said he was told that Zoe would be transferred to Ward 4K and Dr Tim would be instructed not to see her.[161] Shortly after this meeting Zoe was moved to Ward 4K.[162]

Later that night, the after-hours nurse coordinator notified the former Executive Director of Medical Services, Dr Peter Renshaw, of Zoe's allegations.[163] Dr Renshaw was Dr Tim's line manager at the hospital.[164]

Dr Renshaw's file note of matters relating to Zoe ('the Zoe Duncan file note') records that the initial allegations made by Zoe on 19 May 2001 were that Dr Tim had given Zoe a hug, kissed her hand, said she was a pretty girl and that if she were older, he would marry her.[165] The Zoe Duncan file note is generally consistent with the incident report made by the nurse on duty, which records Zoe's allegations as: 'the doctor kissed my hand, cuddled me and said if I was older he would marry me. Please don't tell anyone'.[166] Neither the Zoe Duncan file note nor the nurse's incident report refer to Dr Tim touching Zoe's left breast, tugging her ears or putting his fingers in her mouth.

The Zoe Duncan file note states that staff indicated to Dr Renshaw that these events were 'a highly unusual situation' and that 'no one was certain how it was to be handled'.[167] The Zoe Duncan file note also states that Mr Duncan wanted the complaint to be dealt with 'quietly', that he was concerned for Dr Tim's reputation and that he had asked that no formal complaint be documented. According to the Zoe Duncan file note, nursing staff were not to approach Dr Tim until the Duncans had spoken to Dr Renshaw.[168]

Dr Renshaw gave evidence to us that when he was notified of Zoe's initial allegations on 19 May 2001 he did not perceive them to involve an assault but rather a 'professional boundary violation which could be, but may not have been, child sexual abuse'.[169] Dr Renshaw also said he did not consider that the behaviour reported was at a level that required Dr Tim to be prevented from continuing to work in the emergency department.[170] Dr Renshaw said there was 'no necessity for sudden knee-jerk actions'

on this night.[171] Dr Renshaw confirmed that he did not speak with Dr Tim about Zoe's allegations or take any other steps at that time.[172]

In his evidence to us, Dr Renshaw said that 'Dr Tim was actually told by the after-hours nurse manager' on the night of 19 May 2001 to not visit Zoe.[173] The documentary evidence is unclear as to what time Dr Tim was given this instruction. A Medical Council of Tasmania investigation report (discussed in Section 5.2) notes that the nurse manager 'left instructions' sometime after 9.00 pm that Dr Tim was not to see Zoe.[174]

Mr Duncan said that later that night, while Zoe was on Ward 4K, he retrieved some items from his car.[175] When he returned, Zoe told him that Dr Tim had been to see her.[176] Mr Duncan recalled that Zoe said Dr Tim had been there for 'about 30 seconds' and had said he hoped she was okay and to remember 'this is our little secret'.[177]

Mr Duncan told us that, on the morning of 20 May 2001, he reported Dr Tim's visit to the after-hours nurse coordinator, who suggested he speak with Dr Renshaw.[178] An appointment with Dr Renshaw was arranged for the next day.[179] Mr Duncan recalled encountering the registrar from the previous night, who asked him how Zoe was before saying they had been at Dr Tim's house the night before.[180] Mr Duncan told us that the registrar said to him: 'The doctor is a very nice man, and you better hurry up and decide what you are going to do. I don't think the doctor will take it any further and see his lawyer as he is not that sort of person'.[181] Mr Duncan perceived this as a 'thinly veiled threat' and believed that the registrar was attempting to protect a friend and colleague.[182]

We did not seek or receive evidence from the registrar or the after-hours nurse coordinator who were on shift the night Zoe made her allegations.

Later that day, Mrs Duncan arrived at Launceston General Hospital and Mr Duncan returned home.[183] Mr Duncan told us that, while washing some of Zoe's clothing from the hospital, he noticed blood on Zoe's underpants.[184] Zoe did not have her period.[185]

Later that night, Zoe told Mrs Duncan that Dr Tim had 'put his front bottom on her front bottom'.[186] At the time, Mrs Duncan thought this meant Dr Tim had leant across Zoe.[187]

3 Launceston General Hospital's response to Zoe's allegations

On 21 May 2001, the Duncans met with Dr Renshaw.[188] Mr Duncan recalled telling Dr Renshaw what Zoe had disclosed and who was involved.[189]

The Zoe Duncan file note states that, at the meeting, the Duncans 'thanked me for the way the hospital had dealt with the matter thus far' and indicated that Zoe had raised a further concern about Dr Tim that involved 'touching'.[190] The Zoe Duncan file note records that the Duncans believed 'something unusual had gone on' but were not sure

what it was.[191] The file note also records that Dr Renshaw asked the Duncans whether they thought Zoe would be willing to speak to him directly, in the presence of a family member, so he could 'assess' her story.[192]

The Zoe Duncan file note states that Dr Renshaw told the Duncans that the hospital had 'absolutely no previous problems with [Dr Tim]' but that he would, 'as a matter of urgency', reinforce the hospital's chaperone policy and that the hospital would continue to 'closely but discretely' monitor Dr Tim.[193] At our hearings, Dr Renshaw conceded that there was no suggestion at this point that he would preclude Dr Tim from treating children.[194] When asked at the hearings whether he should have prevented Dr Tim's access to children while he considered the issue, Dr Renshaw said that it would have been 'premature' but conceded that it 'should have been considered'.[195] Dr Renshaw also conceded that he should have reported the incident to Child Safety Services at this time.[196] He agreed that one of the factors that influenced his decision not to report was the reluctance of the Duncans to report, but later conceded that their views should not have influenced his decision.[197]

The Zoe Duncan file note further states that, later that afternoon (at about 4.00 pm), Dr Renshaw spoke with Zoe in the presence of Mr Duncan, a resident medical staff coordinator and a nurse on Ward 4K.[198] According to Mr Duncan, Zoe told Dr Renshaw exactly what she had told Mr Duncan the night before.[199] Mr Duncan recalled that Zoe explained and demonstrated that Dr Tim had tugged at her ears, put his finger in her mouth and touched her like 'this' while flicking her hands down her chest and legs. Mr Duncan also recalled that Zoe told Dr Renshaw about the comments Dr Tim made about her being beautiful and wanting to marry her, as well as Dr Tim telling her: 'This is our little secret'.[200]

Dr Renshaw told us it was during this meeting that Zoe disclosed Dr Tim had touched her left breast during an examination and that it felt 'different' to other examinations.[201] Dr Renshaw told us at our hearings that at the time he accepted what Zoe had told him was true, including that Dr Tim had touched Zoe's breast, kissed her hand, hugged her, spoken about her appearance and said he wanted to marry her.[202] We note that these allegations, taken together, are an allegation of child sexual abuse. Despite Dr Renshaw accepting these allegations as a truthful account, they were not treated as an allegation of child sexual abuse. Dr Renshaw did not report Zoe's allegations to Tasmania Police or Child Safety Services at that time. Instead, Dr Renshaw told Zoe that it was important for her to feel safe and that she had a right to have another person present when she was being examined.[203] Dr Renshaw told us he did not see any difficulty in asking an 11-year-old child under the hospital's care to take steps for her own protection.[204]

Dr Renshaw told us that Zoe also revealed at this meeting that Dr Tim had visited her on Ward 4K in the evening of 19 May 2001.[205] Dr Renshaw told us he explained to Zoe that doctors sometimes follow their patients to check on them after they have been

admitted, but that he also 'agreed' at the meeting that Dr Tim's behaviour constituted a 'further professional boundary issue'.[206]

At our hearings, Counsel Assisting asked Dr Renshaw whether he should have stood Dr Tim down after this discussion with Zoe. Dr Renshaw responded:

> I don't know. I actually don't know that I actually would have had the power to stand him down, but regardless of the [human resources] processes that are required, at that time I don't think it was appropriate to do that, but yes, today I would do that.[207]

When Dr Renshaw was asked if he saw this as an error of judgment at the time, he conceded that it was an error of judgment that arose because he was inexperienced in his role.[208]

Mr Duncan told us that after the meeting he asked Dr Renshaw what he thought about Zoe's allegations. Mr Duncan recalled that Dr Renshaw responded that 'Zoe wasn't upset enough to have experienced sexual misconduct of any kind'.[209] The Zoe Duncan file note records that during this meeting Zoe's 'affect did not seem to reflect the degree of awkwardness or distress that she was describing'.[210] When Counsel Assisting asked Dr Renshaw about this observation in the Zoe Duncan file note, he said he was making a clinical observation.[211] We note that Dr Renshaw's clinical observation and his evidence outlined above that he accepted Zoe's allegations as being true are somewhat contradictory.

Dr Renshaw told us in his statement that, after he spoke with Zoe, he 'deemed that there had been a breach of professional boundaries' but that he 'was not clear that the nature of the breach was sufficient to justify immediate notification to [Child Safety Services]'.[212] Dr Renshaw later told us that, although he discussed the option of reporting with Zoe's family, he did not consider it was necessary to report the matter to Child Safety Services.[213] Dr Renshaw said he did not accept that the allegation Dr Tim touched Zoe's breast, without more, amounted to assault or child sexual abuse.[214] Dr Renshaw also told us he considered a mandatory report was unnecessary for several reasons, including that there was no sexual assault reported.[215]

Claire Lovell, Executive Director, Children and Family Services within the former Department of Communities, gave evidence that it is best practice to report boundary breaches, inappropriate behaviour and sexual abuse as soon as they are observed or reported.[216]

Dr Renshaw conceded at our hearings that, at the time he became aware of the further disclosure that Dr Tim had touched Zoe's left breast, he should have escalated the complaint as a matter of child safety, and taken steps to ensure Dr Tim did not have access to children.[217] These concessions are the subject of findings we make later in this case study.

Mr Duncan told us that on 22 May 2001, he spoke with Dr Renshaw to again put aspects of Zoe's disclosures to him for a response.[218] Mr Duncan recalled that in response to Zoe's disclosure that Dr Tim had touched her breast, Dr Renshaw said that Dr Tim could have been trying to locate the heart.[219] In response to Zoe's disclosure that Dr Tim had put his fingers in her mouth, Mr Duncan recalled that Dr Renshaw said that Dr Tim may have been feeling for ulcers.[220] In response to Zoe's disclosures that Dr Tim had visited her on Ward 4K, Mr Duncan recalled that Dr Renshaw said he encouraged doctors to follow up with admitted patients as good practice.[221] In response to the disclosure that Dr Tim had told Zoe 'this is our little secret', Mr Duncan recalled that Dr Renshaw said this was a silly thing to say and that the standard of English among foreign doctors needed to be addressed.[222] Mr Duncan recalled telling Dr Renshaw that 'one of the parties concerned here has been tragically aggrieved but nevertheless I'm troubled by the nature of Zoe's allegations and the tenuous responses to them'.[223]

The Zoe Duncan file note makes no reference to this exchange. Instead, it states that Mr Duncan 'thanked me for the way the matter had been handled' and records that Mr Duncan asked Dr Renshaw to convey to Dr Tim the Duncans' apologies for having to raise the matter.[224] The file note also states that Mr Duncan 'appeared satisfied with the monitoring plan', although this monitoring plan is not outlined in the Zoe Duncan file note.[225] At our hearings, Dr Renshaw maintained that this file note was an accurate record of the meeting with Mr Duncan.[226] It is apparent to us that Dr Renshaw does not accept Mr Duncan's account of events. It is not necessary to resolve this for the purpose of our Inquiry and we make no finding in this regard.

In his statement to us, Dr Renshaw said that he also met with Dr Tim on 22 May 2001 and 'spoke with him about professional boundaries and the need to observe the hospital's guidance on chaperones'.[227] On one account in Dr Renshaw's statement, he indicated that he counselled Dr Tim about the complaint, provided him with a copy of the hospital's chaperone procedure and told Dr Tim that further complaints would need to be referred to Child Safety Services or to the police.[228] In another account in the same statement, Dr Renshaw said that he mentioned the possibility of police involvement but not the involvement of Child Safety Services.[229] In oral evidence at our hearings, Dr Renshaw told us that at the time of Zoe's allegations he had assumed there was a chaperone policy in place at Launceston General Hospital, but when he went looking for one to explain it to Dr Tim, he discovered the hospital only had an informal policy in place.[230] As a result, he wrote a new chaperone policy (which we discuss in Section 4.1).[231] Dr Renshaw's varying accounts of this meeting are internally inconsistent and consequently impeach the reliability of his account of this meeting.

At our hearings, Dr Renshaw gave evidence that Dr Tim 'was off duty earlier that week' and that he 'didn't get around to actually talking to [Dr Tim] until the week after' Zoe's disclosures.[232] Dr Renshaw told us that the first meeting with Dr Tim occurred on 29 May 2001. Dr Renshaw made a file note of this meeting ('the Dr Tim file note'), which records:

'I explained to [Dr Tim] that a complaint had been made against him from the Duncans' and '[Dr Tim] was immediately distressed and vehemently denied any wrong doing'.[233] Due to the varying accounts across Dr Renshaw's statement and the evidence he gave at our hearings, we cannot be certain that a meeting with Dr Tim took place prior to 29 May 2001 and we make no finding in this regard.

4 Reporting, incremental disclosures and investigations

4.1 Multiple contacts about making a report

On 24 May 2001, after Zoe had been discharged from Launceston General Hospital, Zoe's general practitioner contacted Dr Renshaw. Zoe's general practitioner asked whether a report had been made to Child Safety Services about her allegations.[234] Dr Renshaw told us that he had mentioned the possibility of a report to the Duncans, but they had been reluctant to proceed.[235]

Dr Renshaw stated that Zoe's general practitioner told him Zoe had since made additional allegations against Dr Tim.[236] Dr Renshaw gave evidence that because Zoe's general practitioner was not forthcoming about what the allegations were, he asked them to write to him formally about the concern and that he would confirm 'current actions' about any notifications in writing.[237]

On 25 May 2001, Zoe's general practitioner wrote a letter to Dr Renshaw seeking confirmation that he was 'acting on this matter including reporting, if appropriate to relevant authorities'.[238] It is not clear to us whether Dr Renshaw responded to this letter.

Mrs Duncan also contacted Dr Renshaw on 25 May 2001 to ask if he had reported Zoe's disclosures because Zoe's psychologist needed the matter to be reported before speaking with Zoe.[239]

The Zoe Duncan file note records the conversation with Mrs Duncan on 25 May 2001. It states that Mrs Duncan was 'concerned by Zoe's behaviour, and mentioned crying in school and problems sleeping', that Mrs Duncan had told Zoe's teachers about the 'problem at the hospital', that Mrs Duncan was trying to arrange counselling for Zoe, and that she had contacted Laurel House but:

> ... had not provided full details to Laurel House, because they had told her that they would have to report the matter to [Child Safety Services]. The family was not sure that was the way they wanted it handled.[240]

Further, the Zoe Duncan file note states that Dr Renshaw told Mrs Duncan that 'the hospital would be willing to proceed with the report to [Child Safety Services] if she so desired'.[241]

The Zoe Duncan file note indicates that four days later, on 29 May 2001, Laurel House contacted Dr Renshaw 'to check as to how the reporting process was going'.[242] The Zoe Duncan file note states that Laurel House indicated Mrs Duncan had been reluctant to provide information to them because of the need to advise Child Safety Services.[243] The Zoe Duncan file note also records that Dr Renshaw told Laurel House he would immediately make a report to Child Safety Services given the matter 'had already been mentioned to at least four professionals outside the hospital'.[244] This was the third time that Dr Renshaw had been contacted about reporting Zoe's allegations.

In his statement to us Dr Renshaw wrote that, until 1 September 2021:

> … I had no knowledge, nor had I received any information from Mr and Mrs Duncan, the GP or Laurel House that the investigated complaint against [Dr Tim] extended to physical sexual assault (i.e. well beyond a professional boundary transgression).[245]

Dr Renshaw's evidence suggests a lack of understanding and insight in relation to allegations of child sexual abuse. We note that although it was not apparent to Dr Renshaw at the time, it was apparent to Zoe's general practitioner and Laurel House that the nature of Zoe's allegations about Dr Tim were serious and warranted reporting to Child Safety Services.

On 29 May 2001, before making a report to Child Safety Services, Dr Renshaw met with Dr Tim. The Dr Tim file note states that Dr Renshaw explained to Dr Tim that the Duncans had made a complaint.[246] Dr Renshaw told Dr Tim that further details about the complaint had been provided to others, but that as far as Dr Renshaw was aware, they concerned an allegation that Dr Tim had 'spoken improperly to Zoe and touched her unnecessarily'.[247] The Dr Tim file note records that Dr Tim denied any wrongdoing and stated he would 'cooperate fully with any investigation'.[248]

Dr Renshaw also recorded in the Dr Tim file note that he indicated to Dr Tim that 'the hospital did not have, and had not been provided with, any evidence to support the allegations'.[249] When asked about this by Counsel Assisting our Inquiry, Dr Renshaw said he was not quite sure how telling Dr Tim this could potentially compromise subsequent investigations.[250]

On the same day, after meeting with Dr Tim, Dr Renshaw said that he made a verbal report to Child Safety Services about Zoe's allegations.[251] When speaking with the intake officer at Child Safety Services, Dr Renshaw elaborated on his observation that Zoe's 'affect did not seem to reflect the degree of awkwardness she was describing'.[252] The investigation report from Child Safety Services (discussed in Section 4.3) records that Dr Renshaw told the intake officer that Zoe could not remember whether Dr Tim had a stethoscope when he examined her and that she was smiling when talking about being touched on the chest.[253] It is further recorded that when the intake officer asked Dr Renshaw whether Zoe may have been embarrassed, he said he 'didn't think so', and that Zoe was 'giving very mixed messages' and was 'not as upset as the parents claimed'.[254]

The Zoe Duncan file note states that, after making the report to Child Safety Services, Dr Renshaw phoned Mrs Duncan to advise her that the report had been made. The file note further states that Mrs Duncan 'expressed mixed emotions about this' but 'thanked me once again for our help'.[255]

Dr Renshaw told us that he had 'no further direct involvement' in the investigation of Dr Tim after he made the verbal report to Child Safety Services on 29 May 2001.[256]

The protocol that applied at the time of Zoe's allegations was the *Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect* ('Protocol').[257]

The Protocol contained 'Essential practice guidelines' ('Guidelines'). Under the heading 'consultation', the Guidelines state:

> No decisions or actions in respect of suspected actual or potential child abuse or neglect are to be made by any health worker in isolation unless there is a concern for the immediate safety of the child.
>
> Whenever child abuse is suspected or identified the matter must be given top priority. The most senior medical officer on duty in the unit should be advised at once and the Paediatric Registrar must be contacted immediately ...[258]

We understand that Dr Renshaw was the most senior medical officer on duty at the time.

Under the heading 'Response to Disclosure', the Guidelines state:

> Information volunteered by the child should be fully and accurately recorded. However, no in depth interview of a child, especially regarding sexual abuse should be attempted.
>
> Authorised officers in the Department of Community and Health Services (DC&HS) located in Intake and Assessment units (formerly known as Child Protection Units), and the police, have statutory responsibility for the investigation of child abuse.[259]

Under the heading 'Notification to DCHS Intake & Assessment/Child Protection Unit or the Police', the Guidelines state:

> DCHS Intake & Assessment/Child Protection Units are located in all regions with "after hours" telephone numbers and should be contacted in all cases of suspected child abuse or neglect. However, not all situations will require immediate action by child protection staff. In some cases where there is concern about the child's situation but the child has not been abused, effective preventative interventions supportive to a family environment may be provided after full investigation and assessment.
>
> Decisions about whether to refer, and where, must not be made in isolation. Discuss concerns you may have with an immediate senior colleague and follow the procedure in 6 below.
>
> If you believe a child is in immediate danger do not hesitate to call the Intake & Assessment/Child Protection Unit and a decision can then be made in consultation as to whether it is necessary to call the police.

The procedure in 6, titled 'A general approach for child abuse', states:

- In all cases where child abuse is suspected or identified, make an initial brief assessment and discuss concerns with an immediate senior colleague.
- In all cases of suspected child abuse the Paediatric Registrar must be notified and this person must notify the paediatric consultant on call.
- Standard hospital procedures for medical examination will follow with compilation of history, physical examination, conduct of investigation if necessary, provision of appropriate health care and admission, if required.
- The paediatric team should in all such cases ensure contact is made (if it has not been already) with the 'on call' Intake & Assessment/Child Protection Unit duty officer.[260]

At our hearings, Dr Renshaw told us that contact with the paediatric registrar was not clinically required at the time.[261] He gave evidence that he did not consider it 'clinically appropriate' that Zoe be seen by a paediatric doctor because she had already been examined by the paediatric registrar on admission to the hospital and was already under the care of a paediatric doctor.[262] He said that no examination was undertaken in response to Zoe's allegations because the alleged abuse occurred 'in the context of a normal clinical examination' and 'a touch does not leave a mark'.[263] Elizabeth Stackhouse, former Chief Executive Officer, Launceston General Hospital, told us the requirement to contact the paediatric registrar was included in the Protocol 'because you're dealing with a child'.[264] She indicated it is important to have a doctor with familiarity in paediatrics assist children in cases of potential abuse.[265]

Finding—Dr Peter Renshaw failed to comply with Launceston General Hospital's protocol for reporting and management of cases of suspected child abuse

On 19 May 2001, Zoe's allegations were that Dr Tim had given her a hug, kissed her hand, said she was a pretty girl and that, if she were older, he would marry her.[266] We note that Dr Renshaw gave evidence that when he was notified of Zoe's initial allegations on 19 May 2001, he understood them to be 'a professional boundary violation which could be, but may not have been, child sexual abuse'.[267] On his own evidence, this was an allegation of potential child sexual abuse, which should have activated the Protocol and Guidelines in place at the time.

Dr Renshaw failed to comply with the Protocol and Guidelines in several respects. First, he did not contact the paediatric registrar about Zoe's allegations. This was a missed opportunity to receive assistance from specialist staff.

Second, Dr Renshaw failed to comply with the Protocol because, contrary to what its Guidelines required, he spoke to Zoe about her allegations in circumstances where he did not have the statutory responsibility or authority for investigating whether abuse had occurred. Dr Renshaw's file note indicates that he spoke with Zoe to 'assess her story'. Dr Renshaw later described this as a brief assessment.[268] In our view, however, Dr Renshaw's meeting with Zoe constituted an 'in depth' interview under the Protocol because it extended beyond merely accurately recording 'information volunteered by the child' and involved Dr Renshaw assessing Zoe's 'affect'. The Protocol specifically recommended against undertaking an 'in depth' interview. By this stage, the Duncans had told Dr Renshaw that Zoe had raised further allegations about Dr Tim touching her.

Although our view is that Dr Renshaw's interview with Zoe should not have taken place at all, we also highlight that Dr Renshaw did not have any training in child abuse or experience in interviewing children.

Third, Dr Renshaw failed to consult a senior colleague and consider making a report to Child Safety Services. The Protocol says: 'Decisions about whether to refer, and where, must not be made in isolation. Discuss concerns you may have with an immediate senior colleague and follow the procedure … below'. Having such a discussion may have resulted in a mandatory report being made to Child Safety Services earlier.

We consider that Dr Renshaw's failure to comply with the Protocol—by failing to immediately alert the paediatric registrar of Zoe's allegations, his failure to discuss reporting to Child Safety Services with a senior colleague, and his subsequent interview of Zoe—may have contributed to delaying Zoe's disclosure of more serious allegations against Dr Tim, including that he had raped her. Furthermore, the failure to comply with the Protocol meant that a forensic examination was never entertained as an option. Dr Renshaw told us that he considered 'a forensic examination or detailed interview was simply not required'.[269] This was a missed opportunity to collect forensic evidence that may have been relevant to Zoe's allegations.

Finding—Dr Peter Renshaw failed to comply with his mandatory reporting obligations in a timely manner, which impacted on the ability to gather evidence and future investigations

Ten days passed between Zoe's initial disclosures on 19 May 2001 and Dr Renshaw's verbal report to Child Safety Services on 29 May 2001. During this time, Dr Renshaw received more information about Zoe's disclosures. On 21 May 2001, Zoe told Dr Renshaw that Dr Tim had touched her on the breast, inserted a finger in her mouth, made comments about her appearance and expressed a desire to marry her. Taken together, this was an allegation of child sexual abuse.

At the time of Zoe's allegations, Dr Renshaw had mandatory reporting obligations (as a medical practitioner) under the *Children, Young Persons and Their Families Act 1997*. Specifically, under section 14 of the Act, he was required to report to Child Safety Services as soon as practicable if he knew or believed or suspected on reasonable grounds that a child had been abused.[270] We are of the view that in the circumstances we have outlined, any professional would, on reasonable grounds, form a suspicion that child sexual abuse had occurred and make a mandatory report as required under the Act.

Dr Renshaw could have reported the matter to Tasmania Police and Child Safety Services when he first became aware of it on 19 May 2001, but he should have reported it to these authorities after the Duncans raised the concern about Dr Tim touching Zoe on 21 May 2001. Compounding this, Dr Renshaw did not report the matter after speaking to Zoe in the afternoon of 21 May 2001 when she told him directly that Dr Tim had touched her on the breast, inserted a finger in her mouth, had made comments about her appearance and expressed a desire to marry her.

Dr Renshaw conceded that on 21 May 2001 he should have made a report to Child Safety Services.[271]

Dr Renshaw was also contacted individually, after the initial allegations, by three separate parties (Zoe's general practitioner, Mrs Duncan and Laurel House) before he made a report to Child Safety Services. It is significant that two professional parties and Mrs Duncan were expressing serious concerns about Zoe and her contact with Dr Tim.

Dr Renshaw's inaction had an adverse impact on later investigations. As discussed later in this case study, subsequent investigation reports from Child Safety Services and the Medical Council of Tasmania refer to Dr Renshaw's delay in reporting. They suggest that a more timely report and advice from Child Safety Services may have resulted in a clearer picture of what occurred while also preventing the potential contamination of Zoe's story and reducing the emotional trauma for Zoe.[272]

Finding—Launceston General Hospital failed to consider and take active steps to stand down Dr Tim while Zoe Duncan's allegations were investigated

At no time after Zoe's allegations were made or while subsequent investigations by Child Safety Services or Tasmania Police were underway was Dr Tim stood down from his employment at Launceston General Hospital.

Dr Renshaw gave evidence that he took no steps to limit Dr Tim's access to children. He stated that he believed this step would have been 'premature' and 'an overreaction'.[273] Dr Renshaw also said that standing down a doctor would be

'very hard to do' in a general hospital emergency department, and that he did not know whether he would have had the power to stand Dr Tim down at the time.[274] He conceded that if a similar complaint was made today, this would be a step he would take.[275] As indicated, during examination by Counsel Assisting our Inquiry, Dr Renshaw ultimately conceded that his failure to consider whether to stand down Dr Tim was an error of judgment, which arose because he was in a role where he was inexperienced.[276]

Ms Stackhouse told us that she was not aware of any steps taken against Dr Tim while Zoe's allegations were being investigated.[277] She said that 'upon reflection' Dr Tim should have been 'stood aside while the allegation was investigated by an independent party, not a member of [Launceston General Hospital] staff'.[278]

The failure of Launceston General Hospital to take steps to stand down Dr Tim while the matter was investigated meant that Dr Tim continued to work in the emergency department with no restriction on his ability to treat children. Launceston General Hospital failed to consider this risk and then failed to take steps to mitigate the risk. We received no evidence to suggest that consideration was given to this course of action. The failure to consider and take steps to stand down Dr Tim while Zoe's allegations were investigated also represents a poorer pattern of practice than occurred when immediate steps were taken several years earlier to remove a health professional after an allegation of child sexual abuse was made against them.

As noted, at our hearings Dr Renshaw also told us that at the time of Zoe's allegations he had assumed there was a chaperone policy in place at Launceston General Hospital. However, when he went looking for one to explain it to Dr Tim, he discovered the hospital only had an informal policy in place.[279] As a result, he wrote a new chaperone policy.[280]

This evidence is consistent with evidence given by Ms Stackhouse, who told us that while it was accepted professional practice at the time that patients be offered a chaperone during clinical examinations, the hospital's chaperone policy 'was largely implied' and only appeared in some of the hospital's guidelines for surgical medical staff.[281] Ms Stackhouse said that because of investigations into Zoe's allegations, the hospital drafted a chaperone policy, along with a revised protocol for reporting and managing suspected cases of child abuse and neglect. Ms Stackhouse said that the hospital adopted these documents in 2002.[282]

The relevant draft chaperone policy (drafted by Dr Renshaw) stated:

> It is hospital policy that clinical examinations of children shall not occur, except in circumstances of extreme urgency, without the presence of a chaperone. This will generally be a member of the child's family or a health professional.[283]

The Launceston General Hospital Executive approved and implemented the policy in June 2002.[284]

Finding—Launceston General Hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after Zoe Duncan's May 2001 disclosure and not waited until June 2002

Launceston General Hospital's failure to formalise, implement and enforce a chaperone policy at the time of Zoe's disclosure affected Zoe's safety and the safety of other patients in the hospital's care. It also meant there was no formal policy against which Dr Tim could have been sanctioned had this been pursued.

The hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after Zoe's May 2001 disclosures and not waited until June 2002 to do so.

4.2 Zoe's continuing distress

In mid-2001, Zoe, aged 11, wrote:

> I'm also having problems with a man that I was uncomfortable with. He was telling me he loved me and wanted to marry. He kissed my hand, smothered me and felt me all around the top half. He whispered to me, stuck his fingers in my mouth and felt my tongue, tugged my ears and kept squeezing my hand. And he kept saying sick things. There's more but it's just horrible![285]

Zoe would go on to make further incremental and more serious allegations about Dr Tim, which we describe later in this case study.

4.3 Child Safety Services investigation

On 13 June 2001, Child Safety Services wrote to Mrs Duncan and to Dr Renshaw, advising that Zoe's matter would be investigated.[286] It was stated in that letter that the investigator 'will be following the policy re allegations against an employee of the agency' and that 'this policy is in draft but in use'.[287]

At the time, the relevant policy was the Department of Community and Health Services' *Procedure to be Followed where there is an Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency* (June 1997). The procedure stated that any incident of maltreatment, including sexual maltreatment, by a staff member in the performance of their duties was to be investigated and actioned under the *Tasmanian State Service Act 1984*.[288] The procedure also stated that an initial inquiry was to be undertaken by an agency nominee with the assistance of a child protection officer.[289]

According to the procedure:

> 3.4.1 The purpose of this initial inquiry is to determine whether there is 'reason to believe' that maltreatment may have taken place, and that proper arrangements are made for the care and protection of the child.

> This investigation should not be lengthy nor should it involve the gathering of evidence needed to satisfy either a police inquiry or a State Service inquiry. It should provide enough information only to ensure that the agency nominee can write a report for the Secretary.
>
> This inquiry will normally include:
>
> 1. An interview with the child
> 2. An interview with the employee against whom the allegation has been made
> 3. Consideration of the manager's report
> 4. Any other investigation that the Agency nominee or the Intake and Assessment Officer/Child Protection Officer believe to be necessary in order to make an assessment of the allegation.[290]

The procedure further provided that 'on receipt of the report from the Agency nominee and the Child Protection Unit, the Director, Child Youth and Family Support is to determine future action'.[291] Recommended actions were outlined in relation to the following circumstances:

- where there is no case to answer
- where a criminal offence may have been committed
- where action under provisions of the Tasmanian State Service Act is required
- where no action is to be taken under the Criminal Code or the State Service Act
- where the case cannot proceed to any action beyond interviewing the client.[292]

On 20 June 2001, Dr Renshaw made an addition to the Zoe Duncan file note stating that an investigator from Child Safety Services had contacted him about the Zoe Duncan case. Dr Renshaw recorded that the investigator told him Zoe had made 'fresh allegations' the week before that may require police investigation.[293] It is not clear to us what allegations are being referred to here.

According to Dr Renshaw's file note, the investigator asked Dr Renshaw whether he was aware of the policy on investigations involving departmental employees, to which he replied that he was not.[294] The investigator then faxed a draft copy of the policy dated 1997 (noting it was now June 2001), before supplying a final version and asking the hospital to nominate a person to assist Child Safety Services with its investigation.[295]

Dr Renshaw recorded in the Zoe Duncan file note that, after liaising with Ms Stackhouse, he notified Child Safety Services of the hospital's nominee, who was a different employee of the hospital.[296]

In a request for statement, Michael Pervan, former Secretary, Department of Communities, was asked why Child Safety Services was tasked with the initial investigation and

assessment of Zoe's allegations instead of Tasmania Police.[297] Secretary Pervan responded that according to the Child Safety Services investigation report (discussed below), protocols at the time (and prior to his tenure) 'did not provide instruction for referring matters of a possible criminal nature to Police prior to the Department establishing the facts of a case and interviewing the involved parties'.[298]

At our hearings, representatives from Tasmania Police and Child Safety Services agreed that Zoe's allegations should have been investigated by Tasmania Police. Darren Hine AO APM, former Commissioner, Tasmania Police, told us that Zoe's allegations should have been referred to Tasmania Police, which has primary authority over investigations of this nature.[299] Ms Lovell also told us that where allegations are made, Tasmania Police should be notified straight away to determine who has responsibility for particular aspects of the investigation and the sequence in which aspects of an investigation are to be carried out.[300]

Ms Lovell described Child Safety Services' procedure for investigating the allegations against Dr Tim in 2001 as 'unusual', noting she had not seen a procedure (since beginning work with child safety in 2004) that required Child Safety Services to complete an investigation and be satisfied that there is sufficient evidence before referring a matter to Tasmania Police.[301] Ms Lovell said that she was 'really struggling to imagine a scenario where a child safety officer is leading an investigation like this rather than police'.[302] She described the investigation, including the interviewing of witnesses (discussed below), as forming part of the role of police and as being 'far out of scope for the role of a child safety officer'.[303] She was also of the view that the Child Safety Services procedure did not enhance child safety and would instead delay a police investigation and require victim-survivors to unnecessarily repeat their story to police.[304]

Finding—The procedure used by Child Safety Services to investigate Zoe Duncan's allegations against Dr Tim was inappropriate and not consistent with best practice at the time

We agree with the comments made by former Commissioner Hine and Ms Lovell that it is not an appropriate role of a government department or agency to determine the facts or interview parties involved with allegations of a potential criminal nature before referring the matter to police. Tasmania Police was the agency responsible for investigating criminal allegations of child sexual abuse in 2001 as it is in 2023. The matter should have been referred to and investigated by Tasmania Police in the first instance. We consider that the policy was inappropriate and not consistent with best practice at the time.

The Child Safety Services investigation ran from June 2001 to September 2001. While the investigation was underway, Zoe made further incremental allegations over time, as is common with victims of child sexual abuse.[305] On 25 June 2001, Zoe told Mrs Duncan that Dr Tim had 'put his hands inside her pants around her thighs' and put his finger 'inside her front bottom'.[306] On 27 June 2001, Zoe disclosed that Dr Tim had raped her. Mr Duncan recalled that Zoe asked Mrs Duncan whether she would be pregnant, and when Mrs Duncan asked Zoe why she had asked this question she said 'he put his thing in there'.[307]

The Duncans said that because of this allegation, they took Zoe to her general practitioner for a medical examination on 28 June 2001.[308] They said the general practitioner spoke with Zoe on her own before undertaking the examination.[309] We do not know whether Zoe's general practitioner had any specific training in interviewing children or in completing forensic medical examinations. The Duncans recalled that the general practitioner reported that the 'examination was inconclusive, but there was no evidence of trauma'.[310] They also considered that it was significant that the examination was conducted five weeks after Zoe's initial allegations.[311]

On 11 July 2001, Zoe's psychologist wrote a report for Child Safety Services outlining the allegations and the psychologist's observations.[312] On 22 July 2001, Zoe's general practitioner also wrote a letter to Child Safety Services advising of the outcome of the medical examination.[313]

The investigator from Child Safety Services contacted Zoe's general practitioner, who confirmed that the examination was inconclusive.[314] Zoe's general practitioner indicated that Zoe had said Dr Tim had kissed her, cuddled her and touched her chest, but had not indicated anything else had occurred when asked.[315] The general practitioner also told the investigator that they had informed the Duncans that they considered Zoe's latest allegation, namely that Dr Tim had raped her, to be implausible, because her account had become more serious as time went on and because she claimed the rape had occurred in the emergency department.[316] The investigator relied on the general practitioner's statement in compiling their report.

As part of the investigation, Child Safety Services interviewed the Duncans, Zoe and Dr Tim.[317] The investigation report records that the Duncans were interviewed on 18 and 20 June 2001.[318] They relayed what had occurred and discussed Zoe's health issues and school history with the investigator.

Zoe was interviewed on 19 July 2001. The investigator described her as 'relaxed', 'friendly' and 'quite clear' about why she was being interviewed.[319] Zoe provided an account of her recollection and the investigator explained that they would also need to speak to Dr Tim about what happened.[320]

Dr Tim was interviewed on 24 August 2001. The investigator described Dr Tim as 'quite anxious' and 'extremely defensive and distressed'.[321] Dr Tim declined an interpreter and declined to hear the details of Zoe's additional allegations. Dr Tim suggested to the investigator that the complaint had been made because he was a foreign doctor.[322] Dr Tim denied to the investigator that he had acted inappropriately and indicated that he could not imagine someone acting inappropriately with a child in an emergency department with staff everywhere and only curtain partitions.[323] Dr Tim's support person ultimately terminated the interview, with the investigator observing that Dr Tim 'was reluctant to cooperate in the interview' and that it was 'extremely difficult to get answers to questions'.[324]

Child Safety Services finalised the report of its investigation on 12 September 2001, around four months after Zoe's initial allegations. The report states that 'Zoe's allegations become more serious with time' and that, because Zoe had spoken to several people about her allegations before being interviewed, it was 'likely' her story had been contaminated.[325] The report further states that such contamination 'may have been avoided if the hospital had contacted Child Safety Services to discuss the best way to approach the situation, prior to acting on the information'.[326] The report also states that 'there are numerous reasons why a child may take time to talk about specifics of abuse', including experiencing overwhelming emotions that inhibit their ability to talk about an incident.[327]

Similar to the view of Zoe's general practitioner, the report assessed that Zoe's description of the alleged sexual abuse was 'difficult to accept'.[328] Notwithstanding the investigator's observations about Dr Tim at his interview, the report appears to accept the explanation given by him, and expresses doubt that 'anybody would take this kind of risk in a busy emergency department while they had their back to the entrance of the examination cubicle room, which is only screened by a material curtain'.[329] The report states that Zoe's cubicle was adjacent to the central station, where staff would write their notes, confer and make telephone calls, and that this area was 'unlikely' to have been unoccupied at the time.[330] This finding is in contrast to evidence given by Mr Duncan, who recalled in his statement to us that:

> After Zoe made her disclosure to me, I went outside the cubicle to see if I could talk to someone. There was no one at the nurses' station and I couldn't see any doctors or nurses around in the ward. I called Anne [Mrs Duncan] and told her what had happened, and she told me that I needed to report it. I recall telling Anne I had tried to report it, but I couldn't find anyone to report to. Later [we] were to discover this was a tea break period.[331]

Mr Duncan further stated:

> … I distinctly recall it wasn't a busy [emergency department] on that Saturday night. The only patients on the ward were Zoe, a man two cubicles to the left who appeared to me to be severely drug affected, and an elderly lady on the opposite

> side of the ward who was far from alert … I would describe the department as 'dead quiet'. When I went out to speak to someone following Zoe's disclosure, there was no one around. No nurses or doctors.[332]

The Child Safety Services investigation report concludes that it is not possible to determine what happened to Zoe but notes that '[s]omething certainly appears to have upset her'.[333]

The report recommended that the Department's protocol for investigating matters involving agency staff be reviewed because it 'does not provide instruction for referring matters of a possible criminal nature to police prior to the Department establishing the facts of a case and interviewing the involved parties'.[334] It also states that the matter highlights the importance of chaperone policies.[335]

The Child Safety Services investigator:

- received Dr Renshaw's account of events from the intake officer along with initial reports and file notes
- interviewed the Duncans, Zoe and Dr Tim
- spoke with and received a report from Zoe's general practitioner about the outcome of the medical examination
- received a medical report from Zoe's psychologist.[336]

It is apparent from the investigation report that the investigator did not speak with Dr Renshaw or any staff who were on duty the night of the incident, including the nurse on duty who received Zoe's allegations, the after-hours nurse coordinator and the registrar. Ms Lovell agreed that the fact neither Dr Renshaw nor any of the staff working on the night of the incident were interviewed suggested that the investigation process was not rigorous.[337]

The investigator appears to accept the views and accounts of adults, including Dr Renshaw, Zoe's general practitioner and Dr Tim, over Zoe's version of events.

Ms Lovell expressed concern that the Child Safety Services investigation report accepted Dr Tim's denial of Zoe's allegations over Zoe's clear and consistent allegations, especially in circumstances where Dr Tim declined to hear the allegations:

> It seems that she was making a consistent and clear disclosure that she had been sexually abused, and there doesn't seem to be reason to discredit that or disbelieve her, it's not that she's saying something that's untrue, so why would anyone preference the account of an adult, who's alleged to be responsible for abuse, who has every reason to not be honest about that abuse and in fact is unwilling to hear even the details of what's been alleged; it seems very unusual to me.[338]

The Child Safety Services investigation report accepts that the emergency department was busy at the time of the incident and that Zoe was not left alone with Dr Tim for

any significant period. As noted, Mr Duncan strongly disputes this, describing the emergency department as 'dead quiet' on the night of the incident. He is recorded in the report as having observed Dr Tim alone with Zoe on two separate occasions.[339]

The Duncans believe that Child Safety Services was selective in its use of information in the report and made value judgments about what was likely to have occurred.[340]

When asked to comment on the conclusion reached by Child Safety Services that it was unlikely Zoe's allegations could have occurred on a busy ward, former Commissioner Hine responded that 'you can never assume anything because, if you make an assumption, you may bring a biased mind to the investigation, so assumptions shouldn't be made'.[341]

Additionally, in this report and those of subsequent investigations (discussed later in this case study), the investigator referred to Zoe's evidence as being contaminated because she had to retell her account multiple times. In his statement to our Commission of Inquiry, Michael Salter, Scientia Associate Professor of Criminology, School of Social Sciences, University of New South Wales, opined that this view about contamination demonstrates a bias against children's testimony that is often not warranted.[342] We agree with Mr Salter, but also note that Zoe was remarkably consistent in her account—while she progressively disclosed more detail, she never swayed from her account that something bad happened to her that night and nor did she contradict herself.

Ms Lovell said the following with respect to her assessment of Zoe's matter based on the available material:

> On the balance of probabilities I would say that [Zoe] was sexually abused; she's repeatedly made a clear disclosure, there's nothing to say that that hasn't happened. It doesn't mean there's enough proof for charges or convictions, but certainly for child safety and our substantiation there's certainly enough there by today's standard to substantiate …[343]

Ms Lovell told us that the Child Safety Services investigation resulted in a poor outcome for Zoe and her family because it was apparent that Zoe had been sexually abused. She apologised for this outcome.[344]

Finding—Child Safety Services carried out an inadequate investigation of Zoe Duncan's allegations, which affected subsequent investigations

It is clear to us that the Child Safety Services investigation lacked rigour and was inadequate. The investigator failed to seek the evidence of key staff including Dr Renshaw and other staff who were on duty the night of the incident, such as the

nurse who received Zoe's allegations, the after-hours nurse coordinator and the registrar. We further consider that the investigator's report did not demonstrate an understanding of how children and young people disclose allegations of sexual abuse.

Regrettably, subsequent investigations, including by Tasmania Police in 2001 and the Medical Council of Tasmania in 2003, relied on the Child Safety Services investigation report. As discussed later in this case study, the limitations of the report have adversely affected subsequent investigations.

Secretary Pervan told us that if Zoe's allegations were made today, they would be referred to Tasmania Police and joint agency meetings to determine the response, including an approach that would minimise the need for Zoe to repeat her account multiple times.[345]

Secretary Pervan indicated that the approach to interviewing the alleged abuser would be planned in line with the memorandum of understanding that now exists between Tasmania Police and Child Safety Services.[346] Secretary Pervan also informed us that, today, Child Safety Services would not lead an investigation of a departmental staff member; rather, the matter would be referred to Tasmania Police and the Registrar of the Registration to Work with Vulnerable People Scheme.[347]

Ms Lovell also indicated that it would be her expectation that Dr Tim would be interviewed in a timely manner by Tasmania Police and not Child Safety Services.[348]

At our hearings, Dr Renshaw, unprompted by specific questioning, stated that he did not believe that Dr Tim had raped Zoe, saying: 'Because I know the layout, the set out of our emergency department, it is highly unlikely that [a rape] actually occurred'.[349]

It is unfortunate that Dr Renshaw made this observation. He ultimately accepted that he was not in a position to make an assessment of whether or not a rape had occurred.[350] In a subsequent appearance at our hearings, Dr Renshaw apologised for his comment: 'I know the suggestion caused additional grief to the Duncan family, and for that I … sincerely apologise to the family and to the Commission'.[351]

4.4 Tasmania Police investigation

Mr Duncan recalled to us that on 1 October 2001, after Child Safety Services had completed its investigation, Mrs Duncan reported Zoe's allegation of rape to Tasmania Police.[352] Mr Duncan said that the police asked Mrs Duncan why it took so long for her to make a report. Mrs Duncan told the police it was her belief that the matter would be reported by either Launceston General Hospital or Child Safety Services.[353]

Child Safety Services did eventually make an official notification to Tasmania Police on 8 October 2001. However, by this point, police were already investigating Zoe's

allegations.[354] Former Commissioner Hine told us that the five-month delay in Child Safety Services reporting Zoe's allegations to Tasmania Police was 'not best practice' and 'unacceptable'.[355]

As part of its investigation, Tasmania Police accessed the material provided to Child Safety Services, along with the investigation report.[356] They also interviewed the investigator at Child Safety Services, as well as Zoe and Dr Tim.[357]

The Tasmania Police report records that, at an interview on 2 October 2001, the Child Safety Services investigator said:

> The matter had not been referred to police as protocols at [Child Safety Services] stipulate that where an allegation involves employees of the Department of Health and Human Services, then the Secretary of the Department must notify Police.[358]

Tasmania Police interviewed Zoe on 3 October 2001. In the report, the investigating officer described Zoe as 'extremely confident'.[359] The officer also observed that Zoe had been asked many of the questions before and that her answers did not require a lot of thought.[360] Dr Tim was interviewed on 11 October 2001 and 'emphatically' denied all allegations.[361]

Tasmania Police finalised the report of its investigation on 12 October 2001, around five months after Zoe's initial allegations. The report states that there were no witnesses, forensic evidence or medical evidence to support Zoe's allegations.[362] The report concludes that 'the allegation of rape is unfounded' and that 'there may have been an initial incident that Zoe may have been distressed by, however the fact that she has added to her story on many occasions does not hold her version as credible'.[363]

Counsel Assisting asked former Commissioner Hine at our hearings whether the Tasmania Police investigation report demonstrated a misunderstanding of how children make allegations of sexual abuse, insofar as police interpreted Zoe's incremental allegations as her changing her account of what happened. Commissioner Hine responded that it is now known that a victim's account can evolve over time and that this does not mean they did not experience trauma.[364]

As occurred in the Child Safety Services investigation, Tasmania Police did not contact or interview any of the staff on shift the night of Zoe's allegations, including the nurse who received Zoe's allegations, the after-hours nurse coordinator or the registrar. Tasmania Police did not speak with Dr Renshaw either.

Commissioner Hine retracted his view expressed in an earlier statement to our Commission of Inquiry that the Tasmania Police investigation was 'comprehensive', acknowledging that the police investigation had deficiencies.[365] Commissioner Hine accepted that any investigation should include following up with corroborating witnesses and reviewing evidence that might verify the circumstances being described by a victim, including early observations of how the victim presented in the aftermath of an alleged offence.[366] He agreed that the registrar at the hospital, in particular, should have been contacted by police as part of its investigation.[367]

Finding—Tasmania Police carried out an inadequate investigation of Zoe Duncan's allegations

In conducting their investigation, it appears that Tasmania Police relied on the Child Safety Services investigation report, which we have earlier described as inadequate.

Relevantly, Tasmania Police imported whole paragraphs from the Child Safety Services' report into its own report. These paragraphs reflected the Zoe Duncan file note, the view of Child Safety Services that Zoe's description of the way she was alleged to have been sexually abused was 'difficult to accept', and that the central nursing station was unlikely to have been unoccupied at the time that the alleged rape occurred.[368]

We consider that the Tasmania Police investigation was inadequate.

Former Commissioner Hine told us that Tasmania Police would today take a completely different approach to matters of this nature. He told us that an investigation would now involve an experienced detective assessing the matter, intermediary support being provided to a child while their account of events was collected, and the provision of support to the child and their family throughout the process.[369]

5 Subsequent actions, complaints and investigations

5.1 Attempts to obtain the Child Safety Services investigation report and hospital policies

Mr Duncan recalled that after police read out parts of the Tasmania Police investigation report, they attempted to get a copy of the Child Safety Services investigation report. It was clear to them that the former report had influenced the police investigation, and they wanted to ensure the Child Safety Services report was accurate.[370]

On 14 November 2001, the Duncans met with senior executives at Launceston General Hospital and representatives from the Department to raise concerns about the response to Zoe's allegations.[371] At the meeting, they requested a copy of the Child Safety Services' report but were told they would need to make a Freedom of Information Act application, which they did on 15 November 2001.[372] In their application, they also requested a copy of Launceston General Hospital's policy on the reporting of child abuse and neglect and the investigation protocol applicable to the Child Safety Services investigation.[373]

When the Duncans did not receive a response to their application, they wrote to the Commissioner for Children on 11 December 2001.[374] The Commissioner for Children replied that the Solicitor-General's Office had advised the report was either exempt from the Freedom of Information Act or was given in confidence and therefore could not be released.[375] Over the following months, the Commissioner for Children made several enquiries about the practices and policies in place at the hospital at the time of Zoe's allegation, including in relation to whether there was a chaperone policy, a protocol for reporting suspected abuse and neglect, and procedures applicable to investigating departmental staff.[376] The Duncans also recalled writing to the Ombudsman on 19 December 2001 to appeal the decision not to release the Child Safety Services investigation report.[377] On 21 December 2001, they received 27 of the 43 pages of the investigation report (with six of these pages containing redactions), as well as a copy of Launceston General Hospital's policy on reporting child abuse and neglect.[378] It was now the end of 2001 and Dr Tim had left Tasmania.[379]

On 2 May 2002, sexual assault service Laurel House, wrote to Ms Stackhouse on the Duncans' behalf. Laurel House told Ms Stackhouse that the Duncans were dissatisfied with the hospital's response and that they did not believe the hospital was acting in Zoe's best interests.[380] Laurel House requested that appropriate processes be put in place to keep children safe at the hospital, and that any future allegations of sexual abuse be properly investigated.[381] Ms Stackhouse responded to Laurel House's letter on 8 May 2002. She enclosed a draft chaperone policy with the letter, for comment, along with the protocol for reporting suspected abuse or neglect.[382] As noted, the Launceston General Hospital executive approved and implemented the chaperone policy in June 2002.[383]

5.2 Medical Council of Tasmania investigation

On 28 August 2002, the Duncans lodged a complaint with the Medical Council of Tasmania ('Council').[384] In carrying out its investigation, the Council sought information from Dr Renshaw and Tasmania Police.[385] Two case managers interviewed the Duncans and, unlike the earlier investigations by Child Safety Services and Tasmania Police, these case managers also interviewed the after-hours nurse coordinator (in person) and the registrar (by phone) who were on shift the night Zoe made her initial allegations.[386] Zoe was not interviewed because the case managers did not believe anything would be gained from this, considering it would 'likely … cause undue stress to Zoe'.[387] The Council also sought and received a written response to the complaint from Dr Tim.[388]

The Council finalised its investigation on 19 March 2003. Its investigation report states that the complaint 'has been extensively investigated'.[389] The report further notes that the Tasmania Police investigation report concluded that the allegation of rape was unfounded, that Zoe's general practitioner had been interviewed and examined Zoe and found the allegation to be 'implausible' with no remarkable examination findings, and that Child Safety Services were of the view that Zoe's description of events 'is difficult to accept'.[390]

The Council's investigation report concluded that it is 'highly unlikely' a rape could have occurred without anyone noticing but that 'something that occurred then or at some other time has distressed Zoe'.[391] There was no further comment in the report on Zoe's other allegations, which included that Dr Tim had touched her on the breast, digitally penetrated her mouth, commented on her physical appearance and expressed a desire to marry her.

The report noted that Dr Renshaw should have reported the matter on 21 May 2001 rather than 29 May, as 'an early investigation by appropriate investigators may have resulted in a clearer picture of events and less emotional trauma for Zoe'.[392] The Council wrote to the Duncans on 22 May 2003 advising them that the complaint was determined to be 'unsubstantial in that the complaint could not be proven'.[393]

It is apparent that the findings and observations in the earlier investigation reports by Child Safety Services and Tasmania Police, both of which we have found to be lacking in rigour, heavily influenced the Council's investigation.

These findings were available to and considered by Ahpra in 2021 when it undertook an investigation in response to notifications it received about Zoe's allegations against Dr Tim.

In a statement to us, Matthew Hardy, National Director of Notifications, Ahpra, said that 'Ahpra does not have access to enough information to form a view about the management of the notification by the former Medical Council of Tasmania'.[394] Mr Hardy also stated to us that it appeared that 'subsequent decision-making by the Council was influenced by the investigatory activity already undertaken by [Child Safety Services] and Tasmania Police'.[395]

Mr Hardy said if allegations like those made by Zoe Duncan arose today:

> I would expect that it would lead to a mandatory notification to the National Board. Such a notification would be administered under the National Law which confers investigative and protective powers on the current Medical Board of Australia and other national Boards. These powers allow immediate action to be taken to suspend or restrict a practitioner's registration while an investigation is being undertaken. Advances in approaches to investigating allegations of sexual misconduct and advances in technology facilitating greater collaboration between investigating authorities also play a significant role in today's administration of notifications alleging that a registered health practitioner has engaged in serious and potentially criminal conduct.[396]

We note that Dr Tim was investigated for similar conduct in another jurisdiction in relation to another patient, which resulted in Dr Tim's practice registration being cancelled (although he was permitted to re-apply in due course).

6 Zoe's death

The Duncans recalled that Zoe's final visit to Launceston General Hospital was in April 2015.[397] After this admission, Zoe decided not to return to the hospital.[398] The Duncans said they tried to get Zoe to go back because of her escalating health issues. However, the Duncans said that for several reasons, including the hospital's management of Zoe's allegations in 2001 and Zoe's ongoing distrust of the medical care provided by the hospital, she refused to attend the hospital again. The Duncans recalled that she said to them: 'No one believes me, no one, I can't trust what goes on here, I can't go back'.[399]

The Duncans told us that they knew when Zoe made the decision not to go back to the hospital that they would 'lose her' because her ongoing medical conditions required attention.[400] Because Launceston General Hospital was the only hospital nearby, there was nowhere else for Zoe to go if she became unwell.[401] Zoe died alone at her home in November 2017 from her health issues.[402] We make no finding in relation to the cause of Zoe's death.

Reflecting on their experience, the Duncans told us they 'cannot fathom why the key players involved throughout Zoe's ordeal were unable or unwilling to provide her with the support, understanding and ultimately the justice she deserved'.[403]

Finding—Launceston General Hospital failed in its overall response and did not offer appropriate support to Zoe Duncan and her family

Despite many communications occurring across institutions about Zoe's allegations, at no time did Launceston General Hospital offer Zoe or her family any support. The Duncans recalled that when they did ask to access psychological support for Zoe they were told to make a request in writing to the chief executive officer of the hospital with the assistance of a lawyer.[404] The Duncans ended up arranging their own support for Zoe and, for a period of time, made regular trips to Hobart until Zoe decided to stop these visits.[405]

Ms Stackhouse conceded at our hearings that Launceston General Hospital's response to Zoe's allegations was 'inadequate'. She said the response 'did not prospectively protect other children from harm'.[406] She also said the matter was resolved 'in a manner that would not be considered appropriate today'.[407] Ms Stackhouse apologised to Zoe's family and acknowledged that the hospital had 'collectively let [Zoe's] family down'.[408]

The Department acknowledged the impact on the Duncan family. Kathrine Morgan-Wicks PSM, Secretary of the Department stated:

> To the memory of Zoe Duncan, to Mr and Mrs Duncan, and also to Amanda Duncan, you have waited a long time for Health to believe, and let me say that as the leader of Health, I believe. I am very sorry for what you have gone through for so many years to re-tell Zoe's story. I offer my deepest apology to you for our failure to hear what Zoe tried to tell us and which she ultimately revealed through incremental disclosure to her trusted parents and family.

7 Observations

Zoe's allegations have never been adequately investigated by Launceston General Hospital, Child Safety Services, Tasmania Police or relevant professional regulatory bodies. This failing may have exposed other children and young people to child sexual abuse.

This case study highlights key systemic issues relevant to responding to allegations and incidents of child sexual abuse within a health institution. We consider the lessons of this case study include:

- the need to have appropriate policies and procedures in place to protect children from abuse and to immediately respond to allegations and incidents of child sexual abuse
- the need to provide support to patients who make allegations of sexual abuse and their families
- the need for policies to ensure staff do not assume that their expertise enables them to make judgments about the veracity of abuse allegations by a patient, and that individual staff members at a hospital do not adopt the role of decision-maker and/or factfinder where a patient makes an allegation of sexual abuse
- the need for timely reporting and notification of allegations and incidents to appropriate external agencies
- the need for awareness-raising to break the myth that abusers do not perpetrate sexual abuse in locations where there is a 'high risk' of detection within health settings and elsewhere
- the need to apply independent and rigorous investigatory and disciplinary processes to complaints in health settings, and for these processes to use trauma-informed practices to minimise trauma for complainants.

The systemic deficiencies of Launceston General Hospital revealed by this case study, and ways to address them, are explored in more detail in Chapter 15.

By the time our report is published, 22 years will have passed since Zoe and her parents made a complaint to Launceston General Hospital, and some five and a half years will have passed since Zoe died.

Zoe, her parents, her sister and the broader community were entitled to a thorough and transparent investigation into the matters Zoe disclosed in May 2001. The deficiencies in the various investigations continued over many years. Our Commission of Inquiry has endeavoured to cast light on those events and on the subsequent inadequate investigations.

We acknowledge the pain and trauma these systemic failures visited upon Zoe, her parents and her sister. We acknowledge their love of Zoe, together with their dignity and determination in bringing these circumstances to the public's attention.

It is our hope that the systemic issues highlighted in this case study further increase awareness about the safety and wellbeing of children and young people across all health settings and inform action that is taken to safeguard children.

Case study 3: James Griffin

1 Introduction

James Geoffrey Griffin, also known as Jim, died at Launceston General Hospital on 18 October 2019 after an attempted suicide.[409] He was 69 years of age.[410] At the time of his death, Mr Griffin was facing serious criminal charges related to child sexual offending.[411] The coroner reviewing the circumstances of Mr Griffin's death found that: 'No doubt the charges he was facing at the time motivated his action'.[412]

Mr Griffin left devastation in his wake. Victim-survivors will not see him face accountability for his actions. During our Commission of Inquiry, we heard directly from many victim-survivors who experienced Mr Griffin's abuse and we became aware of more. We know there are many others who live with the uncertainty of never knowing whether they, or a loved one, experienced abuse by Mr Griffin, particularly if this may have occurred under the guise of medical care. Also, and notwithstanding the broad reach of our Inquiry, there are likely to be other victim-survivors of whom we are unaware.

Some victim-survivors of Mr Griffin's abuse were not in any way connected to Launceston General Hospital but came to know him through social or family connections. What they have in common with patients and former patients of Launceston General Hospital is the experience of traumatic abuse by a person they most likely trusted. All the evidence we received about Mr Griffin has been important in helping us understand the type of person he was and the tactics he used to groom and silence his victims. This information has explained, to some degree, how Mr Griffin was able to offend against children for as long as he did.

Mr Griffin's work and personal lives beyond Launceston General Hospital, including the abuse he perpetrated in other settings, were not considered by our Inquiry. This case study documents only the evidence about Mr Griffin's conduct during his employment at Launceston General Hospital and the responses of the Department, the Tasmanian Health Service, Launceston General Hospital and other agencies—including Tasmania Police and Child Safety Services—to his conduct. We also briefly mention his secondment to Ashley Youth Detention Centre.

We recognise that our insight into who Mr Griffin was as a person is somewhat limited because it is gained through the lens of his job at Launceston General Hospital and only a few people who were associated with him in a personal capacity.

1.1 Structure of this case study

This case study is divided into six sections. This section—Section 1—introduces the case study, outlines information sources and provides background information. Section 2 outlines our approach to findings and lists these. Section 3 is an overview of how those providing evidence to our Inquiry described Mr Griffin. Common themes emerged from these independent descriptions, including Mr Griffin's ability to charm those he sought to win over and to deflect and downplay concerns that arose about his behaviour. It is clear to us that Mr Griffin took advantage of his occupation as a nurse—including by positioning himself as going 'above and beyond' his duty to care for his patients—to disarm patients, parents and hospital staff.

We heard accounts of how Mr Griffin groomed young female patients by showing them affection, referring to them by pet names, spending social time with them and winning the trust and confidence of their parents. We also heard about Mr Griffin's opportunistic offending against patients who were admitted to the hospital for a short stay.

In Section 4, we document how leadership at Launceston General Hospital responded to the concerns raised, and complaints made, against Mr Griffin from when he began working on the paediatric ward until the suspension of his registration to work with vulnerable people on 31 July 2019.

The hospital received several complaints about Mr Griffin's behaviour over this period, most of which concerned his repeated breaches of professional boundaries with patients. Nurse unit managers often managed these complaints, sometimes with input from human resources staff. Mr Griffin was repeatedly cautioned and directed to undertake education to change his behaviour, but these low-level sanctions did not deter him. The hospital, Tasmania Police and Child Safety Services missed many opportunities throughout this period to piece together information held by each about Mr Griffin's inappropriate conduct towards children.

In Section 5 of this case study, we document how the hospital responded to the July 2019 notification that Mr Griffin's registration to work with vulnerable people had been suspended, and subsequent events relevant to Mr Griffin up until October 2021, at which time our Commission of Inquiry was underway.

In Section 6, we make some concluding remarks.

We heard about the variety of reactions that revelations of Mr Griffin's offending evoked in his colleagues, some of whom had known him for a long time and questioned whether they could or should have done more to protect the children and young people in their care. Some staff members also described their distress and frustration at the hospital's response, which some felt was not transparent or well communicated.

Presenting the large amount of information relevant to Mr Griffin was a challenge.

We have used a chronological format in Sections 4 and 5 of this case study to collate this information. We have documented the evidence against a timeline of the complaints about, and responses to, Mr Griffin's conduct at the hospital. However, within this chronological format we have sometimes included information from different periods, where that information either relates to the same issue and 'closes the loop' on a matter or where we think the information will clarify the circumstances of the event described.

In Section 4.2, where we summarise undocumented or undated complaints against Mr Griffin, we have grouped the information by source, rather than presenting the information by date. Sections 4 and 5 of this case study have been informed by witness statements, submissions and sessions with a Commissioner, some of which were provided anonymously. For procedural fairness reasons, we have been careful to use anonymous statements only to inform an understanding of the general themes in relation to Mr Griffin's conduct and not to inform our findings about the conduct of individuals.

1.2 Information sources

The information summarised in this case study came from the written statements and oral evidence of victim-survivors, their families and supporters, hospital staff and union representatives, members of the community and experts. Oral evidence was given at public hearings in June, July and September 2022. We also gathered information through public consultations and in private sessions with a Commissioner. Some information was clarified or further explained through our procedural fairness processes.

We also considered statements and oral evidence from senior managers and executives at Launceston General Hospital and the Department.

During Mr Griffin's employment at Launceston General Hospital, various bodies were responsible for the hospital's governance.[413] From 2016, overall governance of Launceston General Hospital sat with the Hospitals North Executive Committee.[414] This committee comprised the following operational roles (noting since this time some role titles may have changed):

- Chief Executive Hospitals North/North West (chair)
- Director Hospital Corporate and Support Services
- Director Launceston General Hospital Operations
- Director of Improvement
- Executive Director of Medical Services
- Executive Director of Nursing
- Nursing Director Primary Health.[415]

The Executive Director of Medical Services was the medico-legal lead for the hospital and police liaison in the response to Mr Griffin's case following the suspension of his registration to work with vulnerable people in July 2019.[416]

Human resources staff and management also played a significant role in managing complaints about Mr Griffin while he was an employee.

At our hearings, Kathrine Morgan-Wicks PSM, Secretary, Department of Health, told us that the executive structure at Launceston General Hospital has been in place for 'an incredibly long time'.[417]

The nursing management structure for the paediatric ward, Ward 4K, where Mr Griffin worked, comprised (in order from most senior to most junior):

- Executive Director of Nursing
- Nursing Director of Women's and Children's Services
- Nurse Unit Manager.[418]

In addition to receiving statements and oral evidence from individuals, we considered many volumes of documents produced by the State and others upon our request.

We received copies of some of Mr Griffin's Performance and Development Agreements on 20 December 2022, after an unmarked personnel file was discovered on Ward 4K. The staff members who found the file signed statutory declarations outlining the circumstances of the discovery. The file was securely provided to the Office of the Secretary of the Department, which provided it to us.[419]

The stated purpose of a Performance and Development Agreement ('Agreement') is to act as 'an essential tool intended to promote effective work practices across the Agency by clearly establishing the performance expected of our employees'.[420] We reviewed Mr Griffin's signed Agreements, which were in the unmarked personnel file described above, dated 31 December 2008, 31 March 2011, 6 March 2013, 21 March 2014, 27 March 2015, 23 March 2016, 25 May 2018 and 22 May 2019. We reference these Agreements throughout this case study.

We note more broadly that:

- We did not receive Agreements prepared before 2008, or those that would have been signed in 2009, 2010, 2012 and 2017. It is unclear whether Agreements were prepared in these years.
- The years when Agreements appear not to have been prepared coincide with years in which a number of complaints were made about Mr Griffin. In circumstances where (as we discuss in this chapter) education and support were the primary strategies to change Mr Griffin's behaviour, we expect that an

Agreement would and should have documented this information. It is unfortunate we have not been able to review these or confirm if they were prepared.

- There is no mention of past complaints about Mr Griffin in any of his Agreements, nor is there reference to behaviours that management identified as problematic.

1.2.1 Tasmania Police reviews

In late 2020 following the release of *The Nurse* podcast (discussed in Section 1.2.3), Tasmania Police initiated several internal reviews to examine the police response to reports from the public and other agencies about Mr Griffin. We outline these reviews here, and we refer to their findings throughout this case study.

On 26 August 2019, a detective inspector prepared the report *Investigation into Allegations of Sexual Assault by James Geoffrey Griffin (14 August 1950)* for the Deputy Commissioner.[421]

On 26 October 2020, a report titled *Griffin, James (Jim) Geoffrey (14/08/1950) - Investigative Review* was prepared by the same detective inspector for the then Acting Commander of the Northern District of Tasmania Police.[422] The following day, the Acting Commander provided a summary and attached a copy of the report in correspondence to the Deputy Commissioner of Tasmania Police, Jonathan Higgins APM.[423] This report was prepared after the Department began an internal and external review. This report documented a review of intelligence holdings and investigative actions by Tasmania Police relating to Mr Griffin.[424]

In November 2020, another investigative review was conducted. This review involved a 'critical analysis of investigations conducted in relation to the various information received in relation to Mr Griffin from 2009 until his death in October 2019'.[425]

On 23 December 2020, a *Revised Interim Report into the Review of Police Investigations Relating to James Griffin* was prepared by another detective inspector for the Commander of Professional Standards of Tasmania Police.[426] In February 2021, a *Review of Matters Surrounding James Geoffrey Griffin* was prepared by a Commander for the then Acting Deputy Commissioner, who is now the Commissioner of Tasmania Police.[427]

On 26 February 2021, the *Outcomes Report—Tasmania Police Internal Review of Police Actions Relating to James Geoffrey Griffin* was released. This report provides an overview of key findings from the abovementioned reviews.[428] The media release accompanying this report included an apology to victim-survivors who were let down by the failures of Tasmania Police in responding to complaints about Mr Griffin. The media release also stated:

> It's important to note that Tasmania Police acted to review our own response—before the Commission of Inquiry was announced—as we wanted to identify issues and areas for change as soon as possible.[429]

The report omits that Tasmania Police were informed about concerns regarding Mr Griffin in 2000 and 2019. The report commits Tasmania Police to developing new guidelines for investigating child sexual offences and new practices of information sharing with other agencies. These changes are discussed in our chapter on criminal justice responses (Chapter 16).

We acknowledge the initiative taken by Tasmania Police to accept responsibility for its failings, which it did so after Mr Griffin's offending became public knowledge. We nonetheless make a number of findings against Tasmania Police throughout this case study, in the interests of transparency and noting the brevity of the outcomes report. We also supplement the key findings of that report with additional information and reflections on Tasmania Police's conduct.

1.2.2 Independent investigation into the management of historical reports of child sexual abuse

As discussed in more detail below, on 22 October 2020, the former Premier, the Honourable Peter Gutwein MP and the then Minister for Health, the Honourable Sarah Courtney MP, announced the Independent Investigation into the Systems of the Tasmanian Health Service and Relevant Government Agencies/Organisations Relating to the Management of Historical Reports of Allegations of Child Sexual Abuse ('Independent Investigation').[430] This occurred after the Department began its own internal review. The terms of reference for the Independent Investigation required examination of the circumstances surrounding Mr Griffin's conduct. The terms of reference also required consideration of what previous or current systems used by the Tasmanian Health Service, the Department and/or other government agencies did or did not operate to:

- require or encourage people to report known or suspected child sexual abuse and/or require appropriate authorities to investigate or respond to the risk of child sexual abuse occurring in the Tasmanian Health Service, or
- alleviate to the best extent possible the risk of the repetition of child sexual abuse by an employee who is alleged to have perpetrated, or is under investigation for, child sexual abuse.[431]

The terms of reference also requested advice about other actions and changes to current systems that could minimise the risk of child sexual abuse within the Tasmanian Health Service, given the Tasmanian Government's agreement to implement recommendations from the National Royal Commission.[432]

Our Commission of Inquiry was announced a month later. The Order establishing our Commission of Inquiry created a remit across a range of government-led and funded institutions, beyond the terms of reference of the Independent Investigation. However, the Order also specifically required us to consider:

> The adequacy and appropriateness of the responses of the Tasmanian Health Service and the Department of Health to allegations of child sexual abuse, particularly in the matter of James Geoffrey Griffin (deceased 18 October 2019).[433]

As a result, the Independent Investigation ended, and information obtained as part of that investigation was given to our Commission of Inquiry to inform our work.[434]

1.2.3 *The Nurse* podcast

Throughout this case study we refer to *The Nurse* podcast, which was produced by freelance journalist Camille Bianchi. The podcast covered abuses at Launceston General Hospital, particularly by Mr Griffin, but also alleged abuses by other health practitioners including Dr Tim (a pseudonym), which we explore in Case study 2.

We recognise the important role *The Nurse* podcast played in bringing Launceston General Hospital's failings to light and contributing to the momentum to establish our Commission of Inquiry. We had the benefit of Ms Bianchi's evidence in hearings and full transcripts of the podcast and are grateful for her assistance.

The Nurse podcast informed our lines of enquiry with various witnesses, particularly in the early stages of seeking information and identifying appropriate witnesses. However, we have not relied on the information in the podcast in our findings, noting we have had the benefit of powers to compel documents and evidence from witnesses, which we have used to inform our conclusions.

2 Findings

We make findings throughout this case study. We explain our general approach to making findings in Chapter 1. For the purposes of this case study, the findings reflect our determination of what did and did not occur at various points throughout Mr Griffin's employment at Launceston General Hospital. Some findings were straightforward to make because we could verify the information we received through documents and independent witnesses, or because those involved conceded or admitted to the subject of the finding. In instances where we did not have corroborative documentary evidence, we have sometimes made a finding where, having assessed all available evidence, we consider it is more likely than not that a particular event or outcome occurred.

We note that as a commission of inquiry we are not bound by the rules of evidence nor the standards of proof that apply to a criminal proceeding. We have adopted a 'balance of probabilities' standard of proof. A commission of inquiry must not express a conclusion of law in respect of the legal liability of a person. We have not recommended any criminal investigation in relation to any of the people against whom we have made adverse findings.[435]

We are conscious that Mr Griffin's death shortly after he was charged put an end to any criminal prosecution against him that might otherwise have followed. This has removed the opportunity for Mr Griffin's conduct to be established as child sexual abuse beyond reasonable doubt as part of a criminal process. As discussed in Chapter 1, we have accepted the truth of the accounts of abuse from victim-survivors but acknowledge that their accounts have not been assessed against this higher criminal standard of proof nor against the civil standard of balance of probabilities.

Some of the information we received from witnesses provided relevant context to understanding what occurred at Launceston General Hospital during Mr Griffin's tenure, but we could not find enough supporting evidence to meet a 'balance of probabilities' threshold. As such, we cannot and do not make a finding. In these circumstances, we have presented the information received (where we had the permission of those providing it to do so) and explained why we could not make a finding.

We also heard several rumours and received other speculative information relevant to Mr Griffin, his perpetration of abuse and the hospital's response. Where this has not fallen within the scope of our Inquiry, or where we have had no means to verify such information, we have not given it any weight when making our findings or included such information in our report.

The findings we have made, particularly against individuals, were not made lightly. We took great care to ensure we considered all relevant information and provided a fair reflection of the evidence we received, including any qualifications, corrections or alternative explanations that witnesses provided us. We have set out much of the evidence that we have received below. It is important to note that no finding is made where we have not specifically identified it as such.

In Section 4, we find there were significant failures on the part of Launceston General Hospital to respond to Mr Griffin's repeated and escalating boundary breaches and his inappropriate contact with child patients. We make several findings in relation to these failings:

- Launceston General Hospital failed to respond appropriately to Kylee Pearn's disclosure of abuse by James Griffin in 2011 or 2012, leaving children exposed to potential risk for eight years.
- Luigino Fratangelo and James Bellinger received a disclosure of child sexual abuse from Kylee Pearn relating to James Griffin in 2011 or 2012.
- Launceston General Hospital did not have adequate processes to ensure the meeting with Kylee Pearn was recorded and that record was retained.
- Launceston General Hospital's response to Will Gordon's 2017 Safety Reporting and Learning System complaint did not comply with the requirements of a State Service Code of Conduct investigation.

- Launceston General Hospital failed to manage the risks posed by James Griffin.
- Launceston General Hospital leadership collectively failed to address a toxic culture in Ward 4K that enabled James Griffin's offending to continue and prevented his conduct being reported.
- Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin.
- The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct.
- Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem.
- Launceston General Hospital did not have a robust system for managing complaints involving child safety.
- Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies.
- James Griffin had the ability to take and misuse medications from Launceston General Hospital.

We consider that many of these failings may have contributed to staff deciding against reporting Mr Griffin's behaviour and contributed to Mr Griffin being able to offend for as long as he did.

We learned that Mr Griffin had come to the attention of other government institutions, including Tasmania Police and Child Safety Services, in the lead-up to and during his employment at Launceston General Hospital. Each agency held vital pieces of the information puzzle about Mr Griffin's risk to children and yet we saw failures to share such information and work collaboratively, noting that information held by Tasmania Police and Child Safety Services was not shared with the Department before July 2019.

Tasmania Police failed to appropriately act when reports of Mr Griffin's conduct were received—most notably in 2015, when Australian Federal Police passed on significant intelligence about Mr Griffin's offending that was not accessed by Tasmania Police until 2019. Despite receiving notifications about Mr Griffin, Child Safety Services took only perfunctory steps to assess the risk that Mr Griffin posed to children. We make the following findings against these agencies:

- Child Safety Services should not have closed its November 2011 case into James Griffin without making further enquiries and ensuring Tasmania Police had all the information it required.
- Tasmania Police should have made further enquiries to receive the notifier's identity and reviewed previous intelligence holdings relating to James Griffin when receiving the November 2011 information from Child Safety Services.

- Child Safety Services should have taken further steps to assess the risk James Griffin posed in 2013 when concerns were again reported about him.
- Tasmania Police should have reviewed all intelligence holdings about James Griffin in 2013 when a report to Child Safety Services was made.
- The child safety system in the mid-2010s was not designed to address child sexual abuse in institutional settings.
- Tasmania Police failed to act on highly probative evidence regarding James Griffin provided by the Australian Federal Police in 2015.

In Section 5, we find that Launceston General Hospital failed in multiple ways to appropriately respond to an extensive history of complaints against Mr Griffin after his registration to work with vulnerable people was revoked, and we make the following findings:

- The response of Launceston General Hospital to revelations about James Griffin's offending was passive and ineffective.
- Leadership at Launceston General Hospital was dysfunctional and this compromised its collective response to revelations about James Griffin.
- Launceston General Hospital did not have clear accountabilities for child safety.
- The lack of a coordinated and transparent response by Launceston General Hospital increased feelings of mistrust among hospital staff.
- Launceston General Hospital should ensure open disclosure processes are trauma-informed.

We have further found that some individuals failed to fully and accurately convey the knowledge they held about Mr Griffin's conduct to the Office of the Secretary of the Department, which had the effect of creating a misleading picture of the scale of the crisis and impairing fully informed decision making by the Secretary and that office. Some of this information was critical and may have changed the course of events, had it been escalated and shared. Our findings in this regard include:

- Dr Peter Renshaw misled the Chief Executive of Launceston General Hospital and the then Secretary of the Department by failing to fully and accurately convey information relating to James Griffin received from Tasmania Police on 31 July 2019.
- The human resources team failed to escalate information they received on 11 October 2019 about Kylee Pearn's 2011 or 2012 disclosure.
- Dr Peter Renshaw should have escalated and acted on knowledge of Kylee Pearn's disclosure to the hospital once advised of it by Tasmania Police on 29 October 2019.

- Dr Peter Renshaw misled the Secretary of the Department about James Griffin.
- James Bellinger did not conduct a proper investigation into James Griffin's complaints history and misled the Secretary of the Department and the Integrity Commission.

We found some significant failures to identify and manage conflicts of interest relating to the hospital's response to Mr Griffin. Our findings in this regard are:

- Launceston General Hospital's human resources team should not have been involved in the request or preparation of a statement from Stewart Millar regarding Kylee Pearn's disclosure.
- James Bellinger should not have taken the statement from Stewart Millar.

The response to Mr Griffin's conduct was further let down by Tasmania's Integrity Commission, which received a complaint in November 2019 outlining major concerns with how the hospital had managed complaints about Mr Griffin over the years. Despite the Integrity Commission's initial assessment of the complaint, which it recognised as serious, it decided to refer the matter back to the Department for investigation. We find that:

- The Integrity Commission should have ensured Will Gordon's complaint to them was robustly and independently reviewed.
- The Integrity Commission's monitoring of the Department's response to Will Gordon's complaint was insufficient and it should have sought further review.

As noted, we have found that one individual, Dr Peter Renshaw, former Executive Director of Medical Services, Launceston General Hospital, deliberately misled his superiors. We also consider he misled our Commission of Inquiry. Dr Renshaw withheld information from us, fundamentally frustrating our ability to fully understand what happened at Launceston General Hospital. Recognising the gravity of such a finding, we applied a high threshold to the evidence that supported it. We disregarded evidence that could be attributed to a mistake or failure of memory and, in relation to questions of fact and findings, we sought clarification and explanation from Dr Renshaw to ensure we did not misunderstand his intention, and to provide a right of response or further explanation. We took a similar approach to those who are subject to our findings.

We found Dr Renshaw misled our Commission of Inquiry about his state of knowledge. We consider this conduct was unprofessional and unethical and brings the State Service into disrepute. We therefore find that Dr Renshaw's conduct constitutes misconduct under section 18 of the *Commissions of Inquiry Act 1995*.

3 How people described Mr Griffin to us

Before we chronicle Mr Griffin's conduct and the hospital's response to it, it is important to summarise evidence we heard about Mr Griffin as a person. The evidence we received suggests that Mr Griffin's way of interacting with others was key to his ability to evade accountability for his actions.

Victim-survivor Tiffany Skeggs described to us how Mr Griffin groomed her:

> Griffin had an aura that oozed kindness and sincerity. He was sympathetic and compassionate. He provided me with all the attention a young girl could possibly want. I was fatherless. I was instinctively searching for a male role model in my life. Griffin provided love and safety. He was understanding and encouraging.[436]

Keelie McMahon, who was also abused by Mr Griffin, told us that Mr Griffin could adapt to whoever he was with to ingratiate himself:

> He made himself 'valuable' to other people. He was always able to find other people's interests so he could talk to them and please them. He would pump you up so you would feel good spending time with him. I can't recall many people ever speaking badly of Jim, and if they did, others around him would always jump to his defence.[437]

By most accounts, Mr Griffin was very effective at grooming young victims, some of whom were highly vulnerable because of their health conditions or family circumstances. A former colleague, who observed Mr Griffin's behaviour on Ward 4K, said:

> James Griffin didn't just groom kids, he groomed everyone. He groomed his colleagues and friends. Now that he's dead, people seem to think that he wasn't smart, but the reality is he was incredibly smart, both intuitively and from a nasty place.[438]

This same colleague described how Mr Griffin would use his age to justify some of his inappropriate jokes or behaviour in the workplace. We heard that when colleagues confronted Mr Griffin about using the term 'baby girl' with female staff, Mr Griffin:

> … replied with words to the effect of 'I'm old guard. I've always said these things. It gets me in trouble sometimes but that's the way I am'. That was James Griffin's tactic if he ever got pulled up on these things. He would say he doesn't do PC [political correctness] and that PC was a construct of generation X and generation Y.[439]

Mr Griffin often did favours for or showed kindness towards female colleagues. Many witnesses told us that they now understand this behaviour was part of his grooming process. A former colleague of Mr Griffin, Maria Unwin, described how he would take shifts for other staff to win their favour.[440] Another former colleague described Mr Griffin's behaviour as: 'He oozed "I'm here for you"'.[441]

Many witnesses shared stories about how Mr Griffin would paint himself as a 'hero'.[442] Mr Griffin told a regular patient of Ward 4K, Kirsty Neilley, that he had saved her life when she was having a seizure from an attempted drug overdose:

> From this day on, Jim would never let me forget that night. He would always tell me how he saved my life. I believed him and regarded him as my hero. My mum regarded him the same way. She still says now that Jim saving my life is worth more than any of the bad things he could have done.[443]

Another Ward 4K patient and victim-survivor abused by Mr Griffin told us: 'After not too long, he had developed a "friendship" with Mum and Dad and had gained their trust. They really trusted him'.[444] These dynamics made her less inclined to disclose the abuse because 'Jim was a big part of our family'.[445]

Kim (a pseudonym) described her experience of Mr Griffin caring for her daughter Paula (a pseudonym) in hospital: 'I observed him to be a "touchy-feely" person, but I thought he was friendly and caring'.[446] She stated that her trust in Mr Griffin developed as her daughter stayed in touch with him outside the hospital setting: 'I thought he could see how hard it was for me with four children, trying to work, trying to care for [Paula], and that his interest in [Paula] was part of him caring about other people'.[447]

One victim-survivor who was abused by Mr Griffin told us: 'In my opinion, James Griffin had a career that was structured around paedophilia'.[448] She described him as having a brazen persona, which seemed unaffected by the abuses he perpetrated. She told us:

> I never confronted James Griffin about what he did to me. He was so confident with everything he did that he just carried on around me like everything was normal and he had done nothing wrong. While he carried on as normal, he knew that I knew.[449]

Those who questioned or challenged Mr Griffin, or who were not the targets of his grooming tactics, often gave us a different view of his personality. One of the former colleagues we mention above stated that Mr Griffin 'appeared to not like the other male nurses on the ward. I think this was because we recognised things that he did openly, things that we as male nurses just would not do'.[450]

Ms Unwin expressed that she felt 'wary' of Mr Griffin from their first meeting. She said that when allocating patients to staff, she would divert vulnerable young female patients from Mr Griffin's care.[451] She described how Mr Griffin would 'glare' when she did this and how, one time, he confronted her in a small staff kitchen about this practice. She characterised his approach and body language on that occasion as 'intimidating'.[452]

Ms Unwin's experience was echoed by Ward 4K nurse Will Gordon, who told us:

> At times James was imposing. Although he wasn't overly tall he was broad, so when he got fired up, he cast a shadow. I felt that some of the nurses were intimidated by him when he did get fired up.[453]

Many victim-survivors believed they were the only one Mr Griffin abused. Ms Skeggs explained: 'The main reason I remained quiet and protected Griffin for such an extended period of time was because I thought I was special. He made me think I was the only one'.[454]

In offering his reflections on Mr Griffin, investigating police officer Detective Senior Constable Glenn Hindle told us that Mr Griffin would often enmesh victim-survivors with his own family so that victim-survivors believed speaking up about their abuse would cause harm to Mr Griffin's children:

> … he sought opportunity to touch children and then said to those children, 'You can never say anything because this is what I'll lose in life, these kids won't have a father' and those sorts of things …[455]

Understanding how Mr Griffin conducted himself goes some way to explaining why many colleagues, managers and others at Launceston General Hospital did not take appropriate action in response to his offending.

4 Complaints about Mr Griffin

Figure 14.1: Timeline of documented or acknowledged complaints about Mr Griffin

On foldout →

In this section—Section 4—we document how Launceston General Hospital responded to the concerns raised about, and complaints made against, Mr Griffin from when he started working on the paediatric ward until the suspension of his registration to work with vulnerable people in July 2019.

We consider the hospital's response to documented and undocumented complaints in turn and make findings in relation to both. Other matters of concern about Mr Griffin, including allegations of Mr Griffin's unauthorised use of hospital medications to drug patients, are considered at the end of this section.

4.1 Documented or acknowledged complaints against Mr Griffin

In this section, we consider the concerns raised and complaints made against Mr Griffin by patients, their family members, staff at the hospital and others that were documented or otherwise acknowledged by the hospital's management, Child Safety Services or Tasmania Police between the year 2000 and July 2019.

Figure 14.1: Timeline of documented or acknowledged complaints about James Griffin

2000

A report is made to Tasmania Police about images and browser history found on Mr Griffin's laptop

2001

September

Mr Griffin is employed on Ward 4K at Launceston General Hospital

2002

A complaint is made about non-care related touching of a patient

2004

July

The hospital receives a complaint about Mr Griffin hugging a former patient

2005

A parent complains about Mr Griffin kissing their daughter on the forehead

2009

Mr Griffin gives his personal mobile number to a patient

Complaints are made about Mr Griffin interfering with a behaviour management plan and cuddling a patient

February

Mr Griffin intends to 'give away' a former patient at her wedding

March

Tasmania Police receive information about Mr Griffin 'upskirting' young girls

May

An email chain that included a former patient is discovered

2011

2011 or 2012

Kylee Pearn discloses childhood sexual abuse by Mr Griffin to Launceston General Hospital

2011 or 2012

Ms Pearn and her friend have an informal discussion with Tasmania Police

2011 or 2012

Ms Pearn and her friend report their abuse to an organisation Mr Griffin volunteered with

November

Child Safety Services receives a report about Mr Griffin and notifies Tasmania Police

2012

November

Concern from the mother of a patient that Mr Griffin was a 'sleaze'

2013

April

A confidentiality breach follows a request that Mr Griffin not visit a patient and her mother

May

A report is made to Tasmania Police about Mr Griffin, which is passed on to Child Safety Services

2015

April

Tasmania Police receives information from the Australian Federal Police about Mr Griffin

November

A nurse raises concerns about Mr Griffin's professional boundaries with teenage girls

2017

March

A young patient reports discomfort with Mr Griffin using pet names

May

A student undertaking a placement complains about Mr Griffin

August

A nurse complains about Mr Griffin having an inappropriate conversation with young female patients

November

Mr Griffin is transferred to work in a fixed-term role at Ashley Youth Detention Centre

2019

July

A nurse complains about Mr Griffin's inappropriate comments and actions when administering medication

May

Tiffany Skeggs reports Mr Griffin's abuse to Tasmania Police

4.1.1 19 September 2000—A report is made to Tasmania Police about images and browser history found on Mr Griffin's laptop

On 19 September 2000, Tasmania Police received information of concern about Mr Griffin.[456] The person who contacted police had purchased a laptop computer from Mr Griffin. Sometime later, having connected the computer to the internet, the person discovered concerning bookmarked links to websites with titles that suggested child exploitation material, as well as a cache of photographs of apparently pre-pubescent girls, naked or wearing only underwear.[457] In correspondence to Tasmania Police, this person wrote: 'I need to know if anything can be done … especially given that he is a [practising registered nurse], possibly working with children'.[458]

We heard that, following some back and forth and a review of the images, Tasmania Police ultimately declined to act, with the person recalling that Tasmania Police said that 'not enough was found on the computer to move forward'.[459] In some of those communications with Tasmania Police, the new laptop owner acknowledged that none of the images he witnessed were 'openly pornographic' but found them concerning nonetheless.[460] Upon learning of our hearings, this person contacted us and told us that 'it is very likely that I was the first person to alert any authorities about [Mr Griffin]' and that, although police decided not to take further action, 'at least my contact would put his name in a detective's mind and create a dot for any future join the dots inquiry'.[461]

Many years later, on 30 November 2019, Detective Senior Constable Glenn Hindle, who was then in charge of an investigation into Mr Griffin, answered a call from the same person who had contacted police in September 2000 about the disturbing laptop content. Detective Senior Constable Hindle told us that during this call the person explained that they had purchased a computer from Mr Griffin many years ago and later identified what they believed to be child exploitation material on the device, which they had reported to the police at the time. Detective Senior Constable Hindle described being 'a little bit perplexed' he hadn't previously come across this information.[462] Detective Senior Constable Hindle could not find evidence in any Tasmania Police records of this person's earlier report to police.[463]

Based on this person again describing the images discovered on Mr Griffin's old laptop, Detective Senior Constable Hindle formed the view that it was unlikely these images met the legal definition of child exploitation material, and hence, while being a moral concern, were not a legal concern to him.[464] He made a record of their 2019 conversation on 1 December 2020.[465] Detective Senior Constable Hindle acknowledged it was possible that he made the record a year after the conversation had taken place, although it is unclear to us how or why this occurred and he had difficulty recalling specific dates.[466]

Former Commissioner of Tasmania Police, Darren Hine AO APM, clarified that hard-copy records indicated the original complaint was escalated to a senior level and referred for investigation in 2001.[467] He confirmed that police in New South Wales carried out a forensic examination of the laptop and that no offences were detected.[468] Commissioner

Hine acknowledged that Tasmania Police had only limited information about this report because it was not entered into a police database until Detective Senior Constable Hindle did so in December 2020. However, Commissioner Hine concluded: 'I am satisfied from the scant information available on this matter that Tasmania Police acted appropriately on this occasion'.[469]

While we recognise information that suggests inappropriate conduct can appear less significant or probative in isolation, such information can become more significant over time when other complaints or concerns are reported to police. It is unfortunate, therefore, that the initial complaint was not recorded in a way that would allow easy access to the information for police in the future so they could 'join the dots', acknowledging that Tasmania Police did not implement an online intelligence system until 2002.[470]

4.1.2 September 2001—Mr Griffin is employed on Ward 4K at Launceston General Hospital

On 11 September 2001, Mr Griffin started working as a registered nurse on Ward 4K—the paediatric ward—at Launceston General Hospital.[471] The evidence we have indicates that he held this role until August 2019, except for two intervening temporary assignments:

- Between 14 June and 11 July 2009, Mr Griffin was assigned as a nurse to the Launceston General Hospital emergency department.[472]
- Between 19 November 2017 and 27 April 2018, Mr Griffin was seconded as a nurse to Ashley Youth Detention Centre.[473]

In all these roles, Mr Griffin had access to children and young people. His secondment to Ashley Youth Detention Centre is discussed in Section 4.1.29.

