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

WITNESS STATEMENT OF EMILY SHEPHERD

I, Emily Irene Shepherd of [redacted], in the State of Tasmania, say as follows:

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

BACKGROUND

2. I am a Registered Nurse and hold a Masters degree in Clinical Nursing. My clinical background includes working as a Nurse Unit Manager, Clinical Nurse Educator, a Nursing Consultant in Safety and Quality as well as working across a broad cross section of clinical areas at the Launceston General Hospital.
3. I have also worked in the Private and Aged Care Sector along with supporting undergraduate Nursing Students as a Clinical Facilitator for the University of Tasmania.
4. I am the Current Branch Secretary of the Australian Nursing and Midwifery Federation Tasmanian Branch (**ANMF**) and the Chief Executive Officer of the ANMF Health Education and Research Centre (**HERC**). The Branch Secretary is a role that is elected by the membership. I have held this position since 2018.
5. In my role as Branch Secretary I am responsible for the strategic direction of both the ANMF and HERC and operational oversight of service delivery of both ANMF and HERC.

ANMF POLICY AND PROCEDURE

6. The primary role of the ANMF is to promote and protect the interest of members and in particular to provide professional, industrial and political leadership for the nursing and midwifery industries and the health sector.
7. The ANMF Tasmanian Branch is a branch of the Australian Nursing and Midwifery Federation. We are a professional organisation as well as an industrial one. Consequently, through our members, the ANMF has a comprehensive understanding of the nursing and midwifery professions. Our members work with small and large employers and in public and private settings.

8. As an industrial and professional organisation, the ANMF advocates on behalf of members when issues arise of a professional or industrial nature for individual members or for a collective of members at an individual ward, unit or workplace. The ANMF works hard to provide members with information and support so that they are enabled to raise concerns with their employer directly.

9. If a member does not feel comfortable with that approach the ANMF will support the member by raising issues with employers on behalf of members. This often occurs when members feel that they may be targeted and treated unfairly by the employer if they were to raise the issue themselves, or are concerned the issue may not be given the due consideration if it is raised by an individual nurse, midwife, or care worker.

10. The ANMF has a National Position Statement on Child Abuse and Neglect, a copy of which is attached to this statement and marked **ES-1**. This position statement is publicly available to all members, community members and employers. It sets out what the ANMF considers to be best practice in the protection of children who may be, or have been, subject to abuse or neglect. This document was used to inform the discussions with the Tasmanian Health Service (**THS**) on behalf of members who raised concerns regarding the handling of complaints and responses to concerns as to how those complaints were followed up on with staff - referred to below.

11. The ANMF Position Statement also acknowledges that child abuse and neglect can have a profound adverse impact on a child or young person's emotional, psychological health and physical development, learning and self-esteem. These affects can be lifelong and may be detrimental to the young person's future wellbeing.

12. The ANMF recognises that nurses and midwives play an important role in the prevention and identification of, and intervention in cases of child abuse and neglect and in the ongoing care, education and support of the children and their families.

13. The Tasmanian Health System is hierarchical. If concerns exist, employees are likely to provide that information to a manager or senior member of staff. Incidents in isolation may not give rise to a 'reasonable belief' which require a mandatory report to be made to the Australian Health Practitioner Regulation Agency (AHPRA) as required under the *Health Practitioner Regulation National Law* or to Communities Tasmania as per the *Children, Young Persons and*

Their Families Act 1997. The cumulative effect of multiple concerns, on the other hand, may do so.

14. The ANMF's position is that employers must have policies, protocols and reporting guidelines in place that support a culture of reporting when children, adolescents and young adults are at risk of abuse or neglect. Employers should support nurses and midwives to fulfil their mandatory reporting obligations and provide nurses and midwives with the necessary education in relation to their legislative and organisational obligations in reporting child abuse and/or neglect.

15. The ANMF is of the view that nurses and midwives who report child abuse and/or neglect should be given support and feedback (e.g. notification the individuals complaint has been received and actioned) on the process and that counselling for nurses or midwives should be readily available as required. Of equal importance is education, training and support being made available to parents of children identified as vulnerable or 'at risk' of abuse and/or neglect along with community education to raise awareness of the impact of child abuse and neglect and to promote and enhance the safety and welfare of children and young people. The obligation to protect children needs a holistic approach and the ANMF is committed to empowering its membership to do so and, more broadly, to being a proactive stakeholder in improving the safety of children in Tasmania.

