TRANSCRIPT OF PROCEEDINGS

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

At Clarendon Room, Country Club Tasmania,
Country Club Avenue, Prospect Vale, Launceston

BEFORE:

The Honourable M. Neave AO (President and Commissioner)
Professor L. Bromfield (Commissioner)
The Honourable R. Benjamin AM (Commissioner)

On 4 July 2022 at 10.07am

(Day 20)

PRESIDENT NEAVE: Ms Norton.

MS NORTON: Good morning, Commissioners. Our first witness this morning is Mr Richard Connock in his capacity as Health Complaints Commissioner. I'll ask the Commissioner to come up to the witness box.

<RICHARD ANTHONY CONNOCK, affirmed: [10.08am]

MS NORTON: Thank you, Commissioner.

COMMISSIONER BROMFIELD: You can remove your mask if you choose to.

<**EXAMINATION BY MS NORTON:**

MS NORTON: Q. Commissioner, can I just have you state for the transcript your full name, professional address and occupation?
A. Richard Anthony Connock. Level 6, 86 Collins Street, Hobart, and on this occasion Health Complaints Commissioner.

Q. Thank you. You've previously given evidence before the Commission in week 1 in your capacity as Ombudsman; is that correct?
A. That's right.

Q. I may refer to some of the evidence you gave on that occasion shortly. In relation to today and in your capacity as Health Complaints Commissioner you've provided a statement dated 24 June 2022. I understand you've got a copy of that statement before you?
A. Yes.

Q. As do I. Yesterday there was an updated statement provided to my instructing solicitors; that's a statement dated 3 July. Am I right to understand that the changes made to that statement are formatting only and not substantive in any way?
A. Yeah, that's right. There were some formatting errors in the original version that was sent through very hurriedly to meet at the deadline, and we cleaned that up so it's just a little easier to read but the text hasn't changed.

Q. We'll work off your original statement for the

purposes of the questioning today but we'll accept your updated statement into evidence.
A. Thank you.

Q. Your current roles include - you talk on page 2 about the functions of the Office of the Ombudsman and Health Complaints Commissioner, and there are six different jurisdictions that are managed within that office including the Health Complaints Commissioner.
A. That's right.

Q. Do you hold all six roles or do you have oversight of all six jurisdictions within that office?
A. I have oversight of all six jurisdictions but each one has a separate manager or a principal officer to manage the day-to-day operations.

Q. So they're separately resourced with you sitting at the top?
A. When I say separately resourced, the office as a whole receives one - you'll have to pardon my voice, sorry, there's not much I can do about it.

Q. Take your time and take some water when you need it.
A. Thank you. It gets one appropriation from the consolidated fund but each of the individual jurisdictions puts in a separate budget bid prior to that allocation, so it's one big pool but it's meted out between the various jurisdictions and we have control of that.

Q. Sorry, I was a bit loose in my question. When I said "resources", I meant staffing resources?
A. Separate staffing.

Q. So you have separate staffing for each of those six jurisdictions?
A. Each of those jurisdictions have confidentiality requirements in the legislation so we have separate teams working in those, there's no crossover.

Q. I think you say in your statement that, in terms of allocating your time, you're approximately 0.2 FTE in your role as Health Complaints Commissioner?
A. I'm divided between the main jurisdictions.

Q. And which of the main jurisdictions?
A. The main jurisdictions are, well, the Parliamentary

Ombudsman, the Ombudsman, Health Complaints Commissioner, I'm a de facto Information Commissioner, Right to Information, and the Energy Ombudsman, and also in the mix there are the official visitors, mental health and prison, but that's not - but that doesn't take up as much of my time as the other two.

Q. Less time. Now, your office or the Statutory Office of the Health Complaints Commissioner was established in 1997. It is a separate statutory appointment to the Ombudsman made under the Health Complaints Act but, as I understand it, a schedule to that Act provides that the same person can be appointed to both of those offices?
A. There's no problem with the Ombudsman being the Health Complaints Commissioner but I'm not Commissioner because I'm Ombudsman.

Q. Yes. In the history of the office have there ever been separate appointments as Ombudsman and Health Complaints Commissioner or have they always resided in the same person?
A. They've always been in the same person.

Q. Yes.
A. Apart from some acting arrangements.

Q. Yes, but in terms of permanent arrangements?
A. In terms of permanent arrangements, yes.

Q. Under the Health Complaints Act you've got broad-ranging functions and they include, and this is not an exhaustive list, but they include complaints handling and assisting with complaints resolution, investigations on your own motion or at the direction of the Minister, and there's also power to play an educative and advice-based role.
A. Yes.

Q. Is it a fair summary of the current activities of your office that most of your resources are spent on complaints handling, conciliation and resolution?
A. That's right.

Q. And would you agree that that's at the expense of investigative work and education?
A. Not necessarily; it contributes to a fall in the investigation work, yes. The main focus is on complaint

resolution rather than investigation, and that has been historically the case.

Q. And I'd like to come to the funding position shortly. Do you perceive a need for greater investigative work from your office? That is to say, are there investigations that you would undertake but for resource and funding constraints?
A. There have been occasions, yes.

Q. In your statement you say that you've got - I think I've done the maths correctly - at page 2 you list the various staff members in your office, and I think they come to 4.4 FTE; does that sound right to you?
A. That sounds about right for the current load, yes.

Q. And, as I understand it, those resources are going to increase in the coming years due to some additional funding?
A. We got some additional funding but it's over a three-year period, so that will increase over time.

Q. Later on in the statement, it's on the next page, you refer to, as a result of that additional funding, a permanent 0.7 FTE Principal Conciliation Officer; is that role included in the roles that are listed on page 2 or is that in addition?
A. No, that's the Senior Conciliation Officer which is the second-last position listed there.

Q. Right, which is listed as 0.6 FTE; is that right?
A. That's right, yes.

Q. So, should that be 0.7 FTE?
A. No it's a band 7 at 0.6. Three days a week, but at band 7 on the stream.

Q. Yes, I'm just a bit confused because over the page on page 3, middle paragraph under the heading, "Could these be strengthened?", you refer to a permanent 0.7 FTE Principal Conciliation Officer; are they the same?
A. That's a typographical error, that's the same position.

Q. And is it 0.6 or 0.7?
A. It's 0.6 at Band 7.

Q. Thank you, thanks for clarifying. Are you able to give the Commissioners a sense of the volume of complaints that your office handles annually, and that's a question on notice; if you don't have the numbers.
A. We're processing those at the moment for the purposes of our annual report; in fact, the business manager's been doing that this week so we'll have definite figures, but it's usually around the 300 or 400 mark and I've been speaking to somebody else about this and with my very rough workings - me and statistics are not the best of friends, but it did look like there was going to be an increase in complaints this year.

PRESIDENT NEAVE: I have a question there.

Q. Have you made a comparison of the number of FTEs - sorry, comparing the number of complaints and your FTEs with other states for example?
A. No, I haven't made that calculation. No, other states are Victoria - sorry, withdraw that. Tasmania and Northern Territory are fairly similar in size and so forth. The Health Complaints Entities in the major jurisdictions, New South Wales, Queensland and Victoria handle vastly more complaints than we do; several of them also have a Code of Conduct for unregistered complainants, so they have that function. We can take unregistered complaints but we don't have the code of prohibition powers as yet. So it's a bit sort of apples and pears, you know, they're slightly different, and it's not a calculation that I have conducted in our office, no.

PRESIDENT NEAVE: Thank you.

MS NORTON: Q. You say in your statement that historical under-funding of your office has had an adverse impact on timeframes for the resolution of complaints. Are you able to provide any sense for the Commissioners of the average timeframe it takes for a complaint to be resolved? And I appreciate that that probably can vary a bit, but are you able --
A. It does vary and there are some, because we haven't had a conciliator for a long time, there have been some files awaiting conciliation. I am happy to take this on notice because that's the sort of statistic that we can prepare for an average day's open.

MS NORTON: Thank you.

A. But as I've said in the statement, I am expecting, and I am certainly hopeful, that we will able to address that with this additional funding. This is the first time, certainly in my time at the office, that we've any significant boost in funding, apart from some in Right to Information in 2019.

Q. Let's perhaps go then to the funding position. You say in your statement that you've been historically underfunded, your office has been historically underfunded, and that this has been noted in your last seven annual reports; you've had this increased recurring allocation of funding over three years to the office. Now, is that to the office of Ombudsman or to the office of Health Complaints Commissioner?
A. It's spread across. It created a new position in the Custodial Inspectorate, it created some new positions in Health, it got a new position in Right to Information, but most importantly it's going to fund the Deputy Ombudsman to assist with running all of these various jurisdictions.

Q. There have been references to this being recurring funding over three years, as I understand it it's coming online progressively.
A. That's right.

Q. Are you able to explain for the benefit of the Commissioners how that's going to work in real terms and what it will enable in practical terms within your office that you're not able to do currently?
A. Well, in terms of health complaints - well, in terms of both health complaints and Ombudsman and RTI, I would like us to be out there talking to stakeholders more than we do at the moment. We started to do that in RTI, I'd like to do it in the other jurisdiction as well to enhance that education/training side of it which we're not really resourced to do at the moment because we've got so many complaints, we're really just dealing with those.

Q. And so, are you talking there about capacity building within agencies?
A. Yes. We'd like to be talking to agencies, and I know this has been happening this week here, about internal complaint handling or internal handling of applications for information so that the agencies themselves deal with more of this themselves in an appropriate constructive - and constructive manner rather than having to come to us and

other entities as a complaint or a review.

COMMISSIONER BENJAMIN: Q. Mr Connock, you use the term "RTI", that's Right to Information?
A. Sorry.

Q. I'm aware of that but there may be others --
A. Sorry.

Q. No, I'm not being critical?
A. No, I'm just used to calling it that, I'll try and be a bit more fulsome.

COMMISSIONER BENJAMIN: Thank you.

MS NORTON: Q. You say in your statement that the increased funding will allow for additional resources, staffing resources, and we've already spoken about an additional Principal Conciliation Officer, and you've said that there will be a Deputy Ombudsman; will the Deputy Ombudsman have any role in assisting the office of the Health Complaints Commissioner?
A. Not on a day-to-day basis. It will free me up to do more in the Health environment, but there's two appointments that I hold: Health Complaints Commissioner and Custodial Inspectorate which are independent of the Ombudsman for the reasons that you've just said. The Acts say there's no problem with the Ombudsman holding both positions but I don't hold them as Ombudsman, so the Deputy won't have a direct role there, but that position will hold full delegations, and I don't have an officer with full delegations now which means, if I'm not present for whatever reason, that Deputy could act as Commissioner who will act as Custodial Inspector, so to that degree they'd be involved, but it will in those two jurisdictions free me up a bit more to be more involved in them.

Q. I understand. Are there any other further positions that you envisage will be created over the coming three years as a result of the additional funding?
A. Yes, there's another Health position next year, I think, and an Ombudsman position as well. It looks like we are recruiting solidly for the next six months, it's been quite a performance, and fortunately or unfortunately a lot of the promotions have been internal which means we've got vacancies opening up in other areas, so it's going to be a while until it all settles down.

Q. Until everyone's fully on board?
A. Until everyone's fully on board, yeah, and I can't - unfortunately the recruitment situation at the moment is very uncertain so I'm unable to say exactly how long that's going to take, but we've got two or three or four positions being recruited at the moment.

Q. You say in your statement that that additional funding will allow for better performance of the functions of your office --
A. I think so.

Q. -- which, I suppose, is a self-evident truth that more money will always assist. Do you think the additional funding will allow adequate performance of your functions?
A. I think so. I mean, as I say, we haven't had this sort of injection before, so I'm a little hesitant to say it will be absolutely, you know, everything will be great. It will certainly be a vast improvement, but to a degree I suppose we'll just have to see how we go. We did ask for more than this, obviously, you always do but we were asked to prioritise and we were given the priority, so I'm hopeful that things will improve.

Q. Would it be right to say that it's your expectation that the additional funding will make a very meaningful, or a meaningful change --
A. Yes, it will make a meaningful change.

Q. -- to your ability to carry out your functions?
A. Across jurisdictions, yes.

Q. One related question I have: you talk in your statement about your office shortly taking on - I think it's at page 11, additional responsibilities in relation to unregistered practitioners, and as I understand it legislation has been passed by Parliament but is yet to be proclaimed?
A. That's right, yes.

Q. Do you have any sense of when?
A. No. This is supposedly a National Code of Conduct and there are already three codified states in South Australia, Queensland and New South Wales, who have their own codes, so they'll have to change them if they want to be compliant with a National Code. Other jurisdictions have not done

anything as yet. We can at the moment take complaints about unregistered medical practitioners if their practices come within the definition of a Health Service under our Act, but we have no power to issue prohibition orders and that sort of thing which is what is contemplated by the National Code.

Q. That sounds to me like that's quite significant additional responsibilities?
A. It is and that's not included in the funding we've received.

Q. So that would be separately funded?
A. That would be separate, and it's quite a different function to what we're doing now, it's more in the nature of a prosecution and an administrative investigation, so it's a different skillset to the sort of work we do now.

Q. Thank you, that's very helpful. I'd just like to go back. We were talking earlier about complaints. When you gave evidence in week 1, and appreciating this was in your facility as Ombudsman, you accepted I think when Ms Bennett put it to you that child sexual abuse is most likely happening in institutional settings but that for some reason it wasn't being reported to the Office of the Ombudsman. Speaking now as the Health Complaints Commissioner do you have anything you'd like to add or any further reflections on why your office, the Health Complaints Commissioner, is not receiving complaints with relation to child sexual abuse in hospital or healthcare settings?
A. Look, I don't know; the sorts of things that I talked about - I don't have a definite answer for that, I have a couple of considerations.

Q. Of course.
A. And perhaps a reluctance to complain for fear of reprisals is an issue; perhaps a lack of awareness of what the Health Complaints Commissioner and what the Ombudsman and what other offices can do. Complaints under the Ombudsman Act and Health Complaints Act cannot guarantee anonymity, and that might also be an inhibitor to people coming forward and making these sorts of complaints, because we don't get them.

But one of the things particularly in the context of Ombudsman is, I think perhaps agencies are not generally

aware of the provisions of the Public Interest Disclosures Act which is designed for this very sort of thing.

In my jurisdictions I don't have jurisdiction over individual offices; the only - its systems and agencies and so forth. Under the Public Interest Disclosures Act we can investigate the conduct of individual offices, and in fact if we find it to be a protective disclosure there's an obligation to investigate. And the powers of investigation under that Act are the same as the Ombudsman - very broad; with respect, have the powers of a Commission of Inquiry when conducting an investigation, so it's a big deal. But there's also protections from reprisals, but I think the problem is that the agencies don't really understand how the Act works or sometimes think it's a bit cumbersome, because it can be, it's not a great Act, but it's not for the discloser to determine whether it's a public interest disclosure, it's for the person receiving it.

Q. As I understand the gist of your evidence in your statement on that point your concern is that public interest disclosures may be being made at a greater rate than that coming to your office because they're not being recognised as such by the recipient?
A. Not recognised, yes, and we've started doing some work in this. We've put out a checklist for people if they come to you. You know, is it a public officer, is the disclosure about a public - you know, just step through the jurisdictional things and at the end, yes, this could be a public interest disclosure or this is a protected disclosure. I have noticed a little more activity in this area. Again, historically we haven't received a lot of disclosures particularly compared to other jurisdictions, but there does seem to have been a bit of an increase with some agencies now aware of the process and that may be because we've just made them all update their processes so it's sort of been front of mind for some of them, but I think it's an under-utilised piece of legislation.