4.1.3 2002—A complaint is made about non-care related touching of a patient

We have received evidence that Mr Griffin was spoken to about professional boundaries in 2002. However, aside from records later made in 2009 by Sonja Leonard, when she was the Nurse Unit Manager of Ward 4K, and Clinical Nurse Educator Michael Sherring, we have little detail about this incident. As discussed further below, as part of her response to a complaint made on 14 January 2009 concerning Mr Griffin handing out his personal phone number to patients, Ms Leonard met with Mr Griffin on 11 February 2009. Ms Leonard's undated notes from this meeting state that she reminded Mr Griffin of the previous times that she or others counselled him about his behaviour. Her notes included the following reference:

> I mentioned there were other times [I had counselled Mr Griffin about professional boundaries] that he obviously didn't recall the time I spoke to him as a Level 2 [registered nurse] re prof. boundaries with [a person] and Michael Sherring and [a nurse unit manager] when he was doing Grad Cert course.[474]

We do not know the identity of the person and we did not request this information.

On 21 January 2009, around the time Ms Leonard was managing this complaint, Mr Sherring was asked by Ms Leonard to document his 2002 meeting with Mr Griffin about his behaviour. In response, Mr Sherring prepared a file note:

> The 2002 discussion concerning professional boundaries has centred around overly friendly behaviour regarding children and young people exhibited by Jim. This includes hugging on greeting and other non care related touching. I identified the inappropriateness of this and the potential risk of people misinterpreting such behaviour. Jim did not appear to identify anything wrong with his behaviour despite advice from myself that it was inappropriate and however innocent would be considered unprofessional.[475]

During the hearings, Mr Sherring was asked to reflect on this 2002 complaint:

> Q [Counsel Assisting]: So is it fair that in the conversation you had with him in 2002, he demonstrated to you a lack of insight into the impropriety of his behaviour?
>
> A [Mr Sherring]: Yep.
>
> Q: Why was he permitted to continue working with children?
>
> A: I can't answer that.
>
> Q: Do you think that a minimum prerequisite was that he understand that what he did was inappropriate?
>
> A: Yes.[476]

Mr Sherring agreed that the 2002 complaint should have been recorded, and that this type of complaint would generally be kept on ward personnel files held in the Nurse Unit Manager's office.[477] This summary is captured in the following exchange:

> Q [Counsel Assisting]: What were the processes for escalating concerns about a person whose behaviour was inappropriate where they failed to appreciate it?
>
> A [Mr Sherring]: Those details would have gone to the Nurse Unit Manager at the time and they as the performance managers would have been the people to pursue that in that first instance.
>
> Q: I've been unable to locate any documents reflecting those 2002 issues. Is it your evidence that there should be some?
>
> A: Yes.
>
> Q: Where would they have been stored?
>
> A: To the best of my knowledge, there were personnel files kept on the ward at that time, in two D-ring folders in the Nurse Unit Manager's office, and my understanding would have been that any documentation related to nurses, whether it was employment records or other file notes, would have been kept in those.[478]

As noted above, we received Mr Griffin's personnel file in December 2022. It did not include any documentation about the 2002 complaint.

In his 2009 file note, Mr Sherring also appears to reference a complaint discussed in Section 4.1.5 regarding Mr Griffin kissing a patient on the head.[479]

4.1.4 July 2004—The hospital receives a complaint about Mr Griffin hugging a former patient

In July 2004, the then Nurse Unit Manager of Ward 4K received an incident form about the way Mr Griffin greeted an adolescent girl who had previously been an inpatient and was visiting the ward.[480] A copy of the form has not been located. The Nurse Unit Manager at the time recalls that it stated Mr Griffin hugged the girl. The Nurse Unit Manager told us that while they had some difficulties recollecting this incident, they agreed that the physical contact amounted to 'professional misconduct'.[481] They described their practice in response to such circumstances as having a conversation with the relevant staff member and then giving them a letter.[482] In this case, their final words in the letter to Mr Griffin cautioned: 'Whilst this behaviour may seem innocent to you, it may well have potential implications in the future and we ask that it is not repeated'.[483]

The Nurse Unit Manager said that a copy of this letter was sent to the human resources team, to be placed on Mr Griffin's file.[484] The Nurse Unit Manager also told us that they would have notified their manager, Sue McBeath, who was Director of Nursing, Women's and Children's Services, about this complaint.[485] However, Ms McBeath did not recall the incident in her statement to us and was not asked for her recollection of the matter during her oral evidence.[486]

4.1.5 Late 2005—A parent complains about Mr Griffin kissing their daughter on the forehead

In late 2005, the same Nurse Unit Manager recalled receiving a phone call from the concerned parent of a young girl. This parent informed the Nurse Unit Manager that Mr Griffin had kissed their daughter on the forehead, resulting in their daughter 'vigorously rubbing her face'.[487] The parent did not wish to make a formal complaint but did tell the Nurse Unit Manager that the incident had made them feel uneasy and that they wanted to express their concern.[488] The Nurse Unit Manager agreed that Mr Griffin's behaviour was 'most inappropriate' and gave Mr Griffin a letter indicating their concern and requesting that he provide them with a written explanation of his conduct.[489]

Mr Griffin responded in writing, acknowledging that the incident did occur. He explained it as a 'spontaneous action' in response to the patient not wanting to go to bed. He added:

> In retrospect I believe I did this as a way of establishing a level of friendship, rather than being seen by her as some kind of authoritarian figure. While this may have been seen by [the parent] in [their] context as a [professional role],

> as an inappropriate act, giving a child a kiss as a show of something caring is something that is done often on the ward by many, nursing, and other, staff. I do, however, accept that this may not be seen as appropriate.[490]

The Nurse Unit Manager again wrote to Mr Griffin, formally requesting that he speak with the Clinical Nurse Educator, Mr Sherring, to 'further discuss issues around associations, care provision, and boundaries relating to gender issues and the workplace'.[491] They included a copy of the document *Professional Boundaries Standards for Nurses in Tasmania* with the letter.[492]

Mr Sherring told us he was concerned about Mr Griffin's behaviour because it was 'outside [the] acceptable professional boundaries guidelines' that applied at the time.[493] Mr Sherring had a discussion with Mr Griffin, which he reported back to the Nurse Unit Manager in a memo.[494] Mr Sherring made several points in the memo about his conversation with Mr Griffin, including that:

- Mr Griffin acknowledged that the incident involving the forehead kiss went beyond what he would normally consider 'an appropriate comfort measure' and that it occurred due to the 'specific circumstances of the events'.[495]
- Mr Griffin agreed to 'step back from direct care', despite a specific request from a patient or their family that he care for them, where doing so may not be appropriate in the circumstances. Mr Sherring and Mr Griffin discussed ways to do this 'without distressing either the child or family'.[496]

Mr Sherring also noted in his memo that:

> Jim recognises that there may be a disproportionate focus on the interactions of males in nursing roles with children in paediatric settings and that there is an increased need for awareness of how nursing behaviours with children may be viewed by others.[497]

The Nurse Unit Manager submitted all the relevant documents to the human resources team, to be placed on Mr Griffin's file 'in case any future issues arise'.[498]

The Nurse Unit Manager believes they 'would have verbally spoken to Sue McBeath, Director of Nursing Women's and Children's Services' about this complaint and the previous complaint of July 2004.[499] They also said there were regular meetings between ward managers and clinical nurse managers and the human resources team.[500] Ms McBeath recalls that the complaint was only informally reported to her after the Nurse Unit Manager had responded to the complaint.[501] She also recalls only discussing a complaint in relation to a male nurse kissing the forehead of a young female patient, and not that it specifically involved Mr Griffin.[502]

Reflecting on their own handling of Mr Griffin's behaviour, the Nurse Unit Manager told us they did not have any professional education about child sexual abuse throughout their nursing career and that they had not had to manage child abuse matters prior to complaints about Mr Griffin.[503] They added:

> At the time I felt I addressed the incidents appropriately, however my focus was on professional boundaries, not sexual abuse. In hindsight, I now understand my concerns were inadequately acted upon.[504]

A subsequent Nurse Unit Manager, Sonja Leonard, told us she was aware that Mr Griffin had kissed a patient on the forehead, but she was not aware of the circumstances surrounding the complaint.[505]

4.1.6 November 2008—Sonja Leonard becomes the Nurse Unit Manager on Ward 4K

A number of current and former staff of Ward 4K described a workplace culture, both post and prior to ward staff's knowledge of Mr Griffin's offending, that was tense, defensive and discouraging of feedback and reflection.

Ms Leonard, who was the Ward 4K Nurse Unit Manager from November 2008 until December 2020, conceded in evidence that she had a different management style to her predecessor and that her style was not well received by staff.[506] Shortly after starting in the role, we were told Ms Leonard was met with a no-confidence motion from staff on the ward. Former Ward 4K nurse, Annette Whitemore, described what happened after this:

> An external facilitator was then engaged to 'rebuild the nursing team' on the ward. I recall the facilitator talking to staff, asking us to blow up a balloon, put our worries in the balloon and pop it.[507]

Ward 4K staff took part in other team building initiatives over the years. In August 2012, for example, Mr Griffin signed a document titled *4K Leadership Team: Agreed Values*, which was in his personnel file.[508] This read in part:

> Following much team building and time, we the members of the 4K … leadership team have agreed on the following values. We believe that following these values and ensuring we work according to these values that our team will build in strength. By doing so we will regain the trust of our leadership team colleagues, and also the respect of 4K staff. As leaders of the 4K team it is important we do this, not only for ourselves, but also our 4K team.[509]

The document included overarching values of 'respect', 'constructive communication' and 'trust'—including 'safety to be able to speak up'.[510] It is unclear why Mr Griffin signed this document given he was not formally on the ward's management team.

Will Gordon, a registered nurse mentioned earlier, recalled that before starting work on Ward 4K in 2016, several nurses told him to 'watch out for the Nurse Unit Manager'.[511] He described the culture when he started on the ward as one of 'tension' and 'high anxiety', adding that nurses were 'constantly watching their backs' and afraid to make any sort of error.[512] Ms Whitemore similarly described an ongoing 'culture of mistrust' and a ward that was 'divided and disjointed'. She added:

> I believe the culture on Ward 4K made it easier for [Mr Griffin] to do what he did. He saw the cracks and put himself in there. He would take Sonja's side. I've been told by other staff they believed he reported things back to her. He tried to win her favour.[513]

It was difficult for us to determine the degree to which the hospital's leadership was aware of the problems with Ward 4K's culture at this time. When questioned about the culture on Ward 4K, Janette Tonks, former Director of Nursing, Women's and Children's Services, replied that on starting her role in 2013: 'I was aware that there was a grievance; I wasn't aware that the culture was as toxic as what I am now led to believe'.[514] Ms Tonks later told us that her observation of Ward 4K was that staff were very happy and noted that none of the nurses had approached her with 'anxieties or lack of confidence in Ms Leonard'.[515] At our hearings, Ms Tonks conceded that she was responsible for making sure Ms Leonard had the tools to properly manage Ward 4K and she did not do so.[516]

Ms Leonard told us that she believed senior nursing management was well aware of the dysfunctional dynamics on the ward.[517] At hearings for our Inquiry, Helen Bryan, the then Executive Director of Nursing, gave evidence that she accepted cultural change was required at the hospital in relation to transparency, openness and honesty.[518] Ms Bryan also later gave evidence that she considered that progress has been made towards effecting those changes.[519]

4.1.7 31 December 2008—Mr Griffin's Performance and Development Agreement is signed off

On 31 December 2008, a Ward 4K staff member acting as the ward's Nurse Unit Manager signed off on Mr Griffin's Performance and Development Agreement.

There were two particularly notable entries in this Agreement. In response to the question 'What has worked well/been done well in the review period?', the Acting Nurse Unit Manager commented on Mr Griffin's 'management of adolescent mental health patients'.[520] Also of note, in response to the question, 'What hasn't worked so well/been done so well in the review period?', was the entry: a 'lack of encouragement and feedback (positive and negative from management)'.[521]

4.1.8 Early 2009—Mr Griffin gives his personal mobile number to a patient

In early 2009, a staff member told Ms Leonard about a professional boundary breach by Mr Griffin. The concern was that Mr Griffin had offered his phone number to a young patient, saying he would 'come back to work and sit with the distressed patient if needed' after his shift.[522] A 'handover memo' written by two staff members indicates that the rostered staff members assured Mr Griffin that the patient was fine and it was not necessary for him to return to work, despite Mr Griffin's insistence that he be called if the patient became distressed.[523] Later, when the patient was upset and staff members

sought to comfort her, she became more distressed saying 'Jim had promised' her that the staff would call him if she wanted him to return.[524]

Ms Leonard told us that she was 'unsure' if this concern relates to the same patient referred to in a complaint made by a Senior Psychiatric Registrar (described in Section 4.1.9), noting that the Registrar also complained that Mr Griffin had given his mobile phone number to a patient and that the concern was 'considered at the same time and in the same manner' as this complaint.[525]

Ms Leonard met with Mr Griffin in February 2009 and directed him to not give out his mobile number to patients.[526] Ms Leonard's handwritten diary note of her discussion with Mr Griffin states: 'Verbal warnings not previously effecting change in [behaviour]' and that Mr Griffin's intention does not equal the 'effect and outcome'.[527] We discuss Ms Leonard's file note of this conversation in more detail in the next section.

Ms Leonard told us that she met with the patient's mother and that the mother advised Ms Leonard that she had deleted Mr Griffin's number from her child's phone.[528] Ms Leonard does not recall whether she reported this incident to her supervisor (who was Ms McBeath at the time).[529] Ms McBeath informed our Inquiry that she did not recall this matter being reported to her.[530]

4.1.9 Early 2009—Complaints are made about Mr Griffin interfering with a behaviour management plan and cuddling a patient

In early 2009, Ms Leonard received a written complaint from a Senior Psychiatric Registrar ('Registrar') about Mr Griffin. The Registrar described having developed a behaviour management plan with a treating paediatrician to overcome a young girl's extreme separation anxiety, which demanded 'a consistent approach from both her parents and ward staff in responding to her distress and demands for company'.[531] The Registrar wrote that in a previous session with this patient's parents they had expressed a view that all nurses should befriend their daughter 'like Jimbo has' to be therapeutically effective.[532]

The care of this young girl had been previously discussed at a weekly multidisciplinary team meeting, where the Registrar was 'surprised' to see Mr Griffin in attendance because Mr Griffin was on annual leave at that time.[533] As recounted by the Registrar in his letter to Ms Leonard, at this meeting Mr Griffin outlined his concerns with the treatment plan, stating that he believed it was 'unkind to leave the patient in a distressed state'. The Registrar explained in some detail the justification for the approach, which Mr Griffin then reluctantly accepted.[534]

In his letter, the Registrar also informed Ms Leonard that Mr Griffin's behaviour had come to his attention on a separate occasion, after Mr Griffin had given his personal mobile number to a highly vulnerable young woman who had been an inpatient on Ward 4K, encouraging her to contact him whenever in crisis.[535] The Registrar wrote to Ms Leonard

that he was finding it 'particularly difficult to reach a mutual understanding' with Mr Griffin on the appropriateness of Mr Griffin's interactions with patients more broadly.[536] The letter said:

> I am deeply concerned about this and request that you address it immediately and thoroughly and that Mr Griffin be referred to a caring professional himself. I imagine referral to a psychologist or psychiatrist would be the most appropriate choice initially.[537]

The Registrar further informed Ms Leonard that he had notified the Clinical Director, Mental Health Services North, of his concerns about Mr Griffin and that the Clinical Director had indicated 'his intention of raising this with management as a performance issue, if the situation persists'.[538] Ms Leonard recalls notifying human resources staff and Ms McBeath about the Registrar's concerns.[539]

Ms Leonard told us that she responded to the Registrar, notifying him that she was going on leave and that the Acting Nurse Unit Manager would take responsibility for the matter.[540] Ms Leonard told us that, during handover, the Acting Nurse Unit Manager told Ms Leonard that they had seen Mr Griffin cuddling the same patient who was the subject of the Registrar's letter. This, the Acting Nurse Unit Manager said, took place in a recliner chair in the patient's room after her mother had left.[541] In a file note that the Acting Nurse Unit Manager prepared for Ms Leonard, they wrote that they 'accepted Jim's actions as being caring and consoling, even though it was an action I would not deem appropriate in my nursing care'.[542] The Acting Nurse Unit Manager acknowledged in their file note that they had since learned that Mr Griffin's actions were in contravention of the patient's treatment plan (as outlined by the Registrar).[543]

A meeting was held between the Acting Nurse Unit Manager, a member of the human resources team and Ms McBeath to discuss the complaint.[544] The file note from this meeting records the following items under the heading 'Issues discussed':

a. Physical touch of patients outside therapeutic boundaries.

b. Giving out mobile phone number to patients/families for contact outside work hours.

c. Development of simpler, more clear cut protocol outlining professional boundaries for staff on Children's Ward LGH.

d. Development of above protocol to be done within a group forum setting inclusive of J. Griffin.

e. Letter to be written by [the Acting Nurse Unit Manager] to James Griffin re confirming our expectations in respect to his professional relationships and boundaries. After inspection by [the human resources staff member] and [Ms McBeath] this will be given to James on his return after Annual leave.

f. This letter will specify the need to refer the matter to the Nursing Board of Tasmania if any further incidents arise.[545]

Our Commission of Inquiry was provided with a letter that is undated and marked 'draft'. Ms Leonard told us that this was the letter the Acting Nurse Unit Manager sent to Mr Griffin at the time.[546] The letter reflected the discussions described above and reiterated that Mr Griffin should not:

- have contact with patients and ex-patients outside a clinical setting
- attend care meetings for patients on days that he is not rostered to work
- continue to care for patients where colleagues or peers identify that this has become 'counterproductive to the team goal'
- have physical contact with patients beyond providing their medical care.[547]

The letter also explicitly warned Mr Griffin that if there was a similar complaint about him in the future, there would be no option but to raise the matter with the Director of Nursing, which may result in the complaint being referred to the Nursing Board of Tasmania.[548]

Later on in early 2009, a message from Ms Leonard's email address (but signed by the Acting Nursing Unit Manager) was sent to the Registrar informing him that Mr Griffin had asked for the letter of complaint that the Registrar had written so he could 'formulate a response to the matter at hand'. This email indicates that the Acting Nurse Unit Manager sought advice from then Human Resources Consultant, Luigino ('Gino') Fratangelo, about providing the letter of complaint to Mr Griffin.[549] Mr Fratangelo was apparently satisfied with it being provided if the Registrar was informed.[550] We have not enquired as to whether (or how) the Registrar responded to this request. Ms Leonard's notes suggest that the complaint was provided to Mr Griffin.[551]

Ms Leonard met with Mr Griffin about the complaint and took notes of their discussion. In these notes, Ms Leonard records that Mr Griffin was upset about the Registrar's letter of concern.[552] The notes record that she asked Mr Griffin how many times similar matters had been discussed with him, and he reportedly replied 'only twice', being this instance and the incident of kissing a patient's head (described in Section 4.1.5). Ms Leonard's notes include the following: 'I mentioned there were other times that he obviously didn't recall … so speaking about it hadn't changed the behaviour'.[553] Her notes go on to indicate that since the complaint had been made by another area of the health service, it was necessary to take appropriate action so the quality of services provided by Ward 4K were without question.[554] This appears to reflect a desire by Ms Leonard to manage the reputational risks (even within the hospital) associated with Mr Griffin's conduct.

In Ms McBeath's view, the wording of the Acting Nurse Unit Manager undated 'draft' letter to Mr Griffin suggested that it was 'more of a warning'.[555] Ms McBeath, noting the letter's reference to a potential report to the Nursing Board of Tasmania, told us 'the issue was obviously viewed as professional role confusion/professional boundary issue and the first time it emerged with Mr Griffin'.[556]

On the evidence, this was at least the fourth time professional boundary issues had been raised about Mr Griffin.

4.1.10 February 2009—Mr Griffin intends to 'give away' a former patient at her wedding

Ms Leonard told our Commission of Inquiry that, in February 2009, Mr Griffin advised her of his intention to 'give away' a former patient, Angelique Knight, at her wedding, which was to take place in several days' time. Ms Leonard said she was concerned when Mr Griffin told her this because it suggested an 'unusually close relationship for a nurse to have with an ex-patient'.[557]

Ms Leonard noted that her manager, Ms McBeath, was not available to advise her; consequently, Ms Leonard sought advice from the then Executive Director of Nursing, Helen Bryan, who was Ms McBeath's manager. Ms Leonard stated that Ms Bryan told her that Mr Griffin could attend the wedding but that he should not 'give away' the bride.[558]

Ms Leonard stated that, on 25 February 2009, she met with Mr Griffin to discuss the matter. At this meeting he confirmed he would not 'give away' Ms Knight.[559] Ms Leonard also stated that, on 2 March 2009, she reiterated their discussion in a letter to Mr Griffin, in which she referred to the importance of maintaining 'appropriate relationships with patients on the ward'.[560] She said that in this discussion she flagged an intention to develop a protocol on the topic of professional boundaries to 'assist all staff members'.[561] As referenced above, Mr Griffin was encouraged to contribute to this protocol.[562] It does not appear that Ms Leonard's letter to Mr Griffin was passed on to the human resources team at the time.

Ms Leonard did ultimately forward a copy of the letter to former Human Resources Consultant Mathew Harvey some time later on 6 March 2017, in response to another complaint about Mr Griffin (described in Section 4.1.26).[563]

As noted above, because of Mr Griffin's conduct, a protocol for Ward 4K staff on professional boundaries was developed.[564] Ms Leonard noted that this protocol was drafted in a group forum, which included Mr Griffin, in mid-2009.[565]

4.1.11 March 2009—Tasmania Police receive information about Mr Griffin 'upskirting' young girls

In March 2009, Victoria Police shared information with Tasmania Police that Mr Griffin had been captured on closed-circuit television 'upskirting' young women—that is, taking sexually intrusive photographs without their permission—while contracted to work as a medic on the *Spirit of Tasmania*.[566]

That same day, a Tasmanian police officer submitted an information report to the relevant Tasmania Police database describing the information received from Victoria Police. The information report included reference to Mr Griffin's role at Launceston General Hospital, stating: 'Unsubstantiated dialogue suggests he may also be employed at Launceston Children's Hospital'.[567] The information was not passed on to the Department or Launceston General Hospital.

Tasmania Police obtained still images from the *Spirit of Tasmania* showing Mr Griffin holding a camera 'in a suspicious manner'.[568] In April 2009, Tasmania Police conducted a search on Mr Griffin's property and asked him about the upskirting allegations.[569] Mr Griffin reportedly could not recall the events.[570] Mr Griffin's computer was examined and, while no unlawful images were found, officers did find hundreds of images of young girls in bathing attire at pools and beaches, as well as girls playing netball.[571] Police noted that Mr Griffin was clearing his internet search history daily.[572]

Mr Griffin refused to take part in a formal interview at this time. Tasmania Police decided there was not enough evidence to proceed with criminal charges, but noted the following in an information report:

> Although there was no evidence of any unlawful behaviour by Griffin this pattern of dealing with young girls … may cause rise to suspicion should other matters be reported in the future.[573]

In relation to the 2009 complaint, all information was ultimately filed in April 2009 with no caveats and was freely accessible to other investigators.[574] We note that this complaint predated the Registration to Work with Vulnerable People Scheme.

A 2020 investigative review into Tasmania Police's handling of information received about Mr Griffin found that a 'thorough and timely' investigation was undertaken in this matter, noting that, while the investigators were suspicious of some of his behaviours, no unlawful images were located in the search. This review does not explain how relevant the still images of Mr Griffin (or the footage it was drawn from) was in substantiating the upskirting allegations. However, this review did conclude the information from the upskirting allegation should have been considered when later reports about Mr Griffin were made, stating that 'not enough weight was placed on these comments when Griffin was investigated in 2011, 2013 and 2015'.[575] Those subsequent investigations are described in later sections.

Former Commissioner Hine told us: 'This matter was investigated appropriately at the time by Launceston detectives, with no offences detected.'[576]

4.1.12 May 2009—An email chain that included a former patient is discovered

In May 2009, Ms Leonard received an email from Mr Griffin on her personal email account, which had also been sent to a broader group, including other Ward 4K staff.[577]

Mr Griffin had also included a former patient in the email chain.[578] Ms Leonard stated that she was aware Mr Griffin knew the former patient's family socially but felt it was inappropriate that Mr Griffin was emailing a former patient.[579] Ms Leonard stated that she met with Mr Griffin and asked that he not send her personal emails or communicate with current or former patients outside a professional capacity.[580]

Based on the evidence we have received, this was the fourth time in six months that Ms Leonard had personally responded to Mr Griffin's inappropriate behaviour, and the sixth such incident that was recorded about Mr Griffin in connection with his role at the hospital.

We note that in December 2020, Ms Leonard forwarded Mr Griffin's email to the human resources team with a note saying: 'I met with Jim to discuss this email as it contained the email address of a patient and detailed that it was inappropriate and directed him to cease'.[581] We do not know what prompted her to send this to the human resources team more than 10 years after Mr Griffin sent it. We note that, by that stage, the Department had initiated its Independent Inquiry and our Commission of Inquiry had been announced.

We did not receive a 2009 Performance and Development Agreement for Mr Griffin.[582] We do not know whether one was completed and not filed, or never completed. Such Agreements should have been an important tool to manage Mr Griffin's behaviour.

Given Mr Griffin's failure to comply with repeated instructions from his manager to stop his inappropriate behaviour towards patients, we consider that, at this point, there was enough evidence that Mr Griffin was engaging in improper contact with current and former patients and should have resulted in formal action.

4.1.13 31 March 2011—Mr Griffin's Performance and Development Agreement is signed off

On 31 March 2011, Mr Griffin's Performance and Development Agreement was signed off by a Ward 4K staff member, who had acted as the Nurse Unit Manager for a period, and Ms Leonard.[583]

Notable aspects of this Agreement include that Mr Griffin wanted to attend an eating disorder workshop but could not because of staffing issues.[584] His performance objectives included a focus on developing knowledge and clinical skills in eating disorders and adolescent mental health.[585]

It seems that Mr Griffin expressed significant confidence in his abilities and his qualification to advance to a Grade 4 position, as the Agreement states: 'He believes his role as a senior nurse on the ward plays an important role in facilitating staff learning and development and assisting management'.[586]

4.1.14 2011 or 2012—Kylee Pearn discloses childhood sexual abuse by Mr Griffin to Launceston General Hospital

In March 2011, Kylee Pearn started as a social worker at Launceston General Hospital.[587] She described finding it 'incredibly confronting' to come across Mr Griffin working on Ward 4K because she had been sexually abused by him as a child.[588] She came to know Mr Griffin as a family friend.[589] Soon after starting work at the hospital, Ms Pearn spoke to a friend who disclosed during a 'chance conversation' that she also had been abused by Mr Griffin when she was young.[590] Ms Pearn expressed feeling 'terrified' after her own child was admitted to the hospital that Mr Griffin would be in contact with her child.[591]

In relation to her decision around that time to report Mr Griffin's abuse, Ms Pearn said:

> I had this innate feeling that other children were at risk on the ward and I knew I couldn't pretend it didn't happen anymore. It was no longer just about me and I had a duty to do something about it, both as a mum and as a social worker.[592]

Ms Pearn 'summoned up the courage' to disclose Mr Griffin's abuse of her to Stewart Millar, who was the head of the social work department and her manager at Launceston General Hospital at the time.[593] Ms Pearn told us that:

> Stewart believed me, supported me and offered options on what I could do. Within a day or two, and with my permission, he organised a meeting with [the human resources team] so I could tell them what happened.[594]

Ms Pearn said that at this meeting she told human resources staff that Mr Griffin had sexually abused her and her friend when they were children. Ms Pearn recalled feeling at the time that the representatives had come to the meeting 'pre-prepared'.[595]

The following reflects Ms Pearn's recollection of the response she received from the human resources staff at the meeting:

> They told me they had looked into Jim, that he had been on the [kids'] ward for a long time and that he was [a union] member. They told me that Jim would ask too many questions and would cause 'too much of a fuss' if he was moved from the children's ward … They then said that there was nothing they could do without a conviction. The meeting was short and would not have gone longer than 20 or 30 minutes. I was stunned at their response and felt quite powerless. I got the sense that my information wasn't going to be acted on unless I got a conviction. At the time I felt I had done everything I could by alerting them and that it was now up to them. They didn't offer me any support after the meeting; however, I was offered support by Stewart.[596]

Mr Millar told us he thought the human resources staff would take the information Ms Pearn provided at the meeting 'and view it within the context of any other information that they had and come to a reasonable, rational decision about how to proceed'.[597] If this had occurred, then the six previous complaints of Mr Griffin's inappropriate behaviour towards child patients could have been considered together with Ms Pearn's

very serious disclosure. Mr Millar said he considered there appeared to be a shared sense among the human resources representatives attending the meeting that the weight of the disclosure 'was not as much as if it had been a formal complaint'.[598] Mr Millar said he did not make a mandatory report to Child Safety Services because the concern related to historical events and there was no evidence of current abuse of a child, aside from the risk arising from an historical abuse.[599]

Ms Pearn said she had hoped that her disclosure to human resources staff would result in having Mr Griffin removed from the paediatric ward.[600]

There was no consensus as to the date of the meeting with the human resources team. Mr Millar recalled Ms Pearn's disclosure occurred in either 2011 or 2012.[601] Ms Pearn's best recollection was that the meeting occurred sometime after March 2011, when she started working at the hospital.[602] Ms Pearn explained that the meeting with human resources took place before she disclosed her abuse to Tasmania Police (on an informal basis) and the head of another organisation, although we have been unable to confirm when these reports (which we describe in Sections 4.1.15 and 4.1.16) were made.[603] Ultimately, we could not conclude when the meeting occurred but consider that it was likely to have taken place in 2011 or 2012.

There is some dispute about who from the human resources team attended the meeting with Ms Pearn and Mr Millar. At hearings, Ms Pearn gave us her best recollection:

> Q [Counsel Assisting]: Who else attended the meeting?
>
> A [Kylee Pearn]: I'm not 100 per cent sure but I believe it was Gino Fratangelo, who was an HR representative, I'm not 100 per cent sure about that. It was certainly a man.
>
> [...]
>
> Q: You say in your statement you think it was Mr Fratangelo, you can't be sure, it may have been two people but you can't be sure; is that right?
>
> A: Yeah, that's correct.[604]

Mr Millar told us that he 'made a phone call to [human resources]' and that 'both James Bellinger and Gino Fratangelo came straight down to my office'.[605] Mr Millar told us he recalled speaking to either Mr Fratangelo or to Mr Bellinger when he placed the call, saying 'I'm 99 per cent sure [Mr Bellinger] was there, and I'm 100 per cent sure the meeting occurred'.[606]

In their statements to us, neither Mr Bellinger nor Mr Fratangelo acknowledged attending the meeting with Ms Pearn and Mr Millar, but neither disputed that the meeting with the human resources team had occurred.

In his statement to us, Mr Fratangelo said: 'My inability to recall this meeting continues to frustrate me'.[607] When the very strong recollections of both Mr Millar and Ms Pearn that

he had been at the meeting were put to Mr Fratangelo at our hearings, he maintained that he could not recall the meeting. Mr Fratangelo did, however, concede that he 'may have been there'.[608] Mr Fratangelo said:

> I've got no reason to doubt Mr Millar … and I've got no reason to doubt Ms [Pearn], and so where they say I may have been there, then I've got no reason to say that, no, I definitely wasn't there; maybe I was and I just can't remember it.[609]

Mr Bellinger's initial statement to us reflects an understanding that the meeting with Ms Pearn occurred in 2010 or 2011 (because he suggests this is what he was told by someone in the Department). In this regard, he said:

> I have no independent recollection or written record of attending any such meeting. If that meeting occurred, as is suggested, in 2010 or 2011, I was not working for the hospital at the time but working for the Human Services portfolio.[610]

At that stage, the Department was the Department of Health and Human Services. Mr Bellinger's evidence is that he was working in the Human Services area of the Department until April 2012 (which we describe as 'the Human Services portfolio'), when he began to provide support to the Health area (which we call 'the Health portfolio')—assuming responsibility for human resources work for Launceston General Hospital at that time.[611]

After reviewing his statement, it was not clear if Mr Bellinger's evidence was that he might have been at the meeting but could not recall attending or that he did not attend.[612] Counsel Assisting sought to clarify Mr Bellinger's evidence at our hearings:

> Q [Counsel Assisting]: Yes. Each of Mr Millar and Ms Pearn said they believed that you attended that meeting; what do you say to that?
>
> A [Mr Bellinger]: I do not believe I was working for the hospital at that time.
>
> Q: I understand that. Did you attend the meeting?
>
> A: No.
>
> Q: In your statement you say you do not recall. Is your evidence that you do not recall attending such a meeting or that you did not attend such a meeting?
>
> A: My apologies, I do not recall.
>
> Q: Is it possible that you attended that meeting, considered it of such little import that you did not remember it?
>
> A: No.
>
> […]
>
> Q: Is it possible you attended this meeting, Mr Bellinger?
>
> A: No.

> Q: So your statement's gone from, you don't recall, to you're certain you didn't attend; is that right?
>
> A: My apologies. I do not recall attending that meeting, I do not believe it's possible, which I have understood to be the question.[613]

We were struck by Mr Bellinger's careful wording. Nevertheless, we consider, based on his statement and his evidence at the hearing, that Mr Bellinger's position is that he was not present at the meeting. We consider Mr Bellinger's evidence around his attendance at this meeting in light of his actions from 2019 onwards, when Ms Pearn's report again came to light (which we discuss in Section 5).

Ms Pearn was less certain that Mr Bellinger attended the meeting than she was about Mr Fratangelo's attendance. She also accepted there was a possibility that only one human resources representative attended the meeting:

> Q: In your evidence earlier, Ms Pearn, and again now you've referred to 'they' in relation to HR.
>
> A: Yeah.
>
> Q: 'They did this, they couldn't do that, they said this.' I know you're not 100 per cent sure.
>
> A: Yep.
>
> Q: Do you think that there was or may have been a second HR representative in that meeting?
>
> A: It's a possibility in my mind.
>
> Q: Do you want to say anything about who that person might have been, if there was a second HR representative?
>
> A: I believe, if there was a second person there, it would have been James Bellinger.
>
> Q: But you're not 100 per cent sure?
>
> A: No, I'm not 100 per cent sure, no.
>
> ...
>
> Q: I expect that Mr Bellinger will say that he has no recollection of that meeting and that he was working in HR outside the hospital at the time. Do you have anything you want to say in response to that evidence?
>
> A: That's possible, yep.[614]

Mr Millar, while not certain, has consistently recalled that Mr Fratangelo or Mr Bellinger 'or both' attended the meeting. This position is reflected in Mr Millar's sworn statements to the Department in 2021 and to our Commission of Inquiry.[615] We also note that Mr Millar made a notable amendment to his draft statement (drafted by Mr Bellinger) to the Department, which was to add the last two words to the phrase

'I believe it was either Gino Fratangelo or James Bellinger *or both*' [emphasis ours].[616] We explain the circumstances surrounding this statement in Section 5.

Mr Millar told us he could not recall who held the relevant portfolio for the social work department at the time of the meeting (noting, as we explain above, Mr Bellinger's evidence that he only assumed the Health portfolio, which included Launceston General Hospital, from April 2012), but confirmed his recollection that Mr Bellinger and Mr Fratangelo attended the meeting:

> Q [Counsel Assisting]: You said you were assigned an HR advisor. Who was your assigned HR advisor?
>
> A [Mr Millar]: Look, my recall isn't fantastic in this regard, but you know, Gino Fratangelo was at some stage and James Bellinger was at some stage. My recall is that they both attended that meeting.[617]

We received information that the human resources team adhered to its portfolio responsibilities. If so, this might make it unlikely that Mr Bellinger would have been involved in such a meeting, at least until assuming responsibility for supporting Launceston General Hospital in April 2012.

Even if the meeting occurred before April 2012, we cannot conclude on the evidence that Mr Millar, as part of the social work department in the hospital, would not have called a human resources representative from the Human Services portfolio and we do not consider it conclusively rules out that Mr Bellinger may have attended to support Mr Fratangelo. If the meeting occurred after April 2012, Mr Bellinger's evidence that it was not possible that he attended does not apply. Mr Bellinger denies he attended the meeting, regardless of when it occurred.[618]

When pushed on the proposition that Mr Bellinger was not at the meeting, Mr Millar recalled that Mr Bellinger attended this meeting:

> Q: Just out of fairness, Mr Millar, Mr Fratangelo has provided a statement to the Commission and he says he doesn't recall that meeting between you and Ms Pearn. Do you have anything to say to that?
>
> A: Well, simply that I'm 99 per cent sure he was there.
>
> Q: And again, out of fairness to Mr Bellinger, he's provided a statement to the Commission and he says that he doesn't recall a meeting and he wasn't working for the LGH at the time. Do you have anything to say to that?
>
> A: Again, I'm 99 per cent sure he was there, and I'm 100 per cent sure the meeting occurred.[619]

We made significant efforts to find an independent method to verify when Ms Pearn's meeting with human resources staff occurred and the attendees. Our enquiries included seeking sworn statements from all human resources staff employed at the hospital at that time to determine any knowledge of Ms Pearn's disclosure, as well as requesting records, calendar entries and emails from that period from the human resources team.

Some of the difficulty in obtaining information was attributed to IT limitations. The Secretary of the Department, Kathrine Morgan-Wicks PSM, explained in a statement to us that there were 'legitimate circumstances that could account for historical emails being "lost" and not retrievable'.[620] This included that:

- the email accounts of staff who left the Department prior to an email system migration in June–July 2019 were not retained
- since around 2012, shared mailboxes have been subject to 'technical challenges' that make them difficult to access
- emails archived by staff may not have been backed up or may have been deleted.[621]

Despite Secretary Morgan-Wicks' statement that the email accounts of former staff members were not retained after 2019, we are aware Mr Bellinger had some access to Mr Fratangelo's emails from 2012 onwards when he responded to a query from Detective Senior Constable Hindle in October 2019 (noting Mr Fratangelo had retired by that time).[622] This is discussed in Section 5.

No other staff member reported knowledge of this meeting with Ms Pearn and Mr Millar. We did not obtain any records of the meeting. The absence of any records of the meeting is a source of great concern to us.

At our hearings, Counsel Assisting asked Mr Fratangelo whether he would have expected there to have been a record of Ms Pearn's disclosure on Mr Griffin's personnel file. He said:

> I'm trying—ah—yeah, I guess it's fair to say I would have expected a note to be made of the meeting, and equally would have expected—well, I would have expected that I would have spoken to my manager about the meeting, if I was there, and equally I suppose I expect that Mr Millar would have spoken to his manager as well.[623]

When asked about how acceptable it would be to not have a record of this critical disclosure, Mr Bellinger responded: 'There should be a file note of that conversation'.[624]

Mr Millar stated he was 'pretty certain' that the human resources representatives took notes during the meeting.[625]

When questioned about what he would have done if he received Ms Pearn's disclosure, Mr Fratangelo said he would have told Ms Pearn to go to the police.[626] Mr Fratangelo also described what he perceived to be limitations on taking disciplinary action against a staff member under the State Service Code of Conduct, a part of which requires employees to abide by Australian law, which often relies on evidence that a person has been convicted of a crime in order to be satisfied.[627] We note that this statement largely mirrors what Ms Pearn recalls being told in the meeting with the

human resources team in 2011 or 2012. We also understand that, at the time, the Department was reluctant to initiate State Service Code of Conduct investigations unless complainants were willing to be identified and departmental staff were sure that 'a termination of the employment' was likely.

Finding—Launceston General Hospital failed to respond appropriately to Kylee Pearn's disclosure of abuse by James Griffin in 2011 or 2012, leaving children exposed to potential risk for eight years

Ms Pearn's disclosure of her sexual abuse by Mr Griffin to the hospital in 2011 or 2012 reflected a level of risk for the hospital of a significance that cannot be overstated. The failure to take any action in response to this disclosure failed to reduce the very significant risks Mr Griffin posed to paediatric patients on the ward for another eight years (and that those risks may have continued beyond this period had another victim-survivor, Tiffany Skeggs, not reported her abuse by Mr Griffin to police in 2019).

That a meeting occurred between Ms Pearn, Mr Millar and at least one representative of the human resources team is not contested. As described earlier, we consider the meeting most likely happened in 2011 or 2012. Launceston General Hospital was given credible information that Mr Griffin had a history of perpetrating child sexual abuse and was provided with an opportunity to prevent other potential risks to children, but did not act. The hospital did not even record the information to provide future weight or context to interpreting Mr Griffin's behaviour, which at that time included multiple allegations of 'boundary breaches' involving inappropriate non-medical contact with child patients.

We could not identify a specific hospital or departmental policy in place at the time for responding to allegations of child sexual abuse about a staff member. We consider it unlikely that any policies would have guided the human resources team to manage Ms Pearn's disclosure in the way it did. However, if the policies of the time did do so, we consider the hospital, at a minimum, should have taken the following action:

- Launceston General Hospital should have requested and examined all available complaints data or relevant information it held relating to Mr Griffin, which would have uncovered six prior complaints of inappropriate and unprofessional behaviour towards child patients. It should have taken steps, based on these complaints alone, to investigate the possibility of a disciplinary process that would mitigate risks to children on the ward.

- Launceston General Hospital should have discussed with Ms Pearn an intention to make a notification to the then Tasmanian Nursing Board, acknowledging that it would need to be sensitive to Ms Pearn's wishes in relation to whether and how this complaint could be made.

We note that no report was made to Child Safety Services by either Mr Millar or the human resources team. We consider this may have arisen because of confusion about obligations when there is a potential risk to a group of children (rather than a specific child) and when a report is made by an adult who requests confidentiality, which we have seen in other cases. We view this potential confusion as a systemic problem and make no findings regarding their failure to report. A best practice response could have considered whether Ms Pearn's disclosure activated mandatory reporting requirements to Child Safety Services and, if not, discussed whether Ms Pearn would be open to the hospital making such a notification (or making one herself). In future, there should be clarity about where to best report such a disclosure and the role of Child Safety Services in responding to institutional child sexual abuse, particularly when Tasmania's Reportable Conduct Scheme commences (discussed in Chapter 18).

We note that, because Ms Pearn was an adult, it was appropriate for hospital staff to defer to her wishes about making a formal police complaint, which we accept she was not willing to do at that time. We note Ms Pearn's initial disclosure predated the Registration to Work with Vulnerable People Scheme. We consider Ms Pearn's belief that no further steps were taken by the hospital to be true, but we cannot discern whether the hospital's failure was the result of a desire to downplay or minimise the disclosure, or because there was a genuine belief that nothing could be done.

Finding—Luigino Fratangelo and James Bellinger received a disclosure of child sexual abuse from Kylee Pearn relating to James Griffin in 2011 or 2012

We consider, on the balance of probabilities, that both Mr Bellinger and Mr Fratangelo were present at the meeting with Ms Pearn and Mr Millar in 2011 or 2012, in which she disclosed childhood sexual abuse by Mr Griffin. We are more confident in Mr Fratangelo's presence but consider there is enough evidence to find that Mr Bellinger was also present. We base this conclusion on the strength and consistency of Mr Millar's evidence (including a variety of documents we reviewed, not all of which have been described for legal reasons), Mr Bellinger's actions in 2019 when Ms Pearn's disclosure again became known (discussed further in Section 5), and because we found Mr Millar to be a more credible witness than Mr Bellinger.

Finding—Launceston General Hospital did not have adequate processes to ensure the meeting with Kylee Pearn was recorded and that record was retained

We could not determine whether a record of the meeting was not taken or was lost or destroyed. However, it is concerning to us that the human resources representatives who attended the meeting would not document a meeting of this nature, sensitivity and significance.

A disclosure of this kind, which describes child sexual abuse at the hands of a person employed on a paediatric ward, is a disclosure that should be treated with the utmost concern and urgency. The disclosure warranted a clear and accurate record being taken of the discussion and escalation to senior managers to determine appropriate action and ensure children on the ward were safe. Responding to the disclosure required care, concern and steps taken to ensure Ms Pearn had appropriate support, particularly given that she often had to encounter Mr Griffin at the hospital. Failure to take action was a missed opportunity to protect children and young people in the hospital from further abuse by Mr Griffin. It also meant that this information was not considered when subsequent complaints against Mr Griffin arose.

The absence of a record of such a serious disclosure is a significant and unacceptable failing. Eric Daniels, then Chief Executive North/North West ('Chief Executive') conceded the absence of a record constituted a 'substantial and catastrophic failure'.[628] We note Mr Daniels was not Chief Executive until 2016 and did not work at Launceston General Hospital at the time of Ms Pearn's disclosure. We agree with Mr Daniels' observations and consider that it suggests the hospital had inadequate processes to ensure the meeting with Ms Pearn was recorded, and that the record was retained.

4.1.15 2011 or 2012—Ms Pearn and her friend have an informal discussion with Tasmania Police

Sometime after Ms Pearn's meeting with the human resources team in 2011 or 2012, she and her friend (who had also been sexually abused by Mr Griffin) spoke informally with a person they knew at Tasmania Police. In Ms Pearn's words, that person gave them a 'very realistic' assessment of their prospects of securing a conviction against Mr Griffin, so they decided not to proceed with a formal police report at that time.[629] However, Ms Pearn recalls that they did discuss the option of putting information about her experiences on the police system 'so it could sit there in case anyone else came forward, I could back them up'.[630] In her statement to our Commission of Inquiry, Ms Pearn qualified this statement and said she believed this option was discussed and agreed but that she wasn't '100 per cent sure'.[631] No record was made on Tasmania Police systems of this discussion.[632] We consider this lack of record is unfortunate, but note

Ms Pearn did not recollect exactly what was agreed. Ms Pearn also reflected positively on the person from Tasmania Police with whom she had the discussion, including their deference to Ms Pearn and her friend about how they wished to proceed.[633]

Ms Pearn told us that she made a promise to herself at this point that she would come forward, if anyone else did, to have Mr Griffin charged—a commitment she honoured in September 2019 when Tiffany Skeggs reported her abuse by Mr Griffin.[634] Both events are discussed in Section 5.

4.1.16 2011 or 2012—Ms Pearn and her friend report their abuse to an organisation Mr Griffin volunteered with

After speaking to their contact at Tasmania Police, Ms Pearn and her friend decided to speak to the head of an organisation where they knew Mr Griffin volunteered.[635] Ms Pearn recalled that the person they spoke to at the organisation was not shocked by the disclosure, telling them that Mr Griffin gave them 'the creeps'.[636] The person gave Ms Pearn and her friend assurances that Mr Griffin would be restricted in some of his volunteering activities and be monitored at all times.[637] Ms Pearn said: 'I remember feeling relieved that we had at least prevented him from accessing children in this setting and how simple the process had been. If only [Launceston General Hospital] had taken similar steps'.[638]

Following the death of Mr Griffin on 18 October 2019, Ms Pearn's disclosure of her abuse to Launceston General Hospital was again raised with the hospital—this time by Tasmania Police and Ms Pearn herself. We discuss the hospital's knowledge and treatment of Ms Pearn's complaint following the death of Mr Griffin in Section 5.

4.1.17 November 2011—Child Safety Services receives a report about Mr Griffin and notifies Tasmania Police

On 17 November 2011, Child Safety Services received a report about Mr Griffin.[639] The notifier stated that they were very concerned after being visited by two people who disclosed that they had been abused by Mr Griffin when they were children.[640] The notifier provided information about Mr Griffin's contact with children in this particular organisation's context.

On 26 November 2011, Child Safety Services passed on the notification about Mr Griffin to Tasmania Police and, on 28 November 2011, to Child Safety Services for a regional response.[641] On 29 November 2011, Child Safety Services recommended that the matter be closed because Tasmania Police had been notified and because a particular organisation with which Mr Griffin was associated was aware of the risks.[642] There is no evidence that Child Safety Services examined the information it may have held (or had access to) to determine whether there was any more information that suggested Mr Griffin posed a risk to children, including in other settings.[643]

On 21 December 2011, an officer from the Launceston Police contacted Child Safety Services seeking information about the name of the notifier to enable them to follow up.[644] The Child Safety Officer who responded advised him that this information could not be shared. The relevant police officer pressed the Child Safety Officer for the information and, when it was not forthcoming, the police officer asked Child Safety Services to request that the notifier contact police directly because, without this information, police could not take the matter further.[645]

Claire Lovell, Executive Director, Children and Family Services within the former Department of Communities, explained to us that the laws and policies around information sharing were 'very confusing' at the time, and police were not included in relevant legislation as an information-sharing entity. She said the guidance that Child Safety Services staff would have received was to 'protect notifier identity at all costs'.[646] She conceded that the failure to contact the notifier to seek their consent for their identity to be revealed to police was 'a missed opportunity', highlighting that legislation is now more conducive to information sharing.[647]

Former Commissioner Hine told us of long-term problems with Child Safety Services sharing information with Tasmania Police:

> The review of the Griffin matter highlighted that there was still some resistance to providing information in instances up until 2021. Anecdotally, police officers have reported that on occasions, [Child Safety Services] Officers had baulked at providing information about reporting persons and required a warrant.[648]

Commissioner Hine stated that Tasmania Police had sought to improve information sharing between Child Safety Services and Tasmania Police by developing a memorandum of understanding in 2021.[649]

Finding—Child Safety Services should not have closed its November 2011 case into James Griffin without making further enquiries and ensuring Tasmania Police had all the information it required

As we note above, Child Safety Services closed this matter after referring it to Tasmania Police. Yet in doing this, it also failed to pass on all the information it held to enable the police to take any meaningful action. This essentially meant that no one acted on the information received through the notification. While it is impossible to know whether a police investigation would have led to earlier charges or actions to limit Mr Griffin's contact with children, it reflected another potential opportunity to disrupt his offending.

As Ms Lovell notes, it is unfortunate that this critical information was not passed on to Tasmania Police to support an investigation at that time. If staff did not feel empowered to provide this information, they could have contacted the notifier to seek their consent or to request the notifier speak to Tasmania Police.

We asked Tasmania Police what steps it took in relation to the formal notification it received from Child Safety Services in November 2011. In his statement to us, former Commissioner Hine reflected that the investigating officer could have escalated this matter to the relevant detective inspector when Child Safety Services told them they could not provide information about the notifier, but this did not occur.[650] There is also no record that the investigating officer examined the police intelligence system, which would have revealed the 2009 report against Mr Griffin relating to the upskirting that flagged Mr Griffin's employment at Launceston General Hospital (described in Section 4.1.11).[651] Instead, Tasmania Police simply filed this information for intelligence purposes on 21 December 2011.[652]

We note again that a police examination of the intelligence system would have also revealed the 2000 report about concerning material found on a laptop previously owned by Mr Griffin had the 2000 report been recorded in an accessible system, even if an electronic records system was not available at that time.

Finding—Tasmania Police should have made further enquiries to receive the notifier's identity and reviewed previous intelligence holdings relating to James Griffin when receiving the November 2011 information from Child Safety Services

While we accept that Tasmania Police made some efforts to obtain information about this 2011 notification and was not assisted by Child Safety Services, we nonetheless consider this should have been escalated to superiors within Tasmania Police, who may have been empowered to remedy the failure to share information. If the relevant officers had checked the intelligence holdings (which former Commissioner Hine noted there was no record of having occurred), the 2009 upskirting complaint made to police about Mr Griffin would have been on the system (which noted he was a paediatric nurse). This should have then added even greater impetus for police to obtain the necessary information from Child Safety Services so it could investigate.

4.1.18 November 2012—The mother of a patient reports concerns that Mr Griffin was a 'sleaze'

On 30 November 2012, a mother of a patient raised concerns about Mr Griffin with Ms Leonard. She told Ms Leonard that she had heard from staff that Mr Griffin was a 'womaniser' and a 'sleaze' (it was unclear if staff told the mother directly or she overheard something to that effect).[653] Ms Leonard's file note of this concern records the mother as saying: 'You've got men here looking after children—bad things happen we all know this'.[654]

Ms Leonard recalled that she subsequently spoke to her manager, Ms McBeath, who told her that 'the complaint would be noted but there was no need to progress the matter' because 'the patient was due to be discharged shortly after the concern was raised'.[655]

Ms McBeath told us that although she recalls Ms Leonard raising this incident in an informal conversation, Mr Griffin was not identified by name.[656]

4.1.19 6 March 2013—Mr Griffin's Performance and Development Agreement is signed off

Ms Leonard and another unnamed person signed off Mr Griffin's Performance and Development Agreement on 6 March 2013.

Notable features of this Agreement include that Mr Griffin was to have key responsibilities in relation to 'inservice sessions to raise the profile and education of resources' for the admission of patients with eating disorders.[657] It also included '[Nurse Unit Manager] role and responsibilities', beginning in March 2014, with Mr Griffin to 'consider topics for support/education'.[658] Rather than reflecting any concern about Mr Griffin's performance, this Agreement reflects a desire to allow Mr Griffin to have greater management responsibility and to pursue professional development activities that related to a highly vulnerable cohort of young female patients.

4.1.20 April 2013—A confidentiality breach follows a request that Mr Griffin not visit a patient and her mother

In April 2013, the mother of a patient made a request to a hospital staff member that Mr Griffin not visit her or her child on the ward. The mother told the staff member that her request was due to 'family issues' and she did not wish to elaborate further.[659]

This request was then raised with Ms Leonard. Ms Leonard told us that she understands that, in response to the request, the staff member asked Mr Griffin not to attend the room where the young patient was staying—a direction that Mr Griffin appeared to accept.[660] Ms Leonard further stated that a few hours after she was told of the request, the mother advised the staff member that she had received a call from a family member.

This family member had asked the mother about Mr Griffin being excluded from the treatment room because 'someone from the hospital' had called the family member and asked questions about the mother's request.[661] As only a few staff knew about the request, the implication was that Mr Griffin had made the call to the family member, in breach of confidentiality.[662] The staff member notified Ms Leonard and Clinical Nurse Educator, Michael Sherring, about this potential breach. The mother also spoke to Ms Leonard and Mr Sherring directly.[663]

Ms Leonard and Mr Sherring met with Mr Griffin to discuss the breach of confidentiality, which culminated in Ms Leonard sending another letter to Mr Griffin. Mr Fratangelo, from the human resources team, edited this letter before it was sent.[664] The letter, dated 17 April 2013, stated there is 'no situation that is acceptable to disclose any information to another person in relation to patients or families [admitted to the hospital]' and cited a range of professional codes and obligations for Mr Griffin's reference.[665] Ms Leonard concluded the letter as follows:

> I trust that as a result of discussions at our meeting you now fully understand the implications of breaches of [patient] confidentiality and that if there is any further breach, that this will require me to explore disciplinary action via formal processes.[666]

In his statement to our Inquiry, Mr Sherring confirmed that he and Ms Leonard met with Mr Griffin on 17 April 2013 to 'discuss the issue'.[667] Mr Sherring stated that his role in attending the meeting was as 'a third party witness of discussions'.[668] When giving evidence at our hearings, Mr Sherring recalled that Ms Leonard communicated to Mr Griffin the inappropriateness of the patient confidentiality breach, that such breaches were a significant issue, and that a number of attachments relating to Nursing Board guidelines were included with the letter.[669]

Ms Leonard stated that the final copy of the letter was also sent to Mr Bellinger in the human resources team.[670] We note that Mr Bellinger did not report to us that his team had knowledge of this complaint.[671]

At the time that Ms Leonard became aware of the request that Mr Griffin not have contact with a patient and their mother on Ward 4K, she was already aware of a series of boundary breaches by Mr Griffin—several concerns had been raised about Mr Griffin with Ms Leonard in 2009 and a further concern had been raised by a parent in 2012.

4.1.21 8 May 2013—A report is made to Tasmania Police about Mr Griffin, which is passed on to Child Safety Services

Tiffany Skeggs was a young girl when she came to know Mr Griffin outside the hospital environment. On or around 8 May 2013, when Ms Skeggs was 15 years old, her mother shared concerns with Tasmania Police at Launceston that Mr Griffin and her daughter were spending a lot of time together and had constant contact over phone, social media

and email.[672] She also reported that she had witnessed Mr Griffin touching her daughter inappropriately and cuddling her excessively.[673] References in this section to Ms Skeggs are to Ms Tiffany Skeggs and not her mother.

On 13 May 2013, police spoke with Child Safety Services about the mother's concerns. We understand the notification included reference to Mr Griffin's employment on Ward 4K.[674]

In response to the notification, Child Safety Services indicated an intention, in the first instance, to contact a counsellor to talk (presumably) to Ms Skeggs about Mr Griffin's behaviour. Child Safety Services told Tasmania Police that they would advise Mr Griffin that a notification had been made to them about his behaviour.[675] At our hearings, Ms Skeggs recalled receiving contact from an officer from Child Safety Services (we are unclear whether this was a counsellor) and the fear this contact provoked in her. Ms Skeggs stated:

> It had been building up to a point that there was so many questions being asked that I knew by this point that it wasn't right and the behaviour wasn't normal, but I was already in so deep that I couldn't get myself out; I needed to get out but I was too scared to do that, and he had told me that it would destroy me and that he would destroy me if I ever said anything.[676]

Ms Skeggs described feeling blamed during a phone call with the officer from Child Safety Services, saying 'her words to me was that I should not continue engaging in that behaviour, that I should know that it's inappropriate to sit on his knee, I need to change what's happening'.[677] When we asked Ms Skeggs to reflect on the way Child Safety Services engaged with her, she responded:

> You heard from … Ms Pearn … that it was known to police by this point, it was known to [Child Safety Services], and no person with an ounce of experience in engaging with children or taking child sex abuse disclosures from children engaged with me in any way, and the only opportunity that I had at that point to disclose was on a phone call with a stranger in front of my mother.[678]

Tasmania Police sought updates from Child Safety Services on 24 and 25 June 2013, but could not reach the relevant person.[679] Eventually, police spoke with the relevant person, who reported that Ms Skeggs did not disclose any abuse or inappropriate conduct by Mr Griffin.[680]

Child Safety Services ultimately formed the view that Ms Skeggs' mother was having difficulties accepting the 'fatherly relationship' that Ms Skeggs had with Mr Griffin.[681] The officer from Child Safety Services informed police that Mr Griffin had stated he was angry that Ms Skeggs' mother had misread his behaviour.[682] The Child Protection Information System record contains a file note of the conversation with Mr Griffin on 14 May 2013:

> This worker stated that at this level he is better being aware of the concerns and making sure everyone is protective of each other. Jim was ok about this and was pleased that it was at this level rather than anything worse but was still dumbfounded that someone would interpret his behaviour as anything but what it was … This worker stated that there had been no more concern around cuddles and sitting on his lap, but in today's world it was up for [misinterpretation] and precautions needed to be taken. Jim said he could understand this but it was still not nice to destroy a person's reputation. This worker stated that it had not but he needed to be aware of the potential.[683]

Ms Lovell conceded that this framing of the matter by Child Safety Services could be construed as agreement with Mr Griffin that there had been an overreaction to his behaviour but added: 'I think this was their way of cautioning him and trying to disrupt the behaviour'.[684]

In his statement to us, former Commissioner Hine said there was no evidence that police searched the police intelligence system after Ms Skeggs' mother made the report. Rather, investigating police formed the view, based on information from Child Safety Services, that Ms Skeggs would be 'hostile' towards police and contact would cause her 'stress and anxiety'.[685] Tasmania Police closed the report, and the information from Ms Skeggs' mother was filed for intelligence purposes on 23 July 2013.[686] Commissioner Hine said this was 'not appropriate and would not be in keeping with the [Tasmania Police Manual] and guidelines as they now stand'.[687]

The Tasmania Police internal review into the handling of its investigation of Mr Griffin acknowledged that it found no evidence of any 'protective, legal or employment interventions' in response to reports about Mr Griffin in 2013 (and in 2011).[688] The review concluded that: 'In the absence of any meaningful follow up enquiries being apparent, Griffin's status was unaffected or impacted upon, and he remained potentially able to continue his behaviours'.[689]

Counsel Assisting asked Ms Lovell whether she would expect a child protection worker to make enquiries about prior concerns reported to police. Ms Lovell acknowledged that information about the upskirting complaint in 2009 would have been relevant to a risk assessment on this notification.[690] She also acknowledged that the information in the notification about Mr Griffin's involvement at the paediatric ward of the hospital meant that he clearly posed a risk to children and young people in professional settings.[691]

Child Safety Services undertook a risk assessment on this notification, which deemed the 'harm consequence' as 'concerning', the 'harm probability' as 'unlikely' and the 'future risk' as 'low'.[692] When asked to reflect on this classification, considered together with all the information about Mr Griffin that was available to, or easily attainable by Child Safety Services, Ms Lovell stated:

> I don't think that's a low risk of future harm. I think that [the child safety officer] overlooked the pattern and history; if [the child safety officer] had seen that, even followed up on that one matter [the 2009 upskirting] or located more information that we had on file [potentially the report made to Child Safety Services on 17 November 2011] I think [the child safety officer] would have seen that there was a pattern of this, it wasn't a one-off incident that was misunderstood.
>
> So I think that [the child safety officer] … either underestimated the likelihood of future harm or potentially it's a form of confirmation bias which isn't necessarily a cognitive action of the officer involved, it can actually be systemic as well; it can actually be a way of justifying the closure of a matter, where you know that you can't do any more or you feel that you can't do any more with it in order to accept the next matter that's waiting for assessment.
>
> I don't think that's right, I think that's very wrong. I think that it should have been—I think the information should have been gathered and that was an oversight. I think that in an ideal world there would have been more done, but I think for its time that seems to me that that's the type of practice that people were engaging with, quite possibly driven as much by necessity as anything else …[693]

Ms Lovell further stated that since 2013 there has been greater understanding about the manipulation that accompanies sexual abuse and how this manipulation may lead a young person to deny that they were being harmed.[694] She stated that: 'I think that today it would be assessed quite differently to what it was then in 2013'.[695] Ms Lovell added: 'We should have protected Ms Skeggs and we didn't protect her, and for that I barely—It's hard to find the words to say how sorry I am. I'm deeply sorry'.[696]

Finding—Child Safety Services should have taken further steps to assess the risk James Griffin posed in 2013 when concerns were again reported about him

Upon receiving the notification, Child Safety Services should have taken more steps to assess the risk Mr Griffin posed to Ms Skeggs and others—particularly given Child Safety Services' knowledge about his opportunities to offend in several settings, including in his professional role. Child Safety Services should have:

- taken the concerns of Ms Skeggs' mother seriously, particularly given her close relationship with Ms Skeggs and the fact that she directly witnessed some of the behaviour that concerned her
- undertaken a records check for any information to suggest Mr Griffin had previously been the subject of a notification—this would have raised the prior notification in 2011 from the head of an organisation who reported that two people had disclosed to them that Mr Griffin had abused them as children

- engaged with Ms Skeggs in person and in a location that was child-centred and created a sense of safety to disclose—if Ms Skeggs did not disclose, she should have been reassured and given the steps for who to contact if she wanted to talk in the future
- sought more information regarding the 2009 notification to Tasmania Police about Mr Griffin to inform its risk assessment process, noting that, in 2011, Child Safety Services had received information about child abuse allegations involving Mr Griffin.

If this matter was reported to Child Safety Services now, we would expect that it would seriously assess the risk a person posed to any children with whom it was aware an alleged perpetrator had contact—including through their family and through social, professional and volunteer roles. We would also expect that it would report all relevant information to the Registrar of the Registration to Work with Vulnerable People Scheme and relevant professional registration bodies (such as the Australian Health Practitioner Regulation Agency, 'Ahpra').

Finding—Tasmania Police should have reviewed all intelligence holdings about James Griffin in 2013 when a report to Child Safety Services was made

Tasmania Police relied entirely on the information it received from Child Safety Services and, having received the information, did not conduct any searches of its own records.[697] If it had, it would likely have found the previous two reports about Mr Griffin:

- the 30 March 2009 'upskirting' complaint
- the November 2011 report from Child Safety Services.

We note also that information provided to the police about the material found on Mr Griffin's computer in 2000 was not entered into the police database until December 2020.

We note that Tasmania Police has since adopted measures to clarify minimum requirements for investigating child sexual abuse matters and established a memorandum of understanding to facilitate better information sharing with Child Safety Services.

Finding—The child safety system in the mid-2010s was not designed to address child sexual abuse in institutional settings

The above findings concerning Child Safety Services and Tasmania Police indicate failures within each of those agencies but also point to a broader system that failed to adequately address risks to children in institutional settings.

The findings against Tasmania Police and Child Safety Services reflect the following:

- Child Safety Services tended to focus primarily on the risk specifically articulated in a notification. In relation to the 2013 complaint, Child Safety Services confined its risk assessment to the risk that Mr Griffin posed to Ms Skeggs, while in 2009 it confined its risk assessment to the risk that Mr Griffin posed in a particular organisational setting. Child Safety Services did not consider the risk that Mr Griffin posed to others, including other children he may have had contact with in professional or other settings.
- Tasmania Police similarly focused on investigating a specific allegation (and considering whether it would meet the relatively high standard for a criminal prosecution), rather than working proactively with other agencies to address the broader risk posed by Mr Griffin.

This narrow focus from both agencies was further hampered by poor information sharing between them.

We note that some of these issues have been overcome through the introduction of the *Registration to Work with Vulnerable People Act 2013* ('Registration to Work with Vulnerable People Act') on 1 July 2014 (and its related information-sharing provisions), which focuses on assessing risk in occupational and organisational contexts, and can act as a trigger for protecting children more broadly (as it indeed did, in the case of Mr Griffin, on 31 July 2019). Tasmania's introduction of Child and Youth Safe Standards and a Reportable Conduct Scheme (discussed in Chapter 18) will further strengthen safety for children in institutional settings.

Ms Skeggs told us she would often visit Mr Griffin on Ward 4K at Launceston General Hospital and that she could enter the secure unit without any problems because nurses would let her in.[698] She told us:

> Griffin sexually assaulted me on several occasions both on the ward and during our travels throughout the hospital … On one occasion, Griffin was almost caught assaulting me by another staff member whom he did not realise was in the office when we entered the room.[699]

A Ward 4K staff member recalled becoming aware at some point that a young girl had moved into the home that Mr Griffin shared with his wife and children.[700] The staff member said the situation confused them but that they understood it was more of a 'surrogate parenting arrangement'.[701] The staff member also recalled thinking

it was strange when they learned Mr Griffin was taking this young person overseas alone, but given the trip was referred to in the local paper, they said they ultimately considered the trip must have been 'above board'.[702] While she was not named, we infer this recollection relates to Ms Skeggs (her overseas trip with Mr Griffin is described further in Section 4.1.23).

When Counsel Assisting asked Ms Leonard whether she recalled Ms Skeggs visiting Ward 4K, she indicated that she did and that 'it was around netball training and going to netball after school or something like that'.[703]

4.1.22 21 March 2014 and 27 March 2015—Mr Griffin's Performance and Development Agreements are signed off

On 21 March 2014, Ms Leonard signed off another of Mr Griffin's Performance and Development Agreements. A notable entry in this Agreement is Ms Leonard's comment that: 'Jim has participated in supporting staff and providing feedback over the past 12 months. He was [integral] in [providing] detailed specific feedback [designed] to support the improved performance and care provided by staff'.[704] The Agreement also states that Mr Griffin would like 'exposure and support to learn the [Nurse Unit Manager] role and responsibilities – double up days'.[705]

One year later, on 27 March 2015, Mr Griffin's next annual Performance and Development Agreement was signed off. In this Agreement, Mr Griffin's key responsibilities are listed as 'leadership, education, portfolio, advanced clinical skills, clinical knowledge, assist management roles, role model'. Ms Leonard writes that Mr Griffin would like assistance to develop his skills through '[o]ngoing [eating disorder] education'.[706]

4.1.23 10 April 2015—Tasmania Police receives information from the Australian Federal Police about Mr Griffin

On 10 April 2015, the Australian Federal Police shared information with Tasmania Police about Mr Griffin. The Australian Federal Police became aware of this information through its work disrupting the production and distribution of child exploitation material.

The information shared with Tasmania Police revealed that a person was communicating with an undercover law enforcement officer through an encrypted messaging application. This person described various acts of abuse against young girls and sent sexual exploitation material to the undercover officer. The person stated that he was a nurse and that he used antihistamines to sedate his victims.[707] The Australian Federal Police traced the internet protocol ('IP') address of this person to Mr Griffin's home.[708]

Not long after, on 16 April 2015, notes on an Australian Federal Police database indicated that federal police were aware that Mr Griffin was travelling with a then 17-year-old girl, Tiffany Skeggs, for two weeks.[709] Presumably this information was shared with Tasmania Police because the system entry noted: 'Comment from [a Tasmania Police detective inspector] happy to allow travel'.[710]

A later internal investigation by Tasmania Police into its handling of Mr Griffin commented: 'At the time Tiffany was 17 and her mother … was well aware of these travel plans. As such nothing further could be done to stop Griffin and Tiffany Skeggs travelling together'.[711] We note that in Tasmanian law, child sexual abuse refers to offences committed against a person under 17 years of age. However, we also note that Tasmania Police received the information about Mr Griffin travelling with Ms Skeggs in the context of known concerns about Mr Griffin's production and exchange of child exploitation material and prior concerns expressed by her mother about Mr Griffin's conduct towards her in 2013.

On 15 April 2015, the same Tasmania Police detective inspector wrote to the Australian Federal Police as follows:

> We have had extensive conversation regarding this one and have decided not to progress a warrant until we receive the … package [of materials]. We need to be confident the picture/s exchanged depict child exploitation material. We [have] considered his travel plans and the risk the child may or may not be in when making our decision. In the past he has declined to be interviewed and has also displayed … knowledge of hiding his PC history so we need to have as much information as possible in the first instance.[712]

On 26 April 2015, the investigating officer from the Northern Criminal Investigation Branch ('Northern CIB') in Launceston made a note that more information about Mr Griffin, being the evidence or 'package' requested from the Australian Federal Police, was available on the relevant secure system, ready for Tasmania Police to access. The note also stated that the police officer from Tasmania Police's Fraud and e-Crime unit in Hobart, who had access to the secure system, was out of the State but would 'return on Monday'.[713]

On 28 April 2015, the investigating officer from Northern CIB filed the Australian Federal Police report as 'pending further review', with the comment: 'See notes below re additional information now available on relevant system – awaiting package'.[714] On the same day, the Australian Federal Police transmitted the package to Tasmania Police on the secure system, which could be accessed by the Tasmania Police Fraud and e-Crime unit.[715] Although former Commissioner Hine confirmed that the package of materials 'was in the possession of Tasmania Police', it was not received by Northern CIB, not accessed by the Fraud and e-Crime unit, and no further action was taken at the time.[716] Northern CIB first obtained the package more than four years later, on 2 September 2019.[717]

Ms Skeggs described being met by Australian Border Force on her and Mr Griffin's return from overseas on 11 May 2015. Australia Border Force searched their luggage and electronic devices and asked Ms Skeggs and Mr Griffin about their travel, accommodation arrangements and the nature of their relationship. They were told it was a 'random inspection', which Ms Skeggs described as a 'poor effort to lie'.[718]

Ms Skeggs said she and Mr Griffin remained within a few metres of each other through the entire search.

Ms Skeggs said that at no point was she asked directly about whether Mr Griffin had offended against her, and she was not made to feel that she could disclose the abuse she was experiencing:

> Perhaps if authorities had been a little more honest with me, or at the very least a little more competent, I may have disclosed then. If I had been told that Griffin was suspected of committing wrongdoing and that there were other children involved, I may have spoken out. If they had told and demonstrated to me that they could protect me from Griffin, I might have been more honest.[719]

Ms Skeggs told us that despite both of their phones containing images of Mr Griffin's abuse of her, Australian Border Force took no further action: 'After the search of our devices was completed by the ABF they handed them back, told us we were free to go and apologised for causing us to miss our connecting flight to Launceston'.[720]

In response to media reporting of this encounter on *60 Minutes*, Australian Border Force issued a statement: 'The ABF has thoroughly reviewed this matter and is satisfied that the officers conducting the intervention took the appropriate action in compliance with our legislative obligations'.[721] We have not investigated this encounter because the conduct of the Australian Border Force is not within the scope of our Inquiry.

An internal investigative review into Tasmania Police's handling of complaints about Mr Griffin conducted in 2020 noted that the package of materials the Australian Federal Police provided to Tasmania Police contained images and information 'of a high evidentiary value and would have most likely resulted in a conviction'.[722] The report also noted:

> Launceston CIB were directly involved in communications concerning the matter and it was their responsibility to lead, drive and manage the police investigation and external agency notification.[723]

This review further determined that due to Tasmania Police filing the Australian Federal Police information without investigation, there was no direct requirement to notify the Registrar of the Registration to Work with Vulnerable People Scheme, although 'a general ability did exist due to a catch-all clause'.[724] The report noted that an investigation would likely have given the Registrar 'solid facts' to take into account in relation to a risk assessment on Mr Griffin's registration.[725]

In addition, the internal review found no record of Tasmania Police making a referral to Child Safety Services in line with mandatory reporting obligations. This is despite Tasmania Police receiving evidence of an identifiable child being a victim of child sexual abuse.[726] Former Commissioner Hine acknowledged that 'the police response to this report was clearly unacceptable'.[727]

Finding—Tasmania Police failed to act on highly probative evidence regarding James Griffin provided by the Australian Federal Police in 2015

From 28 April 2015, Tasmania Police had a package of information about Mr Griffin in its secure system. This secure system was accessible to Tasmania Police's Fraud and e-Crime unit, and to Northern CIB on request. Tasmania Police took no further action to access that data until 2019, when Detective Senior Constable Hindle sought it as part of his investigation into Mr Griffin.[728] While it is somewhat unclear exactly why this happened, it appears to have essentially involved two errors on Tasmania Police's part, as established from an internal investigative review conducted by Tasmania Police:

- Officers from Northern CIB in Launceston failed to seek the information from Tasmania Police's Fraud and e-Crime unit. The investigating officer from Northern CIB filed the report as 'pending further information' when it should have been filed 'pending review', which would have triggered various reminder system alerts to follow up the material.[729] However, given the officer in charge was aware the package was already available and just needed an officer in the Fraud and e-Crime unit to return the following Monday to access the material, we find it surprising they did not remember to do this irrespective of the way the report was filed. However, we note in Chapter 16 that we were told many times police often gave child sexual abuse matters lower priority when pulled into other matters.
- The Fraud and e-Crime unit failed to provide the material to Northern CIB. We find it difficult to understand why this error occurred but consider it had to do with a limited number of officers having access to the material, the relevant officer being away at the time, a miscommunication with the Australian Federal Police about where the material was going to be sent as a result of the officer being away, and it being unclear between themselves and Northern CIB who had ultimate responsibility for following up on the material.[730]

Two Northern CIB police officers were subsequently disciplined for failing to act with care and diligence in this matter.[731] We learned that a range of system changes now prevents a similar error occurring. A new database has an embedded 'supervisor approval' function, which means that a matter cannot be filed away without a superior reading the investigation notes and determining whether closure and filing is, in fact, appropriate.[732] We also understand that since 2015 the process of providing material through secure files has changed, such that material is physically collected from the Australian Federal Police.[733]

We note that on the public release of Tasmania Police's report on the internal review of its handling of complaints against Mr Griffin in February 2021, former Commissioner Hine issued an apology.[734] This was reiterated at our public hearings, where Commissioner Hine added:

> The impact of [Tasmania Police's] failures are deeply felt and we are committed to improving how we protect children within our community.[735]

We acknowledge Tasmania Police's self-initiated internal review and the apology given to victim-survivors of Mr Griffin's abuse before beginning our Commission of Inquiry. However, we cannot overstate the significance of the failure by Tasmania Police to act in a timely way on credible, probative evidence of child sexual abuse perpetrated by Mr Griffin that would likely have resulted in criminal charges and prevented other children and young people from being harmed.

4.1.24 November 2015—A nurse raises concerns about Mr Griffin's professional boundaries with teenage girls

On or around 2 November 2015, Ms Leonard received a handwritten note about Mr Griffin from a colleague. The note reported concerns raised by another nurse on the ward.[736] It described this nurse feeling uncomfortable about inappropriate behaviour on Mr Griffin's part and stated that Mr Griffin was 'overstepping many boundaries'.[737] The note further relayed that the nurse who had raised the concern felt that one-on-one care of patients should be 'ideally same gender, particularly important for adolescent female[s]'.[738] The note also indicated that the nurse holding the concerns was willing to be contacted for more information.[739]

Ms Leonard was not working at the time the concern was raised and cannot recall what the complaint related to precisely.[740] In relation to the conduct that her colleague had described in the note, Ms Leonard said:

> I observed Mr Griffin frequently greet familiar patients with a hug, including standing side by side with patients and hugging them. From my observations children and parents reacted positively to these gestures. The staff witnessing these hugs did not respond negatively to this. Notwithstanding this, I had directed Mr Griffin to desist from this behaviour as in my view it was not a professional manner in which to greet patients.[741]

A diary note from around the same time (4 November 2015) records Ms Leonard telling Mr Griffin not to sit on patients' beds or hug patients.[742]

Ms Leonard did not take further steps in relation to this complaint, such as contacting the person reporting the concerns, and it does not appear that anyone, including staff in the human resources team, was made aware of it.[743]

4.1.25 21 March 2016—Mr Griffin's Performance Development Agreement is signed off

On 21 March 2016, Ms Leonard signed off Mr Griffin's annual Performance Development Agreement. In this Agreement, Ms Leonard documents that Mr Griffin enjoyed his 'leadership role and supporting junior staff, [graduates] and students' and 'enjoy[s] and appreciate[s] the management role when opportunities arise'.[744] Mr Griffin's continued interest in developing professional skills in relation to patients with eating disorders, and supervising more junior staff, are again reflected in the Agreement.[745] Concerns about Mr Griffin's continued boundary breaches were not referenced.

4.1.26 March 2017—A young patient reports discomfort with Mr Griffin using pet names

Ms Leonard told us that on 3 March 2017, she became aware that a highly vulnerable patient was uncomfortable with Mr Griffin calling her 'babe' and 'sweetheart'.[746] A Child and Adolescent Mental Health Services worker reported this discomfort to Ms Leonard and Mr Sherring.[747]

In relation to Mr Griffin's use of pet names for patients, Ms Leonard told us:

> I recall Mr Griffin calling patients by such names, as well as members of staff. While I did not think it was professional, from my observations, children and their parents reacted positively to the names such that it did not concern me until the complaint was made.[748]

Ms Leonard said that due to the 'complex needs' of this patient, she discussed the complaint more broadly—including with Mathew Harvey, the then Human Resources Consultant within the human resources team, Mr Sherring, broader Ward 4K staff, social workers, staff from Child Safety Services and Child and Adolescent Mental Health Services, the patient's paediatrician and the then Director of Nursing Women's and Children's Services, Janette Tonks.[749] Ms Leonard said she then discussed the matter with the patient and 'following her feedback and request, determined that male staff would not care for the patient overnight, and Mr Griffin would not care for the patient at all'.[750]

Ms Tonks did not refer to this complaint in her statement to our Commission of Inquiry nor in her evidence.[751] Mr Bellinger reported that his team had made him aware of this complaint and described it as being 'appropriately dealt with within the employment framework that existed at this time'. Mr Bellinger added that Ms Leonard 'set clear expectations with respect to [Mr Griffin's] behaviour, appropriate relationships and supported these directions with education'.[752] Mr Bellinger did not have any specific documentation relating to his knowledge of, or extent of involvement in, this complaint.[753] He acknowledged, with the benefit of hindsight, that all parties should have documented 'more specific details about the child's concerns'.[754]

Mr Sherring told us he became aware of this incident on 3 March 2017, through a conversation with the Child and Adolescent Mental Health Services staff member.[755] He said that he and Ms Leonard met with Mr Griffin on 6 March 2017 'to discuss the concerns and provide direction'.[756] He told us that during this discussion Mr Griffin's behaviour was 'clearly identified as a breach of professional boundaries' and Mr Griffin was directed to familiarise himself with his professional responsibilities as a nurse and to amend his behaviour.[757]

Ms Leonard wrote a letter to Mr Griffin following the meeting, on 6 March 2017, copied to Mr Harvey. In this letter, she wrote:

> As this is not the first instance of a complaint of this nature brought forward regarding a patient under your care and that external agencies have been made aware of this concern expressed by the patient, I feel that this is a serious breach of your professional boundaries. As such the benefits from focused education on communication style and non-verbal communication with vulnerable children and families would be advantageous in developing a more flexible communication style that is more responsive to [patients'] needs and circumstances.[758]

The wording of this letter suggests Ms Leonard considered Mr Griffin's complaints history, yet the sanction remained the same—education. Accompanying the letter was the companion document to the Code of Professional Conduct for Nurses, entitled *A Nurse's Guide to Professional Boundaries*.[759] In the letter, Mr Griffin was encouraged to identify and attend an education session to support a change in his practice.[760]

At hearings, Counsel Assisting questioned Ms Leonard on the significance, to her mind, of external agencies being aware of Mr Griffin's conduct, noting that this was specifically referenced in her letter. She explained: 'I think it's in relation to other health professionals with experience in child and adolescent mental health that increases the gravity for me'.[761] The letter from Ms Leonard to Mr Griffin canvasses other matters about the importance of maintaining therapeutic relationships, and then warns:

> … if there is a reoccurrence of such a breach of professional behaviour, I may be required to refer this matter to the Director of Nursing or to an external forum for further investigation.[762]

This comment suggests that Ms Leonard had not escalated the matter to Helen Bryan, the then Executive Director of Nursing, either personally or through Ms Tonks. Ms Leonard noted the hospital had a culture of trying to resolve things 'at a low level in the first instance', which she agreed had the effect of keeping matters 'in-house'.[763] She added there was 'not an openness' to engage with regulatory bodies such as Ahpra or the Nursing Board.[764]

4.1.27 May 2017—A student undertaking a placement complains about Mr Griffin

On 19 May 2017, a clinical facilitator from the University of Tasmania notified Mr Sherring that a student had raised concerns about Mr Griffin, who was her clinical instructor during her placement at Launceston General Hospital.[765] The student objected to Mr Griffin calling her 'babe' and touching her on the arm on more than one occasion; she asked not to work with him again.[766] Mr Sherring told us he spoke to the student on 22 May 2017 and requested an email from the Clinical Facilitator to document the issue.[767] On 23 May 2017, the Clinical Facilitator emailed Mr Sherring and Ms Leonard, and this email was forwarded to Mr Bellinger in the human resources team.[768]

Mr Sherring took on this complaint and reported back to Ms Leonard that it was in fact 'some students' who had expressed discomfort with Mr Griffin's 'familiarisations'.[769] Mr Sherring reported that Mr Griffin could not recall using such terms with the students but acknowledged he had done so in the past and had been counselled by Ms Leonard and Mr Sherring about this.[770] Mr Sherring recommended that no students be allocated to Mr Griffin for the remainder of the placement and advised Mr Griffin he would 'let him know' if he heard him using such inappropriate language with students, staff or anyone else in future.[771] Mr Sherring did not recall having to correct Mr Griffin for using terms such as 'babe' and 'baby' following this incident because he did not observe, or have reported to him, any further incidents of Mr Griffin using such terms.[772]

This is the sixth professional boundary breach by Mr Griffin that we have evidence Mr Sherring was aware of and the eighth boundary breach that we have evidence of Ms Leonard being aware of. By this stage, it should have been apparent that a conversation with, or letter to, Mr Griffin, was not having the effect of altering his behaviour.

4.1.28 26 August 2017—A nurse complains about Mr Griffin having an inappropriate conversation with young female patients

Will Gordon, a nurse on Ward 4K, recalled supervising four teenage female patients as they ate dinner on 26 August 2017.[773] He overheard their discussions about 'messaging guys' on the social media app Snapchat. The patients then asked Mr Gordon what they should say to guys.[774] When Mr Gordon said that the topic was not appropriate for him to comment on, he recalls the patients responded: 'Jim talks to us about this stuff'.[775] Mr Gordon told the patients that Mr Griffin should not be discussing such matters with them.[776] One of the patients then said that Mr Griffin described a woman who worked at the hospital as 'titsy' and that 'he wanted to shag her because she had massive tits'.[777] They also said Mr Griffin gave them advice on 'what guys like'.[778] This summary is based on the evidence provided to us by Mr Gordon. We note that there are minor variations in the multiple documents relating to this matter, but we do not consider these variations consequential.

Mr Gordon recalled speaking with colleagues about what these patients had told him. These colleagues encouraged him to report the conversation to Ms Leonard.[779] The next day, Mr Gordon sent Ms Leonard an email summarising the conversation and asked for his complaint to be treated confidentially.[780]

During hearings, Mr Gordon described why he made the complaint:

> … the nature of the conversation and the way they were talking, the tone, some of the other— you know, the way they were talking about the subject matter, it felt highly sexual in nature … it felt like the comments that James had made to them were sexual themselves.[781]

According to Mr Gordon, Ms Leonard asked that he lodge a report in the Safety Reporting and Learning System, which is the hospital's database for reporting incidents. (Note that some statements and transcripts quoted in this chapter refer to this system as the 'SRLS'.) Ms Leonard told us that she does not recall asking him to do so. She instead referred to Mr Gordon's email, which stated 'I have not completed an SRLS tonight as I did not have the time … but the information that I have provided you is the same information that I would put in an SRLS' as being indicative that he already intended to make a report in the system.[782] Mr Gordon did this on 29 August 2017.[783] When lodging the complaint on the system, Mr Gordon designated it an 'SAC4' incident, which is considered a low-level matter.[784] During the hearings, Ms Leonard conceded that the allegation was one of sexualised commentary and not just a boundary violation, and it should have been escalated as such.[785]

Ms Leonard recalled forwarding Mr Gordon's complaint to Mr Harvey in the human resources team on 28 August 2017 and asking to meet with him to discuss it.[786] It is not clear whether Mr Harvey met with Ms Leonard to discuss the complaint before Mr Gordon lodged the Safety Reporting and Learning System report on 29 August 2017. However, Mr Harvey told us he did recall discussing the complaint with Ms Leonard during their 'regular catchups to discuss HR matters on the Ward'.[787]

Ms Leonard was allocated the Safety Reporting and Learning System file of the incident and was therefore responsible for reviewing it, assessing risk and seeking further information from others named in the report, namely the staff members with whom Mr Gordon discussed the incident before making the complaint.[788] The staff members Ms Leonard sought information from were not witnesses to the actual conversation.[789] Ms Leonard emailed five staff members requesting information.[790] Ms Leonard received two responses, although we note that some staff may have missed her email.[791] The two staff responses were pasted into the progress notes on the Safety Reporting and Learning System.[792]

Mr Harvey was granted access to the Safety Reporting and Learning System file on 4 September 2017, which he reviewed and discussed with Ms Leonard.[793] Mr Harvey told us he provided some advice to Ms Leonard about whether these allegations could

be substantiated, although he did not give us the details of this advice. Mr Harvey then helped prepare a letter to Mr Griffin seeking his response to the concerns outlined in the complaint.[794] On 4 September 2017, Ms Leonard emailed the letter to Mr Griffin.[795] The letter clearly identifies Mr Gordon as the complainant and includes a copy of the allegation raised in the Safety Reporting and Learning System as an attachment.[796]

At hearings, Counsel Assisting asked Mr Harvey why Mr Gordon's identity was revealed to Mr Griffin, noting Mr Gordon's request for confidentiality. Mr Harvey explained that while Mr Gordon had requested confidentiality in his email to Ms Leonard, he later made the Safety Reporting and Learning System entry in his name when he had the option to enter it anonymously.[797] Under questioning by Counsel Assisting, Mr Harvey admitted that the complaint could have been progressed without disclosing Mr Gordon's identity.[798]

Ms Leonard seemed to anticipate the potential for conflict arising from revealing Mr Gordon's identity to Mr Griffin. She notes in her letter to Mr Griffin: 'As you may encounter Mr Gordon or such persons named in the complaint during this process, I expect you will conduct yourself in a professional manner towards them'.[799] Ms Leonard also noted in her letter to Mr Griffin:

> I must advise that while this matter is being addressed internally, there is a possibility that at some point during, or after, that this matter may be referred to an external forum through the actions of a party to this complaint.[800]

Mr Gordon told us that Mr Griffin made veiled comments to him that made it clear he was aware that Mr Gordon had made the complaint. Mr Gordon described an interaction with Mr Griffin prior to Mr Griffin's transfer to Ashley Youth Detention Centre, only a short time after Mr Gordon had made what he thought was a confidential complaint. Mr Gordon said:

> We heard that he was going to Ashley and I went up to him and I said, 'I heard you're going to Ashley, how come you're leaving the ward?' And he said, he looked at me in the eyes and he said, 'There's no one but fucking dibber-dobbers on this ward,' and his tone of voice, his body language, that sort of standing tall, broadening the shoulders and staring me straight in the eye; I knew from that moment that he knew I made the report against him, and he—it almost felt like he wanted me to know that he knew as well.[801]

On 6 September 2017, Ms Leonard received Mr Griffin's response to her letter.[802] Mr Griffin admitted that a patient had asked him what he thought guys liked in girls and that: 'I replied briefly something along the lines of being natural and being themselves, and that pictures of airbrushed girls in magazines wasn't seen as natural'.[803] He stated to Ms Leonard that this was the only time he had a conversation like this with patients. Mr Griffin further replied that his use of the term 'titsy' to describe a staff member was likely overheard by one of the patients when he was speaking to their mother outside the hospital setting.[804] He framed the use of this terminology as a benign 'pet nickname' and 'private joke', rather than a derogatory or sexual comment.