16. In terms of the ANMF's own employees, the ANMF National Position statement is supported by a branch Mandatory Reporting Policy which reiterates to ANMF and HERC employees the legislative and registration requirements for mandatory reporting, as well as the options for support for employees who may develop a reasonable belief that a child is at risk. To my knowledge, this has not occurred to date. A copy of the Mandatory Reporting Policy is attached to this statement and marked **ES-2**.

17. Currently all organisers and educators in HERC and the member support team (who provide telephone/email advice) are registered as nurses and midwives and are aware of their mandatory reporting obligations.

18. The Tasmanian Branch also runs annual, all-staff training about the policy and the support that any member of staff can expect in the event that they need to make a mandatory report. Such support includes dedicated time to make the report, administrative assistance and counselling support.

SUPPORT PROVIDED TO MEMBERS

19. The ANMF acts as an advocate to support any member who is required to respond to allegations of a serious nature or otherwise. This involves advising the member on what they can reasonably expect in terms of due process and principles of natural justice. This support continues throughout the course of any investigation and the member is advised what is appropriate in terms of a right of reply. We encourage participation from the member to draft up their own responses or attend meetings as required.

20. The ANMF is not responsible for the conduct of the investigations conducted by the employer. The ANMF would advise members who are subject to allegations of criminal conduct to seek independent legal advice. For matters brought to the attention of the ANMF with respect to a conduct allegation made by an employer, ANMF member support and ANMF organisers will also remind members of their own self reporting requirements to the Nursing and Midwifery Board of Australia.

21. The ANMF also advocates on behalf of members on workplace matters. This includes ward or unit wide workload advocacy. In general, the most significant workplace representations the ANMF undertake is in addressing the working conditions for members due to workloads or workforce challenges associated with high vacancy rates of nurses and midwives.

22. More broadly, the ANMF advocates on behalf of members in negotiating industrial agreements which support improved working conditions and entitlements of members. The ANMF also advocates on behalf of members in relation to health policy which may have a professional impact on members.

JAMES GRIFFIN

23. James Griffin was an ANMF member for 19 years and a workplace delegate on the Children's Ward (Ward 4K) at the Launceston General Hospital (**LGH**). During his 19 years as an ANMF member, James Griffin did not contact the ANMF at any time to seek industrial representation for any disciplinary action matters, nor was the ANMF made aware of any disciplinary matters raised against him. Importantly, the ANMF were unaware of any allegations of child sexual abuse (or even inappropriate behaviours) being levelled against James Griffin until after his death on 18 October 2019.

24. On behalf of members, and in his role as workplace delegate, James Griffin contacted the ANMF on isolated occasions seeking clarification on award and agreement matters and he participated in collective events and action such as the Annual Delegates Conference and industrial campaigns.

25. As at May 2022, there were 201 ANMF workplace delegates across the State, with 40 at the LGH.

26. Details of James Griffin's membership and details of his interactions with member support, as they are documented in the ANMF member database, are attached to this statement and marked **ES-3**.

27. James Griffin was elected as a workplace delegate on Ward 4K in 2004.

28. James Griffin came to be a Ward 4K Workplace Delegate by following the election process. At the time this included:

    (a) Nominating for the role via a nomination form which must be supported by the signatures of two fee paying ANMF members;

    (b) Submitting the form to the ANMF and displaying the nomination in the workplace for 7-10 days; and

    (c) In the event that any objections are raised during the notice period, the nominee is advised that a ballot will be undertaken of all ANMF members on the ward or unit and only a majority vote in the affirmative will result in election.

29. Two years ago an additional step was added to the above process to ensure that all ward/unit members were given notice of a delegate's re-election. The nomination and re-election forms are now sent to all ANMF members who are listed as working in that the relevant ward or unit, along with instructions about how objections can be raised.

30. Mr Griffin carried out his role as a workplace delegate to a satisfactory standard. He raised the occasional basic industrial query on behalf of colleagues on Ward 4K (see **ES-3**), attended the Annual Workplace Delegates Conference and also participated in broad ANMF industrial action such as any campaigns associated with Enterprise Agreement negotiations in the public sector. Mr Griffin's activity as a workplace delegate was not dissimilar to other ANMF workplace delegates and he was certainly not overly enthusiastic. At no time did the ANMF receive any complaints about Mr Griffin in his role as a Workplace Delegate.

31. At various times, while Mr Griffin was a delegate on Ward 4K, there was more than one ANMF representative on the ward. This can be very helpful when assisting a workforce who work shifts on a 24/7 basis.

32. During his time as an ANMF member, Mr Griffin never contacted the ANMF for representation regarding complaints against him, nor were the ANMF ever made aware of any complaints (or concerns) regarding Mr Griffin's conduct until after his death.

