Statement of HELEN BRYAN

RFS-TAS-058

Name Helen Bryan

Address C/O Launceston General Hospital,

Tasmania

Position Executive Director of Nursing, Tasmanian Health Service, North

1. This statement is made by me in response to RFS-TAS-058 (**'RFS'**), issued on 24 May 2022 by the President of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (the Commission), the Honourable Marcia Neave AO.

2. My name is Helen Bryan, and I am employed by the Tasmanian Health Service, North as Executive Director of Nursing.

Q1. When did you start working at Launceston General Hospital?

My history of employment at Launceston General Hospital is:

- Hospital Based Nursing Training Launceston General Hospital (LGH) February 1966 to 1969 (3 x years)
- Clinical Nurse Educator School of Nursing Hospital Based Training LGH permanent part time 1.8.74 – 12.2 1983
- Charge Sister Medical Ward LGH full time permanent 13.2 1983 – 18.2.1990
- Clinical Nurse Consultant Ward 4D Medical Ward LGH 19.2.1990 permanent full time.
- During 1983 to 1997 there were many organisational changes and position/title name changes but the duties were the same.
- Leave without Pay for 12 months 1989 to complete Tertiary Studies at University of Tasmania for post graduate degree. (upgrading from Hospital based training to tertiary qualification).
- Acting Assistant Director of Nursing - Department of Medicine LGH full time April 1997 – July 2002
- Acting Director of Nursing LGH 17.3.2001 - 16.6.2001
- Director of Nursing LGH 2.12.2001 – 2. 3.2002
- Director of Nursing LGH 11.3.2002 – 28.2.2007
- Executive Director of Nursing Northern Area Health Service (NAHS) 16.5.2011 permanent
- Executive Director of Nursing Tasmanian Health Organisation North (THON) 1.7.2012
- Executive Director of Nursing Tasmanian Health Service North (THS-N) July 2015 – current

Q2. Outline the role(s) you have held at Launceston General Hospital, including in respect of each role a brief description of:

(a) the duties and responsibilities of the role:

Clinical Nurse Educator
CNE was to work with nursing students in clinical areas and assess their knowledge, skills and competence to complete/provide nursing care.
Assistant Director of Nursing
Duties and responsibilities were responsible and accountable for medical wards and service areas of the day as to provision of patient care, support and guidance to Nurse Managers of the clinical wards/areas. Responsible to follow up incidents/accidents which was a carbon copy document at that time and any patient complaints
Director of Nursing – LGH
Duties and responsibilities were responsible for profession of nursing staff employed by LGH at that time and patient care provision.
Executive Director of Nursing (NAHS)
Responsible for strategic and professional activities of nursing and midwifery nursing staff
Executive Director of Nursing - (THON)
Duties and responsibilities were responsible for strategic and professional direction of nursing across THON inclusive of Primary Health District Hospitals x 8
Executive Director of Nursing THS- North
duties and responsibilities for strategic and professional direction of nursing across THS North

(b) the period in which you held the role:

Executive Director of Nursing (NAHS)
As set out in response to question 1
Executive Director of Nursing - (THON)
As set out in response to question 1
Executive Director of Nursing THS- North
July 2015

(c) whether the role still exists:

Clinical Nurse Educator
role no longer exists
Assistant Director of Nursing
Role does not exist in this format due to organisational changes, name, title and classification changes
Director of Nursing – LGH
role does not exist now due to organisation structure changes, name/title and classification changes
Executive Director of Nursing (NAHS)
Role as it was at the time does not exist as NAHS was finalised and changed to THON
Executive Director of Nursing - (THON)
THON as an organisation ceased and name change occurred to Tasmanian Health Services – North
Executive Director of Nursing THS- North
Role still exists but new organisation change to Hospitals North

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

Clinical Nurse Educator
operated from School of Nursing LGH and worked in multiple clinical areas
Assistant Director of Nursing

Department of Medicine as it was at that time
Director of Nursing – LGH
LGH wards/departments and services of the day.
Executive Director of Nursing (NAHS)
Wards /departments and services of clinical areas.
Executive Director of Nursing - (THON)
Clinical Areas/departments of LGH and 8 x District Hospitals (St. Helen's, St. Mary's, Campbelltown, Flinders Island, Deloraine, Georgetown, Scottsdale and Beaconsfield.
Executive Director of Nursing THS- North
LGH Wards/Departments/ Services, Primary Health North - District Hospitals x 8, Community Nursing, Palliative Care Community Dementia Unit, Westbury Community Service.

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

Clinical Nurse Educator
Head of School of Nursing of the day [redacted]
Assistant Director of Nursing
Operationally Clinical Director [redacted] and to Director of Nursing LGH the late [redacted] professionally
Director of Nursing – LGH
Reported to the Chief Executive Officer of the time. Ms Liz Stackhouse to 2003 and Dr. Stephen Ayre 2004 – 2011
Executive Director of Nursing (NAHS)
Reported to Chief Executive Officer at that time [redacted]. Assistant Directors of Nursing each clinical stream reported to EDON (NAHS) professionally not operationally.
Executive Director of Nursing - (THON)
Position reported to Chief Executive Officer [redacted] till June 2014. Nursing Directors of Clinical Stream and Primary Health North reported to EDON only professionally not operationally.
Executive Director of Nursing THS- North
Nursing Directors of clinical streams report to EDON only on professional matters. EDON reports to Group Director of Operations and now known as Chief Executive Hospitals- North and North West. Acting [redacted] and currently Mr. Eric Daniels holds the position.

(f) whether you had any personal performance measure, key performance indicators or financial outcomes in relation to how you or your team responded to child sexual abuse, safeguarding children or keeping children safe:

In relation to Child Sexual Abuse and keeping children safe for all the listed below positions I did not have key performance indicators or financial outcome measures in relation to these aspects.

Clinical Nurse Educator
no performance measures
Assistant Director of Nursing
No performance measures in place
Director of Nursing – LGH
report of nursing registration renewals, nursing care standards and safe staffing no performance measures
Executive Director of Nursing (NAHS)
Nursing Registration, sick leave, Nursing Hours per Patient Day- (NHPPD) (early work) benchmarking and monitoring/management of hours, quality service standards for Accreditation process. And monitoring of reregistration for nursing staff.
Executive Director of Nursing - (THON)

Reported on nursing registration renewals including any conditions or notations on staff registrations, Sick leave, NHPPD benchmarking monitoring and management, Overtime. double shifts reporting commenced 2011. Incidents and accidents, accreditation standards/preparation/documentation.
Executive Director of Nursing THS- North
Monitoring, reporting and management of NHPPD including benchmarking process, Sick Leave, Overtime, Double Shift reporting, Quality Standards review, monitoring, management and evidence for recording/reporting for Accreditation process. Monitoring and management of Nursing Services budget allocation and Government Election Commitment Transition to Practice additional positions allocated to the service. Management of Safety Learning Reporting System SRLS events logged relevant to my role and responsibilities. Any Ministerials and complaints received to EDON office.