Q. I wanted to ask you some questions in relation to information sharing with other agencies and if I perhaps start with the Integrity Commission; the Integrity Commissioner gave evidence before the Commission last week. What's the process that you engage in with the Integrity Commission if a complaint comes to one or either of you that concerns - say it's a complaint by a Health Service user with respect to potential misconduct in a Health

setting; how would you determine as between you who would look more closely at that complaint?
A. Well, if it was about misconduct, if it was about a registered practitioner we would be referring that to AHPRA. If it was about an independent officer's conduct we would probably refer that to the Integrity Commission.

Q. And what if the complaint was such that it raised questions of systemic problems within the Health setting; is that something that you might then look at?
A. We can split complaints. If we get a complaint that raises issues concerning the practice of a registered practitioner at this stage and in the future unregistered, we can send that part to AHPRA but retain the primary file to address any systemic issue. And we have a memorandum of understanding with AHPRA, we work together with them so that they do what they need to do and we get the things that we need to be doing.

Q. You talk in your statement about the fact that, if you had a complaint that came to you or to AHPRA which involved both an individual and some systemic issues, then you would divide it up between you --
A. Split it, yes.

Q. -- as appropriate?
A. Well, we can't look at the individual practitioner, so we would refer that and AHPRA reports back to us. And we have - each state has a different relationship with its AHPRA branch office. We have a very good one down here, the CEO and I are in close - in regular contact and at officer level we have good contact as well, so we maintain that communication because it used to be, it's not so much now, that AHPRA would decide to take no further action and the practitioner would think, right-o, that's it, and wouldn't engage with the Health complaints entity, so we're working on processes to ensure that, just because AHPRA has completed its part, that doesn't mean the complaint is now shelved, there still may be things for us to do.

Q. For you to look at. You've included in your statement a copy of that memorandum of understanding; are there any reflections you'd like to offer on how well that process is working?
A. Well, we don't refer to a lot anymore - we abide by it, we mottled our relationships and procedures on it and now we just do it, but it mandates a collaborative approach

which in my view is always best and that's AHPRA's view as well. So, informal communication - the idea is to get complaints and the notifications where they should be to the person or entity best placed to deal with it or who has the jurisdiction to deal with it and I think it's working well in Tasmania; I know it doesn't necessarily in some other states but it does here.

Q. As I understand it, you're working on the development of a similar memorandum of understanding with the Commissioner For Children and Young People; is that correct?
A. That's right, that won't be nearly as formal as the AHPRA one because the Commissioner has an advocate who's up at Ashley a lot. We've always had the jurisdiction to take complaints from Ashley residents.

Q. With respect to Health matters?
A. With respect to Health matters and Ombudsman matters and all the other stuff, but now we're getting more being referred through the advocate so we're working on a memorandum of understanding to make sure that, (a) the young person wants us to deal with the complaint, but also that they understand that there's an avenue that they can go to if they have concerns about a Health Service or their general management at Ashley.

Q. Do you have any idea when that memorandum of understanding might be finalised?
A. Very soon, I would hope. A draft has been done and, as I say, we're keeping that because we anticipate that young people might want to see it at some stage too; we're trying to keep that a lot less formal than the AHPRA arrangement, and it really just is an exchange of information because we're not up on the ground up at Ashley all the time. As Custodial Inspectorate we regularly visit it but we're not - the Commissioner has a far closer relationship with the detainees at Ashley than we do.

Q. I'd like to give you an opportunity to address the Commissioners in relation to reforms. You make the point in your statement that it would be desirable for you as Health Complaints Commissioner to have a separate funding allocation; I assume that means you'd prefer not to have to make a bid for a portion of the funding allocated to the office of Ombudsman?
A. Well, that was the recommendation of a review back

in - I can't remember when, quite a long time ago. There have been issues recently in the past with potential conflict of interest because, as Ombudsman, Health Complaints Commissioner comes within my jurisdiction, so we have had complaints against the Health Complaints Commissioner. We've managed that, it's not been - there has not been a problem, but the perception is there and the capacity for conflict. The Deputy will change a lot of that.

Q. How do you manage that potential conflict?
A. The one that we have had, I had a principal officer in Ombudsman who dealt with it on full delegation and I didn't have to be personally involved, so that was resolved. But when I have a Deputy Ombudsman that person, as I said before, will have full delegations which will allow me to step completely away from that complaint, so that will be a lot more robust internal system from our point of view.

Q. You also mention in your statement the need for a legislative review and, as I understand the position, when the legislation was first introduced there was a provision requiring a legislative review every five years; is that correct?
A. That's right, and that disappeared at some stage.

Q. That's happened once?
A. It's happened once and the review provision has gone. So, yes, it hasn't been looked at for many years. If you have a look at the Second Reading Speech, a prime part of it was to be an alternative to suing for medical negligence so that this would be a free service and resolving complaints and our focus was on conciliation. So, it didn't have things like monitoring and a watchdog role.

Other jurisdictions over time have moved closer to that model but we haven't and I think it is probably time that the Act was looked at to see what more could be done in the Health area, because I think what these hearings have highlighted too is that internal processes - we could have a contribution to complaint handling, to managing these sorts of situations absent the complaint.

Q. And so, what additional powers would you need? I'm conscious that you already have a power to conduct an own motion investigation; what powers, watchdog-type powers would you like to have but currently lack?

A. The statement is responsive to the questions and we were asked about, you know, how do we monitor child sex abuse? Well, we don't have a specific monitoring function in relation to that. We have a function of providing education to service providers; we could be doing more than that. Under the Right to Information Act we can advise agencies as to the operation of the Act and how it works. We can also give guidance in relation to public interest disclosures, which we do in the form of guidelines and these checklists and things; I think we could probably do more of that sort of thing in Health to raise awareness of the importance of internal programs to deal with these sorts of situations before they escalate.

Q. You also say in your statement, and this is in relation to the systemic reviews, those own motion reviews, and you say on page 8 of your statement that those reviews arise out of complaints. So, I understand that to mean that the complaints you receive will inform you and allow you to identify what you see to be the systemic issues.
A. Mainly, in the main, yes.

Q. In the main. Would you accept that, if you're not getting complaints about child sexual abuse, then you're being deprived of an insight into the extent to which that might be a systemic issue in Health settings?
A. I think that's a fair comment particularly in light of the finding of what's been heard here.

Q. I'd like to take you now to some questions in relation to complaints handling within the Tasmanian Health Service. I understand you've conducted a review into sexual abuse of vulnerable adults at the LGH. Now, that was a 2005 review.
A. That's right.

Q. I just pause there to note, Commissioners, this was not in relation to child sexual abuse, it was in relation to sexual abuse of vulnerable adults at the LGH and it was in 2005.

PRESIDENT NEAVE: And did you say that was an own motion review? It was, wasn't it?

MS NORTON: Q. Yes, I believe so.
A. It was on the reference from the then Minister of Health.

Q. From the then Minister. And, you were not Health Complaints Commissioner at the time but you were involved as a private consultant?
A. I was a private consultant at that stage, yes, and there was a two-pronged approach, if I can put it like that: my part was to interview all the participants and my report wasn't actually published because it was not possible to de-identify it appropriately, and it was inappropriate relationships between, from memory, a couple of nurses and a ward assistant and patients.

Q. I appreciate it's some time ago now, but I'd like to invite you to share with the Commissioners any observations that you gained as a result of your involvement in that investigation into the handling of complaints regarding sexual abuse of patients at the LGH.
A. Well, yes, one of the things that we found, and I don't think this was - and I'm sorry, I only had the opportunity to look at this again this morning. I have a recollection of the matter because it was a fairly big and serious one but the very specifics of it, I'm afraid it's 17 years ago now.

But, yes, there was a lack of reporting to senior management; a lack of response from senior management; a lack of transparency in the process; a failure to address some of the concerns that were raised internally and manage them; a failure, from recollection, to support the people involved in it and, yeah, I'm sorry.

Q. No, it's not a memory test.
A. Thank you.

Q. And I might at this point assist you and ask the operator to pull up the document which I understand you have. [COM.0001.0061.0030 at 0074]. It's page 45 of that document.
A. Yes.

Q. And section 20 there, "Complaints" around the middle of the page. So, these are the recommendations that were made coming out of the review and they include:

Implementation of policies and procedures for a continuum that addresses informal notifications of complaints through to sentinel events.

And the policy should deal with a range of different matters. It also talks at 20.2 about - as I understand it, anything on that spectrum from a complaint to a sentinel event being centrally recorded in a database to allow trend analysis.
A. I think record-keeping is essential, that these incidents need to be recorded in a transparent fashion, and those records be maintained and available.

Q. Yes. There's also reference at 20.3 to the skill base of managers and HR staff.
A. Yes, that's very important.

Q. Yes. Are you aware, and I ask the question bearing in mind that you were only a consultant at the time or engaged as a consultant at the time: do you know if the Health Complaints Commissioner did any follow-up work with the LGH in relation to the implementation of these recommendations?
A. I don't - I'm not aware, no. We do generally follow up on recommendations; not necessarily in a structured timetabling way but, no, I can't answer that I'm afraid.

Q. I'll ask you another question which you may not be able to answer but I'd like to give you the opportunity in case you can. I'm conscious that the Commissioners have heard a lot of evidence over the past week about complaints handling in relation to child sexual abuse at the LGH.

I know you're a busy man, you may - I'm not sure to what extent you were able to monitor or be briefed on that evidence?
A. I listened to it as much my other commitments would allow me to.

Q. I just invite you to comment to the extent you would like to or feel able about whether you observe any parallels between the recommendations that were made to LGH in 2005 and the evidence that you've been exposed to over the past week or so?
A. Well, I think the evidence has shown a far more serious situation than the one that we were dealing with back in 2005, but it looks to me from what I've seen that senior management are not being made aware of the complaints being made and that was happening then; they weren't engaging internally with it.

I should say, there was an interim period where this changed, but yeah, there were some very strong parallels between what was going on: inadequate record-keeping, inadequate communications, inadequate support; yes, quite a few similarities but certainly not to the same degree as the Commission has been hearing in the last week.

Q. So is it a fair reading of the evidence you've given that, based on your impressions at least, that not only did things not get better in the long-term following those recommendations but you think they may have got worse?
A. Well, this is a particularly bad situation, yes. Whether they stayed the same and/or amplified because of the circumstances of this, but yes, there certainly are some parallels.

We did for a while have some improvement in complaints handling because there were people who had knowledge and experience and the authority to address and resolve complaints and that worked very well for a while, we developed a network of people, because it's important for us to be able to go to somebody who knows the situation, or, if they don't know, is able to find out and then has the authority to make - well, to resolve issues.

That took a long time to develop and then we had the situation when the Tasmanian Health Service came on and complaints were centralised, with people not necessarily familiar with the process, and our office and AHPRA, and we were getting a lot of delays, things not being investigated in terribly great detail. That centralisation has now gone but at the cost of a lot of skilled and experienced people, so I think there is some room for restructuring the internal complaint handling part.

PRESIDENT NEAVE: Q. Can I just ask you a question about that? Was the centralisation, was any part of the centralisation push to deal with this and deal with complaints and issues more effectively? Is that the view?
A. Well, I suppose that was the thing, but the problem was, it all became a bit of a logjam because there was only, you know, a small team dealing with these complaints which created delays. And I think when I talked about investigation and a lot of reliance being put on the people - on the evidence of the people who were the subject of complaints and so forth and not necessarily a full investigation, and I think that might have been a staffing

issue. But Health and Communities are so diverse that it's very difficult for a centralised agency to be - complaints centre to be on top of everything.

Q. So there was a sort of centralisation/decentralisation again?
A. Say it was a complaint about Out-of-Home Care, we would have somebody in Out-of-Home Care that we could refer that complaint to and try and resolve it without getting, you know, bogged down in too much formality. Whereas with a centralised system that person would then have to go out to Out-of-Home Care, so you're adding another layer which sort of tends to, you know, slow things down a little.

MS NORTON: Q. Commissioner, you've just been speaking about limitations arising from processes and the structure of complaints handling. I'd like to ask you about attitudinal constraints within the Tasmanian Health Service. You say on page 10 of your statement:

> *We have routinely encouraged the THS to be more open with complainants though of recent years we have sometimes encountered a somewhat protective and adversarial attitude.*

Would you like to elaborate on that adversarial attitude and any insights you have into where it comes from?
A. I'm not sure where it comes from but there has been resistance to responding to complaints, and that's partially the delay that I've been talking about. But, yeah, not as open as, when I was talking about when we had network, that was a very open relationship and people would be working to try and resolve the complaints. We don't sense that same commitment to resolution in a timely fashion that we used to have.

So I'm not sure if - adversarial rather than combative, but not as cooperative as it used to be or as it could be. I think the thing is that people don't realise, and this is not just Health, that a complaint - I'm not going to use that dreadful adage that "a complaint is a gift", but it's there to - it can perform a very constructive role. And really, in all our jurisdictions we're on the same page as the stakeholder, and in Health the objective of the exercise is to improve the provision

of health services, so we'd like to be on the same page as the stakeholder. So, if there's a mistake been made, admit it, look at how that happened, strengths and processes, and address the cause of that complaint so it doesn't arise in the future.

COMMISSIONER BROMFIELD: Q. Is it troubling to you to see - in light of the recommendations made in 2005 is it troubling to you to see ostensibly very similar issues in leadership management?
A. It is concerning, yes, particularly given the seriousness of the subject matter, yeah, it is concerning.

Q. Do you have any views on what we could do to ensure that we don't fail to retain what we learn this time around?
A. Well, this is, as I was starting to say before, I think record-keeping is vital in all the jurisdiction that we administer. There needs to be clear records of what's been done and why it was done and for what purpose, and those two can then inform policies and procedures into the future, but unless these are available to everybody who's working in the particular area, you know, things will go un - missed because people are not aware and I've been hearing how people are not aware of what was going on in this instance.

An internal database or good record-keeping about these things. Education is vitally important and good complaint handling has to come from the top down, so the most senior officers have to be supportive of the process and disseminated amongst the rest of their staff.

COMMISSIONER BROMFIELD: Thank you.

MS NORTON: Q. Commissioner, you speak in your statement, at page 8, about your expectations in relation to how the Tasmanian Health Service ought respond to and manage a complaint of child sexual abuse, and I'll just outline the steps briefly and as I understand it in order. There should be a notification to police, it should be brought to the attention of senior management and steps taken to ensure safety; record-keeping regarding the complaint and response. If there's a registered practitioner involved, AHPRA should be notified.

Can I ask: should that notification take place at the

time an allegation is made against a registered practitioner or following the conclusion of an internal investigation?
A. No, AHPRA has - will investigate the conduct of a registered practitioner so that notification should be made at an early stage.

Q. Not after an ED5 process, for example?
A. Not after an ED5, no. ED5 is just a - not a "just" - it's a breach of the State Service Code of Conduct. But if it's a registered practitioner, these are fairly serious practice issues that you're talking about --

Q. Yes, and you say --
A. -- and serious offending.

Q. Sorry, I didn't mean to cut you off.
A. No, that's fine.

Q. You say in your statement that your office refers complaints of child sexual abuse made in relation to registered practitioners to AHPRA. What approach do you take where the allegation is what might be described as precursor behaviour: so, boundary breaches, grooming behaviours that may suggest that child sexual abuse is occurring or may in the future occur?
A. Well, that's a difficult one. I'm not sure where that sits in amongst the various entities. I mean, grooming is an offence, so if you had any evidence of that we'd be referring it to police. Would certainly be notifying senior management about this sort of conduct and whether they're aware of it, how they're responding to it. It shouldn't go unchecked, but to be honest I'm not absolutely sure, I haven't struck that situation, so ...

Q. Can I explore that with you a little bit. You'd accept, wouldn't you, that a complaint about grooming behaviours might come to you and you might feel a bit unsure about what to do with it. It's possible that AHPRA might have in respect of the subject registered practitioner --
A. They may well have a view, be --

Q. Well, they may well have on file notifications of similar allegations, and so, in that situation wouldn't it be of relevance to --
A. To involve them.

