COMMISSION OF INQUIRY INTO THE TASMANIAN GOVERNMENT'S RESPONSE TO CHILD SEXUAL ABUSE IN INSTITUTIONAL SETTINGS

WITNESS STATEMENT OF MATTHEW HARDY

I, Matthew Hardy of 99 Bathurst Street, Hobart, in the State of Tasmania, am employed as the National Director, Notifications at the Australian Health Practitioner Regulation Agency (**Ahpra**) and state as follows:

1. This statement is provided in response to a notice to prepare and produce a document or statement, which was issued under sections 22(1)(b), 23(1) and (4) of the *Commissions of Inquiry Act 1995* (Tas) (**Request for Statement**).

2. As instructed, the answers to the questions contained in the Request for Statement are provided in the order in which the questions are asked.

Overview

Question 1 – Detail your current role and professional background.

3. I am the National Director Notifications at Ahpra. I have been employed by Ahpra for approximately 12 years and have held the role of National Director Notifications since 2017.

4. I was previously employed in the capacity of State Manager with Ahpra, with time in both of the Tasmanian and Queensland offices.

5. Prior to commencing employment with Ahpra in 2010, I worked as a solicitor in private practice and as a policy and legislative advisor in the Tasmanian State Government.

6. As the National Director Notifications at Ahpra, my main responsibilities include:

   (a) ensuring Ahpra has appropriate mechanisms in place to receive and manage concerns raised about registered health practitioners; and

   (b) providing advice to National Boards established under the Health Practitioner Regulation National Law (**National Law**) about matters relating to the management of notifications.

7. I hold the following qualifications:

   (a) Bachelor of Laws;

   (b) Graduate Certificate in Legal Practice; and

   (c) Graduate Certificate in Public Policy.

Question 2 – Describe the Ahpra model, addressing in particular:

(a) how the National Law applies to health professionals in Tasmania (including which Tasmanian health professionals are subject to the National Law and whether their qualification or registration status determines whether or not the National Law applies);

(b) Ahpra's role in implementing the National Law;

(c) Ahpra's powers and functions, including indicating the source of these powers and functions (for example, the National Law or as delegated by a board or committee pursuant to an instrument of delegation);

(d) Ahpra's role in relation to persons who work in a health-related area but do not fall within the definition of a health practitioner under the National Law; and

(e) how Ahpra interacts with the various National Boards, State, Territory and/or regional boards or committees and any other agencies.

The National Law (Question 2(b))

8. Ahpra and the 15 national health practitioner boards (**National Boards**) are established and governed by the National Law. The National Law commenced in each state and territory on 1 July 2010. In Western Australia, the National Law commenced on 18 October 2010.

9. Prior to the commencement of the National Law, each state and territory individually regulated health practitioners. The National Law was developed in response to an agreement between the states and territories (at a meeting of the Council of Australian Governments, as it then was) in 2008 to develop a National Registration and Accreditation Scheme (**National Scheme**) in respect of health practitioners.

10. The National Law uses an 'adoption of laws' model. The majority of jurisdictions have adopted the National Law as a law of that jurisdiction. The 'host' jurisdiction for the National Law is Queensland, and proposed changes to the National Law, which are agreed upon by the Ministerial Council (comprising health ministers from each jurisdiction, including the Commonwealth) are passed by the Queensland Parliament.

11. There are some exceptions and differences in the extent to which the National Law has been adopted in some states. In particular, New South Wales and Queensland. The differences relate *mostly* to the way in which complaints and concerns about practitioners are managed. New South Wales has a separate model for managing complaints and concerns about New South Wales practitioners. Queensland has a single state-based entity for receiving complaints, with some of those matters subsequently referred to Ahpra and the National Board for management.

12. In Tasmania, section 4 of the *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas) provides that:

    The [National Law], as in force from time to time, set out in the Schedule to the Health Practitioner Regulation National Law Act 2009 of Queensland:

    (a) applies as a law of this jurisdiction; and

    (b) as so applying may be referred to as the Health Practitioner Regulation National Law (Tasmania); and

    (c) so applies as if it were part of this Act.

Role of Ahpra and the National Boards (Questions 2(b) and (c))

13. Ahpra is the national organisation responsible for administering the National Scheme (although, as explained above, Ahpra is not established by Commonwealth legislation). Ahpra provides administrative support to the National Boards in exercising their functions under the National Law. Ahpra collaborates with other healthcare regulators, including Accreditation Authorities, Health Complaints Entities (**HCEs**), and co-regulatory authorities, all of whom play an important role in regulating health practitioners and health professions throughout Australia. Ahpra's work is overseen by its Agency Management Committee, appointed by Health Ministers.

14. There are currently 16 health professions which are regulated by the National Law, comprising, as at the time of Ahpra's 2020-21 annual report, 825,720 registered health practitioners in total. The National Law (and the applicable regulations) establishes a separate National Board in respect of each registered profession, save for the nursing profession and the midwifery profession, which are both regulated by the Nursing and Midwifery Board of Australia. As a result, Tasmanian health practitioners in the following professions are subject to the National Law:

Health profession	Applicable National Board	Number of registered practitioners in Australia (at the time of Ahpra's 2020-21 annual report)
Aboriginal and Torres Strait Islander health practice	Aboriginal and Torres Strait Islander Health Practice Board of Australia	829
Chinese medicine	Chinese Medicine Board of Australia	4,863
Chiropractic	Chiropractic Board of Australia	5,968
dental (including the professions of a dentist, dental therapist, dental hygienist, dental prosthetist or oral health therapist)	Dental Board of Australia	24,984
Medical	Medical Board of Australia	129,066
Medical radiation practitioner	Medical Radiation Practice Board of Australia	17,844
Nursing	Nursing and Midwifery Board of Australia	458,506 (including dual-registered nurse/midwives)
Midwifery		36,033 (including dual-registered nurse/midwives)
Occupational Therapy	Occupational Therapy Board of Australia	25,632
Optometry	Optometry Board of Australia	6,288
Osteopathy	Osteopathy Board of Australia	2,951
Paramedicine	Paramedicine Board of Australia	21,492
Pharmacy	Pharmacy Board of Australia	35,262
Physiotherapy	Physiotherapy Board of Australia	37,650
Podiatry	Podiatry Board of Australia	5,783
Psychology	Psychology Board of Australia	41,817

Application of the National Law to health practitioners (Question 2(a) and (d))

15. In general, the National Law only applies to practitioners who are registered in one of the above professions. Registration in a profession involves an assessment of an individual practitioner's qualifications and suitability against a series of *Registration Standards* published by each National Board.

16. The National Law is based on a system of *title protection*. Broadly speaking, it does not seek to govern the scope of practice of professions registered in the scheme. It precludes individuals who do not have the knowledge, skills and suitability to engage in health practice from holding out to the public that they can.

17. The National Law creates a number of criminal offences which prohibit the use of certain protected tittles (such as 'medical practitioner' or 'psychologist') by persons who are not registered under the National Law. The National Law also prohibits conduct (regardless of whether specific words are used or not) by non-registered health practitioners which could be reasonably understood to indicate that the person is a health practitioner registered under the National Law, and/or authorised or qualified to practise in a health profession.

18. Accordingly, while a person with nursing qualifications who is not registered as a nurse would not generally be regulated by the National Law, the National Law would render it a criminal offence for that person to use the title of 'nurse', or otherwise hold themselves out as a registered health practitioner or a nurse (such as by purporting to practise nursing). Additionally, section 138 of the National Law provides that Part 8 of the National Law (relating to health, performance and conduct) is applicable to health practitioners who were formerly, but are no longer, registered under the National Law (in relation to their conduct while they were registered). This section ensures that Ahpra and the Boards are able to receive and investigate notifications about formerly registered health practitioners (and ensures that any investigations into a health practitioner may proceed even if the practitioner surrenders their registration).

19. The National Law can (and does) limit some specific types of practice from being undertaken by individuals outside of specific professions. For example, the National Law precludes individuals from undertaking certain, permanent dental acts unless the person is registered as a dentist. It precludes people from undertaking spinal manipulation who are not registered in the medical, physiotherapy, chiropractic or osteopathic professions.

20. Registration in the National Law enables portability for practitioners. There is no need to register in multiple jurisdictions in order to practise in multiple jurisdictions.

21. The National Law also creates a *national register* of practitioners. The register, which is public and published on Ahpra's website, contains important registration information about every practitioner registered by a National Board. It also contains information about current restrictions that apply to individual practitioners' registrations.

<u>Further information about Ahpra's powers and functions (Question 2(c) and (e))</u>

22. Ahpra's functions are enumerated in section 25 of the National Law. In summary and as mentioned above, Ahpra's primary function is to provide administrative support to the National Boards, and their committees, in exercising their functions. Ahpra also maintains the national register of health practitioners and establishes procedures for the receipt and assessment of notifications and registration applications. Ahpra's powers are enumerated in section 24 of the National Law and include the powers to enter into contracts and do anything necessary or convenient to be done in the exercise of its functions.

23. While the majority of Ahpra's powers and functions are sourced from the National Law itself, section 37 of the National Law empowers a National Board to delegate any of its functions to, relevantly, Ahpra, an Ahpra employee or a person engaged by Ahpra as a contractor. Instruments of delegation are published on the websites of the relevant National Boards, and instruments of sub-delegation (e.g. in relation to powers which might be delegated from Ahpra's CEO to certain Ahpra staff or other office-holders, such as investigators) are published on Ahpra's website.

24. Ahpra has published a Regulatory Guide, which was developed in consultation with the National Boards and which sets out how Ahpra and the National Boards manage notifications under Part 8 of the National Law (**Regulatory Guide**). Now produced and shown to me and marked **MH-1** is a true and correct copy of the current version of the Regulatory Guide (updated June 2022). A number of aspects of this witness statement will refer to the Regulatory Guide.

Question 3 - Describe, briefly, how Tasmania's health regulatory framework compares to other States and Territories (highlighting only key similarities and differences)

25. Ahpra and the Boards are occupational regulators who regulate individual health practitioners; as distinct from systems regulators, who regulate systemic health complaints or complaints in respect of hospitals, health services or non-natural persons involved in the provision of healthcare (e.g. health service organisations like the Tasmanian Health Service, health complaints entities, such as the state-based health complaints commissioners and/or other bodies such as Safer Care

Victoria). It is often necessary for Ahpra and the Boards to work closely with those other organisations and entities in order to ensure that concerns are properly directed, investigated and that protection of the public is achieved. However, there are certain confidentiality, secrecy and information sharing provisions in the National Law which govern the exchange of information in that context.

26. As explained at paragraph 12 above, the enacting legislation in Tasmania adopts the National Law in full (without any qualifications or amendments). Insofar as it is regulated by the National Law, the health professional regulatory framework in Tasmania is identical to that in the other states and territories which have done so. The position is different in New South Wales and Queensland (being co-regulatory jurisdictions which have their own 'co-regulatory authorities' that manage notifications about registered health practitioners). Western Australia (**WA**) has enacted its own version of the National Law (rather than adopting the Queensland Act), however, the differences between the version of the National Law in force in WA and elsewhere are minor.

27. There are other differences between Tasmania's health regulatory framework and that of other states, including that, in my understanding, Tasmania has not yet implemented the National Code of Conduct for Health Care Workers (**National Code**). The effect of this is that, in my understanding, the Tasmanian Health Complaints Commissioner does not have any disciplinary powers in respect of health practitioners who are not registered under the National Scheme (such as counsellors, massage therapists, sonographers, dieticians, naturopaths and personal care attendants). This is a key distinction compared to states in which the National Code has been implemented (including Victoria, NSW, Queensland and South Australia). However, this is not a matter about which I have direct knowledge (being beyond the scope of the National Law).

Question 4 - Describe, briefly, how the extent of Ahpra's powers and functions in Tasmania compares to its position in other States and Territories. In your answer, explain the reason for any differences.

28. Ahpra's formal powers and functions in Tasmania are the same as in Western Australia, South Australia, the Northern Territory, the Australian Capital Territory and Victoria.

29. The powers are the same in Queensland to the extent that a complaint is referred to Ahpra.

30. New South Wales maintains a different system for managing complaints. Outcomes of the complaints managed in New South Wales are shared with Ahpra for the purposes of updating the national database of complaints and, where relevant, the national, public register of health practitioners.