Ms Leonard sent Mr Griffin's response to Mr Harvey. Ms Leonard told us that she and Mr Harvey then discussed the matter and concluded that 'the inappropriate communication did not occur in the course of Mr Griffin's employment and the event should be closed'.[805]

Curiously, the determination that Mr Griffin's conduct did not occur in the course of his employment mirrors the language of what is often considered in a formal investigation pursuant to an Employment Direction under the State Service Code of Conduct (discussed in Chapter 20). We note that neither Ms Leonard nor Mr Harvey had authority to unilaterally initiate or determine a disciplinary matter under the State Service Code of Conduct and it is clearly open to question whether either was sufficiently independent to make a finding about the incident at all. Some of the steps taken in response to Mr Gordon's report gave us the impression of those taken in response to concerns that a breach of the State Service Code of Conduct occurred. Across our case studies, we identified a systemic problem of undertaking such quasi-investigations without the protections accorded through a formal process (including independent investigation and procedural fairness).

Mr Harvey and Ms Leonard made efforts to collate previous complaints about Mr Griffin, but Mr Harvey considered they could not base a decision on these.[806] Mr Harvey told us he believed they were unable to consider 'unsubstantiated' prior complaints when considering fresh complaints against an employee.[807] Mr Harvey stated his understanding of this limitation as follows:

> Q [Counsel Assisting]: And [Mr Griffin's complaints history] nonetheless didn't cause you concern that Mr Griffin's conduct might be seen in a different light?
>
> A [Mr Harvey]: No, because we look at each investigation independently of itself, and then, if we can see that an allegation is proven, then you can look back at the history to say, yes, here is an escalation of what occurred previously. In this one we were able to substantiate that he made the comment about what guys like and we said, yes, that is a concern, that is a breach of your professional boundaries.
>
> Q: So, once a complaint is unsubstantiated it effectively gets put in a memory hole?
>
> A: That is right, because if you can— if you haven't substantiated a claim you can't use that as a basis for finding guilt in future allegations.[808]

Mr Harvey told us that this limitation has been upheld in a matter before the Tasmanian Industrial Commission as recently as 2021.[809] In contrast, Mr Bellinger, also a former member of the hospital's human resources team, told us that 'previous allegations are considered when dealing with new matters and consideration is given to whether the allegations suggest a pattern of behaviour'; however, he was not explicit about the extent to which unsubstantiated complaints could be relied upon.[810] Mr Bellinger also mentioned the 2021 case referenced by Mr Harvey, which suggests a lack of overall clarity about the hospital's position on taking previous complaints into account.

In any event, we note in relation to Mr Griffin that there had been previous substantiated boundary violations with written directions and education that Mr Harvey and Ms Leonard could have considered. In his statement to us, Mr Harvey made a point of noting that Ms Leonard was the delegate responsible for determining the matter and that she ultimately made the decision.[811]

In her statement, Ms Leonard told us that Mr Harvey drafted the letter to Mr Griffin, advising him of the outcome of the investigation, which she signed and sent on 11 September 2017.[812] Mr Harvey initially accepted this evidence during oral evidence but has since clarified that Ms Leonard drafted the final outcome letter and he provided amendments for consideration before the final outcome letter was issued.[813] In part, this letter stated:

> Based on my review of the allegations and with due consideration of the evidence presented, I find that the allegations against you cannot be substantiated.
>
> I am satisfied that the information that you have provided me that the comments made in relation to [another adult] were not made in the course of your employment with Ward 4K.
>
> In relation to patients requesting advice from you, I am satisfied that the response you made was reasonable, well intended and appropriate.
>
> As such, I will not be taking any further action regarding this matter at this point and now consider both matters resolved and closed.[814]

The letter also included a general reminder about maintaining appropriate relationships with patients and their families to ensure 'therapeutic relationships are not compromised'.[815]

In the context of Mr Griffin having received multiple warnings, education and counselling for his unprofessional conduct, Counsel Assisting asked Ms Leonard to explain what she considered to be the threshold for taking more decisive action in response to Mr Griffin's behaviour.

> Q [Counsel Assisting]: At what stage should someone simply be moved away from children? That was a question.
>
> A [Ms Leonard]: Okay, I'm not sure of the answer to that question.[816]

Ms Leonard told us in her statement that 'it was my understanding that meeting with staff, providing education and direction/directives were the first steps in resolving complaints and grievances'.[817] She further stated: 'I always thought that education and redirection would change [Mr Griffin's] behaviour'.[818] As far back as 15 January 2009, in response to a complaint about Mr Griffin, Ms Leonard's own notes stated: 'I mentioned [to Mr Griffin] there were other times that he obviously didn't recall … so speaking about it hadn't changed the behaviour'.[819]

Counsel Assisting questioned Mr Harvey about the characterisation that Mr Griffin's response was 'reasonable, well intended and appropriate'. Mr Harvey conceded that such a description was wrong.[820]

Mr Harvey defended his handling of this incident. In his statement to us, he wrote:

> If the evidence provided in the SRLS indicated that James Griffin made sexual comments to patients, then … I would have recommended further witness statements to assist in determining whether the allegations could be substantiated.[821]

Under questioning, and as later acknowledged by him, Mr Harvey eventually accepted that his view at the time was ill-informed and that the statements (as alleged) were sexual in nature, deeply inappropriate and constituted potential grooming behaviours.[822]

When Counsel Assisting asked Mr Harvey to explain why the patients were not interviewed, Mr Harvey said this was discussed with Ms Leonard but that they ultimately felt they should not interview the patients because 'it would cause a detrimental effect to them whilst they were still under our care'.[823] He added:

> And, yes, obviously now we can say we should have potentially gone to the children. At the time that's the information we received and we thought that was sufficient to make a finding.[824]

Ms Leonard told us that she had no recollection of this decision or turning her mind to whether the patients should be interviewed. She said it would have been important to have external, skilled interviewers undertake this, and that did not happen because the response from Mr Griffin seemed reasonable at the time. Ms Leonard said she felt 'deep regret' and accepted that she should have made further enquiries.[825]

Ms Tonks told us that the Safety Reporting and Learning System complaint was the first time she had heard 'there were concerns with Mr Griffin'.[826] Ms Tonks told us that she did not have regular meetings with Ms Leonard and felt Ms Leonard would come to her if she had any concerns 'as and when required'.[827] Ms Tonks told us at hearings that when she became aware of the Safety Reporting and Learning System complaint, Ms Leonard had alerted her that 'there had been previous … breaches of professional boundaries, but didn't really go into any details about that'.[828] Ms Tonks told us she did not enquire further and understood they occurred prior to 2013 and had been 'addressed appropriately'.[829]

Ms Tonks initially told us that she was satisfied with the response to the complaint at the time, but when asked to reflect on whether she remained satisfied, she replied: 'No, absolutely not.'[830] Ms Tonks reflected:

> I believe that I should have been more actively involved and acknowledge that I should have provided much more support to [Ms Leonard] given that they had absolutely no experience in dealing with grooming behaviours of perpetrators.[831]

Ms Tonks conceded none of the staff had this expertise:

> I don't think any of us had any skills in that area in training and education around potential sexual perpetrators. I don't believe that it was something that we engaged in at all. Should we have been? Absolutely, yes.[832]

Counsel Assisting also asked Mr Harvey about other actions taken to verify Mr Griffin's response, such as contacting the person (the mother of one of the patients) that Mr Griffin said he had the 'titsy' conversation with.[833] Mr Harvey cited a range of barriers to verifying Mr Griffin's account, including that he did not have the mother's contact details and could not access them via patient files. He eventually conceded that Ms Leonard could have obtained this information.[834] Mr Harvey also conceded that no one asked Mr Gordon for more information after he made his report on the system.[835]

Mr Harvey placed great emphasis on his and Ms Leonard's belief that Mr Griffin's comments were not made on the ward and that if they had been made on the ward, there would have been a 'greater escalation'.[836] We note that, in his initial email complaint to Ms Leonard, Mr Gordon contemplated that some of the conversations may have occurred off the ward; however, this did not diminish his concern about Mr Griffin's conduct.[837]

Mr Bellinger was also asked about the management of this complaint, given that he was more senior than Mr Harvey. In his initial statement to our Commission of Inquiry, Mr Bellinger indicated that he accepted Mr Griffin's explanation that the comments were made outside of work.[838] Mr Bellinger noted, as he did in relation to the March 2017 complaint against Mr Griffin, that Ms Leonard 'reminded and set requirements' for Mr Griffin in response to this complaint.[839] Mr Bellinger also stated that a 'more appropriate' response to this situation would have been for Mr Griffin to refuse to engage in any kind of conversation with female patients about 'what guys like' and that 'with the benefit of information that is now available', Mr Griffin's account of the incident should have been tested by speaking with the patients who had relayed the conversation to Mr Gordon.[840]

At hearings, Mr Bellinger told us that Mr Harvey and Ms Leonard should have considered whether Mr Griffin had breached the State Service Code of Conduct. Mr Bellinger also acknowledged that the complaint was of a sexual nature and that it should have been escalated and investigated.[841] He said: 'Given the pattern of behaviour displayed, these matters could and should have been considered differently and more significantly'.[842] He also agreed with the suggestion that a lack of training and awareness likely contributed to their failure to do so.[843] We note that Mr Bellinger was copied into a response that Ms Tonks sent to Mr Gordon on 2 December 2019, after Mr Gordon again raised concerns about how complaints regarding Mr Griffin were managed, following Mr Griffin's death (this is described in Section 5.2.26).

Mr Gordon told us that by reporting the incident to management, he believed he had acquitted his responsibility and therefore he did not notify Ahpra of the incident. He recalled that, at the time he made his report, he received no information about

making a mandatory report. He stated: 'I had faith and trust in the Tasmanian Health Service back then and believe I had fulfilled my obligations by making the SRLS report'.[844]

After logging the report in the system, Mr Gordon said:

> I didn't receive any feedback from Sonja Leonard about the matter. She didn't speak a word to me about it. In my view there should have been some sort of feedback after I made the report. There should have been some follow up to let me know what the outcome of the complaint was. I also expected there would be some sort of investigation, including interviewing the girls. To my knowledge there was no further investigation.[845]

After no action or feedback was provided in response to his complaint, Mr Gordon said he did not report further concerns about Mr Griffin: 'I felt that if I did make a complaint, it wouldn't go anywhere'.[846] Mr Gordon believes that if his Safety Reporting and Learning System complaint was followed up, further abuse of children and young people on Ward 4K would have been prevented.[847] He told us:

> I now feel personally responsible for the children that James abused on the ward following my complaint in 2017. I regret that I didn't pursue the complaint and now refuse to let it go.[848]

We consider that the hospital had the onus to respond appropriately to Mr Gordon's complaint. We discuss Mr Gordon's actions in advocating for greater transparency in how the hospital responded to complaints about Mr Griffin, including his own, in Section 5.

Finding—Launceston General Hospital's response to Will Gordon's 2017 Safety Reporting and Learning System complaint did not comply with the requirements of a State Service Code of Conduct investigation

The response to Mr Gordon's complaint was effectively an informal investigation, which seemed to act as a proxy for escalating Mr Griffin's conduct to the Secretary of the Department for a formal Employment Direction No. 5 investigation for a breach of the State Service Code of Conduct. We are concerned that this reflects a systematic practice we have identified across our case studies of informal investigations being undertaken in response to serious allegations relating to children (whether through one incident or a pattern of conduct), when it would be more appropriate to initiate a State Service Code of Conduct investigation. A formal process can support matters to be investigated by those with the necessary expertise, with appropriate senior management oversight.

There was an inappropriate focus on whether the alleged conduct occurred within or outside the course of employment, which reflects another problem we have identified across our case studies. In this context, such a focus detracts from important considerations, such as whether the person subject to a complaint may pose a risk to children, regardless of how (or where) a complaint about their conduct arises.

Having an independent investigator can increase transparency and confidence in the investigation process and avoid actual or perceived conflicts of interest. In this instance, we consider that the failure to have a suitably independent investigation may have affected the participation of staff witnesses in the investigation. Also, not all relevant people, including the children involved or the adult Mr Griffin referenced regarding the complaint, were spoken to.

Previous complaints were not considered, even when they had been substantiated and responded to with education or direction. In addition, the outcome of the complaint was not appropriately communicated to Mr Gordon.

We consider that Mr Gordon took reasonable steps and acquitted his responsibilities by reporting to the Nurse Unit Manager and lodging a complaint on the Safety Reporting and Learning System. We consider health practitioners should be made aware of mandatory reporting obligations and how to enact them, and of how to make complaints to Ahpra. However, in the context of his overall conduct (including escalation to management), we do not consider that Mr Gordon failed in his duties. We note, also, the general lack of clarity about reporting obligations of junior staff in the hospital (which we discuss in Section 4.2).

4.1.29 4 November 2017—Mr Griffin is transferred to work in a fixed-term role at Ashley Youth Detention Centre

Between 4 November 2017 and 27 April 2018, Mr Griffin was assigned, as a registered nurse, to Correctional Primary Health Services in Ashley Youth Detention Centre (sometimes referred to by witnesses as 'AYDC' or 'Ashley').[849]

Mr Griffin remained a Department employee during this time.[850] Jacqueline Allen, Acting Executive Director, People and Culture at the then Department of Communities, told us that Department was not required 'to conduct any pre-employment checks in relation to employees from other agencies performing duties at AYDC'.[851] Barry Nicholson, Group Director, Forensic Mental Health and Correctional Primary Health Services, told us that health staff at Ashley Youth Detention Centre are employees of the Department of Health and therefore would have already been subject to criminal conviction checks and required to hold registration to work with vulnerable people.[852] Mr Bellinger noted that beyond practicalities (such as determining whether the area that was releasing the potential secondee could effectively backfill them), the hospital would

not take any other steps to determine the suitability of a staff member before they were transferred to Ashley Youth Detention Centre.[853]

It was difficult to find authoritative information about Mr Griffin's transfer to Ashley Youth Detention Centre. Secretary Morgan-Wicks noted that the secondment opportunity was not advertised and that '[t]here is no information in the records available as to how Mr Griffin was known to the Correctional Primary Health team and who requested the transfer'.[854] There is nothing on Mr Griffin's personnel file that made any reference at all to this secondment.[855]

Mr Sherring recalled being included in email exchanges about Mr Griffin's appointment to Ashley Youth Detention Centre, but he could not recall who authorised the transfer or whether it was connected to concerns or disciplinary proceedings.[856] Mr Bellinger was also not aware of the circumstances surrounding Mr Griffin's transfer.[857]

Ms Leonard could also not illuminate the circumstances that led to Mr Griffin's transfer and the process that facilitated it.[858] She was not asked to provide a reference, recommendation or information about Mr Griffin's work history.[859] When asked how she learned of the secondment, Ms Leonard said:

> That's difficult to recall, but I don't know if Mr Griffin told me directly or I was contacted by the manager at Ashley, but I understand as it was a secondment that the HR team were involved in arranging that secondment.[860]

Mr Nicholson speculated that Mr Griffin may have been recruited by an Acting Nurse Unit Manager of Correctional Primary Health Services.[861]

We heard of concerns about Mr Griffin's behaviour while he was at Ashley Youth Detention Centre, although we are not aware of any complaints being made. Former Ward 4K nurse Annette Whitemore told us:

> One of the things I was told by some staff was that J [Mr Griffin] would show them photos of kids' files he had on his phone from when he worked at Ashley Youth Detention Centre. Other nurses would talk about it and say he shouldn't have those photos on his phone, but J never showed them to me.[862]

Mr Gordon also recalled that Mr Griffin, after returning from his secondment in 2018, showed him photographs that appeared to be head shots of children and young people in Ashley Youth Detention Centre. Mr Gordon remembers Mr Griffin describing the offences the young people had committed.[863]

4.1.30 25 May 2018 and 22 May 2019—Mr Griffin's Performance and Development Agreements are signed off

On 25 May 2018, not long after completing his secondment at Ashley Youth Detention Centre on 27 April 2018, Ms Leonard signed off on Mr Griffin's Performance and Development Agreement. His recent secondment to Ashley Youth Detention Centre was not referenced in this document.

In response to a question in the Agreement about how Mr Griffin emulated the values of the organisation, the following was recorded:

- Demonstrating the care and understanding of the challenges and issues surrounding a young patient and family who find themselves in a position of being a patient in a strange environment surrounded by people they don't know.
- Communicating effectively and appropriately to patient.
- Utilising Hospital and Ward policies and procedures to ensure the best health and personal outcomes for young patients and their families.[864]

Performance measures in the Agreement include: 'To provide best possible care to our young patients and their families, and make their hospital stay as enjoyable and stress free as possible' and 'To be a positive role model and provide in-service education and support to fellow staff, junior staff and students on the ward'.[865] We note that in May 2017 a student made a complaint about Mr Griffin's behaviour (refer to Section 4.1.27), yet there is no reference to this in the Agreement, nor any suggestion that Mr Griffin should step back from mentoring or supervising junior staff or students.

Again, there is no mention of any of the complaints about Mr Griffin in the previous year. This indicates to us that Mr Griffin's behaviour apparently bore no consequence to the assessment of his professional performance.

Approximately a year later, on 22 May 2019, Ms Leonard signed off on the next of Mr Griffin's Performance and Development Agreements. This Agreement would be Mr Griffin's last. It largely mirrors, in some parts word for word, the previous year's Agreement.[866]

4.1.31 July 2019—A nurse complains about Mr Griffin's inappropriate comments and actions when administering medication

In mid-July 2019, a nurse on Ward 4K was caring for a patient who required controlled medication, which has additional safeguards in its administration.[867] Mr Griffin prepared the relevant medication, which was checked and administered to the patient with his nursing colleague present.[868] Mr Griffin made a comment to the nurse about the taste of the medication, invited her to put out her hand and placed a drop of the medication on her finger for her to taste.[869] The nurse discreetly disposed of the medication and withdrew from the situation.[870] She then overheard Mr Griffin speaking to the parent of the patient saying 'that's why it is used as a date rape drug'.[871]

The nurse reported this incident to a colleague, who alerted Ms Leonard.[872] Ms Leonard met with the nurse on 22 July 2019 and requested that she put her concerns in the form of a statement.[873] Ms Leonard recalled relaying the complaint verbally to Mr Harvey and Ms Tonks on the same day.[874]

On 31 July 2019 (around the time this complaint was being addressed), hospital staff, including human resources staff, became aware that Mr Griffin's registration to work with vulnerable people had been revoked and that Tasmania Police were investigating him for child sexual abuse. Tasmania Police briefed Dr Peter Renshaw (the then Executive Director of Medical Services) and Mr Harvey about the allegations. Mr Griffin was suspended from duties that day. We discuss this in more detail in Section 5.

On 7 August 2019, Ms Leonard received the written account of the incident from the nurse. As Ms Leonard was aware that Mr Griffin had been stood down in light of a police investigation, and that human resources staff and senior management were managing the hospital's response, she forwarded the written complaint to Mr Harvey and Ms Tonks, describing the concerns reported by the nurse as 'very alarming to me'.[875]

On the same day, Mr Harvey advised Ms Leonard that the complaint would be sent to Tasmania Police through Dr Renshaw to 'determine whether it may be relevant to their ongoing investigation against Mr Griffin'.[876] Ms Leonard told our Commission of Inquiry that she had no further involvement in this complaint and was unsure how it was ultimately resolved.[877] We consider this reasonable given that, by this stage, all matters relating to Mr Griffin (who was by then not in the workplace) were being overseen by the human resources team and senior management.

On 7 August 2019, Mr Harvey forwarded the nurse's complaint to Mr Bellinger and to the Department's former Director of Employee Relations.

Mr Harvey also forwarded the complaint to Dr Renshaw on 7 August 2019, suggesting he send it to Detective Senior Constable Hindle of Tasmania Police. Detective Senior Constable Hindle had initiated an investigation into potential abuse by Mr Griffin following a report, which we describe in Section 5.[878] Dr Renshaw forwarded the complaint to Detective Senior Constable Hindle on 13 August 2019, with a message that it contained 'information from a hospital staff member that may be relevant to your investigation'.[879]

4.2 Undocumented or undated concerns or complaints from staff

In addition to the complaints outlined in Section 4.1, which the hospital acknowledges as having been reported or recorded, we received other information from staff and former staff of Launceston General Hospital about Mr Griffin's behaviour.

We heard that the hospital's practice was to minimise or dismiss concerns, which we consider provides context for why the complaints described below were not documented.[880] In reflecting on the evidence before our Commission of Inquiry, Secretary Morgan-Wicks said:

> From the evidence and from my conversations with several witnesses, including staff that have come forward to report, they all share a common story of feeling fobbed off … or their complaint ignored and they did not feel supported in relation to the serious harms or incidents they reported.[881]

At hearings, Emily Shepherd, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian Branch), described some of the discussions she had with staff after Mr Griffin's death, during which many staff members told her of their concerns about Mr Griffin. Ms Shepherd acknowledged that some of the concerns shared by staff members may not have met the threshold for mandatory reporting, but added:

> … their concern was that there was … what appeared to be a pattern of incidents that, you know, was bordering on unprofessional behaviour, and I think that was really a concern about, well, how is it that it is captured over time and how is that escalated?[882]

We also heard of confusion among staff about how to raise a complaint or a concern about the conduct of a work colleague. Ms Shepherd reported staff telling her of multiple and inconsistent approaches taken by the hospital when a concern about a colleague was reported, which ranged from requests to send an email report, to verbal reporting to a manager to lodging a complaint in the Safety Reporting and Learning System.[883]

This evidence was consistent with the documented evidence we received regarding how Ms Leonard managed different complaints about Mr Griffin. For example, as outlined above, in August 2017, Mr Gordon's complaint was recorded and managed through the Safety Reporting and Learning System, whereas in July 2019, Ms Leonard asked a staff member to write a formal statement and forward it by email. At other times, Ms Leonard recorded concerns in her diary or as a file note. Some complaints were managed via email or letters to Mr Griffin.

We consider that it would have been difficult for staff to raise concerns formally if there was no clear process for doing so and if they did not know what process to expect. Ms Shepherd told us that hospital reporting systems should be improved by implementing a consistent approach for raising concerns across the Tasmanian Health Service.[884]

Several staff described their casual or contracted work status as a disincentive to speaking up about concerns they may have held about a colleague. For example, Maria Unwin, a nurse who worked on Ward 4K between 1993 and 2009, told us:

> I further believe that people who ask questions and make complaints at [Launceston General Hospital] are punished for doing so and treated as trouble makers. In my view there is a very strong practice of choosing and promoting people who say 'yes'. I have witnessed this with staff who are highly qualified for positions missing out, in place of staff who are known to agree with management.[885]

Mr Gordon said that fears about not securing a permanent position at the hospital deterred him from raising early concerns about Mr Griffin:

> … I was quite junior at the time and I did not have permanency on 4K and, in order to not upset the apple cart, I sort of didn't raise any concerns that I deemed were what I thought weren't minor but would cause tension between myself and other staff members. I did want to stay there and I thought, if I … started throwing accusations about James Griffin, the other staff members would not take too kindly to it.[886]

Another former employee echoed these sentiments:

> People are reluctant to challenge things because they don't want to jeopardise their career. Obtaining a permanent contract is also a big carrot for nurses at [Launceston General Hospital], and is something nurses don't want to jeopardise by making waves.[887]

Several other undocumented staff complaints that we outline below show that when staff did raise concerns they did not receive a satisfactory response. Sometimes they were told 'that's just Jim' or were encouraged to resolve the concern with Mr Griffin directly. Mr Gordon told us:

> When a complaint was made the managers would often say 'have you spoken to Jim about it', but most staff felt too nervous to confront him. I'm only aware of one nurse that did confront him and that was before I started.[888]
>
> …
>
> I have been told by other 4K nursing staff that numerous grievances on 4K that should have been reported by staff were not reported because they felt 'why bother'.[889]

As discussed earlier in this section, Ms Leonard acknowledged a 'complicated culture' on the ward.[890] She accepted that this culture impeded the reporting of concerns.[891] She conceded that staff would likely be unwilling to escalate their complaints to more senior nursing managers if they doubted they would manage them fairly.[892] We note that Ms Leonard also defended her management of some of the complaints about Mr Griffin on the basis that the staff members who raised concerns 'did not seek feedback, information on outcomes, or advise that they were not satisfied with the outcome of the process'.[893]

Some of the complaints we outline below raise the question of why staff did not independently report their concerns to external bodies such as Child Safety Services or Ahpra. While this would have been ideal, we do not hold any of the staff mentioned below responsible for not reporting their concerns. We consider that any suggestion otherwise fails to adequately take account of the relevant context. In particular, we consider that there was a culture at Launceston General Hospital of not reporting without the permission of senior management.

Ms Unwin told us that although mandatory reporting under child safety legislation was something all staff were required to know about, 'in practice we were told that mandatory reporting would always be managed by the paediatric registrar or paediatrician'.[894] While we accept that we did not seek evidence from a paediatrician on this point, Ms Unwin's comments reflect what is now current policy in the *Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct*. The protocol, which applies to all Tasmanian Health Service staff since November 2020, states:

> In the case of reporting an offence complaint, this should be undertaken through the relevant Executive/Medico-Legal Advisor (South) through Human Resources. Mandatory reporting of a registered health professional, as represented by the organisation, must be sanctioned formally (in writing) and in accordance with line delegations.[895]

We discuss our concerns with this policy in Chapter 15 but note here that it appears to reflect what several staff told us about reporting practice. We could not find an earlier policy about this.

In addition to what Ms Unwin told us, Ms Whitemore said: 'We all knew we were mandatory reporters, and I don't think we were deliberately not told this, but until 2019 when all this happened … I never knew I could go straight to Ahpra'.[896] Mr Gordon told us that most nurses on Ward 4K did not realise they could report their colleagues to Ahpra.[897] He said: 'We just didn't know, we weren't told about it, there was no education about that sort of complaint process'.[898]

Another Ward 4K staff member said it was their practice as a registered nurse to 'escalate concerns first to management and then be directed as to which direction to take next'.[899]

Given an apparent practice of escalation for reporting, which we accept will often be operationally appropriate, we were concerned that the former Executive Director of Nursing, Helen Bryan, told us she was not aware of the Strong Families, Safe Kids Advice and Referral Line—the first point of contact for child safety and wellbeing concerns and the place to which mandatory reports under child safety legislation should be made.[900] Ms Bryan told us, however, that she had no experience with managing child safety allegations and that she was aware of the legislation underpinning the mandatory reporting scheme and her duties as a mandatory reporter.[901]

4.2.1 Maria Unwin

As a former Ward 4K nurse, Ms Unwin told us about a conversation she had with the Nurse Unit Manager who preceded Ms Leonard, sometime in the early 2000s. Ms Unwin expressed that, at the time, she had a general feeling of unease around Mr Griffin and her concern grew when his preference for caring for, and becoming 'new best friends' with teenage female patients, became apparent.[902] She said that when she told the Nurse Unit Manager about her concerns:

> I clearly recall [the Nurse Unit Manager's] response, which was 'everyone has something to offer'. I don't recall if [they] said anything else but recall this being the end of the conversation … As a result of this, I initially felt guilty for judging Jim and not giving him the benefit of the doubt. I also felt there was nowhere else for me to go with my concerns and that the matter had been dealt with.[903]

Ms Unwin felt she couldn't raise concerns with the Nurse Unit Manager again, but she did talk to a more experienced staff remember (whose name she could not recall) and was met with a response along the lines of 'that's just Jim'.[904]

Ms Unwin noted that she generally had 'a great deal of respect for' the Nurse Unit Manager.[905]

4.2.2 A Ward 4K staff member

Another Launceston General Hospital staff member, who worked alongside Mr Griffin on Ward 4K from 2002 and at times acted as Nurse Unit Manager of Ward 4K, told us:

> I also have knowledge of many other occasions through conversation with other staff members of where Mr Griffin overstepped boundaries by physically touching or being physically overfamiliar with patients. These patients appeared to be mostly highly vulnerable teenage girls or chronic illness type diagnoses.[906]

The staff member said that ward staff often noted Mr Griffin's preference for caring for teenage girls.[907]

The staff member stated that Mr Griffin 'regularly referred to his patients as "chicki-babe, babe or princess", and also referred to female staff members in the same way'.[908] They told us that Mr Griffin was verbally affectionate with females and that multiple staff members had observed Mr Griffin being asked to stop using this language.[909] The staff member also told us of having multiple conversations over the many years they worked with Mr Griffin about Mr Griffin's 'overly affectionate behaviour towards teenage girls both internal and external to the ward'.[910]

The staff member further described witnessing an incident in which Mr Griffin carried a patient with a physical disability from a bathroom outside her room to her bed without first drying and dressing her. They recalled that other staff followed Mr Griffin into the patient's room 'to advocate for the patient'.[911] While the staff member found this behaviour concerning, they thought that because the patient's family was in the room, 'she would be safe once there'.[912]

4.2.3 Will Gordon

In addition to the documented complaint Mr Gordon made about Mr Griffin in 2017, he told us about witnessing other concerning incidents involving Mr Griffin:

- Mr Griffin referred to the drug midazolam as being 'like a date rape drug' in the presence of a young patient and her parents while Mr Gordon was

a junior nurse, in either 2016 or 2017.[913] We note that this account is similar to the documented complaint made by another staff member about Mr Griffin in July 2019 (refer to Section 4.1.31).

- Mr Griffin commented on a female infant's lips in 2018, saying 'people would pay thousands of dollars for lips like that'. Mr Gordon noted that Mr Griffin frequently cared for this patient, often by himself.[914]
- Mr Griffin pulled up the nappy of the same female infant, after what Mr Gordon assumed must have been a nappy change, in the absence of a chaperone. This made Mr Gordon's 'hairs stand up on end'.[915]
- Mr Griffin came out of a communal bathroom, unaccompanied, with the same female infant. Mr Gordon added that he was aware of other occasions when Mr Griffin took patients, unaccompanied, to this bathroom.[916]

4.2.4 Other staff

A number of staff or former staff of Launceston General Hospital provided anonymous statements to our Commission of Inquiry about Mr Griffin. Others asked that their identity not be publicly revealed. We have only included information from these statements where the person directly observed or experienced the conduct.

We are conscious that many of these accounts have not been meaningfully tested with key witnesses. For this reason, we have not relied on them in making our formal findings, which we consider can be made on the strength of documented and acknowledged incidents alone. We have not made efforts to draw conclusions about the accuracy or veracity of any individual concern or complaint. However, we considered it important to include this information for completeness and to provide the public with as much information as possible about Mr Griffin's conduct.

A nurse who worked alongside Mr Griffin described to us the following incidents:

- A senior nurse said to them: 'You know Jim likes the young girls, don't you?'. When the nurse questioned what this meant, the senior nurse replied: 'You watch at handover, he will go for the young girls'.[917] The nurse then observed Mr Griffin nominating to care for young patients with eating disorders or chronic illnesses, which confirmed what the senior nurse had said.[918]
- Mr Griffin cared for several girls on Ward 4K and fulfilled the role of a male figure in their lives, including attending a former patient's wedding.[919]
- When caring for a patient who had electrocardiogram dots on her body after an operation, Mr Griffin removed the dots himself. The nurse believed that nurses would usually tell patients that they should remove the dots themselves.[920]

Another nurse who worked alongside Mr Griffin on the ward relayed the following:

- The nurse reported feeling 'immediately uncomfortable' in Mr Griffin's presence, particularly noticing the way he behaved around women and young women.[921]
- Mr Griffin told a sexual joke about a young girl to a group of nursing staff at handover in the presence of a manager, who laughed.[922] When the witnessing nurse raised the inappropriateness of the joke, the response provided was that Mr Griffin had worked on the ward for a long time.[923]
- The nurse verbally raised two concerns about Mr Griffin's behaviour with management—one involving Mr Griffin inappropriately touching a patient's thigh, and the other concerning Mr Griffin specifically choosing to care for physically or emotionally vulnerable female patients, even when he was not their allocated nurse.[924] The nurse recalled raising concerns about Mr Griffin's behaviour with management another 'half a dozen times' while working on Ward 4K.[925] The nurse described these concerns as being based on their 'own observations and gut instinct' and included Mr Griffin's use of pet names for patients and staff, such as 'baby girl', 'gorgeous', 'sweetheart', 'beautiful girl' and 'sexy'.[926]
- The nurse felt they needed to watch Mr Griffin 'because of the way he would invest in patients lives, not just their care', regularly checking in with female patients who were allocated to Mr Griffin and having to watch Mr Griffin's care of these patients.[927]
- The nurse spoke with a senior nurse about feeling uncomfortable with Mr Griffin's 'presence and bedside manner'.[928]
- The nurse observed Mr Griffin spending a lot of time building trust with patients, saying:

  > He did this subtly, often gaining the trust of single mums before he would try with the patients themselves. He had a clear method of gaining trust quickly and cleanly, and it worked. He would pick vulnerable children and then act in a way that he would say was designed to make them feel safe and secure. He'd place himself as the father figure in the lives of young girls who didn't have a father. He would have deep conversations with them, asking them questions beyond what a nurse needed to know.[929]

- The nurse observed a young female visiting the ward 'on several occasions' during 2016 or 2017 to have her knees and ankles strapped due to injury by Mr Griffin in the treatment room, where the blinds and door would be closed.[930]

Another hospital employee described attending to a young female patient in the emergency department in 2019. They observed Mr Griffin 'hovering in the examination bay standing quite close to the patient'.[931] When the staff member questioned why Mr Griffin was there, he told the staff member that he was a friend of the patient's family.

The employee told Mr Griffin he should leave, which he did.[932] This staff member also recalled that, in or around 2019, Mr Griffin was given responsibility to provide one-to-one care to a highly traumatised teenage girl overnight in a single room.[933]

A nurse at the hospital also told us about having a 'creepy' feeling around Mr Griffin.[934] This nurse observed Mr Griffin's behaviour towards a particular young female patient who was highly vulnerable. The nurse recalled observing Mr Griffin calling this patient pet names, such as 'sweetie', and rubbing her back. The nurse says other people witnessed the behaviour. The nurse could not recall saying anything to management but said 'it stuck in my mind', adding 'I remember thinking, you're a creep. It didn't look good'.[935]

4.2.5 Managers

The Nurse Unit Manager who worked on Ward 4K before Ms Leonard between 2001 and 2008 gave evidence to our Commission of Inquiry about several recollections relating to concerns raised about Mr Griffin.

They had a scant memory that a staff member reported seeing Mr Griffin at a sporting match with a former patient and that they felt they needed to address this with Mr Griffin as a potential breach of the State Service Code of Conduct.[936] Mr Griffin admitted taking the former patient to the game along with his own family.[937] When Mr Griffin was reminded that he should not have contact with former patients, he reported to this Nurse Unit Manager that he had stopped contacting the patient.[938] The Nurse Unit Manager accepted his explanation and did not document the incident.[939]

In addition to the complaints that Ms Leonard directly received or documented about Mr Griffin, which we have outlined above, Ms Leonard also made some general observations to us about Mr Griffin's conduct.

For example, she told us that she tried to ensure procedures involving intimate engagement with paediatric patients, such as bathing, were conducted by a nurse of the same gender as the patient, and that she sometimes reallocated patients to different nurses accordingly.[940] Ms Leonard said:

> In my view, Mr Griffin, as well as other staff, did not always demonstrate an awareness of procedures involving intimate engagement with paediatric patients. By this, I mean that if there had been an inappropriate allocation made [and Mr Griffin was assigned to bathing a female patient], he would not raise the issue and request that it be changed.[941]

Ms Leonard gave evidence that she was aware of Mr Griffin having contact with a patient outside the hospital but was not concerned because this patient knew Mr Griffin socially.[942]

4.3 Undocumented or undated concerns or complaints from patients and their family members

We received numerous accounts of Mr Griffin's conduct that were not the subject of a documented complaint from former Ward 4K patients and their families. These accounts of Mr Griffin's behaviour and abuse had many similarities and reflected staff observations of Mr Griffin's grooming practices. This is not an exhaustive account of all the abuses described to us because some people chose to provide information to us confidentially and did not consent to us publishing this information in our report. We are also conscious that some former patients and victim-survivors have chosen not to share their experiences with us.

We note that, like employees of the hospital, patients and their families commonly experienced barriers to making a formal complaint about Mr Griffin, including a lack of response from hospital staff when raising concerns.

4.3.1 Angelique Knight

Angelique Knight was a patient on Ward 4K on and off from the ages of five to 21. She first complained to nursing staff about Mr Griffin when she met him in around 2001, when she was 14 years old. At this time, she found him to be 'touchy feely' with her and recalled screaming at one point 'get that man away from me'.[943] Ms Knight believes that her mother also requested that Mr Griffin not care for her, but her mother's complaints were not acknowledged or responded to, and, after a short period, Mr Griffin was caring for her again.[944]

Ms Knight stated that nursing staff would observe Mr Griffin 'hug and kiss me in the hallways of ward 4K'.[945] However, staff told her Mr Griffin 'was just a touchy feely kind of guy'.[946] She also stated that nursing staff were aware of how close Mr Griffin had become to her while she was a patient and afterwards, including that he intended to give her away at her wedding (refer to Section 4.1.10).[947] When hospital management told Mr Griffin that it would be inappropriate to give Ms Knight away, he acted as master of ceremonies at her wedding instead.[948]

In a statement that Ms Knight made to Tasmania Police and shared with us, she described Mr Griffin:

- adding her on Facebook and giving her his personal mobile number so they could communicate via Facebook and text message[949]
- physically touching her, including hugging her, giving her bear hugs and putting his arm around her waist while engaging in conversation with other nurses[950]
- helping her prepare for showers and baths, including sometimes helping her to undress and washing her back[951]

- helping her to remove electrocardiogram dots from her body, which had been placed over her breasts, chest and abdomen[952]
- placing his hand on the inside of her thigh and resting his hand on her vagina while he sat with her and talked[953]
- kissing her 'for longer than a usual peck'[954]
- referring to her as 'baby girl', 'my princess', 'you're my girl' or 'my favourite girl' and telling staff 'she is my girl'[955]
- questioning her about the details of her relationship and whether she had been intimate.[956]

Ms Knight said in her statement to police:

> People tell me I am lucky it never went down 'that line'. I think that if I had [have] taken him up on his invitations to go away with him what he would have done to me. It crosses my mind constantly and I honestly do not feel lucky at all. I feel disgusting and violated all the time, it just always seems to be on my mind.[957]

4.3.2 Kirsty Neilley

Kirsty Neilley first met Mr Griffin when she was admitted to Launceston General Hospital in October 2015, at the age of 16.[958] Soon after her admission, Mr Griffin began to overstep professional boundaries.[959] Ms Neilley recalled Mr Griffin looking at her Facebook account with her, including photos on her phone, sending her a message to allow her to see his Facebook account and photos, and exchanging messages with Mr Griffin via Facebook, including on his days off.[960] She said that 'Jim was the only nurse that would look at Facebook with me and send me messages'.[961]

Soon after they began exchanging messages via Facebook, Mr Griffin told Ms Neilley he 'wasn't allowed to talk to me on Facebook anymore, and that he would get into trouble if anyone saw our messages'.[962] Mr Griffin gave Ms Neilley his phone number so they could text instead, telling her that if anyone saw those messages they would not know who they were from.[963] Consequently, they started exchanging messages by phone.[964]

Ms Neilley also described Mr Griffin giving her a 'hug and a kiss in my room' before leaving after a night shift, adding that he would never do this during the day.[965] She described Mr Griffin's hugs as 'long'.[966]

Ms Neilley further recalled Mr Griffin taking her out of Ward 4K to get coffee and, on one occasion, to a shop in the hospital to get lollies. She said Mr Griffin once took her to the top of the hospital to look out over Launceston. On this occasion, he held her close while in the elevator and then stood behind her giving her a hug while they were at the top of the hospital.[967]

One night, Ms Neilley awoke to Mr Griffin 'standing beside my bed, holding his phone up with what appeared to be the torch on'.[968] When she asked what he was doing, Mr Griffin responded he was waking her because he was finishing his shift.[969] Ms Neilley said this 'didn't feel right or normal' and that it occurred 'a couple more times'.[970]

Ms Neilley said that at one point she received a phone call from Mr Griffin, who told her that someone had put in a complaint that he was becoming too close to her and that he had been told not to care for her anymore or have any contact with her.[971] Ms Neilley said Mr Griffin laughed before saying he would always care for her but that it would 'depend who was on shift'.[972] Mr Griffin continued to visit Ms Neilley in her room at least once each shift, shutting the door behind him before sitting with her, talking, looking at Facebook and doing puzzles.[973]

Ms Neilley had later admissions to Launceston General Hospital, during which Mr Griffin provided her with nursing care. On one admission she couldn't walk and needed a shower. Mr Griffin helped her to the shower using a wheelchair, but when she finished showering, she noticed she had left her clothes in her room. Mr Griffin told her no wheelchairs were available before picking her up and carrying her back to her room wrapped in a towel.[974] Ms Neilley did not recall whether anyone saw this, but she said she was carried past other rooms on the ward.[975] When Ms Neilley was discharged from the hospital following this admission, she continued to exchange messages with Mr Griffin by phone 'about once a month'.[976]

Ms Neilley got married in 2018. Mr Griffin attended the wedding and posed for photos, telling everybody he was proud of his 'baby girl'.[977] He said it so much that the photographer asked Ms Neilley whether she wanted a photo with her father before calling Mr Griffin over.[978] Ms Neilley recalled that this was the first time Mr Griffin had called her 'baby girl' in front of others and that he had sometimes called her this when she was in hospital.[979]

Ms Neilley had her first child in 2019. During a visit around this time, Mr Griffin said words to the effect of 'I'm so proud of how much you've grown up baby girl. I've still got all your photos of our time together as a memory'.[980] This statement confused Ms Neilley, who assumed he was talking about her wedding photos. It also prompted Ms Neilley's husband to question Ms Neilley about what photos Mr Griffin was referring to, but Ms Neilley did not think anything of it at the time.[981]

4.3.3 Angela

In 2018, Angela (a pseudonym) raised concerns about the care her daughter Lilian (a pseudonym), who has cerebral palsy, was receiving at Launceston General Hospital from nursing staff, including Mr Griffin.[982] Angela said she first became concerned when she saw Mr Griffin rubbing Lilian despite noticing that Lilian was obviously uncomfortable. Angela asked Mr Griffin to stop.[983] When Mr Griffin left the room, she asked Lilian whether she wanted him to be her nurse, to which Lilian responded 'no' using her hand signals.[984]

Angela became increasingly concerned when she noticed on more than one occasion that somebody had been putting cream on Lilian's vagina. When she queried staff about who was applying the cream, she did not get an answer.[985] Angela requested that the cream not be applied and confronted Mr Griffin, who said to Angela 'show me where the issue is'.[986] At Mr Griffin's insistence, Angela pulled her daughter's nappy down slightly. Mr Griffin tapped his hand on Lilian's vagina and said, 'she'll be fine'.[987] Angela instructed that no more males were to change her daughter's nappy and asked that this instruction be put in writing on Lilian's file.[988] Angela recalled the nurse in charge said she would refer the incident to people higher up in the hospital.[989] It is not clear whether this occurred.

Angela also raised her concerns about Mr Griffin and other staff with Child Safety Services, but these concerns were dismissed and no action taken.[990] We have not been provided with a copy of Angela's complaint about the incident.

4.3.4 Other patients

The material below is drawn from anonymous submissions. We have not been able to independently verify this material, nor the identity of all those who made anonymous submissions. We consider, however, that these disclosures reveal common themes about Mr Griffin's conduct, and it is in the public interest to present this material.

One female patient who was admitted to Ward 4K in 2004 told us that Mr Griffin asked other nurses if they would swap patients so he could treat her.[991] She described Mr Griffin as initially being 'just friendly and cuddly' and said he was like this with a lot of the patients.[992] But he soon started insisting that he be present when she showered.[993] He then began 'pulling my tops up and my pants down to check me and touch my private parts' under the guise of medical care.[994] Mr Griffin then started to enter her room at night and sexually assault her while she pretended to be asleep.[995] The patient frequently discharged herself from the hospital to avoid being around Mr Griffin.[996]

The parents of another female patient who was admitted to Ward 4K for lengthy periods from 2008 described Mr Griffin as befriending them 'very quickly' and becoming their daughter's regular nurse. They recalled Mr Griffin:

- saying to their daughter words to the effect of 'don't worry I'll be your nurse', 'you'[re] my special girl', 'you'[re] my only special one' and 'don't worry I'll look after you'
- being 'handsy, rubbing [their daughter's] back, brushing her hair, touching her in some way, carrying her and putting her on his knee'
- regularly calling the patient's mother 'sweetheart' and saying 'I'll look after our special girl, you go have some tea' or 'I'll shower her today, you go have a cup of tea'

- giving his mobile number to their daughter without their knowledge or consent (the parents were not aware of this until a senior nurse told them not to accept phone numbers from staff)
- adding their daughter on Facebook
- telling them he gave a previous patient away at her wedding and that they were still close
- undertaking 'routine nightly checks' where he would come into their daughter's room and use his torch to check the bed and look around her legs and lower half (Mr Griffin explained this to the parents as 'protocol' for the child's medical condition even though other nurses did not do the same)
- randomly turning up at their holiday home when their daughter was on day release from the hospital.[997]

When they asked another nurse whether it was normal for males to shower female patients and use their phone and torch to check under the bed covers at night, the reply they received was 'it's just Jim and how he does his job'.[998]

The mother of another patient who entered the hospital in the early 2010s contacted our Commission of Inquiry to advise of a negative experience her daughter had with Mr Griffin. The mother told us Mr Griffin was forceful with her daughter in attempting to provide medical care and was rubbing and touching her leg, leaving her daughter to describe Mr Griffin as a 'creep' and threatening to walk out if Mr Griffin continued to treat her.[999] The mother told us she complained to one of the nurses. The nurse reportedly said there was nothing that could be done because Mr Griffin had been allocated to her daughter's care. Yet, the mother said this nurse then quietly approached her and assured her that Mr Griffin would not care for her daughter, telling our Inquiry: '[The nurse] gave me a basic acknowledgment she understood what I was saying and what I was referring to'.[1000] The mother is not sure whether this incident was ever documented.

A female patient who was admitted to Ward 4K in around 2012 told us that Mr Griffin was commonly assigned as her nurse.[1001] She described Mr Griffin:

- touching and rubbing her buttocks, neck and inner thighs[1002]
- frequently hugging her for long periods[1003]
- giving her medication when she was distressed, after which she would wake up hours later[1004]
- watching her when she went to the toilet and shower[1005]
- threatening to show the nurses photos of her naked if she did not comply with her treatment plan.[1006]

This patient told us that Mr Griffin was friendly with her family. She also described abuse by Mr Griffin outside of the hospital.[1007]

Another female patient who was admitted to Ward 4K in 2012 and placed under the care of Mr Griffin described her first interaction with him as 'a bit hostile'.[1008] However, after this, he 'suddenly became very charming and charismatic'.[1009] This patient told us that Mr Griffin called her pet names, which she found 'patronising, gross and inappropriate'.[1010] She said that Mr Griffin 'would mostly sit on my bed when he came to my bedside' and that she felt Mr Griffin 'imposed himself on my personal space and acted too familiar'.[1011] Mr Griffin also asked her about her 'personal life and boys', which she found 'strange' as she 'had never liked conversations about "boys", especially with much older men'.[1012] The patient described other incidents including:

- Mr Griffin insisted she expose more of her body than was necessary and against her will, and stared 'intensely at my groin region' when administering an injection.[1013]
- Mr Griffin insisted that he remove sticky dots from her chest, noting that he went to leave when she objected but then checked if anyone was looking and 'walked back to my bed, pulled down the front of my hospital gown, ran his hands over my chest, and also took these sticky dots off'.[1014] The patient was frozen in shock at this interaction, yet Mr Griffin continued to 'act like everything was normal' afterwards.[1015]
- The patient reported Mr Griffin 'shuffling around the room on multiple occasions' during the night when she was in hospital and 'waking to a light on at least one occasion'. She told us that Mr Griffin gave her a 'threatening "look"' while holding something behind his back with his right hand, when he realised she was awake.[1016]

She also recalled Mr Griffin attending to another unaccompanied young female patient in her room at night and hearing the young patient was 'very distressed'.[1017] At the time, she thought Mr Griffin was performing a medical procedure on the other patient, but on reflection she considered 'it would be highly unlikely that such a distressing medical procedure would have been carried out on this child at the middle of the night and by a solo male nurse'.[1018]

Another female patient who was admitted to Ward 4K in 2014 and 2015 recalled Mr Griffin:

- saying to her parents 'I think of her as a daughter'
- touching her thigh while engaging in conversation (she stated that Mr Griffin 'was very touchy-feely and cuddly, always cuddling me, putting hands on me, touching my thigh and rubbing my leg')
- making her shower in her room with the door open and, on one occasion, coming in to talk to her while she was showering

- taking a photo of her on his phone
- holding her down in the presence of a female nurse to collect blood for a blood test.[1019]

Yet another female patient who was admitted to Ward 4K in or around 2014 or 2015 told us that one night Mr Griffin said he needed to check her heart lead stickers and he touched her breast. She said there was no need for Mr Griffin to touch her breast because there were no lead stickers on them.[1020] She also noted that other nurses had previously asked her to check these stickers herself.[1021] The patient recalled:

> That night I called my mum crying and told her I was scared. When mum came up, I was surprised to see her in the morning. I couldn't remember ringing her. I believe that I must have been under the influence of drugs. Mum says I told her what Jim had done and begged her not to leave me there.
>
> Mum stayed that night in the bed next to me. Later she said during the night Jim entered my room and immediately left when he saw my mum.[1022]

In a separate submission to us, this patient's father outlined these same events and described Mr Griffin as giving him 'the creeps'.[1023]

Another female patient who was admitted to Ward 4K at a young age in the mid-2010s recalled that Mr Griffin, who was her night nurse, showed 'inappropriate favouritism to her' by not requiring her to comply with a medical plan.[1024] She further recalled that Mr Griffin:

- touched her breast and buttocks while undertaking observations[1025]
- frequently visited her even when he was not her assigned nurse[1026]
- sat on her bed and rubbed her leg and inner thigh 'towards my vagina' when her parents were not present[1027]
- gave her back rubs and called her 'baby girl', 'darling' and his 'special girl'[1028]
- insisted she change into a hospital gown in his presence, when other nurses would give her privacy[1029]
- tied her hospital gown at the back and touched her buttocks and the side of her breast while doing this, saying 'don't tell anyone', 'that's what friends do', 'this is our thing' and 'this is our little secret'.[1030]

This patient recalled expressing multiple times that she did not want a male nurse. The patient understood that this request was passed on to the Nurse Unit Manager by her mother, but Mr Griffin continued as her nurse.[1031] The patient said that she complained directly to the Nurse Unit Manager about Mr Griffin touching her but that the Nurse Unit Manager 'was dismissive' and 'brushed off my concerns', saying words to the effect of 'he's just a nurse. You know he has to touch you in those places'.[1032]

The patient also told us that she complained to the Nurse Unit Manager about Mr Griffin watching and talking to her when she showered and insisting on drying her off, which other nurses did not do.[1033]

She recalled also telling a senior nurse that she was uncomfortable with Mr Griffin calling her 'darling' and 'baby'.[1034] She said the senior nurse responded with words to the effect of 'oh, that's fine, Jim just says things like that', which she said made her feel she was acting strangely for bringing it up.[1035]

The patient further described Mr Griffin befriending her family members and 'welcoming himself into our family and making himself a part of our lives by stepping in and acting as a father or grandfather figure'.[1036] She told us that Mr Griffin abused her outside the hospital.[1037]

Another female patient who was admitted to Ward 4K in 2018 told us that 'Jim did lots of touching and showed lots of interest in me'.[1038] She described Mr Griffin:

- being 'overfriendly' and calling her 'baby girl' and his 'special girl'[1039]
- sitting on her bed on top of the covers and touching her upper thigh while a parent was present[1040]
- frequently checking in on her when he was on shift[1041]
- helping her shower[1042]
- coming into her room, touching her leg and moving his hand slowly towards her vagina.[1043]

This patient also described instances of grooming and abuse by Mr Griffin outside of the hospital.[1044]

Another patient who made a submission to us said Mr Griffin sexually abused her on Ward 4K during the 2010s while she was an inpatient. She said she had numerous admissions, sometimes for lengthy stays.[1045] She did not provide further details.

In 2005, a young woman disclosed childhood sexual abuse (which occurred outside the hospital) by Mr Griffin to her general practitioner. She told us:

> My reason for seeking his help, other than for personal reasons, was because I was aware James Griffin was employed at Launceston General Hospital in the paediatrics ward. I was concerned he would come into contact with children through his work.[1046]

This woman described her doctor being somewhat surprised by her disclosure because he knew Mr Griffin through local sport. The doctor arranged a referral for her to sexual assault support service, Laurel House, and told the woman he would 'take care of' the issue of Mr Griffin working in the hospital.[1047]

When she came back to the doctor for an appointment sometime later, she recalled the doctor telling her words to the effect of 'you don't need to be worried about LGH'.[1048] She told us:

> When he said this I felt relieved. In my mind I reconciled that I must be the only victim. My GP didn't tell me who he had spoken to or elaborate on why I didn't need to worry. I trusted my GP and felt reassured by what he told me so didn't take it any further with him. I now wish I had asked more about the steps he had taken, but in a way, it was the answer I was expecting because I always thought it was only me.[1049]

She didn't discuss the matter with the general practitioner again and, shortly after, moved away and changed doctors.[1050]

When we contacted this general practitioner, he stated that he had no recollection of this woman's disclosure and had no clinical records to refer to because his records had been handwritten and were lawfully destroyed following the relevant retention period.[1051] We could not confirm whether the doctor contacted Launceston General Hospital about the disclosure.

4.4 Findings

Below, we make a series of findings about the appropriateness of Launceston General Hospital's response to concerns and complaints about Mr Griffin, as well as the systems and processes the hospital used in response to complaints. As noted above, all these findings are based on recorded and acknowledged complaints alone.

Finding—Launceston General Hospital failed to manage the risks posed by James Griffin

There were at least 14 complaints that related to breaches of professional boundaries and confidentiality and of sexualised, unprofessional behaviour by Mr Griffin during his time at Launceston General Hospital. These were never escalated beyond an education and direction response. Launceston General Hospital was on notice to the potential that Mr Griffin posed a serious risk to children and young people—at least from 2011 or 2012, when Ms Pearn made her disclosure, if not before—and should have known this posed a risk to patient safety. In the following findings we identify different aspects of this failing.

Finding—Launceston General Hospital leadership collectively failed to address a toxic culture in Ward 4K that enabled James Griffin's offending to continue and prevented his conduct being reported

From late 2008, we understand there was a hostile working environment in Ward 4K. Throughout our report we have highlighted how the culture of an organisation can enable abuse to occur, as well as prevent it being reported or appropriately dealt with when it does occur. In Chapter 13, we have also described a range of cultural problems that have been highlighted in previous reviews that show significant cultural problems existed within Tasmanian health services, including Launceston General Hospital. We continued to observe many of these problems in our examination of this case study.

The specific culture of Ward 4K, as described to us by many witnesses, combined with the 'hands off' nature of the senior nursing management, created an environment that enabled Mr Griffin to offend unabated. Ms Leonard acknowledged this, stating that the culture and conflict on the ward was 'a perfect storm for Mr Griffin to take advantage of'.[1052] Ms Leonard also described feeling groomed by Mr Griffin and him taking advantage of the poor culture of the ward:

> I have a lot to learn, as we all do, and part of the challenge in responding is that I feel deep, deep, deeply that we were deceived, we were manipulated, and we were sold a version of Mr Griffin that he wanted us to believe; and, unfortunately with all of the distractions and the difficult personalities and the difficult situations on the ward, it's—I feel that it might have opened up opportunities for Mr Griffin to take advantage of and manipulate us.[1053]

There were at least 14 complaints about Mr Griffin's unprofessional behaviour that were never properly escalated. We suspect there were many more concerns that were raised and not addressed or not raised at all. The culture of an organisation is the responsibility of leadership. We find there was a collective failure of leadership in not addressing this toxic culture at Launceston General Hospital.

Finding—Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin

Each complaint about Mr Griffin was responded to as if it was the only complaint, rather than one in a series of regular boundary breaches against vulnerable children. This meant that the cumulative effect of concerns about Mr Griffin's conduct were not considered and escalated. Professional boundary breach complaints should not be considered as separate individual incidents—such an approach misses the cumulative weight of past complaints or patterns of behaviour when assessing individual

complaints. This is a significant deficit because grooming-related boundary violations often involve multiple individual incidents that on their own may be interpreted as innocuous or one-off instances of poor judgment.

When Ms Pearn's serious complaint was made against Mr Griffin in 2011 or 2012, if not earlier, Launceston General Hospital leadership should have been briefed to support a formal disciplinary response to Mr Griffin under Employment Direction No. 5 for a breach of the State Service Code of Conduct. Around the time we estimate Ms Pearn's disclosure occurred, there were at least seven complaints about Mr Griffin's conduct of breaching professional boundaries. There should have been an escalation to the leadership about the cumulative effect of the concerns to enable an increase in the sanctions imposed on Mr Griffin for repeated unprofessional behaviour.

We accept that in early 2009 some effort was made to consider previous complaints, but only a formal letter was sent to Mr Griffin—there was no evidence of a formal briefing to anyone in the executive. This was the sixth letter sent to Mr Griffin about similar concerns.

In 2017, there were also efforts to collate previous complaints about Mr Griffin, but again, there was no evidence that the leadership was informed about this consolidation of complaints, nor was Mr Griffin reported to Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme (after 2014) or the Nursing Board/Ahpra.

There were several options for reporting Mr Griffin's behaviour. While we accept that many of the individual complaints against Mr Griffin may not have been enough in and of themselves to warrant a report to Child Safety Services, the Nursing Board/Ahpra or the Registrar of the Registration to Work with Vulnerable People Scheme, if the cumulative effect of Mr Griffin's conduct had been considered, a report to external agencies would have been warranted. Alternatively, if Mr Griffin's cumulative conduct had been reported to leadership, it is more likely that the hospital would have treated Mr Griffin's conduct more seriously, triggering a report to these external agencies.

Finding—The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct

None of the numerous concerns raised with Mr Griffin resulted in a disciplinary response harsher than a letter, education and direction. A disciplinary process was only recommended when there was no other option but to do so, namely, when Mr Griffin was unable to perform his duties when his registration to work with vulnerable people was suspended on 31 July 2019. Ms Leonard described the

focus on further education and maintaining professional boundaries as being 'most generous to Mr Griffin' and that in hindsight 'it is difficult to consider the actions in relation to [the] complaints made about Mr Griffin [to be] adequate'.[1054]

Mr Griffin's continual noncompliance with management directions was not even treated as a performance management issue. At least seven of Mr Griffin's Performance and Development Agreements, all of which were positive about his performance, made no mention of his conduct or the reprimands he had received, which suggested efforts to address his behaviour were not embedded, formalised and documented. Despite Mr Griffin being disciplined through counselling and letters in response to numerous concerns about his behaviour, endorsements of Mr Griffin's Performance and Development Agreements would have given Mr Griffin the impression that management was satisfied with his performance.

We consider that allowing Mr Griffin to act as a supervisor of nursing students and to continue to receive development opportunities and assume greater seniority and responsibility sent the wrong message to Mr Griffin. It had the practical effect of undermining the credibility of management's warnings and would have reinforced Mr Griffin's view that there would be no meaningful consequences for his actions.

In addition, Mr Griffin continued to breach professional boundaries with patients even after being asked to stop (in some instances, in writing). Section 9(6) of the State Service Code of Conduct requires employees to comply with any lawful and reasonable direction given by a person having authority to give that direction.[1055] We consider Mr Griffin's continued non-compliance with instructions from his nurse unit managers was likely to have constituted a breach of such a direction, and we consider this would have been sufficient cause for disciplinary processes to be initiated for a breach of the State Service Code of Conduct.

Finding—Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem

We were struck by the relative invisibility of management in the responses to Mr Griffin. We received evidence that senior managers, despite for many years having had responsibilities over Ward 4K or for medico-legal matters, had little to no idea about Mr Griffin's complaints history.

Helen Bryan, who held the role of Executive Director of Nursing said that 'no informal concerns were raised with me in the early stages but in hindsight they should have been'.[1056] In relation to her reported lack of knowledge about Mr Griffin's conduct, Ms Bryan stated:

> Without being able to comment on the specifics of the complaints, I have a general concern that some of the ward staff who received complaints and/or concerns … from staff, patients and/or families did not appropriately escalate those matters and therefore the response to those matters would have been inadequate. I appreciate that this could have had a significant impact on whoever made the complaint.[1057]

Ms Bryan and Eric Daniels, the then Chief Executive responsible for Launceston General Hospital (noting he began this role in 2016), also told us they were not aware of any concerns about Mr Griffin until 2019.[1058]

As we heard from Professor Erwin Loh, Group Chief Medical Officer and Group General Manager, St Vincent's Health Australia, who is an expert in clinical governance and management of complaints and conduct concerns:

> If senior management isn't aware of problems at the ward or unit level, this is generally because middle managers are only sharing the good news … or they're incompetent or ineffective. Either way, it's a problem for senior management. Senior management has to do its bit to ensure that middle managers have what they need to be effective (e.g. funding and workforce resources).[1059]

Janette Tonks, Nursing Director of Women's and Children's Services from 2013 until 2022, conceded that a culture of active and visible leadership 'certainly could have been done a whole lot better' at the hospital.[1060] During oral evidence, Mr Daniels also conceded that there was a catastrophic failure in management, structures and processes at Launceston General Hospital.[1061] Mr Daniels later said that he was unable to explain his answer fully during his oral evidence and has reiterated that he 'had not been made aware of the nature of, nor extent of many of the allegations'.[1062]

Finding—Launceston General Hospital did not have a robust system for managing complaints involving child safety

As noted above, there were at least 14 complaints about Mr Griffin during his employment at Launceston General Hospital that we could find some record of.

We note that the failings in the responses of some individuals to complaints about Mr Griffin were partly a consequence of inadequate policies, processes and systems at the hospital. It is obvious to us that there was no clear and consistent approach to managing complaints about Mr Griffin. Ms Bryan told us:

> … in my opinion we do not have good systems and we do not have good processes, we do not have record keeping and documentation, and we don't have the resources within the organisation with the expertise and experience to handle such situations.[1063]

Standards of behaviour for staff working in child-facing roles should have been in place so that Mr Griffin's conduct could be transparently assessed, and disciplinary action triggered, in response to his repeated failures to comply with the standards.

The State Service Code of Conduct is not sufficient to assess child safety complaints, given its very general nature. In particular, a professional conduct policy would have assisted in identifying boundary breaches that might amount to grooming behaviour.

We note that Ms Leonard recognised the absence of such standards in 2009 when she initiated a professional boundaries protocol for Ward 4K. We do not consider it should have fallen to a role-holder at Ms Leonard's level to have to address this gap—this should have been a hospital-wide policy (or indeed, a statewide departmental policy).

Management's inconsistent approaches to recording and documenting complaints had the effect of fragmenting and isolating important information about Mr Griffin, which made it difficult to identify a pattern of conduct and to respond decisively to his offending.

Complaints against Mr Griffin were not recognised as a patient safety concern that should be consistently recorded in the Safety Reporting and Learning System. Logging the complaints in this system would likely have increased visibility and oversight of Mr Griffin's behaviour and generally improved the integrity of the hospital's response.

Further, the hospital did not have a defined pathway for escalating complaints. Nursing staff were not guided on what kind of incidents should be reported, to which bodies and by whom, and local managers were not guided as to when they should tell human resources and/or nursing management about a complaint. The absence of a defined pathway for escalating complaints contributed to failures by local managers or ward staff to involve other parties consistently in responding to complaints.

The informal and ad hoc practice of escalating some complaints and not others allowed local managers too much discretion about what they escalated, to whom and when. This lack of formality was a particular risk given that managers may have, at times, had self-interested reasons for not alerting their superiors to problems on their ward and because managers appeared to have had little training for determining the potential seriousness of complaints.

While we accept that policies and systems play an important role in any organisation, we also consider that it was incumbent on managers to apply their common sense and professional judgment in response to complaints. If the hospital's systems were not working, managers should have raised their concerns with those empowered to rectify them.

We discuss recent reforms to complaint management processes in Chapter 15.

Finding—Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies

During the time that Mr Griffin was employed at Launceston General Hospital, not one of the internal complaints against him resulted in any referrals or notifications to external agencies such as Child Safety Services, the Tasmanian Nursing Board, Ahpra or the Registrar of the Registration to Work with Vulnerable People Scheme. This hampered the ability of external agencies to scrutinise Mr Griffin's behaviour and to identify continuing risks to child and patient safety.

Matthew Hardy, National Director, Notifications, Ahpra, advised us that the agency received its first (and to that point) only notification about Mr Griffin from Dr Peter Renshaw on 1 August 2019.[1064] Mr Hardy said:

> I am sympathetic to the view that the subsequent alleged extent of Mr Griffin's offending against children, if known to others, could have been acted on sooner had appropriate disclosures have been made to law enforcement, or our agency. I regret that we were not informed of the concerns well before the ultimate notification in August 2019.[1065]

Ms Leonard attributed the failure to notify external agencies about Mr Griffin's conduct to there not being 'an openness that there is today around engaging with those regulatory bodies'. She told us that the tendency was to keep problems in house.[1066] Ms Bryan observed that the hospital did not manage the issue of child safety well and needed to improve, adding:

> Could I guarantee that every nurse, and I'll talk nurse, in our organisation is fully aware of their responsibilities? And I'll be honest and I'll say I couldn't sit here with hand on heart and say yes: I'm going to say no.[1067]

Across the period from 2000 to 2019, there were multiple avenues for reporting Mr Griffin's behaviour, including some mandatory reporting obligations. These reporting options included:

- reporting to a police officer the abuse of a child, noting the offence of failing to report the abuse of a child without a reasonable excuse was only introduced on 2 October 2019[1068]
- informing Child Safety Services (or its predecessor), the Secretary with responsibility for Child Safety Services or a community-based intake service, pursuant to section 13 of the *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act'), noting that there is only an obligation to 'inform' (including making a report) if the person 'knows or gains knowledge, or believes or suspects on reasonable grounds, that a child is suffering, has suffered or is likely to suffer abuse or neglect'[1069]

- informing and/or making a mandatory report to Child Safety Services, the then Communities Tasmania Secretary or a community-based intake service as an employee of a government agency that provides health services under section 14 of the Children, Young Persons and Their Families Act, noting that there is only an obligation to report when, in carrying out official duties or in the course of their work, the employee 'believes, or suspects, on reasonable grounds, or knows … that a child has been or is being abused or neglected'[1070]
- making a complaint to the Nursing Board of Tasmania from 24 November 1995 to 1 July 2010, noting that this would have been a voluntary complaint in circumstances where a person 'is aggrieved by the conduct of a nurse'[1071]
- mandatory reporting to Ahpra from 1 July 2010 to present, noting that during this time registered health practitioners have been subject to mandatory reporting obligations, including the obligation to notify Ahpra if another health practitioner 'forms a reasonable belief' that a 'second health practitioner has engaged, is engaging, or is at risk of engaging, in sexual misconduct in connection with the practice of the practitioner's profession'.[1072] There is also an option for any person to make a voluntary report to Ahpra in circumstances including, among other things, where a registered health practitioner's professional conduct is or may be of a lesser standard than what might be reasonably expected by the public or the practitioner's professional peers; or the practitioner is not, or may not be, a suitable person to hold registration in the health profession because, for example, the practitioner is not a fit and proper person to be registered in the profession[1073]
- making a report of a registered person that has 'engaged, or may have engaged, in reportable behaviour', even if that behaviour was raised to the Registrar of the Registration to Work with Vulnerable People Scheme before or after 27 November 2015.[1074] Reportable behaviour is 'behaviour that poses a risk of harm to vulnerable persons, whether by reasons of neglect, abuse or other conduct'.[1075]

We note that even if, on the facts, there was not a mandatory reporting obligation to some of these bodies, best practice would be to make a voluntary report in a broader range of circumstances.

It was difficult to determine if there were formal policies relevant to the hospital's reporting obligations. In any event, the evidence we heard from several Launceston General Hospital nursing staff suggests there was no clear system, procedure or process in place for reporting concerns about a colleague's conduct during Mr Griffin's employment. This reflects that there was either no relevant policy or that it was

not embedded and followed. As a result, ward staff, nurse unit managers, senior management and members of the executive were not aware of their distinct roles and responsibilities in relation to reporting and could not appropriately guide and support staff on the issue.

The hospital did not have reporting protocols in place to ensure complaints of misconduct, such as those made against Mr Griffin, were reported to Child Safety Services, the Tasmanian Nursing and Midwifery Board, Ahpra or the Registrar of the Registration to Work with Vulnerable People Scheme.

Hospitals should have systems, procedures and processes in place to ensure staff comply with mandatory reporting and to educate and support individual staff members on such reporting. There needs to be a clear process of responsibility for reporting and documented escalation of matters within an organisation. In addition, an organisational reporting protocol should not mean staff cannot make a mandatory report themselves when they have concerns. They can and should.

We discuss recent reforms to support mandatory reporting obligations in Chapter 15.

4.5 Other matters relating to Mr Griffin between 2000 and 2019

4.5.1 Allegations of Mr Griffin's misuse of medication

In light of information from the Australian Federal Police, victim-survivor Tiffany Skeggs and a hospital colleague that Mr Griffin used medication that he sourced from the hospital in his abuses, we enquired further about medication protocols and practices on Ward 4K.

As earlier outlined, in 2015 Australian Federal Police traced chat logs to Mr Griffin in which he identified that he was a nurse who used antihistamines to stupefy his victims before sexually abusing them.[1076] Ms Skeggs told us that Mr Griffin would steal medications from the hospital or ask inexperienced nursing staff to sign out medication for him.[1077] She said that Mr Griffin was very open about the fact that he never paid for medications and simply took them from the hospital.[1078] Ms Skeggs added that:

> The medication that he had included antihistamines, anti-psychotics, numerous types of sleep medication, pain relief including high strength anti-inflammatories, Panadol, tramadol and panadeine forte. He would hand the medication out to myself and other children.[1079]

Ms Skeggs stated that numerous nursing staff told her that Mr Griffin would steal medications, but that they were afraid to come forward because of the potential consequences for not earlier reporting such breaches.[1080] She also relayed that a Ward

4K nurse had told her that they had witnessed Mr Griffin give a patient medication against doctor's advice and take medications (including the sedating controlled drug Rohypnol) out of the hospital.[1081]

We also heard, as previously outlined, that Mr Griffin's administration of medication was unsafe and unprofessional in at least one instance when he encouraged a colleague to taste a restricted medication and then referred to it as a 'date rape drug' to the father of a patient. Another patient described feeling like she was under the influence of heavy drugs while being cared for by Mr Griffin (refer to Section 4.3.4).

We asked Ms Leonard, Ms Bryan and Ms Tonks about how medication was secured and dispensed on Ward 4K to ascertain how Mr Griffin's procurement of medication could have occurred. Ms Bryan and Ms Tonks had limited information to contribute, noting that they were not performing clinical roles on the ward.

Ms Leonard told us that, in her experience, policies and procedures about storing and dispensing controlled drugs, which are subject to strict access and dispensing controls under legislation, 'were generally adhered to'.[1082] Ms Leonard told us that when she started on the ward in 1999, controlled drugs were stored in a double-locked cupboard in a secured room.[1083] If someone wanted to get medications from the cupboard, they would need to ask the nurse in charge, who carried what were referred to as the 'red keys'.[1084] However, Ms Leonard said that if the nurse in charge was busy or unavailable, they would give the 'red keys' to a registered nurse who would (or should) return them as soon as possible.[1085] She said it was 'possible' to remove drugs undetected under this old system.[1086]

From around 2014, a more secure system was introduced, which required swipe access that was traceable to the individual staff member. Any discrepancies in medication access or stores could then be checked against those who accessed the drug cupboard during the relevant times.[1087] Ms Leonard said that when this system was introduced it was 'common practice' for a second nurse to witness the removal of drugs.[1088]

However, in her statement, Ms Leonard gave an example of when the integrity of the system was compromised:

> I understand there was a SRLS event where discharge medication that had been delivered in the late afternoon by the pharmacist was found to be missing from the Ward 4K drug room when nursing staff were preparing the patient for discharge. I am unable to verify the date this incident took place, however having spoken to [a colleague] I understand it is likely to have occurred prior to 2017. Upon investigation, it was determined that the nursing staff working the late and night shifts had been wedging the swipe card access door open with a towel to prevent it from slamming and waking up nearby patients and families. The event was logged, investigated (including by Tasmania Police) and ultimately processes were changed to ensure that appropriate control measures were in place regarding the safety of controlled medications.[1089]

When Ms Skeggs' assertion that Mr Griffin was stealing drugs from the hospital was put to Ms Leonard, she responded that if this were occurring it would have been detected in the controlled drugs count, which occurred daily. She further replied that any discrepancies in the count were required to be logged on the Safety Reporting and Learning System.[1090] At hearings, Counsel Assisting asked how other drugs, such as antibiotics or antihistamines, which were not subject to particular regulation, were stored and accessed. Ms Leonard said that such drugs were also stored within the secured room, which required swipe access, but that there was no formal reconciliation of stock levels like there was with controlled drugs.[1091]

Ms Tonks told us in her statement that since Ward 4K's redevelopment in 2021, there are two drug rooms that each have swipe card access and are video monitored, providing greater security and traceability of improper access.[1092] Ms Tonks also confirmed that this level of security extends to non-controlled drugs.[1093]

Finding—James Griffin had the ability to take and misuse medications from Launceston General Hospital

We did not find conclusive evidence that Mr Griffin took and misused medications from the hospital, and we have no way to verify that he did. No staff came forward to disclose that they witnessed thefts or otherwise facilitated Mr Griffin's access by not following appropriate procedures for signing out and administering drugs. However, based on the evidence heard, we consider that Mr Griffin did have the ability to take and misuse medications from the hospital. We consider that access (and use) of medications is a unique risk that arises in the context of health practitioners.

4.5.2 1 May 2019—Tiffany Skeggs reports Mr Griffin's abuse to Tasmania Police

On 1 May 2019, a now-adult Ms Skeggs contacted Tasmania Police in Hobart and reported Mr Griffin's sexual abuse of her when she was a child.[1094] On 7 May 2019, Ms Skeggs gave a formal statement to Hobart police.[1095] The Department was not aware of Ms Skeggs' complaint until 31 July 2019 (discussed in Section 5).

Ms Skeggs told police that she met Mr Griffin when she was about eight years old at her netball club, where he volunteered.[1096] Ms Skeggs formed a close friendship with Mr Griffin, which extended to going to his house and joining him on camping trips.[1097] Mr Griffin started abusing Ms Skeggs when she was 13 years old. At this time, he advised her on how to covertly communicate with him via an app on her phone.[1098] The sexual abuse of Ms Skeggs by Mr Griffin continued up until, or soon after, Ms Skeggs turned 17.[1099]

Ms Skeggs told us that Mr Griffin was able to groom her because she lacked the 'family stability' required to protect her and that he 'secluded me and generated maximum distance between me and my family and friends'.[1100] Ms Skeggs also stated that Mr Griffin used her interests, such as in Australian military history, to lure her in.[1101] Ms Skeggs said 'he provided me with all the attention a young girl could possibly want'.[1102] Ms Skeggs described Mr Griffin as having 'perfected the art of grooming children'.[1103]

Ms Skeggs' statement against Mr Griffin was not transferred to the Northern CIB until early July 2019 because the officer taking the statement was 'waiting for Ms Skeggs to provide some more information'.[1104] Launceston Police received the statement on 18 July 2019, and on 19 July 2019 it was allocated to Detective Senior Constable Glenn Hindle to investigate.[1105]

In commenting on the impact of her disclosure to police, Ms Skeggs said that 'from a personal perspective I regret opening my mouth', but she went on to say, 'I would do it all over again in a heartbeat to help others and create the change that is happening now'.[1106]

5 Launceston General Hospital's response to revelations about Mr Griffin's offending

Section 4 provides useful context for what various people already knew, including Launceston General Hospital staff, about Mr Griffin's offending behaviour towards children. In this section—Section 5—we focus on the response of Launceston General Hospital to the police investigation into child sexual abuse by Mr Griffin and continuing concerns among staff and victim-survivors about how the hospital managed prior complaints about Mr Griffin. The report Tiffany Skeggs made to police, described in Section 4.5.2, triggered the police investigation.

On 31 July 2019, Mr Griffin's registration to work with vulnerable people was suspended due to the police investigation. This suspension was ultimately the catalyst for action by Launceston General Hospital because it legally prevented Mr Griffin from performing his employment duties.

News of a police investigation into Mr Griffin for child sexual abuse should have been a matter of significant concern to the executive at Launceston General Hospital and treated as a critical incident. The hospital was aware that Mr Griffin was a longstanding employee, having worked as a paediatric nurse at the hospital since 2001, and that he had the opportunity to form close relationships with young patients over the years. As we describe in Chapter 13 about the particular risks that can arise within health services, Mr Griffin's role as a nurse gave him unique opportunities to abuse children.

The hospital would also have been aware that once Mr Griffin was charged, which occurred in September 2019, there would be significant public concern about his role as a paediatric nurse, with attendant reputational and potential legal risks for the hospital.

We acknowledge that responding to an event such as this is never easy and is rarely perfect. There are complex issues to manage, among them the need to respect confidentiality where justified to ensure sensitivity to victim-survivors (and potential victim-survivors), and to take care not to compromise a police investigation. There is also an understandable desire not to alarm or distress people unnecessarily or to inadvertently create harmful misinformation, particularly where information is emerging in a developing situation. Managing information effectively can also be challenging in a small community, where information can be shared quickly and informally and can sometimes become distorted as it passes through multiple people. We recognise that most organisations are not well equipped to respond to events of this scale and complexity, given their relative infrequency. We kept all this in mind when reflecting on the hospital executive's unenviable task.

When a police investigation arises in relation to child sexual abuse and the suspect is (or was) in a child-facing role, we consider it irrelevant whether the alleged conduct occurred within, or in connection to, the workplace. We also consider it irrelevant whether any complaints of child sexual abuse were 'historical' in nature. The starting point for any organisation's response is assessing and responding to any risks to children in the organisation's care. In this case, this extended not only to managing the immediate risks Mr Griffin posed (before his death) but also in assessing—to the extent possible—whether his conduct may have affected current or former patients.

A police investigation can act as a trigger for an organisation to review its child safeguarding systems. If approached with care and a genuine desire to protect children, a 'root and branch' review can uncover previously unknown abuses and harms. Failures can be acknowledged and affected victim-survivors appropriately supported. Improved child safeguarding strategies and practices can then be adopted and implemented to protect children from future risk.

The hospital's response to Mr Griffin's suspension and the circumstances surrounding it was primarily led by its then Executive Director of Medical Services, Dr Peter Renshaw, with assistance from the human resources team. We heard that Dr Renshaw assumed leadership of the hospital's response because of his medico-legal responsibilities. He was the liaison for Tasmania Police and the person responsible for key briefings to the Secretary of the Department on 31 July 2019 and 5 November 2019.

At our hearings, Counsel Assisting asked an expert in health service governance, Professor Erwin Loh, whether, in his experience, responsibility for medico-legal matters tends to sit with a single hospital executive member or across several individuals.

Professor Loh said good governance requires that a single executive member is clearly accountable for such issues but that they should work in a team and draw on the expertise of others.[1107]

Rather than working to understand the scale of Launceston General Hospital's failure to act on potential risks that were known about Mr Griffin and examine the systems, processes and practices that contributed to that failure or even to identify victim-survivors and offer them support, the evidence suggests that the hospital worked to downplay its knowledge and distance itself from Mr Griffin. This was evident in the failures to conduct a prompt and thorough review of all the information the hospital held about Mr Griffin's complaints history and to ensure briefings up the line about the hospital's knowledge of the potential risks Mr Griffin posed to former patients were accurate and comprehensive. Indeed, the hospital only conducted such a 'review' reluctantly, after staff activated the union into advocating for greater transparency.

Much of the leadership of the hospital was noticeably absent from the response to Mr Griffin's offending. We did not receive evidence (or meeting minutes) to suggest this issue was regularly discussed by hospital leadership. The then Chief Executive Eric Daniels and then Executive Director of Nursing, Helen Bryan, in particular, were not referenced by witnesses to our Inquiry, and their names did not often appear in the documents we reviewed relevant to the hospital's response to Mr Griffin's offending. In their evidence to us, they appeared to have little knowledge of the situation; it seemed that they learned the extent of Mr Griffin's offending from *The Nurse* podcast and from our hearings.

The practical effect of their absence from the response is that the evidence we received focused more on the conduct of those who were directly involved, including many who were significantly more junior than those tasked with the hospital's governance.

In some of these findings we include evidence to provide context or to show an enduring problem that predates leadership role-holders at Launceston General Hospital at the time Mr Griffin's offending became known.

We make specific findings that Dr Renshaw misled superiors, including Secretary Morgan-Wicks, in failing to escalate critical information he received about Mr Griffin's behaviour. We also find Dr Renshaw misled our Commission of Inquiry.

In Chapter 15, we discuss the expert evidence we received about responding to critical incidents and recommend that the Department develops a critical incident response plan to respond to traumatic events such as this (refer to Recommendation 15.19). The absence of a plan like this leaves an organisation at risk of compounding trauma and distress when such an event does occur. This is what happened at Launceston General Hospital.

5.1 Overview of Launceston General Hospital's leadership response

Several members of the hospital's leadership indicated to us that they were largely unaware of the extent of Mr Griffin's complaints history until our hearings, which occurred more than three years after Mr Griffin's registration to work with vulnerable people was suspended.

We saw no evidence that Launceston General Hospital took steps to promptly and thoroughly review Mr Griffin's complaints history to satisfy itself of what was known to the hospital about him and to determine whether there was any indication that children may have been harmed under his care.

We requested minutes from any executive meetings at which Mr Griffin was discussed and were told that none existed.[1108]

Ms Bryan told us that she was not aware of any investigations into Mr Griffin's conduct after 31 July 2019: 'I didn't see a report; I had no further input or feedback. I got a lot of my information from the two podcasts I listened to'.[1109] Ms Bryan agreed that although she should have been given more information about the matter, it was an omission on her part not to have sought further information.[1110] Ms Bryan told us that the hospital did not have good systems and processes in place—including in relation to record keeping, resourcing and expertise within the organisation—to respond to situations of this nature.[1111] She agreed that there was a complete failure of senior leadership to respond appropriately to Mr Griffin's conduct.[1112] Ms Bryan later told us that she considers that, since 2022, the hospital has taken steps to improve its systems and processes in relation to child safety.[1113]

When Counsel Assisting asked Dr Renshaw, in September 2022, what changes were made to the hospital's systems and processes in the aftermath of Mr Griffin's suspension, he replied: 'I'm not certain that there have been any marked changes'.[1114] When he was asked how he could be sure the hospital was safe considering this observation, he responded: 'As I'm not aware of any formal action items and what they would be intended to achieve, I really can't answer that.'[1115]

Mr Daniels acknowledged that as the hospital's Chief Executive he had an obligation to ensure Launceston General Hospital was safe.[1116] However, when Counsel Assisting asked why he did not initiate a robust investigation once allegations about Mr Griffin emerged on 31 July 2019, he responded: 'I can't answer that, I'm sorry'.[1117] He added that he believed the police investigation would have acted as an external review.[1118] Mr Daniels later told us that he did not have the opportunity to fully explain his answer in oral evidence and reiterated that he was not aware of the nature or extent of many of the allegations until our hearings.[1119]

Finding—The response of Launceston General Hospital to revelations about James Griffin's offending was passive and ineffective

Senior leaders appeared to have a complete lack of curiosity or sense of duty to examine the systems, practices, policies and work cultures that may have contributed to Mr Griffin continuing to work on the ward for 18 years, despite a series of concerns (many documented by the hospital) about his behaviour. The police investigation into Mr Griffin should have been a catalyst for the hospital's leadership to review child safeguarding systems and processes more broadly at the hospital—and to learn and improve, based on weaknesses uncovered. Yet at no stage did any member of the hospital's leadership seek to comprehensively and independently investigate whether the risks Mr Griffin posed to children could have been foreseen and whether the hospital had the best possible policies, practices and systems in place to safeguard its child patients. Most of this information would have been readily discoverable had the hospital's leadership taken an active interest.

We find that the following should have occurred when the hospital was alerted to the police investigation:

- The risk posed by Mr Griffin, particularly following the laying of charges against him on 17 September 2019, should have been explicitly discussed at executive meetings. Such discussions would have prompted better information sharing between the broader team and provided grounds for a considered and collective response.
- The hospital should have overseen a thorough and rigorous review of all complaints relating to Mr Griffin, rather than relying on the manifestly deficient reviews undertaken by the human resources team (described later in this section), which arguably held a conflict of interest given its role in responding to complaints to Mr Griffin in the past. Such a review would have revealed several systems, process and cultural barriers to effectively managing complaints. These issues should have been escalated to Mr Daniels and the Secretary.
- The hospital should have developed a response strategy to the police investigation of Mr Griffin, including a plan for communicating with staff (particularly Ward 4K staff), patients, their families and the public. This strategy should have anticipated different scenarios—for example, if Mr Griffin was convicted or acquitted—and recognised the ways in which the hospital's interests overlapped or differed from the police investigation (in having a broader systemic focus on safeguarding, for example). The plan

should have supported information sharing with Tasmania Police and other agencies, such as Ahpra, and developed strong information-sharing practices with all relevant agencies.

- The hospital should have taken proactive steps to determine the possibility that patients were harmed by Mr Griffin. This should have included reviewing Mr Griffin's complaints history (described in Section 4) and learning as much as possible from Ward 4K staff about any suspicions and concerns they may have held that could help the hospital determine if particular patients and their families should be contacted or provided with support. The hospital should have liaised with Tasmania Police throughout this process.

Finding—Leadership at Launceston General Hospital was dysfunctional and this compromised its collective response to revelations about James Griffin

We received evidence that the culture among the leadership at Launceston General Hospital was dysfunctional. This evidence provided further context to us for why the hospital's response to Mr Griffin's conduct was manifestly inadequate.

Former Executive Director of Nursing, Ms Bryan, described having 'very little involvement with the allegations relating to Mr Griffin' after 31 July 2019, despite Ward 4K being within her area of responsibility.[1120] She indicated that Dr Renshaw and the human resources team managed the response.[1121] She conceded that she should have been involved, given Mr Griffin was a nurse, but she described feeling 'disconnected' and 'not included in the process'.[1122] She said:

> I don't know [whether Dr Renshaw] deliberately excluded me, but … there were multiple meetings that I had become aware of either after the event that I was never invited to attend or included to attend; that doesn't dissolve my accountability and I accept that and I would do things very differently if this happened tomorrow.[1123]

Ms Bryan apologised for allowing others to exclude her from the process, stating that she 'probably' omitted to properly fulfil her responsibilities.[1124] We also accept Ms Bryan's evidence that Dr Renshaw excluded her, despite her being his peer on the executive.

Dr Renshaw initially did not agree that it was open to us to find that leadership at Launceston General Hospital was dysfunctional and had no clear focus on protecting children from sexual abuse.

Dr Renshaw told us:

> In my view, this was an absolutely unprecedented situation that … nobody had had any experience in, and yes, we muddled through, but it was not ideal. Probably what we could be criticised for was not being dysfunctional but not being resilient or flexible enough to try and work out better ways of ensuring the safety of children in the hospital as a result of this experience.[1125]

When questioned on this point by Commissioner Benjamin, noting (among other things) the evidence of leadership failures in Case study 2 (which occurred while Dr Renshaw was employed at the hospital), Dr Renshaw was invited to closely reflect whether he truly stood by the position he articulated above. He conceded it would be open for us to find that the leadership of the hospital was dysfunctional. We do so.

Finding—Launceston General Hospital did not have clear accountabilities for child safety

Elizabeth Stackhouse, a former Chief Executive Officer of Launceston General Hospital, told our Commission of Inquiry that, during her time in the role between 1998 and 2003, the hospital did not have any strategic plans, performance measures or key indicators that directly or indirectly related to child safety, including allegations of physical or sexual abuse of children.[1126] Dr Stephen Ayre, who was in the role from 2004 until 2008, could not recall whether or what plans were in place.[1127] John Kirwan, who acted in the role from mid-2008 until 2015, also told us that there were no indicators relating to child safety. He explained that, at the time, 'the focus was to move away from detailed input-based metrics to outputs and have the key strategic focus captured on one page'.[1128]

We saw no indication that one individual, committee or role-holder was responsible for ensuring child safety at the hospital.[1129] Ms Stackhouse could not recall whether there was a separate role-holder responsible for child safety during her tenure. She told us that patient safety generally, for adults and children, was monitored by the quality committee.[1130] Dr Ayre said that during his tenure 'the overall safety of the patients and staff at the hospital rested with the executive team and every staff member'.[1131] Mr Kirwan also did not recall the hospital having a specific role-holder responsible for child safety. He stated: 'If it was a requirement of the then National Safety and Quality Health Service accreditation standards, I am sure [there] would have been'.[1132] Despite this, he could not identify which roles held ultimate accountability for child safety.

A shared responsibility for child safety should not be interpreted as a diffused responsibility in which no one is ultimately accountable.