Q. -- inform the Regulator so that they can identify potential patterns?
A. No, that's right, that's something I would do, that is potentially professional misconduct, so yes, you would be referring to AHPRA and to management as well, because it could well be a breach of the State Service Code of Conduct.

Q. You give in your statement some examples of a reluctance to make external reports on the part of the Tasmanian Health Service. You give an example on page 7 of the Tasmanian Health Service advising your office --
A. Yes.

Q. -- that nurses had been reported to AHPRA following an ED5 process, and then you later discovered that hadn't occurred and you ended up making the referral to AHPRA.
A. Yes.

Q. Are you able to provide any further details about when that happened and which Health Service those nurses worked within?
A. I can take that on notice but I'm limited in what I can say about particular complaints and so forth, but I'd be happy to provide whatever further information I can.

Q. Thank you. There's another reference on page 8 to a 2018 example in an Emergency Department; I think it was an assault and there was a reluctance on the part of the hospital to report to police.
A. Yes.

Q. Is there anything further you'd like to add in relation to that?
A. I can't add anything further to that at the moment, but again I'm happy to take it on notice and, if there is anything, I'm happy to.

Q. Thank you. Much of the focus of the evidence last week and in your statement is upon cultures within the LGH, but I'm interested to understand to what extent your observations about complaint handling processes and reluctance to report to external agencies goes beyond the Launceston General Hospital and applies across the Tasmanian Health Service?
A. Well, again it's difficult to say because the reports

aren't being made, um --

Q. Do you hold a concern that it's not limited to LGH?
A. Having heard the evidence that I've heard this week, yes, I would be concerned that this may be happening - I think it's probably in the larger institutions; I say that without really knowing. But look, if it's happened here, it could happen elsewhere.

Q. Thank you. You've talked about a centralised capacity in the past; a centralised complaints handling capacity and as I understand it one of the elements to the announcement that was made yesterday involves, again, a centralised complaints handling system. Do you have any suggestions that you'd like to offer at this point? I understand there's not very much detail --
A. Not a lot to go on at this stage, no.

Q. But anything that you think would be important to bear in mind as that system is designed?
A. Yes, and I think what I was saying before, centralised is good in that you can keep a record of all complaints being made in one spot, but it also needs to have an appropriate network of people to deal with those complaints, so that, a complaint needs to be dealt with in a timely fashion, particularly a Health complaint, where possible, it's not always possible but where possible, deal with it in a timely fashion, and with somebody who has the appropriate skills and knowledge to assess that complaint and to attempt to resolve it.

So, centralised is good in the sense of maintaining a record of everything that's coming in, but it only works if you have the right people around it to deal with the complaints. Again, as I say, Health is a very diverse organisation, there's a lot of areas to cover in there, so you need to have a network of people who can address the actual complaint matters.

Q. I'm conscious of the time, I just have a few more questions, one of them relates to an example you give on page 6 of your statement and this is, as I understand it, your office didn't receive any complaints in relation to James Griffin --
A. No.

Q. -- prior to October 2020 where you received a call

from the mother of a child who was concerned about the lack of action on a complaint she'd submitted to LGH in approximately 2018; there'd been a lack of follow up. She referred to the fact that she'd submitted blue forms to the LGH but had heard nothing back.

You may not be able to comment but I'll ask you in case you can: was that a complaint concerning potential child sexual abuse or grooming behaviours?
A. It was an enquiry rather than a complaint.

Q. Yes.
A. And that's a difficult definition, difference between enquiries and complaints, but this wasn't a formal complaint and it wasn't in relation to the alleged abuse, it was the failure to respond to it.

Q. The Commission has heard evidence about a range of different complaints pathways at the LGH. The reference to "blue forms" comes as a surprise to me at least. Are you familiar at all with that as a complaint pathway?
A. No, I'm not sure what is meant by blue forms. I obviously wasn't involved in this enquiry but, no, I'm not sure what that means.

Q. The Commission heard evidence last week about a complaint that was made to the Integrity Commission by Mr Will Gordon who was and is a nurse on Ward 4K, and it was a complaint that concerned concerns about management's response to staff concerns about Mr Griffin's conduct at work over a long period of time, and it also raised issues of document destruction. Were you aware of that complaint at around the time it was made; that is, November 2019?
A. No, we didn't become aware of the detail of these thing - well, of this situation until about a year later, in 2020.

Q. Because I think Mr Easton's evidence last week, and I'll be told if I'm wrong about this, but I think Mr Easton said that he did speak to the Ombudsman or perhaps to the Ombudsman's Office in the preliminary stages?
A. May do to check whether we had a complaint from that person.

Q. Yes.
A. Not to descend to any great detail.

Q. And you might be aware that that complaint was assessed by the Integrity Commission as being worthy of further investigation but referred to the Department of Health as the most appropriate body to undertake that investigation.
A. Yes.

Q. And it was ultimately referred back to the HR Department. Now, bearing in mind that part of that complaint concerned mishandling of staff complaints by the HR Department, do you have any observations about the propriety or otherwise of HR being responsible for responding to the complaint?
A. I don't think I can comment on that.

Q. Well, can I ask you the question by reference to an answer you gave before about potential conflicts of interest, and you referred to --
A. Yes, no, I see: it should probably have gone to somewhere other than Human Resources in this circumstance, yes.

Q. Thank you. I have just one final question in relation to conflicts while I have you. There's an issue before the Commission in relation to a disclosure that two staff members made to HR, they say, in 2011, and there are questions before the Commission about who attended that meeting and what was said at the meeting.

Now, a state servant who is one of the people said to have been at the meeting was charged with interviewing another person who was at the meeting in relation to who was at the meeting and what was said. Have you got any comments about whether that's an appropriate --
A. I think it would have been probably preferable to have had an independent interviewer.

MS NORTON: Thank you. Thank you, I have nothing further, Commissioners.

PRESIDENT NEAVE: Thank you, Mr Connock, and thank you for accommodating the change in sequence.
A. No, quite all right.

PRESIDENT NEAVE: Thank you. Yes, a brief adjournment, thank you.

SHORT ADJOURNMENT

MS RHODES: If it please Commissioners, our next witness is Kirsty Neilley, she'll take an affirmation.

PRESIDENT NEAVE: Thank you.

<KIRSTY SANDRA NEILLEY, affirmed: [11.26am]

<EXAMINATION BY MS RHODES:

MS RHODES: Q. Ms Neilley, could you state your full name for the transcript, please?
A. Kirsty Sandra Neilley.

Q. And your occupation is - are you a full-time mother; is that correct?
A. Yeah.

Q. You made a statement for the Commission, do you have that statement before you?
A. Yes, I do.

Q. You've had an opportunity to read that statement before now?
A. Yes.

Q. Are the contents of that statement true and correct?
A. Yes, they're true and correct.

Q. Thank you.

Q. Ms Neilley, thank you for doing your statement and for speaking to the Commissioners about your story. Could you please explain to the Commission when and how you first met Mr Griffin?
A. I first met Jim when I was admitted to hospital [redacted], and then, so I was admitted to the kids' ward, and I think he was one of my nurses I think from - maybe a few days in he was one of my nurses and we got on really well.

Q. You say in your statement that that was in about October 2015; how old were you then?
A. I was 16.

Q. You say he was one of your nurses; how often was he

looking after you when you were first admitted?
A. When I was first admitted he was just like any other nurse, he'd look after me maybe once or twice a week, and then once we got to know each other better he was looking after me a lot more.

Q. You say in your statement at paragraph 6 that he would generally look after you as a one-on-one nurse carer; can you explain what that means?
A. So, because I was in there for mental health they used to have, like, a one patient to nurse ratio so that I always had someone watching me and, yeah, it was often Jim at the end because he got along with me better, so I don't know whether he requested me as a patient or he just ended up with me.

Q. Does that mean that, being one-on-one, you didn't have other people caring for you at the same time, it was mostly Mr Griffin?
A. Yeah.

Q. Was that during the day and night-time?
A. Yeah.

Q. You said that he may have requested you but I understand that you had a - what's the word I'm looking for - please excuse me for using the word "relationship", but you had a friendship with Mr Griffin whilst you were on the ward; would that be correct?
A. Yeah.

Q. And how did that friendship develop?
A. Do you mean, like, how did it start?

Q. Yeah, how did it start?
A. It was about a week into being in hospital and he was sitting down, he was looking after me, and I think my art book fell off the bed and then so he found out that [redacted] and so I sort of opened up to him and he was the first one I opened up to about it.

Q. Being the person that you first opened up to about it, that was you trusting him with that story; would that be correct?
A. Yeah.

Q. In your statement at paragraph 7 you talk about

Mr Griffin overstepping boundaries and you talk about how you were both looking at Facebook accounts and things like that; could you explain that to the Commission, about how you and he interacted over Facebook?
A. So we'd just, like, when he was looking after me he'd just sit on the bed, I'd scroll through my phone with him, I would go through his phone; it started off we'd just go through each other's photos and look at his Facebook posts and everything and the same with mine, and then it went on to looking at anything that was on Facebook.

Q. You talk about how you would message each other on Facebook; is that right?
A. Yeah, yep.

Q. Would you be messaging other nurses through Facebook or just Mr --
A. No, just Jim.

Q. So, was that something that you and he did that nobody else knew about?
A. Yeah, like, he, um, he told me not to tell anyone.

Q. From the Facebook messaging I understand it then moved to telephone text messaging and things like that; how did that happen? How did it move from Facebook to telephone texting?
A. Well, I mean, it was a late night, Jim called me up and he'd said that somebody had reported him for getting too close to me, and so that the - I don't know, I think it was like the night nurse who was in charge had told Jim that he was to stop contacting me, so he gave me his phone number instead so that it was just a random phone number come up on my screen instead of his Facebook name.

Q. So, even though you were only a 15-year-old girl at the time, did you think that was strange or not really?
A. Um, I kind of enjoyed having him to talk to, so it wasn't - yeah, I didn't even look at it that way at all.

Q. Were you messaging via text to any other nurses or just Mr Griffin?
A. Just Jim.

Q. Was anything discussed - sorry, I'll rephrase the question. You said that a complaint had been made about Jim being too close to you; did anyone at the hospital come

and speak to you about that?
A. No.

Q. And, were you told by anybody else about that complaint or just by Mr Griffin?
A. Just by Jim.

Q. Correct me if I'm wrong, but was it your understanding at the time that it was to remain a secret?
A. Yeah.

Q. And, how did you know that it was to remain a secret, this communication?
A. Because he told me not to tell anyone because he could lose his job over it, but he didn't want me to be by myself.

Q. And why did he think you were going to be by yourself?
A. Because I didn't really open up at all to anyone else, including my parents, so he was sort of my main support.

Q. You also talk in your statement, at paragraph 10, about Jim giving you hugs at the end of the shift. Could you explain to us about that, why he was doing it or whether other nurses were doing the same thing?
A. No nurses were doing the same thing, but again, at the time it was total - like, I had no problem with it, it just felt that I had someone there for me and, yeah, I don't know why he was doing it but I had no complaints because, yeah, he was there.

Q. You describe these as long hugs and him also kissing you when he said goodbye; is that correct?
A. Yeah.

Q. So, it wasn't a sort of a hug and a kiss that you might get from a family friend or something, it was something a bit more than that from your perspective, would that be correct?
A. Um, I - at the time it was - like, when he was doing it it was just the same as a family friend or something, but now looking at it, like, I wouldn't treat any of my family and friends like that, I wouldn't go out and give them long hugs, so no, probably not.

Q. You also describe how, in paragraph 11 of your statement, you talk about him taking you off the ward and

doing coffee runs; could you explain that a bit to the Commission about what he was doing when he was taking you off the ward?
A. Yeah, so we used to go on - there's, like, that little coffee shop down near the hospital, so he'd just be five or six minutes if they'd want coffees or something, so he'd take me down there and (indistinct words) and take them back up to the ward.

Q. You describe an incident where you were in an elevator and he was taking you to the top of the hospital, can you give us a bit more detail about that?
A. Yeah, so I think it was a really slow day in the kids' ward, so we went out down to the little, like, gift shop in the hospital and got some lollies and then he wanted to show me the view from the top of the hospital, so we went up to, I don't know, whatever the top ward was and, yeah, we were looking out over Launceston.

Q. And, how were you feeling when this was happening?
A. When it was happening it was a little bit, like, it wasn't normal but I didn't really have any reason to be questioning any of it, and I'd been locked in the hospital ward for quite a while so it was kind of good to be out, it didn't really matter where we were going.

Q. Did you feel that your relationship was a special relationship with Mr Griffin?
A. Yeah.

Q. Would you say it was a trusting relationship between the two of you?
A. Yeah.

Q. You also explain in your statement about being woken up in the night by Jim being over your bed with a phone; could you explain again what happened in that situation?
A. That one I did feel, you know, uncomfortable with but I didn't question it because the first time it happened I felt really uncomfortable about it. And he'd come in, I didn't hear him come in or anything, and then I woke up to him sort of, like, leaning over the bed and I felt really weird and I asked him what he was doing and he said he was just waking me up to say goodnight because his shift had finished, but I don't know, I didn't question it but it felt really wrong.

Q. And so, when you woke up, what did you actually see when you woke up?
A. Literally just his phone, like, because the room was really dark.

Q. Okay, so he had his torch on his phone and that's what you woke up to?
A. Yeah, yeah.

Q. Was that the only time that you woke up to that?
A. No; no, it would have happened probably five or six times maybe.

Q. And you weren't really sure what was happening or what he was doing?
A. Um, no, not at all; every time I had never heard him come in, so it was just sort of a woken up thing.

Q. You explained that someone had made a complaint about Mr Griffin. What happened as a result of that complaint or did he maintain being your carer or was there a change in staff?
A. I think there was a change for about, I'd say half a week before he went back to being my carer again.

Q. Do you know why that happened, whether he was rostered on, or he was doing it when he was rostered on somebody else; do you know any --
A. No, every time - he wasn't working or he wasn't onboard for that part of the week for some reason, but he didn't tell me why.

Q. How long were you in hospital that time, the first admission?
A. I have no idea.

Q. Would it be safe to say it was a couple of months?
A. Yeah, yeah.

Q. And most of that time Mr Griffin remained your carer despite a complaint having come to him about your close relationship?
A. Yeah.

Q. You were eventually discharged from the hospital and then I understand that you were re-admitted fairly quickly, we don't need to go into details as to why you were

re-admitted, but on your re-admission I understand that there was some complications and you had a seizure at the hospital.
A. Yeah.

Q. And that you were in ICU for a while and woke up but you didn't have much of a memory about what happened?
A. I have no memory at all.

Q. What were you told about what happened when you woke up?
A. I wasn't told anything of what had happened at all; I was only - the people that told me were mum and Jim, so none of the nurses explained what had happened or anything.

Q. And what did Mr Griffin say to you when you woke up?
A. He said that he'd been to - because I was in ICU, so he said he'd come and visited me a few times when I was in there. And then later on he told me that the red - "You were on the floor in the hospital ward", and he told me that he pulled me out from under the bed and he saved my life when I had the seizure.

Q. And, did you believe him when he told you that?
A. I didn't, but mum told me the same thing, so then I believed them both because - yeah.

Q. And, did that change the way that Mr Griffin acted towards you in any way?
A. No, not really.

Q. Did that change your feelings towards him in any way?
A. I felt like I owed him because he saved my life, but not really, yeah.

Q. You say in your statement at paragraph 19 that you regarded him as your hero; is that correct?
A. Yeah.

Q. And that Mr Griffin would often remind you of the day that he saved your life; is that correct?
A. Yeah.

Q. So it would come up quite often when you were speaking with him or would he say it to other people as well?
A. No, no, it was just sort of when I was talking to him.