31. While there are some differences as to the extent to which the National Law has been adopted in different states and territories, those differences relate to Part 8 of the National Law (health, performance and conduct provisions) only. The sections of the National Law which confer Ahpra's powers and functions have been adopted in full in each jurisdiction. However, there are of course practical differences (in that, for example, notifications in NSW are managed by the Health Care Complaints Commission and the Health Professional Councils Authority).

32. In all states and territories, Ahpra and National Boards have the powers to

    (a) publish registration standards, codes of conduct, guidelines and information that apply to the regulation of practitioners in the 16 professions;

    (b) work with accreditation bodies to ensure a rigorous and high standard of education for individuals wanting to train as a health professional, and determine whether international qualifications obtained by individuals are substantially equivalent to enable practice in Australia;

    (c) register practitioners who are qualified and suitable to practise a health profession (regulated by the National Law) in a safe and ethical manner;

    (d) refuse to register individuals who are not qualified or suitable for registration;

    (e) conduct investigations and make enquiries to ascertain whether at the time of application for registration a person is qualified to be registered;

(f) publish information about individuals on the national public register of practitioners, or the register of cancelled practitioners; and

(g) prosecute offences committed against the National Law, including for *holding out offences* or specific offences of an unregistered person undertaking certain restricted types of practice (including spinal manipulation and dentistry as set out above).

33. In Tasmania, just as in all of the other states in which the formal powers under Part 8 apply, Ahpra and National Boards have the power to receive complaints, assess complaints, investigate complaints that require investigation and, in response to complaints, to take certain *protective* actions to preclude or exclude a registered practitioner from undertaking all or certain types of practice.

Question 5 – Explain whether Ahpra undertakes any training and/or campaigning to educate or raise awareness about its role, powers and functions with:
(a) health consumers
(b) health professionals or students, and/or
(c) the general public.
If so, include in your answer a brief summary of this training and/or campaigning.

34. Ahpra undertakes some training and/or campaigning to educate or raise awareness about its role, powers and functions. Separately, National Boards also undertake some training and/or campaigning to educate or raise awareness about the role of the Boards under the National Law and the national registration scheme more broadly.

35. Both Ahpra and National Boards participate regularly in forums with practitioners, professional associations, employers, indemnity providers, education providers, specialist colleges, health complaints entities and departmental representatives and other entities of each of the Australian states and territories and the Commonwealth about specific and shared roles related to the regulation of health practitioners and the protection of patients from unsafe, and unprofessional practitioners.

36. Ahpra and the National Boards play an important role in setting and maintaining professional standards in regulated health professions. Ahpra and National Boards work in partnership with other bodies to ensure that the large population of registered health professionals in Australia have the knowledge, skill and ability to provide safe and effective health services. Some of the ways Ahpra raises awareness about its role, powers and functions include:

(a) publishing the Regulatory Guide, which is public-facing and available on Ahpra's website;

(b) publishing statutory codes and guidelines created by the National Boards (under section 39 of the National Law and, for example, the Medical Board of Australia's *Good medical practice: a code of conduct for doctors in Australia* and *Registration standard: Continuing professional development* and the multi-profession *Guidelines: Mandatory notifications about registered health practitioners*) on the National Boards' websites (which are administered by Ahpra). Ahpra /and the Boards' publications raise awareness with health consumers, health professionals and students, and the general public of Ahpra's role as the regulator;

(c) working with National Boards and accreditation authorities to establish and implement standards for training programs leading to eligibility for registration in a health profession. For example, the Australian Medical Council (**AMC**) is the accreditation authority for the medical profession under the National Law. Accredited primary training courses in medicine must provide, amongst other things, ethical and legal training. The AMC also plays a role in ensuring that overseas trained clinicians are appropriately qualified and competent to be registered in Australia. These functions contribute to ensuring that the health workforce is suitably knowledgeable and skilled and thus support and promote Ahpra's powers and functions;

(d) collecting personal data, which the National Boards use to, amongst other things, contact practitioners with Board specific newsletters. These newsletters, together with the National Board's and Ahpra's websites and social media accounts, are the platforms by which Ahpra and the National Boards communicate changes to policies and guidelines

and provide other important information such as recent Tribunal decisions. These measures educate not only students / practitioners, but the public facing forums (i.e. websites and social media accounts) are also accessible by health consumers and the general public; and

(e) by way of the Ahpra State Managers. The role of Ahpra State Managers is to maintain relationships with key stakeholders including raising awareness and, upon request, delivering information sessions to health consumer advocacy groups, large employers and health department officials. For example, I am aware that:

(i) prior to the commencement of the National Law in Tasmania, a *transition manager* for the state was appointed by the Council of Australian Governments (COAG) appointed implementation team. The transition manager engaged with state entities on the development of the National Law and helped facilitate the transition from the former, state-based regulatory system to the national system underpinned by the National Law;

(ii) after the commencement of the National Law in Tasmania, the State Manager in Tasmania met with health service employers across both the private and public health systems to provide an overview of the national health practitioner regulatory system and to specifically highlight aspects of the National Law that differed substantially from laws that governed previous state-based regulation of health practitioners in Tasmania. One of the most significant differences, and a feature that was a highlight of our early engagement with employers, was the introduction of mandatory notification laws in the National Law that did not exist under Tasmania's old schemes;

(iii) in April 2021, the Tasmanian State Manager worked collaboratively with Health Consumers Tasmania and the Office of the Health Complaints Commissioner to deliver workshops to health consumers and health system professionals to explain how the health complaints system operates in Tasmania; and

(iv) in July 2021, Ahpra worked with health consumer advocacy groups around the country (including in Tasmania) to hold consultation sessions on the development of a Shared Code of Conduct for 12 of the 16 professions regulated under the National Law.

37. Ahpra's policy, communications and engagement teams manage consultations and proactive campaigns with key stakeholders, including practitioners, regularly when there is:

(a) a subject of focus relevant to our work;

(b) a change in a Board standard, code of conduct or guidelines; or

(c) a change in any provision of the National Law.

38. For example, in 2017, the Medical Board of Australia and Ahpra commissioned an independent review of the use of chaperones as a temporary protective restriction on occasions where allegations of sexual boundary transgressions were alleged against medical practitioners. Following that review, the Medical Board and Ahpra published the final report on the Medical Board of Australia website and engaged with key stakeholders to explain how regulatory practices would change in response.

39. As another example, in 2019, changes were made to the *mandatory notification* provisions of the National Law. The change in provisions provided clarity that practitioners who provided health treatment to another practitioner were, in some circumstances, not required to make a mandatory notification about a practitioner that they were treating.

40. To support that change, Ahpra published updated guidance for the professions about mandatory reporting obligations in March 2020. The new rules and guidance material were communicated to professions through the communication channels which are described below.

41. Coverage of news related to changes of this nature among National Board newsletters, professional association literature and commentary and information made available to

practitioners through professional indemnity providers supplements the specific work that Ahpra has done to promote professional responsibilities.

42. I am also aware that other entities such as state / territory health departments, HCEs, professional associations, universities, specialist colleges, insurance providers, other regulators (such as medicine regulators), education providers and employers provide training and/or education in relation to the legal and ethical obligations of health practitioners in Australia. However, I am unable to speak to the nature of that training / education.

Question 6 – Explain whether it is your expectation that:
(a) health professionals and students understand their mandatory reporting obligations, and/or
(b) health consumers and/or the general public would be aware of the existence of Ahpra and understand how they could make a notification to it.

43. It is my expectation that:

    (a) health professionals and students understand and comply with their mandatory notification obligations; and

    (b) health consumers and the general public are aware of the existence of health professional regulation in Australia and that there are mechanisms by which complaints can be made.

44. I have formed that expectation based on my review of social research into general public and health professional awareness and perceptions of Ahpra and National Boards undertaken by a contracted research provider and published on the Ahpra website.

45. In relation to health professionals and students, Division 2 of Part 8 of the National Law establishes the basis on which reporting obligations are, in fact, mandatory. Those obligations are reinforced and published widely in guidelines, codes and standards published by the respective National Boards. For example, the Medical Board of Australia's *'Good medical practice: a code of conduct for doctors in Australia'* (in effect since October 2020) includes requirements that registered medical practitioners:

    (a) comply with any statutory reporting requirements, including mandatory reporting requirements under the National Law; and

    (b) raise genuine concerns about risks to patient safety to the appropriate authority (locally and/or the Medical Board) and comply with mandatory reporting requirements.

46. The Medical Board of Australia supplements the obligations detailed at 44 above with its '*Guidelines for mandatory notifications*'. The other National Boards take differing approaches as to where they include mandatory notification obligations in their guidelines, codes or standards, however I understand that each of the National Boards have detailed the mandatory notification obligations in at least one relevant guideline, code or standard. The mandatory notification requirements are also explained in the Regulatory Guide at pages 10 – 11.

47. As noted above, the National Boards and Ahpra send newsletters to registered health practitioners which, amongst other things, contain updates in relation to relevant guidelines, codes or standards. Those guidelines, codes or standards are also publicly available via the National Board's websites. There is also a page on Ahpra's website titled 'Mandatory notifications: what you need to know'. Between these forums and information provided by other stakeholders, I would expect that students and registered medical practitioners are aware of their mandatory notification obligations.

48. Health consumers and the general public can access Ahpra and the National Board's websites. These websites aim to inform the community about the accreditation, registration and notification systems and conform to Australian government web content accessibility standards. Ahpra's website has a section titled 'concerns about practitioners', where health consumers and the general public can obtain information on:

    (a) general concerns in relation to a practitioner – including whether the viewer is in the right place;

(b) how to submit a concern – including what types of concerns Ahpra can consider, the extent to which a notification can be made confidentially / anonymously and what happens when a concern is submitted;

(c) mandatory notifications;

(d) how Ahpra manages concerns;

(e) when a concern has been made about the viewer; and

(f) other, general information in relation to the notifications process.

49. For those who were not previously aware of Ahpra's existence, they could:

(a) conduct an internet search, for example, for 'health regulator', 'who is the health regulator' or 'doctor complaint', the result of which is Ahpra's website;

(b) submit a complaint to an alternative entity, for example the Health Complaints Commissioner Tasmania (**HCCT**), which would be referred to Ahpra by the HCCT if appropriate; and/or

(c) speak with another entity or person, such as an alternative health practitioner or Tasmania Police, in relation to their options for making a complaint.

50. The Regulatory Guide is also available on Ahpra's website and it is intended to function as a public facing document (directed at health consumers and the general public as well as practitioners).

Question 7 – Outline your understanding as to how health professionals and students in Tasmania are educated about their mandatory reporting obligations, including your expectations as to whether this education is self-directed or provided by others (for example, an employer). In your answer, explain whether the position differs from other States or Territories and whether the current approach in Tasmania is adequate.

51. As detailed at paragraph 36(c) above, the National Boards, supported by Ahpra, work with accreditation bodies to set minimum standards for the content of training programs leading to registration in a regulated health profession. The guidance or instructions provided by the National Boards and Ahpra ordinarily includes professional obligations.

52. I am unable to speak to the education provided by other entities in relation to mandatory notification obligations. I would trust that education was provided by, for example, employers and universities, however the extent to which such education is provided, and the content of that education, is beyond my knowledge.

53. As noted in response to question 6 above, information in relation to a health practitioner's mandatory notification obligations is widely available for health practitioners, and I would expect that registered health practitioners take reasonable steps to undertake self-directed learning to stay current with changes in their profession. Specifically, I would expect that health practitioners and students undertake a degree of training by employers or other entities, with that education supplemented by self-directed learning, including in relation to the mandatory notification obligations established by their respective National Board or otherwise as published on Ahpra's website. National Boards mandate participation in annual Continuing Professional Development to facilitate this ongoing professional learning and development process.

54. Registered health practitioners are legally required to hold professional indemnity cover. Insurance providers work with their members to minimise risk. For example, I am aware that a number of information resources about mandatory notifications are published to the Avant medical insurance website.

55. The position in relation to education about mandatory notification obligations detailed above is consistent across Australian jurisdictions. I believe that registered health practitioners in Tasmania have access to sufficient information to be informed of their professional obligations. However, I do not have access to enough information to enable me to form an opinion about whether Tasmanian practitioners and employers are appropriately informed about their legal obligations.