Speaking to the more recent governance arrangements at Launceston General Hospital, Mr Daniels wrote in his statement to us:

> There is no one specific committee for [child safety]. All governance committees with Hospitals North, inclusive of the LGH have oversight of child safety. All committees have representation from Women's and Children's Services, representing our paediatric patients. Paediatric needs and child safety issues are addressed under the umbrella of all consumers of our services through the application of the National Safety and Quality Health Service (NSQHS) Standards across all areas of service provision.[1133]

When giving evidence at our hearings, Mr Daniels said he had only recently become aware of some reports about Mr Griffin, and with that knowledge he would reconsider his views about whether the management accountability structures were appropriate. He said:

> [The hospital's governance is] not robust. … it doesn't provide the appropriate amount of accountability, and it doesn't provide for the sorts of things we've been discussing today in terms of ensuring that the safety of children in our care is appropriate.[1134]

We note that Mr Daniels, himself a registered nurse, admitted that he did not know what constituted grooming behaviours.[1135] He was also not familiar with the National Principles for Child Safe Organisations, which emerged from the National Royal Commission (described further in Chapter 18).[1136] He agreed that it was fair for us to conclude that child safety was not embedded in the leadership, governance and culture of the hospital and hadn't been for a number of years.[1137]

5.2 Timeline of response following the suspension of Mr Griffin's registration to work with vulnerable people

Figure 14.2: Timeline of Launceston General Hospital's response, 2019–2021

2019

July 31

Mr Griffin's registration to work with vulnerable people is suspended

Tasmania Police briefs Dr Renshaw and Mr Harvey

The Secretary of the Department is briefed about Mr Griffin's suspension

August 1

Dr Renshaw notifies the Australian Health Practitioner Regulation Agency about Mr Griffin

August 7

Mr Griffin's nursing registration is suspended and Tasmania Police advises the hospital of concerns for Mr Griffin's welfare

August 8

Mr Griffin resigns his role at Launceston General Hospital and surrenders his nursing registration

August 8–14

The then Secretary is briefed on Mr Griffin's resignation and provided advice on his disciplinary investigation

September 2019

Kylee Pearn makes a complaint to police about Mr Griffin

August–September

Tasmania Police investigate and charge Mr Griffin with child sex offences

October 11

Tasmania Police ask human resources staff about Ms Pearn's disclosure

October 8–14

The Acting Secretary is briefed on the status of Mr Griffin's criminal charges

October 18

Mr Griffin dies by suicide

October 29

Tasmania Police briefs Dr Renshaw further about child exploitation images taken on Ward 4K and about

October 29–November 5

The Secretary is briefed on a 'potential legal issue' relating to Mr Griffin

November

Human resources staff review complaints about Mr Griffin

November 21

The Integrity Commission notifies the Secretary of a complaint about Launceston General Hospital's management of complaints about Mr Griffin

2020

January 30

COVID-19 is declared a Public Health Emergency of International Concern

April–August

The Integrity Commission complaint is followed up

September 10

The Secretary responds to the Integrity Commission about its investigation of the complaint

October 13

The first episode of *The Nurse* podcast is released

October 14

The Secretary recommends an immediate review to the Minister for Health

October 22

The Department announces an independent investigation into the management of complaints about Mr Griffin

November 23

The intention to establish a Commission of Inquiry is announced

2021

March 15

Our Commission of Inquiry is formally established

5.2.1 1 July 2019—A search warrant is executed on Mr Griffin's property

On the morning of 31 July 2019, Tasmania Police executed a search warrant on Mr Griffin's property. During this search, police became aware that Mr Griffin sometimes looked after a former patient of the hospital, Penny (a pseudonym), including at his home.[1138] Tasmania Police was already aware of Penny because Ms Skeggs had expressed some concern for Penny's welfare after seeing Mr Griffin with Penny in a chance encounter before making her police report.[1139] She also told police that her concern for Penny was a motivation for making the report.[1140]

Detective Senior Constable Hindle told us that, on 31 July 2019, he shared information about Ms Skeggs' allegations, and the resulting search warrant on Mr Griffin's home, with two risk assessment officers from the Registration to Work with Vulnerable People Unit at the Department of Justice.[1141] The purpose of sharing this information was to expedite the immediate suspension of Mr Griffin's registration to work with vulnerable people.[1142]

On 2 August 2019, Detective Senior Constable Hindle submitted a Child Safety Notification to Child Safety Services, which noted Mr Griffin's care arrangement involving Penny.[1143] The purpose of the notification was to advise Child Safety Services of 'any perceived ongoing risk if exposed to [Mr Griffin] and allow them to act appropriately'.[1144] The notification was allocated to a Child Safety and Wellbeing worker for action.[1145] Detective Senior Constable Hindle was not aware whether Child Safety Services took any further action in response to his notification, and we have not examined this matter.[1146]

In his first statement to us, dated 21 June 2022, Detective Senior Constable Hindle did not mention Penny. At our prompting, after we became aware of Penny's connection to the hospital from other documentation, Detective Senior Constable Hindle told us about her in a subsequent statement, dated 9 November 2022. We understand that the initial omission was due to Detective Senior Constable Hindle's understanding of our request for statement, which asked for information about any formal complaints police had received about Mr Griffin in relation to child sexual abuse. While police held concerns in relation to her, Penny was not the subject of a formal complaint. However, we are of the view that it should have been clear to Detective Senior Constable Hindle when responding to our request for a statement that Tasmania Police's awareness of concerns about Mr Griffin's care of Penny (particularly given her status as a former patient of Mr Griffin's) would have been of particular interest to us.

At a briefing later this day on 31 July 2019, Detective Senior Constable Hindle told Dr Renshaw that police were concerned about Penny.[1147] Dr Renshaw made a commitment to police to confirm whether Penny was a former patient or if she may have had contact with Mr Griffin at the hospital.[1148]

Tasmania Police's knowledge of the care arrangement of Penny (and evidence it advised Dr Renshaw of this) is important because it ultimately formed part of the hospital's notification to Ahpra relating to Mr Griffin, referencing her status as a former patient.

It indicated that Dr Renshaw was aware from this point that Mr Griffin's offending was potentially connected to former patients of the hospital.

5.2.2 31 July 2019—Mr Griffin's registration to work with vulnerable people is suspended

On 31 July 2019, Dr Renshaw received an email notification from the Acting Registrar of the Registration to Work with Vulnerable People Scheme that Mr Griffin's registration had been suspended under the Registration to Work with Vulnerable People Act.[1149] While the notification did not mention a police investigation into sexual abuse nor provide any reasons for the suspension, Dr Renshaw told us he understood that the suspension had been precipitated by such a police investigation.[1150]

On receiving the email, Dr Renshaw immediately sought out Ms Bryan and Mathew Harvey (former Human Resources Consultant within the human resources team), who were in a meeting with union officials. Dr Renshaw asked to speak with Ms Bryan urgently.[1151] Ms Bryan excused herself from the meeting while Mr Harvey remained. After Mr Harvey concluded the meeting, he also joined the discussion with Dr Renshaw and Ms Bryan, as did Janette Tonks, the former Director of Nursing Women's and Children's Services.[1152]

Ms Tonks recalled being told at this meeting that the police were investigating an allegation of sexual assault involving Mr Griffin.[1153] She also recalled being advised that Mr Griffin's devices, including his computer, had been seized, which suggested to her that the police suspected there was child exploitation material on these devices.[1154] Ms Bryan's recollection of the meeting broadly accords with Ms Tonks' account.[1155] Both Ms Tonks and Ms Bryan described being 'shocked'.[1156] Ms Bryan added: 'I had no suspicion at all of any of this behaviour. Nothing had ever been raised at my office in relation to these allegations'.[1157]

At this meeting, Dr Renshaw asked Ms Tonks when Mr Griffin was working next, to ensure that Mr Griffin did not provide further care to children.[1158] Ms Tonks discovered Mr Griffin was, in fact, rostered to work that afternoon, so she went to the ward to wait for him.[1159] Seeing him there early, Ms Tonks asked Mr Griffin to go to Dr Renshaw's office, where Dr Renshaw advised him that because of the suspension of his registration to work with vulnerable people, he was not able to work. Dr Renshaw then requested that Mr Griffin leave the hospital.[1160] Dr Renshaw told us that this was the first and only contact he had with Mr Griffin.[1161] Ms Tonks recalled that Mr Griffin 'seemed very calm about it'.[1162]

Ms Tonks said she escorted Mr Griffin to collect his bag and walked him out of the ward.[1163] Detective Senior Constable Hindle later told to us that allowing Mr Griffin to collect personal items 'undermined' the police investigation because police had intended to search Mr Griffin's work locker.[1164] We are not clear whether Detective Senior Constable Hindle had communicated this intention to anyone at the hospital.

As she was escorting Mr Griffin out, Ms Tonks asked Mr Griffin if he was okay and asked what she should tell the other staff. He told her she should tell staff he was off sick due to a chronic issue with his back.[1165]

Ms Leonard recalled learning about these events from Ms Tonks the following day, on 1 August 2019. Ms Leonard also recalled that the human resources team directed nursing staff to not discuss the allegations about Mr Griffin due to the police investigation. Ms Leonard recalled that this direction was due to a recommendation of Tasmania Police. She told us that Mr Harvey, James Bellinger, Human Resources Manager, Ms Tonks, Ms Bryan and Dr Renshaw all reiterated this 'recommendation' at various points.[1166] There does not appear to have been any formal policy or plan guiding management's response. We note that such a policy could have identified what information could reasonably be provided to staff.

Dr Renshaw described other steps he took following the notification from the Acting Registrar of the Registration to Work with Vulnerable People Scheme that Mr Griffin's registration had been suspended. Dr Renshaw told us that he contacted Tasmania Police to request a briefing. We are not clear who Dr Renshaw spoke to when making this request but consider it most likely to have been Detective Senior Constable Hindle. This briefing occurred later on 31 July 2019. Mr Harvey was with Dr Renshaw during the police briefing.[1167] In a statement to us, Dr Renshaw described himself as 'the defacto executive liaison between Tasmania Police and the LGH'.[1168]

Dr Renshaw told us that he then made a mandatory notification to Ahpra by phoning its state manager on 31 July 2019, followed by a written notification that was emailed on 1 August 2019.[1169] Dr Renshaw said that Ahpra notifications are generally made by the 'professional lead', which in this case should have been Ms Bryan because Mr Griffin was a nurse. However, in this instance, Dr Renshaw assumed responsibility for liaising with Ahpra.[1170] Dr Renshaw did not explain why he assumed this responsibility.[1171] Dr Renshaw also prepared a briefing or 'Minute' for the then Secretary of the Department, Michael Pervan, which was reviewed by Mr Daniels and sent on 31 July 2019.[1172]

These events all assume significance because they establish what Dr Renshaw, in particular, knew and when, as well as the extent to which he shared important information with his superiors about the connection between the investigation of Mr Griffin and possible offending by Mr Griffin against patients. For this reason, we explore these events in some detail.

5.2.3 31 July 2019—Tasmania Police briefs Dr Renshaw and Mr Harvey

As mentioned earlier, Dr Renshaw and Mr Harvey met with Detective Senior Constable Hindle on 31 July 2019 to receive a briefing on Mr Griffin.[1173] What exactly was discussed at this meeting was difficult to ascertain. Detective Senior Constable Hindle's

recollections were confused, and the descriptions of the meeting in both Dr Renshaw and Mr Harvey's statements were brief. However, there seems to be a general consensus, supported by an email from Mr Harvey sent to human resources colleagues on the afternoon of 31 July 2019 capturing the substance of the meeting, that Detective Senior Constable Hindle told Dr Renshaw and Mr Harvey:

- Charges had not yet been laid against Mr Griffin, but police considered they had 'enough evidence' to charge Mr Griffin in relation to child exploitation material and 'maintaining a sexual relationship with a minor'.[1174]
- There were photographs on Mr Griffin's phone in a folder entitled 'Ward 4K', which appear to have been taken of patients in Ward 4K and the intensive care unit between 2015 and 2019.[1175] Other evidence from Tasmania Police indicates photographs were taken from the late 2000s to mid-2010s; however, it is not clear to us the basis upon which Tasmania Police formed that view.[1176] It is also not clear to us if these photographs are additional to the ones discussed at this meeting.

It is unclear whether Detective Senior Constable Hindle stated or implied to Dr Renshaw and Mr Harvey at the meeting that the photos taken at the hospital were potentially child exploitation material. In the email that Mr Harvey sent his human resources colleagues (noted above) on the afternoon of 31 July 2019, he wrote that the photos were 'nothing of a sexual nature'.[1177] However, in evidence to us, Dr Renshaw said that he was advised at this meeting that some child exploitation material may have been taken in the hospital, thus creating a potential connection between Mr Griffin's sexual offending and hospital patients.[1178]

Detective Senior Constable Hindle's oral evidence was that it was on 29 October 2019 that he first became concerned that the photographs in Mr Griffin's phone were evidence of offending by Mr Griffin in his role as a nurse or in connection with patients.[1179] He was unable to explain how Dr Renshaw had become aware of that possibility on 31 July 2019. Detective Senior Constable Hindle said he was not the person who initially showed the photographs to Mr Harvey and Dr Renshaw on 31 July 2019, and he was unaware what information had been exchanged when those photographs were revealed.[1180] Detective Senior Constable Hindle's evidence was that his first contact with Dr Renshaw about the connection between the photographs and patients occurred at the same time he asked Dr Renshaw to convene a panel to help identify those patients, which ultimately occurred on 5 December 2019.[1181]

The fact that Dr Renshaw was aware of the imagery potentially constituting child exploitation material around this time is confirmed by the recollection of Paul Turner SC, Assistant Solicitor-General (Litigation), who reportedly had a conversation with Dr Renshaw 'shortly after 31 July 2019'.[1182] The Solicitor-General, Sarah Kay SC, reported this recollection in a statement to us:

> His recollection, as conveyed to me, is that Dr Renshaw called him, advising that Tasmania Police had identified a number of photographs on Mr Griffin's telephone that appeared to be of paediatric patients at the Launceston General Hospital. The discussion is said by Mr Turner to have centred upon identifying the patients where possible and notifying the patients or their families.[1183]

Ms Kay shared her understanding that Mr Turner 'did not make any notes of the discussion and that he cannot be certain of the exact dates or whether there was more than one discussion'.[1184] We were surprised to learn no notes were taken, given the significance of the query. The absence of these records is a source of frustration for us. Ms Kay asked Mr Turner for his recollections and records about this matter, but we did not.

On balance, we consider it possible that Detective Senior Constable Hindle did not describe the images as sexual and in connection with the hospital at his meeting with Dr Renshaw and Mr Harvey on 31 July 2019, and that Mr Harvey's recollection was correct. However, we consider that Mr Griffin's possession of images of patients, in the context of a police investigation, should have been a significant source of concern to Mr Harvey and Dr Renshaw regardless. It should have also been clear that, given the images had only just been seized, closer analysis might confirm that they constituted child exploitation material.

Dr Renshaw did not mention Penny in his initial statements to us, despite a question that should have elicited this information. Mr Harvey also did not mention Penny in his statement, but said he was not told about her in the meeting and was not present for part of the discussion between Detective Senior Constable Hindle and Dr Renshaw, which we accept.[1185]

It was upon a review of documents received from Ahpra that we noticed a reference to Penny (including her status as a former patient) as part of its communication with Dr Renshaw regarding the mandatory notification he made to them about Mr Griffin on 1 August 2019 (discussed at Section 5.2.5). As previously indicated, Penny is significant in this context because her status as a former patient established a clear and early link between the hospital and the police investigation.

We already noted above that Detective Senior Constable Hindle also did not mention Penny in his initial statement to us. Detective Senior Constable Hindle's subsequent statement to us on 9 November 2022 confirmed that Penny and her potential connection to the hospital was discussed at this meeting:

> As previously stated, Dr Renshaw and a member of his HR team attended the police station following the execution of the search. It was at this time that Dr Renshaw was made aware of the presence of concerning material on Mr Griffin's electronic devices, as well as the continued care/relationship of Penny as a 'private arrangement'.[1186]

Detective Senior Constable Hindle also recalled Dr Renshaw advising him at this meeting that he would check hospital patient records to confirm whether Penny had been a former Ward 4K patient.[1187] Detective Senior Constable Hindle added: 'Dr Renshaw contacted me back in a timely manner (potentially the same day) to confirm that [Penny] was a former patient of Ward 4K and was most likely exposed to Griffin'.[1188] We understand this reference to indicate that Penny most likely had contact with Mr Griffin on the ward.

We asked Dr Renshaw about his knowledge of Penny when he gave evidence at a hearing on 8 September 2022. Dr Renshaw acknowledged that he was aware of Mr Griffin's care of Penny outside the hospital on 31 July 2019 because she was mentioned in his notification to Ahpra.[1189] Dr Renshaw also acknowledged that the question of whether Penny was a former patient of the hospital was significant because it established a clear link between the police investigation of Mr Griffin and Mr Griffin's employment at the hospital.[1190]

The failure to inform us at the earliest opportunity about Penny and her status as a former patient was an omission by Dr Renshaw and Detective Senior Constable Hindle. We note that there were more opportunities for Dr Renshaw, who was leading the hospital's response, to register that Penny was significant to both the police investigation and the hospital's response.

We do not know why this information was not provided to us in a more forthcoming way by Dr Renshaw. We are particularly concerned by Dr Renshaw's misleading responses to our original request for a statement. We discuss this further in our finding of misconduct against Dr Renshaw in Section 5.2.44.

5.2.4 31 July 2019—The Secretary of the Department is briefed about Mr Griffin's suspension

Following Mr Griffin's suspension, Dr Renshaw prepared a briefing for then Secretary Pervan. This briefing was forwarded to Mr Daniels late on the afternoon of 31 July 2019.[1191] The briefing appeared to go directly to Mr Daniels for approval before going to Secretary Pervan that same day because it is not listed as having been endorsed by any other role-holders.

The briefing informed Mr Daniels and the Secretary of the suspension of Mr Griffin's registration to work with vulnerable people and summarised, at a high level, what had occurred that day in terms of the procedural steps to direct Mr Griffin away from the workplace and to block his swipe access to the hospital.[1192] It also stated:

> The [Executive Director Medical Services] is currently conducting a look-back in the SRLS complaints reporting system for any previous issues involving this staff member.[1193]

Ms Bryan recalls being asked (it is unclear by whom and exactly when) to look at the Safety Reporting and Learning System for any incidents concerning Mr Griffin, and that upon doing so she found Ward 4K staff member Will Gordon's complaint from August 2017.[1194] The audit trail of this entry (which we discuss further in Section 5.2.26) shows that Ms Bryan was granted access to Mr Gordon's complaint on the system on 7 November 2019.[1195] Mr Harvey was granted access on 4 September 2019.[1196] This suggests that this 'look-back' was not undertaken immediately but occurred some months later.

We are unclear when Dr Renshaw may have considered Mr Gordon's complaint but believe that he did before briefing staff about the police investigation, which began on 29 October 2019. Staff briefings are described in Section 5.2.22. Mr Gordon's complaint was not mentioned in the subsequent briefing to Mr Daniels or the Secretary, nor were the numerous other complaints against Mr Griffin that were reported to Mr Griffin's managers (including the previous Nurse Unit Manager and Ms Leonard) and the human resources team.

In relation to information received from Tasmania Police, Dr Renshaw's briefing to the Secretary merely notes:

> The [Executive Director Medical Services] and Human [Resources] Consultant have met with Tasmania Police
>
> ...
>
> The Tasmania Police investigation is ongoing.[1197]

Further, Dr Renshaw does not mention in the briefing that Detective Senior Constable Hindle notified him about Penny's status as a former patient, nor that images of patients were found in Mr Griffin's possession.

When asked about his failure to accurately reflect this important information in the Minute to the Secretary, Dr Renshaw stated it was an 'oversight'.[1198] Despite assuming such a central role in responding to the concerns about Mr Griffin—Dr Renshaw was the contact for the Registrar of the Registration to Work with Vulnerable People Scheme and Tasmania Police, he managed Mr Griffin's suspension from work, and he drafted the Minute to the Secretary—Dr Renshaw sought to distance himself from the management of the situation in evidence to us at hearings.

Dr Renshaw told us that 'at that point the management of the issue had passed ... into HR and into the Secretary's office'.[1199] Reflecting on his actions on 31 July 2019, Dr Renshaw concluded that he had 'fulfilled' his medico-legal responsibilities, stating: 'I'm not certain what actions I could have taken beyond what I did'.[1200] For reasons that become clearer as we further explain Dr Renshaw's central role in this matter, we do not agree with this assertion.

The only caution that Dr Renshaw provided Secretary Pervan in the 31 July 2019 Minute was about adverse media attention: 'It is anticipated that if this matter does result in prosecution, there will be significant public concern and media attention'.[1201] Dr Renshaw provided no further context to the Secretary.

We make a finding below that Dr Renshaw misled Mr Daniels and the Secretary by omitting critical information from the brief. Before making this finding, we explain Dr Renshaw's interactions with Ahpra in the days following this briefing, which reveal the extent of the information he withheld.

5.2.5 1 August 2019—Dr Renshaw notifies the Australian Health Practitioner Regulation Agency about Mr Griffin

On 1 August 2019, Dr Renshaw made a formal notification to Ahpra about Mr Griffin. Having received the notification, a staff member called Dr Renshaw for more information. A file note of this discussion, captured by the Ahpra staff member on the day, includes the following:

> PR [Peter Renshaw] advised that he believes a complaint was made to Tas Police in relation to an alleged 'inappropriate sexual relationship with a child under the age of 12'. This child is advised to be a … former patient.[1202]

The file note of Dr Renshaw's advice did not accurately reflect the actions of Tasmania Police, which was investigating Ms Skeggs' complaint. To be clear, there was no police investigation into Mr Griffin's behaviour with Penny, or any other former patient, at this point.

In oral evidence to us, Dr Renshaw agreed that the file note captures the substance of what he told Ahpra, although he could not recall the words he used.[1203] We conclude, based on this file note, that Dr Renshaw told Ahpra about the information he received from Detective Senior Constable Hindle on 31 July 2019.

The Ahpra file note goes on:

> Tas Police have asked the Hospital for info regarding specific patients. They have also advised the hospital that having seized JG's [James Griffin's] mobile phone and home computer, they have found a folder on his phone containing a large number of images of female patients under the age of 16 (non-sexual in nature).
>
> …
>
> PR advised that he did not have access to JG's HR record but believes that there have been prior vague concerns surrounding JG similar in nature but unconfirmed and not to the same extent with patients.[1204]

The extent of the information Dr Renshaw provided Ahpra is in stark contrast to the briefing he provided the Secretary the day before, yet he had the same state of knowledge on both occasions.

On 5 August 2019, an Ahpra staff member contacted Detective Senior Constable Hindle to confirm what information they could rely on to determine any action they might take against Mr Griffin without interfering with the police investigation.[1205]

Finding—Dr Peter Renshaw misled the Chief Executive of Launceston General Hospital and the then Secretary of the Department by failing to fully and accurately convey information relating to James Griffin received from Tasmania Police on 31 July 2019

Dr Renshaw received two critical pieces of information that linked the police investigation into Mr Griffin to the hospital. These two pieces of information were the possibility that images found on Mr Griffin's devices were taken of patients in the hospital (whether they were deemed child exploitation material or not) and the possibility of Mr Griffin's inappropriate contact with Penny, a patient of the hospital.

This information is relevant to the hospital's response to revelations about Mr Griffin's offending for the following reasons:

- The information suggested a risk that photos Mr Griffin took of patients in the hospital constituted child sexual exploitation material.
- Even if the photos of patients did not constitute child exploitation material, Mr Griffin's possession of them suggested a significant breach of professional conduct and a major breach of patients' privacy. Tasmania Police has since told our Inquiry that, to their knowledge, the images of some children would not constitute 'child exploitation material as described in statutory definitions'.[1206]
- Depending on the police's assessment on a closer inspection of the images, it was possible that the hospital would need to undertake an open disclosure process with affected parties. An open disclosure process involves:

  > … a discussion with a patient and carer about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps being taken to manage the event and prevent recurrence.[1207]

- Open disclosure is a process health providers use to transparently acknowledge and explain any errors or adverse events to patients receiving health care. Accepting that Dr Renshaw did not have conclusive information that this would be required, he nonetheless should have cited it as a possibility in his briefing to the Secretary.

- Mr Griffin's 'private care arrangement' of his former patient Penny likely constituted a breach of his professional obligations.
- Given Mr Griffin's connection to Penny was through the hospital, it should have been apparent that other former patients had similar contact with Mr Griffin and had therefore also been at risk from Mr Griffin.
- An examination of Mr Griffin's complaints history would have revealed a pattern of boundary breaches, including Mr Griffin contacting patients outside the hospital setting, which in turn would have alerted the hospital that other patients had been placed at risk. As we noted earlier, there did not appear to have been any effort to review Mr Griffin's prior complaints history within the Safety Reporting and Learning System (and otherwise) at this time.

We find that Dr Renshaw misled Mr Daniels and then Secretary Pervan by failing to convey information fully and accurately to them about the police briefing on 31 July 2019. Dr Renshaw's initial briefing, which positioned Mr Griffin's offending as occurring entirely outside the hospital setting, set the tone for subsequent briefings to the Secretary.

5.2.6 August–October 2019—Rumours circulate in the community about Mr Griffin

After Mr Griffin was removed from the workplace, staff were told that he had taken leave due to an issue with his back.[1208] Mr Griffin had asked Ms Tonks to tell staff that he was 'off with a bad back' and she did so in order to be 'respectful' of Mr Griffin's wishes because no charge had yet been laid.[1209] However, rumours soon began to circulate about the real reasons for Mr Griffin's departure. Former Ward 4K staff member Annette Whitemore told us:

> After J [Mr Griffin] left there was talk among nurses that he was being investigated for something of a sexual nature. I was told that a young girl had made a statement to Police about historical sexual assaults by J. I recall myself and other staff checking to see if he was still registered as a nurse.[1210]

Around August 2019, Ms Leonard took leave and an Acting Nurse Unit Manager stepped into her role.

Mr Gordon told us that when the rumours about Mr Griffin's absence began to circulate, some Ward 4K staff attended a meeting with human resources staff to discuss how to handle questions from the public about Mr Griffin. Mr Gordon did not attend this meeting and we do not have any other information about it.[1211] However, Mr Gordon told us that not long after this meeting, associate nurse unit managers verbally directed Ward 4K staff to not talk about any allegations connected to Mr Griffin.[1212] Ms Tonks confirmed this, particularly given that a police investigation was underway.[1213] Ms Tonks later recalled that this instruction came from Dr Renshaw.[1214]

Ms Leonard told us that Mr Harvey also directed nursing staff to not discuss the allegations made against Mr Griffin because of the ongoing police investigation.[1215] Ms Leonard believed that this direction was given to preserve the integrity of the police investigation and had been recommended by Tasmania Police.[1216] She said:

> The direction for staff not to discuss the allegations against Mr Griffin was very difficult to support, and I was deeply challenged and conflicted by this, frequently requesting the ability for staff to talk about the topic and be offered support. The staff clearly needed the opportunity to talk and were struggling, however I was unable to meet their needs, and support open conversations.[1217]

Dr Kate Brady, a researcher with expertise in supporting communities to recover from traumatic events, explained to us that the close control of information management because of concerns about interfering with investigations can impede appropriate responses to critical incidents:

> … it is important to empower managers to treat people as affected community members first, and as legal witnesses second. In my experience, I have observed that some managers and organisations can be so concerned about what they are 'allowed' to say or what the legal ramifications of any communications are that it impairs their ability to think about responding as humanistically as possible.[1218]

5.2.7 2–8 August 2019—Employment Direction processes relating to Mr Griffin

Dr Renshaw told us that a formal investigation of Mr Griffin, under Employment Direction No. 6, began on or about 2 August 2019.[1219] Employment Direction No. 6 outlines the State Service disciplinary processes for determining whether an employee can perform their duties. This becomes relevant for child-facing roles in circumstances when a person no longer holds registration to work with vulnerable people. We discuss the operation of the Employment Directions, and how they are applied in child sexual abuse matters, in Chapter 20.

On 5 August 2019, then Secretary Pervan approved the suspension of Mr Griffin under the Employment Direction No. 4 process (which outlines the process for suspending employees with or without pay) and a letter was sent to Mr Griffin advising him of this decision on the same day.[1220] We consider it appropriate that Mr Griffin was advised immediately to not attend work on 31 July 2019 and that his formal suspension occurred shortly after.

5.2.8 7 August 2019—Mr Griffin's nursing registration is suspended and Tasmania Police advises the hospital of concerns for Mr Griffin's welfare

On 7 August 2019, Ahpra advised Mr Griffin that the Nursing and Midwifery Board of Australia had proposed to suspend his registration.[1221]

Early that morning, Detective Senior Constable Hindle emailed Dr Renshaw outlining concerns Mr Griffin's family had expressed about Mr Griffin's welfare.[1222] Detective Senior Constable Hindle noted: 'It is not uncommon for people in his current situation to make the ultimate decision'.[1223] Detective Senior Constable Hindle informed Dr Renshaw that Mr Griffin had been provided the details for Lifeline and offered transportation for a mental health assessment, which he declined. Detective Senior Constable Hindle asked Dr Renshaw whether the hospital had taken all steps to offer Mr Griffin follow-up support in relation to his suspension from work.[1224] Mr Harvey attempted to contact Mr Griffin to check on him the following day.

5.2.9 8 August 2019—Mr Griffin resigns his role at Launceston General Hospital and surrenders his nursing registration

On 8 August 2019, Mr Griffin wrote to Ahpra to surrender his registration as a nurse.[1225] Notwithstanding this, the Nursing and Midwifery Board determined to investigate Mr Griffin. The Board ultimately took no further action after Mr Griffin's death.[1226]

Mr Griffin also resigned from the Tasmanian Health Service on 8 August 2019. His employee exit form listed his reason for departure as 'Retirement–Voluntary' and was signed off by Ms Leonard on 9 August 2019.[1227]

Mr Harvey attempted to call Mr Griffin to do a welfare check, but he did not answer.[1228] Mr Harvey then emailed Mr Griffin with information about the hospital's Employee Assistance Program and other support services.[1229]

5.2.10 8–14 August 2019—The then Secretary is briefed on Mr Griffin's resignation and provided advice on his disciplinary investigation

On 9 August 2019, Mr Harvey prepared a Minute to then Secretary Pervan to advise of Mr Griffin's resignation and that Mr Griffin would likely be charged by Tasmania Police, 'which may attract media attention'.[1230] The Minute largely focused on the Employment Direction No. 6 process (triggered by the loss of Mr Griffin's registration to work with vulnerable people) and recommended that disciplinary processes be aborted because Mr Griffin was no longer an employee of the State Service and therefore any determination or sanctions would not have effect.[1231]

The Minute also notes that Ahpra was notified of the police investigation into Mr Griffin and had cancelled his nursing registration. In relation to the Tasmania Police investigation, the briefing states:

> Tasmania Police [is] conducting enquiries and has advised of pending charges being laid which relate to child exploitation and maintaining inappropriate relations with a minor. Further charges may be considered following Tasmania Police interviews with other parties.[1232]

This Minute was endorsed by the then Acting Chief People and Culture Officer. It does not appear that Dr Renshaw had any involvement in this Minute. The then Secretary Pervan approved the advice to abort the Employment Direction No. 6 investigation on 14 August 2019.[1233]

Mr Daniels recalls speaking with then Secretary Pervan around this time, but this conversation did not appear to cover more than Mr Daniels acquitting his responsibilities to advise Secretary Pervan on the actions taken to respond to Mr Griffin, which were reflected in the briefing.[1234]

Dr Renshaw gave the following explanation as to why the disciplinary process in relation to Mr Griffin was aborted:

> My understanding is that the [Employment Direction] processes only apply to current State Service employees and therefore, if a [State Service] employee resigns, the Department of Health no longer has jurisdiction.[1235]

We accept that it was common practice in 2019 to end a disciplinary process if an employee resigned. We also note that this practice means that the institution does not have the opportunity to learn from any systemic issues that may have arisen by examining the alleged conduct, and that once such a process stops, there is no record preventing the ex-employee from being re-employed by the State Service at a later date. This means that even in circumstances where a former employee causes serious harm, they may be able to continue their predatory behaviour in another workplace. We note that the introduction of a Reportable Conduct Scheme in Tasmania will require heads of regulated entities to continue investigations into reportable allegations regardless of whether the relevant worker resigns or is otherwise no longer an employee.[1236]

Given that early indications from the police suggested a link to hospital patients connected to Mr Griffin, we consider an investigation of some form should have continued, notwithstanding Mr Griffin's resignation.

5.2.11 September 2019—Kylee Pearn makes a complaint to police about Mr Griffin

In September 2019, Ms Pearn reported her abuse by Mr Griffin to Tasmania Police. As we discussed in Section 4, Ms Pearn made a promise to herself that she would come forward to support another victim-survivor's police report, if one were ever made. In her statement to Detective Senior Constable Hindle, Ms Pearn referenced her earlier disclosure to human resources staff at Launceston General Hospital in the presence of her then manager, Stewart Millar.

5.2.12 August–September 2019—Tasmania Police investigates and charges Mr Griffin with child sex offences

On 27 August 2019, before Ms Pearn made her report to police, Detective Senior Constable Hindle wrote to the Australian Federal Police about the child exploitation images that Tasmania Police had overlooked in 2015 (refer to Section 4.1.23).[1237] This material was ultimately forwarded to Detective Senior Constable Hindle on 2 September 2019.[1238]

On 3 September 2019, Tasmania Police interviewed Mr Griffin, during which he made several admissions.[1239] After this interview, he was charged with one count of sexual intercourse with a young person under 17 years of age and was bailed to reappear in the Launceston Magistrates Court on 23 October 2019.[1240] Detective Senior Constable Hindle told us that Tasmania Police did not oppose bail at this time because they believed the bail conditions, which included that Mr Griffin not be in the company of a minor without another adult present, were sufficiently stringent.[1241]

On 13 September 2019, Tasmania Police sought approval from the Director of Public Prosecutions to authorise the more serious charge of what is now referred to as persistent sexual abuse of a young person. The Director of Public Prosecutions gave approval shortly after, on 17 September 2019.[1242]

Also on 13 September 2019, Mr Harvey spoke to Tasmania Police. He recalled police telling him that it was unlikely hospital staff would have to make statements because 'the incidents occurred outside the workplace'.[1243] At the time of Mr Griffin's arrest, Dr Renshaw was on long service leave overseas and did not return until after Mr Griffin's death, which would be sometime after 18 October 2019.[1244]

On 3 October 2019, based on a review of the materials Tasmania Police received in 2015 from the Australian Federal Police, Tasmania Police conducted a second search on Mr Griffin's home. This search resulted in Mr Griffin being charged with offences relating to possessing, producing and distributing child exploitation material.[1245] Mr Griffin was also charged with another eight counts of indecent assault relating to four victim-survivors, who had since made a report of their abuse to police, including Ms Pearn and Keelie McMahon.[1246]

Mr Griffin was detained and Tasmania Police opposed bail on the basis that Mr Griffin had 'sought loopholes' on his previous bail conditions and reportedly had plans to attend a recreational event with young people.[1247] However, the Court granted him bail and he was released that day.[1248]

5.2.13 19 September 2019—Secretary Morgan-Wicks visits Ward 4K

On 19 September 2019, the then new Secretary of the Department, Kathrine Morgan-Wicks PSM, who began in the role on 2 September 2019, visited Ward 4K for a site tour

of the new Women's and Children's ward redevelopment. She told us that Mr Daniels and 'key LGH staff' accompanied her on this tour.[1249] Secretary Morgan-Wicks stated that: 'To the best of my recollection, the circumstances of Mr Griffin were not raised during the tour or in meetings that day'.[1250]

5.2.14 9 October 2019—*The Examiner* publishes a brief article about Mr Griffin's criminal charges without identifying him

On 9 October 2019, *The Examiner* newspaper published a brief article about a paediatric nurse in Launceston, which read:

> A former nurse has been accused of possessing, producing and distributing child exploitation material as well as maintaining a sexual relationship with a young person.
>
> The 69-year old Legana man has been charged with eight counts of indecent assault, distribution of child exploitation material, involving person under 18 years in production of child exploitation material, produce child exploitation material, possess child exploitation material and maintain a sexual relationship with a young person.
>
> It is alleged the man maintained a sexual relationship with a young person between August 2009 and August 2013.
>
> He is also accused of involving a person under 18 years in the production of child exploitation material in South Launceston on March 6, 2015. The charges for producing and distributing child exploitation also relate to March 6. The indecent assault charges span across 25 years, with the first alleged offence occurring between 1987 and 1990, and the most recent sometime between 2011 and 2012.
>
> On July 19 this year, the man was also allegedly found in possession of child pornography photos. He will appear in Launceston Magistrates Court on November.[1251]

5.2.15 11 October 2019—Tasmania Police ask human resources staff about Ms Pearn's disclosure

Mr Bellinger told us that on 11 October 2019, Detective Senior Constable Hindle called to 'ask if we had any records about a disclosure by Kylee Pearn or Stewart Millar'.[1252] When Counsel Assisting asked Mr Bellinger for more detail about what Detective Senior Constable Hindle said, Mr Bellinger replied that the request was specific enough to confirm to him that the disclosure related to Mr Griffin's inappropriate conduct in relation Ms Pearn as a child.[1253] Mr Bellinger recalled that Detective Senior Constable Hindle told him that Ms Pearn's disclosure to the hospital was estimated to have occurred in 2010 or 2011.[1254]

Mr Bellinger said that after hanging up from the call with Detective Senior Constable Hindle he searched the human resources team's records and spoke to another, more senior, member of the human resources team to seek their recollection.[1255]

Later that day, Mr Bellinger emailed Detective Senior Constable Hindle, copying in this same member of the human resources team. As referenced in Section 4.1.14, this email included the following:

> I was not working with the LGH at that time, Gino Fratangelo and [the member of the human resources team] were at the LGH at that time. Gino has since retired, [the member of the human resources team] is still in HR with the THS and I have copied [them] in. I have access to Gino's emails from 2012 onwards and a record of some matters dating back to 2004.
>
> I have been unable to find a record of [Ms Pearn's] complaint.[1256]

We note that Mr Bellinger did not try to contact Mr Fratangelo at this point to find out whether Mr Fratangelo could recall the meeting or whether he may have held records or notes relating to it that could have assisted police. Nor did Detective Senior Constable Hindle contact Mr Fratangelo. Mr Bellinger did not make a file note of his conversation with Detective Senior Constable Hindle.[1257]

The reference in Mr Bellinger's email to 'a record of matters dating back to 2004' suggests that Mr Bellinger did at least review some of Mr Griffin's complaints history, given the first recorded complaint with which the human resources team was involved was made in 2004 (described in Section 4.1.4). We understand that information about Mr Griffin's complaints history was never provided to Tasmania Police, noting also that it may not have been requested.

We asked Ms Leonard whether she was asked to provide the human resources team with information to do with the complaints about Mr Griffin, noting that complaints were not always escalated to the human resources team.

> Q [Counsel Assisting]: After Griffin was arrested you [were] asked for all the records concerning Griffin; is that right?
>
> A [Ms Leonard]: I don't recall that.
>
> Q: Did you gather all of the records concerning Griffin after his arrest?
>
> A: I don't recall that.
>
> Q: Did HR ask for access to all of his records after Mr Griffin's arrest?
>
> A: At some stage they asked for all the records.
>
> Q: And you gathered them for them?
>
> A: Yes.
>
> Q: And you made everything available to HR for review at that stage?
>
> A: Yes.[1258]

We are unclear when human resources staff requested Ms Leonard's records in relation to complaints about Mr Griffin. We consider it likely that this request was made in November 2019 when the human resources team conducted a review into complaints about Mr Griffin (discussed in Section 5.2.25).

We expect that the phone call from Detective Senior Constable Hindle would have been a source of significant concern to Mr Bellinger, given our finding that he was at the meeting when Ms Pearn's disclosure was made. The call would also have put Mr Bellinger on notice that his and Mr Fratangelo's inaction in the face of that disclosure was likely to be scrutinised.

Despite having reasonably good recall of a wide variety of matters, including some from many years ago, Mr Bellinger could not recall whether he had escalated his correspondence with Detective Senior Constable Hindle to others, other than copying the member of the human resources team into his email response to Detective Senior Constable Hindle.[1259]

> Q [Counsel Assisting]: Did you speak to anyone else about the conversation you'd had with [Detective] Hindle?
>
> A [Mr Bellinger]: Not that I can recall.
>
> Q: Did you speak to Dr Renshaw?
>
> A: I don't recall.[1260]

Counsel Assisting then asked Mr Bellinger whether he was aware of Dr Renshaw's medico-legal expertise and his role as police liaison. This information is relevant because the failure to take action in response to Ms Pearn's disclosure in 2011 or 2012 exposed the hospital to litigation on the basis that it had prior knowledge of the risk Mr Griffin posed as a paediatric nurse.

> Q [Counsel Assisting]: So, that being [Dr Renshaw's] position, is that the sort of thing that you would have taken to his attention?
>
> A [Mr Bellinger]: Yes.
>
> Q: And, did you take it to his attention?
>
> A: I don't recall.
>
> Q: Would it have been your practice to do so?
>
> A: Yes.
>
> Q: Do you have any file notes that tell us whether or not you did?
>
> A: No, I don't.

Mr Bellinger also could not recall advising the Chief People Officer at the Department about his correspondence with Detective Senior Constable Hindle, despite it being his practice to share information of this nature with the Department.[1261]

Counsel Assisting asked Mr Bellinger whether he appreciated the significance of the information he had received from Detective Senior Constable Hindle.

> Q [Counsel Assisting]: Did you understand [Kylee Pearn's previous disclosure to the hospital] to be a serious matter?
>
> A [Mr Bellinger]: Yes.
>
> Q: Did you not escalate it?
>
> A: I don't know.
>
> Q: You didn't make any records about it beyond that email, did you?
>
> A: Correct.
>
> Q: You didn't formally brief anyone about it, did you?
>
> A: Correct.[1262]

While Dr Renshaw was on leave at the time of Detective Senior Constable Hindle's call, we would have thought the call was something Mr Bellinger or other members of the human resources team would report to Dr Renshaw on his return, as a matter of urgency. Indeed, Mr Daniels and the Secretary should have been alerted immediately. Mr Bellinger's failure to so alert them is notable.

Below, we discuss the possibility that Mr Bellinger or other members of the human resources team told Dr Renshaw about Ms Pearn's disclosure. Another member of the human resources team could not take part in our Commission of Inquiry and we make no findings in relation to them.

5.2.16 8–14 October 2019—The Acting Secretary is briefed on the status of Mr Griffin's criminal charges

While Secretary Morgan-Wicks was on planned annual leave between 9 and 20 October 2019, the Acting Secretary approved a Minute to the Secretary about the status of criminal charges relating to Mr Griffin, dated 14 October 2019.[1263] This Minute was prepared by the former Director of Employee Relations at the Department on 8 October 2019 and was approved by Mr Bellinger on the same date. The Acting Chief People and Culture Officer at the time formally endorsed the Minute on 9 October 2019.

The Minute recapped some of the information provided in earlier briefings to then Secretary Pervan, including that:

- Mr Griffin had been suspended on 5 August 2019 by former Secretary Pervan, following notification that his registration to work with vulnerable people had been suspended pending criminal charges relating to offences involving children.[1264]

- An Employment Direction No. 6—Inability was considered the most appropriate course given that Mr Griffin was not able to fulfil an essential requirement of his nursing role; however, as Mr Griffin resigned on 8 August 2019, no further action was taken.[1265]
- Ahpra had been notified and had cancelled Mr Griffin's nursing registration.[1266]

The Minute noted that the Tasmanian Health Service had cooperated with Tasmania Police and that:

> To date, there has been no notification that offences are linked to Mr Griffin's employment as a Paediatric Nurse with the THS.[1267]

The Minute also flagged that the matter had attracted media attention but that no action was required.[1268]

This Minute had serious omissions and was misleading on numerous fronts. There is no information to suggest that its author, the former Director of Employee Relations at the Department was aware that this document was misleading.

The Minute was technically correct in stating that Mr Griffin's charges were not directly connected to the hospital because Mr Griffin was charged in relation to child sexual abuse of Ms Skeggs, and others who were not patients.[1269] Also, the charges related to child exploitation material and were based on information discovered in the review of the materials that Australian Federal Police had obtained in 2015, not the images of patients at the hospital found on Mr Griffin's devices and described by police at the 31 July 2019 briefing.[1270] However, we consider the following omissions from the Minute to be material:

- As with the earlier Minutes of 31 July 2019 and 9–14 August 2019, the substance of the 31 July 2019 briefing from Tasmania Police was not reflected in this Minute. We received no evidence to suggest that Tasmania Police had categorically ruled out the images of patients as constituting child exploitation material, noting its investigation of Mr Griffin was ongoing. Even if it had, this information should have been included in the Minute.
- By the time the Acting Secretary signed off on the Minute on 14 October 2019, Mr Bellinger and another member of the human resources team were formally on notice about Ms Pearn's disclosure, as Mr Bellinger had received the call from Detective Senior Constable Hindle asking for records relevant to this disclosure on 11 October 2009. Although Mr Bellinger is listed as having endorsed this briefing on 8 October 2019, before receiving the call from Detective Senior Constable Hindle on 11 October 2019, he should have immediately sought to update the Minute or prepared another Minute to reflect this information before it went to the Acting Secretary. When Counsel Assisting asked Mr Bellinger why he did not seek to update the Minute before it was sent to the Office of the Secretary, or to prepare

a subsequent urgent Minute, he agreed that another Minute should have been prepared.[1271] When asked why this did not occur, Mr Bellinger said: 'I can't answer that.'[1272] This is an inexplicable response in the circumstances.

- Mr Bellinger appears to have undertaken at least a cursory examination of Mr Griffin's complaints history in response to Detective Senior Constable Hindle's request, noting the reference in his email to Detective Senior Constable Hindle about 'records dating back to some matters in 2004'.[1273] The Secretary should have been informed of this complaints history at the earliest opportunity—ideally by Dr Renshaw on 31 July 2019—however, there is no justification for the omission in a subsequent briefing to the Secretary.

Dr Renshaw returned from leave sometime after 18 October 2019, after this Minute was approved.

It took until our public hearing on 28 June 2022 for Mr Daniels and Secretary Morgan-Wicks to learn of Mr Bellinger's correspondence with Detective Senior Constable Hindle in October 2019.[1274] In relation to Ms Pearn's disclosure to the hospital in 2011 or 2012, Mr Daniels stated that he only learned of this fact through our hearings.[1275] When Counsel Assisting asked Mr Daniels for his response to learning that people in his organisation did not tell him about the disclosure before the hearings, he replied:

> I am very disturbed about that because, as I think I've indicated in my statement, that I rely very heavily on the advice from those people who manage those processes to advise me, because I can say in all honesty that, had I been aware at the time—not that I was in the role then [at the estimated time of the disclosure]—if that occurred today and that report was made available to me and I was told, I'd take immediate action and that action would be to report it to Tasmania Police and expect some outcome from it, as well as the notifications that are required because of the practitioner.[1276]

Secretary Morgan-Wicks recalls learning of Ms Pearn's disclosure to the hospital on 20 October 2020, which we describe in Section 5.2.45. We established that Dr Renshaw told her and Mr Daniels in an email in general terms about Ms Pearn's disclosure on 16 October 2020 following the release of the podcast *The Nurse*.[1277] Ms Pearn also attempted to alert others to her disclosure once *The Nurse* podcast was released. However, Secretary Morgan-Wicks did not know that Tasmania Police had spoken to the human resources team about this disclosure in 2019.

Secretary Morgan-Wicks gave evidence that, had she been advised of the circumstances of Ms Pearn's missing complaint in her review of the draft response to the Integrity Commission on 10 September 2020, or if it had been escalated earlier to her, she believes she would have immediately instituted an independent investigation into the management of complaints relating to Mr Griffin, given the seriousness of the missing complaint and the behaviour reported in 2011 or 2012.[1278]

Finding—The human resources team failed to escalate information they received on 11 October 2019 about Kylee Pearn's 2011 or 2012 disclosure

As we have described above, the call to Mr Bellinger from Detective Senior Constable Hindle on 11 October 2019 should have been a catalyst for immediate and urgent action from Mr Bellinger and other members of the human resources team. We consider that the human resources team, including Mr Bellinger, should have taken steps to ensure Mr Daniels and Secretary Morgan-Wicks were advised of the request and its implications for the hospital.

The information that human resources staff held about Ms Pearn's disclosure should have been escalated given it indicated that the hospital had known about Mr Griffin's potential offending from that time. This includes fully informing the Secretary of the query human resources staff received from Detective Senior Constable Hindle about Ms Pearn's disclosure—and describing what was known about that disclosure. We understand that for Mr Bellinger in particular, given his attendance at the meeting at which the disclosure was made, acknowledging such a fundamental error of judgment is confronting. However, the implications of mishandling Ms Pearn's disclosure should have been acknowledged at the earliest opportunity.

The tone of the briefing to the Secretary worked to distance the hospital from Mr Griffin's offences and to suggest there was no potential connection or risk to the hospital, beyond a possible and generic reputational risk associated with media attention of Mr Griffin's charges. This framing contributed to the hospital doing nothing and significantly undermined the opportunity for Mr Daniels and Secretary Morgan-Wicks to get on the front foot of the crisis by taking the following actions:

- They could have initiated an investigation into the specific circumstances of Ms Pearn's disclosure to understand exactly what happened and to enable any relevant information to be provided to assist Tasmania Police in its investigation of Mr Griffin.
- They could have closely examined Mr Griffin's personnel file and complaints history to determine whether there was any information that gave rise to concerns he may have harmed or abused patients in any way. This would have uncovered a significant complaints history at the hospital, as described in Section 4. Such a review would have also revealed that Mr Griffin was transferred to Ashley Youth Detention Centre in November 2017, providing an opportunity for the Department to investigate whether there were any complaints or concerns about Mr Griffin during his assignment there, and to determine the full extent of the Department's legal and reputational exposure.

- They could have prepared a plan on how to respond effectively to the hospital's failure to act on Ms Pearn's disclosure and the ongoing police investigation. This plan could have designated appropriate roles and responsibilities for managing the hospital's response and ensured any conflicts of interest were avoided, that legal advice and assistance was sought, and that relevant records and documents were secured and quarantined. This plan could also have guided the Department in responding to any patients and families that may have been affected by Mr Griffin's conduct and in providing accurate information to staff and the community as it was appropriate to do so. Further, contemplation of such a plan may have triggered a realisation that external expertise and assistance may be required, given the scale of this event.

5.2.17 18 October 2019—Mr Griffin dies by suicide

On 13 October 2019, Mr Griffin was found unresponsive at home, because of a suicide attempt.[1279] He was taken to Launceston General Hospital where he received treatment in the Intensive Care Unit, but died on 18 October 2019.[1280] The Coroner later stated in relation to Mr Griffin's death:

> The evidence viewed as a whole satisfies me to the requisite legal standard that the cause of Mr Griffin's death was a mixed prescription intoxication which caused hypoxia. I am satisfied that there are no suspicious circumstances surrounding Mr Griffin's death and that when he took the drugs which caused his death he did so with the express intention of ending his own life, voluntarily and alone. No doubt the charges he was facing at the time of his death motivated his action.[1281]

Shortly after Mr Griffin's death, Ms Leonard told us she learned from a staff member that community members were contacting Ward 4K staff with questions about Mr Griffin. These community members had learned of his death informally, presumably via friends and family of Mr Griffin.[1282]

Ms Leonard told us that she was not aware of Mr Griffin's family having formally announced his death and felt that his family should be entitled to confidentiality and privacy surrounding his hospitalisation. She said she did not think it was appropriate to formally share the news with staff.[1283] Acknowledging rumours were circulating, when conducting morning handover on 21 October 2019, Ms Leonard verbally briefed staff to not discuss the matter. She provided information about how they could access counselling and invited staff to meet with her to discuss any questions or concerns they may have. Ms Leonard acknowledged that not being informed of the circumstances of Mr Griffin's death at this time would have been challenging for some staff.[1284] She added:

> I found this a very difficult path to navigate, so I sought guidance and direction from Ms Tonks, Mr Harvey and Mr Bellinger once they were at work later this morning. I was hoping to receive guidance on how to proceed and I recall that they supported this approach [of not discussing the circumstances of Mr Griffin's death].[1285]

Ms Leonard said she did not receive any support or guidance from the then Executive Director of Nursing, Helen Bryan. Ms Bryan told us: 'I am unaware of any other directions made by LGH to staff on Ward 4K'.[1286] Ms Bryan also told us that, as a patient at the hospital prior to his death, Mr Griffin was entitled to 'the same privacy any other patient would receive' and this right to privacy continued after his death. Ms Bryan said that the hospital has:

> … an obligation to keep confidential from the general nursing staff on Ward 4K the fact that Mr Griffin had been a patient at the Hospital, the reason for his admission to the Hospital, and the fact of Mr Griffin's death, just as Hospital staff would keep confidential the admission and prognosis or health outcome of any other patient from the general staff at the Hospital who were not caring for the patient. This obligation meant that there was a tension between the Hospital's leadership taking steps to provide information to the nursing staff on Ward 4K in an effort to reduce the staff's distress and respecting the obligation to keep Mr Griffin's health information private and confidential.[1287]

Dr Renshaw also said that he was 'unaware' of any directions to staff on Ward 4K and that he consistently encouraged nursing staff to report any useful information to police or to his office.[1288]

Ms Leonard sent an email to staff on Ward 4K later in the day on 21 October 2019. The email read:

> Dear 4K staff,
>
> Due to recent events within the hospital, it has come to my attention that a former employee has recently passed away. I understand that this situation may cause you some distress, can I please again offer you the support of [an employee assistance program, with phone number]. However, due to patient confidentiality issues this should not be discussed by 4K nor any other Hospital employee. I would like to remind you about the ethical requirement as nurses to work within our code of ethics and code of conduct as state service employees. With appreciation for the difficult situation that we find ourselves in and kindest regards, Sonja.[1289]

According to some recipients who gave evidence to our Commission of Inquiry, this email was not well received by staff. Mr Gordon said there was no recognition from Ms Leonard of the fact that some staff had been friends with Mr Griffin for nearly 20 years. He stated: 'One 4K nurse I spoke to told me that she had never felt as insulted or degraded as she did receiving that email'.[1290] Mr Gordon described the rest of his shift that day as the 'worst shift' he had ever worked, as 'we essentially got told by her to shut up and do our jobs'.[1291] He explained: 'Many staff were trying to deal with the conflict of having James as a close friend but then knowing what he was alleged to have done. They were struggling'.[1292]

Mr Gordon also felt that Ms Leonard and the associate nurse unit managers were watching staff to make sure they did not talk about Mr Griffin.[1293] A Ward 4K staff member at the time, Annette Whitemore, agreed with Mr Gordon's recollections of how the email was received and the instructions not to talk. She told us: 'There was no reason to send it out like this … It was really blunt. I told Sonja that I thought it was blunt'.[1294] Ms Whitemore added that Ms Leonard was very upset at the time too:

> She told me that she didn't know [about Mr Griffin's offending]. Nobody knew. … I've been told by a colleague that they observed Sonja write and rewrite that email a number of times. It was very difficult for her to send.[1295]

Ms Leonard said in her statement to us that after Mr Griffin died 'I remember there was more transparent communication'.[1296] When Counsel Assisting asked whether she felt she received enough direction or leadership around managing the issues in the aftermath of Mr Griffin's death she responded: 'No, I don't think so'.[1297]

Meanwhile, Dr Renshaw continued to be the contact point for people concerned about Mr Griffin's actions in the months after his arrest and death. He described being contacted by staff and patients' families reporting concerns or looking for information about whether it was possible their child was harmed under the care of Mr Griffin.[1298] As described above, there seemed to be no clear plan to manage this contact, with responses largely ad hoc and driven primarily by Dr Renshaw.

We heard that over the following weeks staff began to agitate for a group debriefing process. We understand that the desire of staff to talk with each other was to help them process complex emotions, which for some extended to examining their own complicity in tolerating or overlooking Mr Griffin's inappropriate behaviour. In our view, many staff were experiencing what researcher and expert in community trauma recovery Dr Kate Brady calls 'moral injury'. The term moral injury refers to a person's psychological reaction to a serious event that involves a betrayal of their deeply held moral beliefs.[1299] Moral injury can involve feelings of guilt, remorse and anger and may cause a person to blame themselves for failing to prevent an event.[1300]

Mr Gordon described feeling 'extremely guilty' for not speaking up after observing the way Mr Griffin failed to demonstrate best practice in line with the chaperone protocol with a particular patient:[1301]

> … as a result of all the allegations being made against [Griffin] later on down the track, I look at that—I replay that, you know, those two seconds, that two-second memory, and I feel like that patient, without a shadow of a doubt, was a victim, purely because of the way that he would talk about her as well. The way he would talk to the family, the relationship he had with the parents. He would always try and look after this patient; even if he wasn't allocated, he was there. Yeah, without a doubt, I believe she was a victim.[1302]

Ms Whitemore shared with us her experience of working alongside Mr Griffin as a graduate nurse in around 2002 and witnessing him washing a patient:

> … but he moisturised over her chest, and that just keeps coming back, that I— I think I told somebody but I didn't put a complaint in, but it made me feel, 'Is that what we do?' But I knew I wouldn't do that, I wouldn't— if I was a male … So I sort of regret that I never took that further.[1303]

After he completed his shift on the day of Ms Leonard's email to staff, Mr Gordon, who was one of the nursing union delegates on the ward, contacted the union to request assistance. He told us: 'I was already furious about the way staff were being treated by management, the cone of silence that had been imposed and the lack of support offered'.[1304] This led to a meeting between the union and ward staff on 24 October 2019, which we describe in Section 5.2.20.

Some victim-survivors of Mr Griffin's abuse also described insensitive responses from Tasmania Police when they sought information or attempted to make a statement after Mr Griffin's death.[1305]

5.2.18 Sometime after 18 October 2019—Dr Renshaw returns from leave and hears 'corridor rumours' about Ms Pearn's disclosure

Dr Renshaw told us that after he returned from leave at an unspecified date after Mr Griffin's death, he gained 'vague knowledge' that a staff member had raised a concern with Stewart Millar about what Dr Renshaw described as a 'relationship' that the staff member had with Mr Griffin when she was a child.[1306] As we describe in Section 4.1.14, Mr Millar was Ms Pearn's manager at the time she reported Mr Griffin to human resources staff in 2011 or 2012 and attended the meeting held with human resources representatives at that time.

Dr Renshaw described the context in which he heard this information as 'one of these sort of corridor rumour-type situations'.[1307] Dr Renshaw could not recall who passed on this rumour, stating to us: 'How does anybody know when they pick up a rumour?'[1308] He described the hospital being 'rife with rumour' at the time, saying 'you basically had to be there at the time to actually understand the way decision making was being made and so on'.[1309] We do not have evidence of who told Dr Renshaw this 'rumour'.

When asked what enquiries he made to test the accuracy of the 'rumour' he had heard, Dr Renshaw explained that, by then, matters relating to Mr Griffin were largely with the Secretary of the Department and he did not think he should take it upon himself to make enquiries.[1310] We note that the Department disputes that the Secretary was tasked with any actions in relation to Griffin's offending.[1311] After further questioning, Dr Renshaw conceded that he believed the rumour at the time he heard it.[1312] He also told us that he did not believe it was appropriate to escalate this information 'on the basis of a rumour heard in a corridor' despite his belief in its veracity, and that there was not enough information for him to do so.[1313] During our hearings, Dr Renshaw conceded that not advising the Secretary of the rumour was a failing.[1314]

We recognise there were likely rumours swirling around the hospital. However, as reported to us, Dr Renshaw did receive specific information as part of this 'rumour' (namely the fact the disclosure involved Mr Millar) that he could have escalated for closer examination. We consider Dr Renshaw's failure to pass on information arose once Tasmania Police confirmed this 'corridor rumour' to him on 29 October 2019 and find as such in Section 5.2.21.

5.2.19 21 October 2019—The Secretary is verbally briefed on Mr Griffin's death

Secretary Morgan-Wicks told us that when she returned from leave:

> I recall that [the Acting Secretary] briefed me on critical issues of note that occurred during my period of leave, including the prolonged death following attempted suicide of a former employee, Mr Griffin, on 18 October and the earlier information that had been received on 14 October in relation to criminal charges against Mr Griffin.[1315]

Secretary Morgan-Wicks said that when she spoke to the Acting Secretary, she queried whether supports had been put in place for staff in light of Mr Griffin's death, and whether anything further needed to be done.[1316] She recalled that:

> … no further action was recommended at that time, that the Tasmania Police investigation was ongoing and that there was no notification that Mr Griffin's alleged offending was linked to his employment as a Paediatric Nurse with the THS.[1317]

Secretary Morgan-Wicks' impression was that the criminal allegations against Mr Griffin were related to his personal life, as she understood that the Department would be told if the victim-survivor was a patient, or the offending had occurred at the hospital.[1318] Secretary Morgan-Wicks also stated that the specific details of the police charges laid against Mr Griffin do not appear to have been shared with the Department until 2 November 2020, after the Department requested more information.[1319]

5.2.20 24 October 2019—The Australian Nursing and Midwifery Federation convenes a meeting for Ward 4K staff

Following Mr Gordon's contact, the Australian Nursing and Midwifery Federation convened a meeting for Ward 4K staff on 24 October 2019. Mr Gordon told us that the response of almost all attendees at this meeting was 'essentially a vote of no confidence' in Ms Leonard's leadership.[1320] Mr Gordon added: 'Everyone had had enough of the lack of support, information, and the direction to remain silent'.[1321]

Emily Shepherd, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian Branch), gave her recollections of this meeting, which she attended, as follows:

> There was one report that was quite recent from 2016 which was made by one of our workplace delegates. [Note we consider this to be Mr Gordon's 2017 complaint.]

> That information was shared, but then there were also other members indicating that they were aware that other reports had been made, both verbally, via email, on paper-based incident reporting some time ago, and there was a collective recognition that there had been a pattern of reporting over a number of years.[1322]

Sometime after the meeting on 24 October 2019, Ms Shepherd contacted Ms Leonard and Ms Tonks to relay staff concerns and foreshadow the Australian Nursing and Midwifery Federation's intention to put those concerns in writing.[1323] On 28 October 2019, Ms Shepherd wrote to Ms Leonard, requesting a staff group debriefing facilitated by an independent counsellor 'without any management or HR representatives present'.[1324]

Mr Gordon recalled that, as a result of the Australian Nursing and Midwifery Federation's advocacy, the hospital engaged a private counsellor for individual sessions with staff.[1325] When Mr Gordon encountered this counsellor in the staffroom, he learned that their professional expertise was in counselling parents and staff following stillborn births.[1326] He felt that this was not the right skill set for what the nurses required and so did not arrange a session with the counsellor.[1327] Mr Gordon said that other staff were also wary of speaking to this person because there was a perception that the counsellor was reporting back to management.[1328]

The letter Ms Shepherd sent to Ms Leonard on 28 October 2019 also stated that:

> Members articulated an aggrievement with the way their previously lodged complaints regarding Jim have been handled. Members note that they did not receive any acknowledgement, or they were not advised that their complaint/ concern was handled. Considering recent events, the lack of transparency around their concerns is causing them significant distress, it is also driving a lack of confidence in their management. The [Australian Nursing and Midwifery Federation] requests that all previously lodged complaints in relation to Jim Griffin are reviewed and that the complainant is contacted and advised of the action take[n] at the time.[1329]

The request triggered a meeting between the Australian Nursing and Midwifery Federation and hospital management, which is described in Section 5.2.24.

As noted earlier, we did not see evidence of any meaningful examination of complaints about Mr Griffin in the three months from when he became the subject of a police investigation. There is considerable confusion about which complaints concerning Mr Griffin that Dr Renshaw was aware of at this stage. We note that Dr Renshaw had committed, on 31 July 2019, to examining the Safety Reporting and Learning System. At the time of our hearings, Dr Renshaw said that he was only aware of one complaint by a staff member in relation to Mr Griffin.[1330] Dr Renshaw, however, later told us that the search of the Safety Reporting and Learning System 'did not yield any results'.[1331]

5.2.21 29 October 2019—Tasmania Police briefs Dr Renshaw further about child exploitation images taken on Ward 4K and about Ms Pearn's disclosure

Dr Renshaw told us that on 29 October 2019, he received another briefing from Tasmania Police. On this day, he was advised that police had formed the belief that some of the photos that Mr Griffin had taken of Ward 4K patients constituted child exploitation material and that the police investigation was now focused on identifying the children in those photographs.[1332] This advice is confirmed in Detective Senior Constable Hindle's written summary of the meeting:

> Dr RENSHAW informed of the existence of in excess of (50) photographs regarded as Child Exploitation Material which were located on a device (phone) seized from GRIFFIN.[1333]

Detective Senior Constable Hindle told us that he informed Dr Renshaw about Ms Pearn's disclosure at this meeting, although this is not expressly captured in the meeting summary he prepared.[1334] Dr Renshaw said he did not recall Ms Pearn's disclosure being discussed at the meeting but that he had no reason to doubt Detective Senior Constable Hindle's recollection.[1335]

Finding—Dr Peter Renshaw should have escalated and acted on knowledge of Kylee Pearn's disclosure to the hospital once advised about it by Tasmania Police on 29 October 2019

We consider that Detective Senior Constable Hindle told Dr Renshaw about Ms Pearn's disclosure on 29 October 2019. Dr Renshaw had a responsibility to tell the Department and the hospital executive, particularly the Chief Executive Mr Daniels, that there had been a significant failure of systems and processes at the hospital resulting in a paedophile continuing to work in a paediatric ward for several more years. Dr Renshaw, as part of the executive, should have been looking for ways to ensure similar failures did not reoccur. He should also have been ensuring that others were informed of the failures in systems and processes so they could support those affected and take their own actions to ensure similar failures were not repeated.

5.2.22 30 October, 1 November and 13 November 2019—Dr Renshaw facilitates Ward 4K staff information sessions

On top of the distress staff were experiencing about the circumstances of Mr Griffin's death, we heard that staff were also becoming increasingly frustrated about the lack of information from management about how the hospital was responding to allegations against Mr Griffin.

Dr Renshaw facilitated three information sessions with Ward 4K staff to share information about Mr Griffin. These sessions took place on 30 October 2019, 1 November 2019 and 13 November 2019.[1336] Dr Renshaw told us that the 'overall strategy' for these sessions was 'driven by human resource advice'.[1337] Dr Renshaw said that the purpose of the sessions was to provide 'factual information regarding the current situation of the investigations into Griffin', noting that all the information he provided was cleared by Tasmania Police.[1338] Dr Renshaw stated that he advised staff that 'gossiping and innuendo were potentially destructive and unhelpful when the focus should be on supporting the legal processes and healing the broken team'.[1339] We consider it likely that Dr Renshaw was referring to the Tasmania Police investigation when referring to legal processes.

Ms Tonks, who was present during these sessions, told us that the information provided at the sessions was consistent on each occasion and included the timing of the police complaint (and when the hospital became aware of it), the suspension of Mr Griffin and the fact that the investigation (to the extent that it was occurring after Mr Griffin's death) was being managed by Tasmania Police.[1340]

At the hearings for our Commission of Inquiry, Ms Whitemore described a change in Dr Renshaw's approach towards staff during these sessions, saying 'it changed from "We'll support you, we'll support the nursing staff with whatever they need", to "You all should have been mandatory reporting": no respect, no respect'.[1341]

We understand Ms Tonks advised the meeting that there were no outstanding complaints against Mr Griffin. Ms Tonks later explained that she told staff this because she 'could only trust that [she] had been given accurate information by HR'.[1342] Ms Bryan did not take part in these sessions. She told us: 'I was not included in those meetings and so I am unaware of what response/reaction there was to [them]'.[1343]

Dr Renshaw felt the sessions he facilitated were generally well received. He recalled that some staff members sent him emails thanking him for the information provided at the sessions.[1344] However, Dr Renshaw also noted that 'two or three' staff were disappointed that the sessions were information-based and not group debrief sessions and 'expressed themselves quite clearly' on that front.[1345]

On 12 November 2019, before the final session, Mr Gordon, in his capacity as a union representative for Ward 4K, wrote to Dr Renshaw thanking him for hosting two meetings with Ward 4K staff.[1346] In this email, Mr Gordon said he had heard nothing but 'praise and gratitude' for answering staff questions.[1347] However, he reiterated the desire of staff to hold a group debriefing session because many were personal friends of Mr Griffin and felt both saddened by his death and shocked and conflicted by the information that had emerged about his offending.[1348]

Dr Renshaw sought advice from Mr Bellinger, Mr Daniels and Ms Bryan on how to respond to Mr Gordon's request.[1349] We note that this was one of the rare occasions that we are aware of when members of the executive discussed decisions in relation to Mr Griffin.

Mr Bellinger gave Dr Renshaw several options for responding to the request, including encouraging staff to use the services of the counsellor and directing staff to the usual Employment Assistance Program. Mr Bellinger also advised Dr Renshaw to explain that staff debriefs were 'not clinically or therapeutically recommended in these circumstances' because they may contribute to further staff upset or trauma.[1350] Mr Bellinger suggested that Dr Renshaw guide Mr Gordon and other staff 'back towards [Women's and Children's Services] management' to rebuild trust.[1351] Mr Bellinger's advice to Dr Renshaw concluded:

> I am deeply concerned by the breakdown this is now causing and think we need to be very careful to provide appropriate support, and resolve their perceived issues (which in my view are not reasonably held in these circumstances).[1352]

In the final of the three information sessions facilitated by Dr Renshaw, Mr Gordon asked Dr Renshaw whether he was aware of his 2017 complaint.[1353] Mr Gordon told us that Dr Renshaw replied that he had not seen Mr Gordon's complaint, but he was corrected by Ms Tonks, who said that Dr Renshaw had in fact seen the complaint.[1354] Mr Gordon described what happened next:

> I then asked [Dr Renshaw], 'Is this a minor incident?' And he said, 'No, it's not.' So I was like, 'Well, did you actually see it, did you read it?' It felt heavily implied by the contradicting statements of, you know, [Janette] Tonks and Peter Renshaw at the time that one of them wasn't being truthful and it felt heavily like it was Peter Renshaw who was not being truthful at the time.[1355]

Mr Gordon went on to ask why Ms Leonard did not report his complaint to Ahpra. Mr Gordon described Dr Renshaw's response:

> He said, 'Well, if you're going to blame [Ms Leonard]' and he pointed his finger and looked in my general direction, he said, 'Why didn't you report him?' And that's when it truly hit me that this was dead in the water, the THS [Tasmanian Health Service] were not going to do anything about it.[1356]

Mr Gordon reflected on this, telling us:

> It also felt quite personal as if, you know, it was my fault, and the big problem was, is that, he was actually right. Why didn't I? Because I didn't know I could report my own [colleagues] to Working with Childrens. The majority of nurses on that ward, after hearing about this, didn't realise they could report their colleagues to Ahpra, otherwise we might have done.[1357]

Ms Tonks also gave evidence about this exchange between Mr Gordon and Dr Renshaw at the third information session. She said she did not believe Dr Renshaw intended his response to sound accusatory but conceded: 'I believe it was certainly delivered in a way that people would have felt that it was their fault, and that's regretful that's occurred'.[1358]

On 13 November 2019, after the final information session, Dr Renshaw received an email from a nurse on Ward 4K who expressed 'extreme disappointment' about how the session was facilitated.[1359] The nurse complained that Dr Renshaw had not answered staff questions satisfactorily and had 'conducted' the meeting rather than allowing for debrief and discussion.[1360]

In his response to this staff member, Dr Renshaw clarified that his sessions with staff were not intended to be therapeutic debriefings but focused on delivering factual information to 'minimise the impact of gossip and hearsay'. He wrote to the staff member:

> I have been provided with expert advice, both from within the THS and external advice from my colleagues in other jurisdictions that strongly indicates that the 'open de-brief' such as you are requesting can be very damaging to individual members of the ward team … For this reason, and as an LGH/THS member who is personally accountable for the safety and well-being of our staff attending any session for which I am the lead, at the present time, I will not be supporting the open debrief 'quiet chat' approach.[1361] [Emphasis is Dr Renshaw's.]

Dr Renshaw also provided information to the staff member about how the hospital was responding to the allegations against Mr Griffin:

> Relevant members of the LGH Executive (specifically myself, James [Bellinger] – HR Director, Helen [Bryan] – EDON [Executive Director of Nursing] and Janette [Tonks]) have reviewed any matter relevant to Mr Griffin's behaviour of which we have a record. In each instance we can find the matter was reasonably addressed with Mr Griffin. This is not to say there are other matters of which we are unaware of which need to be considered and I welcome the opportunity to review these in order to bring you some closure.[1362]

Mr Gordon told us that it was after this final staff briefing on 13 November 2019 that he made an anonymous complaint to the Integrity Commission about the way senior staff at the hospital responded to concerns about Mr Griffin:

> I made the report to inform the Secretary of Health of the situation on the ward. I was desperate for some sort of investigation into the THS over the handling of the situation.[1363]

Other evidence suggests the Integrity Commission received this complaint on 4 November 2019, after the second briefing session, but that Mr Gordon was engaged with the Integrity Commission about the complaint on 13 and 15 November.[1364] Mr Daniels told us he was not aware of the complaint to the Integrity Commission until our hearings.[1365]

Mr Daniels told us that Dr Renshaw briefed him about these sessions with staff. Mr Daniels recalls Dr Renshaw describing the purpose of the sessions as part of the 'counselling and debriefing for them' and expressed the view that staff would benefit

from further training (presumably about mandatory reporting).[1366] Mr Daniels further stated at hearings for our Inquiry: 'The feedback we've received [from staff] to date [has] been really positive from my perspective'.[1367]

Finding—The lack of a coordinated and transparent response by Launceston General Hospital increased feelings of mistrust among hospital staff

We have received evidence that Launceston General Hospital leadership did not have access to records relating to many potential complaints about Mr Griffin, and that the human resources team did not raise complaints about Mr Griffin with leadership, other than Mr Gordon's complaint.[1368] A review of complaints about Mr Griffin was not conducted until November 2019. We discuss the quality of this review in Section 5.2.25.

We saw no evidence to suggest that Launceston General Hospital leadership actively sought information from human resources staff or anyone else about previous complaints against Mr Griffin, nor was a process conducted to test the rigour or quality of the hospital's records of complaints by human resources or anyone else. Therefore, the assurances provided to staff that complaints about Mr Griffin had been thoroughly examined were misleading.

Instead, staff were given assurances that there were no relevant concerns about Mr Griffin's employment at the hospital, notwithstanding knowledge that:

- Mr Griffin had taken photos of patients on the ward, some of which Tasmania Police considered to be child exploitation material.
- Tasmania Police had advised that Mr Griffin had a care arrangement with a former patient of his, which may have been a breach of his professional boundaries.
- A former staff member, Ms Pearn, had made a disclosure of child sexual abuse by Mr Griffin to the hospital in 2011 or 2012.

While we accept that it would not have been appropriate to share all this information with staff, false assurances should not have been provided.

We were particularly concerned about suggestions that staff felt blamed for not making mandatory reports to Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme and Ahpra. We hold this concern in light of our earlier findings about the hospital's lack of a clear process for staff reporting concerns to external agencies.

The hospital's response would have been assisted if there had been a critical incident response plan informed by open disclosure principles (refer to Chapter 15, Recommendation 15.19). This may have assisted the hospital to:

- seek external guidance on how to respond to staff
- provide accurate, transparent and clear communication to staff, including being honest about what was and what was not known
- trigger an early review of what could be learned about Mr Griffin's conduct within the hospital.

The absence of these elements in the response led to staff mistrusting the leadership team.

5.2.23 29 October–5 November 2019—The Secretary is briefed on a 'potential legal issue' relating to Mr Griffin

On 29 October 2019, the same day that Dr Renshaw received the second briefing from Tasmania Police, he prepared a Minute to the Secretary. Mr Daniels endorsed this Minute the same day, as did the human resources team on 31 October 2019. The Secretary signed the Minute on 5 November 2019. The Minute is significant, and, for this reason, we replicate significant parts of it. As stated in the Minute, the purpose of the briefing to the Secretary contained within the Minute was to:

1. Update you re the status of a Tasmania Police investigation into James Geoffrey Griffin, a previously registered Paediatric Nurse who was suspended from duty at the Launceston General Hospital (LGH) on 31 July 2019 on advice that his Working with Vulnerable People Registration was withdrawn.
2. Update you as to the actions taken by the Tasmanian Health Service (THS) in relation to this investigation.[1369]

We note that at hearings, there was significant back and forth between Counsel Assisting and Dr Renshaw as to how the first three dot points of the Minute under the heading 'Summary of key issues' (refer below) should be interpreted. In essence, Dr Renshaw sought to argue that the chronological nature of the briefing was intended to recap key events for the Secretary and to reflect the hospital's state of knowledge at particular times in the chronology. We do not intend to recount this back and forth, but note our frustration at Dr Renshaw's responses under questioning, when it was clear that what was at the heart of questioning by Counsel Assisting was to seek Dr Renshaw's response to a suggestion that the Minute he drafted was not comprehensive nor accurate.

We have considered the dot points in the Minute in line with how Dr Renshaw felt they should be interpreted—that is, as reflecting his state of knowledge as at 31 July 2019. We consider they are misleading even on this reading.

Under the heading 'Summary of key issues', the Minute starts with the following two dot points:

- Mr Griffin was suspended from duty from the LGH Paediatric Ward (Ward 4K) on 31 July 2019 following the cancellation of his registration for Working with Vulnerable People on the advice of Tasmania Police received by the Executive Director of Medical Services (EDMS).
- At that time, Tasmania Police were investigating a complaint external to the hospital pertaining to his alleged relationship with a young person and possession of child exploitation material. At that time, Tasmania Police advised that there was no evidence to suggest that any criminal activity had taken place within, or connected to, the LGH.[1370]

As described above, at the 31 July 2019 briefing from Tasmania Police, Detective Senior Constable Hindle told Dr Renshaw about police awareness of Mr Griffin's contact with Penny, a former Ward 4K patient. Detective Senior Constable Hindle also advised that photos of patients had been found in Mr Griffin's possession. Dr Renshaw specifically referenced Penny, and her status as a former patient, as part of his Ahpra notification made the following day. Dr Renshaw also told us that during this briefing, he identified that some of the photos, which did not include child exploitation material, were taken in Ward 4K.[1371] This state of knowledge is not reflected in the second dot point above. Dr Renshaw later told us that the absence of any references in the briefings prepared prior to October 2019 to the possibility that photographs may have been taken in the hospital was not an attempt to mislead his superiors, as the possibility was 'obvious to anyone'.[1372] Dr Renshaw also told us that he considered it unnecessary to make specific reference to Penny in the Minute.[1373]

As Dr Renshaw explained to us, the third dot point also relates to his state of knowledge on 31 July 2019:

- The LGH had <u>not</u> received <u>any</u> complaints from patients or their families regarding inappropriate behaviour by Mr Griffin that would warrant a Code of Conduct investigation, [Australian Health Practitioner Regulation Agency] notification or Tasmania Police notification.[1374] [Emphasis is Dr Renshaw's.]

In Section 4, we outline a succession of complaints about Mr Griffin's breaches of professional boundaries and inappropriate behaviour with young patients. We consider that several of the complaints against Mr Griffin, particularly those related to non-care touching of patients, independently met the threshold for disciplinary action. Considered cumulatively, there was no justification for not taking further action in response to Mr Griffin's conduct.

At hearings, Dr Renshaw stated that he had based the content of the third dot point on his interrogation of the Safety Reporting and Learning System, which only included one complaint by a staff member (Mr Gordon).[1375] Dr Renshaw later told us that the search of the Safety Reporting and Learning System 'did not yield any results'.[1376] Dr Renshaw, however, conceded that the content in this third dot point was inaccurate.[1377]

As noted above, Mr Bellinger acknowledged that consideration should have been given to conducting a State Service Code of Conduct investigation in response to Mr Gordon's Safety Reporting and Learning System complaint.[1378] We are not convinced that Dr Renshaw had properly reviewed this complaint, such that he could have formed a view at the time on the appropriateness of a State Service Code of Conduct investigation.

When asked why he did not reflect any potential connections between Mr Griffin's criminal investigation and the hospital in the Minute, Dr Renshaw provided a confused explanation, but ultimately said he 'overlooked it' and that the omission was 'unintentionally misleading'.[1379] Dr Renshaw conceded that the second dot point under the heading 'Summary of key issues' 'should have been worded better than that', and he agreed the term 'connected to' was 'wrong' and 'misleading', given he himself had referred to Penny as a former patient in his Ahpra notification on 1 August 2019, and that he knew images of patients had been found in Mr Griffin's possession.[1380]

The dot points in the Minute following the three discussed above are unremarkable in summarising subsequent events. They include content on the cancellation of Mr Griffin's nursing registration by Ahpra on 4 August 2019 (although we note that the cancellation in fact happened on 7 August 2019); Mr Griffin's resignation from the Tasmanian Health Service on 8 August 2019; the article of 9 October 2019 in *The Examiner*; and Mr Griffin's death, which Dr Renshaw noted was subject to a coronial investigation.[1381]

After this content, the next dot point summarised the information Dr Renshaw received from Tasmania Police on 29 October 2019:

> Tasmania Police met with the Executive Director of Medical Services on his return from leave on 29 October 2019 to provide additional information from their ongoing investigation. They advised that they had found a significant number of photographs classifiable as 'child exploitation material' possibly taken within the hospital over a period of some years. Tasmania Police are working to identify the children involved in this material.
>
> The information provided on 29 October 2019 by Tasmania Police was the first information that illegal / criminal behaviour may have occurred within the LGH.[1382]

We note that Detective Senior Constable Hindle told Dr Renshaw about Ms Pearn's disclosure to the hospital at the 29 October 2019 meeting. This critical information was not reflected in the summary of what Dr Renshaw learned that day. We also note that the human resources team signed off on this Minute and was aware of Ms Pearn's disclosure, noting Mr Bellinger's discussion with Detective Senior Constable Hindle on 11 October 2019. Dr Renshaw acknowledged that the Minute failed to include all relevant information, including Ms Pearn's disclosure: 'I would concede that there should have been a mention towards the bottom of the chronology regarding the most recent information from Tas Police'.[1383] The omission was more significant than this. The

statement that this 'was the first information that illegal / criminal behaviour may have occurred within the LGH' was clearly misleading.

The Minute goes on to detail what was occurring on Ward 4K:

> There is considerable gossip and innuendo in respect of this case across the Launceston community which is generating significant pressure on LGH management to provide statements in relation to this matter.
>
> Some staff on the Paediatric Ward (Ward 4K) have also shown levels of stress which has resulted in a letter from the ANMF (Australian Nursing and Midwifery Federation) claiming, without foundation, that LGH management had ignored potential warning signs in Mr Griffin's behaviour. The LGH offered one-on-one individual counselling to all nursing staff on the ward in addition to the standard Employee Assistance Program. Group debriefs, which the ANMF has requested, is not clinically recommended in circumstances such as this.[1384]

This part of the briefing was of particular concern to us. We consider it appalling to suggest, in the context of Mr Griffin's complaints history, that the concerns staff expressed via the union were 'without foundation'. The inaction on Ms Pearn's disclosure alone, which was known to Dr Renshaw and some members of the human resources team by this point, was a clear demonstration of the hospital ignoring potential warning signs.

The Minute continues:

> Peter Renshaw met with 4K staff on Wednesday 30 October 2019 and the Executive Director of Operations, Executive Director of Nursing and HR are currently arranging to meet with Dr Renshaw with respect to the purpose and content of the meeting.[1385]

We note that Dr Renshaw prepared the Minute on 29 October 2019, before the 30 October 2019 meeting, and suspect that the tense used—that is, that Dr Renshaw had 'met' with staff—was likely changed by those endorsing the Minute up the line, who recognised that the session with staff had happened by the time the Minute reached the human resources team.

The next heading of the Minute is 'Analysis of Issues' and reads:

> This is a serious and sensitive matter, even prior to the new information about potential criminal activity within the hospital. If and when Tasmania Police provide details of LGH patients that may have been the victims of the former staff member's alleged crimes whilst in LGH care, it will be imperative that the THS undertake Open Disclosure with the affected individuals and families.
>
> There is a need for ongoing management in relation to issues of open disclosure, staff assistance (EAP) for stressed or concerned staff members, liaison with Tasmania Police and media liaison as appropriate.

> There may also be publicity surrounding the Coroner's findings into Mr Griffin's death although this is fully dependent on the amount of information that the Coroner chooses to release with his or her findings.
>
> Advice has been sought from Crown Law (through the Assistant Solicitor-General, Mr Turner) regarding the THS response to this matter.[1386]

Dr Renshaw told us at hearings that the request for legal advice was confined to advice on the open disclosure process.[1387] We discussed in Section 5.2.3 the evidence we received from the Office of the Solicitor-General about Dr Renshaw's queries, including the frustrating absence of any records relating to this request for legal advice.

The recommendation in the Minute was simply that Secretary Morgan-Wicks 'note the above advice'.[1388] The previous 31 July 2019 Minute to the Secretary was listed in the 5 November 2019 Minute as an attachment.

On 5 November 2019, Secretary Morgan-Wicks marked the Minute as 'noted' with the following handwritten comment: 'Please advise if/when TasPol share information re past patients identified in any material so that approach to disclosure can be approved'.[1389]

Counsel Assisting invited Mr Daniels, who also received the Minute, to reflect on the many opportunities he had to receive frank advice from Dr Renshaw, given how little he seemed to know about Mr Griffin until our public hearings. Mr Daniels said he felt 'a loss of trust' in Dr Renshaw.[1390] Dr Renshaw said he could understand why Mr Daniels felt this way, given that he did not pass on information that may have assisted Mr Daniels to respond appropriately.[1391]

Counsel Assisting also invited Secretary Morgan-Wicks to reflect on the Minute:

> Q [Counsel Assisting]: From reading this note [the 5 November 2019 Minute], did you learn anything about the Pearn disclosure?
>
> A [Secretary Morgan-Wicks]: No, I did not.

Secretary Morgan-Wicks also agreed that the Minute did not make her aware of Mr Griffin's care of a former patient of the hospital, Penny. Counsel Assisting continued:

> Q: Are those matters that you would expect to be briefed to you if they were known to any person providing you with this briefing?
>
> A: Absolutely.[1392]

Secretary Morgan-Wicks described being 'absolutely horrified' about not having received critical information in the Minute and agreed that it was 'misleading'.[1393] Secretary Morgan-Wicks also told us that she would have liked to have understood the extent of staff anxiety and concerns in late 2019 rather than 2020 so she could have 'better [supported] Ward 4K staff to recover from this traumatic incident'.[1394] She stated that she only became aware of the extent of staff distress once she met with staff after the release of *The Nurse* podcast.[1395]

Reflecting on the importance of briefings to the Secretary being accurate, Secretary Morgan-Wicks said:

> As the Secretary of a department that has some close to 16,000 employees, I rely on the accuracy of information that comes up to me. It's certainly impossible for me to dive into every single issue that actually crosses a Secretary's desk on any day of the week, so certainly I absolutely do rely on the information that comes to me.[1396]

Secretary Morgan-Wicks also said that the information about Ms Pearn, in particular, would have influenced her decisions at this time:

> … if it had been escalated earlier to me at the time of contact from TasPol in October 2019, I believe that I would have immediately instituted an independent investigation in relation to the management of complaints relating to Mr Griffin (as I did on 21 October 2020 upon receipt of this information).[1397]

We discuss the independent investigation in Section 5.2.46.

Finding—Dr Peter Renshaw misled the Secretary of the Department about James Griffin

Of all the Minutes to the Secretary, we consider the Minute of 5 November 2019 to be the most significant and the most misleading. The following reflects the specific information we consider should have been included in the Minute. We then make observations about its overall tone.

Other information that should have been included in the Minute was:

- Mr Griffin was a paediatric nurse on Ward 4K for 18 years. His length of service is relevant given the number of paediatric patients who would have had exposure to him. It is also relevant to understanding the impacts on staff of his conduct and death because many would have known him for a long time.
- Mr Griffin was temporarily assigned to Ashley Youth Detention Centre in November 2017. Mr Griffin would have had contact with a group of highly vulnerable young people in a high-risk setting during this assignment. Steps should have been taken to confirm whether there were any concerns or complaints about Mr Griffin during his time in this role.
- Mr Griffin had an extensive complaints history within the hospital. All the complaints and concerns listed under 'Documented or acknowledged complaints' in Section 4 were known or knowable to the hospital. There were 14 documented complaints about Mr Griffin's inappropriate behaviour and professional boundary breaches in the hospital during his employment.

- In addition to these complaints, a staff member, Ms Pearn, disclosed to the hospital in 2011 or 2012 that she had been sexually abused by Mr Griffin as a child. Inaction by the hospital following this disclosure, including allowing Mr Griffin to remain on the ward, was a major litigation and reputational risk for the hospital and the Department.
- Tasmania Police had raised a private care arrangement regarding a former patient of Mr Griffin's, Penny, which may have constituted a breach of Mr Griffin's professional obligations.

While the Minute gave the Secretary some sense of the seriousness of the situation and the distress of ward staff, it also conveyed that the hospital had no knowledge of the risk Mr Griffin posed to children until 31 July 2019. We consider the wording of what was included, combined with what was excluded, to have been calculated to give the impression to the Secretary that the hospital was not implicated in Mr Griffin's conduct. Secretary Morgan-Wicks agreed, telling us she felt that the wording of the Minute was designed to 'reassure me that there was nothing to see here in terms of the LGH'.[1398]

Dr Renshaw conceded that 'in retrospect' the briefing was significantly deficient, although he qualified that the briefing was written in 'good faith based on the information' he had at the time and 'there was no deliberate intent to mislead'.[1399] He said 'it was just one of those situations where the amount of information we had was pretty well overwhelming'.[1400] Dr Renshaw later told us that he did not include some information in the briefing, because it was 'unnecessary' (in relation to Penny), did not 'warrant advising the Secretary' (in relation to the 'corridor rumour') or was 'well known' (in relation to Mr Griffin's length of employment).[1401] This does not explain why Dr Renshaw did not include information about Ms Pearn's disclosure when it was confirmed by Detective Senior Constable Hindle on 29 October 2019. Dr Renshaw also stated that he regretted his failure to pass on critical information, which contributed to the Secretary not taking appropriate steps in response to the allegations against Mr Griffin and in support of staff.[1402]

The concessions Dr Renshaw made were reluctant and highly qualified and we found his evidence on this Minute to be unconvincing. Overall, we consider that he attempted to minimise his responsibility by suggesting that the Department was taking the lead on coordinating investigations and that any enquiries he may have made to provide more comprehensive advice could have cut across the Department's work.[1403] This position overlooks the obvious fact that the Office of the Secretary was relying on Dr Renshaw's advice—as a senior executive who was receiving or had access to all material information—to inform her decisions on the need for and nature of further enquiries.

5.2.24 6 November 2019—The Australian Nursing and Midwifery Federation meets with hospital management

As noted above, the Australian Nursing and Midwifery Federation wrote to Ms Leonard on 28 October 2019. This letter reiterated staff requests for a group debriefing and raised concerns that hospital management had not properly addressed complaints about Mr Griffin.

After not receiving a response, Ms Shepherd contacted Ms Tonks and was told that her letter had been escalated to Mr Daniels.[1404] On 31 October 2019, Mr Daniels wrote to Ms Shepherd noting that her letter had caused 'significant distress to Ms Leonard as well as the then Nursing Director of Women's and Children's Services [Ms Tonks]'.[1405] Mr Daniels requested a meeting with Ms Shepherd and proposed that it would be 'appropriate to have both the LGH Executive Director of Nursing … Helen Bryan, and James Bellinger, Manager of Human Resources for the North and North West of the THS also attend'.[1406] Mr Daniels ended the letter: 'I am particularly concerned to ensure that relevant executive management staff at LGH are involved' and requested union correspondence to be directed to Ms Bryan in the first instance.[1407]

Ms Shepherd said Mr Daniels' request that she direct correspondence to Ms Bryan was outside usual processes and that the Australian Nursing and Midwifery Federation had previously been directed to always raise concerns with the relevant nurse unit manager in the first instance.[1408]

Our review of the correspondence between the hospital and the Australian Nursing and Midwifery Federation suggests that the relationship between hospital management and the Federation at this point was strained at best.