Q. I understand in that admission you were transferred from the Children's Ward to another ward in the hospital?
A. Yeah.

Q. And during that time did the communications with Jim - Mr Griffin, even though you were out of the Children's Ward, did they still occur?
A. I'd say they occurred more often now that I was off his ward.

Q. How was he communicating with you on the other ward?
A. Either phone calls or text messages.

Q. And was that at different times of the day and night or was it only when he was on shift?
A. No, it was different times of the day and night.

Q. You were then released and again admitted in 2016 given a horse riding accident?
A. Yes.

Q. And that time you were taken to the Children's Ward again. Who was your nurse on that occasion?
A. I don't know who my nurse was originally because I think I was in there for two days, but Jim was my nurse on the second day.

Q. You tell us, at paragraph 21, about an incident of you needing to go to the shower, but because you'd broken your leg you couldn't walk. Could you explain to the Commission what happened on that occasion with going to the bathroom and Mr Griffin?
A. I hadn't broken my leg, I'd torn a muscle, but there was - we were in a split room, so there was my bed next to someone else's bed and the bathroom was next to them, but for some reason, I can't remember, we didn't use the bathroom in our room and he took me down to, like, the main bathroom in the ward. And he took me down in a wheelchair and then I had a shower and I got out and I couldn't find my clothes, so then I called for the nurse - I can't even remember if - yeah, I called for him, and then he carried me back because he said there was no wheelchairs or something, so he carried me back to my room where I found my clothes on my bed.

Q. Just to clarify, when you went down for the shower you were taken down in a wheelchair?

A. Yeah.

Q. But when you had finished your shower you didn't have your clothing and you were taken back to the ward not in a wheelchair but being carried by Mr Griffin; is that correct?
A. Yeah.

Q. Was anyone else around at the time when this happened?
A. I would say so because it's a busy hospital, but I didn't pay attention to who was around.

Q. But you don't recall if anyone made any comments to Mr Griffin about carrying you down the ward?
A. No, I don't know.

PRESIDENT NEAVE: Q. And, by that age, you were 16 or 17 by then?
A. I was turning 17.

PRESIDENT NEAVE: Thank you.

MS RHODES: Q. And then after a while you were discharged from the hospital. Did your communications with Jim stop then or did they keep going?
A. They kept going.

Q. How did you continue to communicate with Mr Griffin?
A. Phone calls or text messages.

Q. And so, at this stage how would you describe your relationship with him? Would you consider that he was just a nurse or was he something more to you and your family at that stage?
A. He was definitely something more; he was, yeah, like a second father, family figure thing.

Q. And he was accepted by your family, your family liked him as well?
A. Yeah.

Q. I understand that in January 2018 you were married and Mr Griffin attended your wedding. Could you explain what happened with the photographer when the photographer went to take family photos?
A. I don't know where he heard it but just, the ceremony had finished and we're sort of, you know, getting family

photos and everything and the photographer asked my dad - oh, a family photo of my dad and me and then he pulled Jim up and then, yeah, so dad sort of backed down and Jim just took photos with me and said he wasn't my dad.

Q. So, the photographer thought that Mr Griffin was your father?
A. Yeah.

Q. Was there anything in particular that Mr Griffin was doing that day that would make the photographer think that?
A. I think he didn't really socialise with sort of anyone else, he was always with me.

Q. You say in your statement at paragraph 25 that he was calling you "baby-girl"?
A. Yeah.

Q. And, had he called you that before?
A. Not that I remember.

Q. I'm going to ask you some questions about when your [redacted] and that Mr Griffin was there some time later in the hospital with you and he said something to you on that occasion, and I'll refer you to paragraph 27 if you need to have a look at it and just recall it before I ask this question. Could you tell the Commissioners what he said to you that day, if you feel comfortable in doing so?
A. Yeah. So, first, like, it wasn't in hospital, we were in the supermarket and we met up, like, we just found each other and then - and he said, I don't know how it was in the conversation, but he did bring up how he saved my life and then he was saying how proud he was of, you know, how much I'd grown up. And then he mentioned that he still had all the photos - yeah, all the photos of memories of us, and it was really --

Q. And what - sorry, you go ahead.
A. It was really confusing but because he was at the wedding I just assumed that it was our wedding photos that he had and that's what he was referring to.

Q. Now with everything that's happened, do you have any concerns about that comment now that you didn't at the

time?
A. Yeah.

Q. And can you explain to us what your concerns are about that?
A. Yeah, I was just concerned that he might have had other photos of when I was in hospital.

Q. And that's something that unfortunately you won't be able to know for sure; is that correct?
A. Yep.

Q. How do you feel about that?
A. Um, I was really upset about it at the time, but the more - it's happened, there's no way I can find out, so yeah.

Q. Thank you. Now, I understand that you found out about Mr Griffin's death in April 2020. Actually, I'll move on from that question. I understand that you also were exposed to the podcast, is that correct, you heard The Nurse podcast?
A. Yeah.

Q. How much of that podcast did you hear?
A. I think Episode 1 and a bit of another episode.

Q. How did you feel after listening to what you heard on the podcast?
A. I just believed that it couldn't be real and, yeah, that wasn't - at the time, that wasn't the person I knew.

Q. How do you feel about it now, now that there's been a little bit of time and a little bit more information has come out about what had happened, what's your feeling when you look back on these events, what do you feel and think about what happened?
A. Yeah, I have so many questions I would have liked to ask Jim himself, so I don't know, I just feel lost a little bit.

Q. What do you feel about the hospital and people there that were supposed to care for you at the time?
A. I don't know, I feel really, like, there was a lot of red flags that people could have picked up on that wasn't sort of - yeah, nothing - obviously something was picked up on because there was a complaint, but yeah, I just feel

like I was really let down that nothing actually happened.

Q. Thank you very much for coming to speak to the Commission today. Is there anything you'd like the Commissioners to know? That's the end of my formal questioning, they may have some questions for you, but is there anything else you'd like the Commission to know?
A. No.

MS RHODES: Thank you.

COMMISSIONER BENJAMIN: I don't have a question, I wanted to say something. Am I looking at the right camera, since you're remote?
A. Yeah.

Q. Kirsty, you're correct and very brave in telling us your story. It helps us and others to understand Griffin's grooming of you and Griffin's behaviour on Ward 4K and beyond. Your story helps us and others to understand Griffin's predatory behaviour towards you and hopefully to ensure that other children are not likewise groomed. So, for my part, thank you.

COMMISSIONER BROMFIELD: Nothing from me, but thank you very much for sharing your story. It can't be an easy thing to put yourself out like this and, as Commissioner Benjamin said, we learn a lot from everything that everybody shares with us, so thank you.

PRESIDENT NEAVE: Thank you so much, Ms Neilley, I completely endorse the comments that have been made by Commissioner Benjamin and Commissioner Bromfield, and I think you've made a great contribution not only to our understanding of what happened but also I hope to the understanding of the whole of the community about how grooming can operate and what dreadful effects it can have on people. We're very glad that you seem to have appeared strong and you've come forward to talk to us about what happened and that will increase everybody's understanding of the way these things can happen, so thank you very much indeed.

MS RHODES: Thank you, Commissioners. I understand that we just need to terminate the link but given the hour that we may continue on, but happy to have a short break. In the hands of the Commissioners.

COMMISSIONER BROMFIELD: I think we'll stay.

PRESIDENT NEAVE: We'll stay, yep.

MS RHODES: Ms Ellyard will take the next witness.

MS ELLYARD: Thank you Commissioners, I'll just wait while the link is terminated.

Members of the Commission, there's an appearance to be announced before the next witness.

PRESIDENT NEAVE: Yes, I understand. Thank you.

MS KEATING: Good morning, Commissioners, my name is Keating, I appear on behalf of Mr Hardy.

PRESIDENT NEAVE: Thank you very much.

MS ELLYARD: I'll call the next witness, Mr Matthew Hardy.

<MATTHEW HARDY, affirmed and examined: [11.57am]

<**EXAMINATION BY MS ELLYARD:**

MS ELLYARD: Q. Thank you, Mr Hardy, please take a seat and tell us, please, your full name?
A. My name is Matthew Hardy.

Q. And you are by profession a lawyer?
A. I am, yes.

Q. Where do you presently work?
A. I work for the Australian Health Practitioner Regulation Agency.

Q. What's the role that you hold there?
A. I'm the National Director For Notifications.

Q. Just to give some context, the Australian Health Practitioner Regulation Agency is a body which has both national and state levels?
A. We're a national entity and we employ individuals across all states and territories, and specifically in relation to notifications we've got a presence in every jurisdiction with the exception of New South Wales.

Q. And one of the functions of the agency is to provide support to the Medical Board and other health practitioner bodies which are responsible for the regulation of health professions, including relevantly for our purposes doctors and nurses?
A. That's correct.

Q. You have made a statement to assist the work of the Commission; do you have a copy of that statement in front of you?
A. I do.

Q. It's dated 27 June 2022?
A. It is.

Q. Are there any corrections that you want to make?
A. There's one correction from me at paragraph 211.

Q. Thank you.
A. The correction there is that the date of death of Mr Griffin was 18 October 2019.

Q. Thank you, so we'll just make that correction. Can I turn back then, Mr Hardy, to ask you a few more questions about what I'll call the regulatory system in Tasmania for doctors and for nurses.
A. Yes.

Q. In the case of each of those two professions there's a board which oversees and supervises them; is that right?
A. That's correct, there's a National Board for each of the professions in the scheme.

Q. And the role of, let's take it in turn, the Nursing & Midwifery Board is firstly to determine who should be admitted to the profession and be registered to be able to work?
A. That's correct.

Q. Secondly, to set standards that will govern how those people once they're admitted ought to conduct themselves in their work?
A. Yes.

Q. And if complaints or concerns are raised about them, to receive with the assistance of AHPRA those concerns and,

if necessary, investigate them?
A. That's correct.

Q. And in the case of doctors there's a similar structure involving the Medical Board; is that right?
A. It is.

Q. At paragraph 25 of your statement you make the point that the role of the boards and of AHPRA is to be an occupational regulator of individual practitioners as opposed to a regulator of the whole system. Could I ask you to tease out for us a bit the roles that AHPRA and the board perform as distinct from other roles that other agencies might perform?
A. Yeah, happy to. So, the role for AHPRA and the board is to, in terms of individual practitioners, register those individual practitioners, annually renew the registration of those individual practitioners and to receive and then manage complaints about them as individuals. The powers that the boards have in relation to those individual practitioners include the ability to restrict someone's practice or to suspend their practice as a health practitioner.

We share responsibilities with other entities in the State Government sector in Tasmania, including the Health Complaints Commission, and also employers who share responsibility for making sure that practitioners are practising safely and that there are safe systems of work for those practitioners to work in.

Q. You've mentioned employers, of course for the most part nurses will be employed by a hospital or care provider and then be subject to the supervision and direction of their employer, but the role of the Nursing & Midwifery Board and AHPRA is quite distinct from that; is that right?
A. That's correct. So, under the National Law there's an obligation for nurses, as you've already introduced, to comply with the Code of Conduct that's published by the Nursing & Midwifery Board, and it's the board's responsibility where there are serious departures from the standards that are set out in those codes to take action once they're aware of behaviour that contradicts the code.

Q. And to take action regardless of whatever view might have been formed by the practitioner's employer?
A. Correct, yes, so the role of the boards is independent

of any other entity, including the employer.

Q. And so, let's just continue with the example of the Nursing & Midwifery Board, recognising that AHPRA acts for all of the various Health Boards. How will the board come to be aware of a concern about a nurse's performance?
A. So, to become aware someone would make a notification and typically a notification is made to the agency, AHPRA, verbally by a person who has a concern or they can lodge a notification online or in writing, and AHPRA's obligation is to put that concern in front of the relevant National Board who's responsible for the registration of that practitioner.

The other way would be for own motion complaints to be commenced by either AHPRA or the board because we've become aware of a concern about a practitioner that has not been the subject of a notification.

Q. And so, are there any limits on who can make a notification to the board?
A. No.

Q. Are there any circumstances where people are under an obligation to make notifications to the board?
A. There is. So, there are three forms of mandatory notifiers identified under the National Law: employers of health practitioners have mandatory obligations to make reports; other health practitioners have mandatory obligations to report certain behaviour to the National Board, and in respect of students who are studying to become health practitioners in the future, education providers also have some mandatory reporting obligations to make certain notifications to the board.

Q. But thinking about, for example, the parent of a child who's in a hospital, can that parent make a notification if they're concerned about the way in which a doctor or a nurse is treating their child?
A. They can.

Q. And similarly, I take it, any colleague on a ward or in a health practice could make a notification either voluntarily or in certain circumstances because they're obliged to?
A. Correct.

Q. At paragraph 70 of your statement you refer to the powers that are available to a board once a notification has been received. Now, it would be fair to say that there's a spectrum of powers and options that the board has, starting from doing nothing going all the way up to making a referral to the tribunal because they think there's been misconduct.
A. Yes.

Q. Thinking about the kinds of matters that this Commission is investigating, if a notification had been received alleging a boundary violation by a nurse or doctor in relation to a child what would be the most likely, if one can say that, pathway that such a notification would follow?
A. The usual course of events for a case like that would involve the board considering in the first instance the complaint; considering what information has been provided in terms of information or evidence that supports the complaint, so that could be a statement from a person who's been affected by behaviour from a practitioner, or it could be a guardian or a parent who's raised that concern.

The board's first obligation when it receives concerns about serious issues, and I'd say that all of the information that the Commission is considering would be in this domain, would be to determine whether or not what is called "immediate action" needs to be taken; that's interim action that restricts or prevents practise by a practitioner while there's an investigation carried out into the concerns that have been raised.

So, for the types of complaints that we're talking about in this Commission I'd anticipate the role would be to consider restricting someone's practice, to then investigate the complaint. If there is a corresponding criminal or other form of investigation going on, the boards might wait to continue their investigation, but they have that really important initial protective action power that enables them to take immediate action so that further harm to the public is stopped.

Q. Can I ask you to explain a little bit more about immediate action? The Commission's heard or been aware of perceptions that nothing can be done in relation to concerns about a health practitioner unless and until there's some criminal law outcome for example. I take it

from what you're saying, is that in certain cases the board might take action to, for example, suspend a practitioner on day one of what might be a long investigation?
A. That's correct. So, subject to the requirement to provide a practitioner with procedural fairness, there are powers for a board to act relatively quickly to stop or restrict practice while there are other investigations carried out, including our own investigation.

Q. As I understand it, the board has a range of circumstances where it can exercise that power of immediate action: firstly, if the board believes that there is a serious risk to patients?
A. Yes.

Q. But also, there can be other categories where the board takes the view that it's in the public interest that a person be suspended. So, does it follow from that, that the board might hear about conduct of a practitioner that doesn't actually relate to their health practice at all but nevertheless be concerned enough to need to take immediate action?
A. That is absolutely correct. An amendment was made to the National Law in 2019 that brought in the public interest test for immediate action, and that was specifically because there was a perceived deficit in the boards being able to take action upon serious offending that might not have been in connection with the practice of a profession.

PRESIDENT NEAVE: Q. So, before 2019, how was public interest defined then?
A. So, thank you for the question, Commissioner. There was no public interest test in the National Law prior to that.

Q. I see, so it was inserted in 2019?
A. Yes.

PRESIDENT NEAVE: I'm sorry, thank you.

MS ELLYARD: Q. So prior to 2019 the board could only take immediate action if it was satisfied that there was a serious risk to public health or to the safety of persons?
A. Yes, that's correct.