33. The ANMF was not made aware of allegations of child sexual abuse being made against Mr Griffin until after his death on 18 October 2019. The ANMF was first made aware of these allegations on 21 October 2019 when ANMF Ward 4K Delegate Will Gordon contacted the ANMF seeking assistance for ANMF members who felt they were not getting enough support after being made aware of the allegations against Mr Griffin and his subsequent death.

34. The ANMF was shocked and horrified to learn of these allegations against Mr Griffin. We were also disappointed by the lack of support provided to Ward 4K staff who were equally distressed and traumatised. Members were further distressed because they were dealing with the death of a long-term colleague who, until the allegations came to light, had been well liked and respected on the ward.

LAUNCESTON GENERAL HOSPITAL

35. The ANMF, as an advocate for members, interact on nursing and midwifery related matters with the applicable nurse or midwife for the relevant area.

36. Individual matters are addressed by working with the individual member, however, on broader matters the ANMF will engage with the Nurse/Midwife Unit Manager if collective matters exist that need to be raised or resolved. The *Nurses and Midwives (Tasmanian State Service) Award* and the *Nurses and Midwives (Tasmanian State Service) Agreement 2019* document the Grievance procedures outlining the communication and governance structure that the ANMF and the Tasmanian State Service have agreed to use in the event that there is a grievance or a specific workload grievance. The workload grievance outlines who the ANMF should contact during these processes and involves the Nurse/Midwife Unit Manager up to the Executive Director of Nursing/Midwifery. During the grievance process, it is the usual practice of the Tasmanian Health Service to have a Human Resources delegate attend

individual member matter meetings or a specialist panel meeting if it is convened as a result of workload grievance.

37. In the instance of concerns raised in October 2019 by the Ward 4K members at the Launceston General Hospital, the ANMF convened a members' meeting on 24 October 2019 (myself and [redacted] (**Organiser**) were in attendance), where we listened to the concerns of members.

38. Following the meeting I made contact with the Nurse Unit Manager of Ward 4K (**NUM**) and the Nursing Director of Women's and Children's at the LGH to verbally report back on members' concerns. I also advised that ANMF would put these concerns into writing on behalf of members to the NUM, Sonja Leonard, to seek feedback to take back to Ward 4K members. This initial correspondence is attached to this statement and marked **ES-4**.

39. When I followed up on a response to that correspondence the Nursing Director (**ND**), Janette Tonks, indicated that a response would be forwarded by the Chief Executive (**CE**) of Hospitals North/North West, Eric Daniels. The response I received to the ANMF's initial correspondence is attached to this statement and marked **ES-5**. The response included a request to direct correspondence regarding the Ward 4K matters to the Executive Director of Nursing (**EDON**). This request was outside the usual process for ANMF correspondence and was an exception to the usual constant reminders that all ANMF matters should first be directed to the NUM.

40. In addition, after a request to meet with the CE, Mr Daniels, he wrote to the ANMF stating: "*Regrettably the tone and content of your email correspondence has caused significant distress*".

41. On 1 November 2019, the ANMF replied to Mr Daniels noting that it was not the intention that our correspondence would cause distress. All efforts to meet with the NUM and ND to discuss members' concerns prior to formalising concerns in writing were noted, as were the attempts to contact the NUM and ND via phone in response to the Ward 4K staff meeting which had been held on short notice on 30 October 2019 by Dr Peter Renshaw to update staff on the investigation status following James Griffin's death. The ANMF subsequently agreed to direct further correspondence regarding this matter to the EDON.

42. On 5 November 2019, the ANMF received an invitation from the Executive Assistant to Mr Daniels, for a meeting to be held on 6 November 2019. The

ANMF indicated that the Branch Secretary and Industrial Officer [redacted] would be in attendance and requested permission for Ward 4K workplace delegate Will Gordon to attend.

43. The request to take Ward 4K Workplace Delegate Will Gordon was not supported by Mr Daniels. I felt at the time having a Ward 4K Workplace Delegate to articulate the views of members was likely to be useful in providing context and clarification to members' concerns rather than raising these second hand via the ANMF. It would also have provided the opportunity for a Workplace Delegate to speak openly with Senior Management, an opportunity which had not been provided previously.