A meeting involving Ms Shepherd, Mr Daniels, Ms Bryan and Mr Bellinger took place on 6 November 2019.[1409] Ms Shepherd told us that a range of issues were discussed at this meeting. Of note, Ms Shepherd recollected that:

- Mr Daniels asked for evidence to support members' claims that complaints about Mr Griffin had been made and not acted on, to which Ms Shepherd referenced Mr Gordon's 2017 Safety Reporting and Learning System complaint.[1410]
- Ms Shepherd had to advocate strongly for a commitment from the hospital representatives attending the meeting that feedback be provided to staff who had previously raised complaints about Mr Griffin, without staff members having to request this feedback themselves.[1411]
- Mr Daniels produced a copy of the Children, Young Persons and Their Families Act to suggest that any members who held concerns about Mr Griffin should have made a mandatory report.[1412]
- Mr Daniels strongly advised against staff speaking to the media, stating that this would be a breach of the *State Service Act 2000* ('State Service Act') and place their employment at risk.[1413]

We did not receive evidence from Mr Daniels or Ms Bryan about this meeting. We note Mr Daniels' evidence that human resources staff and Dr Renshaw informed him that all complaints against Mr Griffin had been 'critically investigated and not substantiated'.[1414]

5.2.25 November 2019—Human resources staff review complaints about Mr Griffin

As we have foreshadowed at various points, despite the assurances given to Ward 4K staff and the Australian Nursing and Midwifery Federation, it was unclear to us what, if any, reviews the hospital undertook into Mr Griffin's complaints history and its state of knowledge of the risks he posed to children.

Mr Bellinger told us that sometime in November 2019 he conducted a review of records in response to staff concerns about how management had dealt with complaints about Mr Griffin.[1415] We note that on 11 October 2019, Mr Bellinger had conducted at least a cursory search of human resources records when Detective Senior Constable Hindle called him asking about Ms Pearn's 2011 or 2012 disclosure to the hospital. As outlined earlier, Ms Leonard recalled the human resources team asking for her records of complaints about Mr Griffin 'at some stage' and we consider it likely this occurred around this time.

Secretary Morgan-Wicks told us that she understood a review of the complaints history against Mr Griffin was conducted after the 6 November 2019 meeting with Ms Shepherd.[1416] It is our view that this review was only conducted because of pressure from the Australian Nursing and Midwifery Federation.

At our hearings, Mr Bellinger stated that after undertaking this review he formed the belief that all complaints relating to Mr Griffin had been 'handled appropriately'.[1417] He subsequently qualified this statement, asserting that it was more accurate to say that the complaints were managed in line with the practice at the time.[1418] Under questioning from Counsel Assisting, Mr Bellinger conceded that Mr Griffin's complaints history suggested a pattern of behaviour that should have been identified and addressed:

> Q [Counsel Assisting]: We've heard the evidence that Griffin was cautioned three times at least that he would be subject to escalation if his conduct did not change. So, as far as you were aware did any escalation ever take place in accordance with those threats?
>
> A [Mr Bellinger]: No.
>
> Q: And is that a matter of concern for you?
>
> A: Yes.
>
> Q: Can you tell the Commissioners why it is a matter of concern for you?
>
> A: Given the pattern of behaviour displayed, these matters could and should have been considered differently and more significantly.[1419]

Of significant concern was that Mr Bellinger's review failed to consider and reflect all available material relevant to complaints about Mr Griffin. Mr Bellinger admitted that Ms Pearn's complaint to the hospital—which, on his evidence, he became aware of from Detective Senior Constable Hindle on 11 October 2019—was not included in his review.[1420] This is a striking omission. Mr Bellinger sought to justify the omission by explaining that his review was limited to complaints that were addressed with Mr Griffin.[1421] He accepted, in retrospect, that the limited scope of the review was not appropriate and that Ms Pearn's disclosure should have been included.[1422] However, he denied that his failure to include Ms Pearn's disclosure in his review was an attempt to cover up that the disclosure was first made to the hospital in 2011 or 2012:

> My involvement may not have been adequate, it may not have been sufficient, but 'cover-up' implies that there was an intent to cover up … That was not the intent; [the review] may not have been exhaustive enough, but it was not the intent to bury it.[1423]

We are not convinced of this and return to this point later.

Reflecting on the review of Mr Griffin's complaints history, Secretary Morgan-Wicks noted that, at the time, she was not provided with the review's findings:

> Although this was not a formal investigation, I am informed that this review took place and feedback was provided to staff involved. No further escalation regarding the review of complaints was made to the Secretary.[1424]

We did not receive evidence to suggest that any such feedback was given to staff about the complaints made or about the outcome of the November 2019 review (noting Ward 4K staff had received assurances before this review that all complaints had been managed appropriately in the staff briefings described in Section 5.2.22).

Mr Bellinger then conducted two 'reviews' into Mr Griffin's complaints history, but there was no evidence before us that those reviews went beyond the initial review. As a result, we consider that the deficiencies and omissions from the first review infected the subsequent reviews. This is significant because one of the later reviews was undertaken on behalf of the Secretary, in response to a complaint to the Integrity Commission. We return to Mr Bellinger's failings in relation to the various 'reviews' in our finding in Section 5.2.38.

Dr Renshaw confirmed his involvement in Mr Bellinger's November 2019 review; however, he was at pains to emphasise that human resources staff were leading this review and that he did not consider all the information that informed it.[1425] This suggests that Dr Renshaw was not aware of Mr Griffin's full complaints history.

5.2.26 November 2019—Mr Gordon becomes concerned his Safety Reporting and Learning System complaint could be modified

After the staff briefings with Dr Renshaw, described above, Mr Gordon became increasingly suspicious of the hospital's response to Mr Griffin's complaints history. So much so that, sometime in November 2019, he took photographs of his complaint in the Safety Reporting and Learning System to ensure he had a record in case the entry was altered or deleted.[1426]

On 14 November 2019, Ms Tonks emailed Mr Gordon stating: 'Peter [Renshaw] and I both share concerns with your comments [at the staff information session] relating to "unanswered complaints"'.[1427] Ms Tonks requested more information from Mr Gordon so she could 'personally review these complaints'.[1428] Ms Tonks followed up this request on 28 November 2019, writing to Mr Gordon that she 'remained concerned' with his assertions. Given Mr Gordon had not provided further information, she requested a meeting, that Mr Bellinger would also attend, on 2 December 2019.[1429]

Mr Gordon ultimately responded to Ms Tonks on 1 December 2019, noting that he had forgotten to send a previous draft response. He wrote: 'Regarding the unanswered complaints I, and the nurses who raised concerns with me on the ward as their ANMF Rep have decided not to pursue these concerns with the THS'.[1430] Mr Gordon indicated that staff had shared their concerns with the Australian Nursing and Midwifery Federation and that they had met with Mr Daniels and were ultimately satisfied. Mr Gordon, did, however, express concern about what happened to his complaint of August 2017, which Dr Renshaw had committed to following up.[1431] Mr Gordon indicated he did not think a meeting was necessary.

Ms Tonks responded to Mr Gordon's email on 2 December, copying in Mr Bellinger. Her email stated:

> I assure you that we have reviewed the matter you raised via SRLS in regards to Jim's behaviour, that particular event was addressed by Sonja with Jim at the time and I am satisfied with the outcome. I can confirm for you that (as [union] delegate) that all of the matters that we have on record were addressed with Jim in a reasonable manner. As I am sure you will appreciate, it can be difficult for managers to share the outcomes of these processes however I hope the assurance that they were addressed provides some comfort.[1432]

Mr Gordon formed a view at around this time that his Safety Reporting and Learning System entry had been changed to remove a specific reference to the comments Mr Griffin made to patients being sexual in nature. He began making enquiries with the hospital's IT team and the administrator in charge of the system about whether this could have happened.[1433] Mr Gordon stated to us that this administrator told him that pursuing his own investigation 'may result in an ED5 [Employment Direction No. 5—Breach of Code of Conduct] and could potentially result in termination of my contract'.[1434] Mr Gordon discontinued his enquiries.

A staff member in the Quality Patient Safety Service North at Launceston General Hospital told us that most staff at health services are 'default reporters', which means they can only report a Safety Reporting and Learning System event, not view, access or manage it.[1435] We were told that staff can see the file status of the event (for example, 'submitted', 'awaiting review', 'being reviewed/under investigation', 'referred for closing' or 'closed').[1436] Changes to safety events logged in the Safety Reporting and Learning System can also be seen via an audit trail, which shows the name of the person who made the changes as well as the date and time of the change and the actual change made.[1437]

We requested information to examine whether Mr Gordon's complaint entry had been altered in any way. As previously outlined, the audit trail shows that a staff member in the Quality Patient Safety Service granted file access to former Human Resources Consultant Mathew Harvey on 4 September 2017 and to Helen Bryan, former Executive Director of Nursing, on 7 November 2019, for review purposes only.[1438] This staff member told us that they did not alter or update the report other than to grant this file access to Mr Harvey and Ms Bryan.[1439] The audit trail also revealed that none of the staff who originally had access to Mr Gordon's complaint, including Ms Leonard and Ms Tonks, made any changes to the event.[1440] We were satisfied with our review of this entry and the audit trail that the entry had not been improperly changed. Mr Gordon was also ultimately satisfied with this conclusion once it was put to him at our hearings.[1441]

5.2.27 21 November 2019—The Integrity Commission notifies the Secretary of a complaint about Launceston General Hospital's management of complaints about Mr Griffin

As we noted above, in his frustration with the staff briefing process, Mr Gordon made an anonymous complaint to the Integrity Commission about the response of certain Launceston General Hospital managers to information about Mr Griffin.[1442] On 21 November 2019, the then Chief Executive Officer of the Integrity Commission wrote to Secretary Morgan-Wicks advising that he had received a complaint on 4 November 2019 about an employee at Launceston General Hospital.[1443] The Chief Executive Officer told Secretary Morgan-Wicks that the 'complaint raises allegations which, if established, might constitute misconduct'.[1444] The Chief Executive Officer referred the allegations raised in the complaint to Secretary Morgan-Wicks as the principal officer of the relevant public authority for investigation and action under section 38(1)(b) of the *Integrity Commission Act 2009*.[1445] His letter outlined the Integrity Commission's expectation that Secretary Morgan-Wicks would 'make sufficient inquiries to satisfy yourself as to whether any act of misconduct has occurred, and if so, to ensure that misconduct is dealt with in an appropriate way'.[1446] His letter also noted that the complaint may 'be an opportunity for you to review any relevant policies and procedures'.[1447]

While we have referred to Mr Gordon as the complainant in this section for clarity, the Chief Executive Officer's letter did not identify the complainant. However, the Chief Executive Officer indicated in his letter to the Department that he would advise the complainant that the matter had been referred to Secretary Morgan-Wicks. [1448] The Chief Executive Officer also noted in his letter that the complaint was 'a protected disclosure for the purposes of the *Public Interest Disclosures Act 2002* and that the protections provided under the Act applied to the disclosure'.[1449]

The Chief Executive Officer's letter did not provide details about the specific conduct of employees who were the subject of the complaint but enclosed a copy of the Integrity Commission's report, *Assessment Greystone*, with the letter. *Assessment Greystone* reflected a summary of the initial assessment of the complaint.[1450] It included the following:

> Multiple complaints were made to the Tasmanian Health Service over the past 18 years about Mr Griffin relating to his inappropriate conduct against minors and others on Ward 4K however that, due to personal relationships between key staff and Mr Griffin, these complaints were not properly investigated and any documentation destroyed.[1451]

The complaint alleged that the employees 'failed to properly deal with reports and complaints about James Griffin relating to his inappropriate conduct on Ward 4K of Launceston General Hospital'.[1452] Their conduct was described as a possible breach of the State Service Code of Conduct, which provides that 'An employee must behave honestly and with integrity in the course of State Service employment' and that 'An employee … must comply with all applicable Australian law'.[1453] *Assessment Greystone* noted that medical practitioners and nurses have mandatory reporting obligations under the Children, Young Persons and Their Families Act.[1454]

Assessment Greystone considered a range of issues raised in the complaint, including Mr Griffin's behaviour, management's response to reports and complaints, the police investigation, workplace culture and mandatory reporting of child abuse.[1455] It made explicit that the Integrity Commission's assessment had not considered any reports or management responses to Mr Griffin's behaviour, apart from a report made in August 2017 (Mr Gordon's Safety Reporting and Learning System report).[1456] This reflects the preliminary nature of the assessment.

The report also referenced Mr Gordon's belief that 'staff stopped making reports about Mr Griffin given management failure to respond to the reports and a fear of losing their jobs if they spoke out'.[1457] In this regard, Mr Gordon referenced an earlier matter where a former nurse on the ward was believed to have been 'bullied out of [their] position' after raising concerns about a procedural change they believed was detrimental to patients.[1458] The complainant surmised that the way this complaint was managed may have influenced staff against reporting future issues.[1459]

Assessment Greystone notes that the Integrity Commission contacted Mr Gordon on 13 and 15 November 2019. It recorded that Mr Gordon indicated he believed that he had been 'targeted' for speaking out at a meeting about Mr Griffin on 13 November 2019 because he was the only one who had received email contact after doing so, despite several other nurses also raising issues at the meeting.[1460] We note this description would likely have made Mr Gordon identifiable as the complainant to certain individuals at the hospital, most notably Mr Bellinger, who Ms Tonks copied in when responding to Mr Gordon raising concerns at a staff information session (described in Section 5.2.22).

Assessment Greystone concluded that:

> On the available evidence, it is likely that there has been knowledge and reports of inappropriate and more serious behaviour by Mr Griffin over an extended period of time, and that these may not have been properly dealt with by the [Tasmanian Health Service]. It is possible that proper reporting and management responses may have prevented Mr Griffin from offending and subsequently being charged with criminal offences, and thus protected vulnerable children and young people.[1461]

Mr Gordon received an email from the Integrity Commission's Chief Executive Officer on 21 November 2019, which read:

> … I consider the best way forward is to refer the matter to Ms Morgan-Wicks, with a request that she take further action. This decision is largely based on my belief that Ms Morgan-Wicks is in a better position to deal with the cultural and workplace issues that envelop your complaint – while we try to work with sensitivity, I do not believe that the commission is the best agency to deal with this matter in the existing circumstances.
>
> In referring the matter, I would expect Ms Morgan-Wicks to make sufficient inquiries to satisfy herself as to whether any act of misconduct has occurred and if so, to ensure that misconduct is dealt with in an appropriate way. It is also an opportunity for her to review any relevant policies and procedures. Ms Morgan-Wicks will advise us of any action she takes and I would be happy to pass that on to you.[1462]

When Counsel Assisting asked Mr Gordon whether he was disappointed by the Integrity Commission's determination not to investigate his complaint, Mr Gordon gave this response:

> I was hoping it would, but I did not expect it to because that submission to the Integrity Commission was highly emotive at the time and it was a lot of hearsay without facts, so I did not expect it to be investigated thoroughly but, like I said, the result I wanted I achieved: Kathrine Morgan-Wicks was aware of it.[1463]

Secretary Morgan-Wicks told us that she did not specifically recall receiving this correspondence from the Integrity Commission.[1464] We consider that it is possible that staff within the Office of the Secretary who received the complaint from the Integrity Commission may not have specifically notified the Secretary, given the volume of correspondence that is transacted through her office.[1465]

On 2 December 2019, the Integrity Commission's letter and report was referred to the then Chief People Officer at the Department with a request that she 'review the appropriate systems and provide advice to the Secretary'.[1466] In line with standard practice, the former Chief People Officer allocated the complaint to Mr Bellinger, as then Human Resources Manager, for investigation.[1467] According to the former Chief People Officer, they did this in consultation with another member of the human resources team. We note that the former Chief People Officer had only been in their role for a few weeks at this time but had previously worked in the Department's human resources area.[1468]

We consider it should have been obvious to the human resources team that allocating the complaint to Mr Bellinger—or indeed to anyone within that team—was inappropriate given their direct involvement in the management of some of the complaints about Mr Griffin (which the complainant took specific issue with). Mr Bellinger had been directly involved in responding to various complaints about Mr Griffin's behaviour over the years and played a central role in the hospital's management of more recent staff concerns about how Mr Griffin's conduct had been managed.

The former Chief People Officer told us they had no reason to believe there was any conflict of interest in Mr Bellinger investigating the complaint forwarded by the Integrity Commission and would have expected either the human resources team or Mr Bellinger to have notified them if there was.[1469] The Secretary echoed the former Chief People Officer's view:

> It's my expectation that when employees receive matters that they are working on, so whether it's an investigation or whether it's a transaction or other matter that they need to work with, that they need to evaluate their own conflicts of interest in relation to handling of matters.[1470]

When Counsel Assisting asked the Secretary whether allocating the complaint to Mr Bellinger in these circumstances was a conflict of interest, she replied: 'I believe so, yes'.[1471] Michael Easton, current Chief Executive Officer, Integrity Commission, similarly acknowledged that there was a potential concern that Mr Bellinger had a conflict of interest and should not have undertaken the investigation.[1472] The Health Complaints Commissioner, Richard Connock, also stated to us that 'it should probably have gone to somewhere other than human resources in this circumstance, yes'.[1473] The Department has since clarified that at the time of the referral the Department was not aware of the scale of the concerns in relation to the hospital's human resources team. However, the Department has acknowledged that, in hindsight, the matter should not have gone to the human resources team at the hospital.[1474]

Mr Easton's evidence also discussed the Integrity Commission's own processes for monitoring complaints. He accepted that in November 2019 the monitoring of complaints that were referred to public authorities was less rigorous than he would have liked it to have been.[1475] However, speaking generally, he held the view that it would be

appropriate at times for a public agency to investigate itself where there is an allegation of potential document destruction and cover up within the organisation.[1476]

Counsel Assisting asked Mr Easton about the reasons for referring the matter back to the Department, querying whether community outrage at the circumstances surrounding Mr Griffin's long-time employment in the paediatric ward should have warranted a more independent investigation. Mr Easton explained that enhancing public confidence was a relevant consideration, but community outrage was not. Mr Easton's evidence on this is set out below:

> Q [Counsel Assisting]: What about the need to restore public confidence in the aftermath of a discovery that a paedophile had worked on a paediatric ward at Launceston General Hospital for 18 years? Did that context and the understandable community outrage that followed weigh at all in your decision about whether or not this matter should be referred back to the Department of Health?
>
> A [Mr Easton]: No.
>
> Q: It didn't?
>
> A: No.
>
> Q: But you'd accept that public confidence in independent— I'm not going to phrase it, it's not going to be spot on— but independent scrutiny of allegations of misconduct is one of your objectives under your Act?
>
> A: It is: … 'enhance public confidence, and misconduct by public officers will be appropriately investigated and dealt with'.
>
> Q: And you didn't take that into account? The fact that this in particular might be a matter where the public, in order to have confidence in the system, would have welcomed an independent investigation of Mr Gordon's complaints, you didn't take that consideration into account?
>
> A: No, we do take—where we can enhance public confidence into account all the time. What you were talking about was community outrage; we don't take that into account, but broadly we need to always be conscious of, whatever we are doing, we are enhancing public confidence that is appropriately investigated and dealt with, and 'appropriately' can mean by us or by another agency. That's the key element, and then by doing that we enhance public confidence. We're not responding to community emotion or outrage—not disrespecting that, it's just, that's not a factor, it's how we enhance public confidence that things are appropriately dealt with, is the key thing.[1477]

Mr Easton indicated that a triage team within the Integrity Commission met every three weeks to discuss the monitoring of active referrals.[1478]

Secretary Morgan-Wicks told us that Mr Daniels was not made aware of the Integrity Commission report on the basis that two of the people named in the complaint reported to him.[1479] The fact that most of the executive were implicated in the complaint meant that there was no scrutiny by senior executives (or anyone else, it seems) of the investigation into the complaint, which was ultimately led by human resources staff.

Finding—The Integrity Commission should have ensured Will Gordon's complaint to them was robustly and independently reviewed

Although we accept that there may be instances where it is appropriate to refer a complaint back to a principal officer of a public authority for investigation, this should only occur in circumstances where the referring agency, in this case the Integrity Commission, is satisfied that:

- the public authority tasked with the review has adequate processes in place to ensure complaints are robustly and independently investigated
- the referring agency has adequate processes in place to maintain a close level of oversight and scrutiny over an authority's investigation, to ensure it is robust and independent.

We note that Mr Gordon's complaint to the Integrity Commission did not name human resources staff as subjects of the complaint. However, we consider the Integrity Commission should have been attuned to the risks that could arise in referring the complaint back to the Department, including that it may be investigated by those who had previously been involved with complaints about Mr Griffin's conduct. The Integrity Commission should have set guiding parameters for the Department to avert this, such as specifying that the complaint should not be investigated by those previously connected to the management of complaints involving Mr Griffin.

5.2.28 5 December 2019—Dr Renshaw receives another complaint about Mr Griffin from a staff member

On 5 December 2019, following Dr Renshaw's invitation to staff at the information sessions to share any further concerns related to Mr Griffin with him, a staff member emailed Dr Renshaw about a comment that a patient had made about Mr Griffin.[1480]

The staff member provided the name of the patient but did not nominate a date or timeframe for the comment.

The reporting staff member told Dr Renshaw that the patient said Mr Griffin would often offer to take her home, which she found confusing in the context of him being a nurse. The staff member added:

> Again, this is very much a Jim sort of thing to say about patients and he would often say the same comment to us about disadvantaged children as a kind of hero like gesture … I thought I better mention it to you as it clearly seemed to be confusing to [the patient].[1481]

This information was suggestive of the 'private care arrangement' that Mr Griffin described to Detective Senior Constable Hindle on 31 July 2019 as explanation for a former patient, Penny, staying with him. Dr Renshaw forwarded the staff member's email to Tasmania Police.[1482]

5.2.29 5 December 2019—A panel of hospital staff examine sanitised photos found in Mr Griffin's possession

As outlined above, Dr Renshaw noted in a Minute signed by the Secretary on 5 November 2019 that the Tasmanian Health Service was 'committed to providing open disclosure to the families of any child identified as a victim of Griffin at the LGH'.[1483] In Chapter 6, we discuss a protocol used in South Australian schools where the parents of all children who have had contact with a person charged with a child sex offence are made aware of their child's exposure to that person regardless of whether complaints were raised.

From 5 December 2019, the hospital assisted Tasmania Police to identify the patients who were in the photographs Mr Griffin took at the hospital. Tasmania Police sanitised the images for the purposes of this identification. Tasmania Police believed that the images were taken between 2009 and 2014, although the date that some were taken could not be verified.[1484]

According to Dr Renshaw:

> Approximately 10 photos were received on 5 December 2019 by a small panel … in the presence of Detective Senior Constable [Glenn] Hindle and [another detective sergeant]. The panel was able to identify one victim with certainty and two victims with significant doubt because of the quality of the photograph and the lack of any date references on the pictures.[1485]

This information, provided to us in Dr Renshaw's statement, was at odds with an email he sent to Secretary Morgan-Wicks on 7 August 2020, which makes recommendations to her about four identified patients the hospital should engage in open disclosure.[1486] We note that we have received evidence from Tasmania Police that three children were positively identified and that the panel disputed the identification of one other.[1487] We return to this email in Section 5.2.37. This email also refers to Mr Griffin's care arrangement with Penny.[1488]

5.2.30 12–20 December 2019—The Australian Nursing and Midwifery Federation engages with hospital management

On 12 December 2019, Ms Shepherd wrote to Mr Daniels expressing concern about the accuracy of draft minutes prepared by the hospital relating to the 6 November 2019 meeting that she had attended with Mr Daniels, Ms Bryan and Mr Bellinger. In addition to making corrections to the minutes, the letter from Ms Shepherd reflected the Australian Nursing and Midwifery Federation's ongoing concerns that

hospital management was not offering appropriate information and support to staff. The Australian Nursing and Midwifery Federation expressed concern about the staff sessions Dr Renshaw facilitated, during which Dr Renshaw blamed staff for not making mandatory reports about Mr Griffin. Ms Shepherd stated in her letter:

> … when staff tried to discuss the ward culture, they felt they were promptly shut down by Dr Renshaw. This has resulted in anger and further dissatisfaction with management, making staff feel that the [Tasmanian Health Service] is not serious about implementing any change as a result of these current events. This has further reduced staff's confidence in senior management for developing a culture of support and to make mandatory reports and a shared attempt for positive reflection.[1489]

Ms Shepherd also raised concerns about failures of the hospital to consistently give feedback to members who had submitted a Safety Reporting and Learning System report, making them feel that submitting a report was 'fruitless'.[1490]

Mr Daniels replied to the Australian Nursing and Midwifery Federation on 20 December 2019 defending the management response. Mr Bellinger prepared the draft of this letter, which was intended to reflect the outcome of his review of Mr Griffin's complaints that began in November (described in Section 5.2.25).[1491] Mr Daniels told us that his response to the Federation reflected the knowledge he had at the time and that his knowledge was limited because key information about Mr Griffin's complaint history and conduct had not been made available to him.[1492]

On the question of complaints, the response letter noted:

> There has been one (1) SRLS that we could find relevant to Mr Griffin's behaviour. Whilst the person submitting it did not receive feedback the matter was appropriately addressed with Mr Griffin and any feedback that would have been provided to the person submitting it would have been in generic and confidential terms.
>
> There were a small number of HR files, each of which were appropriately addressed.[1493]

No further information about the 'small number of HR files' was provided in the response letter. Nor was there any mention of the complaints about Mr Griffin recorded in Ms Leonard's file notes and diary entries. Mr Daniels later told us that he was informed that the records reviewed in relation to Mr Griffin 'had not revealed any substantiation for taking any remedial actions, other than a reminder to Mr Griffin from the [Nurse Unit Manager] about ensuring that he continued to be cognisant of maintaining appropriate professional boundaries associated with his role'.[1494] Mr Daniels told us he understood this to be a result of Mr Griffin's social and external sporting activities.[1495]

Mr Daniels' letter referred to the fact that the Australian Nursing and Midwifery Federation had not provided any additional information from employees about

complaints previously lodged that were unaddressed. He also defended Dr Renshaw's behaviour at the staff sessions and the type of support offered by the hospital. The letter read in part: 'I would ask that we now turn our mind to collectively moving forward in a way that rebuilds team values and respect within the Ward'.[1496]

As we have outlined above, we saw no evidence that Mr Daniels took any steps to test or verify the advice he was receiving from human resources staff about Mr Griffin's complaints history.

Secretary Morgan-Wicks said of this period:

> I recall having a general awareness of direct discussions and correspondence that was occurring between the ANMF and the Chief Executive Eric Daniels in relation to Ward 4K staff concerns regarding past complaints handling and their desire for a group debrief/counselling sessions in late 2019, but was assured that these matters were being investigated and managed appropriately at the local level. I was not aware of the true depth of anxiety being expressed by several Ward 4K staff at this time, because if I had I would have directly engaged with the staff to hear their concerns and further test that local management action was appropriate.[1497]

5.2.31 14 December 2019—Mr Gordon has a chance encounter with a journalist

Mr Gordon told us that on 14 December 2019, he had a chance meeting with a journalist at a social function.[1498] He did not name this journalist in his evidence to us. Mr Gordon shared his concerns and frustrations relating to Mr Griffin and Ward 4K with the journalist. The journalist then asked him to draft three questions that the journalist could take to Secretary Morgan-Wicks, which Mr Gordon did. We were not provided with these questions. Mr Gordon told us: 'I was desperate for the public to realise this was happening and for people to take responsibility'.[1499]

Sometime in early 2020, Mr Gordon received a call from an acquaintance who had also spoken to this same journalist. Mr Gordon said of this call:

> She told me that the journalist would not present the questions to the Secretary in order to protect me … As a result of this, I understood that the journalist would not investigate the matter. I felt like the situation was being covered up again.[1500]

5.2.32 3 January 2020—Mr Gordon learns of the outcome of the Australian Nursing and Midwifery Federation's advocacy

On 3 January 2020, Mr Gordon received an email from a union organiser indicating that Mr Daniels and the Tasmanian Health Service were of the view that all complaints against Mr Griffin had been appropriately addressed.[1501] Mr Gordon stated to us:

> This email made me feel as though the ANMF had been brick-walled. … [It] heavily implied that our requests wouldn't be actioned and that there would not be an investigation unless staff had more evidence. As a result of this, I decided to seek external avenues to pursue this matter.[1502]

5.2.33 30 January 2020–COVID-19 is declared a Public Health Emergency of International Concern

On 30 January 2020, the World Health Organization declared the coronavirus (COVID-19) a Public Health Emergency of International Concern.[1503] On 17 March 2020, the Premier of Tasmania announced that the State would take several public health emergency response measures.[1504] The Director of Public Health in Tasmania made a formal declaration of a public health emergency in relation to COVID-19 on 24 March 2020.[1505]

We acknowledge that the COVID-19 pandemic placed significant strain on the health system worldwide, and the Tasmanian health system. This included the rapid establishment of a number of COVID-19 response teams, including the Incident Management Team, Regional Health Emergency Management Teams, the establishment of the Emergency Coordination and Operations Centres, and responses to COVID-19 outbreaks, particularly in North West Regional Hospital and North West Private Hospital.[1506] We acknowledge that the intensity and pressure on health staff directly involved in responding to the pandemic, maintaining core services and engaging in reviews at this time, was significant.

On 25 March 2020, Secretary Morgan-Wicks appointed experienced Secretary delegate Ross Smith to lead and manage all non-COVID aspects of the Department to enable her to focus on the pandemic as the State Health Commander.[1507] Mr Smith provided non-COVID related support until 10 September 2021, at which time he was transferred to the Department of Justice.[1508]

We acknowledge that this public health emergency required significant attention from everyone working within the health system, including Secretary Morgan-Wicks and staff at Launceston General Hospital. We also acknowledge that the pandemic would have placed significant strain on the Department's resources. We consider the hospital's actions from this period on with this context in mind.

5.2.34 15–19 February 2020—Mr Gordon contacts freelance journalist Camille Bianchi

On 15 February 2020, after Mr Gordon's attempt to have his concerns investigated by a journalist in December 2019 had failed, he contacted Camille Bianchi, who he knew to be a freelance journalist, as a 'last resort'.[1509] Ms Bianchi was Mr Gordon's former housemate.[1510]

Mr Gordon and Ms Bianchi spoke on 19 February 2020, when Ms Bianchi asked Mr Gordon if she could report the story. Mr Gordon agreed she could.[1511] Mr Gordon told Ms Bianchi that he would not give an interview because he wanted to protect himself and his family from any repercussions.[1512] Ms Bianchi went on to produce *The Nurse* podcast.

Ms Bianchi reflected to us on Mr Gordon's tip-off as follows:

> I got a tip and then what quickly became apparent was that, or at least it seemed so at the time, that the only avenue in which victim-survivors, including Keelie McMahon who was wonderfully courageous … would have the chance to [tell their story], was through media. They wanted to tell their stories because the Griffin matter wouldn't proceed to court because he had died and that stymied all sorts of different processes and so, began, yeah, a good seven, eight, nine months of trying to work out how to tell that story and even if I could.[1513]

Keelie McMahon, who was abused by Mr Griffin, told us why she decided to take part in *The Nurse* podcast:

> I made the decision to speak to Camille because I wanted to change the way the hospital was dealing with the situation and hold it to account. I was also sick of hearing what a great guy Jim was and thought that telling my story would help other people speak up.[1514]

Mr Gordon's identity as the initial source for the podcast only became known when he gave evidence at our hearings on 27 June 2022. Indeed, Ms Bianchi confirmed that day that *The Nurse* podcast was, in fact, named after Mr Gordon in honour of him as a whistleblower.[1515]

5.2.35 3 March 2020—Mr Gordon engages a lawyer to write to the then Minister for Health, Sarah Courtney

On 3 March 2020, Mr Gordon engaged a private lawyer to prepare a letter to the then Minister for Health, the Honourable Sarah Courtney MP, on his behalf.[1516] At hearings, Mr Gordon described his thinking at the time:

> You know, this isn't a minor thing to be swept under the rug, this is the sexual abuse of children. At what point do we as healthcare workers, and this includes all levels of management, brush aside our ethics and morals to cover this sort of thing up? That's just frigging, like, despicable, it's deplorable. For the sake of our own reputations, our egos, our money, you know, finances or whatever, it's just—I just couldn't let that happen, so I pushed as far as I could to Sarah Courtney so that she knew this was happening and so that she could not say she did not know about it.[1517]

The letter prepared by Mr Gordon's lawyer, dated 3 March 2020, raised two key points, the first of which is outlined below:

> The first and primary concern which is occasioning significant workplace stress and indeed grief is whether the alleged victims of the perpetrator have been contacted with respect to the matter and whether those persons have been offered counselling and assistance with respect to the alleged historical child sexual abuse. My client tells me that this is of significant concern to professional and other staff within the Launceston General Hospital and a matter which is occasioning significant workplace stress itself.[1518]

The letter also documented ongoing staff requests for proper psychological support and suggested that the ability for staff to speak publicly and openly about the matter may assist.[1519]

Mr Gordon received, via his lawyer, an acknowledgment letter from former Minister Courtney sometime in March 2020 (the letter is not dated).[1520] The letter stated in part:

> I have referred your letter to the Secretary of the Department for urgent attention and advice on appropriate action, and I will write to you again following that further advice.[1521]

This suggests that the letter was forwarded to the Office of the Secretary. We note that Secretary Morgan-Wicks has advised us that between 25 March 2020 and 10 September 2021, all matters requiring the approval of the Secretary that did not relate to COVID-19 were delegated to the Secretary delegate, Ross Smith.[1522]

Minister Courtney sent a final letter to Mr Gordon's lawyer sometime after this (that letter was also not dated).[1523] It explained that the information that could be provided to staff was sometimes limited, where answers were unknown or otherwise restricted by the Tasmania Police investigation.[1524] In relation to the treatment of staff complaints about Mr Griffin, Minister Courtney stated:

> The THS has and is addressing concerns arising from this process. I am aware that staff have raised concerns that their previous issues with respect to the individual employee were not addressed. The Department has reviewed the management records available about the individual and repeatedly requested specific information from the concerned employees; all the issues on record that were raised by staff were appropriately addressed at the time.[1525]

The letter goes on to explain that open disclosure processes would be available to any affected patients, when permitted by Tasmania Police.[1526] The letter listed the supports that had been offered by the hospital, including the Employment Assistance Program, the engagement of the counsellor, training sessions on trauma and grief, training sessions relating to sex offences and related behaviour and several in-service sessions with Dr Renshaw and human resources staff.[1527] The letter from Minister Courtney ended:

> I note you suggest that the staff may be encouraged to raise the matter publicly to address some of the psychological impacts of the alleged abuse. I am advised that the THS does not support raising this publicly as it would be unlikely to positively address the psychological impact, and, to the contrary, may very well cause unnecessary distress to the employees and clients.[1528]

Mr Gordon reflected in his statement to us: 'At this point I knew that the THS were not going to release this information publicly and therefore the media was the only avenue to inform the public of what occurred'.[1529]

Secretary Morgan-Wicks told us in a statement that she did not recall 'discussing or communicating with the then Minister for Health, regarding Mr Griffin prior to 14 October 2020'.[1530] We consider Minister Courtney did refer this correspondence to the Office of the Secretary for advice but as all non-COVID-19 matters were delegated to Mr Smith, we accept that Secretary Morgan-Wicks was not personally aware of it.

5.2.36 April–August 2020—The Integrity Commission complaint is followed up

On or about 15 April 2020, the Office of the Secretary followed up with the Department's human resources team about a response to the Integrity Commission complaint.[1531] It seems no response was provided.

On 29 July 2020, the Office of the Secretary received further correspondence from the Integrity Commission requesting an update on enquiries into the matter.[1532] The Office again followed up with the Department's human resources team on 11 August 2020 and on 18 August 2020.[1533] On 20 August 2020, the Office of the Secretary received a draft response to the Integrity Commission, which the Director of the Office of the Secretary reviewed in consultation with the Chief People Officer.[1534]

Mr Bellinger prepared the draft response. He gave evidence that on receiving the complaint from the Chief People Officer he understood his tasks to be preparing a reply, reviewing the allegations and briefing the Chief People Officer on the issue.[1535] Mr Bellinger's draft response stated that complaints that were known to the Tasmanian Health Service about Mr Griffin had 'been investigated and addressed with Mr Griffin' and that the Tasmanian Health Service had 'reviewed all available records and determined that all matters that were raised with the Agency were addressed in a manner that was reasonable in the circumstances that existed at that time'.[1536]

When Counsel Assisting questioned Mr Bellinger about what steps he took to examine the issues raised in the complaint forwarded by the Integrity Commission, Mr Bellinger confirmed that he did not undertake a fresh investigation into the allegations because he understood a review had already occurred through his previous enquiries.[1537] This appeared to be a reference to his own November 2019 review in which he found that previous complaints had been handled appropriately.[1538] At the hearings, Mr Bellinger agreed that his review of the Integrity Commission complaint was a 'desktop review' and did not involve fresh consideration of any complaints or concerns.[1539]

When Counsel Assisting asked Secretary Morgan-Wicks about the level of investigation required to respond to a complaint of misconduct, she replied that it was her expectation that a 'thorough review' would be undertaken, so she could respond 'accurately and truthfully to the Integrity Commission'.[1540]

Mr Easton from the Integrity Commission described Mr Bellinger's desktop review approach as being insufficient, noting:

> It comes back to our expectation, I guess, which is that the matter be investigated and action taken but, as I said earlier, it doesn't necessarily mean everything is investigated but a desktop review is surely not sufficient.[1541]

5.2.37 17 August 2020—Dr Renshaw provides the Secretary with recommendations relating to open disclosure

In the Minute she received on 5 November 2019, Secretary Morgan-Wicks requested further information, when it was appropriate, about the identities of any patients in the images held by Mr Griffin, so she could approve an open disclosure process.[1542]

As noted above, on 5 December 2019, a small panel of Launceston General Hospital staff viewed sanitised photographs in an effort to assist Tasmania Police to identify some of the people in the photographs taken at the hospital.[1543] In one part of his statement to us, Dr Renshaw indicated that three individuals 'could clearly be identified from the photos'.[1544] However, in another part of the same statement he says one individual was identified 'with certainty' and two individuals 'with significant doubt' due to the quality of the photographs and a lack of date references.[1545]

On 17 August 2020, Dr Renshaw sent an email to Secretary Morgan-Wicks and the Director of the Office of the Secretary with the identities of four patients and associated recommendations for how an open disclosure should proceed.[1546] He noted that there was another patient who appeared to have been a 'one-time' admission, but staff could not recall their name and their identity could not be established.[1547]

Open disclosure was recommended for two patients with their parents.[1548] In relation to one patient, who was an adult by that time, Dr Renshaw's email noted:

> Pictures were hard to identify and were clearly made without this patient's awareness; my own impulse is not to offer open disclosure to [the patient] as it may cause anxiety/distress from matters completely outside [their] knowledge. However, if the decision is to provide open disclosure, this would only require open disclosure to the patient.[1549]

This email also referred to Penny and Mr Griffin's care arrangement with her.[1550] It was clear from that correspondence that Dr Renshaw was still at pains to distance the hospital from Mr Griffin's care of Penny, despite her status as a former patient.

Secretary Morgan-Wicks replied to the email asking whether Dr Renshaw had spoken to any of the patients or parents, noting that Mr Daniels had suggested Dr Renshaw may have spoken to one.[1551] We do not have Dr Renshaw's response to this email, or Secretary Morgan-Wicks' decision in relation to Dr Renshaw's recommendations.

Dr Renshaw told us in his statement that open disclosure occurred with one family, on 28 October 2020, which is described in Section 5.2.47. At one point of his statement, he wrote: 'Two other individuals, who at the time of contact were adults or had already provided evidence to Police regarding Griffin, declined open disclosure'.[1552] At another point of his statement, he told us:

> The family of the identified victim was contacted through the Department of Paediatrics and accepted the offer of open disclosure … The remaining two 'possibles' (who were both aged over 18) declined open disclosure.[1553]

5.2.38 10 September 2020—The Secretary responds to the Integrity Commission about its investigation of the complaint

Secretary Morgan-Wicks reviewed Mr Bellinger's draft response to the Integrity Commission and approved it on 10 September 2020, without amendment.[1554] We note that numerous senior officials reviewed and cleared the draft response prior to the Secretary receiving it.[1555] We reference the most pertinent sections below.

The written response provided the following assurances to the Integrity Commission:

> I assure you that we have considered the matters in a timely manner, as they have been raised in a number of forums since the death of Mr Griffin, including a police investigation and … also a coronial investigation which has only recently concluded.
>
> …
>
> The complainant's concern that past complaints relating to Mr Griffin had been raised but not addressed by the Agency has previously been discussed with, and reviewed by, the Tasmanian Health Service (THS) on a number of occasions.[1556]

The reference to reviewing past complaints 'on a number of occasions' appeared to be a reference to Mr Bellinger's sole review in November 2019. The response goes on to say:

> As reflected in [Mr Daniels'] correspondence to the Australian Nursing and Midwifery Federation (ANMF) (Attachment I) 20 December 2019, several matters have previously been raised with the THS and those have been addressed.[1557]

We note that no details of complaints were provided to the Australian Nursing and Midwifery Federation in the letter dated 20 December 2019, which referred to a 'small number of HR files'.

The response to the Integrity Commission identified eight different concerns raised about Mr Griffin over 14 years, which were described as follows:

- 2005: The former Clinical Nurse Consultant of Ward 4K addressed with Mr Griffin his act of kissing a patient on the forehead whilst redirecting them back to their inpatient bed. A copy of the Agency's available records is provided.

- 2008–2009: A series of undated/unsigned notes that are believed to be Ms Leonard's. The relevant contents relate to Mr Griffin providing his phone number to patients and professional boundary issues.
- January 2009: Concerns were raised by a Psychiatric Registrar with respect to Mr Griffin not complying with the pre-determined care plan and providing his personal contact details to the patient. Further file notes of [a Ward 4K staff member] and Mr Sherring are provided and a draft of the proposed correspondence to Mr Griffin. The final correspondence has not been located in the records.
- March 2009: Record of Ms Leonard's meeting with Mr Griffin with respect to a further boundary issue, that being his intent to 'give away' a former patient at her wedding. Mr Griffin ultimately determined with his manager's counsel not to do so.
- April 2013: Mr Griffin was asked not to tend to a patient as a result of 'family issues'.
- March 2017: Provides a record of a meeting between Mr Griffin and his Nurse Unit Manager on 6 March 2017 with respect to a patient who expressed feeling uncomfortable in Mr Griffin's presence.
- An event was lodged in the Safety Reporting & Learning System on 29 August 2017 as referenced in the complaint provided to the Integrity Commission. The matter was provided to Mr Griffin for his reply, his written response was considered, and a decision reached. Mr Griffin was reminded to maintain appropriate relationships with patients and families. It is acknowledged that the complainant should have received a more informed outcome.
- August 2019: [A nurse] raised a concern with respect to Mr Griffin's conduct in July 2018. At this time Mr Griffin was already the subject to other investigations, and the matter was referred to Tasmania Police. Given Mr Griffin's passing, the matter was not put to him by the [Tasmanian Health Service].[1558]

Launceston General Hospital also supplied its records related to these complaints to the Integrity Commission but not an actual review or explanation of its assessments.

Secretary Morgan-Wicks stated in the letter:

> In summary, the Agency has over the course of 14 years had several complaints pertaining to Mr Griffin that can be broadly characterised as professional boundary issues. Each matter that the THS was made aware of has been investigated and addressed with Mr Griffin.[1559]

She also noted in the letter that there were some incomplete records but that there had been 'no information indicating that evidence has been destroyed and the records reflect that there are several issues on file that have been addressed'.[1560] We are unclear how a desktop review could lead to this conclusion.

The letter concluded:

> The THS has reviewed all available records and determined that all of the matters that were raised at the agency were addressed in a manner that was reasonable in the circumstances that existed at the time. The decisions made over the past 15 years were without the benefit of the information that now exists as a result of the Police investigation and the management actions cannot be judged with that in mind.
>
> Further, the THS has repeatedly sought to particularise and identify any complaints that the employees contend were previously raised and not addressed. No such complaints have been identified.[1561]

The letter named Mr Bellinger as having carriage of the investigation in response to the complaint received by the Integrity Commission.[1562]

The list of complaints in the response, although extensive, does not cover all the complaints about Mr Griffin that were known to or discoverable by the hospital. Omitted complaints included:

- a 2002 concern about Mr Griffin hugging patients and engaging in non-care related touching (this was referenced in a file note by Mr Sherring, retrospectively, in 2009)
- a complaint on 5 July 2004 relating, again, to Mr Griffin hugging a patient (we consider this omission curious, given that Mr Bellinger's response to Detective Senior Constable Hindle on 11 October 2019 noted 'a small number of HR files dating back to 2004', which suggests Mr Bellinger's awareness of this complaint)[1563]
- Mr Griffin being counselled for including a former patient in an inappropriate 'email forward' on 8 May 2009, although we note that this may be captured in the reference to Ms Leonard's unsigned and undated notes from 2008–09
- a concern reported to Ms Leonard about Mr Griffin being a 'sleaze' and suggesting he was a risk to children, in November 2012
- concerns reported by a nurse about Mr Griffin's behaviour with teenage girls in November 2015
- a complaint from a student on placement about Mr Griffin's use of pet names and unprofessional behaviour in May 2017
- the complaint reported on 18 July 2019 about Mr Griffin's inappropriate conversations with a patient and their father about medications and his encouragement that a colleague nurse 'taste' a controlled medication before giving it to a patient.

More information about each of these complaints is in Section 4.

Most significantly, the letter to the Integrity Commission does not include Ms Pearn's disclosure to human resources staff in 2011 or 2012, which Mr Bellinger was reminded of on 11 October 2019.

Finding—James Bellinger did not conduct a proper investigation into James Griffin's complaints history and misled the Secretary of the Department and the Integrity Commission

As we have outlined above, Mr Bellinger appeared to undertake a cursory 'review' of complaints relating to Mr Griffin in November 2019. Mr Bellinger's reference to his various 'reviews' was confusing, but what is clear to us is that there was no meaningful review at any stage. Mr Bellinger told us that his November 2019 review was limited to complaints that were addressed with Mr Griffin, which resulted in Ms Pearn's disclosure in 2011 or 2012 being excluded. Further, this review does not appear to have been recorded and was not communicated to anyone else other than through verbal assurances that responses were appropriate. His subsequent reviews in response to the Australian Nursing and Midwifery Federation's concerns and the Integrity Commission relied on this inadequate review.

Deficiencies in Mr Bellinger's 'review' conducted in response to the Integrity Commission referral included the following:

It was inappropriate for Mr Bellinger and other hospital human resources staff to undertake the review. Mr Bellinger had a direct conflict of interest in the matter, given that he and other human resources staff were involved in managing complaints about Mr Griffin. An investigation should have ideally been undertaken by a person entirely independent of the hospital, but most certainly not by its own human resources team.

- The response omitted important information and complaints about Mr Griffin. Why some complaints were omitted and not others is unclear to us and we can find no logic in their selection.
- One omission was particularly concerning, namely the disclosure by Ms Pearn in 2011 or 2012. We consider it likely that this was omitted either because it would jeopardise the reputation of the hospital or because it would reflect badly on Mr Bellinger and/or the human resources team or possibly both.
- Of the listed complaints, there was inadequate context to convey their seriousness. For example, the description of the January 2009 complaint from the Senior Psychiatric Registrar was limited to not following a care plan and providing contact details to a patient, when in fact the Senior Psychiatric

Registrar was so concerned by Mr Griffin's behaviour (noting it was not his first such observation) that he recommended Mr Griffin seek psychological help. This incident also involved Mr Griffin cuddling the same patient.

- This review does not appear to have been documented, aside from listing complaints and records relating to complaints in the letter to the Integrity Commission. A review or investigation of this nature and significance should have been the subject of a comprehensive written report or briefing that outlined all the relevant facts and appended all associated documentation to explain the reasoning behind the conclusion that matters were handled appropriately (at the time or otherwise). It should have been checked by independent parties on its journey up the line to the Secretary. This way, each person reading it could assess its methodology, including its accuracy, quality and thoroughness, as well as ask questions and escalate any concerns arising from it.
- Noting the complaint referenced possible document destruction and failures to respond to complaints, simply reviewing records of complaints put to Mr Griffin was clearly inadequate. The review should have included interviews with Ward 4K staff to investigate whether there were complaints of which they were aware that had not been responded to, or for which records were now missing or altered.

We are unclear what, if any, scrutiny Mr Bellinger's superiors in the human resources team applied to this review, noting they recalled only seeing the final letter to the Integrity Commission. We are of the view that Mr Bellinger was not closely supported or supervised by senior managers in the task of responding to the Integrity Commission, which demonstrated an absence of concern by senior leaders about the seriousness of the complaint. This lack of scrutiny enabled the response prepared by Mr Bellinger to the Integrity Commission to contain inaccurate and misleading information.

There was no evidence of an investigation beyond a 'desktop review'. Given reported limitations in finding certain records and information, evidence should have been sought directly from key staff. We note that human resources staff requested Ms Leonard's records (although their contents do not appear to have been reflected in their entirety), but further steps should have been taken, such as interviewing or seeking statutory declarations from staff, to supplement the records that were available. We accept that Mr Daniels (via the Australian Nursing and Midwifery Federation) and Dr Renshaw (at staff sessions) did ask staff to share any information about unaddressed complaints. We also accept that by this stage staff may not have trusted management or perceived that they could not prove their prior complaints.

In a statement to us, Secretary Morgan-Wicks said that before hearing Mr Bellinger's evidence at our Commission of Inquiry she was not aware that he had been informed, in October 2019, of the complaint that Ms Pearn made about Mr Griffin.[1564] Secretary Morgan-Wicks said that had she been made aware of Ms Pearn's disclosure, she would have immediately started an internal investigation, rather than waiting until October 2020.[1565] She agreed that Mr Bellinger's draft response was misleading to both her and to the Integrity Commission.[1566]

5.2.39 16 September 2020—The Integrity Commission acknowledges the Secretary's letter

On 16 September 2020, the then recently appointed Chief Executive Officer of the Integrity Commission, Mr Easton, replied to Secretary Morgan-Wicks' letter, noting the 'comprehensive information provided' and the outcome of the Department's investigation. Mr Easton's letter stated:

> The information you have provided confirms the ongoing reports of James Griffin's conduct as described in the original complaint, and describes the management actions taken at the time. While it is now difficult to gauge the appropriateness of individual responses, it is clear that a pattern of behaviour was emerging, the end product of which was allegedly serious misconduct and criminal behaviour by Mr Griffin.[1567]
>
> Our original assessment identified the possibility that some staff stopped making reports about Mr Griffin given a perceived failure of management to respond to earlier reports and a fear of losing their jobs if they spoke out. Mr Griffin's apparent presence and personality also contributed to this reluctance to report.[1568]

The letter also identified the 'need to ensure new or rotating managers have accessibility to prior management actions and responses' to ensure 'continuity in the response and identifying patterns of behaviour across time'.[1569]

When Counsel Assisting asked Mr Easton about specific follow-up the Integrity Commission had pursued to ensure the Department was taking appropriate steps to address these issues, he referenced the Integrity Commission providing general education and training to State Service officials about misconduct. He added that Department employees had attended in greater numbers than any other agency.[1570]

Mr Easton conceded that, apart from providing training, 'we haven't undertaken active follow-up on that particular issue with that particular department'.[1571] He described the monitoring process for complaints in November 2019 (at a time when he was not the Chief Executive Officer) as 'less rigorous than they are now'.[1572] He said:

> My predecessor was not as active or desirous of us to be as active in following things up with agencies; it doesn't mean that he didn't think we should, it's just that I've come into the chair and I really think we should, it's a big part of our reason for

> being, is to build our capacity of agencies to deal with misconduct, it's there in the objectives of the Act, and how else are we to do that without understanding what their weak points are and how they are dealing with misconduct?[1573]

Mr Easton explained that the Integrity Commission now has additional resources for monitoring compliance and was 'trying to build some proactive measures' into these processes.[1574] He told us that once a matter is referred to an agency for response, it moves from the Integrity Commission's complaints stream into its compliance stream.[1575] We heard that the Integrity Commission makes contact with a person at the relevant agency 'within three to four weeks after' a matter is referred to them for a response to ensure they have received the referral and are actioning it, in addition to checking whether the Integrity Commission can assist.[1576]

We further heard that the Integrity Commission generally gives an agency 'about six months' to respond, and then a compliance team, led by the Director of Operations and a senior investigator, follow up the matter.[1577] When a response is received from an agency it goes into a 'compliance triage' run by the senior investigator, who determines, according to criteria, whether the Integrity Commission needs to provide more time or assistance to the agency to respond, or whether the Integrity Commission should manage the response themselves.[1578]

Finding—The Integrity Commission's monitoring of the Department's response to Will Gordon's complaint was insufficient and it should have sought further review

Mr Gordon's complaint, which raised serious concerns about potential misconduct, should have been investigated by the Integrity Commission itself or been subjected to more rigorous and active monitoring by the Integrity Commission. Once the Integrity Commission referred Mr Gordon's complaint to the Department on 21 November 2019, there was no further follow-up until 29 July 2020.

We are pleased to note that the Integrity Commission is now more focused on monitoring compliance, but this does not satisfy the concerns we hold about the Integrity Commission's acceptance of the response letter provided by Secretary Morgan-Wicks on 10 September 2020. The response letter revealed systemic problems with the Department's complaints processes, not least because of the sheer number of complaints it outlined in relation to Mr Griffin, but also the letter's assurance (despite the hindsight knowledge of the serious misconduct and criminal behaviour of Mr Griffin) that they had each been dealt with appropriately. The Department's response demonstrated no reflection on systemic errors or the potential improvements that could be made in its responses. The Integrity Commission identified these systemic problems in its response, but they were not referred to the

Health Complaints Commissioner, nor did the Integrity Commission seek any formal reassurances from the Department that they had been actively addressed. Without adequate redress, children remained vulnerable to the same errors occurring again.

Mr Easton described his reaction to the response letter as follows:

> I actually thought it was comprehensive, but I also just had a visceral reaction to, 'I can't believe nobody has picked up that there's been an issue with this person'. That's my fundamental concern with the response, was that, how can there be this many reports—and I believe there's more since what's in this letter—how can somebody not have picked this up? That's what worries me.[1579]

Given the nature of the complaint, we consider that the Integrity Commission should not have concluded that the matter had been resolved, particularly given Mr Easton's own reaction to its contents.

5.2.40 13 October 2020—The first episode of *The Nurse* podcast is released

The first episode of Camille Bianchi's podcast, *The Nurse,* was released on 13 October 2020. The first episode was titled 'Just Jim'. As of May 2022, this episode had been downloaded more than 1.3 million times.[1580]

The podcast initially provided an avenue for victim-survivors of Mr Griffin's abuse to share their experiences. However, it expanded over time as Ms Bianchi received information from more victim-survivors and about incidents involving other abusers, government departments and institutions. The podcast led to more media reports about Mr Griffin and other abuses at Launceston General Hospital, including those we describe in Case study 2, relating to Dr Tim (a pseudonym).[1581]

Recognising the significant attention that *The Nurse* podcast drew to child sexual abuse in institutions (and how this may have impacted on those affected by such abuses), Mr Gordon wrote in a statement to us:

> I want to make it known I am sorry for any hurt or trauma or collateral damage I may have unknowingly inflicted to victims of abuse by fighting for this event to be released to the public, and in my quest to obtain a Commission of Inquiry. I honestly meant no harm.[1582]

Secretary Morgan-Wicks told us at a hearing that she was alarmed to learn, through the podcast, about the extent of Mr Griffin's behaviour and that the hospital had, at various times, questioned him about these behaviours. We note she was aware of at least the eight complaints listed in her response to the Integrity Commission.[1583] Senior executives at the hospital, Ms Bryan and Dr Renshaw, also told us that the podcast exposed them to new information about Mr Griffin's conduct.[1584]

The podcast made reference to what we presume was Ms Pearn's disclosure, as follows:

> Shockingly, in 2010 a survivor of Jim's abuse told the hospital's HR department something was badly wrong. She told them in a formal meeting he had molested her as a child. She told them to protect the children then in his care. She told them 9 years before he was charged and finally taken off the ward.[1585]

We are not clear how Ms Bianchi learned of this disclosure because Ms Pearn was not the source. However, Ms Pearn, recognising that the podcast was gaining widespread media attention, contacted Dr Renshaw to inform him of the disclosure she had made to the hospital.[1586] Dr Renshaw was already aware of Ms Pearn's disclosure at this point, having been advised by Tasmania Police about it a year earlier, on 29 October 2019. Ms Pearn described a brief phone conversation with Dr Renshaw. She told us that Dr Renshaw was 'very dismissive' in his response to her informing him of her disclosure and that she felt 'fobbed off'.[1587] Dr Renshaw told us in hearings that he did not remember this phone call but did not dispute it occurred.[1588]

5.2.41 14 October 2020—The Secretary recommends an immediate review to the Minister for Health

The day after the first episode of *The Nurse* podcast aired, Secretary Morgan-Wicks contacted Minister Courtney, recommending that she initiate an immediate review into 'internal and external conduct reporting mechanisms and the THS [Tasmanian Health Service] complaints handling process relating to unprofessional conduct and sexual misconduct'.[1589]

Minister Courtney responded in writing on 14 October 2020. She asked Secretary Morgan-Wicks to examine and provide advice on a range of issues, past and current, which we quote directly:

a. the current internal reporting mechanisms of the Tasmanian Health Service and the compliance of these mechanisms with Australian Health Practitioner Regulation Agency standards and mandatory reporting obligations under relevant Tasmanian legislation

b. the appropriateness and effectiveness of Tasmanian Health Service complaints handling processes relating to unprofessional conduct and sexual misconduct

c. the effectiveness of interaction between Working with Vulnerable People systems and the Tasmanian Health Service

d. the degree of compliance with the Tasmanian Health Service complaints handling processes

e. the appropriateness of mechanisms to ascertain and act upon systemic behaviour of an employee

f. any further action required by the Tasmanian Health Service to improve the culture, policies and processes relating to these issues.[1590]

Minister Courtney also requested that Secretary Morgan-Wicks consider the management of any complaints and concerns relating to Mr Griffin, including whether any further action or review needed to be undertaken.[1591] Minister Courtney further requested that a 'centralised mechanism be established for current and former staff and patients to come forward and provide information to assist in the examination of the matter'.[1592]

Secretary Morgan-Wicks confirmed that the Department would lead an examination to respond to the issues raised by Minister Courtney. Secretary Morgan-Wicks then set up a review team to start this work.[1593] Secretary Morgan-Wicks wrote to all staff at the Department to inform them of the internal examination.[1594]

Secretary Morgan-Wicks also set up a public disclosure email address for staff and another for public enquiries, along with a dedicated phone line to triage complaints or submissions and advise on available support services.[1595]

5.2.42 15 October 2020—The Secretary attends a meeting with Ward 4K staff

On 15 October 2020, Secretary Morgan-Wicks sat in on the end of a meeting with Ward 4K staff at the hospital, which was facilitated by the Australian Nursing and Midwifery Federation. We received no evidence that any members of the hospital executive attended this meeting. Secretary Morgan-Wicks told us:

> I recall feeling confronted by the depth of feeling and anxiety in the room and the sense of distrust that anything different was going to happen if information was reported. I explained the nature of a protected disclosure and that the review of the information would be entirely separate from the Ward and from LGH and conducted by an experienced and senior team in the South.[1596]

We can understand why staff would have been wary and sceptical, given the way their concerns had been managed in the past.

Mr Gordon recalled Secretary Morgan-Wicks' attendance:

> I challenged Kathrine Morgan-Wicks that she must have known about the issues on the ward and that it should not have come to nurses becoming whistleblowers in order to get the story out to the public. I also said that the hospital should have and still should take responsibility for their abysmal handling of the situation and asked what changes will be made. Kathrine did not answer questions, instead saying words to the effect of 'if I knew about the situation, something would have been followed up on'. This is despite the response I received from the Integrity Commission and the Minister's letter to my lawyer which stated that she had referred my letter to Kathrine Morgan-Wicks.[1597]

As we noted above, Secretary Morgan-Wicks told us that between 25 March 2020 and 10 September 2021, all matters that were not related to COVID-19 were delegated to Secretary delegate Ross Smith.[1598]

Pressure began to mount for a Commission of Inquiry. As Ms Shepherd of the Australian Nursing and Midwifery Federation stated to us:

> Unfortunately, due to the fact that a report to the Integrity Commission was already known about by the Secretary of the Department of Health and the Minister for Health was also aware of members' concerns, members did not have trust in any internal, departmental or Government led investigation, which is why they, along with the ANMF, called for a Commission of Inquiry.[1599]

As we discuss in other chapters of this report, these calls coincided with concerns about civil and redress claims related to child sexual abuse in schools and youth detention.

Secretary Morgan-Wicks attended several more meetings with ward staff in the coming days and weeks. Dr Renshaw and nursing management also attended some of these meetings. Secretary Morgan-Wicks told us that over the course of these meetings it became apparent to her that:

> Ward 4K staff remained traumatised by the death and alleged criminal conduct of Mr Griffin of which they had no awareness, and felt that they had been 'silenced by Management' unable to grieve or openly discuss the matter and that the issue therefore had continued to fester for over a year, causing significant workplace disharmony.[1600]

5.2.43 15–21 October 2020—The hospital hears concerns from patients' families

On 15 October 2020, likely as a result of *The Nurse* podcast, the Director of Improvement, Quality and Patient Safety Service, North and North West at Launceston Hospital informed Dr Renshaw that the hospital feedback line had received four phone calls and an email from concerned families.[1601]

The Director of Improvement sought guidance from Dr Renshaw about how to handle the matter. Mr Daniels was copied into this email. The Director asked Dr Renshaw: 'Can we please have some direction regarding our responses from a complaints perspective and what direction we should be giving potential new victims in regards to contacting police'.[1602] She also sought guidance on whether a public statement would be required.[1603] It is notable to us that even at this stage, Dr Renshaw was seen as the key contact in relation to matters concerning Mr Griffin.

Dr Renshaw responded to this request for advice on 22 October 2020, the same day that an independent review was announced, which we discuss in more detail below. In his response, Dr Renshaw provided the following instructions:

- All patients or community members were to contact the dedicated public enquiries email, which was established on 22 October 2020.
- Staff were to contact the dedicated staff email address.

- The contact details of support services listed on Minister Courtney's media release—1800 RESPECT, Laurel House, Lifeline, the Sexual Assault Support Service and Relationships Australia—should be provided to concerned families.[1604]

Dr Renshaw added that 'there will be the occasional person who may insist on dealing with us directly' and that this should be assessed on a case-by-case basis.[1605] He also asked that a particular family, who were due to be contacted as part of an open disclosure process, be put through to him immediately, should they call.[1606]

We also received evidence that on 21 October 2020, the hospital's response to an in-person contact from a distressed person concerning comments made by her daughter about Mr Griffin was to provide an email address and a consumer feedback form for them to lodge a complaint, notwithstanding the person had clearly requested to speak with someone.[1607] This person was advised to send an email outlining their concern and that they were seeking to speak to someone or receive counselling about the matter.[1608] They were further advised to include this information in the feedback form, which would be received by Dr Renshaw, who was 'managing all enquiries regarding the matter to see what the hospital could assist with'.[1609]

5.2.44 16 October 2020—The Department is advised that the police investigation into Mr Griffin had been closed and Dr Renshaw seeks advice from the Secretary on responding to queries and disclosures

On 16 October 2020, a detective with Tasmania Police emailed Dr Renshaw advising him that the police investigation into Mr Griffin had been formally closed.[1610]

The detective noted that due to media coverage associated with *The Nurse* podcast, police had received 'a number of enquiries regarding complaints against Griffin at the hospital'. The detective queried whether there was a central point of contact at the hospital to which these queries could be directed.[1611] Dr Renshaw immediately forwarded this email to Secretary Morgan-Wicks, the Director of the Office of the Secretary, Mr Daniels and the Director of Improvement, Quality and Patient Safety Service, North and North West.[1612]

The same day, Dr Renshaw emailed Secretary Morgan-Wicks, copying in Mr Daniels, advising her of Tasmania Police's decision to close the investigation into Mr Griffin.[1613] Dr Renshaw also wrote in this email that following the release of the podcast, the hospital had received calls from concerned patients and their families, as well as former staff, with information about Mr Griffin's conduct.[1614] Dr Renshaw's email read in part:

> While most of the feedback constitutes a desire to simply communicate individual experiences with Mr Griffin, there have been at least two where specific allegations are made about incidents on Ward 4K that are either recollected after a period of time or were allegedly reported to hospital staff at the time but for which we can find no record of complaint. I have also had a call from a former staff member …

> who had had significant concerns from her knowledge of Mr Griffin outside the hospital and who reported the matter to her Manager at the time. The Manager took the matter seriously and pursued the matter through HR. There was no documented outcome of this concern.[1615]

As outlined above, the call Dr Renshaw received from a former staff member was the call from Ms Pearn. To our knowledge, this email was the first time that Mr Daniels and Secretary Morgan-Wicks were notified of Ms Pearn's disclosure, albeit in general terms. Mr Daniels told us that he was not aware of the disclosure by Ms Pearn until he gave evidence during our hearings.[1616] Dr Renshaw does not reveal in the email that he was aware of Ms Pearn's disclosure a year earlier, on 29 October 2019, when advised by Tasmania Police.

In the email, Dr Renshaw asked Secretary Morgan-Wicks for an urgent discussion about 'our strategy to address the concerns that will continue to arrive as the podcast continues over the next few weeks'.[1617] The Director of the Office of the Secretary responded by email on behalf of the Secretary, noting that they had attempted to call Dr Renshaw. The Director of the Office of the Secretary provided Dr Renshaw with the relevant email addresses for queries, told him that a central contact point was being established and that advice would be provided in due course.[1618] The Director of the Office of the Secretary stated in their email to Dr Renshaw that allegations of criminal conduct should be directed to Tasmania Police.[1619] They also flagged a desire to speak with Dr Renshaw about the forthcoming open disclosure process. We do not know whether that call took place and, if it did, what was discussed.[1620]

Shortly after, Mr Daniels forwarded an email chain, which included Dr Renshaw's original recommendations relating to open disclosure, to Ms Bryan, Mr Bellinger and the Director of Improvement.

Misconduct finding—Dr Peter Renshaw misled our Commission of Inquiry about his state of knowledge

Throughout Section 5, we have shown that Dr Renshaw withheld important information, particularly in briefings to the Chief Executive and the Secretary, that significantly and adversely affected their ability to make the best possible decisions to address Mr Griffin's conduct and its implications for staff, patients, the hospital and the broader community. That Dr Renshaw's briefings were factually inaccurate also hampered our Inquiry. We relied on accurate documentation and truthful statements to inform and shape our Inquiry, particularly in the lead up to our hearings. Dr Renshaw did not provide this when it was within his power to do so.

There were many instances during our Inquiry where witnesses forgot certain events or were confused by questions. We accept that giving oral evidence, in particular, is daunting and it can be easy to misspeak. We note this here to make explicit our inclination to give witnesses the benefit of the doubt.

We consider that Dr Renshaw falls into a different category. We consider that in view of the totality of his evidence, the evidence of others and relevant documents provided by other agencies, that Dr Renshaw actively sought to mislead our Commission of Inquiry. We describe how he misled us below.

Dr Renshaw misled us about the extent of his knowledge regarding Penny

Through our hearings, we established that Dr Renshaw had knowledge that Penny was a former patient who had been under the care of Mr Griffin. Tasmania Police was concerned about Penny because Mr Griffin was spending time with her outside the hospital setting. Dr Renshaw learned this from Detective Senior Constable Hindle on 31 July 2019, which is evidenced by Ahpra file notes discussing Dr Renshaw's notification of Mr Griffin to Ahpra the following day.

Dr Renshaw did not convey any information to the hospital executive or the Secretary that suggested his awareness, or the full extent of his awareness, of the above information. His advice to the Secretary on 17 August 2020 acknowledged that Tasmania Police was aware of Penny but does not clarify that this concern was known to him (and hence the hospital) as far back as 31 July 2019.

Dr Renshaw did not alert us to Penny in his statement at all, whether directly or indirectly. When we asked whether he knew of Mr Griffin 'having contact with paediatric patients after hours or when off-duty', Dr Renshaw responded: 'I became aware of this allegation from "The Nurse" podcast'.[1621] When we asked whether he knew of Mr Griffin having 'ongoing contact with paediatric patients after they were discharged from hospital', Dr Renshaw again responded: 'I became aware of this allegation from "The Nurse" podcast'.[1622]

These responses were clearly untrue.

Dr Renshaw misled us about the extent of his knowledge regarding Ms Pearn's disclosure

We have made earlier findings regarding Dr Renshaw's failure to escalate his knowledge of Ms Pearn's disclosure to the hospital.

Through our hearings, we established that Dr Renshaw held the following knowledge about Ms Pearn's disclosure:

- On his return from leave, sometime after 18 October 2019, Dr Renshaw heard a 'corridor rumour' about a former staff member reporting their own child sexual abuse by Mr Griffin to their manager and human resources sometime before.
- Tasmania Police confirmed Ms Pearn's disclosure to Dr Renshaw on 29 October 2019.
- Ms Pearn called Dr Renshaw sometime after the release of *The Nurse* podcast about her disclosure, which was reflected in Dr Renshaw's email to the Secretary on 16 October 2020.[1623]

There is no reference to Ms Pearn, or any information that resembles Ms Pearn's circumstances, in Dr Renshaw's statement to us. In our request for statement, we asked Dr Renshaw: 'Did anyone raise a concern about Mr Griffin with you (either formally and informally). If yes, please detail in respect of each concern'. Dr Renshaw listed some matters, which we have reflected earlier in this case study, but made no mention of Ms Pearn's phone call to him.

While we accept that Dr Renshaw may have been receiving many contacts at the time that Ms Pearn called him, we consider that Ms Pearn's call would have stood out to him, given its significance and his prior knowledge from Tasmania Police about her complaint. We consider that Dr Renshaw recognised the significance of Ms Pearn's disclosure to such an extent that he advised the Secretary about it, although without naming her. We do not accept that information he received about Ms Pearn was information that he would have forgotten. His failure to include this information in his statement to us was deliberately misleading.

As we have flagged elsewhere, we found Dr Renshaw to be an unhelpful witness. He was defensive and pedantic. Each of the concessions he made, once confronted by the evidence, had to be extracted from him during hearings. We consider that Dr Renshaw failed to accept responsibility for his failures. He did not demonstrate even a modicum of self-reflection during our hearings. Dr Renshaw's approach to our Inquiry frustrated many affected parties, particularly victim-survivors and their families, who were understandably seeking some acknowledgment, reflection and, indeed, apologies.

Dr Renshaw's omissions and fabrications amount to misleading our Commission of Inquiry. We do not make this finding lightly. Misleading a commission of inquiry undermines public trust and confidence in the process. Such an act by a senior state servant is unethical and unprofessional and brings the State Service into disrepute.

Under section 18 of the *Commissions of Inquiries Act 1995* ('Commissions of Inquiries Act'), we have the power to make a finding of misconduct. Section 3 of the

Commissions of Inquiries Act defines misconduct as 'conduct by a person that could reasonably be considered likely to result in a criminal charge, civil liability, disciplinary proceedings, or other legal proceedings, being brought against that person in respect of the conduct'. Section 10 of the State Service Act outlines circumstances under which a State Service employee may be subject to disciplinary processes. This includes when an employee breaches the State Service Code of Conduct.

Dr Renshaw's conduct in misleading our Commission of Inquiry meets most, if not all, of these provisions and may be considered likely to result in disciplinary proceedings, which meets the definition of misconduct in the Commission of Inquiries Act. We make a finding of misconduct against Dr Renshaw.

5.2.45 20 October 2020—The Secretary is advised of Ms Pearn's identity and media reports on Mr Griffin's offending

On 19 October 2020, after her conversation with Dr Renshaw, Ms Pearn spoke with the former Director of Employee Relations, who had since taken up a role in the Department's Commission of Inquiry Response and Reform team, to continue her efforts to bring the circumstances of her disclosure to the hospital's attention.[1624] Around this time, Ms Pearn also spoke with Minister Courtney about the handling of her disclosure.[1625]

Secretary Morgan-Wicks told us that she first became aware of Ms Pearn's first complaint to the hospital (in 2011 or 2012) on 20 October 2020, when she was informed about Ms Pearn's conversation with the former Director of Employee Relations.[1626] We note that Dr Renshaw did advise her, in general terms, a few days earlier on 16 October 2019.[1627] Secretary Morgan-Wicks therefore became aware of Ms Pearn's disclosure roughly a year after Mr Bellinger and Dr Renshaw had knowledge of it (if we accept Mr Bellinger's evidence that he was not present at the original disclosure, which we do not).

On the same day, 20 October 2020, *The Examiner* newspaper identified the unnamed paediatric nurse in its report of 9 October 2019 as Mr Griffin (refer to Section 5.2.14 for a discussion of the 9 October 2019 report).[1628]

On 21 October 2020, Secretary Morgan-Wicks received a file note of a conversation that Minister Courtney had with Ms Pearn.[1629]

On the same day, Secretary Morgan-Wicks wrote to Minister Courtney recommending an independent investigation into the hospital's response to complaints about Mr Griffin, in addition to the planned internal examination.[1630] Secretary Morgan-Wicks wrote:

> Whilst my examination of this issue continues, I write to confirm that I have received information which raises serious allegations about the proper conduct, strength and adequacy of historical reporting processes relating to the subject of this matter, involving both the [Tasmanian Health Service] and other Government Agencies.

> Given my remit as the Department of Health Head of Agency, I do not hold the powers necessary to conduct an in depth cross-agency systems review. Noting the serious nature of the concerns raised, I am writing to you to request that you consider instituting an independent investigation in relation to this matter so that this information can be independently assessed and examined.
>
> In the interim, I will continue to undertake my examination of the relevant [Tasmanian Health Service] and Department policies and procedures, as confirmed above.[1631]

5.2.46 22 October 2020—The Department announces an independent investigation into the management of complaints about Mr Griffin

The next day, 22 October 2020, the then Premier, the Honourable Peter Gutwein MP, and Minister Courtney announced the Independent Investigation into the Systems of the Tasmanian Health Service and Relevant Government Agencies/Organisations Relating to the Management of Historical Reports of Allegations of Child Sexual Abuse.[1632] As indicated above, the terms of reference of the investigation required examining the circumstances surrounding Mr Griffin's conduct and other related matters.

On 12 and 17 November 2020, Secretary Morgan-Wicks and the Department's Chief People Officer met with staff on Ward 4K to give an update on the Department's internal examination and to provide them with information about the independent investigation.[1633] During these meetings, staff expressed concern that the issues were not being considered by a Commission of Inquiry.[1634]

5.2.47 28 October 2020—Open disclosure with a family occurs

As foreshadowed earlier on 28 October 2020, open disclosure with a family occurred following the discovery of an image of their child among the photos on Mr Griffin's devices. Open disclosure was provided to the family on 28 October 2020 at a meeting involving Dr Renshaw, a 'social worker/counsellor', a Tasmania Police liaison officer and possibly Ms Tonks.[1635] While Dr Renshaw suggested she was present, Ms Tonks did not recall whether she attended the open disclosure meeting.[1636] Dr Renshaw told us: 'I believe that it went well, the family concerned appeared to be very thankful for it'.[1637]

This family contacted us to share their experience of the process. They told us that Dr Renshaw contacted them after their child had been identified in images found in Mr Griffin's possession.[1638]

Although they found the meeting with Dr Renshaw and Tasmania Police to be 'informative and useful', they also felt that the overall process of disclosure, and the lack of follow-up since, was not ideal.[1639] Their dissatisfaction stemmed from the following:

- They found out about the identification of their child via a voicemail message from the hospital, which was received by the patient's mother while at work. This message left her 'feeling sick and … very upset'.[1640]

- They received assurances from Dr Renshaw that, while the hospital had responded to some concerns relating to Mr Griffin over the years (which Dr Renshaw described to them in general terms), these concerns 'were not of a direct sexual nature or of photos being taken'. The family has since queried the accuracy of this characterisation.[1641] They recall that Dr Renshaw described one complaint as being about Mr Griffin 'giving away… a former patient' (likely a reference to the February 2009 complaint) and another complaint as Mr Griffin giving teenage female patients advice about boyfriends (this was likely Mr Gordon's August 2017 complaint).[1642] We consider it unlikely that Dr Renshaw shared the full extent of Mr Griffin's complaints history with this family.
- The family was not offered any counselling and received no follow-up from the hospital or Tasmania Police. They felt 'it should have been offered, we shouldn't have just been left to sort ourselves out'.[1643]

In describing the effect that the revelation of Mr Griffin's conduct towards their child had on their family, family members told us:

> The long-term impact this has had on our family is significant. Our trust in others to care for [our child] is now very limited … I don't want this to happen to other families … they should be able to leave their children on the ward in the care of nursing staff.[1644]

The *Risk Management Open Disclosure Policy* that forms part of the suite of policies and procedures relevant to open disclosure includes an objective to:

> … ensure that persons who have experienced an adverse clinical event will be provided with timely communication and discussion about what has occurred, why the adverse event occurred, and what is being done to prevent it happening again.[1645]

This objective was a live concern for this family:

> We discussed how as parents we really just wanted to know that the hospital had put processes in place for this to *never* happen again and for future complaints to be addressed. Dr Renshaw talked about personal phone use no longer being allowed when on shift.[1646] [Emphasis is the parents'.]

One of the desired outcomes of an open disclosure process is 'Improved patient satisfaction with the process of managing an adverse clinical event'.[1647] The family told us:

> Our family has always been very respectfully treated by the LGH nursing and medical staff and we have nothing but praise for them. We have no doubt that they have saved [our daughter's] life on several occasions.
>
> We do have concerns about how the photo incident was reported to us and the lack of follow up we have since had.[1648]

We note that a 'social worker/counsellor' was present for this discussion, which the family did not recall (they remembered a person taking notes).[1649] The family told us that no support was offered after the open disclosure process for the patient or her parents.[1650]

Finding—Launceston General Hospital should ensure open disclosure processes are trauma-informed

We note the quite different recollections of how this open disclosure process occurred. We consider that an open disclosure process in relation to child sexual abuse should:

- not discuss the substance of the open disclosure in a voicemail message
- define the actions taken to prevent child sexual abuse occurring again and keep affected parties up to date with subsequent reforms
- ensure the patient and family are personally connected with expert sexual abuse counsellors.

5.2.48 November 2020—Angelique Knight contacts Dr Renshaw

Former Ward 4K patient Angelique Knight contacted Dr Renshaw sometime after *The Nurse* podcast was released. She shared a concern with Dr Renshaw about a reference in the podcast relating to her, namely that Mr Griffin wanted to 'give away' a patient at her wedding (described in Section 4.1.10). Ms Knight told us that Dr Renshaw responded to this concern by saying, 'oh that's interesting', without elaborating further.[1651]

Ms Knight told Dr Renshaw that she was worried that some of the images found on Mr Griffin's phone may have been taken of her because Mr Griffin would have had many opportunities to do this while caring for her.[1652] She wanted to see the images but recalled Dr Renshaw telling her that it 'can't happen' and that only one person had been identified from the photographs.[1653] Ms Knight said 'he didn't explain the process that led to this identification'.[1654] She further stated:

> I don't know if James Griffin did take photos of me and that bothers me … I was really annoyed … and it felt like Peter Renshaw was just brushing me off again. I felt like I was nothing and just a number to him.[1655]

On 10 November 2020, Ms Knight wrote to Dr Renshaw to share her shock and disgust about Mr Griffin's conduct. She told him it made her 'utterly sick and angry knowing how inappropriate he was with me … for half my life on 4K and outside of 4K'.[1656] She wrote: 'I feel so disgusting and I have no idea where to go with this I just know this is extremely hard trying to process! Hopefully someone can help!'[1657] Dr Renshaw wrote back expressing some sympathy and providing assurance that the hospital was cooperating

fully with the independent investigation.[1658] He also encouraged Ms Knight to look after herself and reach out to support services, and he provided the contact details of some of these services.

At our hearings, Ms Knight described finding this response lacking:

> … it just seemed very generic to me, like, you know, a very basic email that he's probably sent everybody that sent him an email—that's how it felt anyway … I just felt like a number to him, you know, like it's … not really important, not a big deal, kind of.[1659]

She acknowledged that Dr Renshaw provided information about support services but felt it was not personalised and required her to seek out help herself, rather than the hospital offering support.[1660]

Ms Knight's experience reinforced our view that Launceston General Hospital did not have an adequate process for responding to victim-survivors and related parties about Mr Griffin. The hospital did not provide clear information about what processes the hospital and police had undertaken to identify potential victims and, aside from a list of support service numbers, did not offer counselling. Providing a list of contact details for support services, while useful, is not an adequate response in these circumstances.

5.2.49 November 2020—A Launceston General Hospital staff member is approached by management following their participation in *The Nurse* podcast

A Launceston General Hospital staff member, who had a family member who was abused by Mr Griffin, spoke to Camille Bianchi for *The Nurse* podcast.[1661] The staff member also had a part-time role at the Sexual Assault Forensic Examiner (known as 'SAFE') in relation to sexual assault victims. SAFE sits within the Launceston General Hospital's area of responsibility.

The staff member told us that during a meeting with a Launceston General Hospital manager and the SAFE medical lead, they were told that due to their participation in the podcast and because of their family member's experience, the staff member's objectivity could be questioned, and this might compromise any prosecutions in which they were involved through SAFE. The staff member said they were confused by this information, given that SAFE is a forensic service and their family member's experience would not change the nature of any forensic evidence.

The Launceston General Hospital manager said that when the podcast was released, the SAFE medical lead approached her to discuss whether there was a potential conflict of interest or perceived bias if the staff member was to give evidence in a future sexual assault case.[1662] The manager told us that the medical lead had sought advice from the Director of Public Prosecutions who said that the staff member potentially could have a conflict of interest. The manager told us that the meeting with the staff member was

intended to see how the staff member might feel about this risk if their objectivity was questioned in a prosecution, given they had shared information about their family's experience publicly through the podcast, and to consider the staff member's wellbeing. The manager also told us that, given the concerns expressed by the medical lead, she considered it was appropriate for her to raise the issue with the staff member, and in doing so she did not express any personal views.

The staff member told us that at the time they interpreted the conversation as reprisal for speaking out, but with the benefit of hindsight they acknowledged it also expressed some concern for their mental health.

The manager denied that her comments were a reprisal for the staff member speaking out about their family's experience publicly. While SAFE does not conduct any general screening to determine if employees have experienced sexual assault, the manager explained that the difference in this situation was that the staff member had made their family's experiences public.

We also heard of other occasions when Launceston General Hospital management spoke to staff who had spoken publicly. We recognise that such conversations might have been based on genuine concerns about conflicts of interest or staff wellbeing. We are concerned, however, that such approaches, at least in the absence of a clear explanation of their purpose, risked contributing to a culture where staff felt reluctant to speak up about sexual abuse or feared adverse consequences if they did so publicly.

5.2.50 23 November 2020—The intention to establish a Commission of Inquiry is announced

On 23 November 2020, the then Premier Gutwein announced that a Commission of Inquiry into the Tasmanian Government's responses to child sexual abuse in institutional settings would be established in early 2021.[1663]

5.2.51 15 March 2021—Our Commission of Inquiry is formally established

On 15 March 2021, our Commission of Inquiry was formally established by Order of the Governor of Tasmania.[1664]

5.2.52 September 2021—Legal Services and the Department convene a group of staff to provide information in response to civil claims lodged in relation to Mr Griffin

In September 2021, the former Director of Employee Relations at the Department (who had since moved to the Department's Commission of Inquiry Response and Reform team) and Mr Bellinger joined a group established by Legal Services either within or designed to assist the Department to provide information to the Office of the Solicitor-General in response to civil claims relating to Mr Griffin.[1665] At least one of these civil

claims referenced a disclosure made to the hospital in 2010.[1666] This may have been drawn from the reference to a disclosure reported in *The Nurse* podcast, which we have presumed to be a reference to Ms Pearn's disclosure, although we consider it occurred in 2011 or 2012.

The former Director of Employee Relations recalled discussing Ms Pearn's disclosure with Mr Bellinger in the context of it coming up in one of the civil claims. We understand that they were already aware of Ms Pearn's disclosure through their conversation with Ms Pearn on 19 October 2020.[1667] On their evidence, they were not made directly aware of the possibility of Mr Bellinger's presence at Ms Pearn's initial disclosure; however, we have not been able to confirm this.

The former Director of Employee Relations and Mr Bellinger's exchange revealed that the Department accepted that the meeting Ms Pearn reported having with hospital's human resources staff did in fact occur, despite the hospital having no record of it.[1668] The former Director of Employee Relations told us that in discussions with Mr Bellinger, he mentioned that he often had contact with Stewart Millar in Mr Millar's capacity as a consultant, and that Mr Millar would likely be willing to provide a statement about Ms Pearn's disclosure, relevant to the claim.[1669]

5.2.53 1 October 2021—Mr Bellinger is asked to obtain statements from Mr Millar and Mr Fratangelo regarding Ms Pearn's disclosure

On 1 October 2021, the former Director of Employee Relations emailed Mr Bellinger asking him to obtain statements from Mr Millar and Mr Fratangelo about Ms Pearn's disclosure, noting they could do this themself if he was unable to.[1670] The former Director of Employee Relations wrote: 'No super urgency – it's not required at this stage but may be later' [Emphasis is the former Director's].[1671]

We note it was around this time that, as part of our evidence gathering, we were also making enquiries about Mr Millar's recollections of Ms Pearn's disclosure. We were not aware at that point that Mr Millar had recently given a similar statement to the Department.

We learned from the Solicitor-General, Sarah Kay SC, that the request for a statement from Mr Millar did not come from her office and it only learned that it had been taken on 28 January 2022 when a solicitor from her office had a discussion with a Department employee. This solicitor's file note of the conversation said:

> James Bellinger had contacted [Mr Millar] (the retiree) in late 2021, as they were unsure of details of alleged discussion of former staff member re abuse by Griffin when she was a child. … [The employee] confirmed OSG didn't ask for it [a statutory declaration] to be done, Health did on own volition and [Mr Millar] (had?) offered to make a stat dec as a record.[1672]

Because Ms Pearn's disclosure was made to the hospital's human resources team, it was not appropriate for anyone from that team to be involved in obtaining statements from Mr Fratangelo or Mr Millar.

On 30 October 2021, Mr Bellinger reported to the former Director of Employee Relations that Mr Millar was reviewing his statement and that Mr Fratangelo 'cannot recall [the disclosure] for the life of him'.[1673] Mr Fratangelo was not asked to complete a statutory declaration to this effect.[1674]

We have compared a draft version of Mr Millar's statement, prepared by Mr Bellinger, with the version that was ultimately signed by Mr Millar. The draft unsigned statement included the following content about who attended the meeting when Ms Pearn disclosed Mr Griffin's abuse: 'I believe it was either Gino Fratangelo or James Bellinger'.[1675]

On 3 November 2021, Mr Millar advised Mr Bellinger that he had made 'a couple of small changes' to the statement and forwarded a revised version.[1676] We identified two changes, one of which we do not consider consequential. On 8 November 2021, Mr Millar attended the hospital to sign the statement. In Mr Millar's final statement, signed on 8 November 2021, the content relevant to who attended the meeting when Ms Pearn disclosed Mr Griffin's abuse read: 'I believe it was either Gino Fratangelo or James Bellinger *or both*' [Emphasis ours].[1677]

We consider Mr Millar's edit notable. We also note that this is the evidence that Mr Millar has consistently given, including to us.

Mr Bellinger said he did not share this information from Mr Millar's statement with anyone at the hospital, beyond providing the former Director of Employee Relations a copy of Mr Millar's statement.[1678] We are not clear whether and how this statement was used.

Mr Bellinger gave evidence at our hearings that he only became aware that Mr Millar placed him at the meeting where Ms Pearn's disclosure took place when he was taking Mr Millar's statement.[1679] He admitted that this knowledge did not prompt him to recuse himself from taking the statement due to a conflict of interest.[1680] Mr Bellinger conceded that 'with hindsight somebody else should have taken over that interview process or that witness statement process'.[1681]

When Counsel Assisting asked Mr Bellinger whether the reason he did not take any steps in response to his conflict of interest was because he didn't want any further scrutiny of Ms Pearn's disclosure, Mr Bellinger responded: 'No, it was not that reason'.[1682]

The former Director of Employee Relations told us that it was not their expectation that Mr Bellinger would discuss Mr Millar's recollection with him and draft Mr Millar's statement himself, only that he would request that Mr Millar provide a statement. They said that they only became aware that Mr Bellinger had prepared the statement himself when they received a copy and saw that Mr Millar's name was misspelt.[1683] They acknowledged that they should not have asked Mr Bellinger to obtain a statement from Mr Millar.[1684]

Finding—Launceston General Hospital's human resources team should not have been involved in the request or preparation of a statement from Stewart Millar regarding Kylee Pearn's disclosure

The Department's Commission of Inquiry Response and Reform team (where the former Director of Employee Relations worked at this time) was responsible for providing our Commission of Inquiry with all relevant documentation from the Department, including in relation to Ms Pearn's disclosure.

Because Ms Pearn's disclosure was made to the hospital's human resources team, it should have been clear to the Department's Commission of Inquiry Response and Reform team that the hospital's human resources team should not have been involved in documenting anything connected to Ms Pearn's disclosure, nor gaining statements from other human resources team members.

Furthermore, it was reasonably foreseeable to the Department's Commission of Inquiry Response and Reform team that Mr Bellinger and Mr Millar would be witnesses at our Commission of Inquiry and that there may have been a point of contention in their differing recollections of who was present at Ms Pearn's disclosure, and that greater care to not compromise the evidence before our Inquiry should have been taken.[1685]

Finding—James Bellinger should not have taken the statement from Stewart Millar

We are concerned that Mr Bellinger took the statement from Mr Millar about Ms Pearn's disclosure in 2011 or 2012 given our finding that Mr Bellinger was at the meeting with Ms Pearn when she made the disclosure.

Even on Mr Bellinger's evidence that he was not at the meeting, when asked by the former Director of Employee Relations to obtain a statement from Mr Millar, Mr Bellinger should have flagged his likely conflict of interest and declined to be involved. Mr Bellinger was a member of the human resources team. It was not appropriate for him to have any involvement in Mr Millar's statement. Even on the most favourable interpretation of Mr Bellinger's evidence, at the point Mr Millar named Mr Bellinger as being at the meeting, he should have reported this to his manager and ceased involvement. Mr Bellinger conceded that somebody else should have taken the statement.

We are concerned about Mr Bellinger's decisions regarding Ms Pearn's 2011 or 2012 disclosure, including:

- not alerting anyone within the hospital or Department to Ms Pearn's disclosure when Detective Senior Constable Hindle enquired about it on 11 October 2019, despite his evidence that it would be his usual practice to do so
- not including Ms Pearn's disclosure in any of his various reviews of Mr Griffin's prior complaints history, including the response to the Integrity Commission.