Q. But now there's that additional source of power?

A. Correct.

Q. Thinking more broadly, we've talked about immediate action as being something you can do at the beginning of the investigation, the question might be posed, well, if someone's alleged to have done something wrong but not at work, in their private life, is there power for the board to investigate it at all? Can the board take a proper interest in the way people conduct themselves in their private life?
A. I think the way you've characterised there as "taking an interest" is absolutely the case. So, the Codes of Conduct that are published by boards speak to behaviour when delivering care to patients, but more broadly to the behaviour of practitioners, the ethical behaviour of practitioners outside of work. The sort of, the way that boards exercise their jurisdiction is to not only make sure that individual patients are protected, but also to think about the requirements that patients - sorry, I'll take that back - the trust that patients ought to be entitled to have in practitioners who provide care to them, so behaviour that's inconsistent with a person deserving that trust can be acted upon by the boards.

Q. You touch on this at paragraph 85 of your statement when you talk about the fact that a notification could be made on the grounds that - or taken up on the grounds that the conduct alleged would be inconsistent with someone being a fit and proper person to practise the profession?
A. That's correct.

Q. And so, thinking for example about some of the evidence that the Commission has heard during last week and this week, suggestions that a person has engaged in criminal conduct outside of their professional life and towards someone that they knew personally, that information, if it were to be made known to the board, might be something that the board could take up as a matter to be investigated?
A. The situation you've outlined there is the case, yes.

Q. You've mentioned already the possibility that police might be involved and the kind of matters that we're talking about are matters where one might expect that the police would also be notified because allegations of child sexual abuse are, by definition, allegations of criminal conduct. What happens if there's a police investigation,

does that potentially limit the way in which a regulatory board can take action about a notification?
A. The answer is pretty technical. First up I'll say that the situation you've outlined, so a person being charged with a serious criminal offence, once the board's in possession of that information we would say the board's responsibility is to ensure that there's protections in place for patients and the public.

Where police are in the early stages, for example, of an investigation, they might ask us not to divulge the fact of an investigation or the substance of an investigation to a practitioner. In those circumstances the board's in a fairly difficult position; it doesn't want to prejudice the criminal investigation of the board but by the same token it's got that responsibility to ensure that people who are registered to practise are fit and proper people.

So there is a really important relationship that AHPRA has with police to make sure that at the earliest possible opportunity we can present that investigation or the information that the police are considering to a practitioner to enable us to propose effectively that restrictions ought to apply because of those serious allegations against the practitioner.

Q. This raises the question of information sharing and the extent to which AHPRA, on behalf of the boards, is able to share information with the police or receive information from the police, and you've answered this at paragraph 179 and following of the statement. One of the things you identify is that in some states, though not as I understand it in Tasmania, there are memoranda of understanding in place to assist in the exchange of information; could you tell us about that?
A. Yep, that's true. There was a review undertaken by the Medical Board of Australia in relation to the use of chaperone conditions as a form of protective action, and that review resulted in some recommendations being made to us about ensuring that there are appropriate information-sharing provisions available. We entered into memorandums of understanding with a number of police forces after that review that result in, you know, a greater awareness of the ability to share.

The situation in Tasmania is that we don't hold a memorandum of understanding with the police. That doesn't

stop us from being able to share with police; in fact, our operational policies specify that, if we become aware of an event that could be evidence of criminal behaviour, it's our policy to disclose that to the police and there are powers under the law that we operate that allow us to do that, but there are also more general powers that enable us to disclose information to police that could be evidence of the commission of a crime.

Likewise, there are information-sharing provisions in our law that enable police to inform us of their work and concerns about health practitioners.

Q. And is that the case in Tasmania?
A. In Tasmania the law enables the police to inform us of their concerns and, subject to that situation that I outlined previously where police may be undertaking covert-type activity and may not want the practitioner alerted to the fact, it's pretty typical that we'd be informed and take action.

Q. So, thinking again about information that the Commission's received here, if, for example, police came into possession of information suggesting that someone who was known to be a member of a registered health profession was engaging in the production of child exploitation material or it was suggested he or she had such a role, under the current state of the law in Tasmania, if the police knew that that person was a member of a health profession they could make a notification or share information with AHPRA?
A. Yes, they could.

PRESIDENT NEAVE: Q. And how long have they been able to do that?
A. The particular ability to raise concerns with a regulatory body, you know, predates the scheme that I work in. Our law commenced on 1 July 2010, so the power existed, you know, in my evidence the power has always existed since 2010 under the National Law. Previously the involvement of police would have been with state-based entities for each of the professions.

PRESIDENT NEAVE: Thank you.

COMMISSIONER BROMFIELD: Q. Sorry, you said that they could, but there's no MOU in place, so does that mean that

they're not required to share that information?
A. There's no MOU in place for Tasmania between AHPRA and the Tasmania Police, but the MOUs that are in place in other jurisdiction supplement the law, so they make it clear the basis upon which police can share the information under the provisions of the National Law.

Q. Sorry, I'm still getting caught on the word "can" versus "required".
A. There's no requirement at law for the police to disclose that information to us.

COMMISSIONER BROMFIELD: Thank you.

MS ELLYARD: Q. Whether there's an MOU or not?
A. Correct.

Q. But I take it, the existence of an MOU does have some benefits in enabling the more timely or easy sharing of information?
A. Yes, that's correct.

Q. Thinking then about --

COMMISSIONER BENJAMIN: Q. Mr Hardy, if I can interrupt, going to paragraph 187 of your report, you say there that:

> *[At present] AHPRA or the National Boards are not subject to the reportable conduct scheme overseen by the Commission for Young Children ...*

And what have you. Is that able to be remedied, as you understand it, by amendment to the relevant state Acts, or does that need an amendment to the Federal privacy laws and the Federal Act or both?
A. They may be areas, Commissioner, that stray outside of my expertise. I'm aware, for example, in Tasmania, that there are mandatory reporters under the Children, Young Persons and Their Families Act, and that includes medical practitioners, nurses, midwives and other health practitioners, not all of the health practitioners registered in our scheme but some. As I am - my evidence is that there's not a requirement on AHPRA as an entity to mandatorily report to those schemes.

If we became aware, though, of allegations of

offending against children we would disclose that information to police rather than to Children, Young Persons and Their Families or the Commission.

COMMISSIONER BENJAMIN: Thank you.

MS ELLYARD: Q. Just thinking through this example of a case where the board becomes aware of an allegation of child sexual abuse that has taken the form of a charge being laid, what happens if for whatever reason the criminal charges don't proceed or are discontinued or perhaps even end in an acquittal, does that limit what the board can do thereafter in considering the allegations that have been made?
A. It doesn't limit it, no; it is something that is considered on a case-by-case basis. Criminal proceedings may not proceed on a number of bases. There can be acquittals in relation to findings to a criminal standard. So, criminal standard requires proof beyond a reasonable doubt. In our scheme, proof of allegations to a tribunal that would count as professional misconduct are to the civil standard which is that it's on the balance of probabilities that something occurred.

Q. And so, that might mean that in a case where, as you've indicated, the criminal standard of proof hasn't been able to be met and a practitioner has been acquitted or charges not proven against him or her, there would still be the possibility for the board to conduct an investigation and take what action it saw as appropriate at National Law?
A. That's correct, yes.

Q. And that might relevantly include that, if the board thought that misconduct occurred, referring the practitioner for a hearing before the tribunal?
A. That's correct.

Q. And that might ultimately mean that the person could have their registration suspended or cancelled?
A. Yes.

Q. Notwithstanding the fact that as a matter of criminal law they hadn't been the subject of any findings?
A. That's correct.

Q. And does that in fact happen in your experience, that

matters proceed against practitioners notwithstanding the fact that criminal charges couldn't be proved?
A. In my experience it does happen and, to the extent that, you know, my evidence explains some of the evolution I think of the way investigations have been carried out, I expect that that may happen more into the future as well.

Q. So, perhaps if we look back a decade or two ago, perhaps it was less common for the board to take its own independent role after a discontinued criminal proceeding?
A. Yeah, look, I can speak to the past 12 years and say that over the course of that 12 years, yes, there has been a change in the advice that would be provided to a board around continuing an investigation and taking a matter through to tribunal even where there may not have been a criminal conviction recorded.

Q. What about if the person has ceased to be a doctor or a nurse, in that they've abandoned their registration; would the board still investigate allegations against them?
A. They would, and in fact there's - in terms of the actions that can be taken against a practitioner by a board, the only one that's mandatory is if the board reasonably believes that a person's behaved in a way that constitutes professional misconduct under our law; they must refer that to the tribunal irrespective of whether the person is currently registered or not.

Q. Thank you. Can I turn then to thinking about - it's I expect self-evident that child sexual abuse would be regarded as a serious exercise in professional misconduct by any doctor or nurse, and it's clear as I understand it from your evidence that there are guidelines and Codes of Conduct in place for all professions that would make it clear to any doctor or nurse that they are obliged to maintain professional boundaries and not engage in sexually exploitative behaviour with children?
A. Each of the National Board Codes sets that out in relation to all patients; some more specifically in relation to children. An example I can give you is the Nursing & Midwifery Board's Code of Conduct which speaks specifically to obligations related to vulnerable people including children and young people.

Q. When the board considers whether or not it's satisfied that misconduct may have occurred, are those Codes of Conduct relevant?

A. They are; they are the standards that practitioners are measured against, if you like, with respect to determinations being made about the conduct and the way that that conduct might be regarded.

Q. And so, how would a nurse or doctor become aware that the Code of Conduct existed and that they were obliged to comply with it?

A. Prior to the commencement of the National Scheme, so a departure from the state-based regulatory schemes that existed prior to 2010, there was a pretty significant information campaign around the changes being made, about what national registration meant, but also there was a lot of publicity around the fact that Codes of Conduct were being published by each of the National Boards.

National Boards communicate regularly with registered practitioners via newsletters to inform them of developments to the Codes of Conduct that apply or the standards that apply to their practice. We, AHPRA, has previously undertaken outreach in terms of education and awareness-raising about the National Scheme, about Codes of Conducts, and about other aspects of the law including mandatory reporting. And each year there's a concerted effort around the campaign for renewal of registration to bring practitioners - or to make practitioners aware of the obligation to be registered under the National Law and to maintain standards of behaviour that are appropriate for someone in the practice of a health profession.

Q. Thank you. I wanted to ask some questions about a couple of the options that are available either to a board or perhaps to a tribunal where there are concerns being raised about the behaviour of a doctor or a nurse towards children.

At paragraph 160 of your statement you refer to the use of gender-based restrictions, by which we mean restrictions that might be placed on a person's health practitioner registration that limit them to only providing health services to people of one gender or another gender, and sometimes I think these are seen in restrictions on doctors who are alleged to have engaged in sexually exploitative behaviour towards women, they're not allowed to treat women. What's the current status of gender-based restrictions in AHPRA's view as a useful means by which to protect patients from the risks that sexually inappropriate

health practitioners might pose?
A. The evidence that I've given in my statement I think I link back to a review - the review that was undertaken by Professor Ron Paterson and it was a review specifically about the use of chaperones, so it was looking at whether or not it was contemporary best practice that, where there were serious allegations made about a health practitioner, having someone else required to be physically in the room during a consultation was a contemporary best practice protective measure.

PRESIDENT NEAVE: Q. Can I just check, was the Paterson Review about medical practitioners or about all health practitioners?
A. Commissioner, it was about medical practitioners in particular but the ramifications from the review have translated to other practice as well.

Q. Thank you.
A. That review recommended that chaperones not be continued, that that practice of using chaperones not be continued. It called or it recommended that in some circumstances a gender-based restriction, so a restriction that limits practice to only one gender, ought to be considered as an alternative to a chaperone restriction applying.

AHPRA's view is that they are not generally suitable as long-term solutions to serious offending; they may be a temporary protective measure that's put in place while an investigation is undertaken and ultimately a referral is made to a tribunal. So, they are a form of immediate action that's used in some cases where there is no evidence of any pattern in relation to an alternative gender; they are not used though - well, they're not recommended by AHPRA for long-term use as a final outcome in relation to a referral to a tribunal.

PRESIDENT NEAVE: Q. And can I ask, is that because they're not considered to be an effective means of protection?
A. Not because --

Q. Sorry, I have read the Paterson Review and I understood that you had perhaps had some cases where people offended despite the use of chaperones; is that correct?
A. Specifically in relation to chaperones that was,

Commissioner, one of the reasons that Professor Paterson didn't recommend chaperones.

For gender-based restrictions what I'd say is that monitoring practitioners who are subject to gender-based restrictions requires fairly detailed examination of billing, prescribing, other type information. The reason that I say that they're not particularly suitable for a long-term outcome, so a final outcome on a notification referral, is because, if the concerns that gave rise to the notification are proven, so serious offending has occurred in relation to a person, from that point on the question is whether or not the practitioner is a fit and proper person to hold any form of registration as opposed to whether they ought to be permitted to practise in relation to one gender.

PRESIDENT NEAVE: Thank you.

MS ELLYARD: Q. Can I ask you, Mr Hardy, what about perhaps cases that are slightly less clear-cut, where for example the conduct of concern that has brought the practitioner to the board's attention is in the nature of grooming and boundary violations that perhaps have fallen short of the criminal standard; those are still, as I understand it, matters that could be the subject of regulatory action by the board?
A. Correct.

Q. And are they the kinds of matters where the use of gender-based restrictions and other mechanisms might be used because of the lower level of conduct, but there's still the existence of a concern?
A. Look, they may be used, again, as an immediate action as an interim measure, generally we would not recommend them. If a finding was made that a person had been grooming patients or members of the public, usually our submission to a tribunal would be that that results in a finding of professional misconduct and we would recommend a period of suspension or cancellation of registration. However, tribunals have a discretion to impose restrictions in the alternative to suspensions or cancellation and those tribunals might see fit to impose a gender-based restriction.

Q. Now, of course, we've been speaking here about the role of AHPRA and the board as the regulator of the

profession, but in most cases, as we've said these, these nurses and doctors will also have an employer, and I take it that it would still always be open for the employer to take such steps as they thought appropriate to, if they were going to continue to employ someone, they might see fit to impose chaperone or other conditions as an employment-related matter?
A. Yeah, that's right. They have contractual arrangements with employees and they can act in relation to that employment relationship.

Q. And perhaps it might be said that sometimes things like chaperones and conditions of that kind are more readily managed by an employer who's right there on the spot as opposed to the regulator who is regulating from a distance?
A. That could be the case, yes.

COMMISSIONER BROMFIELD: Q. Mr Hardy, can I just confirm your evidence in relation to the Chaperone Policy, that it was ineffective as a protective practice where there had been misconduct or alleged misconduct; that's correct, isn't it?
A. It was both in terms of allegations and in terms of proven allegations.

Q. And you're not making any comment on the use of a Chaperone Policy as a preventative measure, for example, in relation to intimate procedures; is that correct?
A. No, not at all, and in fact, you know, some of the medical colleges have recommendations around the use of third parties during intimate examinations for exactly that reason.

COMMISSIONER BROMFIELD: Thank you.

MS ELLYARD: Thank you, Commissioner.

Q. Mr Hardy, I wanted to ask you some questions about the statistics that you've provided in your statement beginning at paragraph 109 about the number and nature of notifications made against Health practitioners in Tasmania when compared with other jurisdictions.
A. Yes.

Q. So, firstly at paragraph 111 of your statement, as I understand it you are able to say that, thinking about the

number of practitioners outside New South Wales in Australia who are registered in one of the Health professions, 3 per cent of them have Tasmania as their principal place of practice?
A. Yes.

Q. So, 3 per cent of the overall statistics kept by AHPRA about the nature and number of notifications - well, they would need to be measured against the fact that the sample size for Tasmania is 3 per cent?
A. Correct.

Q. At paragraph 114 of your statement you've given some information about the overall rate of notifications, which I take it includes all notifications, voluntary and mandatory?
A. Yep, that's correct.