Question 8 – Explain whether any guidance is provided to health professionals and students by Ahpra (or professional bodies) about:
(a) how to engage with children (including informed consent, conducting intimate procedures and/or chaperoning protocols that require parents or carers present for certain procedures)
(b) child sexual abuse identification and prevention
(c) proper boundaries between health professionals or students and children or young people
(d) the identification of and response to boundary breaches by health professionals or students in relation to children or young people; and/or
(e) the identification of and response to the grooming of children or young people by health professionals or students.

56. As stated at 36(a) above, section 39 of the National Law empowers National Boards to develop and approve codes and guidelines to provide guidance to the health practitioners it registers. Section 41 of the National Law provides that an approved code or guideline is admissible in proceedings under the National Law (e.g. section 193 tribunal referral proceedings) as evidence of what constitutes appropriate professional conduct or practice for the health profession. As a result, guidance to health practitioners about how to engage with children in their professional capacity is the domain of the National Boards, rather than Ahpra (though Ahpra maintains the records of those documents and publishes them on the relevant National Board website).

57. Many, though not all, of the primary codes of conduct developed and approved by the National Boards are similar in structure and content, with some differences between professions. These codes of conduct generally include a section in relation to children and young people, though it is important to note that there are significant differences between the roles of the various professions and sub-specialities.

58. For example, the Medical Board of Australia's '*Good medical practice: A code of conduct for doctors in Australia'* provides that, at 4.6:

    (a) Caring for children and young people brings additional responsibilities and challenges for doctors. Good medical practice involves:

        (i) Placing the interests and wellbeing of the child or young person first.

        (ii) Ensuring that you consider young people's capacity for decision-making and consent.

        (iii) Ensuring that, when communicating with a child or young person, you:

            (A) treat them with respect and listen to their views

            (B) encourage questions and answer their questions to the best of your ability

            (C) provide information in a way they can understand

            (D) recognise the role of parents or guardians and when appropriate, encourage the young person to involve their parents or guardians in decisions about their care.

        (iv) Being alert to children and young people who may be at risk, and notifying appropriate authorities, when appropriate.

59. The applicable codes of conduct in relation to all National Boards universally include extensive guidance about maintaining professional boundaries with all patients (sometimes by way of separate and additional documents, such as the Medical Board's '*Guidelines: Sexual boundaries in the doctor patient relationship'*). The prohibition on boundary transgressions of any kind relates to all patients, including children.

60. Other professional organisations (such as professional associations (e.g. the Australian Medical Association), specialist colleagues, insurers, health departments and employers may also publish information or training material about the topics listed in Question 8, though that is not a matter that is formally within my knowledge.

Question 9 – Identify any gaps or limitations in the National Law (or the current manner in which it is implemented) that restrict or otherwise limit Ahpra's ability to effectively prevent, identify or respond to child sexual abuse in an institutional context.

General comments about the process of amending the National Law

61. As stated at paragraph 10 above, legislative amendments to the National Law (as well as other policy directions) are determined by the Ministerial Council. Ahpra and the National Boards are aware of a number of recommendations for reform:

    (a) being considered by Health Ministers through the policy forums that are used to achieve inter-governmental agreement about matters impacting on the National Scheme; and

    (b) that have been tabled for debate in a Bill before the Queensland Parliament.

62. I understand that an intention of the reforms is to enhance the ability of the National Scheme to respond effectively to notifications, including those relating to sexual misconduct against children (though such notifications are rare).

63. Importantly, the Bill that is currently before the Queensland Parliament to amend the National Law includes a number of amendments that are intended to improve responses to notifications. For example, the Bill proposes to enable prohibition orders to be made to prohibit a person from providing unregulated health services following registration action being taken, make public statements alerting the community to risk and seeks to improve the ability to share information to protect the public. A communique has been issued by health ministers about these reforms and the Bill can be found on the Queensland Parliamentary Counsel website. These reforms are known as the 'Tranche 2' amendments and follow previous Tranche 1 and Tranche 1A packages that have already passed and been implemented. An overview of Tranche 1 and Tranche 1A reforms can be found on the Ahpra website.

Specific comments about gaps in Ahpra's ability to prevent, identify or respond to child sexual abuse in an institutional context

64. There have been a number of other bodies or inquiries which have considered related matters, and the findings arising from these are discussed below. However, I wish to emphasise that, as stated at paragraph 62, notifications concerning child sexual abuse are rare and would almost certainly involve alleged criminality of a very serious nature. In that case, as set out in our response to question 31 below, any action by Ahpra or a National Board beyond responding via immediate actions to limit or prevent practice by an alleged perpetrator is likely to occur after the conclusion of a police investigation or a criminal prosecution.

65. The 2017 Commonwealth Royal Commission into Institutional Responses to Child Sexual Abuse recommended that the National Law be amended to provide notifiers with statutory protection from third party reprisal. This recommendation arose from the Royal Commission's observation that a number of mandatory reporting schemes (including that established by the National Law) did not include such protections, and its finding that those protections should be included.

66. The Royal Commission also noted that statutory secrecy provisions, such as section 216 of the National Law, can present an inappropriate impediment to sharing information about child sexual abuse allegations in some circumstances. Those matters are discussed further in response to question 32 below.

Notifications

Question 10 – Outline Ahpra's powers and functions in relation to notifications.

67. As stated above, section 25(i) of the National Law provides that one of Ahpra's functions is *'to establish an efficient procedure for receiving and dealing with notifications against persons who are or were registered health practitioners and persons who are students, including by establishing a national process for receiving notifications about registered health practitioners in all professions'.* As a result (and in accordance with sections 146 and 148 of the National Law), notifications under the National Law are made to Ahpra directly and then subsequently referred to the relevant National Board.

68. All subsequent decision making with respect to notifications and disciplinary action are made by the relevant National Board (though, as explained at paragraph [23] above, some of these functions may be, and routinely are, delegated to Ahpra and/or to committees of the Boards). The exception to this is the statutory offence provisions under the National Law, in respect of which prosecutions are managed by Ahpra.

69. Chapter 2 of the Regulatory Guide (pages 8 – 15) sets out the notifications process in detail, including the powers available to the Boards during the initial assessment phase.

70. After a notification has been received, the actions and powers available to the Board are, in summary:

    (a) to take no further action in respect of the notification (National Law, s 151(2); see Regulatory Guide, page 15);

    (b) to take immediate action, being interim disciplinary action taken on an urgent basis prior to the final resolution of a matter, including by suspending or imposing conditions on the practitioner's registration (National Law, s 156; see Regulatory Guide, Chapter 3);

    (c) to commence an investigation into the practitioner (National Law, s 160; see Regulatory Guide, Chapter 5);

    (d) to caution the practitioner (National Law, s 178; see Regulatory Guide, Chapter 6 and page 74);

    (e) to impose conditions on the practitioner's registration (or accept an undertaking from the practitioner) (National Law, s 178; see Regulatory Guide, Chapter 6 and pages 75 – 78);

    (f) to direct the practitioner to attend a health or performance assessment (National Law, ss 169 – 170; see Regulatory Guide, Chapter 4);

    (g) to refer the practitioner to a hearing by a health panel or a performance and professional standards panel (National Law, ss 181-182; see Regulatory Guide, Chapter 7); and

    (h) to refer the practitioner to a hearing by a responsible tribunal (National Law, ss 193; see Regulatory Guide, Chapter 8).

Question 11 – Describe how Tasmanian notifications are managed or responded to by Ahpra. In your response, you should address the role of the Health Complaints Commissioner Tasmania.

71. Notifications received are assessed and otherwise managed under Part 8 of the National Law. Specifically, notifications are:

    (a) made under Division 4 of Part 8;

    (b) received under Division 2 and Division 3 of Part 8;

    (c) assessed under Division 5 of Part 8;

    (d) managed under Division 6 and Division 7 of Part 8;

    (e) investigated under Division 8 of Part 8; and

    (f) assessed and/or determined under Division 9, Division 10, Division 11 and Division 12 of the National Law.

72. As noted at paragraph 70], once a notification has been assessed, there are various actions and powers available to the Board.

73. Ahpra routinely receives the details of complaints made to the HCCT. This is a specific legislative requirement under section 150 of the National Law, which requires that all complaints about health practitioners made to the HCCT be shared with Ahpra. Similarly, where Ahpra receives a notification that provides a ground for a complaint to the HCCT, it will notify the HCCT of the alleged conduct under section 150 of the National Law.

74. The arrangements for joint consideration set out in section 150 of the National Law mean that all complaints made to a Tasmanian statutory complaints body with respect to the conduct or performance of an individual registered health practitioner will be shared with Ahpra. Our national database of complaints contains all complaints made about registered practitioners since the commencement of the National Law, irrespective of whether the complaint was made to the HCCT or a National Board.

75. Information about those complaints is available to support the assessment of future complaints about an individual practitioner.

76. Our database also contains information about complaints that were made to Tasmanian state health practitioner regulators before the commencement of the National Law to the extent that those complaints were known to and maintained in a system prior to the commencement of the National Law.

Question 12 – Describe how Ahpra carries out investigations in response to notifications about child sexual abuse. In your answer, explain the involvement of other boards or committees.

77. Investigations, including but not limited to those in relation to child sexual abuse, are conducted by Ahpra on behalf of the relevant National Board in accordance with Division 8 of Part 8 of the National Law. Under that Part, and amongst other things:

    (a) Ahpra will appoint an investigator to conduct the investigation (section 163);

    (b) the investigator will conduct the investigation as quickly as practicable (section 162);

    (c) the health practitioner is to be given notice of the Board's decision to commence the investigation *'as soon as practicable after making the decision'* (section 161(1));

    (d) the health practitioner must be given notice of the nature of the matter being investigated (section 161(2));

    (e) the health practitioner is invited to provide response(s) to the matters being investigated; and

    (f) *'as soon as practicable after completing an investigation…an investigator must give a written report about the investigation to the National Board*' which *'must include the investigator's findings about the investigation; and the investigator's recommendations about any action to be taken in relation to the health practitioner…*' (section 166).

78. Committees of each National Board are also involved in a case that is the subject of an investigation. These committees act in accordance with delegations made by each National Board enabling procedural and usually final administrative decisions to be made about the management of an investigation into an individual registered practitioner. Committees are responsible for making decisions about:

    (a) the assessment of a notification, including whether it is a notification requiring further enquiry by Ahpra and the National Board via an investigative process;

    (b) immediate action. These actions arise when interim protective decisions to limit or preclude a practitioner's practice of a profession are needed pending the outcome of the investigation (section 156);

    (c) the referral of a practitioner to a Panel following an investigation where a finding of unprofessional conduct might be required, or

    (d) the referral of a practitioner to a Tribunal following investigation where a finding of professional misconduct might be required.

79. A committee of each National Board will consider an investigation report at the conclusion of an investigation and determine whether:

    (a) to take no further action; or

(b) to take further action under Part 8 of the National Law.

80. The actions available to a Board at the conclusion of an investigation are set out at page 32 of the Regulatory Guide.

81. Notifiers and witnesses who are likely to be able to provide relevant evidence about issues the subject of a notification are invited to provide witness statements. Notifiers and witnesses are regularly updated during the course of the investigation (though there are limitations on the extent to which non-notifier witnesses can be provided with information about the investigation).

82. The level of involvement of notifiers and witnesses is largely dependent on the extent to which they have information that could assist the investigation. Some notifiers who are personally affected by the behaviour of a practitioner may be involved throughout a proceeding or investigation about a practitioner and require significant support from investigators during the course of an investigation. Some notifiers or witnesses are reluctant to participate in the investigation at all or are willing to provide a statement but do not wish to be contacted for any other reason.

83. Ahpra established the Notifier Support Service (**NSS**) in August 2021. The NSS was specifically introduced as part of Ahpra's ongoing work to improve witness and notifier experience in matters involving sexual boundary breaches and misconduct. The NSS comprises a lead social worker and a social worker, and has been established to, amongst other things:

(a) support Ahpra's notifications and legal staff by providing a social work service to focus on emotional and process support to notifiers and witnesses; and

(b) support notifiers and witnesses to remain engaged and to participate throughout all stages of the process to assist in facilitating and promoting best regulatory outcomes.

84. Relevantly, the NSS prioritises cases in which the notifier or witness is under 18 years of age.

Question 13 – Explain whether there is a difference in how Ahpra treats a notification if the relevant conduct arises within a health setting or outside it. If this has changed over time, explain how and why.