These decisions contributed to our finding that he was present at the 2011 or 2012 meeting.

6 Observations

Despite considering the documents and other evidence relevant to Mr Griffin for some months, we struggle to come to terms with the enormity of the collective failure by a range of institutions—including Launceston General Hospital, Child Safety Services and Tasmania Police—that characterises their responses to the risks Mr Griffin posed. These collective failures enabled a motivated sexual predator to repeatedly groom, harm and abuse vulnerable young patients and other children with whom he had contact. The extent of Mr Griffin's sexual abuse of children and young people is astounding and devastating. We acknowledge that the incidents we are aware of likely reflect only some of Mr Griffin's sexual offending across a range of contexts. We only examined one facet of Mr Griffin's abuse, namely his abuse within an institution. We know of many more victim-survivors and witnesses who decided not to share their experiences with us.

What is clear from the evidence we have laid out in Sections 3 and 4 is that:

- Mr Griffin had a clear modus operandi in often (but not always) targeting particularly vulnerable young girls who, because of their family circumstances, poor mental health or physical illness, were more susceptible to his grooming. While we heard evidence that Mr Griffin could be opportunistic in offending against short-stay patients, it was young people with ongoing chronic conditions whom Mr Griffin most often targeted because their extended stays in hospital created more opportunities for him to groom them and their families, build relationships that could extend beyond the hospital and offend against them.
- Mr Griffin was tactical in his interactions with people who may have detected his abuses or raised the alarm. He groomed colleagues, managers and the families of patients to build their trust and to make them less likely to recognise, report or act on his behaviour. This grooming lowered the guard of some people and made them more inclined to view Mr Griffin's inappropriate behaviours as benign or indicative of a higher level of care and concern for patients.

- When Mr Griffin's charm did not work, particularly with male nursing colleagues who were conscious of the professional conduct expected of male nurses, he revealed glimpses of a more intimidating and hostile side that made people wary to confront him. Mr Griffin's aggressive side was apparent on the few occasions that he was confronted with complaints or resistance from patients and very evident in his abuse of Ms Skeggs. While the revelations about Mr Griffin were a shock to some, they were a confirmation of the suspicions held by others who had encountered or detected his menacing side.
- Much of Mr Griffin's inappropriate behaviour occurred in plain sight, which at times made it less likely to be detected. He groomed, breached professional boundaries with and inappropriately touched children with brazenness. His behaviour was facilitated by his confidence that he could act with impunity—when concerns were raised, the hospital, Tasmania Police and Child Safety Services largely failed to intervene. His unabashed behaviour was also a strategy to reassure people that his conduct was appropriate. In being so open with some of his conduct, those around him often did not recognise his behaviour as abusive (or second guessed their sense that it was) and even participated in assuring others, including patients and their family members, that his behaviour was 'just Jim'.
- Mr Griffin often encouraged relationships between his victims and his family. This had the effect of making the time he spent with his victims less suspect. It also made his victims feel that they had a duty to protect his children from the distress of disclosures about his conduct. This kept them silent. Many victim-survivors that we heard from were careful to ensure the information they provided us would not hurt Mr Griffin's family, who have no doubt suffered considerably. We expect that many others did not provide us with information for this reason.
- The health setting that Mr Griffin operated in gave him unique opportunities to offend. It gave him access to young girls who were often in a frightened and highly vulnerable state. Many of these young girls spent long periods on the ward and initially welcomed his warmth and attentiveness, which informed how their families interpreted Mr Griffin's keen interest in their care. Patients' need for physical care (including for bathing, dressing or other intimate procedures) provided a veneer of legitimacy for his abuses, particularly because chaperone protocols were not strongly embedded and enforced on the ward, and children and young people (and their families) had little information to help them identify what was normal and what was unprofessional practice (although some did come to recognise how Mr Griffin's behaviour differed from that of other nurses).
- The dysfunctional nature of Ward 4K enabled Mr Griffin to offend. He took full advantage of this toxic work culture. Staff were mired in interpersonal conflict for many years, which had the effect of demotivating them, making them less likely

to speak up about their concerns, and allowing management and human resources staff to be sceptical or dismissive of their complaints.

- The systems, policies and processes of the hospital were not adequate to protect children from sexual abuse. The hospital provided inadequate guidance on expected standards of behaviour in child-facing roles, showed lax enforcement and embedding of the chaperone protocol, demonstrated poor complaints-handling processes, showed reluctance to take disciplinary action in the face of escalating noncompliance, and failed to adequately notify and involve senior management and external agencies about the multiple complaints against Mr Griffin. The combination of all these factors contributed to a disclosure as significant as Ms Pearn's in 2011 or 2012 being met with complete inaction.
- Similarly, the failures of Child Safety Services to properly share information and create meaningful opportunities for disclosure meant chances were missed to piece together information that could have revealed Mr Griffin's abuses at a much earlier stage. The response of Child Safety Services to concerns about Ms Skeggs in 2013 did not feel safe or helpful to her; instead, it cast doubt on reported concerns in a rush to close its file. This response may well have been a product of a pressured and overstretched system, but it contributed to allowing Mr Griffin to continue his abuses.
- Following the email it received in 2000 onwards, Tasmania Police similarly failed to act on critical information at various times and to review prior intelligence holdings that would have allowed a more complete assessment of Mr Griffin's modus operandi. Mr Griffin was not given priority as a suspected offender despite significant risks to children. The failure of Tasmania Police to act diligently on intelligence gathered by the Australian Federal Police in 2015 cannot be overstated. While Tasmania Police has rightly reviewed its actions and apologised accordingly, this failing was so egregious as to warrant revisiting by our Inquiry.
- Each organisation—Launceston General Hospital, Tasmania Police and Child Safety Services—should have done more to assess and act on the risks posed by Mr Griffin, acknowledging that the extent of the risk was only fully apparent when the information held by each of these agencies was put together. Mr Griffin had a pattern of abusive behaviour towards children that was stark and undeniable. The failures to share information, particularly between Tasmania Police and Child Safety Services, meant that opportunities to identify this pattern earlier were lost.

The following is clear to us from the evidence presented in Section 5:

- Launceston General Hospital only acted in response to Mr Griffin when forced to do so and as a result of the police investigation prompted by Ms Skeggs' report in 2019. The lack of any pre-existing plans or strategies to manage a crisis of

this nature—that is, employing a paedophile in a paediatric ward for 18 years—combined with the completely dysfunctional dynamics within the hospital, created significant vulnerabilities that were ultimately catastrophic in terms of the hospital's response.

- Leadership of this response was largely absent. However, to the extent that the hospital's leadership was involved in the response, it did not properly acquit its responsibilities.
- Secretary Morgan-Wicks came to our hearings to listen and accept responsibility. She stood out as one of the few senior witnesses to genuinely appreciate the scale of the catastrophe that was the hospital's response to revelations of Mr Griffin's offending and that the task ahead of rebuilding community trust will be enormous. Her willingness to be accountable was as appropriate as it was heartening. It was clear to us that Secretary Morgan-Wicks was not only poorly advised, but also misled.

Several staff from Ward 4K who provided evidence to us showed great vulnerability and courage in honestly admitting what they felt were their own failings to report, record actions or to take greater steps in response to Mr Griffin's conduct. There can be a fine line between self-condemnation, genuine regret and appropriate reflection on what one would do differently if they had their time again. We hope bystanders of Mr Griffin's abuse learn from their experience and work towards safer practices in future. Some of these individuals have done the most—alongside victim-survivors—to draw attention to the systemic failures within the hospital. They have spoken up and spoken out, notwithstanding their own fears of reprisal. We, and the broader Tasmanian community, owe a great debt to them for their fearlessness and tenacity.

What was apparent to us is that the people who most berated themselves for their decisions and actions were those least responsible for Mr Griffin's abuse—victim-survivors. We witnessed the anguish of many victim-survivors who believed that they alone were being abused by Mr Griffin and felt wracked with guilt when the extent of his abuse became known. They expressed to us that they should have raised the alarm. These feelings come from a deep concern for others and for the protection of children, which we greatly admire, but it is not a burden victim-survivors of abuse should have to carry. It is not their responsibility to protect others from their abuser. It is the responsibility of institutions tasked with their care and protection.

Our Commission of Inquiry would not have been possible without the willingness of victim-survivors and their supporters to share their most painful and distressing experiences with us. We know there are many other people who have chosen not to do so, which we respect. We had hoped our hearings would offer a degree of healing and catharsis for many who held unanswered questions or were rightly hoping and expecting some proper acknowledgment of their suffering and their

efforts to bring attention to concerns about Mr Griffin with the hospital. Instead, they—like us—were met with a response from senior executives at the hospital that lacked empathy, insight, reflection and care for them.

We hope this report—alongside our Commission of Inquiry's care and deep admiration for all victim-survivors—nonetheless offers some measure of comfort and closure that can be further reinforced by the recommendations that we discuss in Chapter 15.

Notes

Introduction

1 Order of the Governor of Tasmania made under the *Commissions of Inquiry Act 19.95*, 15 March 2021.

In accordance with the Restricted Publication Order of the Commission of Inquiry dated 30 August 2023 and section 10(3) of the *Commissions of Inquiry Act 1995* (Tas), the Governor has omitted Volume 6, Chapter 14, Case Study 1 because the public interest in the disclosure of that part of the report is significantly outweighed by other relevant considerations, namely the right of any person to a fair trial.

In accordance with the Restricted Publication Order of the Commission of Inquiry dated 30 August 2023 and section 10(3) of the *Commissions of Inquiry Act 1995* (Tas), the Governor has omitted Volume 6, Chapter 14, Case Study 1 because the public interest in the disclosure of that part of the report is significantly outweighed by other relevant considerations, namely the right of any person to a fair trial.

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Case study 2: Response to complaint about Dr Tim (a pseudonym)

137 Statement of Craig Duncan, 8 June 2022, 2 [6].

138 Statement of Craig Duncan, 8 June 2022, 2 [6].

139 The name 'Dr Tim' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 27 June 2022.

140 Statement of Craig Duncan, 8 June 2022, 1 [5].

141 Statement of Craig Duncan, 8 June 2022, 17–18 [93].

142 Statement of Craig Duncan, 8 June 2022, 10 [46]; Statement of Craig Duncan, 8 June 2022, Annexure CD-004 (Letter from Zoe Duncan, undated); Statement of Craig Duncan, 8 June 2022, Annexure CD-036 (Marked-up 'How to Stay Safe' booklet, undated).

143 Statement of Craig Duncan, 8 June 2022, 2 [7].

144 Statement of Craig Duncan, 8 June 2022, 2 [7].

145 Statement of Craig Duncan, 8 June 2022, 2 [10].

146 Statement of Craig Duncan, 8 June 2022, 2 [10].

147 Statement of Craig Duncan, 8 June 2022, 3 [11].

148 Statement of Craig Duncan, 8 June 2022, 3 [11].

149 Statement of Craig Duncan, 8 June 2022, 3 [12].

150 Statement of Craig Duncan, 8 June 2022, 3 [13].

151 Statement of Craig Duncan, 8 June 2022, 3 [13].

152 Statement of Craig Duncan, 8 June 2022, 3 [14].

153 Statement of Craig Duncan, 8 June 2022, 3 [14].

154 Statement of Craig Duncan, 8 June 2022, 3 [14].

155 Statement of Craig Duncan, 8 June 2022, 3 [14].

156 Statement of Craig Duncan, 8 June 2022, 4 [14].

157 Statement of Craig Duncan, 8 June 2022, 4 [14].

158 Statement of Craig Duncan, 8 June 2022, 4 [17].

159 Statement of Craig Duncan, 8 June 2022, 4 [18].

160 Statement of Craig Duncan, 8 June 2022, 4 [18].

161 Statement of Craig Duncan, 8 June 2022, 4 [18].

162 Statement of Craig Duncan, 8 June 2022, 5 [19].

163 Statement of Peter Renshaw, 20 June 2022, 19 [17], 46 [68.1]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

164 Statement of Peter Renshaw, 20 June 2022, 19 [17.1], 46 [67.1].

165 Statement of Peter Renshaw, 20 June 2022, 47 [69.3]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

166 After Hours Nurse Coordinator, 'Incident Report', 20 May 2001, 1, produced by the Department of Communities in response to a Commission notice to produce.

167 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

168 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

169 Transcript of Peter Renshaw, 8 September 2022, 3737 [1–7].

170 Transcript of Peter Renshaw, 8 September 2022, 3737 [16–20].

171 Transcript of Peter Renshaw, 8 September 2022, 3739 [39–40].

172 Transcript of Peter Renshaw, 8 September 2022, 3740 [36]–3741 [2].

173 Transcript of Peter Renshaw, 8 September 2022, 3753 [37].

174 Medical Council of Tasmania, 'Investigation Report', 19 March 2003, 3, produced by the Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

175 Statement of Craig Duncan, 8 June 2022, 5 [19].

176 Statement of Craig Duncan, 8 June 2022, 5 [19].

177 Statement of Craig Duncan, 8 June 2022, 5 [19].

178 Statement of Craig Duncan, 8 June 2022, 5 [20].

179 Statement of Craig Duncan, 8 June 2022, 6 [25].

180 Statement of Craig Duncan, 8 June 2022, 5 [21].

181 Statement of Craig Duncan, 8 June 2022, 5 [21].

182 Statement of Craig Duncan, 8 June 2022, 5 [21].

183 Statement of Craig Duncan, 8 June 2022, 5 [22].

184 Statement of Craig Duncan, 8 June 2022, 5 [22].

185 Statement of Craig Duncan, 8 June 2022, 5 [22].

186 Statement of Craig Duncan, 8 June 2022, 6 [24].

187 Statement of Craig Duncan, 8 June 2022, 6 [24].

188 Statement of Craig Duncan, 8 June 2022, 6 [25].

189 Statement of Craig Duncan, 8 June 2022, 6 [25].

190 Statement of Peter Renshaw, 20 June 2022, 48 [69.8]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

191 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

192 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

193 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

194 Transcript of Peter Renshaw, 8 September 2022, 3745 [16–18].

195 Transcript of Peter Renshaw, 8 September 2022, 3745 [20–23].

196 Transcript of Peter Renshaw, 8 September 2022, 3747 [27–35], 3752 [3–5].

197 Transcript of Peter Renshaw, 8 September 2022, 3747 [37]–3749 [21].

198 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes); Statement of Craig Duncan, 8 June 2022, 6–7 [26].

199 Statement of Craig Duncan, 8 June 2022, 7 [26].

200 Statement of Craig Duncan, 8 June 2022, 7 [26].

201 Statement of Peter Renshaw, 20 June 2022, 48 [69.9]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

202 Transcript of Peter Renshaw, 8 September 2022, 3751 [33]–3752 [1].

203 Statement of Craig Duncan, 8 June 2022, 7 [26]; Statement of Peter Renshaw, 20 June 2022, 48 [69.9]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

204 Transcript of Peter Renshaw, 8 September 2022, 3753 [15–17].

205 Statement of Peter Renshaw, 20 June 2022, 49 [69.10]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

206 Statement of Peter Renshaw, 20 June 2022, 49 [69.10].

207 Transcript of Peter Renshaw, 8 September 2022, 3752 [34–39].

208 Transcript of Peter Renshaw, 8 September 2022, 3752 [34]–3753 [3].

209 Statement of Craig Duncan, 8 June 2022, 7 [26].

210 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

211 Transcript of Peter Renshaw, 8 September 2022, 3750 [37–42].

212 Statement of Peter Renshaw, 20 June 2022, 20 [18.3].

213 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 2–3.

214 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 3.

215 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 2–3.

216 Transcript of Claire Lovell, 4 July 2022, 2274 [3–4].

217 Transcript of Peter Renshaw, 8 September 2022, 3742 [14–15], 3743 [30–37], 3745 [20–23] 3746 [30–36], 3747 [34–35].

218 Statement of Craig Duncan, 8 June 2022, 7 [27].

219 Statement of Craig Duncan, 8 June 2022, 7 [27].

220 Statement of Craig Duncan, 8 June 2022, 7 [27].

221 Statement of Craig Duncan, 8 June 2022, 7 [27].

222 Statement of Craig Duncan, 8 June 2022, 7 [27].

223 Statement of Craig Duncan, 8 June 2022, 7 [27].

224 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

225 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

226 Transcript of Peter Renshaw, 8 September 2022, 3754 [14–16].

227 Statement of Peter Renshaw, 20 June 2022, 49 [69.11].

228 Statement of Peter Renshaw, 20 June 2022, 20 [18.4].

229 Statement of Peter Renshaw, 20 June 2022, 49 [69.11].

230 Transcript of Peter Renshaw, 8 September 2022, 3738 [42]–3739 [8].

231 Transcript of Peter Renshaw, 8 September 2022, 3739 [1–2].

232 Transcript of Peter Renshaw, 8 September 2022, 3752 [11–19].

233 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

234 Statement of Peter Renshaw, 20 June 2022, 49 [69.12].

235 Statement of Peter Renshaw, 20 June 2022, 49 [69.12].

236 Statement of Peter Renshaw, 20 June 2022, 20 [18.5].

237 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes); Transcript of Peter Renshaw, 8 September 2022, 3755 [3–8].

238 General Practitioner, Letter to Dr Renshaw, 25 May 2001, produced by the Department of Communities in response to a Commission notice to produce.

239 Statement of Craig Duncan, 8 June 2022, 8 [30].

240 Statement of Peter Renshaw, 20 June 2022, 49 [69.13]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

241 Statement of Peter Renshaw, 20 June 2022, 49 [69.13]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

242 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

243 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

244 Statement of Peter Renshaw, 20 June 2022, 50 [69.14]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

245 Statement of Peter Renshaw, 20 June 2022, 50 [71.1], 52 [72.4].

246 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

247 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

248 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

249 Peter Renshaw, 'File Note – Meeting with Dr Tim', 29 May 2001, 1, produced by the Department of Health in response to a Commission notice to produce.

250 Transcript of Peter Renshaw, 8 September 2022, 3760 [17–20].

251 Statement of Peter Renshaw, 20 June 2022, 20 [18.5], 50 [69.14]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes); Statement of Craig Duncan, 8 June 2022, 8 [31].

252 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes); Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 3, produced by the Department of Communities in response to a Commission notice to produce.

253 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 3, produced by the Department of Communities in response to a Commission notice to produce.

254 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 3, produced by the Department of Communities in response to a Commission notice to produce.

255 Statement of Peter Renshaw, 20 June 2022, 50 [69.14]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

256 Statement of Peter Renshaw, 20 June 2022, 50 [69.15].

257 Statement of Peter Renshaw, 20 June 2022, Annexure 2 (Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect, implemented 6 March 1998); Transcript of Elizabeth Stackhouse, 27 June 2022, 1735 [26]–1736 [5].

258 Statement of Peter Renshaw, 20 June 2022, Annexure 2 (Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect, implemented 6 March 1998).

259 Statement of Peter Renshaw, 20 June 2022, Annexure 2 (Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect, implemented 6 March 1998).

260 Statement of Peter Renshaw, 20 June 2022, Annexure 2 (Protocol for Hospital-Based Medical and Nursing Staff for the Reporting and Management of Cases of Suspected Child Abuse or Neglect, implemented 6 March 1998).

261 Transcript of Peter Renshaw, 8 September 2022, 3739 [42]–3740 [20].

262 Transcript of Peter Renshaw, 8 September 2022, 3739 [42]–3740 [20].

263 Transcript of Peter Renshaw, 8 September 2022, 3742 [43]–3743 [2].

264 Transcript of Elizabeth Stackhouse, 27 June 2022, 1737 [27–32].

265 Transcript of Elizabeth Stackhouse, 27 June 2022, 1737 [37]–1738 [3].

266 Statement of Peter Renshaw, 20 June 2022, 47 [69.3]; Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

267 Transcript of Peter Renshaw, 8 September 2022, 3737 [1–7].

268 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 2.

269 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 2.

270 *Children, Young Persons and Their Families Act 1997* s 14.

271 Transcript of Peter Renshaw, 8 September 2022, 3747 [20–35].

272 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce; Medical Council of Tasmania, 'Investigation Report', 19 March 2003, 3, produced by the Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

273 Transcript of Peter Renshaw, 8 September 2022, 3745 [22], [39–42].

274 Transcript of Peter Renshaw, 8 September 2022, 3746 [12–15].

275 Transcript of Peter Renshaw, 8 September 2022, 3752 [34–39].

276 Transcript of Peter Renshaw, 8 September 2022, 3753 [1–3].

277 Statement of Elizabeth Stackhouse, 22 June 2022, 10 [77].

278 Statement of Elizabeth Stackhouse, 22 June 2022, 14 [107].

279 Transcript of Peter Renshaw, 8 September 2022, 3738 [42]–3739 [8].

280 Transcript of Peter Renshaw, 8 September 2022, 3739 [1–2].

281 Statement of Elizabeth Stackhouse, 22 June 2022, 13 [102]; Elizabeth Stackhouse, Letter to Laurel House, 8 May 2002, produced by the Department of Health in response to a Commission notice to produce.

282 Statement of Elizabeth Stackhouse, 22 June 2022, 11 [78], 14 [110].

283 Department of Health and Human Services, 'Examination of Patients by Medical, Nursing and Allied Health Staff (Chaperone Policy)', undated, 3, produced by the Department of Health in response to a Commission notice to produce; Statement of Craig Duncan, 8 June 2022, Annexure CD-011 (Draft Department of Health and Human Services – Launceston General Hospital Policy – Examination of Patients by Medical, Nursing and Allied Health Staff (Chaperone Policy), undated).

284 Department of Health and Human Services, 'Examination of Patients by Medical, Nursing and Allied Health Staff (Chaperone Policy)', June 2002, 1–2, produced by the Commissioner for Children and Young People in response to a Commission notice to produce.

285 Statement of Craig Duncan, 8 June 2022, 9 [37]; Statement of Craig Duncan, 8 June 2022, Annexure CD-003 (Annotated 'Term One Reflection' worksheet by Zoe Duncan, undated).

286 Intake and Assessment Coordinator, Letter to Peter Renshaw, 13 June 2001, 1, produced by the Department of Communities in response to a Commission notice to produce; Intake and Assessment Coordinator, Letter to Anne Duncan, 13 June 2001, 1, produced by the Department of Communities in response to a Commission notice to produce; Statement of Craig Duncan, 8 June 2022, 9 [34]; Statement of Craig Duncan, 8 June 2022, Annexure CD-002 (Letter from Child and Family Services to Anne Duncan, 13 June 2001).

287 Intake and Assessment Coordinator, Letter to Peter Renshaw, 13 June 2001, 1, produced by the Department of Communities in response to a Commission notice to produce.

288 Department of Community and Health Services, 'Procedure to be followed where there is an allegation of maltreatment of a client (who is a child) by an employee of the Agency', June 1997, 1, produced by the Department of Communities in response to a Commission notice to produce.

289 Department of Community and Health Services, 'Procedure to be Followed where there is an Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency', June 1997, 5–6, produced by the Department of Communities in response to a Commission notice to produce.

290 Department of Community and Health Services, 'Procedure to be Followed where there is an Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency', June 1997, 8–9, produced by the Department of Communities in response to a Commission notice to produce.

291 Department of Community and Health Services, 'Procedure to be Followed where there is an Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency', June 1997, 12, produced by the Department of Communities in response to a Commission notice to produce.

292 Allegation of Maltreatment of a Client (who is a Child) by an Employee of the Agency', June 1997, 12–15, produced by the Department of Communities in response to a Commission notice to produce.

293 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes).

294 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes) 3.

295 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes) 3.

296 Statement of Peter Renshaw, 20 June 2022, Annexure 19 (File note of Peter Renshaw regarding Zoe Duncan, 29 May 2001 with additional notes) 3.

297 Request for statement served on Secretary, Department of Communities, 1 June 2022, 8 [20(c)].

298 Statement of Michael Pervan, 4 July 2022, 22 [121].

299 Transcript of Darren Hine, 6 July 2022, 2465 [24–30].

300 Transcript of Claire Lovell, 4 July 2022, 2274 [22–42].

301 Transcript of Claire Lovell, 4 July 2022, 2275 [39–47].

302 Transcript of Claire Lovell, 4 July 2022, 2279 [18–26].

303 Transcript of Claire Lovell, 4 July 2022, 2279 [36–44].

304 Transcript of Claire Lovell, 4 July 2022, 2276 [1–6].

305 *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 4, 30–33, 52–55; Statement of Helen Milroy, 28 April 2022, 4 [16–17]; Statement of Michael Salter, 7 April 2022, 8 [30], 15 [58].

306 Statement of Craig Duncan, 8 June 2022, 9 [39].

307 Statement of Craig Duncan, 8 June 2022, 9 [40].

308 Statement of Craig Duncan, 8 June 2022, 9 [41].

309 Statement of Craig Duncan, 8 June 2022, 9 [41].

310 Statement of Craig Duncan, 8 June 2002, 10 [43].

311 Statement of Craig Duncan, 8 June 2022, 10 [43].

312 Psychologist and Rehabilitation Provider, Report to Child and Family Services, 11 July 2001, produced by the Department of Communities in response to a Commission notice to produce; Statement of Craig Duncan, 8 June 2022, 8 [32]; Statement of Craig Duncan, 8 June 2022, Annexure CD-001 (Report by [confidential] Psychologist and Rehabilitation Provider regarding Zoe Duncan, 11 July 2001).

313 General Practitioner, Letter to Child and Family Services, 22 July 2001, produced by the Department of Communities in response to a Commission notice to produce.

314 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 6, produced by the Department of Communities in response to a Commission notice to produce.

315 Child and Family Services, 'Initial Enquiry Report',1. September 200 1. 6, produced by the Department of Communities in response to a Commission notice to produce.

316 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 6, produced by the Department of Communities in response to a Commission notice to produce.

317 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 4–10, produced by the Department of Communities in response to a Commission notice to produce; Statement of Craig Duncan, 8 June 2022, 10 [48].

318 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 5, produced by the Department of Communities in response to a Commission notice to produce.

319 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 7, produced by the Department of Communities in response to a Commission notice to produce.

320 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 8, produced by the Department of Communities in response to a Commission notice to produce.

321 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 8–9, produced by the Department of Communities in response to a Commission notice to produce.

322 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 9, produced by the Department of Communities in response to a Commission notice to produce.

323 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 9, produced by the Department of Communities in response to a Commission notice to produce.

324 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

325 These people included Zoe's parents, Dr Renshaw, Zoe's General Practitioner, Zoe's psychologist, Zoe's school teachers and Laurel House. Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

326 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

327 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

328 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

329 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 10, produced by the Department of Communities in response to a Commission notice to produce.

330 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 11, produced by the Department of Communities in response to a Commission notice to produce.

331 Statement of Craig Duncan, 8 June 2022, 4 [16].

332 Statement of Craig Duncan, 8 June 2022, 12 [57].

333 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 11, produced by the Department of Communities in response to a Commission notice to produce.

334 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 11, produced by the Department of Communities in response to a Commission notice to produce.

335 Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 11, produced by the Department of Communities in response to a Commission notice to produce.

336 Child and Family Services, Initial Enquiry Report, 12 September 2001, 2–10, produced by the Department of Communities in response to a Commission notice to produce.

337 Transcript of Claire Lovell, 4 July 2022, 2279 [3–12].

338 Transcript of Claire Lovell, 4 July 2022, 2278 [21–38].

339 Statement of Craig Duncan, 8 June 2022, 12 [57]; Child and Family Services, 'Initial Enquiry Report', 12 September 2001, 5, produced by the Department of Communities in response to a Commission notice to produce.

340 Statement of Craig Duncan, 8 June 2022, 13 [61].

341 Transcript of Darren Hine, 6 July 2022, 2467 [6–17].

342 Statement of Michael Salter, 7 April 2022, 9 [31–32].

343 Transcript of Claire Lovell, 4 July 2022, 2281 [7–17].

344 Transcript of Claire Lovell, 4 July 2022, 2281 [30–42].

345 Statement of Michael Pervan, 4 July 2022, 23 [125].

346 Statement of Michael Pervan, 4 July 2022, 23 [125], 24 [131].

347 Statement of Michael Pervan, 4 July 2022, 23 [129].

348 Transcript of Claire Lovell, 4 July 2022, 2278 [3–4].

349 Transcript of Peter Renshaw, 8 September 2022, 3763 [5–11].

350 Transcript of Peter Renshaw, 8 September 2022, 3764 [6–31].

351 Transcript of Peter Renshaw, 9 September 2022, 3844 [6–19].

352 Statement of Craig Duncan, 8 June 2022, 11 [49].

353 Statement of Craig Duncan, 8 June 2022, 11 [50].

354 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001); Statement of Craig Duncan, 8 June 2022, 13 [62]; Statement of Craig Duncan, 8 June 2022, Annexure CD-005 (Letter from [confidential] to Craig and Anne Duncan regarding 'Zoe Duncan – Criminal injuries compensation application', 25 February 2003).

355 Transcript of Darren Hine, 6 July 2022, 2465 [13–15], [21–22].

356 Statement of Darren Hine, 14 June 2022, Annexure DH-38 (Subject Report by Detective Sergeant, 12 October 2001).

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398 Statement of Craig Duncan, 8 June 2022, 21 [111].

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Case study 3: James Griffin

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437 Statement of Keelie McMahon, 9 May 2022, 2 [7].

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439 Anonymous Statement, 21 June 2022, 3 [14].

440 Statement of Maria Unwin, 22 June 2022, 5 [18].

441 Anonymous Statement, 20 June 2022, 2 [9].

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524 Statement of Sonja Leonard, 21 June 2022, Annexure SL-23 (Handover notes regarding James Griffin) 1.

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526 Statement of Sonja Leonard, 21 June 2022, 21 [160].

527 Statement of Sonja Leonard, 21 June 2022, Annexure SL-24 (Handwritten diary note for 11 February 2009) 1.

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532 Letter from a Senior Psychiatric Registrar to Sonja Leonard, early 2009, 2.

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559 Statement of Sonja Leonard, 21 June 2022, Annexure SL-26 (Letter from Sonja Leonard to James Griffin with subject 'professional boundaries') 1.

560 Statement of Sonja Leonard, 21 June 2022, Annexure SL-26 (Letter from Sonja Leonard to James Griffin with subject 'professional boundaries') 1.

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621 Statement of Kathrine Morgan-Wicks, 30 August 2022, 25 [161].

622 Statement of James Bellinger, 10 June 2022, Appendix 39 (Email from James Bellinger to Glenn Hindle, 11 October 2019).

623 Transcript of Luigino Fratangelo, 29 June 2022, 1960 [39–46].

624 Transcript of James Bellinger, 28 June 2022, 1891 [47].

625 Transcript of Stewart Millar, 28 June 2022, 1852 [26–30].

626 Transcript of Luigino Fratangelo, 29 June 2022, 1956 [45–46].

627 Transcript of Luigino Fratangelo, 29 June 2022, 1957 [11–21].

628 Transcript of Eric Daniels, 30 June 2022, 2109 [34–37].

629 Statement of Kylee Pearn, 24 June 2022, 3 [13].

630 Statement of Kylee Pearn, 24 June 2022, 4 [14].

631 Statement of Kylee Pearn, 24 June 2022, 4 [14].

632 Transcript of Glenn Hindle, 6 July 2022, 2426 [3–18].

633 Statement of Kylee Pearn, 24 June 2022, 4 [14].

634 Statement of Kylee Pearn, 24 June 2022, 4 [14].

635 Statement of Kylee Pearn, 24 June 2022, 4 [15].

636 Statement of Kylee Pearn, 24 June 2022, 4 [15].

637 Statement of Kylee Pearn, 24 June 2022, 4 [15].

638 Statement of Kylee Pearn, 24 June 2022, 4 [15].

639 Statement of Michael Pervan, 4 June 2022, 9 [58].

640 Statement of Michael Pervan, 4 June 2022, 10–11 [62].

641 Statement of Michael Pervan, 4 June 2022, 11 [62].

642 Department of Communities, 'Summary of facts – James Geoffrey (Jim) Griffin', 12 April 2021, 1—2, produced by the Tasmanian Government in response to a Commission notice to produce.

643 Statement of Michael Pervan, 4 June 2022, 9 [58].

644 Statement of Michael Pervan, 4 June 2022, 1 [62].

645 Statement of Michael Pervan, 4 June 2022, 1 [62].

646 Transcript of Claire Lovell, 4 July 2022, [23–41].

647 Transcript of Claire Lovell, 4 July 2022, [32–46].

648 Statement of Darren Hine, 14 June 2022, 57 [223].

649 Statement of Darren Hine, 14 June 2022, 58 [224].

650 Statement of Darren Hine, 14 June 2022, 93 [418].

651 Statement of Darren Hine, 14 June 2022, 93 [418].

652 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

653 Statement of Sonja Leonard, 21 June 2022, Annexure SL-29 (Handwritten diary entry for 30 November 2012) 1.

654 Statement of Sonja Leonard, 21 June 2022, Annexure SL-29 (Handwritten diary entry for 30 November 2012) 1.

655 Statement of Sonja Leonard, 21 June 2022, [186].

656 Sue McBeath, Procedural Fairness Response, 28 April 2023, 7 [5.3].

657 Department of Health and Human Services, Performance and Development Agreement signed by James Griffin and Sonja Leonard, 6 March 2013.

658 Department of Health and Human Services, Performance and Development Agreement signed by James Griffin and Sonja Leonard, 6 March 2013.

659 Email from a nurse to Sonja Leonard, 'Incident 16/4/13', 16 April 2013 5:21pm.

660 Email from a nurse to Sonja Leonard, 'Incident 16/4/13', 16 April 2013 5:21pm.

661 Email from a nurse to Sonja Leonard, 'Incident 16/4/13', 16 April 2013 5:21pm.

662 Email from a nurse to Sonja Leonard, 'Incident 16/4/13', 16 April 2013 5:21pm.

663 Email from a nurse to Sonja Leonard, 'Incident 16/4/13', 16 April 2013 5:21pm.

664 Statement of Sonja Leonard, 21 June 2022, Annexure SL-21 (Email from Luigino Fratangelo to Sonja Leonard and draft letter) 2.

665 Statement of Sonja Leonard, 21 June 2022, Annexure SL-21 (Email from Luigino Fratangelo to Sonja Leonard and draft letter) 2.

666 Statement of Sonja Leonard, 21 June 2022, Annexure SL-21 (Email from Luigino Fratangelo to Sonja Leonard and draft letter) 2.

667 Statement of Michael Sherring, 10 June 2022, 27 [76].

668 Statement of Michael Sherring, 10 June 2022, 27 [76], 30 [92(a)].

669 Transcript of Michael Sherring, 10 June 2022, 1971 [22–28].

670 Statement of Sonja Leonard, 21 June 2022, Annexure SL-21 (Email from Gino Fratangelo to Sonja Leonard and draft letter) 1.

671 Statement of James Bellinger, 10 June 2022, 34.

672 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

673 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

674 Transcript of Claire Lovell, 4 July 2022, 2287 [46]–2288 [3].

675 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

676 Transcript of Tiffany Skeggs, 30 June 2022, 2032 [33–39].

677 Transcript of Tiffany Skeggs, 30 June 2022, 2032 [1–4].

678 Transcript of Tiffany Skeggs, 30 June 2022, 2033 [13–20].

679 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

680 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

681 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

682 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

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684 Transcript of Claire Lovell, 4 July 2022, 2289 [40–42].

685 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

686 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, and Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

687 Statement of Darren Hine, 14 June 2022, 93 [419].

688 Tasmania Police, *Revised Interim Report into the Review of Police Investigations Relating to James Griffin* (Report, 23 December 2020), produced by Tasmania Police in response to a Commission notice to produce.

689 Tasmania Police, *Revised Interim Report into the Review of Police Investigations Relating to James Griffin* (Report, 23 December 2020), produced by Tasmania Police in response to a Commission notice to produce.

690 Transcript of Claire Lovell, 4 July 2022, 2286 [36–42].

691 Transcript of Claire Lovell, 4 July 2022, 2287 [46]–2288 [3].

692 Child Protection Services, Notification Report [redacted], produced by the Tasmanian Government in response to a Commission notice to produce.

693 Transcript of Claire Lovell, 4 July 2022, 2290 [8–30].

694 Transcript of Claire Lovell, 4 July 2022, 2291 [17–19].

695 Transcript of Claire Lovell, 4 July 2022, 2291 [19–21].

696 Transcript of Claire Lovell, 4 July 2022, 2292 [46]–2293 [1].

697 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

698 Statement of Tiffany Skeggs, 23 June 2022, 7 [22], 24 [94].

699 Statement of Tiffany Skeggs, 23 June 2022, 24 [95].

700 Statement of a Ward 4K staff member, 21 June 2022, [55].

701 Statement of a Ward 4K staff member, 21 June 2022, [55].

702 Statement of a Ward 4K staff member, 21 June 2022, [55].

703 Transcript of Sonja Leonard, 29 June 2022, 2009 [40]–2010 [4].

704 Department of Health and Human Services, Performance and Development Agreement signed by James Griffin and Sonja Leonard, 27 March 2014.

705 Department of Health and Human Services, Performance and Development Agreement signed by James Griffin and Sonja Leonard, 27 March 2014.

706 Department of Health and Human Services, Performance and Development Agreement signed by James Griffin and Sonja Leonard, 27 March 2014.

707 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

708 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

709 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

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711 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

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713 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

714 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

715 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

716 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce; Transcript of Darren Hine, 6 July 2022, 2460 [12–15].

717 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

718 Statement of Tiffany Skeggs, 23 June 2022, 18 [68].

719 Statement of Tiffany Skeggs, 23 June 2022, 19 [75].

720 Statement of Tiffany Skeggs, 23 June 2022, 19 [73].

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726 Tasmania Police, Revised Interim Report into the Review of Police Investigations Relating to James Griffin (Report, 23 December 2020), produced by Tasmania Police in response to a Commission notice to produce.

727 Statement of Darren Hine, 14 June 2022, 94 [420].

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731 Letter from Tasmania Police Commander to Michael Easton, 'Outcome of Investigation into Alleged Misconduct by a Designated Public Officer', 1 July 2021.

732 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

733 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

734 Transcript of Darren Hine, 6 July 2022, 2453 [35–47].

735 Transcript of Darren Hine, 6 July 2022, 2453 [35–47].

736 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten note) 1.

737 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten note) 1.

738 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten note) 1.

739 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten calendar note for 4 November 2015) 1.

740 Statement of Sonja Leonard, 21 June 2022, [137].

741 Statement of Sonja Leonard, 21 June 2022, [138].

742 Statement of Sonja Leonard, 21 June 2022, Annexure SL-15 (Handwritten calendar note for 4 November 2015) 1.

743 Statement of Sonja Leonard, 21 June 2022, [137].

744 Tasmanian Health Organisation North, Performance Development Agreement signed by James Griffin and Sonja Leonard on 21 March 2016.

745 Tasmanian Health Organisation North, Performance Development Agreement signed by James Griffin and Sonja Leonard on 21 March 2016.

746 Statement of Sonja Leonard, 21 June 2022, [140].

747 Statement of Sonja Leonard, 21 June 2022, [140].

748 Statement of Sonja Leonard, 21 June 2022, [141].

749 Statement of Sonja Leonard, 21 June 2022, [143].

750 Statement of Sonja Leonard, 21 June 2022, [144].

751 Statement of Janette Tonks, 10 June 2022, 11–12 [32].

752 Statement of James Bellinger, 10 June 2022, 42 [47].

753 Statement of James Bellinger, 1 June 2022, 42 [47].

754 Statement of James Bellinger, 10 June 2022, 42 [47].

755 Statement of Michael Sherring, 10 June 2022, 26 [75].

756 Statement of Michael Sherring, 10 June 2022, 26 [75].

757 Statement of Michael Sherring, 10 June 2022, 26 [75]; Statement of Michael Sherring, 10 June 2022, Annexure 22 (Letter from Sonja Leonard to James Griffin, 6 March 2017).

758 Statement of Sonja Leonard, 21 June 2022, Annexure SL-16 (Letter from Sonja Leonard to James Griffin) 1.

759 Statement of Michael Sherring, 10 June 2022, Annexure 22 (Letter from Sonja Leonard to James Griffin, 6 March 2017).

760 Statement of Sonja Leonard, 21 June 2022, Annexure SL-16 (Letter from Sonja Leonard to James Griffin) 2.

761 Transcript of Sonja Leonard, 29 June 2022, 2005 [47]–2006 [2].

762 Statement of Sonja Leonard, 21 June 2022, Annexure SL-16 (Letter from Sonja Leonard to James Griffin) 2.

763 Transcript of Sonja Leonard, 29 June 2022, 2006 [16–23].

764 Transcript of Sonja Leonard, 29 June 2022, 2006 [36–37].

765 Statement of Sonja Leonard, 21 June 2022, Annexure SL-17 (Email to Michael Sherring) 1.

766 Statement of Michael Sherring, 10 June 2022, 26.

767 Statement of Michael Sherring, 10 June 2022, 26.

768 Statement of Sonja Leonard, 21 June 2022, Annexure SL-17 (Email to Michael Sherring) 1.

769 Statement of Sonja Leonard, 21 June 2022, Annexure SL-18 (Email from Michael Sherring to Sonja Leonard) 1.

770 Statement of Sonja Leonard, 21 June 2022, Annexure SL-18 (Email from Michael Sherring to Sonja Leonard) 1.

771 Statement of Sonja Leonard, 21 June 2022, Annexure SL-18 (Email from Michael Sherring to Sonja Leonard) 1.

772 Statement of Michael Sherring, 10 June 2022, 32 [94(g)]; Michael Sherring, Procedural Fairness Response, 15 May 2023, 7.

773 Statement of Will Gordon, 30 March 2022, 3 [9].

774 Statement of Will Gordon, 30 March 2022, 3 [9].

775 Statement of Will Gordon, 30 March 2022, 3 [9].

776 Statement of Will Gordon, 30 March 2022, 3 [9].

777 Statement of Will Gordon, 30 March 2022, 3 [9].

778 Statement of Will Gordon, 30 March 2022, 3 [9].

779 Statement of Will Gordon, 30 March 2022, 3 [10].

780 Statement of Will Gordon, 30 March 2022, 3 [11].

781 Transcript of Will Gordon, 27 June 2022, 1750 [36–32].

782 Transcript of Sonja Leonard, 28 June 2022, 2006 [43]–2007 [2].

783 Statement of Will Gordon, 30 March 2022, 3 [14].

784 Transcript of Mathew Harvey, 28 June 2022, 1834 [40–42].

785 Transcript of Sonja Leonard, 29 June 2022, 2007 [4–15].

786 Statement of Sonja Leonard, 21 June 2022, Annexure SL-30 (Email from Sonja Leonard to Mathew Harvey, 28 August 2017) 1.

787 Statement of Mathew Harvey, 17 August 2022, 20 [97].

788 Statement of Sonja Leonard, 21 June 2022, [192].

789 Transcript of Mathew Harvey, 28 June 2022, 1833 [7–8].

790 Statement of Sonja Leonard, 21 June 2022, 25 [192].

791 Statement of Sonja Leonard, 21 June 2022, 25 [195]; Statement of Mathew Harvey, 28 June 2022, attaching the 'Safety Event Management Form (Safety Event ID 52489)', produced by the Tasmanian Government in response to a Commission notice to produce.

792 Statement of Sonja Leonard, 21 June 2022, 25 [195].

793 Statement of Mathew Harvey, 17 August 2022, [25].

794 Statement of Mathew Harvey, 17 August 2022, [25].

795 Statement of Sonja Leonard, 21 June 2022, [193]; Statement of Sonja Leonard, 21 June 2022, Annexure SL-32 (Email from Sonja Leonard to James Griffin and attached letter).

796 Statement of Sonja Leonard, 21 June 2022, Annexure SL-32 (Email from Sonja Leonard to James Griffin and attached letter) 1.

797 Transcript of Mathew Harvey, 28 June 2022, 1826 [35–39].

798 Transcript of Mathew Harvey, 28 June 2022, 1827 [10–12].

799 Statement of Sonja Leonard, 21 June 2022, Annexure SL-32 (Email from Sonja Leonard to James Griffin and attached letter) 1.

800 Statement of Sonja Leonard, 21 June 2022, Annexure SL-32 (Email from Sonja Leonard to James Griffin and attached letter) 1.

801 Transcript of Will Gordon, 27 June 2022, 1754 [45]–1755 [7].

802 Statement of Sonja Leonard, 21 June 2022, [194].

803 Statement of Sonja Leonard, 21 June 2022, Annexure SL-33 (Email from Sonja Leonard to Mathew Harvey with attached letter from James Griffin, 11 September 2017) 1.

804 Statement of Sonja Leonard, 21 June 2022, Annexure SL-33 (Email from Sonja Leonard to Mathew Harvey with attached letter from James Griffin, 11 September 2017) 1.

805 Statement of Sonja Leonard, 21 June 2022, [200].

806 Statement of Mathew Harvey, 17 June 2022, 9 [35].

807 Statement of Mathew Harvey, 17 June 2022, 9 [35].

808 Transcript of Mathew Harvey, 28 June 2022, 1847 [22–37].

809 Statement of Mathew Harvey, 17 June 2022, [35].

810 Statement of James Bellinger, 10 June 2022, 21 [23].

811 Statement of Mathew Harvey, 17 June 2022, [30].

812 Statement of Sonja Leonard, 21 June 2022, 26 [201].

813 Statement of Mathew Harvey, 24 March 2023, 2 [8–11].

814 Statement of Sonja Leonard, 21 June 2022, Annexure SL-34 (Email from Sonja Leonard to James Griffin attaching letter, 11 September 2017) 2.

815 Statement of Sonja Leonard, 21 June 2022, Annexure SL-34 (Email from Sonja Leonard to James Griffin attaching letter, 11 September 2017) 2.

816 Transcript of Sonja Leonard, 29 June 2022, 2004 [45–47].

817 Statement of Sonja Leonard, 21 June 2022, [180].

818 Transcript of Sonja Leonard, 29 June 2022, 2004 [36–37].

819 Statement of Sonja Leonard, 21 June 2022, Annexure SL-25 (Handwritten notes regarding James Griffin) 1.

820 Transcript of Mathew Harvey, 28 June 2022, 1844 [11–13].

821 Statement of Mathew Harvey, 17 June 2022, [30].

822 Transcript of Mathew Harvey, 28 June 2022, 1828 [40]–1829 [32]; Statement of Mathew Harvey, 24 March 2023, 2 [13]–4 [19].

823 Transcript of Mathew Harvey, 28 June 2022, 1834 [10–18].

824 Transcript of Mathew Harvey, 28 June 2022, 1839 [11–14].

825 Transcript of Sonja Leonard, 29 June 2022, 2007 [26]–2008 [7].

826 Transcript of Janette Tonks, 30 June 2022, 2057 [37–39].

827 Transcript of Janette Tonks, 30 June 2022, 2048 [38–47].

828 Transcript of Janette Tonks, 30 June 2022, 2057 [43–46].

829 Transcript of Janette Tonks, 30 June 2022, 2057 [43]–2058 [5].

830 Transcript of Janette Tonks, 30 June 2022, 2058 [7–13].

831 Transcript of Janette Tonks, 30 June 2022, 2058 [17–21].

832 Transcript of Janette Tonks, 30 June 2022, 2053 [22–26].

833 Transcript of Mathew Harvey, 28 June 2022, 1844 [22–24].

834 Transcript of Mathew Harvey, 28 June 2022, 1844 [26]–1845 [27].

835 Transcript of Mathew Harvey, 28 June 2022, 1830 [9–27].

836 Transcript of Mathew Harvey, 28 June 2022, 1831 [36]–1832 [6].

837 Transcript of Mathew Harvey, 28 June 2022, 1839 [41]–1940 [6].

838 Statement of James Bellinger, 10 June 2022, 43 [47].

839 Statement of James Bellinger, 10 June 2022, 43 [47].

840 Statement of James Bellinger, 10 June 2022, 43 [47].

841 Transcript of James Bellinger, 28 June 2022, 1873 [7–24].

842 Transcript of James Bellinger, 28 June 2022, 1878 [1–3].

843 Transcript of James Bellinger, 28 June 2022, 1867 [1–26].

844 Statement of Will Gordon, 27 June 2022, 10 [45].

845 Statement of Will Gordon, 27 June 2022, 4 [16].

846 Statement of Will Gordon, 27 June 2022, 6 [25].

847 Statement of Will Gordon, 27 June 2022, 19 [85].

848 Statement of Will Gordon, 30 March 2022, 10 [45].

849 Statement of Kathrine Morgan-Wicks, 22 August 2022, 25 [157–158].

850 Statement of Jacqueline Allen, 15 August 2022, 27 [150].

851 Statement of Jacqueline Allen, 15 August 2022, 27 [150].

852 Statement of Barry Nicholson, 18 August 2022, 11 [88].

853 Transcript of James Bellinger, 28 June 2022, 1871 [40–44].

854 Statement of Kathrine Morgan-Wicks, 22 August 2022, 25 [160].

855 Ward 4K personnel file of James Griffin.

856 Transcript of Michael Sherring, 29 June 2022, 1972 [28–34], 1973 [8–11].

857 Transcript of James Bellinger, 28 June 2022, 1872 [4–6].

858 Transcript of Sonja Leonard, 29 June 2022, 2008 [9–25].

859 Transcript of Sonja Leonard, 29 June 2022, 2009 [3–6].

860 Transcript of Sonja Leonard, 29 June 2022, 2008 [21–25].

861 Statement of Barry Nicholson, 18 August 2022, 11 [88].

862 Statement of Annette Whitemore, 20 June 2022, 4 [19].

863 Statement of Will Gordon, 27 June 2022, 4 [19].

864 Tasmania Health Organisation North, Performance Development Agreement signed by James Griffin and Sonja Leonard, 25 May 2018.

865 Tasmania Health Organisation North, Performance Development Agreement signed by James Griffin and Sonja Leonard, 25 May 2018.

866 Tasmania Health Organisation North, Performance Development Agreement signed by James Griffin and Sonja Leonard, 22 May 2022.

867 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

868 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

869 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

870 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

871 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

872 Statement of Sonja Leonard, 21 June 2022, [151].

873 Statement of Sonja Leonard, 21 June 2022, [151].

874 Statement of Sonja Leonard, 21 June 2022, [152].

875 Statement of Sonja Leonard, 21 June 2022, Annexure SL-22 (Email from Matthew Harvey to James Bellinger and former Director of Employee Relations forwarding further emails, 7 August 2019) 1.

876 Email from Mathew Harvey to Sonja Leonard, 7 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

877 Statement of Sonja Leonard, 21 June 2022, [154].

878 Email from a nurse to Peter Renshaw, 5 December 2019, produced by Peter Renshaw in response to a Commission notice to produce.

879 Email from Peter Renshaw to Glenn Hindle, 13 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

880 For example, Statement of Maria Unwin, 22 June 2022, 6 [23]; Statement of 'Angela', 3 May 2022, 4 [25]; Witness Statement of Kylee Pearn, 8 November 2021, 5 [17]; Transcript of Kylee Pearn, 28 June 2022, 1793 [36–43], 1794 [7–19].

881 Transcript of Kathrine Morgan-Wicks, 5 July 2022, 2376 [6–11].

882 Transcript of Emily Shepherd, 29 June 2022, 1940 [24–28].

883 Statement of Emily Shepherd, 23 June 2022, 11 [56–57].

884 Statement of Emily Shepherd, 23 June 2022, 12 [62(a)].

885 Statement of Maria Unwin, 22 June 2022, 5 [21].

886 Transcript of Will Gordon, 27 June 2022, 1746 [22–32].

887 Anonymous Statement, 20 June 2022, 7 [37].

888 Statement of Will Gordon, 30 March 2022, 2 [8].

889 Statement of Will Gordon, 30 March 2022, 15 [73].

890 Transcript of Sonja Leonard, 29 June 2022, 1985 [15–18].

891 Transcript of Sonja Leonard, 29 June 2022, 1988 [16–18].

892 Transcript of Sonja Leonard, 29 June 2022, 1984 [20–33].

893 Statement of Sonja Leonard, 21 June 2022, [180].

894 Statement of Maria Unwin, 22 June 2022, 4 [15].

895 Statement of James Bellinger, 10 June 2022, Appendix 8 (Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct) 4.

896 Transcript of Annette Whitemore, 29 June 2022, 1905 [24–36].

897 Transcript of Will Gordon, 27 June 2022, 1762 [20–23].

898 Transcript of Will Gordon, 27 June 2022, 1762 [27–28].

899 Statement of a Ward 4K staff member, 21 June 2022, 5 [25].

900 Transcript of Helen Bryan, 30 June 2022, 2087 [32]–2088 [4].

901 Transcript of Helen Bryan, 30 June 2022, 2082 [1–9], 2086 [36–41], 2087 [19–22].

902 Statement of Maria Unwin, 22 June 2022, 3 [9].

903 Statement of Maria Unwin, 22 June 2022, 3 [9].

904 Statement of Maria Unwin, 22 June 2022, 4 [13].

905 Statement of Maria Unwin, 22 June 2022, 3 [9].

906 Statement of a Ward 4K staff member, 21 June 2022, [46].

907 Statement of a Ward 4K staff member, 21 June 2022, [67].

908 Statement of a Ward 4K staff member, 21 June 2022, [45].

909 Statement of a Ward 4K staff member, 21 June 2022, [47].

910 Statement of a Ward 4K staff member, 21 June 2022, [66].

911 Statement of a Ward 4K staff member, 21 June 2022, [49].

912 Statement of a Ward 4K staff member, 21 June 2022, [49].

913 Statement of Will Gordon, 27 June 2022, 2 [5].

914 Statement of Will Gordon, 27 June 2022, 5 [22].

915 Statement of Will Gordon, 27 June 2022, 5 [23].

916 Statement of Will Gordon, 27 June 2022, 6 [24].

917 Anonymous Statement, 20 June 2022, 2 [10].

918 Anonymous Statement, 20 June 2022, 2 [11].

919 Anonymous Statement, 20 June 2022, 3 [12].
920 Anonymous Statement, 20 June 2022, 5 [24–25].
921 Anonymous Statement, 21 June 2022, 2 [7].
922 Anonymous Statement, 21 June 2022, 2 [8].
923 Anonymous Statement, 21 June 2022, 2 [9].
924 Anonymous Statement, 21 June 2022, 2 [10–11].
925 Anonymous Statement, 21 June 2022, 4 [20].
926 Anonymous Statement, 21 June 2022, 5 [21–22].
927 Anonymous Statement, 21 June 2022, 3 [15].
928 Anonymous Statement, 21 June 2022, 3 [13].
929 Anonymous Statement, 21 June 2022, 3 [16].
930 Anonymous Statement, 21 June 2022, 7 [31].
931 Anonymous Statement, 2 March 2022, 4 [16].
932 Anonymous Statement, 2 March 2022, 4 [17].
933 Anonymous Statement, 2 March 2022, 5 [19–20].
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935 Anonymous session, 6 October 2021.
936 Statement of a Nurse Unit Manager, 22 June 2022, 4 [35, 38].
937 Statement of a Nurse Unit Manager, 22 June 2022, 4 [40].
938 Statement of a Nurse Unit Manager, 22 June 2022, 4 [41].
939 Statement of a Nurse Unit Manager, 22 June 2022, 4 [42].
940 Statement of Sonja Leonard, 21 June 2022, [156].
941 Statement of Sonja Leonard, 21 June 2022, [157].
942 Statement of Sonja Leonard, 21 June 2022, [171].
943 Statement of Angelique Knight, 2 June 2022, 2 [8].
944 Statement of Angelique Knight, 2 June 2022, 2 [11].
945 Statement of Angelique Knight, 2 June 2022, 2 [11].
946 Statement of Angelique Knight, 2 June 2022, 3 [11].
947 Statement of Angelique Knight, 2 June 2022, 4 [18].
948 Submission 38 Angelique Knight, 5.
949 Submission 38 Angelique Knight, 3.
950 Submission 38 Angelique Knight, 3.
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954 Submission 38 Angelique Knight, 4.
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956 Submission 38 Angelique Knight, 4.
957 Statement of Angelique Knight, 2 June 2022, Annexure AK-001 (Statutory Declaration, Angelique Knight, 25 May 2021).
958 Statement of Kirsty Neilley, 29 March 2022, 2 [5].
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961 Statement of Kirsty Neilley, 29 March 2022, 2 [9].
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963 Statement of Kirsty Neilley, 29 March 2022, 2 [8].
964 Statement of Kirsty Neilley, 29 March 2022, 2 [8].
965 Statement of Kirsty Neilley, 29 March 2022, 2 [10].
966 Statement of Kirsty Neilley, 29 March 2022, 2 [10].
967 Statement of Kirsty Neilley, 29 March 2022, 3 [11].
968 Statement of Kirsty Neilley, 29 March 2022, 3 [13].
969 Statement of Kirsty Neilley, 29 March 2022, 3 [13].
970 Statement of Kirsty Neilley, 29 March 2022, 3 [13].
971 Statement of Kirsty Neilley, 29 March 2022, 3 [14].
972 Statement of Kirsty Neilley, 29 March 2022, 3 [14].
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982 The names 'Angela' and 'Lilian' are pseudonyms; Order of the Commission of Inquiry, restricted publication order, 30 August 2023.
983 Statement of 'Angela', 3 May 2022, 3 [16].
984 Statement of 'Angela', 3 May 2022, 3 [16].
985 Statement of 'Angela', 3 May 2022, 3 [17].
986 Statement of 'Angela', 3 May 2022, 3 [20].
987 Statement of 'Angela', 3 May 2022, 3 [20].
988 Statement of 'Angela', 3 May 2022, 3 [24]–4 [24].
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991 Submission 118 Anonymous, 1 [3].
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997 Submission 135 Anonymous, 1.
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999 Information received anonymously, 21 July 2022.
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1001 Submission 113 Anonymous, 2 [11].
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1007 Submission 113 Anonymous, 1 [4]–2[9].
1008 Submission 134 Anonymous, 2 [2.2.1].
1009 Submission 134 Anonymous, 2 [2.2.2].
1010 Submission 134 Anonymous, 2 [2.2.3].
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1012 Submission 134 Anonymous, 2 [2.2.2].
1013 Submission 134 Anonymous, 3 [2.2.5.1].
1014 Submission 134 Anonymous, 3 [2.2.5.2].
1015 Submission 134 Anonymous, 3 [2.2.5.2].
1016 Submission 134 Anonymous, 4 [3.2].
1017 Submission 134 Anonymous, 4 [3.2.4].
1018 Submission 134 Anonymous, 4 [3.2.4].
1019 Submission 120 Anonymous, 1 [2]–2 [6].
1020 Submission 117 Anonymous, 1 [4].
1021 Submission 117 Anonymous, 1 [4].
1022 Submission 117 Anonymous, 1 [5–6].
1023 Submission 116 Anonymous, 2 [7].
1024 Submission 115 Anonymous, 1 [2], [5].
1025 Submission 115 Anonymous, 2 [6].
1026 Submission 115 Anonymous, 2 [8].
1027 Submission 115 Anonymous, 2 [9].
1028 Submission 115 Anonymous, 2 [9].
1029 Submission 115 Anonymous, 2 [10].
1030 Submission 115 Anonymous, 2 [10].
1031 Submission 115 Anonymous, 2 [12–13].
1032 Submission 115 Anonymous, 2 [14].
1033 Submission 115 Anonymous, 3 [15].
1034 Submission 115 Anonymous, 3 [16].
1035 Submission 115 Anonymous, 3 [17].
1036 Submission 115 Anonymous, 3 [20].
1037 Submission 115 Anonymous, 4 [22–24].
1038 Submission 114 Anonymous, 2 [6].
1039 Submission 114 Anonymous, 1 [4].
1040 Submission 114 Anonymous, 1 [5].
1041 Submission 114 Anonymous, 1 [6].
1042 Submission 114 Anonymous, 2 [6].
1043 Submission 114 Anonymous, 2 [7].
1044 Submission 114 Anonymous, 2 [11–13.].
1045 Submission 33 Anonymous, 1.
1046 Anonymous Statement, 1 June 2022, 1 [4].
1047 Anonymous Statement, 1 June 2022, 2 [6].
1048 Anonymous Statement, 1 June 2022, 2 [7].
1049 Confidential Statement, 1 June 2022, 2 [7].
1050 Confidential Statement, 1 June 2022, 2 [8].
1051 Email from the Health Practitioner to the Commission in response to a Request for Statement, 20 June 2022, 1.

1052 Transcript of Sonja Leonard, 29 June 2022, 2018 [36–41].

1053 Transcript of Sonja Leonard, 29 June 2022, 2018 [45]–2019 [6].

1054 Statement of Sonja Leonard, 21 June 2022, [256].

1055 *State Service Act 2000* s 9(3).

1056 Statement of Helen Bryan, 10 June 2022, [47].

1057 Statement of Helen Bryan, 10 June 2022, [48].

1058 Statement of Eric Daniels, 15 June 2022, 17 [35]; Statement of Helen Bryan, 10 June 2022, 16.

1059 Statement of Erwin Loh, 24 June 2022, 8 [43].

1060 Transcript of Janette Tonks, 30 June 2022, 2055 [13–18].

1061 Transcript of Eric Daniels, 30 June 2022, 2109 [16–19].

1062 Eric Daniels, *Procedural Fairness Response*, 12 July 2023, 17; Statutory Declaration of Eric Daniels, 12 July 2023, [17].

1063 Transcript of Helen Bryan, 30 June 2022, 2082 [47]–2083 [4].

1064 Statement of Matthew Hardy, 27 June 2022, 31 [198].

1065 Statement of Matthew Hardy, 27 June 2022, 33 [219].

1066 Transcript of Sonja Leonard, 29 June 2022, 2006 [20–41].

1067 Transcript of Helen Bryan, 30 June 2022, 2081 [41–47], 2082 [11–15].

1068 *Criminal Code Act 1924* s 105A as amended by the *Criminal Code and Related Legislation Amendment (Child Abuse) Act 2019* s 7.

1069 *Children, Young Persons and Their Families Act 1997* s 13.

1070 *Children, Young Persons and Their Families Act 1997* s 14(2). Other prescribed persons for the purposes of mandatory reporting under s 14(2) include a medical practitioner, a registered nurse or enrolled nurse, a person registered under the Health Practitioner Regulation National Law (Tasmania) in the midwifery profession, a person registered under the Health Practitioner Regulation National Law (Tasmania) in the dental profession as a dentist, dental therapist, dental hygienist or oral health therapist, a person registered under the Health Practitioner Regulation National Law (Tasmania) in the psychology profession, or a police officer. Refer to Children, Young Persons and Their Families Act 1997 s 14(1).

1071 *Nursing Act 1995* s 55.

1072 *Health Practitioner Regulation National Law Act 2009 (Qld)* sch 1, ss 141, 141A, as adopted by the *Health Practitioner Regulation National Law (Tasmania) Act 2020* s 4.

1073 *Health Practitioner Regulation National Law Act 2009 (Qld)* s 144(c*).*

1074 *Registration to Work with Vulnerable People Act 2013* s 53A.

1075 *Registration to Work with Vulnerable People Regulations 2014* r 5A.

1076 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1077 Statement of Tiffany Skeggs, 23 June 2022, 25 [99].

1078 Statement of Tiffany Skeggs, 23 June 2022, 25 [100].

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1080 Statement of Tiffany Skeggs, 23 June 2022, 26 [105].

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1082 Statement of Sonja Leonard, 21 June 2022, [64].

1083 Statement of Sonja Leonard, 21 June 2022, [96].

1084 Statement of Sonja Leonard, 21 June 2022, [97].

1085 Statement of Sonja Leonard, 21 June 2022, [98].

1086 Transcript of Sonja Leonard, 29 June 2022, 2011 [6–8].

1087 Transcript of Sonja Leonard, 29 June 2022, 2012 [4–21].

1088 Transcript of Sonja Leonard, 29 June 2022, 2011 [23–30].

1089 Statement of Sonja Leonard, 21 June 2022, [64].

1090 Transcript of Sonja Leonard, 29 June 2022, 2011 [10–26].

1091 Transcript of Sonja Leonard, 29 June 2022, 2013 [2–12].

1092 Statement of Janette Tonks, 10 June 2022, 9 [29].

1093 Janette Tonks, *Procedural Fairness Response*, 3 April 2022, 11.

1094 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1095 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1096 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1097 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1098 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1099 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1100 Statement of Tiffany Skeggs, 23 June 2022, 1 [5].

1101 Statement of Tiffany Skeggs, 23 June 2022, 2 [6].

1102 Statement of Tiffany Skeggs, 23 June 2022, 2 [8].

1103 Statement of Tiffany Skeggs, 23 June 2022, 2 [9].

1104 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1105 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1106 Statement of Tiffany Skeggs, 23 June 2022, 43 [185].

1107 Transcript of Erwin Loh, 4 July 2022, 2250 [29]–2251 [4].

1108 Notice to produce to State of Tasmania, 4 August 2021, 4 [8(b)]; Letter from Solicitor General of Tasmania to Commission of Inquiry, 'Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings', 25 March 2022, 4 [11].

1109 Transcript of Helen Bryan, 30 June 2022, 2089 [30–36].

1110 Transcript of Helen Bryan, 30 June 2022, 2089 [37–44].

1111 Transcript of Helen Bryan, 30 June 2022, 2082 [47]–2083 [4].

1112 Transcript of Helen Bryan, 30 June 2022, 2090 [41]–2091 [1].

1113 Helen Bryan, *Procedural Fairness Response*, 28 June 2023, [12].

1114 Transcript of Peter Renshaw, 9 September 2022, 3831 [12–15].

1115 Transcript of Peter Renshaw, 9 September 2022, 3831 [17–21].

1116 Transcript of Eric Daniels, 30 June 2022, 2115 [5–8].

1117 Transcript of Eric Daniels, 30 June 2022, 2116 [10].

1118 Transcript of Eric Daniels, 30 June 2022, 2116 [7–18].

1119 Eric Daniels, *Procedural Fairness Response*, 12 July 2023, 14–16; Statutory Declaration of Eric Daniels, 12 July 2023, [12–17].

1120 Statement of Helen Bryan, 10 June 2022, 19.

1121 Transcript of Helen Bryan, 30 June 2022, 2089 [17–22]; Statement of Helen Bryan, 12 June 2022, 19.

1122 Transcript of Helen Bryan, 30 June 2022, 2088 [6–45].

1123 Transcript of Helen Bryan, 30 June 2022, 2089 [4–9].

1124 Transcript of Helen Bryan, 30 June 2022, 2089 [11–15].

1125 Transcript of Peter Renshaw, 9 September 2022, 3845 [3–14].

1126 Statement of Elizabeth Stackhouse, 22 June 2022, 2, [7], 5 [33].

1127 Statement of Stephen Ayre, 24 June 2022, 3 [18].

1128 Statement of John Kirwan, 21 August 2022, 4 [20–22].

1129 Statement of Eric Daniels, 15 June 2022, 4 [6.1]; Transcript of James Bellinger, 28 June 2022, 1864 [7–13]; Transcript of Mathew Harvey, 28 June 2022, 1824 [6–12], 1824 [32–43].

1130 Statement of Elizabeth Stackhouse, 22 June 2022, 5 [30].

1131 Statement of Stephen Ayre, 24 June 2022, 3 [17].

1132 Statement of John Kirwan, 21 August 2022, 4 [15].

1133 Statement of Eric Daniels, 15 June 2022, 4 [6.2].

1134 Transcript of Eric Daniels, 30 June 2022, 2108 [47], 2109 [1–14].

1135 Transcript of Eric Daniels, 30 June 2022, 2110 [9–24].

1136 Transcript of Eric Daniels, 30 June 2022, 2110 [26–28].

1137 Transcript of Eric Daniels, 30 June 2022, 2111 [4–24].

1138 The name 'Penny' is a pseudonym; Order of the Commission of Inquiry, restricted publication order, 4 July 2022; Statement of Glenn Hindle, 9 November 2022, 2 [4].

1139 Statement of Glenn Hindle, 9 November 2022, 5 [16].

1140 Statement of Glenn Hindle, 9 November 2022, 5 [16].

1141 Statement of Glenn Hindle, 9 November 2022, 3 [10].

1142 Statement of Glenn Hindle, 9 November 2022, 3 [10].

1143 Statement of Glenn Hindle, 9 November 2022, 4 [12]; Statement of Glenn Hindle, 9 November 2022, Annexure 1 (Occurrence enquiry log report, 2 August 2019).

1144 Statement of Glenn Hindle, 9 November 2022, 4 [12].

1145 Statement of Glenn Hindle, 9 November 2022, 4 [12].

1146 Statement of Glenn Hindle, 9 November 2022, 4 [14].

1147 Statement of Glenn Hindle, 9 November 2022, 2 [4].

1148 Statement of Glenn Hindle, 9 November 2022, 2 [6].

1149 Statement of Peter Renshaw, 20 June 2022, [41.1].

1150 Statement of Peter Renshaw, 20 June 2022, 19 [16.1].

1151 Transcript of Helen Bryan, 30 June 2022, 2083 [6–11], [39–41].

1152 Transcript of Helen Bryan, 30 June 2022, 2083 [41–43]; Transcript of Janette Tonks, 30 June 2022, 2063 [30–35].

1153 Transcript of Janette Tonks, 30 June 2022, 2065 [34–37].

1154 Transcript of Janette Tonks, 30 June 2022, 2066 [39–44].

1155 Transcript of Helen Bryan, 30 June 2022, 2084 [3–14].

1156 Transcript of Janette Tonks, 30 June 2022, 2066 [12]; Transcript of Helen Bryan, 30 June 2022, 2084 [20].

1157 Transcript of Helen Bryan, 30 June 2022, 2084 [21–23].

1158 Transcript of Janette Tonks, 30 June 2022, 2064 [8–10].

1159 Transcript of Janette Tonks, 30 June 2022, 2064 [13–14].

1160 Transcript of Janette Tonks, 30 June 2022, 2064 [13–23].

1161 Statement of Peter Renshaw, 20 June 2022, [35.1].

1162 Transcript of Janette Tonks, 30 June 2022, 2064 [26].

1163 Transcript of Janette Tonks, 30 June 2022, 2064 [39–41].

1164 Transcript of Glenn Hindle, 6 July 2022, 2442 [22–28].

1165 Transcript of Janette Tonks, 30 June 2022, 2065 [6–14].

1166 Statement of Sonja Leonard, 21 June 2022, [238–239].

1167 Statement of Peter Renshaw, 20 June 2022, [42(e)].

1168 Statement of Peter Renshaw, 20 June 2022, [16], [63].

1169 Statement of Peter Renshaw, 20 June 2022, [42(c)], [52.3.9].

1170 Statement of Peter Renshaw, 20 June 2022, [21.2].

1171 Transcript of Peter Renshaw, 9 September 2022, 3827 [42]–3828 [1].

1172 Statement of Peter Renshaw, 20 June 2022, [16], [42(a)].

1173 Statement of Peter Renshaw, 20 June 2022, [41.1], [42.6(f)].

1174 Email from Mathew Harvey to former Director of Employee Relations, James Bellinger and another, 'Re: Registration to Work with Vulnerable People Act 2013 – Immediate Suspension Notification to Named Employer – Griffin', 31 July 2019 3:18pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1175 Email from Mathew Harvey to former Director of Employee Relations, James Bellinger and another, 'Re: Registration to Work with Vulnerable People Act 2013 – Immediate Suspension Notification to Named Employer – Griffin', 31 July 2019 3:18pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1176 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1177 Email from Mathew Harvey to former Director of Employee Relations, James Bellinger and another, 'Re: Registration to Work with Vulnerable People Act 2013 – Immediate Suspension Notification to Named Employer – Griffin', 31 July 2019 3:18pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1178 Transcript of Peter Renshaw, 8 September 2022, 3777 [21–25], [44–47].

1179 Transcript of Detective Hindle, 6 July 2022, 2441, [29–34].

1180 Transcript of Detective Hindle, 6 July 2022, 2439, [23–47].

1181 Transcript of Detective Hindle, 6 July 2022, 2441 [39–47].

1182 Statement of Sarah Kay, 1 February 2023, 1 [4].

1183 Statement of Sarah Kay, 1 February 2023, 1–2 [4].

1184 Statement of Sarah Kay, 1 February 2023, 2 [4].

1185 Mathew Harvey, *Procedural Fairness Response*, 24 March 2023, 6 [26].

1186 Statement of Glenn Hindle, 9 November 2022, 2 [4].

1187 Statement of Glenn Hindle, 9 November 2022, 2 [6].

1188 Statement of Glenn Hindle, 9 November 2022, 2 [6].

1189 Transcript of Peter Renshaw, 8 September 2022, 3778 [35–47].

1190 Transcript of Peter Renshaw, 8 September 2022, 3779 [34–36].

1191 Statement of Peter Renshaw, 20 June 2022, [42.1].

1192 Dot points for the Secretary, 'Notification of Action Taken under Work with Vulnerable People Act 2013', 31 July 2019, produced by Peter Renshaw in response to a Commission notice to produce.

1193 Dot points for the Secretary, 'Notification of Action Taken under Work with Vulnerable People Act 2013', 31 July 2019, produced by Peter Renshaw in response to a Commission notice to produce.

1194 Transcript of Helen Bryan, 30 June 2022, 2092 [38–47].

1195 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 10 [24], 17 [58].

1196 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 10 [24], 17 [58].

1197 Dot points for the Secretary, 'Notification of Action Taken under Work with Vulnerable People Act 2013', 31 July 2019, produced by Peter Renshaw in response to a Commission notice to produce.

1198 Transcript of Peter Renshaw, 8 September 2022, 3788 [7–8].

1199 Transcript of Peter Renshaw, 8 September 2022, 3788 [9–11].

1200 Transcript of Peter Renshaw, 8 September 2022, 3788 [20–23].

1201 Dot points for the Secretary, 'Notification of Action Taken under Work with Vulnerable People Act 2013', 31 July 2019, produced by Peter Renshaw in response to a Commission notice to produce.

1202 Australian Health Practitioner Regulation Agency, 'File note – Telephone Call', 1 August 2019, 1, produced by the Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

1203 Transcript of Peter Renshaw, 8 September 2022, 3778 [35–47].

1204 Australian Health Practitioner Regulation Agency, 'File Note – Telephone Call RN James Griffin', 1 August 2019, produced by Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

1205 Australian Health Practitioner Regulation Agency, 'File Note – Telephone Call Re: Griffin James', 5 August 2019, produced by Australian Health Practitioner Regulation Agency in response to a Commission notice to produce.

1206 Tasmania Police, *Procedural Fairness Response*, 23 March 2023, 8.

1207 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (2nd ed, 2017) 74.

1208 Transcript of Janette Tonks, 30 June 2022, 2065 [6–14]; Statement of Annette Whitemore, 20 June 2022, 2 [11]; Statement of Will Gordon, 30 March 2022, 6 [26].

1209 Janette Tonks, *Procedural Fairness Response*, 3 April 2023, 13.

1210 Statement of Annette Whitemore, 20 June 2022, 3 [12].

1211 Statement of Will Gordon, 30 March 2022, 6 [28].

1212 Statement of Will Gordon, 30 March 2022, 6 [29].

1213 Transcript of Janette Tonks, 30 June 2022, 2070 [21–25].

1214 Janette Tonks, *Procedural Fairness Response*, 3 April 2023, 13.

1215 Statement of Sonja Leonard, 21 June 2022, 30 [238]; Transcript of Sonja Leonard, 29 June 2022, 2014 [15–16].

1216 Statement of Sonja Leonard, 21 June 2022, 30 [238].

1217 Statement of Sonja Leonard, 21 June 2022, 32 [253].

1218 Statement of Kate Brady, 4 July 2022, 9 [30].

1219 Statement of Peter Renshaw, 20 June 2022, [53.1].

1220 Minute to Secretary, 'Employment Direction No. 4 – Suspension of Mr James Griffin', 5 August 2019; Letter from Michael Pervan to James Griffin, 'Suspension from Duties with Pay—Intention to Investigate', 5 August 2019.

1221 Statement of Matthew Hardy, 27 June 2022, 32 [203–205].

1222 Email from Glenn Hindle to Peter Renshaw, 'James GRIFFEN', 7 August 2019 7:30am, produced by Peter Renshaw in response to a Commission notice to produce.

1223 Email from Glenn Hindle to Peter Renshaw, 'James GRIFFEN', 7 August 2019 7:30am, produced by Peter Renshaw in response to a Commission notice to produce.

1224 Email from Glenn Hindle to Peter Renshaw, 'James GRIFFEN', 7 August 2019 7:30am, produced by Peter Renshaw in response to a Commission notice to produce.

1225 Statement of Mathew Hardy, 27 June 2022, 32 [203–205].

1226 Statement of Mathew Hardy, 27 June 2022, 32 [209–211].

1227 Tasmanian Health Service, Employee Exit Form for James Griffin, dated 8 August 2019.

1228 Statement of Mathew Harvey, 18 August 2022, [109].

1229 Statement of Mathew Harvey, 18 August 2022, [109].

1230 Minute to Secretary Michael Pervan, 'Resignation – Mr James Griffin', 14 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1231 Minute to Secretary Michael Pervan, 'Resignation – Mr James Griffin', 14 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1232 Minute to the Secretary Michael Pervan, 'Resignation – Mr James Griffin', 14 August 2019, produced by the Tasmanian Government in response to a Commission notice to produce.

1233 Statement of Mathew Harvey, 18 August 2022, [72].

1234 Transcript of Eric Daniels, 30 June 2022, 2015 [42]–2106 [15].

1235 Statement of Peter Renshaw, 20 June 2022, [53.1].

1236 *Child and Youth Safe Organisations Act 2023 s* 35(3*).*

1237 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1238 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1239 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1240 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1241 Transcript of Glenn Hindle, 6 July 2022, 2443 [6–10].

1242 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1243 Statement of Mathew Harvey, 18 August 2022, [113].

1244 Statement of Peter Renshaw, 20 June 2022, [52.1].

1245 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1246 Letter from Tasmania Police Detective Inspector to Acting Commander Northern District, 'Griffin, James (Jim) Geoffrey (18/08/1950) – Investigative Review', 26 October 2020, produced by Tasmania Police in response to a Commission notice to produce.

1247 Transcript of Glenn Hindle, 6 July 2022, 2443 [10–22], 2444 [1–4].

1248 Tasmania Police, 'Investigative review – James Geoffrey Griffin', undated, produced by Tasmania Police in response to a Commission notice to produce.

1249 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [13].

1250 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [13].

1251 Sarah Aquilina, 'Man Faces Child Sex Charges', *The Examiner* (Launceston, 9 October 2019).

1252 Transcript of James Bellinger, 8 September 2022, 3700 [13–16].

1253 Transcript of James Bellinger, 8 September 2022, 3700 [26–44].

1254 Transcript of James Bellinger, 8 September 2022, 3701 [17].

1255 Transcript of James Bellinger, 8 September 2022, 3701 [23–32].

1256 Email from James Bellinger to Glenn Hindle, 'J Griffin', 11 October 2019 11:32am, produced by the Tasmanian Government in response to a Commission notice to produce.

1257 Transcript of James Bellinger, 8 September 2022, 3701 [7].

1258 Transcript of Sonja Leonard, 29 June 2022, 2013 [25–42].

1259 Transcript of James Bellinger, 8 September 2022, 3701 [39], [42].

1260 Transcript of James Bellinger, 8 September 2022, 3701 [27–42].

1261 Transcript of James Bellinger, 8 September 3712 [13–23].

1262 Transcript of James Bellinger, 8 September 2022, 3702 [21–35].

1263 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [15]; Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1264 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1265 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1266 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1267 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1268 Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 1 (Minute to Secretary, 14 October 2019).

1269 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1270 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1271 Transcript of James Bellinger, 8 September 2022, 3704 [9–13].

1272 Transcript of James Bellinger, 8 September 2022, 3704 [19].

1273 Email from James Bellinger to Glenn Hindle, 'J Griffin', 11 October 2019 11:32am, produced by the Tasmanian Government in response to a Commission notice to produce.

1274 Statement of Kathrine Morgan-Wicks, 30 June 2022, 4 [26]; Transcript of Eric Daniels, 30 June 2022, 2107 [47]–2108 [9].

1275 Transcript of Eric Daniels, 30 June 2022, 2107 [25–38].

1276 Transcript of Eric Daniels, 30 June 2022, 2107 [47]–2108 [9].

1277 Email from Peter Renshaw to Kathrine Morgan-Wicks, Director of the Office of the Secretary and Eric Daniels, 'Open Disclosure CONFIDENTIAL', 16 October 2020 11:46am.

1278 Statement of Kathrine Morgan-Wicks, 30 June 2022, 5 [32].

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1281 *Inquest into the Death of James Geoffrey Griffin* (Magistrates Court of Tasmania, Coroner's Division, Coroner Cooper, 18 May 2020) 4 <https://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0004/589531/Griffin,-James-Geoffrey-web.pdf>.

1282 Statement of Sonja Leonard, 21 June 2022, [241].

1283 Statement of Sonja Leonard, 21 June 2022, [241].

1284 Statement of Sonja Leonard, 21 June 2022, [242].

1285 Statement of Sonja Leonard, 21 June 2022, [242].

1286 Statement of Helen Bryan, 10 June 2022, [56].

1287 Helen Bryan, *Procedural Fairness Response*, 28 June 2023, [9–11].

1288 Statement of Peter Renshaw, 20 June 2022, [61].

1289 Statement of Will Gordon, 30 March 2022, Annexure WG-003 (Email from Sonja Leonard to Staff, 21 October 2019).

1290 Statement of Will Gordon, 30 March 2022, 7 [34].

1291 Statement of Will Gordon, 30 March 2022, 7 [35].

1292 Statement of Will Gordon, 30 March 2022, 8 [34].

1293 Statement of Will Gordon, 30 March 2022, 7 [34].

1294 Statement of Annette Whitemore, 20 June 2022, 5 [25].

1295 Statement of Annette Whitemore, 20 June 2022, 5 [26].

1296 Statement of Sonja Leonard, 21 June 2022, [244].

1297 Transcript of Sonja Leonard, 29 July 2022, 2018 [9–12].

1298 Statement of Peter Renshaw, 20 June 2022, [43(g)].

1299 Statement of Kate Brady, 4 July 2022, 10 [35].

1300 Statement of Peter Gordon, 23 June 2022, 16 [52]; Statement of Debora Picone, 21 June 2022, 25 [100].

1301 Statement of Will Gordon, 27 June 2022, 6 [25].

1302 Transcript of Will Gordon, 27 June 2022, [5–14].

1303 Transcript of Annette Whitemore, 29 June 2022, 1904 [31–40].

1304 Statement of Will Gordon, 30 March 2022, 8 [37].

1305 Statement of Keelie McMahon, 9 May 2022, 4 [22]; Statement of Angelique Knight, 2 June 2022, 3 [12].

1306 Transcript of Peter Renshaw, 8 September 2022, 3780 [16–22], 3795 [16–20].

1307 Transcript of Peter Renshaw, 8 September 2022, 3780 [16–26].

1308 Transcript of Peter Renshaw, 8 September 2022, 3780 [42], 3781 [20–21].

1309 Transcript of Peter Renshaw, 8 September 2022, 3793 [19–21].

1310 Transcript of Peter Renshaw, 8 September 2022, 3783 [30–34].

1311 Department of Health, *Procedural Fairness Response*, 28 April 2023, Annexure D (Response table) 40 [99].

1312 Transcript of Peter Renshaw, 8 September 2022, 3794 [33–34].

1313 Transcript of Peter Renshaw, 8 September 2022, 3784 [19–22]; Peter Renshaw, Procedural Fairness Response, 12 July 2023, 5.

1314 Transcript of Peter Renshaw, 8 September 2022, 3796 [31–36].

1315 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [19]; Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3855 [17–26].

1316 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [19].

1317 Statement of Kathrine Morgan-Wicks, 22 June 2022, 3 [19].

1318 Statement of Kathrine Morgan-Wicks, 22 June 2022, 4 [20].

1319 Statement of Kathrine Morgan-Wicks, 22 June 2022, 6 [35]; Statement of Kathrine Morgan-Wicks, 22 June 2022, Annexure 4 (Email from Director of the Office of the Secretary to Kathrine Morgan-Wicks, 2 November 2020) 1.

1320 Statement of Will Gordon, 30 March 2022, 8 [38].

1321 Statement of Will Gordon, 20 March 2022, 8 [38].

1322 Transcript of Emily Shepherd, 29 June 2022, 1937 [26–33].

1323 Statement of Emily Shepherd, 23 June 2022, 7 [37–38].

1324 Statement of Emily Shepherd, 23 June 2022, Annexure ES-4 (Letter from Emily Shepherd to Sonja Leonard, 28 October 2019).

1325 Statement of Will Gordon, 30 March 2022, 8 [39].

1326 Statement of Will Gordon, 30 March 2022, 8 [39].

1327 Statement of Will Gordon, 30 March 2022, 8 [39].

1328 Statement of Will Gordon, 30 March 2022, 8 [39].

1329 Statement of Emily Shepherd, 23 June 2022, Annexure ES-4 (Letter from Emily Shepherd to Sonja Leonard, 28 October 2019).

1330 Transcript of Peter Renshaw, 8 September 2022, 3789 [42–47].

1331 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 5.

1332 Statement of Peter Renshaw, 20 June 2022, [54.2].

1333 Email from Glenn Hindle to Peter Renshaw, 'RE: JG Incident Report – 18 July 2019', 29 October 2019 2:23pm, produced by the Tasmanian Government in response to a Commission notice to produce; Statement of Glenn Hindle, 15 August 2022, 2 [8].

1334 Statement of Glenn Hindle, 15 August 2022, 2 [8].

1335 Transcript of Peter Renshaw, 9 September 2022, 3801 [12–18].

1336 Statement of Janette Tonks, 10 June 2022, 15 [67], 17 [73].

1337 Statement of Peter Renshaw, 20 June 2022, [63].

1338 Statement of Peter Renshaw, 20 June 2022, [63].

1339 Statement of Peter Renshaw, 20 June 2022, [61.1].

1340 Statement of Janette Tonks, 10 June 2022, 15–16 [67].

1341 Transcript of Annette Whitemore, 29 June 2022, 1908 [32–35].

1342 Janette Tonks, *Procedural Fairness Response*, 3 April 2023, 15.

1343 Statement of Helen Bryan, 10 June 2022, [58].

1344 Statement of Peter Renshaw, 20 June 2022, [63.2].

1345 Statement of Peter Renshaw, 20 June 2022, [63.3].

1346 Email from Will Gordon to Peter Renshaw, 12 November 2019 3:29pm, produced by Peter Renshaw in response to a Commission notice to produce.

1347 Email from Will Gordon to Peter Renshaw, 12 November 2019 3:29pm, produced by Peter Renshaw in response to a Commission notice to produce.

1348 Email from Will Gordon to Peter Renshaw, 12 November 2019 3:29pm, produced by Peter Renshaw in response to a Commission notice to produce.

1349 Email from Peter Renshaw to James Bellinger, Eric Daniels and Helen Bryan (forwarding Will Gordon's email) 12 November 2019 4:31pm, produced by Peter Renshaw in response to a Commission notice to produce.

1350 Email from James Bellinger to Peter Renshaw, Eric Daniels and Helen Bryan, 12 November 2019 4:52pm, produced by Peter Renshaw in response to a Commission notice to produce.

1351 Email from James Bellinger to Peter Renshaw, Eric Daniels and Helen Bryan, 12 November 2019 4:52pm, produced by Peter Renshaw in response to a Commission notice to produce.

1352 Email from James Bellinger to Peter Renshaw, Eric Daniels and Helen Bryan, 12 November 2019 4:52pm, produced by Peter Renshaw in response to a Commission notice to produce.

1353 Transcript of Will Gordon, 27 June 2022, 1762 [4–12].

1354 Transcript of Will Gordon, 27 June 2022,1762 [17–19].

1355 Transcript of Will Gordon, 27 June 2022,1762 [24–30].

1356 Transcript of Will Gordon, 27 June 2022,1762 [39–44].

1357 Transcript of Will Gordon, 27 June 2022,1762 [16–23].

1358 Transcript of Janette Tonks, 30 June 2022, 2074 [28–29].

1359 Email from Ward 4K staff member to Peter Renshaw, 13 November 2019 3:16pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1360 Email from Ward 4K staff member to Peter Renshaw, 13 November 2019 3:16pm, produced by the Tasmanian Government in response to a Commission notice to produce.

1361 Email from Peter Renshaw to a Ward 4K staff member 14 November 2019 2:25pm, produced by Peter Renshaw in response to a Commission notice to produce.

1362 Email from Peter Renshaw to a Ward 4K staff member, 14 November 2019 2:25pm, produced by Peter Renshaw in response to a Commission notice to produce.

1363 Statement of Will Gordon, 8 March 2022, 10 [46].

1364 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 1, 3.

1365 Statutory Declaration of Eric Daniels, 12 July 2023, [23].

1366 Transcript of Eric Daniels, 30 June 2022, 2113 [19–26].

1367 Transcript of Eric Daniels, 30 June 2022, 2125 [39–41].

1368 Transcript of Peter Renshaw, 8 September 2022, 3805 [7–19].

1369 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1370 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1371 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 4.

1372 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 4.

1373 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 4.

1374 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1375 Transcript of Peter Renshaw, 8 September 2022, 3789 [42–47].

1376 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 5.

1377 Transcript of Peter Renshaw, 8 September 2022, 3789 [42–47].

1378 Transcript of James Bellinger, 28 June 2022, 1867 [1–26].

1379 Transcript of Peter Renshaw, 8 September 2022, 3789 [22–26].

1380 Transcript of Peter Renshaw, 9 September 2022, 3810 [20–47].

1381 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1382 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1383 Transcript of Peter Renshaw, 9 September 2022, 3819 [26–29].

1384 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1385 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1386 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1387 Transcript of Peter Renshaw, 9 September 2022, 3805 [25–26].

1388 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1389 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1390 Transcript of Eric Daniels, 30 June 2022, 2113 [28–35].

1391 Transcript of Peter Renshaw, 9 September 2022, 3803 [20–38].

1392 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3855 [2–20].

1393 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3857 [25–30].

1394 Statement of Kathrine Morgan-Wicks, 22 June 2022, 15 [88].

1395 Statement of Kathrine Morgan-Wicks, 22 June 2022, 15 [87–88].

1396 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3854 [39–44].

1397 Statement of Kathrine Morgan-Wicks, 30 June 2022, 5 [32].

1398 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3856 [39–41].

1399 Transcript of Peter Renshaw, 8 September 2022, 3793 [43–47], 3794 [3–8]; Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 4.

1400 Transcript of Peter Renshaw, 8 September 2022, 3794 [7–8].

1401 Peter Renshaw, *Procedural Fairness Response*, 12 July 2023, 5–6.

1402 Transcript of Peter Renshaw, 9 September 2022, 3819 [47]–2820 [5].

1403 Transcript of Peter Renshaw, 8 September 2022, 3792 [35–42].

1404 Statement of Emily Shepherd, 23 June 2022, 7 [39].

1405 Statement of Emily Shepherd, 23 June 2022, Annexure ES-5 (Letter to Emily Shepherd from Eric Daniels, 31 October 2019).