Q. And you've indicated that the rate of notifications in Tasmania is equal to or slightly higher than the rate for other jurisdictions?
A. That's correct, based on the number of notifications and the population size, yep.

Q. Turning then to notifications specifically about boundary issues including sexual boundary issues, you've said at paragraph 116 that the data available suggests that there, too, in Tasmania the rate of boundary notifications is equal to or slightly higher than that in other jurisdictions?
A. Correct.

Q. Turning to mandatory notifications, you've said that the rate of mandatory notifications, that is, notifications made by designated people, like other practitioners and relating to certain kinds of conduct, is slightly higher for practitioners in Tasmania compared to outside of Tasmania?
A. That's correct.

Q. Then can I turn then to paragraph 129 and the table that you've given there which is about the source of mandatory notifications, and I wonder if it might be possible, Commissioners, for paragraph 129 of Mr Hardy's statement to come up on the screen, of the table that's shown there.

We see there, as I understand it, Mr Hardy, that there has been in the last few years a shift in the percentage of mandatory notifications that come to AHPRA from different sources. Thank you very much, madam clerk.

So, if we look at the table there, we've got a heading there for Tasmania that shows that there's been a change over the last few years as to the number of notifications that come from employers as opposed to other practitioners?
A. That's correct.

Q. And in particular in the most recent year a very substantial number of notifications being made about practitioners by other practitioners?
A. That's correct. Just, the data provided for the current - I should, it's now 4 July - for the financial year 2021/2022 was through until 31 May, so there will be an update in relation to that table based on the full year's data, but it did indicate that for 2021-2022 there was a shift in the proportion of mandatory notifications being made by employers and other practitioners.

Q. Now, of course, the fact of where notifications come from doesn't necessarily say anything at all about where the notifications will go and whether they're likely to result in regulatory action against a practitioner?
A. That's right.

Q. And I don't want to ask you about any current matters that the boards may be investigating arising out of the facts that the Commission's considering, but to the extent that any of these notifications relate to matters that the Commission is considering, those notifications will go through the normal processes that we've already been talking about?
A. That's correct.

Q. And subject to the conclusions that the boards reach, may result in some form of regulatory action in the future?
A. Yes.

Q. Thank you, that can come from the screen. Having regard to those statistics which suggest that rates of notifications in all areas in Tasmania are comparable to other jurisdictions, I wanted to ask you about some evidence that the Commission has received, Mr Hardy, about

the apparent ignorance or lack of knowledge on the part of some people working at the Launceston General Hospital and indeed on the part of patients as well about whether they could make reports about a practitioner and to whom they could make those reports. Are you aware in general terms that that evidence has been given?
A. Yes, I am.

Q. And, no doubt, that evidence is concerning to you as the manager for AHPRA?
A. It's concerning to me that there are individuals who are not aware of either mandatory reporting obligations or of the ability to voluntarily alert us especially, I guess, in the legislative framework that exists in the state that would enable them to report their concerns to us, to the Commissioner for Children, to police.

Q. You've set out in your statement at paragraphs 43 and following and then 51 and following the reasons why you feel confident that people in the Tasmanian community, including members of health professions, ought to be aware and have access to information that would help them to understand the fact that they could make a complaint and how to make a notification. Have you got any views or comments on how it might be that, notwithstanding those various steps taken by AHPRA and the boards, there seems to have been this lack of understanding on the part of some of the witnesses the Commission's heard from?
A. My evidence, I guess, is that the requirements aren't new, they have been around for some time, when we talk about mandatory reporting in particular, and I've said that I am concerned to learn that there are individuals who may not know that there is an ability, irrespective of mandatory reporting requirements, to make voluntary notifications.

To the extent that AHPRA and National Boards can, as a model regulator we should expand the information or the awareness-raising about those abilities and those requirements, and I expect that that will be one of the outcomes that we take away from our involvement with the Commission, is to ensure that we are more proactive in the awareness-raising of those notification requirements and (indistinct) --

Q. And so, for example, to the extent that a culture might develop in a particular workplace that says that it's

the job of the unit manager or the CEO to make notifications, that culture is not consistent with the National Law which provides that anyone can make a notification and some people should make notifications?
A. Yes, that's correct. I might just draw attention that it would not be wholly surprising to know that employees within a service who are making complaints or raising concerns with people in positions of governance for the institution to expect that they may make the mandatory notification to us, and there is a provision of the law that expressly provides an exemption for people from making a complaint to us if they're aware that a notification has already been made.

Q. Thank you.

PRESIDENT NEAVE: Q. I have one question to follow up on that. Is this a pattern that you have observed in other jurisdictions, or are you able to comment on that? That is, that more junior people tend to leave it to people further up the hierarchy to make a mandatory notification or a voluntary notification?
A. Commissioner, I think anything I say is probably going to be a little bit anecdotal, so it might not refer to a specific jurisdiction.

Q. Right.
A. What I'd say is that, when we've seen hierarchies of complaints handling in institutions we tend to see that, if a complaint is made by a member of staff it's acted upon by those in the governance - you know, someone with governance responsibility, and that includes alerting other regulators to that concern. And my personal view is that that's appropriate; that if a strong reporting culture exists in an institution and people can rely on their leaders to make disclosures to the appropriate regulator, I'm wholly satisfied that that would be an appropriate arrangement.

Q. If there is a strong complaints mechanism?
A. Correct.

PRESIDENT NEAVE: Thank you.

COMMISSIONER BENJAMIN: Q. And in terms of education, you or the national regulator and the state boards are in a pretty good position to contact anybody who is licensed at virtually at any time, aren't you?

A. We are and we do, Commissioner. So, routinely each of the National Boards' rights to each of its registrants multiple times a year, at least quarterly, sometimes monthly, and that communication does alert people to their responsibilities in terms of Codes of Conduct and each of the Codes of Conduct are quite explicit about requirements to report. There's also, you know, moral obligations, I believe, to bring to people's attention serious concerns about the wellbeing of patients.

MS ELLYARD: Q. Thinking about what the boards do with notifications that they receive, of course not every notification gets acted on?
A. Yes.

Q. But I take it, as subsequent notifications or concerns might be raised, the board receiving them is able to look back to whatever complaints or notification history a practitioner might have?
A. It's absolutely correct and one of the, I guess, strong advantages of a national system over state-based system is that there's one single national database of all complaints about health practitioners in Australia.

Q. And so that, for example, if there had been a pattern of concerns expressed about boundary breaches or violations, none of which had risen to the level of taking action for misconduct but which could be seen to demonstrate a pattern, a regulatory board would be in a position to identify that perhaps and on the fourth or fifth similar concern institute some kind of investigation?
A. Yes.

Q. Thank you. Can I ask a couple of specific questions about the way in which investigations are conducted, drawing your attention to paragraphs 92 and following in your statement?
A. Yes.

Q. You explain the nature of the training that over time it's expected that all investigators will receive and in particular at paragraph 95 you refer to some additional training that is provided to investigators who are going to be investigating boundary violation cases; can you tell us about that?
A. Yes, and the specific additional training that we provided was largely in response to Professor Paterson's

review of the chaperone restrictions. At that time we employed the services of an individual who had quite specialist skill at investigating sexual crimes as a member of the Victorian Sexual Offences and Child Abuse Team. That program was developed then specifically to our regulatory context; it included ways to take trauma-informed approaches to the investigation of concerns about boundary violations, and that training was provided at the time to all of the investigators who were employed at that time. It's now routinely, so twice a year, provided as a supplementary course that investigators take who are responsible for investigating these serious notifications.

Q. You've also identified at paragraph 98 that there's a system in place to ensure that there's consistency across investigations; can you tell us about that?
A. Yes, I can. So, there's two individual members of my team employed specifically for, again, their expertise in managing cases that are of a sexual nature. They're responsible for setting the investigation strategies for each of the cases that involves allegations of boundary transgressions by a practitioner; that's really important to us because it helps us to make sure that patterns of grooming are considered as part of our routine approach to investigating these types of allegations.

Q. Thank you. At paragraph 104 you refer to some specific processes that exist for the Medical Board including a specified committee that deals with issues of sexual misconduct and which is now to be expanded as I understand it to include family violence.
A. Yes.

Q. The question might be posed, why just the Medical Board? Would there be a role for such a specialised committee for other professions, including for example the nursing and midwifery professions?
A. So, the Medical Board were the board who specifically commissioned the report from Professor Paterson and they acted upon his recommendation that specific training be provided to people who are making decisions. They also went further I think than his recommendation which was to establish a single delegate who's responsible for making those decisions.

I mean, I take your point that there may be some

criticism of boards who didn't adopt that same practice. We've made sure as an agency that anyone who's involved in the making of decisions about boundary transgressions has had similar training to the committee that the Medical Board engage, and certainly any learnings that we've observed as an agency responsible for investigating have been applied to all professions regulated in the National Scheme.

Q. Thank you. As the last section and relatively briefly, Commissioners, I wanted to ask you, Mr Hardy, for some evidence in response to a couple of the case studies that the Commission has been concerned with this week.

I'm drawing your attention to the final section of your statement, in particular first to paragraph 240 and following of your statement where you offer some reflections on the way in which matters relating to a practitioner who the Commission has called "Tim" and where the patient victim was Ms Zoe Duncan, you've offered some reflections with the benefit of hindsight and the expertise that you bring on the way in which the previous investigations conducted by the Medical Board's predecessor, the Medical Council of Tasmania, was conducted.

I think you touched on this earlier when you said that over the 12 years that you've been involved perhaps there's been a shift in the way in which matters relating to sexual boundaries and sexual violations are investigated by boards?

A. I'd say very strongly that I agree with that statement, particularly I guess in the wake of the Royal Commission. The Royal Commission's findings prompted us to take a look at the way we investigate concerns. I think there were some really important lessons coming out of the Royal Commission's findings around the nature of victim behaviour, things that traditionally may have been viewed as posing problems in terms of evidence, conflicting versions of events. We know now from the findings of the Royal Commission that that's entirely consistent with the way victims' memories might respond to trauma --

Q. And so, for example, thinking about the specifics of Zoe's case where her account was discounted because there was a perception that it had changed over time; we would now understand that that doesn't affect the credibility of

an account at all?
A. Our approach to that would be that that's the evidence that's provided by the patient and, irrespective of inconsistencies, that evidence needs to be tested, I guess, by a responsible tribunal.

COMMISSIONER BROMFIELD: Q. Sorry, can I just pick up on that word "inconsistency" and check whether you feel if that's the appropriate term in the Zoe Duncan case? I'd put it to you that rather than "inconsistent information" she just provided incrementally more information?
A. I apologise, Commissioner, yeah, if I gave the impression that there was inconsistent evidence, I think your characterisation there was much better.

COMMISSIONER BROMFIELD: Thank you.

MS ELLYARD: Q. Another point that you've made, thinking about the way in which a case like Zoe's might be dealt with today, is that there would need to be a mandatory notification, would there not, in today's case if allegations like those made by Zoe were to be made about a doctor now?
A. I would expect - so, the law says, if a person forms a reasonable belief that there's an incident that involves sexual misconduct on the part of a practitioner they're mandatorily obliged to report it; that wasn't in place under the Tasmanian state system before 2010, it is in place now.

Q. And what's also in place now, as I understand your evidence, is a mechanism for the taking of immediate action, interim measures in appropriate cases, whilst a matter is investigated?
A. I agree with that wholeheartedly, yep.

Q. One of the other points that you've made that perhaps reflects the difference in the way in which a case like Zoe's might be treated today is a matter that you refer to at paragraph 243(g) and (h) about perhaps evolving understandings about the way in which children should be understood and their evidence received?
A. Yes.

Q. Can you just tell us about what might be expected now in the case involving a child complainant; what sources of expertise might a board draw on to assist it in deciding

how to deal with notifications of this kind?
A. Specifically, we would obtain the services of someone with forensic expertise in relation to children and that would be a feature of the investigation, and that information then would be shared with the board.

Q. Thank you. I then wanted to ask you some questions about the case of James Griffin which you've dealt with in your statement beginning at paragraph 198. Firstly, perhaps to be clear, thinking about AHPRA and the Nursing & Midwifery Board as it existed from 1 July 2010, there was only one notification that was ever received about Mr Griffin; is that right?
A. That's correct.

Q. And that was a notification received in August 2019?
A. Yes.

Q. Where, as the Commission understands it, postdating some disclosures, serious disclosures, the laying of criminal charges and the suspension of his Working with Vulnerable Children card?
A. That's correct.

Q. What appears to have been the case is that, from the time the board received that notification it proposed to take immediate action to suspend Mr Griffin?
A. It did, yes.

Q. But ultimately it wasn't necessary to take that immediate action because Mr Griffin surrendered his registration?
A. That's correct.

Q. Now, had Mr Griffin not died, his suspension of registration wouldn't have prevented the board from continuing to investigate him?
A. His surrender of investigation would have precluded him from calling himself a nurse and practising as a nurse; it would not have stopped the investigation into the concerns that were raised, and I imagine in the fullness of the investigation that those sorts of allegations would have ultimately been put to a tribunal.

Q. Thank you. The Commission is aware from the evidence that's been heard over the last week and a half that, prior to that notification which AHPRA received in August 2019,

there were a number of people over a number of years who had concerns about Mr Griffin that could have but did not find their way to AHPRA and to the Nursing & Midwifery Board. But I wanted to ask you about whether the kinds of matters that were known about him might have prompted regulatory action if they had been made known to the board.

So, for example, there's been some evidence about a suggestion as early as 2001, around about the time Mr Griffin was first going to be registered as a nurse, that he might have been in possession of child exploitation material. Had that matter come to the attention of the board at or around the time he was seeking to be registered or after he was registered, would that have been a matter that might have warranted or received some kind of attention from the Nursing Board?

A. In my experience those forms - those sorts of allegations, yes, would have been acted upon either by the notifications pathway as treated very seriously or may have been an issue that precluded someone from being registered altogether.

Q. Then there's a number of pieces of evidence that the Commission has received about what appears to have been a pattern of Mr Griffin being disciplined in his workplace or counselled in relation to boundary violations but none of those concerns ever made their way to the board. Had each of those notifications or concerns about boundary violations been notified to the board as a potential concern, would there have been the possibility of the board taking action about them?

A. Again, from my position, my team would have ensured that that information was put to the board and given, you know, really serious consideration in terms of his ongoing fitness to be registered.

Q. What about the suggestion that a nurse has been accused of engaging in what's been called "up-skirting" behaviour and there's been some concerns about whether or not that kind of impropriety is happening; would that be conduct of interest to a board if they knew that a registered nurse was engaging in it, or alleged to be engaging in it?

A. I would regard that as serious and we would have given advice to a board that it should be taken seriously.

Q. And then, perhaps you'll feel you've already answered

this, but one of the more significant pieces of evidence that the Commission has received - not to suggest that any of it is not significant - is the suggestion that in or around 2011 allegations were made that Mr Griffin had sexually abused someone outside of a work context but that information was brought to the attention of his employer at a time when he was working as a nurse, and the view appears to have been taken, and it's a matter for the Commission to resolve in evidence, that absent a criminal complaint and a criminal finding nothing could be done. Had an allegation of that kind of criminal conduct outside of the workplace been brought to the board's attention in 2011, would there have been things the board could have done about it?
A. Again, I mean, it's really important that I make the point that I'm not the decision-maker of what would be done with the information, but all of that information - and I'm sure that the Commission is of a similar view, the pattern of information that was presented, put together retrospectively, gives you a pretty strong impression that serious action would have been taken by a board in relation to, if not each individual allegation, certainly over the fullness of all of those allegations had that information been shared with us.

Q. So that, if in fact individual allegations as you've said were noted but not progressed with as further matters came to the board's attention the threshold for investigation and some form of action might have been --
A. I would say definitely, yes.