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

Clinical Nurse Educator
no requirements
Assistant Director of Nursing
No credentials/qualifications at that time were required
Director of Nursing – LGH
not required to hold qualifications or credentials other than nursing registration. This would include Conditions or notations within registration
Executive Director of Nursing (NAHS)
No credentials of qualifications only Nursing Registration
Executive Director of Nursing - (THON)
no qualifications or credentials only nursing registration.
Executive Director of Nursing THS- North
Working with Children checks were implemented in 2015 – 2016 for staff working majority of time with children. This was not required for EDON position.

Q3. Outline any qualifications you hold that are relevant to the role(s) you have held at Launceston General Hospital.

Bachelor of Health Science in Nursing – Administration University of Tasmania-May 1992
Post Graduate Certificate in Health Services Management Edith Cowan University - August 2003

Q4. If you no longer work at Launceston General Hospital but continue to work within the Tasmanian Health Service or Department of Health, please state your current role and provide a brief description of the duties and responsibilities in that role.

I currently work at Launceston General Hospital.

Incident Management Systems

Q5. Explain the incident management systems that were in place during your time at Launceston General Hospital, including how incidents were reported, recorded and investigated. Include in your answer the time periods for which each system applied.

Initially when in the Charge Nurse and CNC Medical Ward a paper -based system with triplicate carbon copies (white, blue, yellow) was utilised. The incidents were recorded by staff on the clinical areas and submitted to the Nurse In Charge who reviewed investigated and then forwarded these on to the Assistant Director of Nursing of the Department for final review and any required further actions.

From the best of my knowledge I cannot remember timeframes or dates of this but would relate to my roles 1983 to 1997.

The organisation then transferred to Electronic Incident Monitoring System (EIMS) in 2006 with a final report provided by "Taz-e" in September 2011. From this report a Procurement process was undertaken for a new SRLS system. Once a new SRLS system was approved and develop including education and training for staff the "Go Live was 2014. During this period EIMS system continued to be utilised. EIMS system is archived under "EIMS Legacy" on the Department of Health Intranet. Past events are accessible by request to the Safety Reporting Learning System– Statewide Manager. The Department then implemented Safety Reporting Learning System - (SRLS) in 2014 which is the current system being utilised.

Staff complete the report and record the incident/accident event electronically. The Nurse Unit Manager/Department Manager reviews the event logged checking the Severity Assessment Classification (SAC) as per Tasmanian Health Service Protocol - P17/000063 but within the SRLS system it is documented as Severity and Consequence (SAC) rating decision support tool. A File Owner is allocated. The investigation and ultimately closure of event is monitored and reported/documented within the SRLS system.

Q6. Detail any training you have received in relation to using the Safety Reporting and Learning System, and the frequency of this training.

When the new SRLS system was introduced I received training from the Quality Patient Safety Service staff and ongoing training one on one for myself as required as system changes occurred and inclusion of new sections/components such as Alert management. There is available for staff a Module in THEO Learning Management System on the Department of Health Intranet. - htpps://theo.dhhs.tas.gov.au

Q7. Explain your understanding of the Safety Reporting and Learning System, including:

(a) what it is designed to record:

Patient Safety Events, Work Health and Safety, Hazards, Service Delivery events. There is a Tasmanian Health Service Protocol "Patient Safety Event Management" - number P17/000063 available for reference and guidance for staff. Once the safety event is logged within the electronic system it then is forwarded to the relevant supervisor/manager for review/investigation. This includes a Severity and Consequence Rating (SAC 1, 2, 3 or 4). The safety event must be reported as soon as possible but ultimately within 24 hours.

(b) the process a report goes through once logged in the Safety Reporting and Learning System:

Safety event is logged and is forwarded to all Senior Executive staff if the rating is a SAC 1 or 2. If it is a SAC 1 then a "safety huddle" is convened by the Quality Patient Safety Service (QPSS) with membership of a QPSS representative, Director of relevant area, clinicians and executive members to review event and consider the level of care, harm or treatment that may be required. A Reportable Event Brief (REB) needs to be completed and submitted within two business days to the Department of Health Clinical Governance Officer (DoH CGO). Quality Patient Safety Service Staff or Work Health Safety staff review relevant events logged as to event/investigation and review. All SAC 1 events have an investigation undertaken using Root Cause Analysis (RCA) process with membership of personnel not involved in the event. The RCA must be completed in 70 days with a report and recommendations submitted to THS Executive and then to DoH CGO for endorsement of the report. A file owner is allocated to the safety event and needs to be a suitably trained senior staff member and or manager. There is an audit trail within the system and identifies whom has undertaken what actions/step/s. The event is investigated actions recorded

electronically and feedback in writing, email and in person if deemed required to the reporter once the event is referred for closing as to incident/event actions/learnings from investigation including Root Cause Analysis (RCA) panel outcomes and or London Protocol investigation.

(c) the internal notification processes (for example, who would be notified of an incident and when and how they would be notified):

All SAC 1 and SAC 2 events are notified to all Senior Executive staff from the SRLS system as soon as event recorded/reported by email. SAC 3 and 4 events are alerted to manager/supervisor/s for investigation follow up. As a senior Executive staff member I do have access to SAC 3 and 4 events if required for review but investigation/s are undertaken by clinical operational managers of the area.

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

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

SAC 1 a Safety Huddle is scheduled by Quality Safety Service staff with key senior executive invited including the EDMS, EDON and now the newly appointed Director of Operations plus representative of the clinical division where the incident relates to, such as Director of Division, Clinical Medical Manager of the area, Nursing Director of the Division and QPSS - Director of Improvement to discuss and review the event. From that process a Root Cause Analysis Panel would be established with independent panel members included not involved in the event. If it is a SAC 2 a London Protocol investigation would be followed up with members who are not involved in the event with recommendations recorded on agreed template and submitted to the THS - North Quality and Patient Safety peak committee and actions recorded within the SRLS system 'actions' by the allocated file owner.