44. On 6 November 2019, the ANMF ([redacted] and myself) met with Mr Daniels and the THS Human Resources Representative (James Bellinger) along with Helen Bryan, Executive Director of Nursing and Midwifery. There was also a THS minute taker present. Mr Daniels thanked the ANMF for attending and then immediately again raised his perception that the ANMF correspondence had caused significant distress to the Ward 4K NUM and that it was incongruent with the assertions that ANMF had wanted to support all Ward 4K staff. Mr Bellinger said something along the lines that the way in which an issue was pitched had a big impact on outcomes. I reiterated that it was not the intention to cause distress and regretted any distress that had been caused. I reiterated that steps were taken by the ANMF in an attempt to minimise any potential distress to the NUM and ND by declaring the member concerns immediately following the meeting and advising that these issues would now be put in writing to enable a response. It was noted that the views in the letter were not the personal views of the ANMF, they were in fact the views of ANMF members on Ward 4K, which were perfectly legitimate concerns which needed resolution.

45. Mr Daniels asked where the evidence was to support ANMF member claims that complaints had been made and not acted upon. The ANMF outlined one example of a recent report on the Safety, Reporting and Learning System (**SRLS**) report that had not resulted in any feedback to the individual staff member. Mr Daniels suggested that the nurse should seek this feedback themselves. The ANMF asserted that the whole point of the SRLS was to be a continuous feedback loop where individuals who raised reports could understand the outcome and any safety and quality improvements

implemented as a result. The ANMF were advised that feedback is not automatically given to the person raising a concern. The ANMF had to advocate strongly to seek a commitment for feedback to be provided to any staff member who had previously raised complaints about James Griffin without the staff members having to request this, even though the ND had already provided this commitment.

46. Mr Daniels produced a copy of the *Children's Young Persons and Their Families Act 1997* (Tas) and asked if members had made a mandatory report about James Griffin as they were mandatory reporters and were responsible to make a mandatory report. The ANMF highlighted that members had reported concerns to their manager. However, due to the culture of being discouraged, by medical staff who wished to make the report and management, from making individual reports they were of the belief that a report would be made following assessment by management.

47. Mr Daniels then stated that as employers they felt there was insufficient evidence to substantiate mandatory reporting to be carried out by THS. In my view, if that were the case, given that all concerns had been escalated to management, it is difficult to see how an individual employee would have sufficient evidence to raise a like concern. However, if management were aware of multiple complaints from different staff members, this could indicate a pattern as opposed to an isolated event, which is what the individual reporting a one-off concern considered their complaint to be.

48. The ANMF reiterated members' concerns about feeling silenced and unsupported. Mr Daniels asked who they had raised their concerns with. The ANMF advised that individual members had raised the concern with the NUM but felt powerless and unsure as to who next to raise concerns with, which is why they then approached the ANMF. The ANMF reinforced that it was reasonable for members to seek ANMF support. Mr Daniels replied that he was not questioning ANMF involvement, his primary concern was about the distress of NUM and ND.

49. Mr Daniels stated that a group debrief was not supported due to his personal experience in group debriefs, the advice taken by HR and the risk of vicarious trauma. The ANMF highlighted that they had also taken advice and had been advised that whatever support is required (and requested) by those affected by the trauma should be provided and that vicarious trauma could also arise by

staff having to talk in code, listening to rumours and not having a forum in which to seek support.

50. The meeting with Dr Peter Renshaw on 30 October 2019 was raised, by Mr Daniels, as evidence of having provided staff with information. The ANMF raised the short notice of the meeting and the anxiety this had caused members and the ANMF were assured this had been addressed.

51. Further, Mr Daniels stated that had this issue 'only' been the loss of a colleague to successful suicide, a group debrief may have been an option but given the complexities around this case it was not supported.

52. At the conclusion of this meeting, I again highlighted the fact that members were in desperate need of support, that they were focused on ensuring that this never happens again and had a strong desire to protect children in their care on Ward 4K. They had also voiced a desire to be assured that any potential victim(s) from Ward 4K be identified and notified so that they could receive support as members recognised the detrimental impact that sexual abuse has on children, families and the community. The ANMF indicated that members felt so strongly about this that they were considering going to the media if it was not appropriately addressed by THS.

53. Mr Daniels strongly advised against this and said that any staff member speaking to the media would be in breach of the *State Service Act 2000* (Tas) and would be placing their employment at risk.

54. My colleague and I were surprised by Mr Daniels' demeanour. We found his approach in attacking the concerns of ANMF members and his defensive attitude drew a parallel to the description that ANMF members advised they had already received when attempting to raise concerns individually.

55. My perception was that ANMF members were being blamed for not having made a mandatory report, despite having made internal reports to their manager. Further, it appeared that nurses had been assigned the sole accountability for failing to seek feedback on these reports. The ANMF felt that the suggestion by members to have management proactively deliver feedback from SRLS reports and other complaints to the individuals who made them along with a group debrief to discuss their concerns regarding reporting, was largely ignored by Mr Daniels. These suggestions could have improved the ward culture and helped the ward collectively move forward to address any system issues and improve safety.