1406 Statement of Emily Shepherd, 23 June 2022, Annexure ES-5 (Letter to Emily Shepherd from Eric Daniels, 31 October 2019).

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1408 Statement of Emily Shepherd, 23 June 2022, 7 [39].

1409 Statement of Emily Shepherd, 23 June 2022, 8 [44].

1410 Statement of Emily Shepherd, 23 June 2022, 8 [45].

1411 Statement of Emily Shepherd, 23 June 2022, 8 [45].

1412 Statement of Emily Shepherd, 23 June 2022, 9 [46].

1413 Statement of Emily Shepherd, 23 June 2022, 1 [55].

1414 Transcript of Eric Daniels, 30 June 2022, 2113 [1–17].

1415 Transcript of James Bellinger, 28 June 2022, 1879 [23–27]; Transcript of James Bellinger, 8 September 2022, 3708 [15–25].

1416 Statement of Kathrine Morgan-Wicks, 22 June 2022, 18 [109].

1417 Transcript of James Bellinger, 28 June 2022, 1879 [29–35].

1418 Transcript of James Bellinger, 28 June 2022, 1876 [19–22].

1419 Transcript of James Bellinger, 28 June 2022, 1877 [36]–1878 [3].

1420 Transcript of James Bellinger, 8 September 2022, 3708 [43–45].

1421 Transcript of James Bellinger, 8 September 2022, 3710 [19–26].

1422 Transcript of James Bellinger, 8 September 3710 [20–33], 3709 [8–10].

1423 Transcript of James Bellinger, 8 September 3715 [36–41].

1424 Statement of Kathrine Morgan-Wicks, 22 June 2022, 18 [109].

1425 Transcript of Peter Renshaw 9 September 2022, 3829 [4]–3830 [14].

1426 Statement of Will Gordon, 30 March 2022, 3 [14].

1427 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1428 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1429 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1430 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1431 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1432 Statement of Will Gordon, 30 March 2022, Annexure WG-006 (Chain of emails between Janette Tonks and Will Gordon).

1433 Statement of Will Gordon, 30 March 2022, 1 [68].

1434 Statement of Will Gordon, 30 March 2022, 1 [68].

1435 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 11 [27].

1436 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 11 [27].

1437 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 9 [22].

1438 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 10 [24]; 17 [58].

1439 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 17 [58].

1440 Statement of a staff member in the Quality Patient Safety Service North, 3 June 2022, 17 [59].

1441 Transcript of Will Gordon, 27 June 2022, 1752 [41]–1753 [46].

1442 Transcript of Will Gordon, 27 June 2022, 1763 [34–40].

1443 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1444 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1445 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1446 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1447 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1448 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1449 Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019.

1450 *Integrity Commission Act 2009* s 35.

1451 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 1

1452 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 2

1453 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 1. Refer also to *State Service Act 2000* s 9(1), (4).

1454 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 2.

1455 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 4–7.

1456 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 5.

1457 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 5.

1458 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 6.

1459 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 6.

1460 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 6.

1461 Assessment Greystone report, attached to Letter from former Chief Executive Officer, Integrity Commission to Kathrine Morgan-Wicks, 'Referral of complaint from the Integrity Commission', 21 November 2019, 9.

1462 Statement of Will Gordon, 30 March 2022, Annexure 7 (Letter from the former Chief Executive Officer, Integrity Commission to Will Gordon, 21 November 2019); Submission 102 Will Gordon

1463 Transcript of Will Gordon, 27 June 2022, 1764 [15–20].

1464 Statement of Kathrine Morgan-Wicks, 30 June 2022, 2 [10].

1465 Statement of Kathrine Morgan-Wicks, 30 June 2022, 2 [10].

1466 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3 [12]; Statement of the former Chief People Officer, 28 November 2022, 7 [30]; Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3865 [42–47].

1467 Statement of the former Chief People Officer, 28 November 2022, 7 [31–32]; Transcript of James Bellinger, 28 June 2022, 1879 [14–19].

1468 Statement of the former Chief People Officer, 28 November 2022, 1 [1(i)], 7 [34–35].

1469 Statement of the former Chief People Officer, 28 November 2022, 7 [39–40].

1470 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3866 [42–47].

1471 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3867 [35–38].

1472 Transcript of Michael Easton, 30 June 2022, 2154 [2–20].

1473 Transcript of Richard Connock, 4 July 2022, 2198 [19–21].

1474 Department of Health, *Procedural Fairness Response*, 28 April 2023, Annexure D (Response table) 43 [107].

1475 Transcript of Michael Easton, 30 June 2022, 2135 [1–10].

1476 Transcript of Michael Easton, 30 June 2022, 2138 [47]–2139 [4].

1477 Transcript of Michael Easton, 30 June 2022, 2148 [35]–2149 [27].

1478 Transcript of Michael Easton, 30 June 2022, 2151 [33–46].

1479 Statement of Kathrine Morgan-Wicks, 30 June 2022, [23].

1480 Email from Staff member, Launceston General Hospital to Peter Renshaw, '4K', 5 December 2019 6:11pm, produced by Peter Renshaw in response to a Commission notice to produce.

1481 Email from Staff member, Launceston General Hospital to Peter Renshaw, '4K', 5 December 2019 6:11pm, produced by Peter Renshaw in response to a Commission notice to produce.

1482 Statement of Peter Renshaw, 20 June 2022, [43.2].

1483 Statement of Peter Renshaw, 20 June 2022, [55.1].

1484 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1485 Statement of Peter Renshaw, 20 June 2022, [56.1].

1486 Email from Peter Renshaw to Kathrine Morgan-Wicks (Director of the Office of the Secretary copied in), 'Open Disclosure CONFIDENTIAL', 17 August 2020 1:55pm.

1487 Letter from Tasmania Police Detective Inspector to Deputy Commissioner J Higgins, 'Griffin, James (Jim) Geoffrey – Investigative Review', 18 November 2020, produced by Tasmania Police in response to a Commission notice to produce.

1488 Email from Peter Renshaw to Kathrine Morgan-Wicks (Director of the Office of the Secretary copied in), 'Open Disclosure CONFIDENTIAL', 17 August 2020 1:55pm.

1489 Letter from Emily Shepherd to Eric Daniels, 'Re: Launceston General Hospital ward 4K', 12 December 2019.

1490 Letter from Emily Shepherd to Eric Daniels, 'Re: Launceston General Hospital ward 4K', 12 December 2019.

1491 Transcript of James Bellinger, 8 September 3709 [23–30].

1492 Eric Daniels, *Procedural Fairness Responses*, 12 July 2023, 23 and 16 August 2023, 3–8.

1493 Letter from Eric Daniels to Emily Shepherd, 20 December 2019.

1494 Statutory Declaration of Eric Daniels, 12 July 2023, [18–20].

1495 Statutory Declaration of Eric Daniels, 12 July 2023, [20].

1496 Letter from Eric Daniels to Emily Shepherd, 20 December 2019.

1497 Statement of Kathrine Morgan-Wicks, 22 June 2022, 9 [51e].

1498 Statement of Will Gordon, 30 June 2022, 11 [52].

1499 Statement of Will Gordon, 30 June 2022, 11 [52].

1500 Statement of Will Gordon, 30 June 2022, 11 [53].

1501 Statement of Will Gordon, 30 June 2022, 11 [54].

1502 Statement of Will Gordon, 30 June 2022, 11 [54].

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1505 Director of Public Health, 'Public Health' (Declaration of Public Health Emergency – COVID-19), Tasmanian Government Gazette, No 21955, 24 March 2020, 147. <https://www.gazette.tas.gov.au/editions/2020/march_2020/21955_-_Special_24_March_2020.pdf>

1506 Department of Health, *Procedural Fairness Response*, 28 April 2023, Annexure D (Response table) 44—46 [111].

1507 Statement of Kathrine Morgan-Wicks, 24 May 2022, 8 [61]; Statement of Kathrine Morgan Wicks, 22 June 2022, 1 [5].

1508 Statement of Kathrine Morgan-Wicks, 24 May 2022, 8 [61]; Statement of Kathrine Morgan Wicks, 22 June 2022, 1 [5].

1509 Statement of Will Gordon, 30 June 2022, 1 [56].

1510 Transcript of Will Gordon, 27 June 2022, 1766 [12–13].

1511 Statement of Will Gordon, 30 June 2022, 11 [55].

1512 Statement of Will Gordon, 30 June 2022, 11 [54].

1513 Transcript of Camille Bianchi, 5 May 2022, 444 [9–91].

1514 Statement of Keelie McMahon, 9 May 2022, [38].

1515 @CamilleBianchi (Camille Bianchi) (Twitter, 27 June 2022, 5:09pm AEST) <https://twitter.com/camillebianchi/status/1541317874450501632?s=46&t=M4BfbtR56Bj2FHhvNmLk-A>.

1516 Statement of Will Gordon, 30 June 2022, 12 [57].

1517 Transcript of Will Gordon, 27 June 2022, 1765 [26–36].

1518 Statement of Will Gordon, 30 June 2022, Annexure WG-009 (Letter from a Solicitor to Sarah Courtney, 3 March 2020).

1519 Statement of Will Gordon, 30 June 2022, Annexure WG-009 (Letter from a Solicitor to Sarah Courtney, 3 March 2020).

1520 Statement of Will Gordon, 30 June 2022, Annexure WG-010 (Letter from Sarah Courtney to a Solicitor, undated).

1521 Statement of Will Gordon, 30 June 2022, Annexure WG-010 (Letter from Sarah Courtney to a Solicitor, undated).

1522 Statement of Kathrine Morgan-Wicks, 13 April 2023, 6 [30–32].

1523 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1524 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1525 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1526 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1527 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1528 Statement of Will Gordon, 30 June 2022, Annexure WG-011 (Letter from Sarah Courtney to a Solicitor, undated).

1529 Statement of Will Gordon, 30 June 2022, 12 [61].

1530 Statement of Kathrine Morgan-Wicks, 22 June 2022, 13 [71].

1531 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3 [16].

1532 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3 [17]; Statement of Kathrine Morgan-Wicks, 30 June 2022, Annexure 62 (Letter from Integrity Commission to Kathrine Morgan-Wicks, 29 July 2020).

1533 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3 [18].

1534 Statement of Kathrine Morgan-Wicks, 30 June 2022, 3–4 [20–21].

1535 Transcript of James Bellinger, 28 June 2022, 1879 [42–44].

1536 Letter from Kathrine Morgan-Wicks to former Chief Executive Officer, Integrity Commission, 'Matter MM19/0172', 10 September 2020.

1537 Transcript of James Bellinger, 28 June 2022, 1880 [3–13].

1538 Transcript of James Bellinger, 28 June 2022, 1879 [21–31].

1539 Transcript of James Bellinger, 28 June 2022, 1880 [25–30], 1883 [16–19].

1540 Transcript of Kathrine Morgan-Wicks, 9 September 2022, 3869 [31–35].

1541 Transcript of Michael Easton, 30 June 2022, 2154 [47]–2155 [4].

1542 Minute to Secretary, 'Potential Legal Issue – Launceston General Hospital (LGH) in relation to ex-employee James Griffin', 5 November 2019.

1543 Statement of Peter Renshaw, 20 June 2022, [56.1].

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

Who was looking after me? Prioritising the safety of Tasmanian children

Volume 6: Children in health services
Book 2

August 2023

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

Volume 6
Children in health services (Book 2)

The Honourable Marcia Neave AO
President and Commissioner

Professor Leah Bromfield
Commissioner

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Commissioner

August 2023

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15 The way forward: Children in health services

1 Introduction

Health services have a duty of care to patients, which extends to keeping them safe from sexual abuse while they are under care. The National Safety and Quality Health Service Standards require that health services protect the public from harm and provide quality health care to all patients. The National Principles for Child Safe Organisations, which have now been substantially adopted in the *Child and Youth Safe Organisations Act 2023* ('Child and Youth Safe Organisations Act'), set out the expectations of organisations to create cultures that foster child safety and wellbeing. The *Children, Young Persons and Their Families Act 1997* ('Children, Young Persons and Their Families Act') and the *Health Practitioner Regulation National Law Act 2009* (Qld) ('National Law') require that sexual misconduct by health practitioners be reported, including to the Australian Health Practitioner Regulation Agency ('Ahpra').[1]

There is limited research into the prevalence of sexual abuse in health services. However, we know from the available evidence that abusers who are also health workers will exploit their often unquestioned, intimate access to young patients, and that children and young people's vulnerability to abuse is heightened when they are sick, injured or otherwise unwell.

This volume makes a much-needed contribution to the research on child sexual abuse in health services. We learned that abusers use tactical strategies to avoid detection when offending in health services. They leverage the trust and deference that many of us afford health workers, take advantage of the assumption that sexual abuse cannot

happen undetected in a health service, and are effective at grooming vulnerable young patients, as well as their families and their colleagues. They can enhance their perceived trustworthiness by appearing to go 'above and beyond' in providing health care to young patients and supporting their family and carers.

A health service can provide an ideal environment for health workers to abuse young patients if it does not have systems, policies and protocols in place relevant to preventing, detecting and responding to child sexual abuse.

In Chapter 14, we examined Launceston General Hospital's response to allegations of child sexual abuse. We identified systemic problems with leadership, culture, policies and processes at the hospital.

In this chapter, we discuss some of the work already underway to address these problems. In Section 2, we outline recent reviews and numerous new initiatives designed to improve children's safety in health services and better support staff to identify signs of abuse. In Section 3, we discuss the foundations that can assist health services to protect children, reflected in the National Principles for Child Safe Organisations, including building a strong culture, strengthening leadership and accountability, empowering children and young people, and investment in clear policies and professional development. In Section 4, we discuss responses to complaints, concerns, and allegations of child sexual abuse. In Section 5, we discuss the importance of recognising the impact of Mr Griffin's offending on Launceston General Hospital and restoring trust in that institution. In Section 6, we discuss the role of oversight bodies.

Throughout this chapter, we make recommendations to further enhance work already underway. Our recommendations are aimed at ensuring the Tasmanian health system is better placed to identify child sexual abuse and respond appropriately when it occurs in future.

In summary, we recommend:

- developing and communicating a policy framework and implementation plan to improve responses to child sexual abuse in health services
- that the Tasmanian Government advocates for the National Principles for Child Safe Organisations to become a mandatory requirement for accrediting health services nationally
- increasing the participation of children and young people in decisions affecting health care delivery, including through:
    - establishing a health services young people's advisory group
    - increasing young people's and their families' and carers' knowledge of patient rights

    - regularly monitoring children and young people's sense of safety within health services
    - identifying actions that can be taken to make health services safe and inclusive for diverse groups of children and young people
- increasing the accountability of leaders and staff in protecting child safety and embedding safety through cultural improvement initiatives
- reviewing and consolidating departmental policies, procedures and protocols to address gaps in the safeguarding of children, including publishing child safety policies to promote accessibility and transparency within the community; in particular, improvements to, or developing, policies on key child safety matters, including mandatory reporting and voluntary reporting, professional conduct for staff and chaperones
- establishing minimum requirements for staff professional development on child safety
- improving responses to child safety concerns, including establishing a clear complaints management, escalation and investigation pathway and developing a critical incident response plan to respond to human-caused traumatic events
- restoring trust through Launceston General Hospital, the Department and Tasmania Police offering ongoing assistance to known and as yet unknown victim-survivors of child sexual abuse by Mr Griffin that related to the hospital
- reviewing the *Health Complaints Act 1995* ('Health Complaints Act') to ensure the role of the Health Complaints Commissioner extends to addressing systemic issues within health services related to child safety.

2 Implementing recent reviews

In 2022, following the revelations about Mr Griffin's offending, and throughout our Commission of Inquiry, the Department began addressing risks to child safety within health services. In particular, the Department initiated two reviews—the *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* ('Child Safe Governance Review') and the *Launceston General Hospital Community Recovery Initiative* ('Community Recovery Initiative'). Kathrine Morgan-Wicks PSM, Secretary, Department of Health, has accepted all the recommendations of these two reviews.[2] The Department has also introduced reforms under its Child Safe Organisation Project, which primarily sought to implement the National Principles for Child Safe Organisations and the associated Child Safe Standards recommended by the National Royal Commission.[3]

In this section, we provide an overview of these reviews and reforms. The Department has also set up a Statewide Complaints Oversight Unit in the Office of the Secretary, and a statewide policy framework and incident reporting system. We discuss this in a later section on improving responses to child sexual abuse in health services.

We conclude that while the Department's recently initiated reforms represent progress on improving child safety, it remains unclear exactly which reforms will be implemented and by whom. The community is entitled to know more about the Department's reforms, how the reforms will work to provide a system-wide response to child sexual abuse in health services, how the reforms are being prioritised, and the expected timeframes for implementation. To this end, we recommend that the Department develops and communicates a policy framework and implementation plan.

2.1 Recent reviews and reforms

Following evidence presented to our Commission of Inquiry at hearings relevant to Launceston General Hospital, the Department announced the Child Safe Governance Review and the Community Recovery Initiative to respond to community concerns about the hospital.

2.1.1 Child Safe Governance Review

On 3 July 2022, the Honourable Jeremy Rockliff MP, Premier of Tasmania, together with Secretary Morgan-Wicks, announced the immediate establishment of the Child Safe Governance Review.[4] The Premier said:

> We knew the evidence before the Commission of Inquiry would be confronting and there would be serious lessons to learn. There is nothing more important than keeping children safe which is why we are listening and acting now to ensure past wrongs are not repeated.[5]

Two external and independent co-chairs were appointed to lead the Child Safe Governance Review—Adjunct Professors Karen Crawshaw PSM and Debora Picone AO.

The terms of reference for the Child Safe Governance Review were to consider a range of operational matters related to Launceston General Hospital, including assessing its organisational structure, the roles and responsibilities of leaders and managers, training and staff development, policies and procedures and the management of complaints.[6] Some of the terms of reference went to issues beyond the focus of our Inquiry, particularly around clinical governance and patient safety more broadly.

A Lived Experience Expert Reference Group was established as part of the Child Safe Governance Review. Although the membership of this group was not made public, we know that it comprised victim-survivors.[7] The report of the Child Safe Governance Review states that the Lived Experience Expert Reference Group was given the opportunity to inform the review and shape recommendations to the Secretary.[8]

The report of the Child Safe Governance Review contained 92 recommendations, including in relation to the role and skills of leadership, staff and human resources; governance structures; strengthening child safeguarding; and improved record keeping. We discuss specific recommendations, where relevant, in subsequent sections.

Secretary Morgan-Wicks confirmed to us that the Tasmanian Government had accepted all recommendations set out in the Child Safe Governance Review report.[9] She also wrote to us following the public release of the report to provide an update on the progress of implementing the recommendations. She told us that:

- a Statewide Child Safety and Wellbeing Service had been established, with child safeguarding officers to be recruited and located onsite at all major hospitals in Tasmania, including at Launceston General Hospital
- a fact sheet for staff had been drafted and promoted to guide the reporting of child safety concerns
- the Chief Executive Hospitals North would assume responsibility for safeguarding children at Launceston General Hospital[10]
- the co-chairs would be appointed to monitor implementation of the review's recommendations.[11]

Adjunct Professors Picone and Crawshaw advised us in July 2023 that many of their recommendations involved 'major systemic changes in technology, business operations and culture', some of which take months or years to fully implement and embed.[12] However, they said that in overseeing the implementation of all the recommendations, they maintained a particular focus on those relating to child safety and that 'significant progress' had been made.[13] Areas identified as most relevant for priority oversight included:

- strengthening complaints and incident management policies
- ensuring delivery of child safety training
- embedding accountabilities for child safety in all statements of duty
- appointing child safeguarding officers within each region
- supporting implementation of the Child Safe Organisation Framework
- ensuring leadership is proactively working to improve the culture of Launceston General Hospital.[14]

We provide some more detail on progress related to these matters in relevant sections.

Seven working groups were established, each chaired by a health executive role holder and focusing on different aspects of implementation—with progress to be reported back to the broader Health Executive, acting as the Steering Committee.[15]

Adjunct Professors Picone and Crawshaw described their process of independent monitoring as involving a wide range of sources—including documentary evidence (progress reports, draft policies, relevant data), as well as targeted meetings with departmental executives that often involved 'probing questioning' and requests for additional information and follow-up.[16] The co-chairs advised us that they also met with a range of other stakeholders and role-holders, including victim-survivors involved in the development of recommendations, Launceston General Hospital's Community and Consumer Engagement Council, employee and professional organisations, as well as focus groups with frontline staff.[17] Where the co-chairs felt implementation was 'sub-optimal' or required additional support, they raised these concerns with Secretary Morgan-Wicks, who they described as having been 'responsive and timely in addressing our concerns'.[18]

We were pleased to be advised that Adjunct Professors Picone and Crawshaw's independent oversight role had been extended by Secretary Morgan-Wicks until the end of December 2023, and greatly encouraged by the overall positive assessment made by them of the Department's (and Launceston General Hospital's) progress in promoting the safety of children receiving health services.[19]

2.1.2 Community Recovery Initiative

Elizabeth Daly OAM and Malcolm White, two 'experienced and known members of the northern region community', were appointed to act as co-chairs of the Community Recovery Initiative, designed to improve community trust in Launceston General Hospital.[20]

The key objectives of the Community Recovery Initiative are to:

1. **Learn from the community** – for the Department to gain a deeper understanding of the northern community's concerns, and have those concerns inform its efforts to improve the [Launceston General Hospital's] systems, processes and culture to prevent child sexual abuse from happening again.
2. **Restore community confidence** – to rebuild the northern region community's confidence in the [Launceston General Hospital] as a trusted public institution.
3. **Build community capacity** – through this process, aim where possible or appropriate to build ongoing capacity, strength and resilience within the northern region community.[21]

The co-chairs of the Community Recovery Initiative made eight recommendations directed at improving management, leadership and culture; improving communication with staff and the media; and increasing staff training.

Secretary Morgan-Wicks told us that she accepted the recommendations of the Community Recovery Initiative, which she believes are consistent with, and able to be implemented through, the recommendations of the Child Safe Governance Review.[22] The co-chairs of the Community Recovery Initiative stated an intention to liaise with the Department to monitor progress of actions towards the implementation of their recommendations.[23]

2.1.3 Child Safe Organisation Project

Other Department-initiated reforms are relevant to our Commission of Inquiry. In particular, the Child Safe Organisation Project was set up primarily to implement the National Principles for Child Safe Organisations and associated Child Safe Standards, as recommended by the National Royal Commission and endorsed by the former Council of Australian Governments in February 2019.[24]

The objective of the Child Safe Organisation Project was to ensure the Department has a strong, common understanding of child safety and wellbeing, that children's voices are heard, and that children and their families are involved in decisions affecting them.[25]

Key elements of the Child Safe Organisation Project were to develop a framework for child safety and wellbeing, set up an independent panel for child safety and wellbeing, and establish a new Child Safety and Wellbeing Service within the Department.

The Child Safe Organisation Project finished in December 2022. The Child Safety and Wellbeing Service now leads implementation of the Department's work to improve child safety and wellbeing.[26] We understand that child safeguarding officers located at Tasmania's four public major hospitals are also supporting implementation of the Department's *Child Safety and Wellbeing Framework*, including providing education on mandatory reporting and identifying grooming and professional boundary breaches.[27] We have been advised that these roles have been successfully filled in each region.[28]

We note that Tasmanian health services will be subject to legislative requirements to embed the Child and Youth Safe Standards (which are based on the National Principles for Child Safe Organisations) and will also be subject to a Reportable Conduct Scheme to enable oversight of how investigations of reportable allegations (which includes child sexual abuse and sexual misconduct) are conducted.[29] For further discussion on these schemes, refer to Chapter 18.

2.2 A policy framework and implementation plan

Although substantial reform work is underway across the Department, we consider this would be strengthened by clarifying:

- how the reforms will work together to provide a system-wide response to child sexual abuse in health services
- how the reforms are being prioritised
- expected timeframes for implementation.

To this end, we recommend that the Department develops and communicates a policy framework and implementation plan for reforms to improve responses to child sexual abuse in health services, against which it will be accountable to the community. This plan should explain how reforms—including departmental reforms, those recommended by the Child Safe Governance Review, Community Recovery Initiative and our Commission of Inquiry—fit together to ensure the safety of children in health settings. Publishing the policy framework and implementation plan will provide a greater degree of transparency and accountability around the Department's implementation of reforms.

In February 2023, Secretary Morgan-Wicks provided a written update on the Department's reform work. She told us that an implementation plan had been prepared and included the recommendations of the Child Safe Governance Review and Community Recovery Initiative.[30] She said the plan covers implementing the recommendations not only within Launceston General Hospital but also across the Department.[31] She also told us that several of the recommendations have already been 'completed'.[32]

We are pleased that the Department has started implementation planning in relation to the recommendations of the Child Safe Governance Review and Community Recovery Initiative. However, given the number and complexity of recommendations to be implemented (and, as we note above, the fact that some may take time to become fully embedded), we consider the Department and the community would benefit from a policy framework and implementation plan that outlines:

- the purpose and need for the reforms
- the role, responsibilities and interactions of bodies the Department has set up as part of the reforms
- how the reforms work together to provide a system-wide response to child sexual abuse in health services
- how the reforms are being prioritised for implementation and who is responsible for their implementation
- the expected timeframes for implementation.

We asked the co-chairs of the Child Safe Governance Review about the features they considered important in a monitoring and oversight function relating to health services. Adjunct Professors Picone and Crawshaw advised us that, in their view, the following skills and capabilities are needed:

- independence (actual and perceived)
- strong understanding of public sector management, health service administration and subject-specific knowledge relevant to recommendations
- good access to engage with individuals responsible for implementation and scope to offer objective guidance and advice
- sound reporting methodology, which includes monitoring of front-line staff experiences of the implementation of recommendations
- a long enough period of oversight to cover the reform agenda.[33]

We acknowledge that the policy framework and implementation plan may need to evolve over time because of changes in implementation dependencies and unexpected challenges, but we consider that, at the outset, the policy framework and implementation plan should contain the elements set out in the following recommendation.

Recommendation 15.1

The Department of Health should develop and communicate a policy framework and implementation plan for reforms to improve responses to child sexual abuse in health services. The policy and implementation plan should:

a. set out the purpose and need for the reforms

b. set out the role, responsibilities and interactions of bodies the Department has set up as part of the reforms

c. explain how reforms, including departmental reforms and those recommended by the Child Safe Governance Review, Community Recovery Initiative and this Commission of Inquiry, will work together to respond to child sexual abuse in health services

d. outline how the reforms are being prioritised for implementation and who is responsible for their implementation

e. set out the expected timeframes for implementation

f. be published on the Department's website.

3 Creating strong foundations to protect children

In this section, we make recommendations aimed at creating child safe cultures across Tasmanian health services including:

- establishing the National Principles for Child Safe Organisations as a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards
- creating a child safe culture in Tasmanian health services
- empowering children to influence how health care is delivered
- creating safe physical environments for children
- ensuring the development and implementation of key child safe policies that are publicly accessible and create a shared understanding of the rights of children and expectations of staff conduct
- improving professional development for staff about child sexual abuse and related matters such as grooming and professional boundaries.

3.1 Implementing the National Principles for Child Safe Organisations

Health services that prioritise child safety share key organisational characteristics. These characteristics are reflected in the expectations of the National Principles for Child Safe Organisations ('National Principles') and include good culture, competent leadership, the empowerment of children and young people, safe physical environments, appropriate policies and targeted professional development. Although these principles are reflected in Tasmania's Child and Youth Safe Standards, we refer to the National Principles in this chapter because health services must be accredited nationally.

The Tasmanian Government and the Department should continue to work to implement the expectations of the National Principles in Tasmanian health services. The National Principles should also be a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards.

3.1.1 National Safety and Quality Health Service Standards

The National Safety and Quality Health Service Standards ('National Standards') are the starting point for determining what is required for a hospital (or any health service) to be safe for patients. The National Standards are a consistent statement on the level of care consumers can expect from health services across Australia.[34]

The primary aims of the National Standards are to 'protect the public from harm and to improve the quality of health service delivery'.[35] All public and private hospitals, as well as other health services, are assessed for compliance with the National Standards as part of their accreditation under the Australian Health Service Safety and Quality Accreditation Scheme.[36]

While the National Standards make no express reference to child safety, the Standards most relevant to child safety are the Clinical Governance Standard and the Partnering with Consumers Standard.[37] Aspects of these Standards are discussed throughout this section.

3.1.2 Launceston General Hospital's accreditation against the National Standards

The last organisation-wide assessment of Launceston General Hospital against some of the National Standards occurred in 2022.[38] As of July 2023, the Australian Commission on Safety and Quality in Health Care's website indicates that the Launceston General Hospital is accredited, with an assessment against the National Standards 'to be completed by 12/12/2022'.[39]

One of the co-chairs of the Child Safe Governance Review, Adjunct Professor Debora Picone, also gave evidence to us in her capacity as Chief Executive Officer, Australian Commission on Safety and Quality in Health Care. She told us that in June 2022, the Tasmanian Health Service North Region, which includes Launceston General Hospital, underwent assessment during the week of 4 April 2022.[40] The assessment covered three of the eight Standards—the Partnering with Consumers Standard, the Preventing and Controlling Infection Standard and the Comprehensive Care Standard.[41] Independent assessors were also specifically asked to review the hospital's systems for incident reporting, complaints handling, risk management and open disclosure.[42] The assessors found the systems in place at the hospital 'were effective, were being used appropriately, and were being monitored'.[43]

3.1.3 Integrating the National Principles into the National Standards

While the National Standards apply to services provided to all patients, including children and young people, they do not specifically address issues of child safety.[44] Adjunct Professor Picone told us that aspects of the National Principles are reflected in the National Standards, particularly in the Clinical Governance Standard and Partnering with Consumers Standard.[45] Although it is not currently mandatory, there is an expectation that health services will implement systems to keep children safe and manage risks to children as part of complying with the National Standards.[46]

Adjunct Professor Picone told us that it would be possible, and indeed preferable, to embed the National Principles into the National Standards, making the National

Principles mandatory for all accredited health services.[47] She noted that the Australian Commission on Safety and Quality in Health Care has not previously had enough information about the failures of child safety systems in health services to warrant this.[48]

The Tasmanian Government has recently made efforts to implement the expectations of the National Principles, including within the Department (as evidenced in the new *Child Safety and Wellbeing Framework* referred to above and discussed below).[49] The enactment of the Child and Youth Safe Organisations Act will also legislate that health services providing care to children and young people must adopt the National Principles in the form of the Child and Youth Safe Standards, and implement a Reportable Conduct Scheme.[50]

However, in our view, the expectations of the National Principles should be reflected explicitly within mandatory requirements for accreditation against the National Standards under the Australian Health Service Safety and Quality Accreditation Scheme. This will highlight the core importance of child safety to broader concepts of patient safety, provide another safeguard for children and young people, and allow implementation of the National Principles to be assessed at least once every three years by a body that is familiar with the operating environments of health services.

We anticipate the Australian Commission on Safety and Quality in Health Care will engage and share information with the Independent Regulator of the Child and Youth Safe Standards and Reportable Conduct Scheme in Tasmania, as well as with the Tasmanian Health Complaints Commissioner, Ahpra and the National Health Practitioner Boards ('National Boards'), about the compliance of health services and health practitioners with the National Principles.

The need to ensure compliance with principles and standards of child safety extends beyond health services to health departments as system administrators for state-based public health systems and regulators of the private health sector.[51] Secretary Morgan-Wicks told us that the Department had not previously identified child sexual abuse in public health services as a specific strategic risk; instead, risk assessments tended to form part of patient safety and clinical decision-making processes in individual health services.[52] Secretary Morgan-Wicks identified areas in the Department that provide direct service delivery to children and young people, or that have access to the personal information of children and young people, as posing the greatest risk of child sexual abuse.[53] These areas included Women's and Children's Services, and Child and Adolescent Mental Health Services.[54]

Secretary Morgan-Wicks acknowledged that it was a 'critical oversight' that there was not a broader focus on managing the risks of child sexual abuse in public health services and indicated that the occurrence of child sexual abuse had now been added to the Department's Strategic Risk Register and approved by the Health Executive.[55] Secretary Morgan-Wicks told us that the Department's Child Safe Organisation Project was managing work to address this risk.[56]

The case studies discussed in Chapter 14 highlight the risk of child sexual abuse in health services and demonstrate that these services need to have systems in place to prevent such abuse occurring, and to respond appropriately when it does occur. The Tasmanian Government should advocate for the Australian Commission on Safety and Quality in Health Care to formally integrate the expectations of the National Principles into the National Standards.

Recommendation 15.2

1. The Tasmanian Government and Department of Health should continue to implement the National Principles for Child Safe Organisations across all health services.
2. The Tasmanian Government should advocate at a national level for compliance with the National Principles for Child Safe Organisations to be a mandatory requirement for accrediting health services against the National Safety and Quality Health Service Standards under the Australian Health Service Safety and Quality Accreditation Scheme.

3.2 Protecting children through a child safe culture

In this section, we recommend that the Department takes steps to embed a child safe culture in health services.

As noted in other chapters of our report, an organisation's 'culture' refers to the assumptions, values, beliefs and norms that distinguish appropriate from inappropriate behaviours in an organisation, and how those assumptions, values, beliefs and norms translate into practice, including staff conduct.[57]

Professor Ben Mathews, Research Professor, School of Law, Queensland University of Technology, told us that in Australia and other countries such as the United States it has been found that institutions with strong leadership and a positive culture have higher prospects of early recognition, reporting and appropriate responses to child sexual abuse.[58]

In Chapter 13, we outlined previous reviews that had identified common themes related to a poor organisational culture across Tasmanian health services including:

- ineffective governance arrangements and a lack of clarity about roles and responsibilities among health service staff
- an absence of scrutiny over staff conduct and decision making, and a lack of accountability for senior managers and executives

- organisational cultures characterised by poor leadership and poor behaviour, including misconduct by State Service employees in relation to conflicts of interest, underperformance and mistreatment of other staff
- failures to report misconduct due to fear of retribution
- instability because of changes in organisational and governance structures.

In the health context, the National Standards explicitly require that the governing body of a health service 'provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation'.[59] The Australian Commission on Safety and Quality in Health Care defines a safety culture as:

> A commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management. Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.[60]

We consider that this requirement of leadership to support a safety culture should extend to ensuring safety and quality processes protect children and young people who are under a health service's care. Given our findings, achieving this outcome will require cultural change, at least within Launceston General Hospital and possibly across the Department.

Professor Erwin Loh, Group Chief Medical Officer and Group General Manager, Clinical Governance, St Vincent's Health Australia, told us: 'Culture change management is probably the hardest thing to do in any organisation, no matter what the profession or industry'.[61] As an expert in facilitating such change within health services, he offered the following reflections:

- Organisations need to have broad strategies for encouraging staff to speak up and not be afraid to 'challenge the status quo'. Organisations cannot rely on single initiatives alone.[62]
- Senior leadership must model the desired behaviours. The leadership should welcome criticism and feedback from staff and patients, ensuring those who have spoken up feel appreciated, listened to and that their concerns have been acted on.[63]
- Middle management (such as nurse unit managers and heads of medical units) must also be engaged in creating a safety culture.[64]

3.2.1 Cultural improvement initiatives

Secretary Morgan-Wicks recognised that organisational change is 'one of the most significant challenges' facing the Department.[65] She told us of several measures being implemented across the Department and at hospitals that are directed at improving organisational culture. These include:

- the Speaking up for Safety program being implemented at Royal Hobart Hospital, which is designed to build 'a culture of safety and reliability' in the hospital by encouraging all staff to speak up if they experience or observe concerning actions or behaviour[66]
- the One Health Cultural Improvement Program, which the Department began working on in January 2022.[67]

Professor Loh explained that the Speaking up for Safety program is based on the Vanderbilt Promoting Professional Accountability model ('Vanderbilt model') that is used widely in the United States and in some Australian hospitals.[68]

Professor Loh gave evidence of a similar program he is responsible for administering in St Vincent's Health Australia, known as the Ethos Program. Like Speaking up for Safety, this is a peer-based early intervention program designed to recognise staff who demonstrate positive behaviours, remove barriers from speaking up about concerns that affect patient or staff safety, and allow for a quick, fair and transparent response 'to all staff', including those making a complaint and those with concerning behaviours.[69]

Under the Ethos Program, staff are trained on how to 'speak up' effectively and can use an online messaging system to submit feedback for recognition (to acknowledge positive behaviour) or reflection (to offer feedback for improvement).[70] This feedback is delivered by a trained Ethos Messenger, who is generally a peer of the staff member, via an informal conversation.[71] The program allows for anonymous reports; however, Professor Loh told us that, in his experience, most people using the program are happy to be identified.[72] The Ethos Program supplements other practices at the hospital, including raising a concern directly with a colleague.[73]

Trained staff triage reports received through the Ethos messaging system across four levels, depending on the seriousness of the incident.[74] Less serious behaviour would not necessarily be formally reported. While Speaking up for Safety and the Ethos Program have a similar intent, a key difference is that the Ethos Program includes an option for positive recognition, whereas Speaking up for Safety facilitates only feedback in response to negative interactions.[75]

We consider a staff reporting system that applies to all staff, volunteers, contractors and sub-contractors in a hospital is a valuable initiative for creating a culture that enables giving and receiving of feedback.

We note, however, that professional boundary breaches towards a child by a staff member, whether they are an employee, volunteer, contractor or sub-contractor, should always be formally reported, responded to and recorded in centralised records for future reference.

Secretary Morgan-Wicks told us that the Department's One Health Cultural Improvement Program is based on a 'cultural baseline' of information drawn from staff interviews; an academic literature review relating to health care and organisational culture; departmental surveys and reviews; and data relating to workers compensation, State Service Code of Conduct investigations and workplace safety reports.[76] In May 2022, Secretary Morgan-Wicks told us that work had begun under the program to:

- develop and embed departmental values that signal acceptable behaviours, and what to do if these are not upheld
- build leadership and management skills, including around communication and how to respond to complaints or grievances
- improve induction procedures for new employees to help them better understand values and desired behaviours
- improve complaints and disciplinary policies and processes.[77]

When Secretary Morgan-Wicks gave evidence at our hearings in September 2022 she advised that the Department was putting the finishing touches on the program.[78]

The Child Safe Governance Review made several recommendations to improve the culture at Launceston General Hospital.[79] These included recommendations to:

- set up a specific advisory group at the hospital with diverse membership[80]
- improve communication with staff about progress against cultural improvement plans[81]
- clarify the expectations of executive and management through performance agreements[82]
- develop a culture improvement strategy[83]
- monitor staff feedback through annual surveys on patient safety culture.[84]

As noted above, the Tasmanian Government has accepted all the recommendations set out in the Child Safe Governance Review.[85]

In a written update provided to our Commission of Inquiry in February 2023, Secretary Morgan-Wicks stated that senior leadership at Hospitals North, which includes Launceston General Hospital, is implementing an accountability and culture framework called Excellence Together.[86]

3.2.2 Our observations

We welcome the focus of the Tasmanian Government and the Department on addressing organisational culture to address child safety concerns. We consider that these reforms should be guided by a set of principles, which we set out in the following recommendation. We also consider that progress reports to the Child Sexual Abuse Reform Implementation Monitor (Recommendation 22.1) should demonstrate how these principles have been translated into policy and practice.

Initiatives designed to support cultural change should be informed by a range of sources and be the subject of regular review and evaluation against pre-established criteria to ascertain whether they are achieving desired outcomes.

Recommendation 15.3

The Department of Health should ensure its cultural improvement program embeds a safety culture in health services by:

a. requiring clear organisational values be observed across all levels of health services, including in relation to staff conduct

b. establishing strong governance arrangements to address staff practices that place children at risk of abuse, and complementing established patient safety governance structures

c. ensuring all levels of management demonstrate a commitment to a safety culture, including by addressing poor staff conduct

d. clarifying roles and responsibilities among staff when there is a suspicion that child sexual abuse has occurred or that safety policies are not observed

e. ensuring there are processes that hold senior managers and executives accountable to respond appropriately to the conduct of their staff, including through performance agreements and role descriptions

f. establishing measures of a strong organisational culture that indicate an organisation

    i. welcomes concerns about staff and sees them as an opportunity to improve safety for staff and patients

    ii. empowers staff to feel safe and supported to raise concerns about colleagues with their leaders and gives them confidence in the ability of leaders to respond to concerns and take disciplinary actions (including termination) where appropriate

iii. ensures staff are clear about the process for raising concerns, how these concerns will be addressed and what feedback they can expect to receive

g. providing progress reports to the Child Sexual Abuse Reform Implementation Monitor to demonstrate how these principles have been translated into policy and practice (Recommendation 22.1).

Recommendation 15.4

1. The Department of Health should consider integrating features of the St Vincent's Health Australia's Ethos Program into its cultural improvement program.
2. The Department of Health should ensure, in adopting its cultural improvement program, professional boundary breaches by staff towards a child are always formally reported, responded to and recorded in centralised records for future reference.

3.3 Embedding child safety as a priority for leadership

The National Principles state an expectation that 'child safety and wellbeing is embedded in organisational leadership, governance and culture'.[87] As Professor Mathews says:

> To succeed in preventing child sexual abuse requires a genuine commitment by the institution or organisation to children's rights to safety. If the leadership in an organisation does not possess this quality, it is near impossible to prevent instances of child sexual abuse.[88]

3.3.1 Problems of leadership and accountability

In Chapter 14, Case study 3, relating to James Griffin we make several findings about the failures of leadership in Launceston General Hospital. These included findings that:

- Launceston General Hospital leadership collectively failed to address a toxic culture in Ward 4K that enabled James Griffin's offending to continue and prevented his conduct being reported.
- Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem.
- Leadership at Launceston General Hospital was dysfunctional, and this compromised its collective response to revelations about James Griffin.
- Launceston General Hospital did not have clear accountabilities for child safety.

Several senior executive staff at Launceston General Hospital told us that responsibility for child safety was not part of senior executive roles and that they were not subject to any performance measures, indicators or financial outcomes in relation to safeguarding children.[89]

3.3.2 The need for accountability

Dr Samantha Crompvoets, Director, Australian Human Rights Commission and sociologist with expertise in organisational culture, was frank in her evidence to our Commission of Inquiry about the limits of incremental organisational change in response to a crisis. She noted that there may be times, due to the nature and significance of particular events, when a 'complete reset' of the organisation will be required from the ground up.[90] Dr Crompvoets said that leadership accountability is essential to achieving change within an organisation.[91] She spoke about the importance of 'tangible' accountability, which requires a specific person to be responsible for a particular recommendation or action.[92] Dr Crompvoets noted that accountability should not be a 'tick and flick' exercise, but built into a leader's key performance indicators.[93]

Will Gordon, the Launceston General Hospital nurse who blew the whistle on the management of complaints about Mr Griffin, told us that nothing would change at the hospital 'unless management at every hierarchical level … changes'.[94] Another staff member said that the hospital needed 'to be flushed from the top down' and that '[n]ew staff should be put in all senior positions'.[95] The co-chairs of the Community Recovery Initiative described 'strong feelings' among those they consulted that senior leaders who gave evidence at our Commission of Inquiry 'be seen to be made accountable and be seen to be removed and not allowed just "to retire"'.[96] The co-chairs went on to say:

> To not meet this criterion will, in our view, lead to the risk of an overall failure assessment of restorative trust actions from those we heard from and, more generally, for those whom [the Department] seeks to restore a trusting relationship.[97]

At our hearings, Secretary Morgan-Wicks also acknowledged that it was time Launceston General Hospital had a 'complete reset'.[98]

3.3.3 Recent reforms

The Department has developed the *Child Safety and Wellbeing Framework* as part of its Child Safe Organisation Project. This framework, publicly released in September 2022, has the objective of establishing 'a systemic approach to enhance the way the Department of Health works with vulnerable people, specifically children and young people'.[99] It:

- ensures structures, systems and processes are in place to mandate and foster a child safe organisation and child safe culture[100]
- establishes the National Principles as key priorities to be embedded into the Department's child safe approach[101]

- applies to the entire Department, as well as organisations funded by the Department[102]
- details the responsibility and requirements to be met by all people engaged by the Department in protecting the health, safety, welfare and wellbeing of children and young people.[103]

Secretary Morgan-Wicks told us that the framework is an important step in ensuring a Department-wide commitment to child safe practices and reporting of suspected child sexual abuse.[104]

The Tasmanian Government has also committed to clarifying expectations and improving accountability for child safety through Head of Agency performance agreements.[105] Jenny Gale, Secretary, Department of Premier and Cabinet and Head of the State Service, told us on the final day of our hearings:

> Every Head of Agency's performance agreement with the Premier will commit them to identify and take action within their own department and across the service that will keep children safer. This commitment applies regardless of whether that agency engages directly in child-related work.[106]

We would expect such performance measures to also filter down into the responsibilities of other management teams in health services.

Adjunct Professors Picone and Crawshaw advised us in July 2023 that Secretary Morgan-Wicks had issued a directive to all staff under section 34 of the *State Service Act 2000* ('State Service Act') in respect of their child safeguarding responsibilities as employees of the Department of Health, and is updating all statements of duties to include the following:

> Champion a child-safe culture that upholds the National Principles for Child Safe Organisations. The Department is committed to the safety, well-being, and empowerment of all children and young people, and expects all employees to actively participate in and contribute to our rights-based approach to care, including meeting all mandatory reporting obligations.[107]

The Child Safe Governance Review also made several recommendations for ensuring accountability of leadership through improved governance, organisational structure, clearer roles and accountabilities, and professional development. Although many of these recommendations relate to Launceston General Hospital, they are relevant to other health services across Tasmania. Key recommendations of the Child Safe Governance Review include:

- ensuring collective and individual commitment to child safety through the Secretary, executive and clinical leadership of Launceston General Hospital implementing the *Child Safety and Wellbeing Framework*, signing a statement of commitment and undertaking an annual review of child safety and wellbeing status, confirmed by a publicly reported attestation statement[108]

- changes to the organisational structure and executive titles at Launceston General Hospital, including splitting the role of Chief Executive Hospitals North/North West and advertising for a new Chief Executive Hospitals North[109]
- more frequent meetings between various management and governance groups in Hospitals North, including at least a quarterly discussion on culture improvement initiatives and the implementation of the Child Safe Organisation Framework, which, under the Child and Youth Safe Organisations Act, comprises the Child and Youth Safe Standards and Reportable Conduct Scheme at Launceston General Hospital[110]
- various changes to role responsibilities and added performance measures relating to child safety, culture, workplace and patient safety for executives and senior managers, supported by annual performance reviews.[111]

On accepting the interim recommendations of the Child Safe Governance Review in September 2022, the Premier announced more changes to support leadership renewal at Launceston General Hospital and the Department, including changes to existing positions and the creation of new positions.[112] The announcement stated that some key members of Launceston General Hospital's executive team had either moved to another leadership role, were acting in their current role or were 'on a period of extended leave' before their impending retirement.[113]

3.3.4 Our observations

Health leaders need to be equipped and empowered to embed the expectations of the National Principles and related reforms in the day-to-day work and practice of staff working in health services. Various activities will aid their endeavours, including culture-improvement initiatives, refreshed policies and practices, and relevant professional development, for which we make recommendations elsewhere in this chapter.

Health leaders (and State Service staff) are subject to annual performance reviews. We consider that health leaders should have accountability measures for child safety in their performance agreements and that they should receive regular feedback on their performance against these measures.

The Australian Commission on Safety and Quality and Health Care's *User Guide for Acute and Community Health Service Organisations that Provide Care for Children* ('User Guide') suggests mechanisms through which health services should adopt the Charter on the Rights of Children and Young People in Healthcare Services in Australia (discussed below), including:

- allocating responsibility for the implementation of the Charter to a senior individual or committee
- building the requirements of the Charter into the organisation's safety and quality systems, and processes of care for children

- displaying the Charter in areas within the organisation frequented by children, such as paediatric units or play areas
- providing accessible copies of the Charter in formats that meet community needs, especially for those with limited capacity to read and comprehend complex written text
- providing education about the Charter to new members of the workforce responsible for providing care for children
- using the Charter as the basis for discussions between clinicians and children about care planning and treatment
- using play-based techniques when appropriate
- adding specific questions relating to the Charter to consumer experience surveys.[114]

We consider some of these mechanisms could be used to support a commitment to child safety across health services. We also recommend that the Department have appropriate processes in place to ensure leaders have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation.

Recommendation 15.5

The Department of Health should make health leadership accountable for embedding child safety as a priority, including by:

a. ensuring that all relevant health leaders have an obligation to act consistently with the National Principles for Child Safe Organisations (reflected in Tasmania's Child and Youth Safe Standards) in their role descriptions and performance agreements, with compliance with this obligation to be reviewed annually

b. ensuring that the role descriptions and performance agreements of all staff providing services to children require them to protect child safety, with compliance with this obligation to be considered as part of annual performance reviews.

Recommendation 15.6

The Department of Health, to support health services become child safe organisations, should ensure:

a. child safety, including safety from abuse in health services, is overseen by the governance and leadership structures established through the cultural improvement program

b. child safety is built into the safety and quality systems of health services

c. staff responsible for providing care to children have the knowledge and skills to respond to child safety concerns in line with the expectations of a child safe organisation and relevant health service policies, including being equipped to identify and respond to indicators of child sexual abuse

d. staff act consistently with the National Principles for Child Safe Organisations (reflected in Tasmania's Child and Youth Safe Standards) when performing their work, including in discussions between health practitioners, health workers and children about care planning and treatment.

3.4 Empowering children, families and carers

Children's views about their health care are important and should inform health services' policies and practices. In this section, we consider the barriers that children and their families and carers may face in identifying inappropriate behaviour by health workers and in raising concerns with health services, particularly in a hospital setting. We also consider how children can and should influence health services' policies and practices more generally. We make recommendations that will help to:

- facilitate engagement with children about safe health care
- address concerns about children's perceptions of safety in hospitals, including by creating a safe physical environment
- ensure consistent information is provided to children and their families and carers about patient rights, what they can expect of staff, and ways to provide feedback.

3.4.1 Empowering children and young people through meaningful engagement and participation

Principle 2 of the National Principles states, in part, an expectation that organisations ensure children and young people participate in decisions affecting them.[115] In health services, this means that children and young people should have the opportunity

to inform decisions about their individual health care, and be consulted about the development, implementation and evaluation of health services' policies and strategies that are relevant to their care and safety.[116]

The Australian Commission on Safety and Quality in Health Care's User Guide states that health services can involve children and young people (as well as their families) in the development, implementation and evaluation of relevant policies and strategies through a governance structure that, among other things:

- effectively engages children and their families and carers
- has representation from children and their families and carers
- includes mechanisms to maximise engagement with children
- includes the views of children and their families when planning new facilities or redesigning existing ones.[117]

The National Standards also require health services to 'seek regular feedback from patients, carers and families about their experiences and outcomes of care' and to 'use this information to improve safety and quality systems'.[118]

At our hearings in September 2022, we asked Secretary Morgan-Wicks about how the voices and views of children were informing the Department's work. She indicated that the Department had engaged the Commissioner for Children and Young People and Child Wise, a child safeguarding consulting organisation, to provide expert advice on the best ways to ensure children's perspectives were reflected in the *Child Safety and Wellbeing Framework* and new policies and procedures.[119] In November 2022, Secretary Morgan-Wicks wrote to our Commission of Inquiry to tell us that the Department had worked with the Commissioner for Children and Young People to consult with children on a new name for the paediatric ward (previously known as Ward 4K) at Launceston General Hospital.[120] In a progress update provided to our Inquiry in February 2023, Secretary Morgan-Wicks wrote:

> The consultation process with children to engage them initially on child safeguarding themes is progressing and will also include consultation on renaming the children's wards across the State. The Department of Health will implement an ongoing engagement mechanism from the initial consultation process. Engagement with children will also feed into the development of child safe behaviours and further consideration of child-friendly complaint mechanisms.[121]

In June 2023, it was announced that paediatric wards across Tasmania's major hospitals will soon be known as the 'Wombat Ward', based on consultative processes with young Tasmanians aged 8 to 18 years through workshops at the Royal Hobart Hospital, Launceston General Hospital and the North West Regional Hospital in April 2023.[122] We were advised that these workshops also canvassed broader discussion of children's experiences of health services, including what was working well and what could be improved.[123]

We welcome this engagement, but consulting children and young people on the renaming of a hospital ward is a small step. While we are encouraged by some broader discussions about children and young people's experiences of health services, we would like to see the Department's engagement with children and young people continue to expand as reforms are further planned and implemented.

In December 2022, the Child Safe Governance Review reported that children and young people who are treated at Launceston General Hospital do not have a pathway for reporting concerns about their safety, other than raising these concerns 'in person' with a staff member.[124] The review made two recommendations relevant to this issue:

- the Department of Health [develops] an online form for children and young people to report concerns about their safety (in real time)[125]
- children and young people who are provided with health care within the Tasmanian Health Service be provided with the opportunity to complete a survey of their patient experience.[126]

Again, these steps are commendable. But we consider that the Department should go further to proactively empower children and young people to meaningfully participate in decision making on matters that affect them, including their safety. The Department could do this by setting up ways to engage with children and young people regularly and meaningfully.

The relationship between children and young people feeling heard and feeling safe was something identified through our commissioned research into safety in government run organisations.[127] Associate Professor Tim Moore, Deputy Director, Institute of Child Protection Studies, Australian Catholic University, who was one of the researchers we commissioned, told us:

> Children and young people want to play a part in their own protection and, in building alliances with adults to develop strategies to meet their safety needs, they can build confidence, awareness and an ability to turn to adults if they are being harmed … 'participatory' strategies need to empower individual children and young people through child-friendly and proactive means as well as through collective activities such as youth advisory groups.[128]

Liana Buchanan, Principal Commissioner, Commission for Children and Young People (Victoria), similarly stated that:

> Efforts to empower children in organisations are critical. An organisation can have perfect policies, processes and systems but if children do not feel that they will be listened to if they speak up, and that they will be believed and action taken, the policies and systems will be of little value.[129]

Victoria's Commission for Children and Young People has developed a guide for organisations working with children and young people.[130] The guide recognises that everyone benefits when children and young people's participation is done well,

outlining principles to support the meaningful participation of children and young people in decision making.[131] The Commission for Children and Young People's guide also includes specific advice for involving children and young people of different ages.[132]

The Office of the Advocate for Children and Young People in New South Wales has developed a comprehensive guide for setting up a children and young people's advisory group.[133] The purpose of such an advisory group is to facilitate the voices of children and young people on a range of issues relevant to service delivery.[134] An advisory group is a way to gather feedback, test ideas and ensure policies and practices best reflect the unique needs of children and young people.[135] Participation in an advisory group can build children and young people's trust and confidence in an organisation, improve the experience of children and young people within that organisation, and enhance the knowledge of an organisation's leaders about child safety.[136]

Establishing a dedicated health services young people's advisory group in Tasmania will help facilitate the contribution of young people in creating safer health services and will complement measures the Department is already implementing.

The types of issues that the health services young people's advisory group could contribute to, using developmentally appropriate methods, include:

- policies and practices that relate to providing health care to children and young people (for example, expected standards of staff behaviour, use of chaperones (or accompanying persons/observers) and processes for getting informed consent, or how to make a complaint)
- induction materials for staff in child-facing roles
- the design, interpretation and response to surveying children and young people cared for in Tasmanian health services recommended by the Child Safe Governance Review[137]
- initiatives to improve the experience of health care for groups with particular needs (for example, Aboriginal and other culturally diverse children, gender diverse young people and those with disability or mental illness, or those who identify as LGBTQIA+)
- analysing complaints data and advising on how to avoid future complaints
- implementing initiatives under the Child Safe Organisation Project
- built environment projects or upgrades to facilities that will affect younger patients
- contributing to recruitment processes for senior roles focused on child safety.

It is important that the health services young people's advisory group is adequately funded and that the role and functions of the group, including the scope of its authority, are clear from the outset. Without this support and role clarity, participants may feel the group is tokenistic or hollow, creating understandable cynicism and distrust that only serve to damage an organisation.

It would be beneficial for senior leaders within the Department and its agencies, as well as statutory role holders—such as the Health Complaints Commissioner, Ahpra, the National Boards and the Commissioner for Children and Young People—to regularly engage with the health services young people's advisory group. This engagement could include making themselves available for questions and discussion.

We acknowledge that setting up a health services young people's advisory group may mean that only a small number of children and young people are consulted. It is therefore important that the Department also pursues other strategies to engage children and young people of all ages. These strategies may include consultations, surveys, youth forums and events, staff communications and social media.[138] One strategy, for example, could involve extending the role of hospital-based child safeguarding officers to include engaging and empowering children and young people through regular visits to hospital wards and providing information to them in appropriate formats. It is imperative that the Department identifies age-appropriate ways to engage with all children and young people on questions of patient safety.[139] The health services young people's advisory group would be well placed to advise on these strategies.

Recommendation 15.7

1. The Department of Health should establish a health services young people's advisory group. The advisory group should:
    a. have a clear purpose and objectives
    b. be guided by clear terms of reference developed in consultation with children and young people
    c. comprise young people with significant lived experience of health services, including young people of different ages, from diverse backgrounds and with different care needs
    d. enable young people to contribute to decision making in a safe and meaningful way about issues that affect them
    e. allow young people to have a say in departmental strategies, policies, procedures and protocols that affect them
    f. be adequately funded and resourced.
2. Summaries of the health services young people's advisory group meetings should be prepared and distributed to all senior executive teams in the Department.

3. The Department should report on the activities of the health services young people's advisory group and on other engagement with children and young people through its annual report.
4. The Department should undertake other age-appropriate engagement with children to ensure as many children and young people as possible can take part in shaping health services.

3.4.2 Children and young people's perception of safety in hospitals

Our commissioned research showed that children often feel unsafe and disempowered during hospital stays. Some reported feeling unsafe because they were given little information about their treatment or because medical staff dismissed their opinions.[140] Associate Professor Moore said:

> Children continue to report that they feel disrespected, their needs and wishes disregarded and their ability to influence change as limited. While we see children as having less value to adults and their views and needs as secondary to those of adults, children are vulnerable.[141]

Speaking of their experience receiving care at a hospital, one young person explained how not being believed affects how safe and well young people feel:

> Socially, often, children aren't believed when they say something. Their opinions aren't valued as much because they're children, because they're young.
> A lack of life experience. I also think because I was unwell mentally, physically.
> But regardless, if I'm unwell, I should still be treated with compassionate decency.
> To treat somebody in that state in such [a] dehumanising and most humiliating way, it just makes you feel worse. It makes you not want to commit to getting better.
> I makes you feel like you're hopeless.[142]

This young person went on to describe how raising concerns did not resolve their negative situation at the hospital and left them feeling their issues were not taken seriously. They said that for children to feel safe in institutions like hospitals it is essential that they are believed and listened to.[143]

Some people, including children and young people, are not aware of their rights when receiving health care.[144] Angelique Knight, a former Ward 4K patient, told us: 'You are so vulnerable while you are in hospital because you are completely reliant on someone else doing everything for you'.[145] She said: 'Patients should be told about how they can make complaints. There could be signs up on the wall or a pamphlet could be placed in your hospital pack'.[146] This sense of disempowerment can also extend to parents and carers of child patients. For example, Angela (a pseudonym) described the challenge she faced when she raised concerns about vaginal cream being used for her young daughter, who has cerebral palsy and needs support to communicate.[147] Angela said she raised her concerns but felt staff dismissed them and that she was unaware of any action being taken.[148]

It can be difficult for children, families and carers to identify improper conduct when receiving health care or medical treatment. Some witnesses only came to understand the behaviour of Mr Griffin as inappropriate once they were adults. For example, Kirsty Neilly, another former Ward 4K patient, reflected on an incident where Mr Griffin had carried her from the ward shower back to her room, wrapped only in a towel: 'I now think that Jim carrying me from the shower like that is weird. I shouldn't have been so casual about it'.[149]

To further complicate matters, children and young people and their families and carers can sometimes understandably perceive inappropriate and unprofessional behaviours as the actions of dedicated and caring health workers. Kim (a pseudonym) told us that when she attended Launceston General Hospital with her daughter Paula (a pseudonym), Mr Griffin was a familiar face at a time she was feeling scared.[150] She described perceiving Mr Griffin's interest in her daughter and his 'touchy-feely' nature as him being friendly and caring.[151]

Sonja Leonard, former Nurse Unit Manager, Ward 4K, Launceston General Hospital, commented that children and parents often reacted positively to Mr Griffin's boundary breaches, such as hugging child patients, and that staff witnessing the behaviour 'did not respond negatively'.[152]

3.4.3 Rights when receiving health care

Health services have a critical role to play in promoting patients' rights, expected standards of staff behaviour and complaints pathways.

The National Standards Partnering with Consumers Standard requires that 'leaders of a health service organisation develop, implement and maintain systems to partner with consumers' in relation to 'the planning design, delivery, measurement and evaluation of care'.[153]

Under the National Standards, health services must adopt a charter of rights that is consistent with the *Australian Charter of Healthcare Rights* and ensure this local charter is accessible to patients, carers, families and other consumers.[154] The *Australian Charter of Healthcare Rights* describes what patients, families and carers should expect when receiving health care. It says that an individual has the right to:

- provide feedback or make a complaint without it affecting the way they are treated
- have concerns addressed in a transparent and timely way
- share their experience and take part in improving the quality of care and health services.[155]

The *Charter on the Rights of Children and Young People in Healthcare Services in Australia* also sets out 11 rights that 'aim to ensure that children and young people receive health care that is both appropriate and acceptable to them and to their families'.[156]

These include the rights of children and young people to:

- express their views, and to be heard and taken seriously
- participate in decision making and, as appropriate to their capabilities, to make decisions about their care
- be kept safe from all forms of harm.[157]

Secretary Morgan-Wicks told us that the information given to patients, including children and young people, varies across Tasmanian public health services.[158] Information is sometimes provided through the following publications:

- *Australian Charter of Health Care Rights*, including the consumer booklet *Understanding My Healthcare Rights* (published by the Australian Commission on Safety and Quality in Health Care)
- *Young People's Healthcare Rights* (published by Children's Healthcare Australasia)
- *The Rights of Every Child in Healthcare* (also published by Children's Healthcare Australasia).[159]

Secretary Morgan-Wicks also told us that the practices of different health services relevant to informing patients about their rights will align as part of the Department's ongoing reform work.[160]

In our view, the Department should ensure all health services provide consistent information to young patients and their families and carers about rights, safety and care. This information should be delivered in accessible and age-appropriate language and formats. Health workers should also receive professional development on these issues. Again, child safeguarding officers in Tasmania's four major public hospitals could help provide such information to health consumers and staff.

Recommendation 15.8

1. The Department of Health should ensure consistent information is provided to patients, including suitable age-appropriate resources for children and young people and their families and carers, across its health services. These resources should include information on:
    a. requirements and expectations of a child safe organisation
    b. patient rights when receiving health care, including the rights of children and young people

c. expected standards of behaviour for health service staff

d. processes for raising concerns and making complaints internally and externally

e. roles of health regulatory bodies in receiving complaints.

2. This information should be provided in formats that meet community needs, especially for those with less capacity to comprehend complex written text.

3.4.4 Creating a safe physical environment

The National Principles state an expectation that an organisation's physical environment must promote the safety and wellbeing of children and young people while minimising the opportunity for them to be harmed.[161] The National Standards require health services to maximise safety and quality of care for patients through the design of the health service's environment and by ensuring buildings, equipment, utilities, devices and other infrastructure are fit for purpose.[162]

In this section, we discuss physical factors that can affect the safety of children and young people in health services. We also summarise what we heard about recent efforts to improve the physical environment of Launceston General Hospital.

We make recommendations to ensure children and young people's sense of safety is monitored to inform improvements in the physical environment of health services, and that these safety considerations extend to the needs of children and young people with diverse needs and backgrounds (for example, those who are Aboriginal, come from culturally diverse backgrounds, have disability or mental illness or identify as LGBTQIA+).

3.4.5 Physical factors affecting the safety of children and young people

In our commissioned research into children's perceptions of safety, several young people said that they did not feel safe in hospitals because of their physical characteristics. These young people described:

- hospitals as 'creepy' and 'sterile'[163]
- their hospital room as dark and not having a window—'I didn't feel like I could flourish in an area like that'[164]
- feeling uncomfortable 'being in a room with strangers'[165]
- hospitals not being welcoming spaces for Aboriginal children and young people.[166]

Catherine Turnbull, Chief Child Protection Officer, SA Health, Department for Health and Wellbeing, told us about a range of physical factors that make children and young people vulnerable to abuse and harm in hospital settings. These include children and young people being kept in individual rooms that are not closely monitored by staff or CCTV, and health workers examining children and young people without a chaperone present (such as a parent, carer or other staff member).[167]

Others who shared their experiences made observations about the physical environment of Launceston General Hospital at the time of their admission and how they felt unsafe, isolated, out of view of others, or that staff could easily be alone with patients.[168]

This evidence illustrates why health services should not assume that the 'busyness' of a hospital ward, emergency department or other health service negates the risk of abuse of children and young people.

3.4.6 Efforts to improve physical safety at Launceston General Hospital

One of the Department's new Child Safety and Wellbeing Principles in its *Child Safety and Wellbeing Framework* focuses on providing safe health care environments (including physical and online environments), and ensuring health services that contract third-party providers have 'procurement policies that ensure the safety of children and young people'.[169]

Launceston General Hospital's paediatric ward has recently undergone an extensive redevelopment as part of broader upgrades to the hospital's Women's and Children's Services precinct.[170] This redevelopment was completed in November 2022.

Secretary Morgan-Wicks described the redevelopment as adding a 34-bed children's ward and a paediatric outpatient clinic incorporating allied health.[171] Secretary Morgan-Wicks also described that the new ward offers more single rooms with bathrooms, is divided into two age-appropriate pods for younger patients and adolescents, and meets Australian building standards.[172] Other features include a playroom, playground and outdoor courtyards.[173]

Secretary Morgan-Wicks said the redevelopment has resulted in 'improved observation of patients by staff' and provided 'room for an adult support person to stay with a child patient throughout the admission, promoting safety, advocacy and comfort for everyone'.[174] She said that in addition to providing 'a brand new, contemporary and safer layout', the redevelopment has also 'helped to trigger significant staff conversations in relation to brand new models of safer care in their new environment'.[175] Commissioner Benjamin visited the redeveloped paediatric ward on 14 March 2023.

We welcome these improvements and view them as a good start, but not an end point, for improving child safety.

The Department should seek feedback on how to ensure health spaces designed for children feel safe and welcoming. The Child Safe Governance Review recommended that children and young people be provided with the opportunity to complete a survey on their patient experience.[176] This survey should include questions about children and young people's perception of safety, including physical safety, in the hospital. Responses should inform ongoing monitoring, evaluation and improvements to the hospital's physical environment. Data obtained from this and other surveys such as the Patient Safety Culture Survey, Child Safe Organisation Survey and People Matter Survey may also inform improvements. We would like the Department to work to ensure the physical environments of all its health services are safe for children and young people. Again, the child safeguarding officers at each of Tasmania's four major public hospitals could play a role in this work.

We understand that the Department has embedded Aboriginal health liaison officers at its major hospitals. We have not, however, seen evidence of any work to ensure the paediatric ward, Launceston General Hospital or other Tasmanian health services are culturally safe spaces for Aboriginal children and young people.[177] In our view, the Department should actively consider actions in this regard.

The Department should work with relevant stakeholders to consider diverse and varied needs and backgrounds of children and young people using health services, including those who are Aboriginal, come from culturally diverse backgrounds, have disability or mental illness or identify as LGBTQIA+.

Recommendation 15.9

The Department of Health should require its health services to undertake regular and ongoing monitoring of children and young people's sense of safety in health services to inform continuous improvements to child safety, including in the safety of the physical environment.

Recommendation 15.10

The Department of Health should work with relevant stakeholders to consider the needs and backgrounds of children and young people using health services, including Aboriginal children, children from culturally diverse backgrounds, children with disability, children with mental illness and children who identify as LGBTQIA+. The Department should consult with Aboriginal communities on how it can provide culturally safe spaces for Aboriginal children across its health services.

3.5 Policies, procedures and protocols on child safety

Policies, procedures and protocols play a key role in supporting health services to reduce the risk of child sexual abuse and to appropriately respond to concerns when they arise. As our case studies in Chapter 14 show, informally assessing or responding to concerns about staff conduct with children and young people does not keep them safe. Well-drafted, targeted and up-to-date policies, procedures and protocols on child safety enable child safety to be embedded in practice and for any concerns to be quickly raised by staff and appropriately addressed by the health service.

In this section, we recommend a review and consolidation of the Department's existing policies to identify gaps in safeguarding children. Once consolidated and revised, these policies should be regularly reviewed so they reflect best practice and provide accurate, up-to-date information to staff, who rely on them to effectively perform their roles and fulfil their responsibilities. We also identify key policies in relation to child safety—such as those that explain external reporting obligations, professional conduct and chaperoning—that need revising or drafting and should be prioritised in the review of policies and procedures.

3.5.1 The importance of child safety policies

The National Principles recognise the importance of policies to safeguard children.[178] The Australian Commission on Safety and Quality in Health Care's User Guide provides that 'policies, procedures and protocols should include processes for identifying children at risk of harm from health care'.[179] The User Guide suggests several strategies to protect children's safety and privacy, including minimising non-essential exposure of children to people not authorised to provide their care, detailing requirements for mandatory reporting and balancing the promotion of children's rights to use electronic devices with the risks posed by these devices.[180]

3.5.2 Current policies and procedures

The Department has 'numerous' policies, procedures and protocols in place to reduce the risk of child sexual abuse.[181] These include those relating to pre-employment, clinical practice, behavioural standards, identifying child sexual abuse, consumer complaints, complaints and incident handling, external reporting, targeted supports, and records and information management.[182]

These policies, procedures and protocols are available to staff through the Department's Strategic Document Management System, which is accessible via the intranet.[183] Changes to key policies, procedures and protocols are communicated to staff through a communications platform called 'Reach', as well as through email, updated hardcopies and at staff meetings.[184]

Secretary Morgan-Wicks told us that staff are made aware of the location of policies, procedures and protocols when they start in their role. She said it was her expectation that managers would draw key policies, procedures and protocols to the attention of staff and encourage them to familiarise themselves with those that are relevant to their role.[185] Secretary Morgan-Wicks also stated that volunteers are expected to comply with departmental policies, procedures and protocols.[186]

We received some evidence that the technology used to access policies needed improvement. For example, Sue McBeath, Nursing and Midwifery Director, Women's, Adolescent and Children's Services, Tasmanian Health Service South, told us the intranet site used by staff relies on outdated technology, which contributes to 'confusion and delays' in accessing relevant information.[187]

Our examination of departmental policies, procedures and protocols revealed that many were past their review date or only applicable to particular regions, areas or services. Further, many focused primarily on the risk of familial abuse of children and young people, rather than the risk of child sexual abuse being perpetrated by a health worker. There did not appear to be any policies, procedures or protocols developed specifically in response to the National Royal Commission's recommendations.[188]

Launceston General Hospital used several overarching policies and information guides covering the care of children and young people including:

- *A Manual for Working with Vulnerable Children and Their Families*[189]
- *Child Safety Practice Framework*[190]
- *Reporting Concerns About the Safety and Wellbeing of Children and Young People*[191]
- *Charter on the Rights of Children and Young People in Healthcare Services in Australia*.[192]

Again, most of these resources focused on the risk of familial abuse of children and young people rather than the risk of child sexual abuse in health settings. The Child Safe Governance Review also noted that Launceston General Hospital had been inconsistent in implementing and following statewide policies and frameworks.[193]

Ms Turnbull told us that SA Health has developed several policies, guidelines and directives that specifically address the safeguarding of children and young people in the health system, including the *Child Safe Environments (Child Protection) Policy Directive* and the *Responding to Suspected or Alleged Offences Against a Child or Young Person Occurring at a SA Health Facility or Service Policy Guideline which are available online*.[194]

In contrast with the Tasmanian Department's policies, procedures and protocols discussed above, SA Health's policies are clearly targeted at preventing and responding to child safety concerns in a health service context.

3.5.3 Efforts to improve child safety policies

Secretary Morgan-Wicks told us that one of the Department's recent initiatives has been to review and align its policies, procedures and protocols.[195] She described this process as 'time-consuming' and requiring 'significant change management to align disparate regional practices into a consistent and statewide protocol that is accepted by all health professional and support staff groups'.[196] She also said that the COVID-19 pandemic had slowed progression of this initiative.[197]

One of the Department's Child Safety and Wellbeing Principles in its *Child Safety and Wellbeing Framework* is '[a]ccessible and inclusive child safety and wellbeing policies'.[198] The framework foreshadows the development of several policies, protocols and guidelines relating to child safety, including:

- a child safety and wellbeing policy
- a protocol for interacting safely with children and young people
- a policy for safeguarding children and young people
- a protocol for safeguarding children and young people.[199]

The *Child Safety and Wellbeing Framework* is accompanied by practice guidance titled *Recognising the Signs of Harm to Children and Young People* and practice guidance titled *Disclosures of Harm to Children and Young People*.[200]

3.5.4 Our observations

We agree that child safeguarding policies should apply to health services statewide.

We also agree that the Department's review of policies should include specific policies for safeguarding children in health services. We discuss specific policies below.

The Department should ensure it complies with the requirements set out in Action 1.7 of the National Standards when conducting its review of policies, including to:

- set out, review and maintain the currency and effectiveness of policies, procedures and protocols
- monitor and take action to improve adherence to policies, procedures and protocols
- review compliance with legislation, regulation and jurisdictional requirements.[201]

It is also our view that children and young people be involved in the development and testing of existing and new policies that affect them, through the health services young people's advisory group we recommend above and other empowerment and engagement strategies (refer to Recommendation 15.7).

We consider that the Department should make its child safety policies and guidelines publicly available on its website, so they are easily accessible to staff, patients, families and consumers. This will promote transparency, consistency and accountability in approaches to child safety across the Department and its services. It will also assist children, young people and their parents and carers to understand how to raise a concern, and what process to expect in response. We also consider there is a potential role for child safeguarding officers in ensuring children and young people and their families and carers are aware of these policies, what they say and where to find them.

Recommendation 15.11

1. The Department of Health should review and consolidate its policies, procedures and protocols. This review should prioritise identifying gaps in relation to safeguarding children and should inform the development and implementation of consistent statewide policies, procedures and protocols on child safety.
2. The Department's safeguarding policies should include implementing the National Principles for Child Safe Organisations and other recommended policy changes (namely, policies on reporting obligations, professional conduct and providing a chaperone (Recommendations 15.12, 15.13 and 15.14)).
3. The Department should undertake regular scheduled reviews of its policies, procedures and protocols for child safety to ensure they continue to reflect best practice and organisational changes.
4. The Department should publish its policies, procedures and protocols for child safety on its website to promote transparency and ensure accessibility to staff, patients and their families.

3.5.5 Mandatory and other reporting policies

Doctors, nurses, midwives and departmental employees and volunteers are all prescribed mandatory reporters under the Children, Young Persons and Their Families Act.[202] Mandatory reporters must report to Child Safety Services when 'in carrying out official duties or in the course of [their] work' they believe, or suspect 'on reasonable grounds' or know that 'a child has been or is being abused'.[203]

Employers and staff who are registered in a health profession under the National Law are also obliged to make mandatory notifications to Ahpra and the National Boards in circumstances including when they form a 'reasonable belief' that a health practitioner has engaged in sexual misconduct in connection with the practice of a health profession.[204]

In Chapter 14, we find that Launceston General Hospital had no clear system, procedures or process in place to report complaints about Mr Griffin to external agencies, such as Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme or Ahpra. Consequently, ward staff, nurse unit managers, senior management and members of the executive were not aware of their distinct roles and responsibilities for reporting. Many staff members were also not aware that they could independently make reports to external agencies on a mandatory or voluntary basis.

The *Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct* ('Complaints Protocol'), which came into effect in November 2020 and applies to all Tasmanian Health Service staff, sets out how staff should report complaints or concerns about colleagues.[205]

The Child Safe Governance Review recommended that the Complaints Protocol focus on practical guidance for staff in managing and responding to risks of child sexual abuse.[206] The Complaints Protocol states:

> In the case of reporting an offence complaint, this should be undertaken through the relevant Executive/Medico-Legal Advisor (South) through Human Resources. Mandatory reporting of a registered health professional, as represented by the organisation, must be sanctioned formally (in writing) and in accordance with line delegations.[207]

We have two concerns about this approach.

First, although it is reasonable—for the purpose of keeping management informed of concerns or to avoid multiple staff making a report about the same incident—that an organisation has a process in place for reporting child safety concerns through senior personnel, a staff member cannot be precluded from making a mandatory report themselves, and this should be made explicit in the Complaints Protocol. Put another way, there should be no suggestion in the Complaints Protocol that a staff member's reporting of a health worker must be authorised according to line delegations. Under the Children, Young Persons and Their Families Act, it is a defence to a charge of failing to make a mandatory report if a person can prove that they 'honestly and reasonably believed' another person had already made a report.[208] It is not a defence that they did not make the report because they were not given approval to do so by their manager or an executive at their organisation.

Second, a protocol that relies on senior personnel to make a mandatory report must be supported by a transparent reporting process against which senior personnel will be held accountable. It also requires that health service executive members be aware of their reporting obligations and requirements.

We heard evidence that some health service executive members at Launceston General Hospital were not aware of the Strong Families, Safe Kids Advice and Referral Line—the first point of contact for reporting child safety and wellbeing concerns, including making mandatory reports under the Children, Young Persons and Their Families Act.[209]

In our view, the Complaints Protocol should provide more guidance on external reporting obligations, including about voluntary pathways for reporting and support for staff.

Adjunct Professors Picone and Crawshaw advised us that, as of July 2023, a draft complaints management framework had been developed by the Department and has been subject to some initial consultation. This initial feedback is being incorporated before a broader round of consultation, which will involve consumer engagement.[210]

Recommendation 15.12

1. The Department of Health should ensure there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct, and that these are effectively communicated to staff. These policies must not require that reporting be formally authorised.
2. The Department's review of the *Tasmanian Health Service Protocol – Complaint or Concern about Health Professional Conduct* and associated documents should include:
    a. a description of external reporting requirements in relation to child safety, including voluntary reporting pathways, and reporting to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency
    b. guidance on when it is appropriate to acquit mandatory reporting obligations by reporting concerns to a superior (for example, to avoid multiple notifications). This should make clear that a person is always entitled to make a notification to an external agency if they wish to do so
    c. a list of internal contacts for staff who have questions about child safety concerns and their reporting obligations.

3.5.6 Developing and implementing a professional conduct policy

The National Royal Commission identified an increased risk of institutional child sexual abuse when expectations of conduct between children and staff are not clear or consistently enforced.[211] This clarity and consistency can be achieved by implementing a professional conduct policy for staff (including employees, volunteers, contractors and sub-contractors). The Australian Commission on Safety and Quality in Health Care's User Guide states that creating a 'code of conduct that establishes clear expectations for appropriate behaviour with children' is one strategy for building a child safe culture in health services.[212]

The National Royal Commission recommended that a code of conduct contain clear descriptions of acceptable and unacceptable behaviour towards children, articulate the process to be followed in response to breaches of the code, be signed and acknowledged by all staff, and be broadly publicised, including to children and their families.[213]

Neither the Department nor Launceston General Hospital appear to have had a professional conduct policy beyond the State Service Code of Conduct in place during the period under examination by our Commission of Inquiry.

We recommend that the Department develops and implements a professional conduct policy for staff including employees, volunteers, contractors and sub-contractors who have contact with children and young people. The policy should reflect the content recommended by the National Royal Commission and include information about what constitutes a boundary violation or grooming behaviour. The policy should give examples of behaviours that are inappropriate in clinical and a non-clinical contexts, such as being overly or unnecessarily familiar with children, making inappropriate comments to children, engaging with children through online social networks, and having inappropriate and unnecessary contact with children outside the professional relationship. The policy should also address the challenges of maintaining these expectations of staff when they live in small communities, and outline realistic ways in which these expectations can be met. The policy should also state that a breach of the professional conduct policy may amount to a breach of the State Service Code of Conduct and result in disciplinary action (refer to our discussion and recommendations in Chapter 20).

Given the diversity of staff working in the Department and across its services, the professional conduct policy may need to differentiate between general expectations relevant to all staff and expectations that are specific to particular staff—for example, clinical staff, some of whom will be registered health practitioners under the National Law. The latter are subject to other professional codes and guidelines developed by their respective National Boards.

Recommendation 15.13

1. The Department of Health, in developing a professional conduct policy (Recommendation 20.2), should ensure:
    a. there is a separate professional conduct policy for staff who have contact with children and young people in health services
    b. the professional conduct policy for health services, in addition to the matters set out in Recommendation 20.2
        i. specifies expectations outlined in other relevant Department of Health policies and procedures
        ii. refers to other professional obligations of registered health practitioners, including those developed by the Australian Health Practitioner Regulation Agency and the National Boards
        iii. reflects the specific risks that arise in health services, particularly the sometimes intimate and invasive nature of health services, and the significant trust and power afforded by patients and the broader community to those providing health services
    c. the professional conduct policy for health services spells out expected standards of behaviour for volunteers, contractors and sub-contractors
    d. the Department uses appropriate mechanisms to ensure compliance by volunteers, contractors and sub-contractors with the professional conduct policy for health services.
2. The professional conduct policy for health services should be reinforced through professional development requirements (Recommendation 15.15).

3.5.7 The importance of chaperone policies

Chaperone (or Accompanying persons/Observer) policies are designed to ensure children and young people have another person (be that a parent, guardian or another health practitioner) present when any intimate examinations are undertaken on them (for example, an unclothed examination).

Adjunct Professor Picone of the Australian Commission on Safety and Quality in Health Care emphasised the importance of chaperone policies in health services:

> Now, as far as clinical practice is concerned it is essential if you're doing intimate procedures, particularly on children, and also in my view older cognitively impaired people or people that may have an intellectual or some other disability, you must have two people there: that's the end of it.[214]

The *Tasmanian Health Service Statewide Chaperone Protocol for Intimate Examinations* ('Chaperone Protocol') (effective from September 2016) states that all patients 'must be offered the presence of a chaperone during any intimate examination and/or treatment', with 'consideration for higher risk patients', who include 'children and adolescents—in addition to the parents'.[215]

The Chaperone Protocol provides guidance on documenting the request for, and use of a chaperone, obtaining consent from the patient to the examination and the presence of a chaperone, the role of the chaperone, and sexual misconduct by a health practitioner in connection with their profession.[216]

We find in Chapter 14, Case study 2, relating to Dr Tim (a pseudonym) that Launceston General Hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after Zoe Duncan's May 2001 disclosure, and not waited until June 2002 to do so.[217] We heard evidence to suggest that staff at Launceston General Hospital are still not aware of the Chaperone Protocol.[218]

The Child Safe Governance Review observed that, apart from the Chaperone Protocol, there were no other policies, procedures or guidelines in the Department or Tasmanian Health Service covering the accompanying of children and young people (or other vulnerable people) when accessing health services.[219]

The Child Safe Governance Review recommended that the Chaperone Protocol be broadened to include all examinations (not just intimate examinations) of vulnerable or at-risk patients, including children and young people, and that the information pack the hospital provides to patients on admission be updated to include the offer of the presence of an extra staff member during examinations or episodes of care where no family member or carer can be present.[220]

In our view, children and young people, and other vulnerable patients, should be offered a chaperone for all examinations and treatments. The risk for abuse is not confined to examinations or treatments of an intimate nature.

Recommendation 15.14

The Department of Health's chaperone (or Accompanying Person/Observer) policy should be updated to require the presence of an extra staff member during examinations or episodes of care where no family member or carer can be present.

3.6 Professional development for health service staff

Many people (including employees, volunteers and contractors) who work with children and young people in health services are in a unique position to identify and respond to child safety concerns because they develop a rapport with children and young people as part of the care relationship. However, to run a child safe health service, staff must know how to recognise the indicators of child sexual abuse, respond to disclosures and comply with relevant reporting requirements. As Professor Mathews from the Queensland University of Technology School of Law told us:

> Education and training are the cornerstone of any effort by an institution to embed the capacity and skills to properly recognise child sexual abuse.[221]

Policies, procedures and protocols relating to child safety must be supported by comprehensive induction and ongoing professional development programs that equip staff to see the practices and behaviours of others through a child safety lens.[222] The National Principles (Principle 7) state the expectation that staff and volunteers are 'equipped with the knowledge, skills and awareness to keep children and young people safe through ongoing education and training'.[223]

This section summarises what we heard about professional development relevant to child safety in the Department and Launceston General Hospital, and how it should be improved. We recommend that the Department identifies minimum requirements for professional development on child safety for different levels of staff, including leadership.

3.6.1 Professional development at Launceston General Hospital

We observed a lack of awareness about the risks to child safety at Launceston General Hospital. This lack of awareness was apparent among paediatric ward staff, middle management, human resources staff and executives. Staff at the hospital did not have specific training on, or an understanding of, grooming behaviours and professional boundary breaches. They didn't know where to go with concerns or how to fulfil reporting requirements.

At our hearings, Eric Daniels, former Chief Executive, Hospitals North/North West, acknowledged a 'significant failure' to provide professional development to all staff (from frontline staff through to senior management), particularly for identifying grooming behaviours.[224] Mr Daniels told us that additional training has since been developed in relation to child safety.[225]

Secretary Morgan-Wicks told us that while there are mandatory training requirements for departmental staff, they are not specific to identifying, reporting or responding to child sexual abuse, or to trauma-informed practice.[226] Secretary Morgan-Wicks advised that staff training needs are assessed by managers and officials at the local level, and that the focus on child safety depends on the type of service provided.[227]

Michael Sherring, Clinical Nurse Educator, Women's and Children's Services, Department of Health provided the details of mandatory and voluntary training sessions organised for staff in Women's and Children's Services at Launceston General Hospital, including Ward 4K staff, during the period examined by our Commission of Inquiry. These sessions covered topics such as Child Safety Services, vulnerable children, the effects of child abuse, the child safety liaison officer role and trauma-informed care.[228]

Mr Sherring advised that orientation packs for new staff (including support and administrative staff) have always included information about child safety, mandatory reporting and professional boundaries.[229] However, we saw no evidence of any training or resources provided to staff specifically covering the risk of child sexual abuse perpetrated by a staff member at the hospital. Also of note is that the findings of the National Royal Commission did not prompt the hospital to provide any training to its staff on child sexual abuse in institutional settings.[230]

Other evidence confirmed that limited professional development on recognising and responding to child sexual abuse was provided to the staff, management and executive at Launceston General Hospital before the revelations of Mr Griffin's offending in 2019.[231]

We accept Mr Sherring's evidence that he arranged training for staff on professional boundaries, but we consider that training could be strengthened. Emily Shepherd, Branch Secretary, Australian Nursing and Midwifery Federation (Tasmanian Branch), met with Ward 4K members on 24 October 2019 after Mr Griffin's death.[232] In her statement to us, she wrote that 'members reported minimal, if any, education and training on mandatory reporting obligations or grooming behaviours'.[233]

Ms Shepherd said that it was clear to her that 'there was confusion, lack of clarity, and there was a myriad of different reporting systems'.[234] Ms Shepherd also observed that, beyond raising concerns with their nurse unit manager or nursing director, Ward 4K members were not clear on the processes for escalating their concerns.[235]

We recommend that the Department ensures there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct (refer to Recommendation 15.12).

However, policies alone are not enough—staff must also receive regular professional development that reinforces their reporting obligations and provides the opportunity to clarify these obligations.

3.6.2 Professional development for human resources staff

Human resources staff in health services have a central role in responding to complaints and concerns about staff and, by extension, in managing risks connected to child sexual abuse. They are often the first port of call for a staff member or manager who is unsure about how to respond to concerns or complaints about the behaviour of a colleague.

We were extremely concerned about the clear lack of understanding among human resources staff at Launceston General Hospital about child safety issues, including risks of child sexual abuse, grooming and professional boundary breaches perpetrated by staff members. Mathew Harvey, former Human Resources Consultant, Department of Health told us that, to the best of his knowledge, prior to the allegations concerning Mr Griffin becoming more broadly known in 2019, neither he nor anyone else in the human resources department had received any professional development in relation to identifying child sexual abuse or grooming behaviours.[236] This lack of training was confirmed by other human resources staff.[237]

It is our view that human resources staff must have sufficient knowledge to recognise potential risks to child safety and to provide advice and direction to staff on how to respond to and navigate these risks, as well as associated concerns such as staff animosity and disagreements that may arise when a complaint is made.

Knowledge relevant to child safety and abuse is particularly important when managers and staff have a close working, or even personal, relationship with the staff member against whom a complaint is made. This relationship, in the absence of a trained response to child safety risks, can compromise objectivity and create difficult dynamics in a workplace. To ensure accurate advice and appropriate referrals, it is critical that human resources staff understand child sexual abuse risks, know their reporting and notification requirements, and are familiar with all relevant hospital policies, procedures and protocols related to child safety.

3.6.3 Recent professional development on child safety

Secretary Morgan-Wicks acknowledged an absence of department-wide training in child safety.[238] However, we understand that since revelations about Mr Griffin's offending in 2019, some steps have been taken to improve professional development opportunities for staff on child safety matters. For example, following feedback from a staff member, Launceston General Hospital arranged education sessions for Ward 4K staff on abuser profiles, tactics and strategies with respect to grooming behaviour. An external organisation delivered this training in February and March 2020.[239] As far as we are aware, this was one-off training provided only to Ward 4K staff.

Secretary Morgan-Wicks told us that in May 2022, mandatory child safety training had also been developed as part of the Department's Child Safe Organisation Project.[240] We understand from the Child Safe Governance Review that this training is being delivered across the Department and Tasmanian Health Service.[241] Secretary Morgan-Wicks reported that key areas of focus for the training include the National Principles, indicators of abuse and grooming behaviours, mandatory reporting, and trauma-informed approaches to receiving reports or complaints about child safety.[242]

In a written update provided to our Commission of Inquiry in February 2023, Secretary Morgan-Wicks told us that the Australian Childhood Foundation's 'Foundations of Safeguarding Children and Young People' course was made available to departmental staff in November 2022.[243] Secretary Morgan-Wicks also reported that 'short online sessions' on mandatory reporting, professional boundaries, grooming and lodging child safeguarding concerns in the Safety Reporting and Learning System had been developed and would be available 'over coming months'.[244]

The Child Safe Governance Review made numerous recommendations for staff professional development across Launceston General Hospital and the Department. Key recommendations included that:

- a capability review be conducted for any necessary training and upskilling of statewide human resources staff[245]
- a full-time child safety liaison officer role and a dedicated child safe unit be established to support reporting and training in child safety at Launceston General Hospital and to provide expert advice to staff[246]
- the content and frequency of mandatory training for all Launceston General Hospital staff be reviewed as soon as possible to streamline, and ensure an optimum environment for, implementing mandatory child safety training.[247]

The Child Safe Governance Review's recommendations are consistent with a more general recommendation made by the co-chairs of the Community Recovery Initiative that all staff 'undergo training in their responsibility to prevent and report incidents of child sexual abuse and more generally in the principles and pillars of the Launceston General Hospital safety culture'.[248] The co-chairs of the Child Safe Governance Review advised us that, as of July 2023, more than 15,500 staff have undertaken mandatory child safety training.[249] We were told the Department is mindful that undertaking such training may be difficult for staff with their own personal experiences of abuse, which has contributed to the development of a confidential Safety Plan tool. This tool can be used by affected staff with their line manager to ensure they receive sufficient support to undertake their work duties safely.[250]

3.6.4 Improving professional development on child safety

The ability of staff to view the clinical practice of their colleagues through a child safety lens is a key part of ensuring child sexual abuse and inappropriate behaviours, including grooming and professional boundary violations, are identified and acted on early.