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

If Work Health and Safety event then it may need to be reported to Worksafe Tasmania, Child Safety Services, Tasmanian Police, AHPRA or relevant external body as deemed required such as Pharmaceutical Board. This could be notified by any staff member or public to AHPRA but under Children, Young persons and their Families Act 1997 (Tasmania) as a registered nurse I am required to report any concerns. I would inform the CEH North /North West as the event and need for reporting to above areas.

(e) Whether reports can be edited, changed or deleted by staff, and if so:

(i) By whom edits can be made:

Events are be logged by staff member/s all edits made are recorded and are able to be identified who made the edits/changes within the SRLS system through the audit trail process if changes are made. I cannot think of any incident I would close and I certainly would not personally alter information submitted in a report by another person. I am not aware of any ability of masking of the audit trail within the system.

(ii) How edits can be made; and

Feedback either in writing, email and or verbal face /face meeting is provided by the allocated File Owner as to the event investigation, steps and process to be undertaken are provided to the reporter.

(iii) How edits can be identified.

Feedback to patient and or family as to investigation are discussed with patient/family using Open Disclosure process. Depending on circumstances this may include the need for referral to counselling or EAP in relation staff members. For example if it was in relation to Child Sexual Abuse I would expect discretion and ensure systems have been activated and in place.

Reporter is kept informed of the investigation any action/steps being undertaken during the process. This would be recorded in the system for review purposes.

Q8. Outline your experience (if any) using the Safety Reporting and Learning System, including:

(a) the circumstance in which you as Executive Director of Nursing would be made aware of or have access to a Safety Reporting and Learning System report and your role in responding to such a report;

I have ability to report any safety event into the system I become aware of. Areas of my operational responsibility that report directly to me such as Infection Prevention & Control Unit, Rostering and Information services. I review the safety event, ensure a file owner as well as Risk Owner is allocated. The investigation of the event is then commenced with that being changed in system from submitted to investigation under review. A review SAC risk rating and determine if the rating is correct as per risk. Contact the reporter as and when required if further details are deemed required or there may be a need to follow up with another department manager or external contractor/s that may be undertaking work within the organisation.

SAC 1 and 2 I receive electronically so I am informed of the event in a very timely manner at time of logging the event. (Only issue is I cannot review SRLS from home if event is after hours system not accessible).

(b) if you are or have been responsible for responding to a Safety Reporting and Learning System report of child sexual abuse or inappropriate behaviour towards a child, outline the general steps you have taken (or would take) to investigate and respond to the report, including:

I have never had to investigate or report on a Child Sexual Abuse or inappropriate behaviour towards a child in any of the roles I have undertaken at LGH.

(i) the circumstances (if any) in which you might alter the report;

I would review the incident and never alter what has been recorded by the reporter. If it was a report I had prepared I would correct any typos and or grammatical errors, but if it was a report prepared by someone else I would refer my comments/feedback to the person who had prepared the initial report.

(ii) the individuals you would consult as part of your investigations;

I would advise the Chief Executive Hospitals North /North West as my supervisor. Advise Senior HR Consultant. The CEH N/NW would notify Department of Health as to the safety

event. I may need to contact the reporter of event, manager and another department manager, depending on investigation. I ensure I have sound systems and processes in place and obtain Statements from relevant staff who may be involved in the event or aware of event including Manager and any witnesses to the event. Depending on the report/allegations it may be required for the employee to be suspended with pay until the investigation is fully undertaken. Hence why CEH N/NWest and Senior HR Consultant need to be informed so natural justice and procedural fairness can be applied. Once investigation is completed CEH, HR and Department representative are provided with report as to determination/recommendation/actions including notification of AHPRA as to professional conduct and mandatory notification for potential sexual misconduct, impairment, intoxication, practice outside accepted professional standards. Also as a registered nurse under Children, Young Persons and Families Act 1997 (Tas) I am required to report any concerns with abuse or neglect.

(iii) the criteria you would apply in order to determine whether the report was "substantiated" or "unsubstantiated"; and

I base my decisions as to if the report is substantiated or unsubstantiated on the balance of probabilities to substantiate the findings. I apply procedural fairness and natural justice principles and obtain statements from reporter and or complainant, any witnesses to the event their statements and any other named or key person in relation to the event. I would gather facts and base the substantiation of the investigation and facts and balance of probabilities as to whether the allegations can be substantiated.

(iv) the individuals who would be informed of the outcome of your investigations.

I would inform the CEH North/NorthWest, HR Consultant, Area Manager, reporter and or complainant and witnesses. Open disclosure process would be implemented/ addressed with the complainant. The CEH would notify DoH CGO.

Risk management at the Launceston General Hospital

Q9. Outline the risk management framework or structure at Launceston General Hospital during the Relevant Period and the role of Executive Director of Nursing within it. Include in your answer any significant changes that occurred during the Relevant Period and the role of Launceston General Hospital executive management team and/or its committees.

At time of Tasmanian Health Service North (THON) there was a Risk Management Policy (2014) – P14/000004 and at that time Risk Registers were maintained electronically via spread sheet/excel by the Department /Service Area. I maintained register for Nursing overall as well as I was Risk Owner for Infection Prevention & Control as I manage that service day to day for the THSN. This was replaced with the Tasmanian Health Service Risk Management Protocol September 2018 – P16/000281 which is still the current protocol being utilised. There is a Department of Health Risk Management Policy – P2012/0190-007- April 2016 which is still current at this time. The policy mandates the use of the Risk Management Framework and is clear that risk management is every staff member has responsibility. At this time the Risk Registers were included within the SRLS system. The protocol is aligned to the Risk Management Framework and provides direction and allocates responsibility ensuring systems and processes are in place. The framework is aligned to Australian Standard AS ISO 31000:2018 Risk Management Guidelines.

SRLS Risk Registers are in place and identifies the risks, risk owners, and application of risk management process. THS State-wide Risk Register is managed by Health Executive, THS Executive and THS Quality

and Safety Committee. The Quality and Safety Committee name changed at Hospitals North to Healthcare Quality Executive Committee after consultation where Executive and Quality committees were joined together as one in late 2021 where the Terms of Reference were endorsed. Extreme risks are documented, monitored and discussed as to identify if strategies/actions are addressing the risk. For Nursing and Midwifery as EDON and Risk Owner I am accountable to maintain, manage, monitor and report on documented known risks for Nursing. For example on the risk register there is a risk related to Workforce, Safe Staffing, Double shifts, Vacancy rates and this highlights management of the risk, actions and treatments and is currently a risk score of high.