PRESIDENT NEAVE: Q. Can I have a follow-up question? Your answers relate to a situation where there has been a series of notifications to the board. My question is this: if there had been only the notification that was made at the end of the process and an investigator had been commissioned to examine the issue, would the investigator confine the investigation to the particular allegation before the board or perhaps make other enquiries, for example, of the police about whether there'd been some prior concern expressed to the police or something along those lines? How proactive, I suppose I'm asking you, would the investigation be?
A. It probably varies, Commissioner, on a case-by-case basis. Where, for example, a notification was made by an employer and they'd reached the point of making a notification but it involved historical concerns that have led them to the position of notifying, all of that would be

taken into consideration. I would imagine that where the case involved - and in this case it did - our communication with police, we would have been looking for information that had been disclosed to police previously and that that would have driven our investigation to be expanded beyond a particular incident.

Q. So that, if the investigator went to the police in those circumstances and said, "Do you know anything about this person --
A. Yes.

Q. -- then assuming the lines of communication worked, the investigator would be made aware of the fact that there were previous allegations?
A. Yes.

Q. And could look at that as part of a pattern of behaviour, even if there hadn't been a formal notification to the board about the particular previous incident?
A. That's what I believe will happen.

PRESIDENT NEAVE: Thank you.

MS ELLYARD: Q. Just as a final matter to get the timelines right, Mr Hardy, as you said in your statement, the notification about Mr Griffin was received on 1 August 2019?
A. That's correct.

Q. And it appears that AHPRA sought information from the police the following day, on 2 August, and there was then some correspondence between AHPRA and police because charges at that time hadn't yet been laid?
A. Yes.

Q. But the advice was given, as I understand it, that it was open to the board to proceed with immediate action rather than waiting because of police investigation requirements?
A. Yes, the police confirmed that they'd made Mr Griffin aware of the concerns that it was investigating.

Q. And so, once he knew he was under investigation, there was nothing to stop the board commencing its own investigation and taking immediate action?
A. That's right.

Q. Which it did?
A. It proposed to do it, yeah, and because of the procedural fairness requirement there was a few days given for Mr Griffin to respond to the proposal to suspend his registration.

Q. Ultimately you've indicated in your statement that after Mr Griffin died the view was taken that the investigation into his conduct wouldn't continue, and you've acknowledged in your statement that some may take a view that there was a proper basis to continue investigating the truth of what had happened even after he'd died. What's your response to that suggestion?
A. So, I think an investigation into the extent of the allegations was not something that we were alert to at the time that that decision was made. So, it's my evidence that, wherever there is a death of a practitioner, the board's ability, I guess, to act in relation to that practitioner, which is their primary responsibility, is extinguished; that there's no possible way that that practitioner can continue to pose harm to the public.

There are other organisations I think that are better placed to consider whether or not there were others involved in enabling the continuing commission of offences, and I don't think that our investigation at that point in time was incorrectly discontinued. In hindsight I think making our information available to organisations like the Health Complaints Commission in Tasmania who have a responsibility for systemic matters may have been a more appropriate path to go down.

Q. Just to be clear, the investigation that was concluded was the investigation into Mr Griffin's conduct?
A. That's correct.

Q. To the extent that issues were subsequently or are yet subsequently yet to be brought to the board's attention about the conduct of other registered practitioners, that will be a matter for the board to consider on the merits of whatever those allegations are?
A. Yes.

MS ELLYARD: Thank you, Mr Hardy, thank you, Commissioners, those are my questions.

COMMISSIONER BENJAMIN: Q. In relation to AHPRA and the boards, they have a significant educative role, don't they, or part educative role?
A. I would agree with you, Commissioner, it's not a statutorily required role, but I think as a model regulator we do have an obligation to make sure that our practitioners are educated, that we engage with employers of those practitioners and that the community is aware of who we are and what we do.

Q. I think you said that some of the board send out monthly or quarterly newsletters. One of the things in my background as a legal practitioner, and sadly in my background as a private pilot, I used to get stories which were told in short-form about where practitioners went bad or where airplanes went wrong, or pilots went wrong.
A. Yes.

Q. Does that sort of thing happen in terms of what you do, because you have information about where medical practitioners made mistakes or breach standards. Now, are they regularly published to the professions so that they can understand how it operates in the real world?
A. They are, Commissioner. So, there's a couple of ways it happens. In those newsletters there's publication of the cases that have been before tribunals. We also publish regulatory insights fairly regularly around, what are the most common types of complaints and what are the ways that practitioners can, I guess, improve their practice to limit the possibility that they become the subject of a similar complaint.

COMMISSIONER BENJAMIN: Thank you.
A. Thank you.

COMMISSIONER BROMFIELD: Q. Mr Hardy, we understand that in addition to his employment as a Registered Nurse, Mr Griffin also was either employed or volunteered as a medical attendant in the Netball Association and in netball clubs. Would his activity in that role be something that AHPRA could look into?
A. Yes. So, there are questions we could have asked in relation to the extent to which he was providing services, and I guess we may not have been able to preclude him from continuing to work at those premises, the fact that he would not have been able to refer to himself as a nurse. Our system of regulation is a regulation of title, so it

would have been something that he would not have been able to continue to call himself a nurse to gain other roles beyond his work at the hospital.

Q. And, could you have looked into his behaviour if people had called and complained about his behaviour in that medical attendant role?
A. We certainly could be made aware of those concerns and it would be my expectation that, if it was similar behaviour to the behaviour that we've been alerted to through the LGH, then they would have been complaints passed on to police.

COMMISSIONER BROMFIELD: Thank you.

PRESIDENT NEAVE: Q. I have one further question - well, I have two actually. If you were to receive the power to deal with - I'm sorry, I'll start again. If the power to regulate unregistered practitioners existed, that would have enabled you to perhaps look at the behaviour in relation to being a medical attendant on the ferry and also in the Netball Association; is that right?
A. Yes. So, we regulate, I guess, in partnership with other entities and the HCC here in Tasmania would have been able to look into health services that he was providing beyond his work as a nurse. The Code of Conduct and that National Code for unregulated health practitioners that I know the Health Complaints Commissioner gave evidence about earlier today, for me that's a really important addition to the overall system of regulation because it gives teeth to those health complaints and it is to publish prohibition orders from providing any form of health service.

There's also some amendments that are before the Queensland Parliament now to increase our powers to publish orders that prohibit people from specifically providing any form of health service beyond their practice as a registered practitioner.

Q. Thank you. My other question: you commented about the effect of the death of Mr Griffin on the board's investigation power, so I wasn't sure whether that was a statutory restriction or the exercise of discretion?
A. Formally it's an exercise of discretion to stop investigating and the rationale for that is that statutorily the powers that exist are --

Q. Yes, I understand that, thank you.
A. Yes.

MS ELLYARD: Thank you, Commissioners, that concludes ...

PRESIDENT NEAVE: Thank you very much, Mr Hardy.

MS ELLYARD: I'm sorry. I've got a question that I'll ask at the request of the Bar table.

Q. The question, if you know the answer, Mr Hardy, is: how many practitioners have had their registration suspended or cancelled in Tasmania since the National Law came in effect?
A. It's a question that I'll have to take on notice and provide the Commission with that answer.

Q. And then, just to be clear, those would be practitioners who have had their registrations either suspended under the intermediate action provisions, or suspended or cancelled by the responsible tribunal following a referral.
A. And we will be able to provide both, yep.

MS ELLYARD: Thank you, I'll ask you to do that and I'll liaise with your counsel. Thank you very much.

PRESIDENT NEAVE: Thank you, Mr Hardy.

LUNCHEON ADJOURNMENT

PRESIDENT NEAVE: Ms Norton.

MS NORTON: Thank you, President Neave. Our first witness this afternoon is professor Erwin Loh of St Vincent's Health Australia. Professor Loh joins us remotely and I'll ask that he be sworn in.

<ERWIN CHUN KONG LOH, sworn: [2.05pm]

<EXAMINATION BY MS NORTON:

MS NORTON: Q. Professor Loh, thank you for joining us. Would you like to repeat for the transcript your full name, professional address and occupation, please?
A. Sure, thank you for this opportunity to be here. My name is Erwin Loh, I'm the Group Chief Medical Officer at

St Vincent's Health Australia, located in East Melbourne here in Victoria, and yeah, I'm pleased to be here.

Q. Thank you, Professor Loh. We have a stenographer here who is preparing transcript in real-time, are you able to just speak up a bit and just slow your answers down, that would be of great assistance?
A. Not a problem, I'm happy to do that. Thank you.

Q. Thank you. Professor Loh, you've prepared a statement for the benefit of the Commission dated 24 June 2022; have you recently reviewed that statement?
A. Yes.

Q. And is it true and correct to the best of your knowledge and belief?
A. Yes, it is.

Q. Thank you. Professor Loh, exhibited to that statement is a very extensive CV, I'd like to just run through some of the high points of your CV and I'll ask you to confirm each as I say them.

You have undergraduate qualifications in medicine and law?
A. Yes.

Q. You have post-graduate qualifications in management and business administration, including in the healthcare sector?
A. Yes.

Q. And that includes a PhD?
A. Yes.

Q. Can you remind me of the field that your PhD was in?
A. The doctorate studies specifically looking at doctors transitioning from clinical practice to senior hospital management.

Q. Thank you. And you're a Fellow of the Royal Australian College of Medical Administrators?
A. Yes, Australasian College.

Q. Australasian, I'm sorry. And is it correct that you're the vice-president of that college?
A. Yes, I am.

Q. You've previously held governance roles at Monash Health and the Peter MacCallum Cancer Centre?
A. Yes.

Q. You've got, if I might say, quite a distinguished CV. Are the postgraduate qualifications you hold or qualifications of that kind the sorts of qualifications that you think are necessary where a doctor moves from a clinical role into an executive role in a health setting?
A. I would say that a doctor who moves from clinical practice into a senior executive management role should have further training and qualifications in management; I wouldn't expect them to have everything that I've done, but I would think that further training would definitely be beneficial for not only the individual but also for the organisation.

Q. Are you able to give the - I'm sure there are a range of appropriate courses of further study, are you able to give the Commissioners any sense of what you would regard to be the minimum additional qualifications for doctors making that transition?
A. Sure, I mean, this is a specific area of interest of mine. My view is that Health executive roles are very important and require very specific knowledge and expertise, and therefore doctors who seek to move into those roles should pursue further training, and that training does exist in Australia. There is a - specifically for doctors there is the Royal Australasian College of Medical Administrators, that is a specialist medical college that's recognised by the Australian Medical Council as a specialist qualification for doctors, and my understanding of that, a lot of doctors who are in senior executive roles in hospitals across the country are Fellows of the college, but some aren't. As part of the training to become a Fellow they do undertake multiple years of experiential on-the-job training as well as a mandatory Masters program at an accredited university, so it is fairly intensive, but at the end of the training the Fellow who graduates will be someone who has - my belief is - the experience and the knowledge required to be an executive.

COMMISSIONER BROMFIELD: Q. Professor Loh, is there an equivalent for nurses who move into executive management roles in the health system?

A. I beg your pardon, for who?

Q. For nurses?
A. Oh, for nurses?

Q. Yes.
A. There is a separate college called the Australasian College of Health Services Management, I am also a Fellow of the college. They do provide training and examination for other health professionals, including nurses. Doctors who become Fellows of the Royal Australasian College of Medical Administrators, or RACMA, there is a joint Fellowship recognition, the College of Health Service Management. So, yes, so nurses do have the opportunity to undertake that training as well.

MS NORTON: Q. Thank you, Professor Loh. If I can move on to your current role as Group Chief Medical Officer and Group General Manager of Clinical Governance at St Vincent's, you've held that role since 2018; is that right?
A. Correct.

Q. As I understand it, you're the Group Chief Executive accountable for, among other things, clinical governance and that includes both patient quality and patient safety.
A. Yes.

Q. Is that right, that you have both a clinical and a non-clinical aspect to your patient lens, if you like?
A. In a way, yes. I mean, I view patient quality of care and patient safety as still a clinical issue as far as I'm concerned, but yes, I look after that, as well as patient experience, that falls to me as well.

Q. I'd just invite you to address the Commissioners on - it sounds to me like you see clinical outcomes and patient safety as inextricably linked, are you able to elaborate on that for the Commissioners?
A. From my perspective, having clinical governance systems in place to ensure that the care that we provide to patients, and to our residents in aged care facilities, are safe, are effective, are in the best quality so that they get the best outcomes; I mean, to me they're one and the same, you can't really separate the concepts really. So, you know, that includes a clinical governance framework that has a leadership component where there is that safety

culture that exists all the way from the board to the frontline and you need to have policies and procedures in place to support those systems and then you need to institute a way of monitoring the outcomes that you're providing so that you can pick up trends and, if there is any variation to the outcomes that they expect you need to have a system to benchmark with other peer organisations and a system where you have peer review, whether you have morbidity and mortality meetings, and you can also implement audits as required to ensure that there's compliance to your policies and procedures. So, really what I'm describing is a clinical governance framework that is mature, to be honest, in all health organisations.

Q. Can I ask you a question about that. You referred at the beginning of your response there to clinical governance starting at the board and then permeating all levels of the organisation.
A. Yes.

Q. Based on your experience in hospitals is it generally the case or always the case that the hospital executive will report to a board?
A. To my understanding, that is the governance structure that exists in most hospitals across this country, especially after the most recent national health reforms, there is usually a board. In some hospitals they become part of a network, so there might be a local health district board or a board that looks after multiple organisations. So, for example, at St Vincent's Health we've got a National Board looking after our 16 hospitals and our aged care facilities, so that's a single board, but that board that we do have leads from the top in terms of the organisation's culture, so yeah.

Q. Thank you, I want to come back to culture a little bit later on, can I ask you one more question on the role of the board. What do you see as being the main advantages of having a hospital executive reporting to a board?
A. There are multiple advantages --

Q. I should say, I'll limit my question, I'll narrow it in a little bit. In terms of governance and in particular patient safety?
A. Okay. So, the value of the board is that they provide an additional layer of oversight in terms of how clinical competence is managed at an organisation. So, clearly the

executive team carries out the operational management overseeing the work that the hospital does. The board then - that's the additional layer where they're made up of people from other industries, from leaders in the profession, who then keep the executive accountable for what they're doing, provide additional levels of monitoring and essentially it's just good governance from that point of view; it's the same with corporate governance, that's just with clinical governance.

PRESIDENT NEAVE: Q. Can I ask a question there, Professor Loh? Do you have consumer reps on your board?
A. Very good question. Not currently. In one sense our board members are like consumer maps, they are - the majority of them are non-clinicians, so they do provide a consumer lens. We do invite consumers to come to every board member to present the patient's story but we do not at St Vincent's have a specific board member who represents consumers, not a consumer representative as such.

Q. Would it be useful to have consumer representatives on a board if you had a board?
A. Yes. At Monash Health where I was working at previously we did have a very specific board member who was a consumer rep.

PRESIDENT NEAVE: Thank you.

MS NORTON: Q. Just returning to patient safety concerns, and of course, Professor Loh, you will be aware that the focus of this Commission is on child sexual abuse in institutional contexts in Tasmania and in particular we're looking presently at the Health setting. Do you have any views about the point at which safety concerns in relation to, say, allegations of child sexual abuse in a hospital setting ought be elevated to the executive level within the hospital and when they should be elevated to the board?
A. I think, if it's to do with issues that you just described it should be elevated all the way to the board, you know, as soon as there is any knowledge that something like that's occurred because that is - allegations of that nature is extremely serious and should be notified to the highest level so that there is knowledge of it.