85. Under section 144 of the National Law, a voluntary notification about a registered health practitioner may be made on grounds which include, relevantly *'that the practitioner is not, or may not be, a suitable person to hold registration in the health profession, including, for example, that the practitioner is not a fit and proper person to be registered in the profession'* (section 144(c)). This ground captures conduct that arises outside of a typical health setting (including in a practitioner's private life) which renders them unsuitable, or possibly unsuitable, to hold registration. It is not uncommon for notifications to be made in respect of conduct engaged in by practitioners outside of health settings (such as relating to family violence or non-patient related criminal offending, or in relation to inappropriate conduct on social media).

86. The process of managing an investigation for notifications made under this ground might not differ from that detailed at paragraphs 77] to [81] above. There are different approaches to managing an investigation of a matter where another entity is also investigating. For example, where a practitioner has been charged with a serious criminal offence, our investigation may be secondary to the outcome of those charges. It might be necessary for us to re-cover terrain that was traversed during another entity's investigation if it is required to enable proper characterisation of the issue raised in the notification. Or, our role might be limited to providing evidence of a conviction of serious criminal behaviour to the responsible tribunal to enable a tribunal to make a finding of professional misconduct.

87. The way in which a National Board might be asked to consider whether *interim actions* need to be taken, using their immediate action powers, to different types of matters can also be different. The two most common grounds upon which National Boards rely to take immediate action to restrict practitioners' practice are:

(a) because the Board perceives the individual poses a serious risk to persons and it is necessary to restrict their practice of the profession while an investigation occurs, and

(b) because it is otherwise in the public interest to take immediate action while an investigation occurs.

88. An immediate action taken in response to a serious issue arising from practice will more likely result in a Board forming a reasonable belief about the practitioner posing a serious risk to the public.

89. Where serious misconduct occurs outside of practice, it is more common for immediate action to be taken on the basis that it is otherwise in the public interest. This is because it is more difficult to argue that conduct occurring in a practitioner's personal life will transfer into their practice of the profession creating a risk for their patients. The public interest test is a more recent addition to the law and tends to be used in cases where the behaviour of a practitioner could cause the public to lose trust in health professions generally if it were not addressed by the Board.

90. The potential outcomes from an investigation, as set out in sections 178, 181 and 193 of the National Law, are not contingent on the alleged conduct having occurred in a health setting.

91. Over the last few years Ahpra has worked to improve the management of notifications. Significantly, we have undertaken a number of initiatives to reduce the negative impact of the notifications process on stakeholders, introduced a new framework for assessing and responding to risk and have improved the timeframes for completing notification assessments and investigations.

Question 14 – Explain the training and qualifications generally required of investigators engaged by Ahpra to undertake investigations. In your response, you should address:
(a) any particular training required to carry out investigations into notifications of child sexual abuse; and
(b) any particular training that relates to investigative practices relevant to interviewing child witnesses, including whether and how investigators adopt a trauma informed approach.

92. Ahpra's investigators come from a variety of backgrounds, however they are required to hold a relevant tertiary qualification and have experience that is relevant to the role of investigating. There is no defined qualification or experience required under the National Law, however Ahpra's investigators typically have a background in law, policing, journalism, public sector investigations and/or are a current or previous registered health practitioner.

93. Ahpra provides induction training to new investigators that addresses the fundamental aspects of the role. That training is supplemented with ongoing professional development opportunities and internal publications, including the Regulatory Guide.

94. Since 2021, Ahpra has committed to ensuring that all employed investigators and the staff who manage those investigators are trained to the standard of a Certificate IV in Government Investigations, modified with reference to our statutory role and the provisions of the National Law. Around half of all investigators have undertaken training to this level and it is our expectation that all investigators will be provided with training to support the acquiring of a Certificate IV before the end of this calendar year.

95. Investigators who work on files relating to misconduct that arises through transgression or exploitation of professional boundaries (including allegations of inappropriate sexual behaviour) are provided with additional training. This extension training is delivered in-house by former police officers who have experience in dealing with the Sexual Offences and Child Abuse Investigation Team (**SOCIT**) in Victoria (noting that the training program is delivered nationally that includes education on trauma-informed approaches to working with witnesses and other stakeholders.

96. There is no specific training currently offered by Ahpra routinely in relation to the investigation of matters involving children. In over 12 years of involvement with the management of investigations in response to notifications, I am personally aware of only a handful of cases that required us to consider engaging directly with a person who was under the age of 18 in the course of our investigation. In instances where that has arisen, Ahpra has contracted with an external investigator who has suitable experience to work with the child and who meets appropriate vetting processes associated with working with children.

97. It is more common, during our involvement in investigating a practitioner, that any victim of offending has reached adulthood by the time that they report concerns to police or to us. This is consistent with the findings of the Royal Commission, which found that offending against children was often not reported until decades after it had occurred.

98. To provide consistency across investigations, there are two specific management roles at Ahpra who case conference and determine strategy across investigations that raise issues concerning transgression of professional boundaries in a sexualised manner, sexual offending and/or family violence. Supervision during the investigation of these matters is provided by Operations Managers who work across a variety of cases but who work closely as a network to ensure these specific investigations proceed in accordance with the in-house training program.

99. During an investigation, new information may be received that raises concern that a person may have engaged in sexual misconduct. In these circumstances the concern would be escalated to an Operations Manager, a referral to police would be made if criminal offending may have occurred and the concerns would be progressed to the relevant National Board (or a delegate such as the Special Interests Notification Committee) for assessment if they related to a registered health practitioner or student. It is likely that immediate action processes would then be initiated.

Question 15 – Explain how long the average investigation takes and whether this differs for investigations into notifications of child sexual abuse.

100. In the 2020 to 2021 financial year:

    (a) 72% of notifications were closed in less than six months;

    (b) 21% of notifications were open and under investigation for longer than 12 months; and

    (c) the average duration of investigations was 180 days.

101. It is my experience that investigation for serious issues, including sexual abuse and most likely including sexual abuse against a child, would tend to fall into the category of cases that take longer than 12 months to conclude.

102. This is because, in the majority of these cases, investigations by Ahpra will be affected by concurrent criminal investigation and prosecution. In those cases, it is common for an immediate action decision to be made that precludes the practitioner from practising while the concurrent investigation and prosecution occurs.

Question 16 – Explain how Ahpra makes decisions or provides advice in response to investigations into notifications of child sexual abuse and how has this changed over time. In your answer, you should address:
(a) how this differs between health professions (particularly doctors and nurses)
(b) the current or previous role of the National Special Issues Committee; and
(c) whether there are any different considerations for notifications of child sexual abuse compared to sexual abuse of adults.

103. The general decision-making process by National Boards in response to investigations is outlined above. There are no differences (as a matter of law) between the powers available to the Boards or their delegates in the context of investigations into child sexual abuse or other notifications.

104. These decision-making processes include:

    (a) since 2017, the Medical Board of Australia has maintained a Sexual Boundaries Notifications Committee to undertake specialised decision-making in response to matters involving alleged sexual misconduct. This Committee has a broad scope and is responsible for assessing and making immediate action and other decisions involving practitioners who are the subject of allegations ranging from inappropriate intimate examination, inappropriate comments and sexualised touch in the provision of a health service to sexual assault.

    (b) in 2022, the Sexual Boundaries Notifications Committee was renamed the National Special Issues Committee, so as to also capture:

        (i) family violence; and

        (ii) all matters that have a connection with sexual misconduct in the medical profession;

The National Special Issues Committee members receive additional training and access to information to support their work, and ensures consistency amongst all cases concerning the matters detailed at (a) above; and

(c) Ahpra plays an important role in sharing learnings and information arising from the work of the Medical Board of Australia's National Special Issues Committee with broader Boards and Committees, so as to facilitate consistent regulation of the health profession.

105. The process and considerations in responding to allegations concerning children differ to process involved in other circumstances. Specifically:

(a) the age and maturity of the child or young person and the (whether as a witness or notifier) impact of those factors on memory, cognition and the need for support when raising concerns and/or participating in information gathering and decision-making. Accordingly, Ahpra offers greater support to children the subject of notifications. As I stated in my answer to question 14 above, Ahpra would likely seek the assistance of a specialised external services if it was necessary to work directly with a child;

(b) parents or guardians often participate in investigation and decision-making processes, so as to provide support to the child and also as they often become a pertinent witness themselves. That said, conflicts can arise between the interests of care givers and children / young people;

(c) there can be a role in the process for third party entities, such as child protection authorities, in circumstances where a child does, or may not, have a parent willing and able to protect them from harm; and

(d) Ahpra may be required to make referrals for external support. A child would likely be referred to more specialist services than those available for adults. For example, Laurel House in Tasmania.

Question 17 – Provide the average substantiation rate for notifications of child sexual abuse.

106. The function of investigations under the National Law is not to 'substantiate' or 'not substantiate' notifications, but rather to prepare a report for the Board's consideration which lists all the relevant issues investigated, and the investigator's findings and recommendations in respect of each. At the conclusion of an investigation, the Board considers the investigator's report and decides whether, on the available evidence, it:

(a) considers it appropriate to take action under section 178 of the National Law. This option is open to the Board if it *'reasonably believes'* that the *'way a registered health practitioner…practises the health profession, or the practitioner's professional conduct, is or may be unsatisfactory'* (emphasis added), and where the alternative options detailed below are not open or considered warranted, based on a practitioner's alleged conduct;

(b) ought to establish a health panel under section 181 of the National Law. This option is available if the Board 'reasonably believes*…that a registered health practitioner or student has or may have an impairment*' (emphasis added);

(c) ought to establish a performance and professional standards panel under section 182 of the National Law; or

(d) is required to refer the matter to a responsible Tribunal. A referral to a responsible Tribunal '*must*' be made under section 193 of the National Law if the Board *'reasonably believes'*, amongst other things, that *'the practitioner has behaved in a way that constitutes professional misconduct*'.

107. Substantiating allegations is a matter for the responsible Tribunal if a decision to refer a matter is made under section 193 of the National Law. I have provided further detail in relation to this process at 145 below. Ahpra has not collated data from responsible Tribunals which would enable it to determine the average substantiation rate for notifications of child sexual abuse.

Question 18 – Explain the average number of notifications of child sexual abuse Ahpra receives annually:

(a) on a national basis; and
(b) in Tasmania.

108. In its data collection, Ahpra does not distinguish sexual misconduct cases involving children from other cases. My experience is that cases of sexual misconduct involving a child are exceedingly rare.

To assist the Commission of Inquiry, I will set out data collected by Ahpra that compares the numbers of registered health practitioners and rates of notifications and sexual misconduct allegations between Tasmania and other jurisdictions.

Registrant data where principal place of practice (PPP) = Tasmania

109. There are over 800,000 health practitioners registered in our National Scheme.

110. For the purposes of exploring notification data and notification rates, we have excluded the number of practitioners registered with a PPP in New South Wales. This is because New South Wales maintains a different complaints process and data for those complaints is maintained differently to data for other jurisdictions.

111. The number of practitioners registered with a PPP in Tasmania, compared with the number of practitioners registered with a PPP outside Tasmania is shown below, along with the proportion of the overall (non-NSW) health workforce with a PPP in Tasmania.

	2018/19	**2019/20**	**2020/21**	**2021/22***
Number of (non-NSW) practitioners with a principal place of practice outside Tasmania	516,028	556,589	573,943	592,889
Number of practitioners with a principal place of practice in Tasmania	16,202	17,540	18,390	19,197
Total practitioners excluding NSW-based practitioners	**532,230**	**574,129**	**592,333**	**612,086**
Proportion of practitioners with a PPP = Tas	3.0%	3.1%	3.1%	3.1%

Overall notification data in Tasmania

112. The following information relates to total numbers of notifications.

113. The total numbers of notifications received by Ahpra in the last four years, compared with the number of notifications received in Tasmania, is set out in the following table. The data does not include NSW data. *The data for FY2021/22 is to 31 May 2022.

	2018-19	**2019-20**	**2020-21**	**2021-22***
Notifications received about practitioners with a PPP outside Tasmania	8976	9931	9811	9720
Simple % notifications per practitioner for PPP outside Tasmania	1.7%	1.8%	1.7%	1.6%
Notifications received about practitioners with a PPP in Tasmania	362	305	336	310
Simple % notifications per practitioner for PPP Tasmania	2.2%	1.7%	1.8%	1.6%*

114. The data indicates that the rate of notifications about practitioners with a PPP in Tasmania is equal to or slightly higher than for other jurisdictions.