Within the Protocol we utilise a Risk Acceptance Table which includes low to extreme risk by a risk score. As part of this table it includes the acceptance of the risk, timeframe, action and treatment as well as the SAC rating. According to the risk acceptance table this identifies the timeframe for review within the SRLS logged Risk Register. THS Departments and Service areas are responsible to maintain the risk registers for respective areas and report through to Hospitals North Healthcare Quality Executive as the peak Quality and Safety Committee for THSN any new risks or extreme risks including actions and treatment plans. There is a THS Risk Management table within the protocol for assigning risks and at what level and to whom the Risk is allocated. The Risk Owner and file owner are different when assigning the risk.

Q10. Explain how the framework described in your answer to paragraph 9 was implemented in relation to the following matters:

(a) Professional boundary breaches:

The SRLS and or Risk register from the best of my recollection/knowledge did not include professional boundary breaches. These were managed and reported to the CEO prior to appointments of CEH North/North West as well as Senior HR Consultant when I may have been informed of a potential breach Any potential professional boundary breaches that were reported to EDON that I was involved in managing the staff member would be kept fully advised of the process in place where it was up to in the system and copies of documentation being provided either by written letter email or personally face to face meeting always with the offer of a support person for the staff member involved to be included in the face to face meeting. These potential professional breaches are investigated and reports/documentation forwarded to AHPRA under mandatory notification. Prior to AHPRA being implemented these were referred to the then Nursing Board of Tasmania. The principles of natural justice and procedural fairness were always applied. AS EDON I am reliant on other managers reporting through potential professional breaches through to myself that they may become aware of. The communication channel in Nursing for reporting is Nurse Unit Manager to Nursing Director of the area through to the EDON.

(b) Professional misconduct:

Again to the best of my knowledge the Risk Registers were not utilised for recording professional misconduct risk management. When these potential professional misconduct concerns were raised the process was managed by Senior HR Consultant, CEH N/NW and EDON or Nursing Director of the area. The CEHN/NW or HR would consult with Head of Agency as to whether ED4, ED5 or ED 6 process/s would be actioned if there were reasonable grounds to believe they should be and it is in the public interest.

(c) Child Safety:

At the time to the best of my knowledge Risk Register was not utilised for recording Child Safety events. When an allegation may be raised under the Children, Young persons and Families Act 1997 (Tasmania) it is clear to name some of the people required to report concerns related to

abuse or neglect are Medical practitioners, registered and enrolled nurses and midwives. The Child Safety Service Liaison Officer (Social Worker) should be notified. THSN have a role such as this working between Child Safety Services and THSN. The manager of the area and the Nursing Director should be informed who in turn inform the EDON, Senior HR and Medical Director, CEH N/NW as well as Head of Agency should be informed of potential allegation As EDON I have a reliance on other senior managers to report concerns to me in a timely manner.

My expectations are that I would expect to be notified by the Nursing Director and or the Nurse Unit Manager of the respective area as soon as they have become aware of an incident related to professional boundary breaches, professional misconduct or Child Safety.

Include in your response your expectations as to when concerns in relation to the above matters would be escalated to you as Executive Director of Nursing, how these expectations were communicated to ward staff, and the circumstances in which you would report concerns to the Executive Director and/or the Head of Agency.

Q11. During the Relevant Period, did you hold any concern that matters in relation to paragraph 10 (a) to (c) were not being escalated to you as Executive Director of Nursing in circumstances where they should have been? If yes, explain the timing and nature of your concerns and any action you took in response, including whether you raised your concerns with anyone else and, if so, what the response was.

No concerns as to the matter. I did not raise concerns with anyone else as the process was not escalated to EDON to manage as it was being managed by Management Women's and Children's, EDMS, HR and Department of Health.

I was made aware of the concern at 1200 midday on the 31st July 2019 by EDMS and no concerns or incidents were reported to EDON prior to 31st July 2019.

Q12. During the Relevant Period, where you referred matters in relation to paragraph 10(a) to (c) to the Executive Director and/or the Head of Agency, did you have any concerns about the response you received? If yes, explain the timing and nature of your concerns and any action you took in relation to them, including whether you raised your concerns with anyone else and, if so, what the response was.

No. Matters that I have been involved with in escalating and actioning I have no concern in the response received or timing of investigation when escalated in relation to ED4,ED5 or ED6 processes. At times there are delays in AHPRA investigation and communication as to outcome, including notifications, suspensions or conditions on staff practice. There has been no delay in any matters I have been involved in.

Professional Misconduct

Q13. Outline the circumstances in which health practitioners or other staff members at Launceston General Hospital would be investigated under the ED4, ED5 or ED6.

Once an allegation is raised with me either in writing, email or personally face to face meeting I discuss directly with CEH North/N West and Senior HR Consultant as to the potential of ED4,5 or 6. As to a potential breach of the professional code I would collect the initial information and if I form a reasonable belief of a potential breach of the code I would refer to HR who would liaise with the Department as to the potential for an ED5 investigation being commenced. Advice and counsel is received from CEH, HR or the Department of Health as to process with determination made by the person with delegations and powers to investigate. Examples of investigation under ED4, 5 or 6 could

include practice by placing public at harm, sexual misconduct, impairment, intoxication drug and alcohol concerns, sexual harassment, Ill health of a staff member unable to fulfil duties.

Q14. In relation to the ED4, ED5 and ED6 processes, explain:

(a) whether, when and how the Executive Director of Nursing would be involved;

EDON would be involved if initially the position was informed and was made aware of allegations. It could be the Area manager, Nursing Director or HR informing the EDON of allegations or a Safety Event reported/logged and forwarded through the SRLS system.

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

CEH N/NWest , HR , Nursing Director of clinical division and the Head of Agency/Department of Health. There may be a need to refer to AHPRA and or to the Office of Chief Nurse/Midwife of the Department of Health.

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

Once I am made aware I inform the CEH N/N/West, HR and CEH in conjunction with HR advise the Head of Agency /Department of Health as soon as concern is informed.

Q15. Explain whether the commencement of an ED4, ED5 or ED6 process at Launceston General Hospital requires reporting to an external body (for example, Tasmania Police, Child Safety Services, the Integrity Commission, the Registrar under the Registration to Work with Vulnerable People Act 2013 (Tas) or other relevant professional bodies). In your answer, refer to any relevant policies, procedures, codes or guidelines and explain whether this position has changed during the Relevant Period.