Many management and executive staff who made statements to our Commission of Inquiry said that professional development on child safety was a way to improve the health system's response to allegations of child sexual abuse and would help restore community confidence in Launceston General Hospital.[251] We consider that substantial

professional development is required across all levels of staff at Launceston General Hospital and the Department on a range of matters concerning child safety.

Professional development in relation to children and young people should be designed for all health workers, not just those who are specially trained to deliver health care to children.[252] It should also extend to a health service's executive and human resources personnel so they can understand the risks of abuse to children and young people, identify staff training needs to address these risks, and ensure managers are well supported to respond to and manage complaints about staff conduct.

However, over-reliance on professional development to address child safety concerns must be avoided. An ability to identify and respond effectively to child abuse must also be coupled with a preparedness to act.

The executive and senior managers who appeared at our hearings were well into long careers in the health sector. While employers have a responsibility to provide professional development opportunities to staff on a broad range of matters, including child safety, individuals also have a responsibility to be attuned to the types of risks that may arise within their workplace. This extends to applying good judgment and common sense to situations and to escalating concerns up the chain or to external agencies (as the case may be). This is particularly important in paediatric wards where frontline staff would more routinely be confronted with disclosures or evidence of child abuse that has taken place elsewhere, including the family home.

In our view, the work already underway by the Department and the implementation of the Child Safe Governance Review's recommendations are appropriate to address concerns about the lack of professional development on child safety and must be given time to succeed. We consider that child safeguarding officers at Tasmania's major public hospitals are well placed to help plan and deliver training to staff on child safety issues in health services.

We consider the professional development requirements for staff in relation to child safety should be subject to public reporting. This would be one way to assure the community that a particular standard of knowledge and capability has been reached across the workforce. Periodic evaluations also enable assessment of whether existing professional development requirements and opportunities continue to align with best practice and, importantly, whether the desired uplift in workforce capability has been achieved and maintained over time.

3.6.5 Enhancing leadership skills

Above we discuss the importance of leadership in establishing a child safe culture. Professor Loh, from St Vincent's Health Australia, described the importance of management training for health practitioners moving from clinical practice into senior executive roles. For doctors, this may be training through the Royal Australasian College

of Medical Administrators, and for nurses and other health practitioners, training through the Australasian College of Health Service Management.[253] In evidence during our hearings, Adjunct Professor Picone indicated that either an undergraduate or postgraduate degree in management was required, at a minimum.[254] Ms Turnbull, from SA Health, agreed, adding that those making the transition to management should also receive ongoing mentoring and supervision.[255]

Ms McBeath, who at one point held the role of Director of Nursing at Launceston General Hospital, told our Inquiry about the challenges some nursing staff face when transitioning from a clinical to a managerial or leadership role:

> 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.[256]

The Child Safe Governance Review considered the professional development needs of leaders, including managers. It noted that a key component of the Department's One Health Cultural Improvement Program is 'consistent and effective leadership and management development and training across the Department and Tasmanian Health Service'.[257] The Child Safe Governance Review noted that the Department was participating in a range of leadership and management development activities and developing two more management and leadership programs for staff, one with the University of Tasmania.[258]

The Child Safe Governance Review recommended that leadership and management training be prioritised for frontline and middle managers at Launceston General Hospital, and that the Department's leadership and management training 'retain a multi-disciplinary focus rather than a siloed approach involving different professional cohorts'.[259]

In a written update provided to our Commission of Inquiry in February 2023, Secretary Morgan-Wicks identified two professional development programs the Department is delivering: the Aspire Leadership Program and the Elevate Management Program.[260] She told us that the Aspire Leadership Program is a specialised program designed to 'identify and support our senior leaders' and was piloted with 18 participants from different health services and professional areas between August and December 2022.[261] A second cohort of 20 participants began the program in February 2023.[262] Secretary Morgan-Wicks stated that the Elevate Management Program is designed to develop management skills in staff across areas such as governance, risk, problem solving, communication, people management and project delivery and execution.[263]

In July 2023, we were advised by Adjunct Professors Picone and Crawshaw that the One Health Culture Elevate Management Development Program had commenced, which is specifically designed for the Department and is:

> … designed to upskill managers in the non-clinical aspects of their roles and focuses on development in the areas of planning, delegating, financial and people management, governance, performance management, communication and human resources.[264]

While we welcome the Department's recent efforts at improving the professional development of those in leadership roles, organisations such as Launceston General Hospital and the Department must have leaders and managers who are committed to prioritising children's and staff safety and wellbeing over the long term. In the context of our findings in Chapter 14, Case study 3, relating to James Griffin, leaders must have the capacity to effect organisational change, the curiosity to ask questions to understand problems, and an aptitude for developing and implementing reforms. Managers must also be supported to confidently perform their roles and responsibilities through appropriate professional development and ongoing supervision and mentoring. Because their roles and responsibilities include managing and responding to complaints about staff conduct and any associated conflict in an open and transparent way, their training must focus on helping them to discharge these responsibilities well. Ideally, staff applying for senior leadership and management roles in the Department and at Launceston General Hospital should have leadership and management qualifications or training at the time of appointment. At a minimum, the organisation should support them to undertake this training and obtain these qualifications when new to the role. New and emerging leaders, such as those being promoted from clinical practice into people management roles, should be provided with professional development to help them navigate this transition.

Professor Mathews commented on the need for external governance to be in place to ensure institutions and their leaders have a genuine commitment to child safety. Such governance may include requirements for leaders to hold certain qualifications or undertake professional development related to child sexual abuse, and for leaders to prove its workforce meets a standard of education.[265]

3.6.6 Our observations

In addition to the Department's recent professional development initiatives, we consider that the Department should monitor the effectiveness of these initiatives. Outcomes-based measures of effectiveness could include consumer and staff feedback on the knowledge and skills of staff and leadership, including through consumer and staff surveys.

Recommendation 15.15

1. The Department of Health should identify minimum requirements for professional development on child safety for different levels of staff, including staff, volunteers and contractors, as well as leadership. Professional development should cover, at a minimum:
    a. understanding child sexual abuse (including grooming and boundary breaches)
    b. the requirements and expectations of a child safe organisation
    c. mandatory and voluntary reporting obligations, including the role and function of Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency
    d. relevant child safeguarding policies and procedures.
2. The Department should have appropriate processes in place to ensure leaders have the knowledge, skills, aptitude and core capability requirements to effectively manage people and to lead a child safe organisation.
3. The Department should develop outcomes-based measures of the effectiveness of child safety professional development initiatives for all categories of staff, volunteers, and contractors, including management, leadership, human resources, and professional and non-professional staff.
4. These outcomes-based measures should be reviewed annually and the results used to inform further professional development initiatives and leadership selection.

4 Improving responses to child sexual abuse

The National Principles aim to prevent the likelihood of child sexual abuse occurring in institutions. However, the National Principles require that organisations have robust systems in place to respond to child safety concerns where they arise. Principle 6 states that processes to respond to complaints and concerns should be 'child focused'.[266] Robust complaints management and investigations systems are also requirements of the National Standards.[267]

The National Royal Commission noted that responses to complaints of child sexual abuse encompass a range of actions that institutions should take. These actions include:

- identifying complaints—child or adult survivors who report possible child sexual abuse should be taken seriously
- assessing risk—potential safety issues for victims and other parties should be identified and action taken to ensure their safety (including for the subject of the complaint where necessary)
- reporting—all relevant bodies and institutions should be informed of the complaint, including, for example, the police, the Registrar of the Registration to Work with Vulnerable People Scheme, the Strong Families, Safe Kids Advice and Referral Line and any relevant professional oversight body
- communicating and providing support—institutions may need to communicate with all affected parties and must assess the need for, and be able to provide, support for those involved, including complainants, parents, employees and other affected children
- investigating—this process should begin after a complaint is received and risk assessment completed; some actions, such as ensuring the integrity of a location as soon as possible after a complaint is received, can be crucial to an investigation
- maintaining records—institutions should maintain relevant records, including of investigation processes
- completing a root cause analysis—where required, institutions should review the circumstances of the complaint to identify possible systemic factors that may have contributed to the incident
- monitoring and reviewing—institutions must have policies and procedures to help continually improve the 'protection of children for whom the institution has responsibility'.[268]

The case studies in Chapter 14 show that Launceston General Hospital and the Department more broadly did not have a robust complaints management framework in place for responding to child safeguarding concerns. In Case study 3, we make findings that:

- Launceston General Hospital failed to manage the risks posed by James Griffin.
- Launceston General Hospital did not have a robust system for managing complaints involving child safety.
- Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin.
- Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies.

- The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct.

The case studies in Chapter 14 have also exposed a disciplinary system that is not tailored to addressing high-risk, sensitive complaints involving children's safety. In the health service context, we saw a highly conservative approach to initiating disciplinary proceedings.

In Chapter 6, we recommend that a Child-Related Incident Management Directorate be established. This directorate would support agencies to meet the requirements outlined by the National Royal Commission in relation to child safety concerns and complaints about staff conduct. The Directorate would also receive, assess, investigate, coordinate and oversee responses to allegations of child sexual abuse against staff. The Directorate's management of such misconduct matters, including procedures for an investigation and the recommendations made at the end of an investigation, would be controlled by the State Service's disciplinary system. We discuss the failings of the State Service disciplinary system extensively in Chapter 20.

In this section, we make recommendations to improve the Department's complaints and disciplinary processes in line with the directorate we recommend in Chapter 6.

4.1 Complaints

This section considers the systems and processes required to effectively respond to complaints in a health service and outlines the reforms currently underway to strengthen the complaints and disciplinary processes at Launceston General Hospital and across the Department. We discuss the specific problems we identified at Launceston General Hospital, so the Department and the hospital can focus on addressing these problems when implementing reforms. We recommend a series of principles to shape reforms to complaints processes.

4.1.1 Best practice approaches to complaints about child sexual abuse

It is important to use a consistent and transparent process in responding to all complaints about health workers. Complaints that may initially seem minor or trivial can hold vital information or reveal more concerning behaviour on further investigation. Complaints about professional boundary breaches, for example, often point to more serious misconduct.[269]

Complaints can also be an important sign that something is not working as intended in the health system and that clearer policies, changed practices or improved staff training and development are necessary. Professor Loh told us that research into doctors consistently shows that the more complaints that are made about a doctor, the more likely their patients will experience adverse clinical events and outcomes.[270]

In the context of child sexual abuse, complaints that a health worker is overly familiar with young patients, has made inappropriate comments in the presence of young patients or has contact with young patients outside the clinical setting, may indicate grooming, which is a serious precursor of other forms of child sexual abuse. We consider that the Department should adopt the widest possible interpretation of what defines a child safety complaint, and therefore what may or may not constitute child sexual abuse. Kathryn Fordyce, Chief Executive Officer, Laurel House, told us:

> Low reporting thresholds are important in protecting children from child sexual abuse. If minor issues are identified, corrected and dealt with constantly and consistently, this deters perpetrators of child sexual abuse from committing child sexual abuse because they are aware that the system will be able to identify them … If we reaffirm that reporting is for the purpose of protecting children from child sexual abuse rather than prosecuting offenders, the process will be more effective.[271]

Adjunct Professor Picone told us that an effective complaints management system is underpinned by health services encouraging all staff to bring concerns to management at the earliest opportunity.[272] She said that health services should record all incidents, including 'near-misses or complaints', which can act as a public health tool in providing 'intelligence' to inform system improvements.[273]

Adjunct Professor Picone also made clear that child sexual abuse complaints should be treated as 'extremely serious' and require a 'thorough' response from senior management.[274] She laid out the following best practice approach to child sexual abuse complaints:

- the matter is immediately escalated to the appropriate senior manager
- the senior manager immediately reports the matter to the police
- the senior manager takes an immediate administrative decision regarding the duties of the alleged offender, including whether they are to be suspended
- the senior manager initiates an open disclosure process with the victim and their family.[275]

Adjunct Professor Picone emphasised that it is not the role of senior management to determine whether an alleged abuser has engaged in child sexual abuse; rather, part of their role is to notify the police of the allegation as soon as possible.[276] We would add that a senior manager must act on the basis that the allegation is true, ensure the risks to child safety as a result of the allegation are addressed and gather organisational information on any previous conduct of concern relating to child safety or professional boundary breaches that might relevant to an investigation and/or assessment of child safety risks. They will also need to ensure all mandatory external reporting requirements are met and appropriate records made.[277]

4.1.2 Current complaints processes

Secretary Morgan-Wicks described the following key features of the Department's complaints system:

- Complaints about child sexual abuse in health settings can come through several channels including online enquiries, consumer feedback, public interest disclosures, referrals to human resources staff, reports made on the Department's Safety Reporting and Learning System, notifications of suspensions of registration to work with vulnerable people or other mandatory accreditation, self-disclosures, unions and media reports.[278]
- On admission, health services give patients, families and carers information about how to raise concerns or to make complaints.[279]
- Supports provided to parties involved in complaints about child sexual abuse are managed on a case-by-case basis, with consideration given to who the most appropriate person is to make contact with a complainant and the way to make contact (in person, by phone, by email or by letter).[280] Other supports offered to affected parties may include the Employee Assistance Program or referrals to external support services and providing a contact person at the Department.[281]

Secretary Morgan-Wicks conceded that the Department's complaints process departed from best practice in the following ways:

- The various avenues for receiving complaints mean that the approach to 'recording, reviewing, investigating and reporting is varied and uncoordinated'.[282]
- There is no consistent governance and oversight of complaints. The person responsible for the complaint depends on how the complaint is received.[283]
- Complaints can be referred to the area that is the subject of the complaint, creating potential conflicts of interest and concerns about confidentiality.[284]
- There is no 'regular, structured analysis, reporting and monitoring of complaints data' due to the disparate ways complaints are managed. This means information on 'trends and systemic issues' is not available to the governance committee to inform decision making.[285]

The evidence we received about how poorly Launceston General Hospital responded to complaints about health practitioners reinforces our view that all complaints about staff conduct towards children should be independently managed through a dedicated unit, such as a Health Services Child-Related Incident Management Directorate. Before outlining the desirable features of such a unit, we describe some reforms in relation to child safety complaints recently announced by the Department.

4.1.3 Efforts towards ensuring a stronger, safer child safety complaints system

In her statement of 22 June 2022, Secretary Morgan-Wicks advised us that she was establishing a complaints management oversight unit ('Statewide Complaints Oversight Unit') in the Office of the Secretary.[286] She said the unit will be responsible for recording and tracking the progress of complaints in a document management system, assessing complaints against previous complaints, and allocating the complaint to an appropriate business unit for action after identifying any potential conflicts of interest.[287] She said the unit will be supported by internal trauma-informed investigators to assist with employee misconduct matters.[288]

As noted above, in November 2020 a Complaints Protocol was introduced across the Tasmanian Health Service. The Complaints Protocol distinguishes between complaints that are 'minor' and able to be 'immediately resolved', and those considered 'serious'.[289]

Under the Complaints Protocol, complaints from consumers are considered more serious where they give rise to a possible legal claim, are a 'public relations risk', may require an external peer review or a root cause analysis investigation, or are subject to open disclosure.[290] In such instances, the relevant executive must be notified—in the case of Launceston General Hospital, this is the Executive Director of Medical Services.[291] Complaints about staff conduct are also considered serious if they give rise to potentially significant misconduct under the State Service Act.[292] The responsibility for deciding whether a matter is minor or serious sits with the relevant manager.[293] We are concerned that the focus of the Complaints Protocol is managing reputational risk and public perception, rather than the harm or risk of harm to patients. We recommend below that the Department's complaints policy prioritises risks of harm to children.

We understand that the Child Safety and Wellbeing Service has been established to receive and triage at least some child safety complaints. The new Child Safety and Wellbeing Service sits with the Deputy Secretary, Community, Mental Health and Wellbeing.[294] The Child Safe Governance Review reported that the Child Safety and Wellbeing Service would receive and triage all concerns and complaints about child safety and make determinations about referrals to other entities (including the Statewide Complaints Oversight Unit, Ahpra and the National Boards), departmental human resources, child safeguarding officers in hospitals, the Strong Families, Safe Kids Advice and Referral Line or the police.[295] We are uncertain about the proposed relationship between the Child Safety and Wellbeing Service and the Statewide Complaints Oversight Unit.

The Child Safe Governance Review also made a broad range of recommendations for managing complaints, the most relevant of which can be summarised as follows:

- The Statewide Complaints Oversight Unit should develop clear and consistent forms, policies and practices for complaints, and the Tasmanian Health Service should review its complaints management framework.[296]

- The Department's Safety Reporting and Learning System should be the single point for recording complaints and concerns.[297]
- There should be increased monitoring, auditing and public reporting of incidents logged in the Safety Reporting and Learning System.[298]
- The Complaints Protocol (described above) should be reframed to include a focus on providing practical guidance in responding to concerns about staff, and a concise document summarising patient safety reporting obligations based on the different categories of staff should be developed.[299]

The Secretary has accepted these recommendations.

Secretary Morgan-Wicks gave evidence that she is establishing an independent statewide Child Safety and Wellbeing Panel. The purpose of the panel will be to oversee the monitoring and investigation of child safeguarding concerns in the Department. The Child Safety and Wellbeing Panel will comprise experts in child safeguarding and health systems.[300] Its specific functions will include:

- reviewing and assessing all serious child safeguarding events referred by the Secretary (including completing a root cause analysis)
- conducting research and providing advice or evaluations on evidence-based approaches to safeguarding
- advising on improvements based on lessons from serious safeguarding incidents.[301]

The Department has since appointed several individuals to serve on the Child Safety and Wellbeing Panel, including two consumer representatives.[302]

4.1.4 Principles to guide the implementation of reforms

Our evidence pointed to specific weaknesses and shortcomings in complaints handling in the Tasmanian health system. From this we have developed principles that we consider should drive reforms to the Department's complaints management system. This is in addition to the need we identify above that the complaints process should have clear escalation processes, internal and external reporting requirements within specific timeframes, and address immediate risks to children's safety. These principles are that:

- Complaints processes should be well understood, trusted and accessible to staff, patients and others.
- There should be appropriate scrutiny and oversight of how complaints about child safety are escalated to senior staff, managed and recorded.
- Complaints about child safety should be recorded comprehensively and stored securely in incident management (Safety Reporting and Learning System) and human resources systems.

- Complaints about unprofessional conduct and boundary violations with child patients should be recognised as a patient safety issue and treated as serious.
- Complaints data should support decision making and inform system improvements.
- There should be appropriate communication and supports provided to those making complaints or affected by the alleged conduct, including through open disclosure processes.

Except for appropriate communication and supports (which we discuss below), we discuss each of these principles, and the evidence that gave rise to them, in turn.

4.1.5 Complaints processes should be well understood, trusted and accessible

Our case studies in Chapter 14 reveal shortcomings in Launceston General Hospital's complaints management processes. Chapter 14, Case study 3, relating to James Griffin most clearly illustrates the lack of clarity and inconsistency in managing complaints, which were received, recorded and responded to in a variety of ways and with no clear process. This was, in large part, because of:

- a failure to recognise boundary violations towards child patients as a potential child safety concern
- the absence of clear, organisation-wide directives on how child safety concerns should be managed
- the significant discretion given to staff in responding to complaints of this nature.

We heard that line managers were often the first port of call for any child safety complaints, with the occasional involvement of the human resources team.[303] Ms Shepherd, from the Australian Nursing and Midwifery Federation, told us that the Tasmanian health system is hierarchical and therefore staff are likely to report any concerns to a manager or senior staff member.[304] Secretary Morgan-Wicks made a similar observation, noting a tendency for health workers to report suspected misconduct by another health worker to a direct line manager such as a nurse unit manager.[305]

The absence of a transparent and user-friendly complaints process also meant that patients were not supported and empowered to report concerns. Chapter 14, Case study 3, relating to James Griffin outlined that attempts made by Ward 4K patients to raise concerns about Mr Griffin's conduct were often dismissed or downplayed by senior and frontline staff. We also heard that patients were not aware they could report a concern to external agencies.

It is vital that any complaints framework is clear, simple to use, consistently applied, accessible and transparent.

4.1.6 Internal and external scrutiny and oversight

The absence of a transparent and consistent complaints framework at Launceston General Hospital meant that line managers, some of whom were relatively junior in the overall hospital hierarchy, carried significant responsibilities for assessing and resolving serious complaints. Most of the complaints made about Mr Griffin were reported to his nurse unit manager at the time, who sometimes (but not always) sought advice and assistance from human resources staff. We heard that the human resources team may or may not be notified, depending on the nature of the complaint and how it was made.

Very few complaints filtered up to senior nursing management. This reflects the significant power and responsibility placed on local managers to designate a matter as 'minor' and manage it informally. Perverse incentives may motivate managers to resolve complaints informally; for example, they may be worried about how such complaints reflect on their own performance. The lack of formality in responding to complaints creates many problems.

As we saw across our case studies, an informal approach to complaints management contributed to failures or delays in notifying or involving external agencies such as the Registrar of the Registration to Work with Vulnerable People Scheme, Child Safety Services, Tasmania Police and professional regulators. The involvement of these agencies would likely have made the risks posed by particular staff more apparent and empowered agencies to take protective measures. External oversight by these agencies would have also facilitated some scrutiny of the hospital's response.

Line managers should not be unilaterally responsible for determining complaints connected to child safety. Information about 'minor' complaints, as defined in the Complaints Protocol, should also not be held exclusively by line managers in file notes or diary entries. There should be one system for capturing all complaints, no matter how minor.

4.1.7 Recording and storing information about complaints

The purpose of the Safety Reporting and Learning System is to record reports of all safety concerns in clinical settings, including any complaints of child sexual abuse.[306]

Nursing staff and managers who gave evidence to our Commission of Inquiry seemed to believe that the Safety Reporting and Learning System was primarily for recording clinical events (for example, medication errors), rather than concerns about staff conduct towards a patient.[307]

Human resources staff also gave evidence to our Inquiry that the Safety Reporting and Learning System was not designed to capture child safety concerns, which were instead addressed through local managers.[308] Mr Harvey noted that human resources staff never see most reports in this system.[309]

Adjunct Professor Picone told us that although systems such as the Safety Reporting and Learning System are more frequently used to record clinical incidents, they should also be used to record non-clinical incidents—for example, complaints about abuse or suspected abuse.[310]

At our hearings, Adjunct Professor Picone confirmed that she had examined the Department's Safety Reporting and Learning System and that, while records can be altered, and frequently are altered from what is first recorded, there is a clear record of such alterations, and the original entry is not destroyed.[311] Adjunct Professor Picone described the system as 'probably the best in the country' in this regard.[312]

Ms Turnbull, from SA Health, told us there is often confusion about what is a human resources issue and what is a clinical issue, and that it is important that staff understand that a complaint about child safety must be recorded in a hospital's incident management system and its human resources system.[313] Ms Turnbull indicated that in South Australia, which uses the same incident management system as Tasmania (but called the Safety Learning System), there is a specific notification section that deals with child sexual abuse complaints.[314]

We understand that a new Child Safety Module has been specifically developed to 'facilitate the reporting of child safety incidents and issues' in Tasmania's Safety Reporting and Learning System. This new model is supported by training and 'how to' guides for staff.[315] Complaints made under this module are sent directly to the Child Safety and Wellbeing Service to be risk assessed and referred for follow-up and ongoing management with appropriate respect for confidentiality.[316] Individuals who made the relevant report are advised of the actions taken, and outcomes of the safeguarding concern.[317] Adjunct Professors Picone and Crawshaw advised us in July 2023 that while the module was relatively new, reporting to date has been stronger in the Northern region of Tasmania compared to other areas, and that the Child Safety and Wellbeing Service would continue to promote awareness and reporting across the State.[318] A new complaints reporting dashboard has also been created, which is consistent across all three Tasmanian regions.[319]

We consider that in addition to recording concerns or complaints about child safety in the Safety Reporting and Learning System, complaints involving staff should also be recorded in a health service's human resources system to ensure they are accessible to those who require such information to inform decision making about staff management, including disciplinary action.

4.1.8 Recognising complaints about child sexual abuse as a patient safety issue

Launceston General Hospital's Quality and Patient Safety Unit is dedicated to managing and resolving complaints.[320] Despite the central role that the Quality and Patient Safety Unit apparently holds in managing complaints, we received little evidence that those making or responding to complaints about child safety concerns dealt directly with this unit.

Dr Peter Renshaw, former Executive Director of Medical Services, Launceston General Hospital, described the Quality and Patient Safety Unit (and its various iterations over the years) as being the area that records 'complaints or grievances made by either staff, patients or family members of patients at the LGH'.[321] He described the unit allocating complaints and clinical incidents to a senior clinician or manager in the affected area, who would oversee an investigation and determine the appropriate response.[322] He said that the Quality and Patient Safety Unit was responsible for ensuring that a response to the complaint was provided within 28 days and 'evaluated the quality of the complaint responses through audit of complainant experience'.[323]

A former nurse within the Quality and Patient Safety Unit at Launceston General Hospital told us that the service coordinates patient safety programs, quality improvement, and risk and incident management.[324] The nurse said that the Quality and Patient Safety Unit is not directly tasked with investigations into staff performance or other human resources matters but that these issues are sometimes uncovered in the unit's reviews of patient safety events, and are then referred to the relevant manager or director, or to the human resources department.[325]

The nurse told us that the Quality and Patient Safety Unit held safety event meetings attended by relevant staff from the unit and by the Executive Director of Medical Services (who, until recently, was Dr Renshaw).[326] The purpose of these meetings was to review serious incidents and discuss investigation processes and improvement opportunities.[327] Following the public release of *The Nurse* podcast, the matter of Mr Griffin was apparently discussed at a serious safety event meeting.[328] The Quality and Patient Safety Unit also sought advice from Dr Renshaw on how to respond when queries from concerned families related to Mr Griffin were raised with the hospital.[329]

Other than this meeting, the Quality and Patient Safety Unit does not appear to have been involved in any of the complaints about Mr Griffin. Again, this suggests that child safety governance arrangements at the hospital have primarily focused on clinical risks, with risks to child safety posed by staff boundary breaches considered a matter for the human resources team. It is important that organisational and governance arrangements in health services recognise that the risk a staff member poses to the safety of children is a serious patient safety issue and not simply a staffing problem to be managed locally.

4.1.9 Complaints data should support decision making and inform system improvements

One of the main problems we noted across all our case studies was that complaints about child sexual abuse or boundary breaches tended to be considered as isolated incidents and did not prompt reviews of child safeguarding systems more broadly. Rarely were complaints routinely escalated to the Secretary to contemplate disciplinary action. This represents many missed opportunities to learn from mistakes and to work to prevent future misconduct.

As previous reviews have revealed, there is a defensive culture within the Tasmanian Health Service. Richard Connock, Health Complaints Commissioner, described how he had 'encountered a somewhat protective and adversarial attitude' within the Tasmanian Health Service in responding to complaints, and had 'routinely encouraged the [Tasmanian Health Service] to be more open with complainants'.[330]

Mr Connock told us that complaints can take an extremely long time to arrive at his office and often seemed to be 'waylaid in the "legal department" for long periods'.[331] We agree with Mr Connock that the Department could do more to recognise the value of complaints across the organisation and, in doing so, apply principles promoting open disclosure by admitting mistakes and identifying opportunities to implement improvements.[332]

While the Department has started work to improve its complaints management processes for child safety concerns, there is not a clearly defined and publicised pathway for escalating, managing and investigating complaints across the Department and within its health services. The governance and review arrangements underpinning such complaints processes are also unclear. We acknowledge that this work is underway, but we consider that the Department must ultimately clarify the complaints pathway along with the roles and responsibilities of the various bodies involved in responses to child safety concerns. We consider that this information could be conveyed through an information diagram showing the complaint escalation, management and investigation pathways for child safety issues in the Department and associated governance and review arrangements. The diagram should be included in the complaints escalation, management and investigation policy that we recommend below, and be made available to health service users and the public.

Recommendation 15.16

1. The Department of Health should have a specific policy on responding to complaints and concerns about staff conduct. The policy should establish a complaints escalation, management and investigation process that is informed by the following principles:
    a. Complaints processes should be well-understood, trusted and accessible to staff, patients and others.
    b. Complaints processes should have clear escalation processes, internal and external reporting requirements within specific timeframes, and address immediate risks to children's safety.
    c. There should be appropriate scrutiny and oversight of how complaints about child safety are escalated to senior staff, managed and recorded.

d. Complaints about child safety should be recorded comprehensively and stored securely in incident management (such as the Safety Reporting and Learning System) and human resources systems.

e. Complaints about unprofessional conduct and boundary breaches with child patients should be recognised as indicating a patient safety issue and treated as serious.

f. Complaints data should support decision making and inform system improvements.

g. There should be appropriate communication and supports provided to those making complaints or affected by the alleged conduct, including through open disclosure processes (Recommendation 15.18).

2. The policy should include a diagram showing the complaints escalation, management and investigation pathways for child safety concerns and associated governance and review arrangements. It should also outline the roles and responsibilities of the various bodies involved in responding to child safety concerns.

3. This policy and diagram should be available to health service users and the public.

4.2 Staff disciplinary processes

Despite being one of the largest public sector agencies, the number of preliminary assessments and Employment Direction No. 5—Breach of Code of Conduct investigations conducted by the Department of Health between 2000 and February 2023 were the lowest across all three child-facing agencies we examined.[333] We describe the data we received from the Department relating to disciplinary processes taken against its staff in greater detail in Appendix H.

In this section, we discuss disciplinary processes and make recommendations for a reformed disciplinary process for child safety concerns and staff behaviour towards children, managed by a Health Services Child-Related Incident Management Directorate. This is consistent with recommendations we make for a new Child-Related Incident Management Directorate in Chapter 6.

4.2.1 Receiving complaints and concerns about child safety and staff conduct

Irrespective of where a complaint or concern about child safety is raised, it should be reported to a central body, which should be staffed by people with child safeguarding

expertise who can assess and triage complaints and concerns. We consider this function should be rolled into the Health Services Child-Related Incident Management Directorate we recommend below. We have been told the intention is for the Child Safety and Wellbeing Service to 'work closely' with the Statewide Complaints Oversight Unit.[334]

4.2.2 Incident Management Directorate

In Chapter 6 on our recommendations for the way forward for children in schools, we describe the findings of the 2014 South Australian *Report of the Independent Education Inquiry* led by the Honourable Bruce Debelle AO KC (and often referred to as 'the Debelle Report'). The South Australian Government commissioned this Inquiry in response to the handling of an incident of child sexual abuse at a local school.[335] While this report was prepared with education settings in mind, it provides useful guidance to all organisations on how to respond effectively to complaints and incidents of child sexual abuse, including health services.

As part of implementing the Debelle Report, investigations into child sexual abuse in South Australian schools are now managed by a specialised Incident Management Directorate.[336] The South Australian Education Department has published guidelines that outline in some detail the steps to take after receiving a complaint of sexual misconduct against a staff member.[337] There is also a clear procedure for public disclosure processes when a staff member has been charged with child sexual abuse offences.

The Department should draw on insight from the Debelle Report when establishing the Health Services Child-Related Incident Management Directorate and associated policies on mandatory and voluntary reporting obligations, open disclosure processes and a critical incident response plan (refer to Recommendations 15.12, 15.18 and 15.19).

We recognise that there may be features of the health service environment that call for a tailored approach in responding to and investigating complaints. An understanding of the health care context (and sometimes specialised clinical knowledge) may be required to consider and investigate complaints of child sexual abuse effectively, particularly where conduct occurs under the guise of a medical procedure or nursing care. For this reason, we do not specifically recommend that complaints about grooming, child sexual abuse and other related harms to children in health services be considered by the Child-Related Incident Management Directorate that we recommend be set up in Chapter 6. Rather, we consider the Tasmanian Government should consider the most appropriate model for managing complaints of this nature against health workers. This could occur by the Tasmanian Government electing to partner with the Child-Related Incident Management Directorate and ensuring the Directorate has access to specialist skills and knowledge relating to complaints in a health services context when required. Alternatively, the Tasmanian Government may decide a separate Health Services Child-Related Incident Management Directorate is needed. If this is the case,

it should be structured and operate consistently with the approach we recommend for the Child-Related Incident Management Directorate, including having three arms of responsibility—for incident report management (including complaints and case management), investigations, and misconduct and disciplinary advice respectively. We briefly summarise these functions below, but further detail can be found in Chapter 6.

We recommend an incident report management arm, which would assess and triage the complaint or concern and determine how it should be managed, including whether a formal investigation is necessary. Any conflicts of interest that may arise in this process should be promptly identified, documented and dealt with. This arm of the Directorate should also:

- ensure compliance with the policy on responding to concerns and complaints about child safety issues and staff conduct
- ensure staff have made appropriate notifications to agencies including Ahpra and the National Boards, Tasmania Police, Child Safety Services and the Registrar of the Registration to Work with Vulnerable People Scheme and the Independent Regulator of the Reportable Conduct Scheme, and act as liaison for these agencies regarding the complaint (such liaison must include seeking confirmation with agencies about whether and when the Department can initiate an investigation without compromising parallel criminal or regulatory investigations)
- ensure other agencies involved in a complaint about staff behaviour towards children (such as the new Commission for Children and Young People, the Health Complaints Commissioner or the Integrity Commission) receive any information they need to acquit their functions
- provide support and guidance, including through fit-for-purpose case management, to the relevant health service about: how any potential risks to patients can be managed while a complaint or concern is investigated; what information should be provided to different audiences (staff, patients and their families and the community) and when; ensuring affected children and young people (and their families and carers) are updated on the status of any complaint, receive appropriate support and can continue to safely receive the health care they need
- ensure all records about the complaint (and the staff member) are comprehensive, accurate and stored in incident management (such as the Safety Reporting and Learning System) and human resources systems.

Rather than human resources staff, the investigations arm of the Directorate should conduct or oversee investigations where sexual misconduct and professional boundary breaches related to children are alleged. Although the human resources team will not have a role in managing and investigating such matters, as noted above, we consider that human resources staff should be familiar with child safety policies so they can

ensure any child safety concerns are appropriately responded to and referred when they arise.

Investigations of complaints should be undertaken by independent investigators who are trained and skilled in child development, child sexual abuse and trauma-related behaviours, and in interviewing vulnerable witnesses. Wherever possible, investigators should have knowledge and experience of the health services context.

Investigations should include the following processes:

- Complainants, their families and key witnesses should be invited to provide evidence or information if they choose to do so. If a decision is made to not contact a complainant or key witness, this should be explained and justified to the decision-maker (Head of Agency).
- Investigators should have access to the specialised and independent clinical knowledge or expert opinion required if a staff member argues that the behaviour subject to a complaint was legitimate clinical care.
- Once started, investigations should be undertaken promptly, and a clear and evidence-based report provided to legally trained adjudicators, who should then make recommendations to the relevant decision-maker (Head of Agency).

We consider some form of investigation should occur even if a staff member leaves the State Service. This investigation would need to determine the full extent of any possible open disclosure or mandatory reporting obligations and identify any necessary system improvements.

The misconduct and disciplinary advice arm should comprise staff who are trained to weigh evidence and assess compliance with procedural fairness requirements. Where a breach of the professional conduct policy, the State Service Code of Conduct or another associated departmental policy is found, this should be outlined in an investigation report provided to the Head of Agency, alongside any advice and recommendations.

Recommendation 15.17

1. The Department of Health should establish a separate Health Services Child-Related Incident Management Directorate or partner with the Child-Related Incident Management Directorate (Recommendation 6.6) to respond to allegations of child sexual abuse and related conduct by staff, breaches of the State Service Code of Conduct and professional conduct policies, and reportable conduct (as defined by the *Child and Youth Safe Organisations Act 2023*) in health services.

2. If the Department partners with the Child-Related Incident Management Directorate, it should ensure the directorate has access to specialised advice to inform investigations against health services staff, particularly where allegations have arisen in the context of provision of health care.
3. If the Department establishes a new Health Services Child-Related Incident Management Directorate, it should mirror the functions and manner of operation reflected in the Child-Related Incident Management Directorate, including having three distinct roles and skill sets covering incident response management, investigations, and misconduct and disciplinary advice.

4.3 Communicating with and supporting victim-survivors

A key element of an organisation's response to child sexual abuse is communicating with and supporting victim-survivors, their families and carers, and others affected by the abuse.

4.3.1 An effective open disclosure process

Under the National Standards, health services must implement a framework of open disclosure with patients, family members and carers in relation to critical incidents that occur in their health service and result in harm to a patient.[338]

An open disclosure process involves an honest discussion with a patient or carer 'about an incident that resulted in harm to the patient while receiving health care'.[339]

Adjunct Professor Picone told us that the key elements of an open disclosure process are:

a. an apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'
b. a factual explanation of what happened
c. an opportunity for the patient, their family and carers to relay their experience
d. a discussion of the potential consequences of the adverse event
e. an explanation of the steps being taken to manage the event and prevent recurrence.[340]

Adjunct Professor Picone also told us that the principles of open disclosure can be applied at the broader community level. In such circumstances, the principles are:

a. being open and honest about the fact that an incident has occurred
b. admitting fault for the error or set of circumstances as appropriate
c. making a very genuine apology to the affected persons and community

d. identifying what has been learnt from the error

e. advising the community about what is being done or will be done to address the problem

f. demonstrating to the community that the organisation is following through with its promises.[341]

We discuss how open disclosure can be applied at the community level in more detail below (refer to Section 5).

Adjunct Professor Picone said a health service cannot promise an incident will never happen again, but the community needs to see that it is working to resolve issues and is taking steps to prevent recurrence.[342]

The Debelle Report discussed the concept of 'responsible disclosure' for schools managing child sexual abuse allegations. It described responsible disclosure as providing factual information, at an appropriate time, to the various people who have been or may be affected by an event.[343] It notes that providing information after a critical incident or other crisis helps parents (in particular) to maintain their confidence in the institution. Such confidence can be 'greatly undermined' if important information is instead learned through the media.[344]

There was little evidence that the response of Launceston General Hospital to victim-survivors or potential victim-survivors of Mr Griffin's abuse followed best practice. Conversely, there was much evidence that the hospital attempted to manage the revelations of Mr Griffin's offending by restricting communication and the information provided to victim-survivors, former patients, and their families and carers.

Many of the elements of open disclosure (listed above) were missing from Launceston General Hospital's response to the community in 2019, 2020 and thereafter. It was only at our hearings that Mr Daniels, former Chief Executive of Hospitals North/North West, showed some empathy and understanding for the scale of suffering that had occurred at the hospital.[345]

Secretary Morgan-Wicks issued a public apology to victim-survivors, validating a widespread feeling that the Department and Launceston General Hospital had not reckoned with the scale of suffering:

> I am personally horrified by the lack of empathy, humanity and often a lack of trauma-informed approach by the Department and the Tasmanian Health Service to such devastating accounts of abuse from the victim-survivors who have shown immense courage to come forward.[346]

We consider that supports such as counselling should always be offered to patients and their families and carers as part of the open disclosure process.[347] People looking for support should be personally assisted to access this support rather than just provided

with information about how to seek support themselves (that is, they should be provided with a warm referral to a service).

Recommendation 15.18

The Department of Health should ensure open disclosure processes for patients who experience child sexual abuse in health services and their families and carers that:

a. create a safe, trauma-informed pathway for victim-survivors, or others affected by an event, to receive clear and personalised information in response to their questions or concerns

b. facilitate appropriate notifications including to Tasmania Police, Child Safety Services, the Registrar of the Registration to Work with Vulnerable People Scheme, the Independent Regulator under the *Child and Youth Safe Organisations Act 2023* and the Australian Health Practitioner Regulation Agency

c. make appropriate supports available to affected people, including victim-survivors, their immediate family and carers, where abuse is connected to the Department's health services, including warm referrals, with the person's consent, to trained and experienced child sexual abuse counsellors.

4.4 Developing and implementing a critical incident response plan

Child sexual abuse in an institution can trigger a trauma event felt by many.[348] The implications of this are discussed in Section 5. The sexual abuse of a child in a health service, particularly by a staff member who has worked in the service for a long time, can also be described as a critical incident for the purposes of workplace policies, procedures and protocols.

It is not uncommon for institutions to be unprepared and unsure about what to do when a critical incident occurs in the workplace.[349] Dr Kate Brady, Research Fellow, Community Resilience, Melbourne School of Population and Global Health, University of Melbourne, told us that those tasked with managing recovery following a critical incident may not be trained in crisis management and often do not have the skill set required to respond appropriately.[350] Dr Peter Rob Gordon OAM, a clinical psychologist specialising in trauma, emergencies and disasters, explained that a disturbing, tense and threatening event will place a person in a state of 'high arousal'.[351] When those responding to a critical incident enter a 'high arousal state' it can limit their ability to look at what has occurred systematically and morally, resulting in poor decision making.[352] He said that

those tasked with responding may focus on strategies to limit liability, such as forbidding or inhibiting communication outside the institution, and not acknowledging what has happened or not apologising to those involved.[353]

The behaviours described by Dr Gordon were apparent in Launceston General Hospital's response to revelations about Mr Griffin. It is our view that the sheer scale of events connected to Mr Griffin overwhelmed the hospital's executive and management. We heard that managers did not feel equipped or supported to respond to these events. While some senior staff, such as Dr Renshaw, had previously confronted matters of child sexual abuse in their careers (for example, in response to Dr Tim), for most staff it was the first time they had to respond to such a crisis. Helen Bryan, former Executive Director of Nursing, Tasmanian Health Service North, told us that, while she did not agree that there was a lack of urgency from senior management in response to this critical incident, 'this was an incident or allegations that none of us had ever had to manage, experience, and we were navigating through an area that we were not familiar with'.[354] Sonja Leonard, former Nurse Unit Manager, Ward 4K, Launceston General Hospital similarly reflected that 'we were all in very uncharted waters and didn't have any knowledge, or experience, or training in how to deal with this'.[355]

In response to a question from Counsel Assisting our Inquiry about whether management could have done more to ensure greater transparency in the hospital's response, Janette Tonks, former Nursing and Midwifery Director, Women's and Children's Services, Launceston General Hospital said the following:

> Yes … but I also need to acknowledge that we were navigating an issue that—that most of us had never travelled before. We also had been traumatised and significantly affected by the events that had occurred. I think that everything we did was in good faith, we did what we thought at the time was in the best interest of the staff, as well as maintaining the police request about their investigation.
>
> It was extremely difficult to know what was the right thing and what was the wrong thing; there isn't actually a rule book around how you navigate through this particular type of issue.[356]

We heard expert evidence that poor responses to critical incidents can be averted by developing a clear and considered critical incident response plan that leaders can refer to in unprecedented or unanticipated situations. Dr Gordon told us that while health services may have policies, procedures and protocols in place to guide responses to critical incidents such as natural disasters, they are less likely to have explicit policies designed to promote recovery following human-caused traumatic events (that is, intentional acts at the hands of humans such as deliberate negligence or criminal offending) including child sexual abuse by a member of staff.[357] However, he indicated that policies that respond to these types of events can be developed.

In Chapter 14, Case study 3, relating to James Griffin, we find the lack of a coordinated and transparent response by Launceston General Hospital increased feelings of mistrust among hospital staff. Neither the Department nor Launceston General Hospital appear to have had a critical incident response plan in place at the time that Mr Griffin's offending became widely known. However, Mr Daniels indicated that the hospital had started work on critical incident stress management processes for staff and the community in response to the Hillcrest School tragedy, which occurred in December 2021.[358] Mr Daniels indicated that critical incident stress management processes could also apply in circumstances such as those involving Mr Griffin.[359]

In February 2023, Secretary Morgan-Wicks told us that a department-wide 'Critical Incident Response Protocol' would be developed as part of the *One Health Culture Strategy 2022–2027*.[360] She said that the Critical Incident Response Protocol 'will align with the [Department's] overarching Health and Wellbeing program to provide guidance on what support is available, how it is arranged and monitored'.[361]

In our view, the Critical Incident Response Protocol should go further, acknowledging that it is currently under development.[362] Dr Brady told us that a critical incident response plan should draw on Australia's nationally endorsed principles for disaster recovery, which promote community care through psychological first aid.[363] The principles were developed by the Social Recovery Reference Group Australia and are available on the Australian Institute for Disaster Resilience's website.[364] They are: understanding the context; recognising the complexity; use community-led approaches; coordinate all approaches; communicate effectively; and recognise and build capacity.[365]

Dr Brady also highlighted the importance of good communication after collective trauma events, which typically requires regularly communicating with those affected about what is known, what is not known, what is being done and what people can do to help.[366]

Dr Gordon told us it is crucial that those responding to critical incidents seek assistance from people who are external to the institution and its associated organisations to support clear thinking and to form appropriate responses.[367]

Those responsible for responding to critical incidents in health services should have clear policies, procedures and protocols to support their decision making. These policies, procedures and protocols should outline the key steps to take in communicating with and supporting those affected by the incident.[368] We consider that other Tasmanian Government departments should also review whether they have appropriate policies, procedures and protocols in place.

Recommendation 15.19

The Department of Health should develop and implement a critical incident response plan for human-caused traumatic events where numerous staff and patients are affected, including serious child-related incidents. The response plan should:

a. identify who is responsible for leading the response to a critical incident and set out the applicable reporting arrangements

b. identify the steps to responding to a human-caused traumatic event (including incidents relating to child safety)

c. provide for external assistance from experts with training and expertise in crisis management

d. be based on best practice responses to traumatic events

e. provide for early communication of information about the event

f. provide psychological first aid to affected people

g. provide extra support from skilled psychologists on an 'as needed' basis to affected people

h. provide for information about other support services that can assist affected people

i. facilitate communication and support among affected people as a means of social support

j. provide for critical incident debriefing run by a neutral and trained expert where appropriate

k. provide for a review of the Department's response to the critical incident

l. provide for an evaluation of any actions to be implemented as part of the Department's response to the critical incident

m. provide for any lessons from a review or an evaluation of the Department's response to the critical incident, to be shared with the Secretaries Board to further inform responses to critical incidents across the whole of government.

5 Restoring trust

The Launceston community has been profoundly affected by child sexual abuse at Launceston General Hospital and how that abuse was managed. These impacts are manifest in submissions, witness testimony, sessions with a Commissioner and consultations.

There has been a significant and long-term loss of trust in health workers among some in the Launceston community, with some parents avoiding taking their children to Launceston General Hospital and some victim-survivors refusing health care because they feel unsafe in health services. Where victim-survivors have sought health care at Launceston General Hospital, many described the feelings associated with their past experiences of abuse being reactivated, which hospital staff were often not well equipped to mitigate. This is a significant public health concern.

A lack of consistent and transparent information from a health service about what is being done in the wake of child sexual abuse revelations can serve to create an information vacuum. In the case of Mr Griffin, insufficient communication by Launceston General Hospital—with victim-survivors, their families and carers, former patients, staff and the broader community—led to various theories and rumours, some of which were well founded and others that we have not been able to substantiate. More generally, the hospital's approach invited suspicion that it was, above all, trying to protect its reputation.

As already noted, Dr Brady told us that child sexual abuse (particularly on this scale) can become a collective trauma event requiring a response that promotes community care and the restoration of trust using principles of disaster recovery.[369] While it is always best to adopt this approach as quickly as possible after an event, experts assured us that it is never too late to start responding in ways that help a community to heal and regain trust.

Shortly after our first week of hearings relevant to Launceston General Hospital in June 2022, the Department took steps to address some of the issues that emerged from these hearings. These steps included conducting the Child Safe Governance Review and the Community Recovery Initiative. On 8 November 2022, the Tasmanian Parliament apologised to all victim-survivors of child sexual abuse in Tasmanian Government institutions, including those connected with Launceston General Hospital.[370] These responses reflect a start, rather than an acquittal, of what is required to re-establish trust and goodwill in the Northern Tasmanian community.

The public release of our final report, which includes a range of information that has not yet been made public, may have a further unsettling effect on the community and will require a thoughtful and nuanced response from the hospital and the Department. There is a long road ahead.

In this section, we provide a summary of the evidence we heard from victim-survivors, their families and hospital staff about the loss of trust they have experienced following Launceston General Hospital's response to child sexual abuse, particularly the response to the 2019 revelations about Mr Griffin's offending.

We then consider the response of the hospital and the Department to this loss of trust and some of the Department's efforts towards restoring community trust in Launceston General Hospital and public health services more generally.

We recommend that Launceston General Hospital and Tasmania Police assist victim-survivors of child sexual abuse at the hospital on an ongoing basis.

5.1 The loss of trust

This section describes some of what we heard from victim-survivors, their families and supporters about the effects on them of alleged abuse at Launceston General Hospital, including how these events have impacted their overall trust in health services. We also describe some of what we heard about the psychological toll on staff at Launceston General Hospital following the hospital's manifestly deficient approach to responding to disclosures of abuse.

5.1.1 Victim-survivors' loss of trust in the health system and particularly Launceston General Hospital

Several witnesses described to us the trust that they placed in health workers to care for their children. For example, Kim (a pseudonym), whose daughter Paula (a pseudonym), was nursed by Mr Griffin at Launceston General Hospital, told us: 'We trusted the doctors and nurses, we trusted our children to LGH when they were at their most vulnerable'.[371]

Those whose trust has been undermined described an ongoing wariness and, at times, fear about seeking health care, particularly for their children.[372]

Several victim-survivors who experienced Mr Griffin's abuse also told us that their abuse had made them reluctant to seek health care for themselves or their children. One person who had experienced abuse by Mr Griffin said: 'I still feel uncomfortable going to LGH and hospitals in general because of what happened'.[373] Another victim-survivor said: 'Ever since the abuse, I have avoided hospitals and where I have required admission, I have discharged myself shortly after admission. I feel panic when I go near hospitals'.[374] Keelie McMahon, who also experienced abuse by Mr Griffin outside of the hospital, said: 'I shouldn't be putting my children's health on the line purely because I can't step foot in that hospital'.[375]

Michelle Nicholson, a community health social worker, suggested that the reluctance to access health services, as described by some of the witnesses to our Inquiry, is widespread. She told us that it was not uncommon for her clients to avoid seeking health care due to their past experiences.[376]

The effects of breaches of trust by health workers can also extend to other care arrangements. One family that participated in Launceston General Hospital's open disclosure process after their child (who has a disability) was identified in photographs found in Mr Griffin's possession, said:

> The long-term impact this has had on our family is significant. Our trust in others to care for [our child] is now very limited. We cannot bring ourselves to arrange overnight respite in supported accommodation facilities, even though we have been advised by other parents that the care is very good.[377]

We heard that mistrust in Launceston General Hospital has also resulted in people seeking care outside the region. Angela (a pseudonym) told us that she prefers to travel to Hobart to seek health care for her daughter (who has cerebral palsy) after receiving no response from Launceston General Hospital to a complaint she made about the care her daughter was receiving from nurses on Ward 4K, including Mr Griffin.[378] Angelique Knight, a former Ward 4K patient, told us that she, too, attends another hospital whenever possible. She said 'sometimes because of the complexities of my condition they send me to LGH. I dread going there every time'.[379]

Another victim-survivor who experienced abuse by Mr Griffin described going to significant lengths to avoid Tasmanian health services when her children need care. She said: 'When my children have had medical issues and a choice has existed around their treatment, I have made the decision to take them out of the state for treatment'.[380]

We heard from several witnesses that they avoid Launceston General Hospital because being there triggers the trauma of their abuse or otherwise makes them feel unsafe.[381]

One victim-survivor of Mr Griffin stated: 'My son was in hospital recently. I wanted to stay with him but felt unsafe being by myself. Hospital staff did not let my partner stay with me. This response failed to cater to my needs associated with the trauma of the abuse'.[382]

The Child Safe Governance Review reported that '[s]ome survivors perceived staff interactions with them, albeit well intentioned, as making them feel treated as "victims" in a notorious case of serial child abuse rather than as members of the community attending for health care'.[383]

While acknowledging these experiences and the importance of providing trauma-informed care to victim-survivors, Ms Nicholson advocated for individual hospital staff to not be left navigating responses to intergenerational trauma caused by sexual abuse. She said:

> … by and large the vast majority of health workers are doing the best they can in difficult and challenging understaffed circumstances where they are not provided with the necessary trauma informed care training … While on the surface it may look like people are failing to do their duty of care to survivors of historical trauma and children, I believe it is mainly not individuals but a flawed system that is the problem.[384]

The report of the Child Safe Governance Review, reflecting the views of the Lived Experience Expert Reference Group, states that any patient may have experienced prior trauma and therefore all patients should enjoy a level of care and sensitivity based on that assumption. We recommend in Chapter 19 that the Tasmanian Government should develop a whole of government approach to professional development in responding to trauma within government and government funded agencies that provide services to children, as well as statutory bodies that have contact with child sexual abuse victim-survivors (refer to Recommendation 19.2).

5.1.2 Loss of trust among Launceston General Hospital staff

Former and current Launceston General Hospital staff spoke to us about how the mismanagement of allegations of child sexual abuse at the hospital had affected them.

Maria Unwin, a former Ward 4K nurse, recalled that when she joined Launceston General Hospital in 1993, a colleague told her that a nurse had been caught in the act of sexually abusing a child on the ward during night shift. Ms Unwin stated:

> It was clear that when I started at the hospital some staff were still traumatised by this incident and how it had been handled. When it was discussed you could sense a level of fear from the people who were talking about it … When I heard the allegations I was shocked and felt sick. I was always shocked that even [when] someone was caught in the act of child sexual abuse they would only be moved on and that it would be covered up. I would never have expected this to be happening at the hospital in the 1990s.[385]

Kylee Pearn, a former hospital employee, told us that when Mr Griffin was allowed to remain on Ward 4K after she disclosed to human resources staff, in 2011 or 2012, that he had sexually abused her as a child, she 'couldn't cope'.[386] She left her social work role at the hospital and moved to a new role in a school.[387]

Annette Whitemore, a former Ward 4K nurse told us that the hospital's response to allegations against Mr Griffin contributed to her resigning from Ward 4K.[388]

We also heard that some staff were reluctant to seek health care from Launceston General Hospital because of the hospital's failure to effectively respond to allegations of sexual abuse against young patients.[389]

5.2 Launceston General Hospital's response to loss of trust

As outlined in Chapter 14, Case study 3, Launceston General Hospital offered open disclosure to some patients who were identified in photographs found in Mr Griffin's possession. The one family that took part in the open disclosure process expressed concerns about how this process was conducted, in particular:

- hearing about Mr Griffin's offending through a voice message left on their phone while they were at work
- whether they were told the truth that previous concerns raised with the hospital about Mr Griffin were not of a sexual nature
- not being offered counselling or follow-up support from Tasmania Police or the hospital.

The absence of clear communication from the hospital about the photographs found in Mr Griffin's possession has also left some former patients, and their families, wondering if the patients may have been in the cache of images seized by Tasmania Police.

As discussed in Chapter 14, Case study 3, after hearing details of Mr Griffin's offending on *The Nurse* podcast, Ms Knight recalled asking the hospital whether any of the photos found were of her and whether she could see them.[390] The hospital told her that only one patient had been identified from the photos.[391] Ms Knight said that the hospital 'did not explain the process that led to this identification or explain why I couldn't see [the photos] myself'.[392] She went on to explain:

> I don't know if James Griffin did take photos of me and that bothers me. He had plenty of opportunity. I showered in front of him. I was naked in his presence. If there were photos of me on his phone I would have been able to identify myself. I was really annoyed by all of this and it felt like [the hospital] was just brushing me off again. I felt like I was nothing and just a number …[393]

As becomes clear in Chapter 14, Case study 3, beyond the existence of the photographs, the hospital's executive was denying, internally and externally, that there was any connection between Mr Griffin's offending and hospital patients. This denial continued until our hearings when the extent of complaints against Mr Griffin and the experiences of former patients became more broadly known.[394]

Dr Renshaw, who was involved in the response to revelations about Mr Griffin, told us that he had turned his mind to communicating more broadly with potential victims, however:

> I considered the logistics of doing a mail-out to the families of every paediatric patient of the LGH over the previous 15 or so years were well beyond the resources available within the LGH. It was also a factor that there were periods when Griffin was not working at the LGH. I did consider approaching patients and their families who had been inpatients for longer than a specified period of time (for example, over a week or over a month) as being more likely to have been victims of Griffin. However, there was also the potential with such a blanket approach to cause unnecessary distress and anxiety to families whose children had no contact at all with Griffin during their hospital stay.[395]

As set out in Chapter 14, Case study 3, we also heard that some victim-survivors who contacted the hospital were given generic lists of phone numbers for psychological support.[396] While such resources can be useful, simply providing contact details for support services is not an appropriate response from an institution that has a duty to protect patients from harm.

We invited the leadership of Launceston General Hospital to reflect on what could be done to restore the trust of victim-survivors and staff of the hospital. Unfortunately, the responses we received suggested that restoring trust had not been the subject of any deep thought or reflection. Where suggestions were made, they tended to be superficial.[397]

It was clear to us that the hospital's leadership lacked a meaningful understanding of the impact that Mr Griffin's offending has had on victim-survivors, staff and the broader community, and that the leadership has failed to grasp the extent of the work required to restore trust. The hospital's leadership provided no evidence to suggest any insight that acknowledging the extent of Mr Griffin's offending, and providing information about how such offending continued for many years, are essential to restoring trust. We hope that our Commission of Inquiry and final report will provide some of these answers.

We accept that, due to poor records, failed memories, the absence of any witnesses and the reality that the full extent of Mr Griffin's abuse is unlikely to ever be known, Launceston General Hospital will not be able to answer every question and reassure every individual. However, the hospital has an obligation to do what it can to provide some clarity and closure to those who remain distressed or concerned about the implications of Mr Griffin's offending.

Launceston General Hospital's response to victim-survivors, their families and carers, staff and the broader community must not be a bureaucratic exercise. The hospital must consider the needs of known and as yet unknown victim-survivors and, as we recommend above (refer to Recommendation 15.18), make appropriate supports available to affected people including victim-survivors and their immediate family and carers, including warm referrals to trained and experienced child sexual abuse counsellors.

We consider that Launceston General Hospital and Tasmania Police have an ongoing obligation to help identify victim-survivors of Mr Griffin when requests emerge, or, if this is not feasible, to clearly explain why. We are aware that other jurisdictions are using advances in technology to identify victim-survivors in child sexual exploitation material.[398]

We also consider that any communications with the broader community following an incident, such as the potential sexual abuse of patients by a staff member at a hospital, should be informed by the principles of open disclosure applied at the community level, which we have outlined earlier (refer to Section 4.3).

Recommendation 15.20

1. The Department of Health, Launceston General Hospital and Tasmania Police should make clear that they will continue to assist, on an ongoing basis, known and as yet unknown victim-survivors of child sexual abuse by James Griffin related to the hospital and should nominate a contact person for people who have enquiries.
2. Assistance should include:
    a. outlining what is known about Mr Griffin's offending at the hospital
    b. taking steps to ascertain whether a person is or may be a victim-survivor of Mr Griffin's offending or clearly explaining why this cannot be done.
3. The Department and Launceston General Hospital's communications with known and as yet unknown victim-survivors of Mr Griffin and their families and carers and the broader community should be informed by the principles of open disclosure.
4. Launceston General Hospital should ensure victim-survivors and their families and carers who do not receive individual open disclosure (Recommendation 15.18) still receive a warm referral to trained child sexual abuse counsellors if desired.

6 The work of oversight agencies

In Chapter 13, we provided a brief overview of key agencies that oversee aspects of Tasmania's health system, including health practitioners and health services. These agencies include Ahpra, the National Boards and the Health Complaints Commissioner. A core role of these agencies is ensuring the safety of children and young people who receive health care.

In this section, we discuss the role of each agency and make observations about how these agencies might be made more effective in helping to protect the safety of children. In relation to Ahpra and the National Boards, we highlight a general lack of community awareness of their roles and functions. We consider that the recommendations we make above will address concerns about ensuring consistent information is provided to patients, including age-appropriate resources for children and young people and their families and carers (Recommendation 15.8), ensuring there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct (Recommendation 15.12), developing of a professional conduct policy for staff who have contact with children and young people in health services (Recommendation 15.13) and strengthening professional development around child safety for different levels of staff (Recommendation 15.15).

In relation to the Health Complaints Commissioner, we highlight problems in its ability to fully perform its role and functions, and identify possible areas of improvement. We do not make recommendations about these improvements because we consider the new Commission for Children and Young People that we recommend be established (refer to Chapter 18) will be the peak oversight body responding to concerns about children and young people. We do, however, recommend a review of the Health Complaints Act to consider some of the problems we discuss.

6.1 Ahpra and the National Boards

Ahpra is the agency that administers the National Registration and Accreditation Scheme for health practitioners in Australia. It also provides administrative support to 15 National Boards, which carry out a range of functions for overseeing health practitioners registered across 16 health professions under the National Law.

6.1.1 Codes of conduct

Staff who are registered under one of the health professions recognised by the National Law must follow codes of conduct established by their respective National Board. These codes offer guidance on the expected standards of conduct for registered health practitioners that apply to health practitioners when they are delivering care and to their behaviour outside the workplace.[399] These codes require that health practitioners maintain professional boundaries with patients.[400]

Codes and guidelines that have been approved by the National Boards are admissible in disciplinary proceedings under the National Law. They can be used as evidence of what constitutes appropriate professional conduct or practice for a particular health profession.[401]

6.1.2 Notifications to Ahpra and the National Boards

The National Law provides for notifications to be made to Ahpra and the National Boards where the health, conduct or performance of a registered health practitioner poses a risk to the public.[402]

Registered health practitioners and their employers are mandated under the National Law to report a registered health practitioner if they form a reasonable belief that the practitioner has engaged in 'notifiable conduct'.[403] Notifiable conduct includes 'engaging in sexual misconduct in connection with the practice of a health profession'.[404] Examples of sexual misconduct include sexual activity with a current patient, making sexual remarks, touching patients in a sexual way, touching a patient in an intimate area without clinical indication and engaging in sexual behaviour in front of a patient.[405]

A health practitioner who forms a reasonable belief that another health practitioner has engaged in notifiable conduct and does not make a mandatory notification may be subject to regulatory action.[406]

In addition to mandatory notifications, any entity or person, including patients or members of the public, can make a voluntary notification about a health practitioner.[407] Voluntary notifications can be made to Ahpra and the National Boards on several grounds, including that the practitioner is or may not be a suitable person to hold registration in a health profession because they are not, for example, a fit and proper person to be registered in the profession.[408] A notification may also be about concerns that a practitioner's conduct is unprofessional, unlawful or below acceptable standards.[409]

6.1.3 Managing notifications involving sexual misconduct

Ahpra refers notifications about health practitioners to the National Boards.[410] The National Boards are empowered to take a range of steps in response to a notification, including:

- taking immediate action to stop a health practitioner from practising
- launching an investigation
- imposing registration conditions
- directing the practitioner to attend a health or performance assessment.[411]

Where there is enough evidence for a National Board to form a reasonable belief that child sexual abuse has occurred, the National Board will refer the matter to a responsible tribunal under the National Law.[412] In Tasmania, this tribunal is the Tasmanian Civil and Administrative Tribunal.[413] After considering a matter, the tribunal may make a range of orders, including cautioning or reprimanding a practitioner, imposing conditions on their registration, imposing a fine, or suspending or cancelling the practitioner's registration.[414]

A strength of the National Registration and Accreditation Scheme is that it hosts a single database of all notifications and complaints made about registered health practitioners in Australia.[415] The national database records all notifications about registered health practitioners since the National Law began, irrespective of whether the notification was made to a National Board or to another health complaints entity (such as the Tasmanian Health Complaints Commissioner).[416] The database helps in assessing future complaints about registered health practitioners by enabling patterns of behaviour that have not otherwise resulted in disciplinary action to be identified—for example, repeated concerns about boundary violations.[417]

It is important for health services to have clear systems and processes in place that inform and guide staff about reporting to Ahpra and the National Boards.

6.1.4 Awareness of Ahpra and the National Boards

Despite Ahpra and the National Board's role in managing notifications about health practitioners, we identified through our Inquiry that staff, former patients and the community are not aware of their regulatory functions, nor of their ability and, in some cases, obligation, to make notifications to Ahpra and the National Boards under the National Law. In Chapter 14, Case study 3, relating to James Griffin, we find that Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies.

In relation to staff at Launceston General Hospital, Ms Unwin told us that although she was aware of the obligation to report suspected abuse including mandatory reporting under child safety legislation, she had 'always been led to believe that evidence was required to make a complaint'.[418] She said it was not until 2020 that she became aware that she could have made a complaint to the former Tasmanian Nursing Board or Ahpra about Mr Griffin based on her concerns alone.[419]

Similarly, another former Ward 4K nurse, Annette Whitemore, said: 'We all knew we were mandatory reporters, and I don't think we were deliberately not told this, but until 2019 when all this happened … I never knew I could go straight to Ahpra'.[420] Will Gordon, Ward 4K nurse, told us that most nurses on Ward 4K did not realise they could report their colleagues to Ahpra.[421] He said: 'We just didn't know, we weren't told about it, there was no education about that sort of complaint process'.[422]

Dr Renshaw agreed that 'it was clear' staff at Launceston General Hospital were not aware of their mandatory reporting obligations under the National Law.[423] He confirmed that prior to the public revelation of events involving Mr Griffin, there was no training provided to staff about the National Law.[424]

In a statement to us, Matthew Hardy, National Director, Notifications, Ahpra, said:

> Information in relation to a health practitioner's mandatory notification obligations is widely available for health practitioners, and I would expect that registered health practitioners take reasonable steps to undertake self-directed learning to stay current with changes in their profession. Specifically, I would expect that health practitioners and students undertake a degree of training by employers or other entities, with that education supplemented by self-directed learning, including in relation to mandatory notification obligations established by their respective National Board or otherwise as published on Ahpra's website. National Boards mandate participation in annual Continuing Professional Development to facilitate this ongoing professional learning and development process.[425]

In relation to awareness of Ahpra and the National Boards among patients and the community, Ms Knight, a former Ward 4K patient, told us: 'I have never heard of the Australian Health Practitioner Regulation [Agency], even though I've spent so much of my life in hospitals'.[426] Another witness and victim-survivor said

she ‘wasn’t aware of the existence of Ahpra as an independent body’ and, in their experience, ‘people generally aren’t aware of Ahpra like they are with the Ombudsman, Teachers Registration Board or the Integrity Commission’.[427] They said that had they known about Ahpra, they would have contacted the agency about Mr Griffin at the earliest opportunity.[428]

Secretary Morgan-Wicks described the Department’s promotion of Ahpra and the National Boards’ notification processes to patients as ‘limited’, adding that information is ‘more likely’ to be provided once a complaint is received.[429]

Mr Hardy told us that it was his expectation that ‘health consumers and the general public are aware of the existence of health professional regulation in Australia and that there are mechanisms by which complaints can be made’.[430] He said health consumers and the public can access Ahpra and the National Boards’ websites, which provide information on ‘accreditation, registration and notification systems’.[431]

We consider that more must be done to raise awareness about the role of Ahpra and the National Boards among health workers, patients and the broader community. Mr Hardy agreed that although Ahpra does not have a legislated educative role, as a model regulator, the organisation does have ‘an obligation to make sure that our practitioners are educated, that we engage with employers of those practitioners and that the community is aware of who we are and what we do’.[432]

Our Commission of Inquiry’s mandate does not extend to making recommendations to Ahpra or the National Boards. However, we hope that they increase their educational activities, particularly in relation to the ability of any member of the public to report concerns about the conduct of health practitioners.

The Department should ensure staff who are registered health practitioners are aware of their obligations under the National Law. This can be achieved through professional development and by implementing policies that outline what staff should do when they have concerns about a colleague who is a registered health practitioner. We make recommendations above about ensuring there are up-to-date policies on mandatory and voluntary reporting obligations, including for concerns about staff conduct, as well as strengthened professional development on child safety for different levels of staff (refer to Recommendations 15.12 and 15.15).

The Department can also play a role in increasing patient awareness of their rights to make a notification about a health practitioner to Ahpra and the National Boards by including this information in any documentation they produce about patients’ rights and expectations. We make a recommendation above about ensuring consistent information is provided to patients, including age-appropriate resources for children and young people and their families (refer to Recommendation 15.8).

6.2 Health Complaints Commissioner

In Chapter 13, we briefly discuss the role of the Health Complaints Commissioner under the Health Complaints Act. Richard Connock is the current Health Complaints Commissioner. Mr Connock is also the Tasmanian Ombudsman.

Mr Connock leads the Office of the Ombudsman and Health Complaints Commissioner. Together, these offices cover six separate jurisdictions—those of the Parliamentary Ombudsman, the Health Complaints Commissioner, the Energy Ombudsman, Right to Information, the Official Visitors Programs and the Custodial Inspectorate. Mr Connock referred to his Right to Information role as a 'de-facto' role.[433]

The relevant key functions of the Health Complaints Commissioner are:

- receiving, assessing and resolving complaints about Tasmanian health service providers in the public and private sectors
- inquiring into and reporting on matters related to health service providers and health services at the discretion of the Health Complaints Commissioner or at the direction of the Minister for Health.[434]

6.2.1 Complaints involving children and young people

The Health Complaints Commissioner can receive complaints from a parent or guardian of a child under 14 years of age, a person appointed by a child who is aged 14 years or older, or the child directly in circumstances where the Health Complaints Commissioner agrees the child is capable of lodging a complaint.[435]

Matters to note about the Health Complaints Commissioner's management of complaints involving children and young people and child sexual abuse include:

- Complaints are initially referred to Tasmania Police given the behaviour is potentially criminal in nature.[436]
- Complaints involving a health worker who is not registered under the National Law are considered and investigated by the Health Complaints Commissioner, but the Commissioner does not yet have any powers to impose sanctions on that worker.[437]
- Complaints about a health practitioner registered under the National Law are referred to Ahpra and the National Boards (discussed above).[438]
- The Health Complaints Commissioner has a memorandum of understanding with Ahpra that requires complaints to be managed collaboratively. Where a complaint relates to a registered health practitioner and the health service they work in, the complaint can be separated, with the Health Complaints Commissioner investigating the aspects of the complaint relating to the health service to identify broader systemic issues and Ahpra investigating the aspects relating to the individual practitioner.[439]

While we do not consider that the Health Complaints Commissioner should be the first port of call whenever there is a complaint of child sexual abuse within a health service, the Health Complaints Commissioner plays a unique and important role in identifying systemic risks to child safety within health care settings, particularly in relation to health services that do not do enough to address poor or unprofessional staff conduct.

6.2.2 Strengthening the role of the Health Complaints Commissioner

The Health Complaints Commissioner also has an important role in informing and empowering consumers, including children and young people, with respect to their health care rights and the options available to them when they are dissatisfied with or have concerns about their health care. The community should be aware of this role and benefit from these options.

However, the Health Complaints Commissioner faces barriers in effectively performing its legislative functions including a lack of public awareness about the Health Complaints Commissioner's role and inadequate funding.

6.2.3 The Health Complaints Commissioner's response to child sexual abuse in health services

Complaints made to the Health Complaints Commissioner cover a broad spectrum of issues, which vary in nature and degree of seriousness.[440] Mr Connock told us that although his office does not specifically monitor risks in relation to child sexual abuse, it is vigilant in responding to enquiries and complaints involving vulnerable groups and people.[441] He also told us his office had not received any complaints about child sexual abuse in health services throughout the period our Commission of Inquiry is examining (that is, since 2000).[442] However, his office has received complaints about the alleged sexual abuse of vulnerable adults in health services (refer to the Health Complaints Commissioner's report into Ward 1E, which is summarised in Chapter 13).[443]

While the Health Complaints Commissioner would not ordinarily be the first point of contact for those affected by child sexual abuse (in a way that the police or Child Safety Services may be), the absence of any complaints about child sexual abuse is surprising, particularly given how enduring the complaints and concerns were about Mr Griffin and Launceston General Hospital's response.

Mr Connock acknowledged that not receiving complaints about these matters means his office does not have insight into the extent of systemic issues relevant to child safety.[444] He said the absence of complaints connected to child sexual abuse may be because of:

- a lack of awareness among health service users and the community in general of the role of the Health Complaints Commissioner and the Ombudsman, as well as the ability to make notifications to Ahpra and the National Boards

- the Health Complaints Act and *Ombudsman Act 1978* being unable to guarantee anonymity in relation to complaints
- reluctance to make complaints due to fear of reprisals.[445]

6.2.4 Funding the Health Complaints Commissioner

Mr Connock told us that most of his office's resources are dedicated to complaints handling, conciliation and resolution.[446] Data shows that the number of complaints the Health Complaints Commissioner receives has increased considerably since 2019–20. Most recently, in 2021–22, the Health Complaints Commissioner received 769 complaints, up from 440 complaints in 2020–21.[447] These figures do not include enquiries made or notifications received from Ahpra and the National Boards, which accounted for another 541 contacts in 2021–22 and 625 contacts in 2020–21.[448]

Mr Connock told us that the health complaints jurisdiction had historically been underfunded.[449] A review of the Health Complaints Act, completed in 2003, identified funding as a key issue affecting the health complaints jurisdiction. The review concluded that 'the Commissioner's office had been under-resourced since it was first established'.[450] Underfunding is also referenced across several of the Health Complaints Commissioner's annual reports.[451]

Mr Connock also described to us the effects of having very few staff:

> In the past, low staff numbers in the Health Complaints jurisdiction had not only an adverse impact on the time taken to resolve complaints but also, with a necessary focus on complaint resolution, resulted in an inability to perform other functions prescribed under the [Health Complaints] Act. These include things such as: education on health rights; building complaint resolution capacity in providers; auditing improvements to health services and conducting own motion investigations.[452]

All these functions—education on health rights, building health services' capacity in relation to complaints handling, auditing and investigations—are important to ensuring health services protect consumers, including children.

Mr Connock told us that a lack of funding is a key barrier to his office's ability to improve complaints handling procedures in Tasmanian health services.[453] While his office provides feedback to health services about how complaints might be better handled in the course of day-to-day management of health complaints, Mr Connock explained that he has not been able to exercise his broader functions in educating health services on how to manage complaints internally because 'we've got so many complaints; we're really just dealing with those'.[454] Mr Connock also indicated that there have been occasions when he would have undertaken more substantive investigations but did not have the funding and staff available to do so.[455]

Mr Connock told us that the Office of the Ombudsman began receiving extra three-year funding in 2021 to be spread across all six jurisdictions of the Office of the Ombudsman and Health Complaints Commissioner identified above. This was the first increase to funding the Office of the Ombudsman and Health Complaints Commissioner had received since 2014 (apart from dedicated funding for the Right to Information jurisdiction in 2019).[456]

Mr Connock said he was 'hopeful' but 'hesitant' to say that the increased funding, which was significant, would enable the Office of the Health Complaints Commissioner to adequately perform its legislated functions. He noted that the increased funding will 'certainly be a vast improvement' but '[the Office] will just have to see how we go' because an increase of this scale had not occurred before.[457] He did, however, indicate that the funding would 'make a meaningful change' to the performance of functions across all jurisdictions, including the health complaints jurisdiction.[458]

6.2.5 Appointing a separate Health Complaints Commissioner

The Health Complaints Act permits a person who holds the position of Ombudsman to also be appointed to the position of Health Complaints Commissioner.[459] Mr Connock was appointed to the role of Ombudsman and Health Complaints Commissioner in July 2014. He told us that, since the Office of the Health Complaints Commissioner was established in 1997, both appointments have always been held by the same appointee.[460]

The 2003 review of the Health Complaints Act identified distinct advantages in amalgamating review bodies. These advantages included the ability to offer the community the same range of review services present in larger jurisdictions, as well as cost savings associated with salaries, shared premises and shared administrative and infrastructure support.[461]

Since the review, the Ombudsman's roles have greatly increased. Mr Connock said that with responsibilities for six jurisdictions, he only dedicates about one day a week to the performance of the Health Complaints Commissioner role.[462] All other Australian states (although not territories) have appointed a separate Health Complaints Commissioner (or Director, as is the case in Western Australia).[463]

Mr Connock also referred to the potential for conflicts of interest to arise when the Ombudsman is investigating the administrative actions of the Health Complaints Commissioner. He said:

> There have been issues recently in the past with potential conflict of interest because, as Ombudsman, Health Complaints Commissioner comes within my jurisdiction, so we have had complaints against the Health Complaints Commissioner. We've managed that, it's not been— there has not been a problem, but the perception is there and the capacity for conflict.[464]

6.2.6 Code of conduct for unregistered health workers

Health services often employ registered and unregistered health workers. The conduct of registered health practitioners is subject to Ahpra and National Board oversight. A National Board must refer registered health practitioners located in Tasmania to the Tasmanian Civil and Administrative Tribunal where it reasonably believes the practitioner has behaved in a way that constitutes professional misconduct.[465] Our case studies primarily focused on nurses and doctors who are registered in this way.

There is currently no similar professional misconduct process for health workers in Tasmania who are not registered under the National Law.

Health workers who are not registered under the National Law include counsellors, social workers, massage therapists, dietitians, speech pathologists, naturopaths, alternative therapists, personal care attendants and pharmacy assistants.[466] People in these roles often have contact, including close physical contact, with children and enjoy significant community trust. These factors can increase the risks of child sexual abuse.

A complaint can be made to the Health Complaints Commissioner about a health worker who is not registered under the National Law. The Commissioner may investigate and make recommendations in relation to such a complaint, but the Commissioner does not have any disciplinary powers to impose sanctions on the worker.[467] Unregistered health workers who are employed in the State Service are subject to Employment Direction processes (discussed in Chapter 20) or may also face consequences associated with losing, or not obtaining, their registration to work with vulnerable people, including children. However, the Health Complaints Commissioner has no ability to ensure these processes are followed.[468] Because unregistered health workers are not overseen by Ahpra or any National Board, there is a regulatory gap for this group.

In June 2013, at a meeting of the Commonwealth Parliamentary Standing Committee on Health, Australia's health ministers agreed in principle to establish the National Code of Conduct for Unregistered Health Care Workers ('the Code').[469] Drafting the Code was also agreed at a meeting of the former Council of Australian Governments' Health Council in 2015.[470] Each Australian state and territory is responsible for giving effect to the Code.[471] Regimes have been introduced in New South Wales, Queensland, South Australia and Victoria.[472] The Tasmanian Parliament passed amendments to the Health Complaints Act to implement the Code in 2018, but no date has been set for them to begin.[473] The Health Complaints Commissioner will be responsible for administering the Code in Tasmania.[474]

The Code outlines minimum standards of conduct and practice for unregistered health workers who provide a health service.[475] Implementation of the Code in Tasmania will allow the Health Complaints Commissioner to act against unregistered health workers who fail to comply with the standards of conduct and practice set out in the Code. The Health

Complaints Commissioner will have powers to make public warning statements and publish prohibition orders in relation to unregistered health workers who have breached the Code and who pose a risk to public health and safety, including to children.[476]

Mr Connock told us that the administration of the Code will be different from the work his office currently undertakes.[477] He described the Health Complaints Commissioner becoming 'in effect, the equivalent of Ahpra for unregistered practitioners' and that investigations 'required to justify the making of prohibition orders and public statements will be more in the nature of a prosecution than an investigation'.[478] In his 2021–22 annual report, Mr Connock observed that any complaints related to the Code 'would mean an added strain on resources that are already stretched' and require 'extensive modifications to our case management system to accommodate workflows related to the administration of the Code'.[479]

6.2.7 Review of the Health Complaints Act

At the time of establishing the Health Complaints Commissioner in 1997, the role was modelled on health complaints entities in Victoria and Queensland.[480] These entities focused heavily on resolving and conciliating complaints.[481] Mr Connock told us that, as a result, the Health Complaints Commissioner in Tasmania has traditionally dedicated most of its time to conciliating rather than investigating complaints.[482]

The role of health complaints entities in other Australian jurisdictions has since evolved to become 'more of a watchdog' body.[483] The Health Complaints Act has not, however, been reviewed or updated to reflect this more contemporary role, nor has it been substantially reviewed since the National Registration and Accreditation Scheme began in 2010.

When the Health Complaints Act first began, it contained a provision requiring the Health Complaints Commissioner to review the Act three years after its commencement and at five-year intervals thereafter.[484] This provision was repealed by the *Justice and Related Legislation (Miscellaneous Amendments) Act 2006*.[485]

Mr Connock told us that the Health Complaints Act had only been the subject of one legislative review, which, as noted above, was published in 2003.[486] This review resulted in 35 recommendations, including in relation to the early resolution of complaints, the Commissioner's powers of investigations, the appointment of a separate Health Complaints Commissioner, increased responsiveness to the needs of the community and resource allocation. Most of the report's recommendations were incorporated into the *Health Complaints Amendment Act 2005*.[487]

6.2.8 Our observations

In our view, it is unsatisfactory that the Health Complaints Commissioner appears unable to perform its legislated functions appropriately due to a lack of funding and resources.

Given what has emerged about Launceston General Hospital's inability to respond to and manage complaints from health service users and staff in relation to child sexual abuse, there is an urgent need to resource the Health Complaints Commissioner to provide education to the community about its role and to undertake capacity-building work in health services about internal complaints management processes. The Health Complaints Commissioner must also be equipped to undertake investigations when needed. Ensuring health services are safe and trusted is an important contribution to public health objectives and will contribute to keeping children safe from harm.

The current time dedicated to performing the role of the Health Complaints Commissioner (estimated by Mr Connock as the equivalent of one day a week) is inadequate and should be increased.[488] Performing the role with such little time cannot ensure sufficient oversight of the health complaints jurisdiction or the effective acquittal of the Health Complaints Commissioner's legislated functions so far as they relate to complaints connected to child sexual abuse.

The potential for conflicts of interest to arise between the Ombudsman and the Health Complaints Commissioner in circumstances where the Ombudsman is investigating the administrative actions of the Health Complaints Commissioner is also an issue that must be addressed to ensure the community can have confidence in the exercise of functions with respect to each role. A Health Complaints Commissioner who is separate from the Ombudsman should be appointed.

A need for more funding also arises from the expected implementation of the *Code of Conduct for Unregistered Health Care Workers*. Implementing the Code would be a significant step to address a current gap in oversight by improving responses to the conduct of health workers who pose a risk to children and young people and who are not currently captured by existing regulatory schemes. However, implementing the Code will result in more responsibilities for the Health Complaints Commissioner and an added strain on already stretched resources. The Tasmanian Government must ensure the Health Complaints Commissioner has the resources to implement and administer the Code.

In our view, the issues we raise would be best addressed through a comprehensive review of the Health Complaints Act and the role of the Health Complaints Commissioner. We understand the Health Complaints Commissioner secured funding for a consultant to complete a review of the Act by the end of the previous financial year (2022–23).[489] This review may prove a useful first step towards modernising the Act.

We consider that with the introduction of the new Commission for Children and Young People (refer to Chapter 18) and the implementation of the Reportable Conduct Scheme

under the Child and Youth Safe Organisations Act (also discussed in Chapter 18), most concerns about child sexual abuse and related matters in health services will be within the jurisdiction of the new Commission for Children and Young People. We view this new Commission as the primary oversight body for the safety of children and young people in Tasmania. We also consider professional regulation of unregistered health workers a priority because they are a cohort that often provides services to children.

Recommendation 15.21

The Tasmanian Government should ensure a review of the *Health Complaints Act 1995* is completed and considers the role of the Health Complaints Commissioner in relation to:

a. addressing systemic issues within health services related to child safety

b. incorporating the administration, monitoring and oversight of the Code of Conduct for Unregistered Health Care Workers

c. coordinating with the role of the new Commission for Children and Young People (Recommendation 18.6), and the Independent Regulator under the *Child and Youth Safe Organisations Act 2023*.

7 Conclusion

The case studies our Commission of Inquiry considered make clear the enormous suffering caused to victim-survivors, their families and staff, as well as the far-reaching adverse impacts on the broader community and the health system overall, when health services fail to:

- appreciate the risks of abuse to children and young people
- prioritise the safety and wellbeing of children and young people
- respond appropriately to risks and disclosures of harm.

The recommendations we outline in this chapter, and the reforms the Department has recently adopted, represent the beginning, not the end, of the Department's efforts to safeguard children and young people in health services. Keeping children and young people safe is not a one-off endeavour, but a process of continuous improvement that must be informed by children and young people, victim-survivors, independent experts and health workers, including those who have worked tirelessly to advocate for children's safety. Current and future leaders and senior managers at the Department and Launceston General Hospital must be up to this task.

We wish to emphasise that all Tasmanian health services, not just Launceston General Hospital, should reflect on their own child safe practices and closely consider the findings and recommendations in this volume. The issues identified at Launceston General Hospital can, and no doubt do, occur in other health services. We would like all health services to benefit from implementing our recommendations.

We once again recognise the hard-working people in Tasmania's health services, the great majority of whom always seek to act in the best interests of children and young people and ensure their safety. We again express our profound appreciation to the many victim-survivors, their families, current and former staff, advocates and others who contributed to our Commission of Inquiry. We acknowledge your suffering and pay tribute to your efforts to bring incidents of abuse, and the broader matters at Launceston General Hospital, to the public's attention, motivated by a desire for justice and to ensure other children and young people do not have to experience the same trauma. We also recognise former patients and their families and carers who have experienced abuse at Launceston General Hospital or in other Tasmanian health services, and those who may have chosen, for a range of reasons, not to come forward.

The commitment of many who spoke with us about improving the safety of all children and young people in health services was palpable. We trust that this will translate into meaningful and long overdue change in Tasmanian health services.

Notes

1 As adopted by the *Health Practitioner Registration National Law Act (Tasmania) 2010* s 4.

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3 'Child Safe Organisation Project', *Department of Health* (Web Page) <https://www.health.tas.gov.au/health-topics/child-and-youth-health/child-safety-and-wellbeing/child-safe-organisation-project>.

4 Debora Picone and Karen Crawshaw, *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (Report, December 2022) 7.

5 Jeremy Rockliff and Kathrine Morgan-Wicks, 'Child Safe Governance Review of the Launceston General Hospital and Human Resources' (Media Release, 3 July 2022) <https://www.premier.tas.gov.au/site_resources_2015/additional_releases/child_safe_governance_review_of_the_launceston_general_hospital_and_human_resources>.

6 For the full terms of reference, refer to Debora Picone and Karen Crawshaw, *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (Report, December 2022) 23–24.

7 Debora Picone and Karen Crawshaw, *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (Report, December 2022) 27 [2.47].

8 Debora Picone and Karen Crawshaw, *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* (Report, December 2022) 27 [2.48].

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10 We understand that the Chief Executive, who was appointed in December 2022, resigned from the position in or around April 2023. Refer to Charmaine Manuel, 'Jen Duncan Departs as Hospitals North Chief Executive', *The Examiner* (online, 22 April 2023) <https://www.examiner.com.au/story/8168233/departing-hospital-north-boss-to-ensure-a-smooth-transition/>.

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14 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 2.

15 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 6.

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17 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 1.

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19 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 3.

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21 Elizabeth Daly and Malcolm White, *Launceston General Hospital Community Recovery Initiative Co-Chairs' Report* (Report, 16 November 2022) 7.

22 Letter from Kathrine Morgan-Wicks to Commission of Inquiry, 17 December 2022, 1.

23 Elizabeth Daly and Malcolm White, *Launceston General Hospital Community Recovery Initiative Co-Chairs' Report* (Report, December 2022) 16.

24 Statement of Kathrine Morgan-Wicks, 24 May 2022, 9 [64(e)], 56 [474]; Statement of Kathrine Morgan-Wicks, 22 June 2022, 16 [92]. The National Principles for Child Safe Organisations and the Child Safe Standards are discussed in more detail in Chapter 18.

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28 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 9.

29 *Child and Youth Safe Organisations Act 2023*.

30 Letter from Kathrine Morgan-Wicks to Commission of Inquiry, 10 February 2023, 2.

31 Letter from Kathrine Morgan-Wicks to Commission of Inquiry, 10 February 2023, 2.

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33 Letter from Debora Picone and Karen Crawshaw to Commission of Inquiry, 'Submission from the Independent Oversight Group on the implementation of the recommendations arising from the Independent Child Safe Governance review of the Launceston General Hospital and Human Resources', 6 July 2023, 2–3.

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46 Statement of Debora Picone, 21 June 2022, 10 [42].

47 Statement of Debora Picone, 21 June 2022, 10 [42].

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49 Statement of Kathrine Morgan-Wicks, 24 May 2022, 9 [64(e)], 56 [474]; Statement of Timothy Bullard, 12 September 2022, 9 [29]–10 [31]; Statement of Jenny Gale, 23 November 2022, Annexure A (Responses to Commission of Inquiry questions, undated) 8–9 [10]; Department of Health, Child Safety and Wellbeing, 'Framework for the Implementation of the National Principles for Child Safe Organisations – Draft', produced by the Tasmanian Government in response to a Commission notice to produce.

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65 Statement of Kathrine Morgan-Wicks, 24 May 2022, 17 [142].

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68 Statement of Erwin Loh, 24 June 2022, 3 [15].

69 Statement of Erwin Loh, 24 June 2022, 4 [18].

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71 Statement of Erwin Loh, 24 June 2022, 4 [20].

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88 Statement of Benjamin Mathews, 10 June 2022, 12 [41].

89 Statement of Elizabeth Stackhouse, 22 June 2022, 3 [7(f)]; Statement of John Kirwan, 21 August 2022, 4 [20]; Statement of Peter Renshaw, 20 June 2022, 2 [2.1(e)], 3 [2.2(e)], 3 [2.3(e)], 4 [2.4(e)]; Statement of James Bellinger, 10 June 2022, 2 [2.2(f)]; Statement of Helen Bryan, 10 June 2022, 3 [2(f)]; Statement of Susan McBeath, 22 June 2022, 2 [2.7]; Statement of Janette Tonks, 10 June 2022, 2–3 [5]; Statement of Sonja Leonard, 21 June 2022, 3 [14]; Statement of a Nurse Unit Manager, 22 June 2022, 2 [14].

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102 Department of Health, *Child Safety and Wellbeing Framework* (7 September 2022) 9.

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