56. During the initial meeting with Ward 4K members, the ANMF raised the legislative requirements for members to make mandatory reports if they develop a reasonable belief that a child is at risk. Members immediately raised the varied reporting processes that take place when a mandatory report for a child on the ward is required and that sometimes they are advised by medical staff that they will take responsibility to make mandatory reports in relation to children on Ward 4K, as they admitted under their care. Members therefore indicated that at times they still made a report themselves, while others indicated that they felt that the medical staff member in that instance had taken the responsibility to make the report. This led to the perception that it was the medical staff members' responsibility as the child was admitted under the medical staff member. Adding to this confusion was the reporting lines when members formed a concern regarding their colleague.

57. Members advised that when speaking with senior nursing staff about their concerns related to Mr Griffin they were at times advised to send an email, at other times the Manager would just take the verbal report and the Manager would verbally advise that the concern would be followed up or at other times an SRLS was advised. This inconsistent advice coupled with the reminders to raise concerns with Managers in the first instance led to confusion regarding reporting requirements, especially when a concern was developed regarding an employee versus a child's domestic situation when admitted to Ward 4K.

58. In addition, members reported minimal, if any, education and training on mandatory reporting obligations or grooming behaviours. The ANMF has since repeatedly reminded members of their mandatory reporting obligations and circulated a broad communication to all members regarding these obligations.

59. Following this meeting, the ANMF continued to provide as much support and guidance to members as possible. Members continued to be distressed by the lack of investigation into the potential and/or actual victims on Ward 4K, although were later aware of an open disclosure process, or any attempts to improve systems and policies to prevent this from happening again. The ANMF therefore recommended to members that they could consider lodging a complaint with the Integrity Commission. As a result, the ANMF is aware that a report was made by a Ward 4K staff member and referred to the Secretary of the Department of Health, Kathrine Morgan-Wicks. The ANMF is also aware that the then Minister for Health, Sarah Courtney, was made aware of

members' concerns via a Ward 4K staff member but again, no further action was taken. The ANMF had also discussed members concerns with the Secretary of the Department of Health, with the Minister for Health during quarterly meetings and continued to advocate for members with respect to escalating concerns where they feel they need to, including outside of the Tasmanian Health Service. This type of advocacy is ongoing and occurred as recently as 29 June 2021, through communication to the Acting Executive Director or the Royal Hobart Hospital (**RHH**), when a communication memo and flow chart was released to RHH staff indicating that all concerns must first be raised with the Nurse Unit Manager. A copy of this communication memo and flowchart is attached to this statement and marked **(ES-6.**

60. On 30 October 2020 a podcast titled '*The Nurse*' was released by independent journalist Camille Bianchi detailing the allegations against James Griffin. When *The Nurse* podcast was released, it was only then that an investigation was launched by the Department of Health. 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.

61. Attached to this statement on a confidential basis and marked **Confidential ES-7** is an earlier submission from the ANMF which has been provided to the Commission. Members were quite clear that this to be provided on a confidential basis due to their fear of reprisal if they were to speak publicly.

RECOMMENDATIONS

62. The ANMF request the Commission consider the following recommendations with respect to the Tasmanian Health Service:

(a) Reporting systems be improved to ensure that one consistent approach is utilised Statewide and records, tracks and highlights themes and provides alerts where required for further investigation.

(b) Mandatory education and training is provided on reporting requirements, monitoring and identifying grooming behaviours for all staff (caring for children) every 12 months and more frequently in areas where children are present.

(c) Provide patients and their families with information on expected professional care standards and their rights as patients/parents as well as what to do if they have concerns.

(d) Work on improving an open and transparent culture right across the Tasmanian Government, Department of Health and the Tasmanian Health Service, that values reporting, continuous feedback mechanisms free from victimisation, is essential.

(e) Consider whether there is actual value in regular 'working with vulnerable people' checks given that these will only detect behaviour that has been reported to the police *and* been the subject of a finding. An initial police check at the time of employment would serve the same purpose.

(f) Ensuring early sharing of potential risks between Government agencies could avoid an over reliance of the working with vulnerable people checks as a single safety mechanism (if these are to be retained).

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

Declared at [redacted]

on 23 June 2022

.....[redacted].....

Emily Irene Shepherd

Before me

...[redacted].....

[~~Full name of Justice~~, Commissioner for Declarations ~~or Authorised Person~~]

[redacted]

[Full name of witness]

Dated: 23 June 2022