Notifications about boundary issues, including sexual boundary issues

115. The following information relates to the number of notifications raised with us annually about concerns that a practitioner has failed to maintain appropriate boundaries. The types of boundary

transgressions raised with us in this data include sexual boundary transgressions. Data for FY2021/22 should be treated with care because it is for notifications received before 31 May 2022 only.

	2018-19	**2019-20**	**2020-21**	**2021-22***
Boundary issue notifications for practitioners with a PPP outside Tasmania	375	249	547	826
Simple % boundary issue notifications per practitioner for PPP outside Tasmania	0.07%	0.04%	0.10%	0.14%
Boundary issue notifications for practitioners with a PPP in Tasmania	12	11	21	41
Simple % boundary issue notifications per practitioner for PPP in Tasmania	0.07%	0.06%	0.11%	0.21%

116. The data indicates that the rate of boundary notifications about practitioners with a PPP in Tasmania is equal to or slightly higher than for other jurisdictions.

Mandatory notifications data in Tasmania

117. The following table sets out the numbers of mandatory notifications received about practitioners with a PPP in Tasmania as compared with across other jurisdictions. Data for FY2021/22 should be treated with care because it is for notifications received before 31 May 2022 only.

	2018-19	**2019-20**	**2020-21**	**2021-22***
Mandatory notifications for practitioners with a PPP outside Tasmania	1103	1050	1198	891*
Simple % mandatory notifications per practitioner for PPP outside Tasmania	0.21%	0.19%	0.21%	0.15%*
Mandatory notifications for practitioners with a PPP in Tasmania	52	53	72	55*
Simple % mandatory notifications per practitioner for PPP in Tasmania	0.32%	0.30%	0.39%	0.29%*

118. The data indicates that the rate of mandatory notifications made about practitioners with a PPP in Tasmania is slightly higher than for practitioners with a PPP outside of Tasmania.

119. The following table sets out mandatory notifications received as a percentage of all notifications received for PPP outside Tasmania and PPP in Tasmania. Data for FY2021/22 should be treated with care because it is for notifications received before 31 May 2022 only.

	2018-19	**2019-20**	**2020-21**	**2021-22***
Mandatory notifications received as a % of all notifications received where PPP outside Tasmania	12.2%	10.5%	12.2%	9.1%*
Mandatory notifications received as a % of all notifications received where PPP in Tasmania	15.7%	18.7%	23.5%	19.4%*

Mandatory notifications in relation to sexual boundary and misconduct matters

120. The following table sets out the number of mandatory notifications received about boundary issues (inclusive of adult and child patients. As stated above, reports of sexual misconduct occurring with respect to child patients are rare). Data for FY2021/22 should be treated with care because it is for notifications received before 31 May 2022 only.

	2018-19	**2019-20**	**2020-21**	**2021-22***

Number of mandatory notifications made about boundary issues where PPP outside Tasmania	85	56	137	170
Number of mandatory notifications made about boundary issues where PPP in Tasmania	3	3	8	13

121. Mandatory notifications about sexual misconduct have been generally increasing across all jurisdictions, which partially informs my view stated at paragraph [43] above that practitioners are generally aware of their mandatory notification obligations.

Question 19 – Explain whether the data referred to in your answer to paragraph 18 above indicates that Tasmanian levels of reporting are high, low or in line with expectations when compared to other jurisdictions.

Total numbers of notifications

122. Of the total number of notifications received over the last four years, 3% have related to practitioners whose principal place of practice is Tasmania. Notification rates about Tasmanian practitioners tend to demonstrate a reporting that is consistent with, or slightly higher than the combined rate for all other jurisdictions.

Mandatory notifications

123. Of the total number of mandatory notifications received since FY 2018-19, 5.2% related to Tasmanian practitioners. The rate of mandatory notifications made about Tasmanian based practitioners has been slightly higher than for other jurisdictions. This was particularly the case in 2020-21.

124. In interpreting the mandatory notifications data, it should be noted that an amendment to the National Law came into force on 1 March 2020 that changed the mandatory notification requirements.

125. The data for notifications about boundary issues, including sexual boundary issues, indicates that the rate for practitioners with a PPP in Tasmania is equal to or slightly higher than for other jurisdictions.

Question 20 – Outline the source of the notifications (for example, an employer, colleague or patient) referred to in your response to paragraph 18 above. In your answer, describe whether this is different or largely consistent with other jurisdictions.

126. The most common type of notification is a voluntary notification made by a patient of a practitioner. These complaints do not commonly refer to instances of alleged sexual misconduct – and instead usually relate to concerns about clinical care provided to the patient.

127. The total number of voluntary notifications about boundary issues, including sexual boundary issues, each year is shown below. Data for FY2021/22 should be treated with care because it is for notifications received before 31 May 2022 only.

	2018-19	**2019-20**	**2020-21**	**2021-22**
Voluntary notifications about boundaries for practitioners with a PPP outside Tasmania	290	193	410	656
Simple % for PPP outside Tasmania	3.68%	2.17%	4.76%	7.43%
Voluntary notifications about boundaries for practitioners with a PPP in Tasmania	9	8	13	28
Simple % for PPP in Tasmania	2.90%	3.17%	4.92%	10.98%

128. The mandatory notification figures in Tasmania are included above. Mandatory notifications are generally made most often by other practitioners. However, in 2020-21 in Tasmania, there was a notable shift in the source of mandatory notifications to employers, and an even more substantial shift back to other practitioners in 2021-22.

129. The following table sets out the source of mandatory notifications in Tasmania, as compared with other jurisdictions:

	2018-19	2019-20	2020-21	2021-22
All other				
Employer	38.2%	41.8%	45.2%	37.8%
Government Department	0.5%	0.4%	0.4%	0.7%
Other Practitioner	44.5%	43.8%	44.0%	52.2%
Self	2.9%	2.9%	1.3%	1.0%
Treating Practitioner	7.1%	7.1%	7.3%	5.7%
Tasmania				
Employer	28.8%	41.5%	50.0%	25.5%
Government Department	3.8%	0.0%	2.8%	1.8%
Other Practitioner	55.8%	41.5%	36.1%	61.8%
Self	1.9%	9.4%	4.2%	1.8%
Treating Practitioner	3.8%	3.8%	4.2%	9.1%

Question 21 – Explain whether complainants, witnesses and victim-survivors are kept updated on the status of a complaint involving them and/or informed about the outcome.

130. Efforts are made to ensure that notifiers and witnesses (including complainants and victim-survivors) are kept updated about the status of investigations (and any Board decisions, as they are made), in accordance with their wishes (i.e. the extent to which they wish to be provided with updates).

131. There are various provisions in the National Law that require Ahpra / the Boards to keep notifiers updated during the course of an investigation, including:

(a) section 159A – notifiers may be provided with notice of a decision to take immediate action that arises from the notification and the reasons for that decision;

(b) section 167A – notifiers may be provided with notice of a decision made in relation to their notification, and the reasons for that decision, following an investigation;

(c) section 180 – notifiers must be provided with written notice of a decision to take relevant action in response to a notification. The National Board has discretion on whether to provide the notifier with the reasons for the decision.

132. Section 161 of the National Law requires that we inform notifiers of the progress of an investigation at intervals of not less than 3 monthly during the life of the investigation.

133. Updates detailed at paragraph 132 above are provided by Ahpra in writing, and the nature of the information provided to notifiers is determined with reference to the National Law, the Australian Privacy Principles and the *Common Protocol for informing notifiers about the reasons for National Board decisions*. Under that protocol, and when a Board decides to provide reasons for a decision to the notifier (i.e. at the conclusion of an investigation), there are various constraints, in that the information disclosed will:

(a) only provide information about a practitioner that is in response to concerns raised by the notifier;

(b) de-identify personal information relating to other people unless it is reasonably necessary to disclose that information in order for a person to understand the basis of the decision;

(c) provide a general overview of performance assessment processes and conclusions as they relate to the concerns raised by the notifier. This will generally not provide detailed information about the care or treatment provided by a health practitioner to patients involved in the assessment;

(d) not provide detailed information about health assessment processes and conclusions; and

(e) not provide information about a practitioner's health.

134. As Ahpra and the National Boards are subject to Commonwealth privacy legislation, as well as the confidentiality provisions contained in the National Law (discussed further in response to questions 32 – 34 below), there are some limitations on the provision of information to witnesses who are not notifiers. However, witnesses who are victim-survivors have the option of being added as a notifier so as to facilitate the provision of that information where appropriate.

135. While section 216 of the National Law does not permit the provision of information to non-notifier witnesses or victim-survivors (i.e. during the course of an investigation), it does enable the disclosure of information relating to a proceeding before a responsible tribunal (where that proceeding is or was open to the public) (section 216(2)(f)). Accordingly, persons who are not notifiers but are nevertheless involved in a notification / investigation may be updated as to the outcome of any Tribunal proceeding under this provision.

Question 22 – Explain what happens to an investigation if a health practitioner surrenders their registration, moves overseas or dies.

136. If, during the course of an investigation under section 160 of the National Law, a practitioner:

(a) surrenders their registration under section 137, the investigation continues notwithstanding that the practitioner is no longer registered. This is due to the operation of section 138 of the National Law, which provides that Part 8 applies if a person '*was, but is no longer, registered in a health profession under this law*' (section 138(1)). Accordingly, *'a notification may be made, and proceedings may be taken, under this Part in relation to the person's behaviour while registered as if the person were still registered under this Law*' (section 138(2));

(b) moves, the investigation continues as the National Law has been adopted in all Australian states and territories and also has extraterritorial operation (see section 8); or

(c) dies, the investigation ceases as there is no longer a registration and person to whom the investigation applies.

137. I understand that investigations being undertaken by other entities (e.g. systemic health service investigations being conducted by an HCE) will not necessarily be discontinued in circumstances where Ahpra's investigation into the behaviour of a deceased registrant is discontinued.

Question 23 – Where Ahpra receives a notification of child sexual abuse, explain whether Ahpra makes any referrals or offers support to those impacted by the sexual misconduct of health professionals or students.

138. Ahpra assesses each case individually and, amongst other things, considers the supports / services that notifiers / witnesses already have in place. Where appropriate, Ahpra makes internal and external referrals to appropriate services. In the first instance, notifiers / or witnesses requiring support /or services are referred to the NSS (discussed at paragraph [83] above). Further referrals, including external referrals, would then be considered by the social workers employed in that service.

Question 24 – Explain whether and how Ahpra could improve its approach to responding to notifications of child sexual abuse and/or other misconduct involving children.

139. Ahpra has been proactive and responsive to policy reviews, Tribunal and Court decisions and other feedback in relation to the way in which it could improve its regulatory practices. For example, after the Paterson Review, which primarily recommended against the use of chaperones and for improved handling of sexual misconduct cases, Ahpra shifted its practice away from the customary use of chaperones. This shift is indicative of Ahpra's openness to ongoing continual improvement of policy and practice.

140. Ahpra believes that the Tranche 2 legislative amendments and consequential changes to practice will further enhance its ability to respond to notifications and to protect the public.

141. Ahpra is also conducting an evaluation of the NSS based on its initial period of operation to identify opportunities for improvement.

142. In summary, Ahpra has, and will continue to, continually look for ways in which it can improve its policies and practice, including in response to notifications of child sexual abuse and other misconduct involving children.

143. We are working to continually improve our approach to managing notifications, including those involving alleged sexual misconduct towards children. This includes:

(a) reviewing our processes to ensure that they are child safe and as accessible as possible to children;

(b) improving organisational capacity to work with children in response to a notification;

(c) finalising the evaluation of the NSS and ensuring that is has the capacity to effectively support children and young people; and

(d) ensuring that staff are aware of the actions they need to take in order to promote the objectives of reportable conduct schemes in relevant jurisdictions.

Taking action

Question 25 – Outline the actions that can be taken in response to a substantiated notification of child sexual abuse. In your answer, explain which of these actions can be taken by Ahpra and which can be taken by third parties (for example, committees, boards or tribunals).

144. As outlined at paragraph [106] above, notifications are not 'substantiated' or 'unsubstantiated'. The action available in response to a notification depends on a number of factors, including the nature of any reasonable belief formed by the relevant Board – as a matter of law, there are no differences in the actions available in response to child sexual abuse or any other conduct. However, child sexual abuse is naturally an extremely serious matter and, provided there is sufficient evidence for the Board to form a reasonable belief that the conduct occurred, such conduct is unlikely to be considered by a Board as constituting anything less than professional misconduct. As a result, the outcome would almost certainly be to refer the matter to a responsible tribunal pursuant to section 193 of the National Law.