Depending on the allegation there is always the potential that the external bodies such as those listed may need to be included in the reporting. For example allegations of drug theft or suspicion of theft would need to be reported to Police and maybe Pharmaceutical Society Policies/procedures in place included procedures for Employment Direction 4, 5 and 6 including determinations. Mandatory notification for AHPRA process and Children, Young persons and Families Act 1997 (Tasmania) requirements to report.

Tasmanian Health Service "Workplace Behaviour and Performance" November 2018 and Tasmanian Health Service Protocol "Workplace Behaviour"– November 2019.

Nursing and Midwifery Board of Australia "Code of Conduct for Nurses and Midwives" March 2018, implemented following the retiring of previous versions of Professional boundaries, Code of Conduct, Code of Ethics prior to 2018 version introduction.

Mandatory Reporting

Q16. What is your understanding of when and how to report a concern of child sexual abuse or other child abuse to Child Safety Services? Who do you understand is responsible for making that report?

The "Children, Young persons and their Families Act 1997 (Tasmania) it is clear as to who is required to report any concerns of abuse or neglect in relation to children or young persons.. Included in that are registered nurses and midwives and enrolled nurses, medical practitioners to name some people

required to report. The report should be made at the time the information is received or when aware of concerns.

Q17. What is your understanding of when and how to report a concern about a health practitioner to a professional or regulatory body (including the Australian Health Practitioners Regulatory Agency? Who do you understand is responsible for making that report?

Any member of the public or a staff member can submit a notification to AHPRA. When I as EDON I am informed or made aware of a concern I advise CEH/N/NW and Senior HR Consultant. Statements are obtained in writing including from witnesses if included. AHPRA are notified via mandatory notification/reporting process with all included documentation available by EDON.

Q18. What is your understanding of when and how to make a complaint under the Health Practitioner Regulation National Law (Tasmania) Act 2010 and the Health Complaints Act 1995 (Tas)?

At the time when an allegation /concern is notified to me. Under Health Practitioner Regulation National Law Act 2010 the mandatory notification is forwarded via AHPRA electronic notification site with any documentation that may be available at the time included in notification.

Under the Health Complaints Act 1995 (Tasmania) a complaint can be lodged by a health service user, a child of 14 years of age or a person appointed to lodge complaint on child's behalf, if the child not 14 years of age then the parent or guardian can lodge a complaint, health service provider, the Minister, Health Minister and or the Secretary of the Department of Health can all lodge a complaint.

Q19. What is your understanding of when and how to report a concern about inappropriate conduct to Tasmania Police? Who do you understand is responsible for making that report?

If I have concerns I would raise them at the time with my supervisor the CEH North/North West and or Senior HR Consultant as to my concern and allegation. My understanding is the EDMS normally makes the report to Police. I have never during my employment been required to contact the Police directly.

Q20. What is your understanding of when and how to report reportable conduct to the Registrar under the Registration to Work with Vulnerable People Act 2013 (Tas)? Who do you understand is responsible for making that report?

As per Department of Health – "Employment Checks" January 2022 this needs to be reported to Management and or Human Resources as soon as this is known. Under the Work with Vulnerable People Act 2013 (Tasmania) their is a duty of the reporting body to report if they have suspicion or reasonable grounds of reportable behaviour and notify the Registrar -Department of Justice if this is warranted.

Q21. Are there other notifications you are aware of that are relevant and required to be made in your role, including when and to whom voluntary notifications can be made?

No.

Handling, storing and dispensing controlled drugs and prescription medication

Q22. Where were controlled drugs stored in Ward 4K and how were they secured?

I have never worked clinically on Ward 4K. From my knowledge and required legislation the Poisons Act 1971 and Poisons Regulations 2008 are followed, implemented and managed. This includes securing medications behind two locks. All controlled medications have a Drug Register where controlled drugs are to be checked three times a day for correct count, drugs order is checked then recorded in register and medication chart after administered and signed by two staff members. For Ward 4K child safety needs for storage is to be always considered. Other policies include "Medication Management for Nurse and Midwives" Policy July 2018, Department of Health "Storage of Medicines" Policy November 2021 which are all related to legislation. Cameras have been installed in drug rooms and are monitored and if any concerns are raised footage can be reviewed and checked as to any potential incident but with the cameras installed and signage in rooms as to this this is highly unlikely that incidents may occur. Ward 4K has recently been refurbished through capital works project but all legislative requirements would still be adhered to of Storage and dispensing of Controlled Drugs.

My expectation would be staff followed all the legislative requirements as to Acts and Policy/protocols including two staff checking the order on medication chart, counting the drugs for correctness, administering the ordered/correct dose to right child and right time, checking child armband and always with two staff present. Drugs should never be left sitting in ward/locker/bedtable unattended.

Q23. How were controlled drugs dispensed in and around Ward 4K?

There would be controlled drugs stored in Ward 4K in a secured locked room in cupboard with two locks. Access to the drug room is by card access and can be tracked if required. There are controlled drug checks undertaken by two staff at each shift change with the storage of controlled drugs with the drug register and signed as per the check for correctness. If an error or discrepancy is identified then this needs to be reported to the Nurse Unit Manager or Registered Nurse in Charge of shift and escalated to Nursing Director of the Area or the After Hours Nurse Manager on shift if the error is identified after hours, weekends or public holidays. Pharmacy would also be informed of incorrect count.

From my experience and knowledge I would advise it is highly unlikely as all areas with controlled drugs have same legislative processes in place as previously described.

Q24. Was there any system in place to record when controlled drugs were removed from storage or dispensed in Ward 4K? How were these records maintained and reconciled?

If controlled drugs were removed from storage to other parts of LGH this should be recorded in the Drug Register and signed by two staff with the action taken recorded in the drug register. This process for both for removing from Ward 4K and the ward receiving the drug then documentation of both area drug registers have the recorded action taken.

Q25. Was it possible for nurses or other staff members to remove controlled drugs from other parts of Launceston General Hospital premises into Ward 4K? If so, how?

It is highly unlikely that controlled drugs could be removed with the cameras in situ and regular process for counting/checking correct numbers of controlled drugs at the beginning of each shift to check for correct count of each controlled drug stored on each respective ward.

Q26. Was there any system in place to record when drugs were removed from storage or dispensed from other parts of Launceston General Hospital premises to Ward 4K? How were these records maintained and reconciled?

Controlled drugs have a process in place that is based on legislation as I have previously documented above. The storage and dispensing of antihistamines, antibiotics are not counted as controlled drugs but I again would advise that it is highly unlikely for this to occur without detection.

Q27. Was it possible for nurses or other staff members to remove controlled drugs from Launceston General Hospital premises without detection?

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

Yes it is possible but with the systems and processes in place with checking by two staff members , counting, administration and signing of drug register and the patient Medication Chart it is highly unlikely but if staff do not follow policy particularly at checking and administration then there is a possibility this could occur.

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

Q28. Respond to paragraphs 22 to 27 again but with reference to the storage, handling and dispensing of antihistamines, antibiotics, sedatives and pain killers.

The storage of antihistamines, antibiotics are stored in imprest systems in the clinical areas and there is a possibility that these could be removed as there is not the same processes in place as is for Controlled Drugs including pain killers and sedatives. All Schedule 4 and 8 drugs are recorded in Drug Registers.

James Griffin

Q29. Have you ever worked with Mr Griffin? If so, for how long (including date ranges) and in what capacity?

I have not worked with the deceased Jim Griffin in any capacity whilst employed at LGH.

Q30. How would you describe your relationship with Mr Griffin?

A staff member of the LGH and I had no personal interaction with him.

Q31. Describe any contact you had with Mr Griffin outside of work.

Q32. Do you have knowledge of or did you observe Mr Griffin doing any of the following during the Relevant Period:

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

No.

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

No.

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

No.

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

No.

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

No.

(f) using his mobile phone while on shift;

No.

(g) giving his mobile phone number to paediatric patients;

No.

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

No.

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

No.

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

No.

Q33. If yes, detail:

(a) the nature of the behaviours;

(b) when they occurred;

(c) how you became aware of them;

(d) whether you were concerned by any of them (giving reasons why/why not) you were or were not concerned;

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

(f) how the behaviours were addressed.

Not applicable.

Q34. Do you have knowledge of, or did you observe anything else about Mr Griffin that concerned you, including in relation to his interactions with paediatric patients and/or children and young people generally? Please explain your answer.

No. I did not have any knowledge of any incidents/concerns related to Mr. Griffin prior to 31st July 2019 but from that date and following meeting with EDM and listening to Podcasts I am now aware of allegations.

Q35. In relation to any concern you did hold about Mr Griffin, did you report those concerns to anyone at Launceston General Hospital?

(a) If yes, please explain:

(i) the nature of your concerns; and

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

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

Prior to 31 July 2019, I did not hold any concerns about Mr. Griffin, as at no time was I informed of any concerns or allegations.

After 31 July 2019, whilst I had concerns, those concerns had been as a result of reported allegations which were actively dealt with.

Q36. In respect of any report made by you to anyone at Launceston General Hospital, what process was followed after you made your report? In your answer, explain:

(a) how your report was recorded;

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

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

(d) whether you reported the concern to the Launceston General Hospital executive;

(e) how Launceston General Hospital's executives responded (if at all);

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

(g) whether the process that followed was consistent with your understanding of the relevant policies, procedures, codes and guidelines.

I did not make any notification or report but I understand the Report was prepared by the EDMS. When I was informed by the EDMS of the allegations, I attended the EDMS office and had a meeting with the EDMS, Senior HR, Nursing Director of WACs and in attendance Mr. Griffin where the allegations were explained and discussed with Mr. Griffin and the was advised of the ED

4 process that would be implemented. EDMS notified AHPRA as to nursing registration and situation as was Working with Vulnerable People.

Q37. In relation to any concern you did hold about Mr Griffin, did you or someone else from Launceston General Hospital report your concern to:

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

(b) a Minister or Ministerial Office;

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

(d) Child Safety Services.

(e) the Department of Justice and/or the Registrar under the Registration to Work with Vulnerable People Act 2018 (Tas), and/or the Consumer, Building and Occupational Services business unit within the Department of Justice;

(f) Tasmania Police;

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

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

I did not personally report any concern that I had to any of those bodies. After 31 July 2019, my understanding is that the required reports were made by the EDMS.

Q38. If reports were made to any organisation listed in paragraph 37, detail:

(a) who made the report;

(b) how the report was made;

(c) when the report was made;

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

(e) the outcome of the report.

I am of the understanding that the EDMS made the report(s) and I am unable to comment further on the specifics of the report(s).

Q39. Was the process that followed your report consistent with your understanding of the relevant policies, procedures, codes and guidelines? If no, identify the relevant policy, procedure, code or guideline and explain the way(s) in which the process did not comply with it.

Because I did not make any report(s), I am unable to comment. I am unaware of whether the report(s) made by the EDMS were in accordance with the relevant policy, procedures codes and guidelines.

Q40. Did the fact that Mr Griffin was the delegate of the Australian Nursing & Midwifery Federation impact your response to concerns you held in relation to him? If yes, explain how and why this was the case.

There are ANMF delegates appointed by ANMF and are on all wards of LGH. They work in conjunction as the liaison between ward staff and Industrial Organisation- ANMF raising industrial matters that ward may be experiencing. Once I was informed of the allegations at no time did the fact that Mr. Griffin as a delegate of ANMF have any influence on my actions.

Other people's concerns about Griffin

Q41. In the event that a person raised concerns on the ward about Mr Griffin in relation to the behaviours outlined in paragraph 32, would these concerns automatically be escalated to you as Executive Director of Nursing? If no, who was responsible for determining whether concerns would/wouldn't be referred to you?

No matter is automatically referred to the EDON. I rely on the Nurse Unit Manager and/or Nursing Director of the area to inform or refer matters to me. The Nurse Unit Manager and/or Nursing Director are responsible for determining when matters are referred to me, unless I receive them from someone else directly.

Q42. Did anyone raise a concern about Mr Griffin with you, including the behaviours outlined in paragraph32? If yes, please detail in respect of each concern:

(a) the nature of the concern;

(b) how and when the concern was raised;

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

(d) whether you reported the concern to your supervisor or Launceston General Hospital's executives;

(e) the response of your supervisor and/or Launceston General Hospital management and/or the Launceston General Hospital executive to the concern;

(f) whether the concerns were reported to the organisations listed in paragraph 37; and

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

No one raised any concerns with me about Mr Griffin's conduct.

I conduct an annual review of each nurses Nursing Registration with AHPRA as at 31st May and 30 June each year.

In late May and early June each year, I receive a report from the Rostering and Information Office at the LGH which shows details of all nursing and midwifery staff registration.

Within that report it shows any notations, conditions, suspensions or endorsements for each nurse and midwife. This report does not show if someone has had a complaint made about them to AHPRA, however if that complaint had resulted in any notations, conditions, suspensions or endorsements that would appear.

During my time as EDON, and prior to 31 July 2019, there was no record or documentation of any notations, conditions, suspensions or endorsements on Jim Griffin's employment. The same applied for his Working with Vulnerable People.