145. The outcomes that may result from a referral to a responsible tribunal are set out at section 196 of the National Law and depend on the nature of the allegations, whether they are found proven (to the requisite *Briginshaw* standard of proof) and how they are characterised under the National Law. However, generally, a responsible tribunal may decide:

(a) to caution or reprimand the practitioner (National Law, s 196(2)(a));

(b) to impose a condition/s on the practitioner's registration (National Law, s 196(b));

(c) to require the practitioner to pay a fine of not more than $30,000 (National Law, s 196(c));

(d) to suspend the practitioner's registration for a specified period (National Law, s 196(d)); and/or

(e) to cancel the practitioner's registration (National Law, s 196(e)).

146. If a responsible tribunal decides to cancel a practitioner's registration, or the practitioner is no longer registered at the time of the hearing, the tribunal may also decide to:

(a) disqualify the practitioner from applying for registration as a registered health practitioner for a specified period (National Law, s 196(4)(a)); and/or

(b) prohibit the person, either permanently or for a specified period, from:

(i) providing any health service or a specified health service; or

(ii) using any title or a specified title,

(National Law, s 196(4)(b)).

147. The actions set out in paragraphs 145 and 146 above (referred to as **determinations**) are discussed in detail in Chapter 10 of the Regulatory Guide. The general principles relating to determinations under the National Law are discussed in detail in Chapter 11 of the Regulatory Guide.

148. All of the potential actions available in respect of a notification (which are set out at paragraph 70 above) may be taken by the relevant National Board only. The decision of whether or not to refer a matter to a responsible tribunal is, as a matter of practice, unlikely to be delegated to Ahpra or an employee of Ahpra, though may sometimes be delegated to a committee of a Board (such as the Medical Board's National Special Issues Committee).

Question 26 – Explain whether Ahpra can take action if it holds concerns about a health practitioner or student in circumstances where a notification is not substantiated in respect of that person.

149. As outlined at paragraph [107] above, notifications are not 'substantiated' or 'unsubstantiated'. However, in circumstances where, for some reason, a Board decides to take no further action (under section 151 of the National Law) in respect of a notification, the Board is expressly permitted to take the notification into consideration at a later time 'as part of a pattern of conduct or practice by the health practitioner'.

150. Australian law regulates the circumstances in which it is appropriate to amend, repeal or vary a previous administrative decision. For example, it may be appropriate to take such a step when a previous decision was affected by jurisdictional error or material new information becomes available. I note that administrative decision-makers under the National Law have the power to amend or repeal their decisions in certain circumstances. This is an exercise of the power set out in clause 23 of schedule 7 of the National Law. This power cannot be used to amend or repeal the administrative decisions of other regulatory bodies and those made under other statutes.

151. In some circumstances a National Board may lose the legal ability to further consider a matter. For example, once a matter is referred to a responsible tribunal, the tribunal is seized of the matter and a National Board is no longer empowered to be the decision-maker in respect of the referred matter.

152. Complaint information, including information regarding historical notifications and regulatory action involving a particular registered practitioner, is held on our database and is routinely reviewed by Ahpra and by delegates of National Boards any time there is a notification or complaint made about a practitioner, either to us or to a health complaints entity (such as the HCCT).

153. Ahpra assesses declarations made by practitioners against National Boards' criminal history registration standard annually. If there is a change in criminal history, there is an opportunity to review the change annually during the renewal cycle. We also audit a randomised sample of these declarations against information shared with us directly by the Australian Criminal Intelligence Commission (ACIC).

154. Section 130 of the National Law mandates that practitioners inform Ahpra, within 7 days, of becoming aware, of a criminal charge against the practitioner. These declarations are recorded in our system. They trigger a review of notification or complaint history about a practitioner with the intention that similar concerns that might indicate a pattern of conduct, and therefore might raise concerns about the practitioner are flagged.

155. In response to salient cases, public policy discourse or concerns raised with us by another entity, we review our practices to ensure that they align with contemporary academic understanding of offending behaviour. This includes undertaking reflective reviews of historic cases to ensure that the policies and processes are effective in protecting the public.

Question 27 – Explain the circumstances in which gender restrictions may be an appropriate response to a notification (for example, where a practitioner cannot see female patients). Explain whether restrictions against treating children are ever imposed (whether or not by Ahpra) and, if so, in what circumstances.

156. As explained previously at paragraphs [67] and [68] above, virtually all decisions in response to notifications are made by National Boards, co-regulatory authorities and, often, responsible tribunals or relevant panels (rather than by Ahpra).

157. There are a number of means, and/or points in time, by which conditions may be imposed on a practitioner's registration under the National Law, including:

(a) by a National Board:

(i) when taking immediate action under section 156 of the National Law;

(ii) when taking relevant action under section 178 of the National Law;

(b) by a panel (such as a health or performance and professional standards panel), under section 191 of the National Law; or

(c) by a responsible tribunal under section 196 of the National Law.

158. As a matter of law, there are no relevant distinctions as to what kinds of conditions may be imposed under the above sections of the National Law. However, as gender-based conditions are usually suggestive of a concern having been made about a practitioner that relates to professional boundaries and/or sexual misconduct, it is highly unlikely that such matters would be the subject of a decision under section 178 of the National Law or by a performance and professional standards panel. That is so because allegations concerning subject matter of that nature would be very unlikely to be considered as constituting anything less than professional misconduct (and, in circumstances where a National Board has formed a reasonable belief that a practitioner has engaged in professional misconduct, a referral to a responsible tribunal is mandated by section 193 of the National Law).

159. Accordingly, as a matter of practice, a decision to impose gender-based restrictions on a practitioner's registration would likely be generally made:

(a) in the immediate action context (by either a National Board or, where a practitioner has sought merits review of a Board decision, by a responsible tribunal); and in substitution for the National Board's decision); or

(b) occasionally, by a responsible tribunal in the context of a referral proceeding.

160. Ahpra's general position (noting that it is not a decision-maker with respect to notification outcomes in relation to serious concerns) is that gender-based restrictions ought to be used in the immediate action context only. In my experience such restrictions are only used sparingly. I believe that in cases involving allegations of sexual misconduct towards children a suspension has the best effect in mitigating serious risk to public safety and the public interest. Ahpra does not consider gender-based restrictions to be an appropriate long-term measure. In circumstances where a responsible tribunal has found allegations of sexual misconduct against a practitioner to be substantiated, I believe that the imposition of a gender-based restriction would not reflect best practice. In most cases involving sexual misconduct allegations, Ahpra's view is that suspension is the more appropriate form of immediate action. However, it is often the case that the responsible tribunals (which, pursuant to section 199 of the National Law, hear appeals from decisions of a National Board to take immediate action) have a higher risk tolerance than the National Boards, and, in the context of sexual misconduct cases, decisions by a Board to suspend a practitioner by way of immediate action are on occasion overturned in favour of gender-based restrictions. Some decisions in which this has occurred over the last two years include *Cheema v Medical Board of Australia* [2020] SACAT 40 and *Goh v Medical Board of Australia* [2021] VCAT 1536.

161. Following the imposition of any particular restriction by a responsible tribunal (e.g. gender-based restrictions), Ahpra must administer that restriction (including by publishing the details of the restriction to the National Register and by monitoring the practitioner's compliance with the restriction).

162. Age based restrictions are employed in a variety of situations. For example, a practitioner may be required to not perform procedures on children to mitigate clinical risk arising from performance concerns. However, I believe that imposition of age-based restrictions would not ordinarily be an appropriate determinative regulatory response to allegations of sexual misconduct for the same reasons set out at paragraphs 160 and 161 above.

Question 28 – Describe the use of chaperones as an action in response to a notification and any changes in approach to the use of them.

163. For the reasons set out at paragraphs [160] and [161] above, conditions requiring a practitioner to have a chaperone present during consultations (**chaperone conditions**) are similarly unlikely to be imposed other than in the context of immediate action (or, rarely, in a referral proceeding).

164. In August 2016, the Medical Board of Australia and Ahpra commissioned an independent review into the use of chaperones to protect patients in Australia. The review was undertaken by Professor Ron Paterson and is referred to as the **Paterson Review**). The purpose of the review was to consider whether (and if so, when) it is appropriate to impose a chaperone condition to protect patients while allegations of sexual misconduct are being investigated (i.e. in the immediate action context) and to recommend whether changes to regulatory practice are required in order to better protect patients and the public. The key findings of the Paterson Review were that:

(a) chaperones are of limited effectiveness in protecting patients;

(b) chaperone conditions as applied at the time of the report were inappropriate given the importance of trust and informed consent between patients and health practitioners;

(c) chaperone conditions are inappropriate in some situations;

(d) improvements were needed to inform and protect patients if chaperone conditions are retained;

(e) Board committees were inconsistent at assessing the need for immediate action and the use of chaperone conditions;

(f) improvements were needed in the national chaperone protocol, current practice and escalation processes;

(g) more restrictive regulatory measures should be used to protect patients while allegations of sexual misconduct are investigated;

(h) no change was needed to the *Regulatory principles for the National Scheme*; and

(i) legislative reform should be considered by Ministers to better protect patients while allegations of sexual misconduct are investigated (namely, by way of introducing a 'public interest' criterion into section 156 of the National Law).

165. The recommendations arising from the Paterson Review were implemented in full and, as a result, chaperone conditions are no longer imposed by the National Boards or recommended by Ahpra. However, as set out above in relation to gender-based conditions, there have been occasions (subsequent to the implementation of Professor Paterson's recommendations) on which chaperone conditions have been imposed by responsible tribunals (and which therefore must be administered by Ahpra). A recent example of this is the decision of *Lahanis v Medical Board of Australia* [2021] VCAT 440, in which the VCAT decided on an interim basis that a National Board decision to suspend the practitioner's registration by way of immediate action was stayed, subject to chaperone conditions being imposed on the practitioner's registration. The chaperone condition was not then subsequently maintained by VCAT at the hearing of the substantive appeal, and the Board's immediate action decision to suspend Dr Lahanis was ultimately affirmed: *Lahanis v Medical Board of Australia* [2022] VCAT 427).

Question 29 – Explain whether Ahpra requires any additional powers or functions to respond effectively to a notification of child sexual abuse.

166. As set out at paragraph [64] above, notifications involving child sexual abuse are rare and save for immediate action, any substantive action taken by Ahpra or the Boards is likely to be occurring subsequent to a police investigation or prosecution. As further set out at paragraph [144] above, there are no (legal) distinctions between the powers available to Ahpra or the Boards in the context of child sexual abuse or any other kinds of notification. Allegations about sexual boundary transgressions involving children are rare and treated extremely seriously.

167. Paragraphs [63] and [65] above list some recommendations which have been made by external bodies or inquiries in order to improve the National Scheme (including in the context of responding to child sexual abuse), however, none of those recommendations specifically relate to Ahpra's powers or functions in responding to notifications of child sexual abuse.

Question 30 – Identify any other actual or potential strategies that could protect the community from health professionals or students where there has been a substantiated notification of child sexual abuse.

168. The National Boards and responsible Tribunals, including the Health Practitioners Tribunal (Tasmania), have jurisdiction under the National Law to enable it to protect the community from health practitioners and students the subject of substantiated notifications of child sexual abuse. As detailed in response to question 17 above, substantiating allegations is a matter for the responsible Tribunal. Once allegations have been substantiated, the Tribunal may decide to do one or more of the actions detailed at paragraph [145] under section 196(2) of the National Law.

169. As detailed at paragraph [146] above, under section 196(4) of the National Law, if the tribunal decides to cancel a person's registration or if the practitioner does not hold registration as of the date of the Tribunal's orders, the relevant tribunal may also decide to make orders disqualifying a practitioner from applying for registration and/or prohibiting a person from providing any health service or using any title.

170. Where a practitioner has been disqualified or otherwise not registered for a period of time and wishes to apply for registration with a National Board, they are required to make a, and the Board is required to determine their, registration application under Part 7 of the National Law. Under this part, the Board can, amongst other things and so as to ensure that the practitioner is safe to the community

    (a) exercise powers under section 80, which include powers to investigate an applicant (section 80(1)(a)) and/or require the applicant to undergo a health assessment (section 80(1(e));

    (b) refuse to grant an applicant registration (section 82((1)(c)); or

    (c) decide to grant the application for registration (section 82(1)(a) and (b)).