Q43. Was the process that followed the raising of the concern consistent with your understanding of the relevant policies, procedures, codes and guidelines? If no, identify the relevant policy, procedure, code or guideline and explain the way(s) in which the process did not comply with it.

When the allegation was raised with me on 31 July 2019, it is my understanding that the relevant policies, procedures, codes and guidelines were complied with.

Q44. Do you have any concerns or complaints about how the concern was responded to by your supervisor and/or the Launceston General Hospital management team and/or executives? Were you directed (formally or informally) to take particular actions that you did not agree with? If so, please detail.

No, I do not have any concerns as to the response of my supervisor.

I have not been directed formally or informally to take any particular action that I did not agree with.

Q45. Did the fact that Mr Griffin was a Ward 4K Australian Nursing & Midwifery Federation Delegate impact your response to concerns raised by others in relation to him? If yes, explain how and why this was the case.

No impact.

Q46. Do you consider the action you took in response to concerns raised by others in relation to Mr Griffin was adequate? Please provide reasons. To the extent that you now consider your actions to have been inadequate, state what action you would take now and why.

Yes, as soon as I was informed of allegations, I responded to the EDMS who requested I speak with him in his office. I had very little involvement with the allegations relating to Mr Griffin after that meeting, as far as I am aware, the EDMS and HR took over the management of the complaint(s) and that was appropriate in the circumstances.

Q47. Are you now aware of any concern(s) or formal reports raised by others in relation to Mr Griffin's conduct, including in relation to the behaviours outlined in paragraph 32, that were not escalated to you at the time but should have been? If yes, explain the nature of the concern or report and the action you would have taken, had the concern or report been escalated to you.

No informal concerns were raised with me in early stages but in hindsight these should have been raised with EDON. As far as I am aware there was only one SRLS logged in the system and this was fully investigated at the time of the event being logged. That SRLS report did not get escalated to me.

Matters related to Mr Griffin should have been escalated to me prior to 31st July 2019. Since that date the Nursing Directors are informing me as to any professional breaches or professional conduct or child safety concerns in their respective portfolios.

Q48. Do you have any other concerns or complaints about how staff, patient or family concerns in relation to Mr Griffin's conduct toward paediatric patients (including the behaviours listed in paragraph 32 above) were responded to by ward staff and/or Launceston General Hospital's executives during the Relevant Period?

(a) If yes, please explain your concerns and what you think should have been done differently;

(b) If no, please explain why you have no concerns.

As I now understand the allegations prior to 31st July 2019, these concerns should have been referred/escalated to the EDON. I listened to the Podcasts by Media where the allegations and concerns were raised but I was unaware of these before that.

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 during the Relevant Period 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.

Q49. Prior to 31 July 2019, were you aware of any allegation that Mr Griffin had engaged in child sexual abuse or had had an inappropriate relationship with a child or young person (whether or not a paediatric patient of Launceston General Hospital)? If yes, state the nature of each such allegation and when and how you became aware of it.

No. I was not informed or aware of concerns until the 31st July 2019.

Your Actions after Mr Griffin's Arrest

Q50. What actions (if any) did you take upon Mr Griffin being arrested by police, including making any mandatory notifications, briefing the Executive Director and/or Secretary, or taking steps to terminate Mr Griffin's employment?

I first became aware when the EDMS Dr. Peter Renshaw came to my office on 31st July 2019 at 1200 midday and asked to speak to me urgently. I was in a meeting with HACSU Officers [redacted] and [redacted] and HR Consultant Mat Harvey. I excused myself and Mat then concluded the meeting on my behalf. I went to EDMS office where EDMS briefed me as to allegations. I contacted Nursing Director WACs to come to EDMS office to inform her of allegations. Mr. Griffin was rostered to work the late shift on 31st July. The Nursing Director went to Ward 4K and asked Mr. Griffin to attend with her to a meeting in EDMS office to discuss the allegations which proceeded with all stated above in attendance and led by EDMS. Mr. Griffin's personal items were retrieved from his locker on Ward 4K by Nursing Director and given to Mr. Griffin after allegation explained and ED$ process and Nursing Director walked with Mr. Griffin from the building. Ward were notified by Nursing Director that Mr. Griffin would not be working shift and would was off sick. It is my understanding that the EDMS notified AHPRA re the nursing registration and the allegation and with HR consultant and CEH N/N/West notification to the Department of Health.

I had very little involvement with the allegations relating to Mr Griffin after that meeting, as far as I am aware, the EDMS and HR took over the management of the complaint(s) and that was appropriate in the circumstances.

Q51. What involvement (if any) did you have in investigating allegations of child sexual abuse and production of child exploitation material by Mr Griffin of patients at Launceston General Hospital? To the extent that you were involved, explain the steps you took and the outcome of the investigation.

I was aware that Mr. Griffin personal phone/computer had been taken by Police to review any material in reference to victim- survivors as EDMS had explained this. After initially being informed of allegation by EDMS on 31st July 2019 and what I contributed my involvement was limited.

I did not have any involvement in investigating any matters in relation to Mr Griffin.

Support offered by Launceston General Hospital

Q52. What action was taken by Launceston General Hospital to identify and support any potential victim-survivors of child sexual abuse by Mr Griffin?

I did not have any personal involvement in relation to this.

I do not have any knowledge of what was done in relation to this.

I believe that this is best answered by the EDMS, WAC's Management, HR or Department of Health.

The following questions relate to how Launceston General Hospital staff were supported by Launceston General Hospital after the allegations about Mr Griffin and his death were known.

Q53. When did you first become aware of allegations that Mr Griffin engaged in child sexual abuse?

31st July 2019 at 12 midday.

Q54. Please explain how you have been impacted by the allegations about Mr Griffin.

I was extremely shocked, very surprised and in disbelief as at no time had Mr. Griffin's professional behaviour or clinical practice/performance concerns been raised or bought to my attention with any related concerns of these allegations.

I was personally notified/reported to AHPRA by [redacted] on 17th October 2020 stating" I had overseen and failed a complaints process that allowed many inpatient children to have been violated by a paedophile and that I was centrally involved". This notification to AHPRA has impacted me greatly personally as the complaint is still under investigation/unresolved as at 9th June 2022.

Q55. What support was offered to you by Launceston General Hospital after the allegations about Mr Griffin were known to you?

EAP /counselling services were available for contact arrangements.