171. In the event that the Board decides to grant an application for registration, it can impose conditions on the applicant's registration at the time of deciding to register the practitioner (section 83).

Information-sharing

Question 31 – Explain how Ahpra's investigations sit alongside concurrent or completed police investigations, employment investigations and/or investigations undertaken or monitored by other regulators (such as those relating to the Registration to Work with Vulnerable People Act 2013 (Tas) *or Reportable Conduct Schemes).*

<u>Police or other regulatory investigations</u>

172. In circumstances where there is a concurrent investigation into the practitioner being undertaken by police or another regulator which has coercive powers or the power to bring prosecutions, it is common for investigations under the National Law to be placed on hold with a view to allowing the separate investigation to be completed first. This is of course considered on a case by case basis, however, the reasons for doing so include (particularly with respect to police investigations or other potential prosecutions):

(a) to avoid any risk of prejudicing the police investigation or prosecution;

(b) to minimise the risk of any witness (particularly relevant for victims of sexual misconduct or other vulnerable witnesses) being required to give evidence twice. While this is sometimes unavoidable, it is unlikely that a witness will be required to give evidence in a referral or other proceeding under the National Law if findings of guilt have already been made in relation to the same conduct, so there is merit in first awaiting the outcome of that proceeding; and/or

(c) to simplify the investigation (and/or subsequent referral proceeding) where findings of guilt have been made in relation to the alleged conduct on the basis of the criminal standard of proof (being a higher standard than the *Briginshaw* standard), it is likely to be unnecessary for the Board to gather further evidence and the referral proceeding is unlikely to be contested.

173. In the vast majority of circumstances in which an investigation is placed on hold, immediate action (i.e. conditions or suspension) will be in place on the practitioner's registration to protect the public in the meantime.

174. In some cases, the matters which are the subject of the criminal investigation form only part of the issues identified for investigation under the National Law. In those circumstances, it may still be possible to progress some aspects of the investigation without interfering with the criminal investigation, so there may not be a need to place the investigation on hold.

175. In circumstances where a police investigation results in a prosecution, the National Law investigation is likely to remain on hold until the final outcome is determined. As noted above, if relevant findings of guilt are made, the Board's investigation is likely to be straightforward (as well as any subsequent referral proceeding) and witnesses are unlikely to be required to give evidence. However, there are also cases in which either:

(a) criminal charges do not proceed (i.e. because they are not laid or are withdrawn); or

(b) the accused is acquitted.

176. In many of those cases, an investigation (and often, subsequent referral proceeding) under the National Law will nonetheless proceed. The potential reasons for this are explained in detail at pages 70 – 71 of the Regulatory Guide, and include:

(a) the fact that there is a lower standard of proof, and generally no formal rules of evidence, in proceedings under the National Law; or

(b) the differences between criminal conduct and conduct that might still be considered professional misconduct (for example, the differences between the concept of 'consent' under the criminal law compared with in professional disciplinary setting, which requires consent to be 'informed').

<u>Employment investigations</u>

177. It is less common for there to be an employment investigation operating concurrently alongside an investigation under the National Law. This is because a notification is often made to Ahpra by a practitioner's employer after the conclusion of an internal investigation (and on the basis of any findings made in that investigation). However, in circumstances where an employment investigation is taking place, there is generally no reason as to why Ahpra's investigation cannot proceed in the meantime because:

(a) the employment investigation is likely to be conducted on the basis of a lower standard of proof compared with a referral proceeding under the National Law, i.e. the balance of probabilities compared with the *Briginshaw* standard (albeit that the standard of proof for a referral decision to be made is 'reasonable belief');

(b) in many cases, a claim of legal professional privilege might be made over the employer's investigation report and/or documents, so it may not be made available to the Board in any event; and

(c) the employer does not have any coercive powers to compel the production of information or documents (so the investigation may not be informed by all of the relevant evidence).

178. Those matters are also relevant to the weight that is placed on the findings of any employment investigation (which would generally not be significant).

Question 32 – Explain how information is shared between Ahpra and agencies (including police, employers, the Registrar under the Registration to Work with Vulnerable People Act 2013 (Tas) *and/or Child Safety services). In your answer, explain whether there are any barriers which impact Ahpra's ability to share information with or receive information from these agencies.*

179. Investigators (appointed under section 163 of the National Law) have broad powers to compel the production of information pursuant to Schedule 5 of the National Law. A limitation of the Schedule 5 powers is that they do not allow information to be compelled from Commonwealth entities, though such information sharing is enabled on a voluntary basis by section 27 of the National Law. National Boards can also seek the voluntary cooperation of Commonwealth entities under section 32.

180. Ahpra maintains a National Information Release Unit (**NIRU**) which provides a central point of contact for police and other government entities who are seeking access to protected information under the National Law (being information that comes to a person's knowledge in the course of, or because of, the person exercising functions under the National Law).

181. The NIRU routinely responds to requests for information from entities involved in determining the suitability of persons to work with children, people with a disability or in the aged care sector. In many situations it would not have been possible for Ahpra to proactively share information with such entities without being placed on notice that a person was employed, or intended to seek employment, in those industries. Information is commonly shared in response to compulsive notices, with the consent of a person to the extent that it relates to their personal information, as a generally permitted situation under section 16A of the *Privacy Act 1988* (Cth) (**Privacy Act**) or because the disclosure is expressly authorised under the National Law (e.g. see sections 219 and 220).

182. Ahpra also has powers to share information with government entities for the purposes of minimising serious risk associated with the practise of a health profession (see National Law, section 220) and for other purposes having a connection with the regulation of a health service or a health profession (see section 219).

183. Ahpra approaches inter and intra governmental information sharing on the basis of establishing a legitimate forensic purpose with reference to the entity's statutory functions and releasing as much information as is authorised or required by law.

184. The statutory secrecy provision set out within section 216 of the National Law does prevent Ahpra from responding to certain enquiries. For example, police often seek assistance to identify health practitioners who may have treated a victim of a criminal offence. Because the health practitioner is not suspected of having committed an offence the sharing of the information is not a generally permitted situation under section 16A of the Privacy Act and is not authorised by another law. Section 216 of the National Law therefore prohibits the sharing of the requested information in these circumstances.

185. Wherever possible, Ahpra reaches and enters into memoranda of understanding (**MOU**) with other regulators and entities to facilitate information sharing (to the extent that this is permissible under the National Law and other legislation). For example, the MOU between Ahpra and Victoria Police expressly sets out the circumstances in which Ahpra will disclose information to Victoria Police (in accordance with the National Law and Privacy Act). It also records Victoria Police's agreement to disclose information to Ahpra (i.e. when relevant allegations are being investigated by police which concern a registered health practitioner). Notifications are routinely received from Victoria Police in relation to matters that have come to the attention of police.

186. Ahpra has written to all Australian police services to invite them to enter into MOUs regarding information sharing. An MOU has been established with those forces that were willing to enter into one. An MOU was not established with Tasmania Police.

Question 33 – Explain how and when Ahpra communicates or engages with regulators of reportable conduct schemes (for instance, the Victorian Commissioner for Children and Young People).

187. Ahpra's ability to share information with other regulators is limited by the provisions of the National Law and Privacy Act which are set out above. Ahpra or the National Boards are not currently subject to the reportable conduct scheme overseen by the Commission for Children and Young People (**CCYP**) as they are not entities to which the scheme applies under the *Child Wellbeing and Safety Act 2005* (Vic). The effect of this is that there is not any specific exception to the general secrecy provision contained in the National Law which allows Ahpra to disclose information to the CCYP, though information may still be disclosed pursuant to section 220 when the relevant preconditions exist.

188. However, Ahpra does assist the Victorian Commissioner for Children and Young People as an occupational regulator under the relevant legislative framework.

189. Ahpra supports the other reportable conduct schemes in New South Wales and the Australian Capital Territory through the sharing of information to the extent that it is authorised or required by law.

190. It is difficult to anticipate whether a health practitioner will, or will not, seek permission to work with a vulnerable class of persons at the point that a notification is received, or action is taken. It is my expectation that proactive release should occur where Ahpra believes that a reportable conduct regulator is in a position to take action to mitigate a serious risk to persons. Similarly, Ahpra expects that other government agencies will share information with the regulator when it may inform a response to a public safety issue.

Question 34 – Explain the circumstances (if any) in which Ahpra notifies the operator of a health service that there is an investigation into a notification of child sexual abuse that relates to an employee, contractor, volunteer or student.

191. At present Ahpra can disclose information to a health service (who is not a notifier) if the health service is a practice information entity (see sections 132 and 206 of the National Law) or if a generally permitted situation, such as to lessen or prevent a serious risk to a person's safety, exists under section 16A of the *Privacy Act 1988* (Cth).

192. Ahpra can also disclose information to other government entities under section 220 of the National Law (if a National Board reasonably believes there to be a risk to public health or patient safety), though this does not apply to private health services.

193. In general, an allegation about child sexual abuse would almost always be considered to constitute a serious risk such as to justify disclosure. However, the ability to share information may be limited if another entity such as a Court has already taken action to mitigate the risk.

194. The Tranche 2 legislative amendments propose to enhance Ahpra's ability to inform health services (including prior employers) of the existence of an investigation or risk in certain circumstances.

COMMISSION OF INQUIRY INTO THE

TASMANIAN GOVERNMENT'S RESPONSE

TO CHILD SEXUAL ABUSE IN INSTITUTIONAL SETTINGS

CONFIDENTIAL ANNEXURE TO THE WITNESS STATEMENT OF MATTHEW HARDY

Question 35 - Share any observations on the incoming National Code of Conduct and whether it will help to address issues of child sexual abuse.

195. I am aware that the National Code for unregulated workers has already been adopted by several states and territories in Australia. I understand that it has not yet been adopted in Tasmania.

196. The National Code provides state and territory health complaints entities (as defined by the National Law) in the adopting jurisdictions with a clearer mandate and power to take action to protect the public from risk arising from the provision of an unregulated health service. The Code could assist in protecting children. For example, by precluding a person from delivering an unregulated health service, a health complaints entity may contribute to minimising access to children in that context. This may complement arrangements for determining suitability to work with children. However, there is currently a risk that a prohibited unregulated worker could continue to provide a health service by moving to a jurisdiction that has not adopted the Code.

Question 36 - Explain whether there any other contemplated future reforms relevant to Ahpra's functions as they relate to issues of child sexual abuse. If so, outline these reforms.

197. I have outlined the reforms currently being considered at paragraphs 63 and my response to question 24 above. I believe that these measures will further improve the capacity of the National Scheme to respond to notifications and, specifically, to the needs of children and young people.

Question 37 – Describe any steps taken by Ahpra in response to notifications about Mr James Griffin and Ahpra's reasons for those responses, including the decision to close its investigation.

198. Ahpra received its first (and to that point only) concern about Mr Griffin on 1 August 2019. On that date, a mandatory notification was made by Dr Peter Renshaw, (**Dr Renshaw**), in his capacity as the Executive Director of Medical Services of Tasmanian Health Service – North for Launceston General Hospital.

199. In the notification, Dr Renshaw advised, "*As Executive Director of Medical Services, I received notification from the Registrar responsible for Registration to Work with Vulnerable People of the suspension of Mr Griffin's WVP certification. I was verbally advised by the Registrar that the suspension related to a current investigation by Tasmania Police.*"

200. Ahpra received correspondence from Tasmania's Department of Justice confirming Mr Griffin's immediate suspension from the Working with Vulnerable People register.

201. Ahpra sought information from Tasmania Police on 2 August 2019 and we were informed that an investigation with regards to Mr Griffin had commenced, was ongoing and had not resulted in any charges at that time.

202. Further contact was made by Ahpra with the notifier and Tasmania Police between 2 and 5 August 2019 about the extent to which Mr Griffin was aware of the nature of the police investigation and whether the reasons for the investigation could be communicated to Ahpra for the purposes of disclosing these to the Board and, in the event that the Board sought to rely on the information to take action with respect to Mr Griffin's registration, with Mr Griffin.

203. The notification was presented to a delegate of the Nursing and Midwifery Board of Australia on 7 August 2019. The Board proposed to take immediate action in relation to Mr Griffin's registration pursuant to section 156 of the National Law. Specifically, the Board proposed to suspend Mr Griffin's registration.

204. Ahpra, on behalf of the Board, wrote to Mr Griffin setting out the reasons for the Board's proposal to suspend his registration.

205. On 8 August 2019, Mr Griffin wrote to Ahpra and surrendered his registration. From that time, Mr Griffin ceased to be registered as a nurse.

206. Ahpra was aware at that time that Mr Griffin

    (a) was the subject of a criminal investigation

    (b) had been stood-down from his workplace, the Launceston General Hospital, and

    (c) had his Registration to Work with Vulnerable People suspended with respect to working with children by the Department of Justice.

207. On 9 August 2019, Ahpra informed the Board of Mr Griffin's surrender of registration.

208. On the basis of that information, the Board decided not to take immediate action under section 156(1)(a) or (e) of the National Law. The Board noted that if Mr Griffin had not surrendered his registration:

    (a) the Board would have continued to hold a reasonable belief that because of his conduct;

        (i) Mr Griffin posed a serious risk to persons and it would have been necessary to take immediate action; and/or

        (ii) that it was otherwise in the public interest to take immediate action and.

    (b) the Board would have taken immediate action to suspend Mr Griffin's registration under s156(1) of the National Law.

209. Notwithstanding that Mr Griffin was no longer registered, the Board decided to investigate Mr Griffin.

210. We informed Mr Griffin, the notifier and Tasmania Police of the fact that Mr Griffin was no longer registered as a nurse from 8 August 2019.

211. Mr Griffin died on 18 August 2019.

212. On 21 November 2019, the Board decided no further action be taken in relation to the matter given Mr Griffin was deceased.

Question 38 - With the benefit of hindsight, explain whether you now consider that a different approach ought to have been adopted in relation to Mr Griffin. If so, explain why.

213. Ahpra was notified by Dr Renshaw on 1 August 2019 about Mr Griffin. Ahpra made initial inquiries to confirm the particulars of the allegation and to liaise with Police. The Board then considered the matter on an urgent basis. Mr Griffin surrendered his registration within 8 days of the notification being received by Ahpra.

214. An investigation was commenced. The purpose of the investigation under the National Law was to consider whether information could be obtained and presented, by way of an investigation report, to a Board that could enable it to ascertain whether it reasonably believed that Mr Griffin had engaged in conduct that ought to be referred, as professional misconduct, to the responsible tribunal in Tasmania.

215. Mr Griffin's death caused us to consider that there was no longer a need to continue to investigate the concerns raised with us. Our role is to ensure that only persons suitable to

be registered and able to practise in a safe and ethical manner are permitted to do so. Without a person to refer to the tribunal, we regarded our role as complete.

216. At the time of closing our investigation, more extensive concerns about Mr Griffin's alleged offending were not clear to us. We had been informed of a police investigation in relation to potential offences against children, were aware that his working with vulnerable persons authority had been suspended and that he had been stood-down from his workplace.

217. I am not aware of any other action that could have been taken by Ahpra or the National Board in order for it to ensure that Mr Griffin was not able to hold himself out as being registered as a nurse and was not eligible to practise as a nurse.

218. There may be a view that our investigation could have continued notwithstanding Mr Griffin's death. I am not of that view. As an agency funded entirely by registrant fees, I believe our obligation is to make judicious use of our resources by taking action against living practitioners who can continue to cause harm to members of the public through their actions when risky behaviour is reported to us.

219. I am sympathetic to the view that the subsequent alleged extent of Mr Griffin's offending against children, if known to others, could have been acted on sooner had appropriate disclosures have been made to law enforcement, or our agency. I regret that we were not informed of the concerns well before the ultimate notification in August 2019.

Question 39 - Describe any information and knowledge held about George *in connection to Mr Benjamin Felton and any steps taken by AHPRA in relation to* George

220. George

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222. George

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Question 40 - Explain whether you are satisfied with how matters involving George *were, or are, being managed.*

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Question 41 - Describe any information and knowledge held about Tim *in connection to Ms Zoe Anne Duncan and any steps taken by Ahpra in relation to Ms Duncan's matter.*

Notification made to the former Medical Council

226. On 12 November 2021, the Commission of Inquiry Response and Reform, Office of the Secretary - Department of Health, Tasmania (**DoH**) wrote to Ahpra. The DoH requested documents which the Tasmanian Health Service (**THS**) provided to the former Medical Council of Tasmania concerning an investigation of a complaint against Tim Tim which was finalised in April 2003.

227. On 16 November 2021, the DoH confirmed in writing that THS was part of the Department of Health and Human Services (**DHHS**), now known as the DoH. Given THS and DHHS are legacy entities of DoH it was determined that the documents provided by THA/DHHS could be administratively released to DoH.

228. The documents were released to DoH by the secure file sharing service Kiteworks on 13 December 2021.

229. The original notification and the subsequent investigation were managed by the former Medical Council of Tasmania. Ahpra and the Boards commenced operation on 1 July 2010 in Tasmania. Pursuant to section 296 of the National Law, from 1 July 2010 historical registration records relating to complaints and notifications about, and proceedings against, individuals who are or were registered, transitioned to be records of the Board.

230. Due to the retrieval of the former Medical Council's file, at the request of DoH, Ahpra reviewed the file and formed the view that the information and file should be brought to the attention of the COI. Accordingly Ahpra voluntarily contacted the COI with the information.

Background

231. The following is a summary of the contents of archival documents reviewed by Ahpra:

(a) Zoe's parents initially complained to LGH on 19 May 2001. In reviewing the records, it appears Dr Peter Renshaw, assumed the task of managing the matter on behalf of the LGH. The matter was investigated internally and by the Child Protection Unit;

(b) on 19 May 2001, Zoe's father reported to the [redacted] at LGH that Dr Tim [redacted] kissed Zoe's hand and said he would like to marry her, but not to tell anyone. He also touched her chest/breasts. Zoe was 11 years old at the time;

(c) Dr Renshaw was informed of the incident on 20 May 2001;

(d) on 21 May 2001, Dr Renshaw interviewed Zoe's parents and Zoe (separately, but with a support person). Zoe's parents advised that Zoe had raised some further concerns of intimate touching. The touching involved Dr Tim [redacted] putting his hand on Zoe's breast, as well as putting a finger in her mouth;

(e) on 24 May 2001, Dr Renshaw was contacted by Dr [redacted] GP. Dr [redacted] advised Dr Renshaw that Zoe's parents had told her of the incident and she wished to know whether the matter had been reported to relevant authorities. Dr Renshaw requested that she formalise her concerns and he would respond in kind. Dr [redacted] sent a letter to Dr Renshaw;

(f) on 25 May 2001, Zoe's mother contacted Dr Renshaw with further concerns;

(g) on 29 May 2021, Dr Renshaw was contacted by Laurel House to ask if the matter had been reported to the authorities. Dr Renshaw advised Laurel House that he would do so immediately. He observed that at least four professionals from outside the hospital were already aware of the matter;

(h) Dr Renshaw reported the matter to Child and Family Services, Tasmania Department of Health and Human Services, on 29 May 2001;

(i) on 12 June 2001, Child and Family Services contacted Zoe's mother;

(j) on 27 June 2001, Zoe's mother contacted Child and Family Services and informed the investigator that Zoe had come home from school on Monday, 25 June 2001, and informed her that Dr Tim [redacted] had put his hand inside her pants and was feeling all down the front and in between. It was alleged that he had placed his fingers inside her vagina;

(k) on 28 June 2001, Zoe was medically examined by Dr [redacted] On 22 July 2001, Dr [redacted] provided a letter to Child and Family Services;

(l) on 3 July 2001, Zoe's mother contacted Child and Family Services and informed the investigator that Zoe had made further allegations against the practitioner, specifically that he had inserted his penis into her vagina;

(m) on 19 July 2001, Zoe was interviewed by Child and Family Services;

(n) on 24 August 2001, Dr Tim was interviewed by Child and Family Services;

(o) a report by Child and Family Services, dated 12 September 2001, was submitted to John Ramsay, Secretary of the DHHS.;

(p) on 1 October 2021, the Tasmanian Police were informed of the alleged rape by Zoe's mother;

(q) on 2 October 2001, the Police contact Child and Family Services about the matter. The Police were formally notified by the Director of Child and Family Services on 8 October 2001;

(r) on 3 October 2001, the police conducted a video interview with Zoe;

(s) on 11 October 2001, the police conducted a video interview with Dr Tim and

(t) on or around 12 October 2001, the Police concluded their investigation and determined the allegation of rape was "*unfounded*".

Legacy Notification – former Medical Council of Tasmania

232. On 3 September 2002, a complaint was made to the former Medical Council of Tasmania by the parents of Zoe Duncan. It was alleged that Dr Tim had raped their daughter in the Department of Emergency Medicine at the LGH on 19 May 2001.

233. By way of a letter dated 22 May 2003, the former Board advised Zoe's parents that, on 4 April 2003, the 'Council determined the complaint was unsubstantiated in that the complaint could not be proven.'

234. The file has been provided to the Commission of Inquiry.

Notification No.

235. Tim

236.

Notification No.

237.

238.

Outcomes of Notification No.

239. The Board accepted that the former Tasmanian Medical Council's decision could not be displaced as there was no significant and relevant new or fresh information to justify a new investigation under s 160(1)(a), and the previous decision was not affected by jurisdictional error.

Question 42 - Explain whether you are satisfied with how Ms Duncan's matter was managed (both in 2001 by the Medical Council of Tasmania and more recently by Ahpra). In your answer, explain whether this complaint would be managed any differently if it were made today.

240. Ahpra does not have access to enough information to form a view about the management of the notification by the former Medical Council of Tasmania. However, it is clear that the former Medical Council was not informed of the allegations at the same time as other bodies. This may be because practitioners and employers were not, at that time, subject to mandatory notification laws that feature in the National Law, in place since 2010.

241. It appears to me that subsequent decision-making by the Council was influenced by the investigatory activity already undertaken by the Department of Health and Tasmania Police.

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

243. In reviewing the archival records, Ahpra noted the following issues that the Commission of Inquiry may wish to consider further:

(a) The LGH did not inform the Police or the Medical Council of Tasmania of the allegations that had been made to it until some time after it had undertaken investigation of the allegations.;

(b) the allegations appear to have been quickly escalated internally within the Tasmanian Department of Health, leading to an internal investigation by Child and Family Services. [redacted]

(c) Dr Peter Renshaw played a significant role in LGH's management of the concerns raised by Zoe in the first instance. Dr Renshaw appears to have led the initial investigation himself. This included conducting the initial interview with Zoe. [redacted]

(d) when concerns were raised with the former Medical Council of Tasmania largely relied upon the investigations of the Tasmanian Department of Health and the Police in its decision-making. By the time the Medical Council was in a position to consider the allegations under the former regulatory scheme, Zoe had been the subject of both the LGH and Police investigations;

(e) the archival documents reviewed by Ahpra suggest that little weight was placed on Zoe's report that she had been raped because she had 'changed her story' from the inappropriate comments and touching allegations that formed the basis of the original concerns raised. I expect that this position would be substantially different today, in part because of the body of evidence heard by and recommendations made by the Royal Commission which have resulted in changes to the way evidence from victims is assessed;

(f) Zoe was physically examined by [redacted] General Practitioner. However, the practitioner's observations are unclear on the face of the records reviewed by Ahpra. The practitioner recorded that Zoe's presentation was consistent with the expected sexual maturity of a child of that age, or words to that effect;

(g) a psychologist working for Child and Family Services, Department of Health, examined Zoe and opined that her presentation was consistent with a child who had experienced significant trauma. The records reviewed by Ahpra do not record

any action that was taken by Tasmania Police, the Department of Health or other authorities in response to that report; and

(h) the records reviewed by Ahpra do not indicate that Zoe and the evidence gathered through various investigations were reviewed by health practitioners with expertise in providing forensic medico-legal services to inform investigations about the sexual abuse of children.

Other information

Question 43 - Is there further information you would like to provide to the Commission?

244. I trust that the information set out above is of assistance to the Commission of Inquiry in understanding the National Scheme and how the notifications system operates to protect the public.

245. I thank the Commission of Inquiry for the opportunity to make this statement.

I make this statement at Hobart, Tasmania on 27 June 2022.

[redacted]

MATTHEW HARDY,

National Director, Notifications

Australian Health Practitioner Regulation Agency