Q56. Were any directions given to staff on Ward 4K regarding their ability to discuss the allegations against Mr Griffin and/or his death? If yes, outline the nature of the each

such direction, who gave the direction, to whom the direction was given to and the reason the direction was given.

There were no directions from EDON office circulated. I am unaware of any other directions made by LGH to staff on Ward 4K.

Q57. What was the response of Launceston General Hospital management and/or executive to the allegations against Mr Griffin and/or his death? Did this response change over time? If so how and why?

I was verbally advised by Nursing Director Critical Acute Care Inpatient Services [redacted] that Mr. Griffin had been admitted to Intensive Care Unit and that he was very unwell. This is not a normal process implemented when staff members are admitted to the LGH as all patients have, as Mr. Griffin did as a patient his right to confidentiality. The only time I am made aware if a staff member is admitted as a patient is if they ask me to be informed. I did not have direct interaction with clinical staff on the Ward. The conversations I had were very limited and these were with two to three staff, all of whom were shocked and surprised as had not heard about the allegations prior.

Q58. How did staff on Ward 4K react to the response of Launceston General Hospital management and/or executive to the allegations against Mr Griffin and/or his death? How were any concerns raised by or on behalf of staff responded to by Launceston General Hospital management and/or executive?

The interactions I had were very limited and those staff I did have interactions with were very surprised and shocked. My understanding informally was that there were various degrees of Staff responses to the situation. There were meetings held between LGH executives and Ward 4K staff but I was not included in those meetings and so I am unaware of what response/reaction there was to that.

Q59. Do you consider the direction and/or responses detailed in your answer to paragraphs 57 and 58 to be appropriate or adequate? Please provide reasons for your answer.

Yes. The response was appropriate as to the limited interactions I had.

Q60. To the extent that you were responsible for any direction or response detailed in answer to paragraph 57 and 58, would you give the same direction or response today? If not, what would you do differently and why?

There was no direction to staff from the EDON office.

In future, I would strongly recommend that the EDON position be included in future management alongside the Clinical Operation Managers in responding to matters of this nature.

Q61. Outline any supports you believe would have assisted you and other staff at Launceston General Hospital to recover and learn from the impact of the allegations about Mr Griffin.

Potentially the offer financial assistance to seek a private provider for counselling outside the organisation.

Other people of concern

Q62. Did you have any concerns about any conduct similar to that described in paragraph 32 in relation to other staff members at Launceston General Hospital or Royal Hobart Hospital? Please answer paragraphs 32 to 39 in relation to each such staff member.

I have no responsibility or accountability for the Royal Hobart Hospital so cannot comment on that. I have had no concerns of similar conduct in relation to any other staff members of LGH raised with me.

Q63. Did anyone raise concerns with you in relation to other staff members at Launceston General Hospital or Royal Hobart Hospital? Please answer paragraphs 41 to 44 and 46 to 48 in relation to each such staff member.

No one raised concerns with me.

Q64. During the Relevant Period, were you aware of past allegations of child sexual abuse at Launceston General Hospital or Royal Hobart Hospital and how such allegations have been managed? If yes, did such awareness influence the action you took in response to concerns in relation to Mr Griffin or any person identified in answer to paragraphs 62 and/or 63 above.

Only staff members I am aware of are:

George - Registered Nurse who is currently Suspended with Pay. I was not involved in the past investigation but I understand this was fully investigated at the time by the then management. The only involvement that I have had in this matter was to notify George that he would be subject to an ED4 suspension with pay.

[redacted] - Registered Nurse on receipt of the anonymous allegations enquiry this was followed up/investigated with a minute signed by the Secretary on the 5th January 2021 advising no further action to be taken. I was personally involved in the investigation of the anonymous allegation made against [redacted] and assisted the acting CPO in preparing documentation to go to the Secretary for consideration.

What should change and how

Q65. With the benefit of hindsight, do you consider that you acted appropriately in relation matters outlined in your statement? If so, why? If not, what would you change or do differently?

I believe once I became aware I acted appropriately in the notification/reporting and escalation.

Q66. Given your experiences at Launceston General Hospital, what do you think needs to change to make children safer from child sexual abuse whilst patients at Launceston General Hospital?

1) Provide annually a module for Education and training for clinical staff on Mandatory notification processes responsibility and accountability.
2) Reinforcement and further training in relation to Professional boundaries/ Conduct of Conduct for staff.
3) Clear Lines of communication and expectations for staff and their associated responsibilities.
4) Design new systems/processes/tools for reporting purposes.

Q67. How do you think the health system's response to allegations of child sexual abuse can be improved?

Clear system /process including a flow chart to be in place with regular education and training for staff with associated responsibilities and accountabilities clearly articulated and explained as well as mandatory requirements.

Q68. What steps do you think Launceston General Hospital should take in an effort to rebuild community trust in Launceston General Hospital?

Community to be informed of changes to system/processes that are to be implemented as outcomes of the Commission of Inquiry. What changes have been implemented as a result. Process of how community consumers are able to submit a complaint of this nature in future to whom with expected timeframes in relation to the process.

The Commission

Q69. Has anyone in a position of authority (whether or not employed by Launceston General Hospital) discouraged you from assisting this Commission? If yes, please outline in general terms the form the discouragement took.

No one has discouraged me in assisting the Commission of Inquiry.

Sources of information for this statement

Q70. Have you refreshed your memory for the purposes of this statement by reviewing any documents or other records or by speaking to any other person (other than a lawyer assisting you with the statement)? If so:

(a) please give details of each person you spoke to and the matters you discussed; and

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

I have asked Director of Human Resource Services Department of Health - [redacted] to obtain my employment history from my personnel file which she has assisted me. Of note " Peruse " is the database that keeps the record of old Payroll System and this was introduced in February 1983 Therefore difficult for me to obtain my employment details prior to that date. Many of the positions I held over time now longer exist and this includes position description/statements of duties.

Other information

Q71. Is there further information you would like to provide to the Commission regarding Launceston General Hospital or Royal Hobart Hospital?

Reflecting on AHPRA re registration and Working with Vulnerable People Check we currently rely on staff members honesty in declaring any aspects that may be associated and should be notified. Consider how the Department may be able to have checks in place with some agreement/approval process to follow up on what is documented.

Investigate an HR process as to AHPRA registration and associated documented conditions/notations on registration in particular when staff member transferring from one facility to another other than referee checks what process could be included from a Recruitment /HR perspective be included as a safeguard mechanism.

Q72. Is there further information you would like to provide to the Commission regarding the Tasmanian Health Service (including any other hospital within the Tasmanian Health Service) and/or the Department of Health?

No.