Q. Just to make sure I'm clear on your answer, when you say "as soon as there's any knowledge", do you mean at the

point an allegation is made or the point at which an investigation into the allegation concludes?
A. It's a good question, I think if at the point where management considers the allegation to be substantive, so you know, vexatious, inappropriate allegations have been discounted and there is - and it is a substantive and serious allegation, then I think the CEO of the organisation should be made aware and then an assessment should be made as to whether the Chair of the board or the whole board should be told because of the serious nature of it. You know, we're talking about the safety of a patient or staff members of a serious nature and they may potentially be external parties or more, like lawyers and the police and potentially the media, so I think it's - yep, the board should be made aware if it's a serious allegation.

Q. Thank you, Professor Loh. I suppose there are two broad circumstances in which that issue could arise: you might have an allegation that comes to the attention of the hospital about the conduct of a medical professional while at work, and I'll just confirm with you that the answer that you've just given about escalation would apply in that circumstance because it's conduct within employment; is that right?
A. Correct, yes.

Q. Would you follow the same process, that is, notifying the Chief Executive Officer if the allegation that is made - and again, putting to one side vexatious allegations that you have reason to believe are not true, but credible allegations of child sexual abuse against an employee but the abuse occurs outside of work; is that still a matter that you would expect to be elevated to the Chief Executive?
A. So, to understand your scenario, you are saying that we are notified of serious child sexual abuse allegations against an employee that's occurred outside of work, what would be the escalation point? I mean, I'll tell you what I would do if I get an allegation like that --

Q. Please.
A. -- I would, first of all, as you say, try to verify and if there is substantive potential of truth in the allegations then what would happen is that, because then the practitioner, if it's a doctor, the practitioner's registration will be at risk because allegations like this

do or should get reported to AHPRA, the regulator, and the doctors may potentially have conditions put on their registration. I would clearly, if I hear of an allegation like this, contact the doctor to speak to the doctor personally to find out, "Tell me about this", and it may be that we may restrict the doctor's practice while investigations occur because of the potential risk to our patients or also members of staff. So that would happen. And at that point, because our bylaws require the CEO and the board to be involved in the restriction of practices for our doctors, they will be told at that point when we decide to have some actions around the person's employment.

Q. You've been talking about the steps you would take in respect of a doctor; would you expect similar steps to be taken where the allegation concerns a nurse?
A. It would be exactly the same, subject to AHPRA regulation, yes.

Q. Would your response differ and, if so, how if the allegation of child sexual abuse was historical, that is, had occurred years before but was being brought to the attention of the hospital due to concerns about patient safety?
A. Yeah, if - it's a very good question. If it's historical, again, there is that balance between natural justice and procedural fairness, and I suppose the legal principle of presumption of innocence, and so, if it's historical we need to consider how substantive the allegations are; I mean, a lot of times we never know. But allegations like this need to be taken seriously and a discussion needs to be had with the employee himself or herself, and I think any decision that is made about whether there is a risk to patient or staff safety and then steps will be taken. So, I don't know that I can give you a generic answer, I think things like this need to be considered case-by-case, but --

Q. Of course.
A. -- the bottom line is it will be taken seriously if they are serious allegations. Especially on behalf of the public there is the potential reputational risk for our organisation, so that has to be considered as well in the mix. Clearly at that point, if it's public, again, things will be escalated all the way to the top, you know, CEO and to the board because they need to be aware that something like this has happened.

Q. Thanks, Professor Loh. Just to recap what I understand to be your evidence and it's very reasonable for you to say you need to make decisions informed by the facts, but it sounds as though at a minimum you would be contacting the employee who was the subject of the allegations. Would you also review their HR file to see if there were any complaints on file such as grooming behaviours or professional boundary breaches that might affect the approach you take there on in?
A. Yes, that's a definite, absolutely.

Q. Would you contact police? At what point would you contact police? And, if I'm being too abstract, feel free to say so.
A. Yeah, I mean, my way of working is that I have a low threshold in contacting the police. If there is any suspicion of criminal activity, in this case if it's child sexual abuse it would be criminal, then yes, we do have a police liaison officer at St Vincent's Health but also at Monash where I used to work a person who we run questions past, and this could be something that you could contact that person to say, "Look, we have got this scenario, what do you think?", without identifying anybody at that point, run by the police as to whether they're interested and whether they need to be involved. So, yeah, we attach it with - we involve the police very early on.

Q. Thank you. I have one further question on governance matters and it relates to responsibility for medico-legal matters in a hospital. In your experience does responsibility for medico-legal matters tend to sit with a single member of the executive or is responsibility more devolved across a number of individuals?
A. Yes, as I said before, good governance would require a single executive accountable clearly for things. So, legal and medico-legal issues usually in most organisations, that sits with the Chief Legal Officer or whoever it is that looks after that area, whether it's Executive Director or Legal or Governance.

Having said that, when it comes to medico-legal issues, especially with medical negligence, malpractice that involves clinicians, so myself I am involved, so in my organisation I do look after - I am the executive looking after medical malpractice issues but I work very closely with our Chief Legal Officer and with the expert panel of

lawyers, I do have a team of people of experts who review cases. So, to answer your question, usually there is a single executive but they work within a team and they do get expertise from other people as well.

Q. You said that it's not uncommon for the executive in a role like yours, Chief Medical Officer, to be responsible for medico-legal matters such as medical malpractice and the reasons for that are plain. Would you also expect the Chief Medical Officer to necessarily be the medico-legal representative on the executive for matters like allegations of child sexual abuse that don't include a clinical component?
A. No, not at all. So, if it's something like that, clearly then the Chief of People and Culture or HR person would be involved in there, the Chief Lawyer would be involved because that's a highly complex and serious matter and that would not be something that I would be managing myself at all.

Q. Thank you, Professor Loh, you've been very generous in answering questions that go outside your statement, so I'm grateful to you for that. If we could return to matters you do discuss in your statement, I'd like to speak about culture within hospitals generally, there's a quote from your statement I'd like to invite you to discuss. You say at paragraph 34:

> *Having a culture where people feel they can speak up about concerns not only keeps staff safe but also keeps patients safe.*

Can you discuss that relationship between staff and patient safety?
A. Sure. So, I'm referring to a safety culture that is very - not just in Health but in all sorts of other industries, like the airline industry or mining, where people feel that they have the authority and the ability and the skills to be able to speak up when they see something they experience in a (indistinct) witness in a system that is unsafe but is for patients or staff that they're able to speak up at the time and address the issue and prevent injuries to staff or patients, and so, that really is the essence of the safety culture, and we measure that actually to safety kind of surveys and all of that.

Q. There's an interesting relationship that you mention

in paragraph 14 of your statement and I'll just state it in case there's anything you'd like to add, where you say that:

> *The more complaints that are made against a doctor the more likely that doctor's patients are to experience adverse clinical events or outcomes.*

I think you're there referring to workplace-type complaints, is that right, or is it more general?
A. In fact it's both. The more complaints a doctor gets - and this is well researched, there are papers published on this topic - if the complaints can come from within the organisation, it can come from patient complaints, it can come from outside, then there is a reason to show that the doctor has a worse record in terms of patient outcomes and they are also the people who get - who generate more complaints in the future. So, doctors getting complaints is the best predictor of whether they get complaints in the future; that's all in the research.

Q. Thank you. You've talked about the importance of hospitals sending clear signals about a safety culture within the environment.
A. Yes.

Q. And inappropriate behaviour not being tolerated. Does that extend to less serious examples of inappropriate conduct and concerns? Is it important that it's a strong message sort of across the spectrum of - in this case we're talking really about workplace behaviour, but that the message needs to be strong and consistent?
A. Yeah, absolutely. So, you know, it's to do with - this is the same with any other types of culture, it's really strong messaging from the leadership; it basically states that there will be zero tolerance in relation to inappropriate behaviour and that people need to speak up and if they're not free to speak up they should report it and then something will be done with that person. So, it's not just talking the talk but walking the walk and actually showing the people that you are going to actually take action when reports are made, because what's happened in the past is that people report on other people and they've been able to get away with it, so this is about a zero tolerance attitude towards inappropriate behaviour.

Q. You talk in your statement about particular features of hospital settings that can make it particularly difficult for staff to speak up about workplace behaviours, and by that I mean things like bullying and workplace harassment. Would you like to just elaborate on the features of hospitals as workplaces that can make speaking up difficult?
A. Yeah, sure. There are a few factors: well, one, in hospitals and Health in general can be very hierarchical and positional, so in medicine but also in nursing and other health professions junior clinicians tend to be very respectful and fearful sometimes when it comes to their seniors, so that's the one thing, is the hierarchical structure that's embedded into the system.

Secondly, because of the way Health works a lot of more junior clinicians are fearful of the careers if they speak up, so there is that imbalance in power where they feel they need recommendations and referrals to get jobs and to get into training programs, so that's the second thing.

The third thing is that Health is a very insular environment, it's not dissimilar to the law and other industries, where if you work in Health everybody knows everybody, and it's high stress and therefore there is a tolerance of inappropriate behaviour in a sense that under stress people react in different ways and there is a lot of excusing of bad behaviour which can happen.

And I think a last thing is that, in Health - this happens in research as well - when you get high performance people who are very good at what they do, so examples would be doctors who do procedures, they are very good at what they do, they have very high success rates, but then they demonstrated bad behaviours, grooming behaviours; they get away with the bad behaviour because they're very good at what they do, and I think we have moved on as a society, we no longer accept that, you know, just because you are good at what you do means that you can get away with that behaviour, so we moved away from that, but in the past people like that have been able to, you know, be excused from their behaviour.

Q. And, Professor Loh, would you agree that those factors that you've just described which make it perhaps more difficult to raise concerns about a colleague's workplace

behaviours might also make it more difficult to complain or to raise concerns about safety issues?
A. Yeah, absolutely, yes.

Q. I think you've referred before to hospitals being close-knit environments and that can be another reason why it can be difficult to raise concerns. Would you accept that that difficulty is magnified in small communities?
A. Yes, it can be in rural settings where people begin in the workplace but they know people outside the workplace, that can make it very difficult to raise issues.

Q. Now, St Vincent's Health Australia has introduced the Ethos Program and it was introduced in 2017; I know it was created by a colleague of yours but you're now principally responsible for it. I'd invite you to summarise for the Commissioners what that program seeks to do?
A. Sure. So, Ethos is an international culture change program that we implemented across our private, public and aged care facilities, public hospitals. It's part of a $1.2 million NHNRC funded research project that we did with Macquarie University --

Q. Sorry, Professor Loh, I can just see our stenographer looking rather panicked, if you could just slow down again, please. Thank you.
A. I understand, no worries. So we implemented it because of private and public hospitals and aged care facilities as part of a $1.2 million NHNRC funded research project at Macquarie University and it was to address a major problem that was identified in Health about five or six years ago now, and that problem is a culture of bullying, harassment and inappropriate behaviour that I think we're all familiar with.

So, it's comprehensive, it's multi-pronged, and it seeks to establish a safety culture about teaching people the skills to speak up when they experience or witness inappropriate behaviour at the time, and if they feel that they are unable to do so, to report that behaviour using what we call the Ethos messaging system that allows people to submit feedback with the option of doing so anonymously.

Q. I want to come to more of those details but before you move on from training, you said that in the first instance ideally staff would feel comfortable to raise concerns in the moment, and you say in your statement that as part of

the program you conduct training about that. Are you able to elaborate on some of the key features of the training that are intended to create that Speak Up culture?
A. Yeah, so it's done by trained facilitators, ideally face-to-face but we do have online modules to teach it, and we use scenarios where people witness either an unsafe practice, an unsafe piece of equipment or inappropriate behaviour and then we run scenarios as to what do you do with that, how would you raise it with the offending person at the time and, if you can't do that, how would you address it through other means. So, it's very practical training to teach people what to say at the time, so to be able to challenge someone who may be more senior in a respectful way and to draw attention to the problem and then to be able to assert the person, you know, the individual's own authority. So, it's about teaching people confidence, the language to use, to teach them how to react if the person's defensive, and then to know how to escalate if they're not getting anywhere at the time.

PRESIDENT NEAVE: Q. Can I ask a question about that, Professor Loh. As I understand it that is cross-disciplinary, is that right?
A. Yes.

Q. So that if you had a junior nurse who observes something that he or she feels is contrary to safety, not in the context that the Commission's talking about necessarily, they would receive some training as to how to raise that with a medical practitioner?
A. Yes, absolutely, and I have to say the nurses do that extremely well. The majority of our feedback of our doctors come from our nurses and we specifically acknowledge that and celebrate that because that is something that didn't used to happen and we are very glad the nurses are feeling that they have the courage and the ability to be able to speak up about this.

PRESIDENT NEAVE: Thank you.

MS NORTON: Q. Professor Loh, just backtracking slightly, when you were talking about features of hospital culture that can make it difficult to speak up, you were using the language of "clinicians". Just so there's no uncertainty, presumably those same environmental factors can affect the ability of all staff, not just clinicians, but all staff within hospitals to speak up?

A. Absolutely. Right now the majority of our Ethos managers are actually coming from non-clinical areas in hospitals, so it probably not only occurs with Health professionals but also administrative and back office departments.

Q. You've spoken about training. The other key feature of the Ethos Program is the messaging system?
A. Yes.

Q. As I understand it this is an alternative for an employee who for whatever reason doesn't feel able to speak up in the moment or to speak directly with a colleague about their behaviour and they can instead submit a message to the system and, as I understand it, that can be positive feedback or it can be what we would say is negative feedback, although I understand you describe it differently. Can you explain for the Commissioners how the messaging program works?
A. Sure. I suppose the best way to describe it is to use an example or a case study. So, let's assume we have a doctor who became upset because they've been waiting for a patient to be transferred to the operating theatre from Emergency, and so - and this is loosely based on a real scenario - the doctor decides to go down to the Emergency Department himself to push the patient to theatre but on the way he becomes abusive, swearing, he becomes rude and angry in front of staff, patients and family members, and in that scenario then multiple messages are put in by different staff members about his behaviour.

And so, that message goes to a system that is secure, that's private, that only certain people have success to depending on their level of seniority. Then the message can be put in anonymously or identified. The message goes to what we call a triage team, which is a team of people specifically trained to look at incoming messages and then they triage those messages depending on how serious they are, or they may decide to put the message aside if it's not able to be followed up because there are not enough details or it's considered vexatious or inappropriate. And that team in each facility is set up, it consists of people from peer backgrounds, some are from HR and some are from the administrative area. They then will decide the seriousness of the message and then, as you say, most of our messages are at the level where they can be dealt with informally, in which case the message goes to the Ethos

messenger who is a peer of training, again, over a two-day workshop to be - and usually you have to be a peer of the person who has been giving feedback about - sorry, in this case if it was a doctor, it would be a doctor at the same level, so a lot more senior opportunity at the same level, who then meets up with this doctor over a cup of coffee informally to deliver feedback, which is what we call feedback for reflection.

Now, as you say, in the opposite scenario where this doctor pushes this patient from Emergency but does it in a very happy way, is cheerful, saying, "Don't worry I'm going to do this, you don't need an orderly to do it" and receives compliments, those would be feedback for recognition, and it would go through the same kind of process but then he would get feedback for recognition; usually that goes to the person's manager so that the manager can decide how best to recognise the person's positive behaviour.

Q. I'll just summarise what I understand to be the four different levels that the triage team looks at, and there's further detail in the statements, Commissioners, so I'll just summarise: Level 1 and 2 behaviours are the behaviours that might go through this informal messaging program, but when you have more serious behaviour that's classified as Level 3, that's behaviour warranting a formal warning or Level 4 which is very serious or illegal behaviour, are Level 3 or 4 complaints, or messages, I should say, dealt with in the Ethos Program or are they dealt with in another way?
A. Thank you for clarifying that. So, yeah, you have four levels, four categories of messages. Level 1 is where - and this refers only to feedback for reflection or the negative, so-called negative feedback that we get. Level 1 is really minor incivility or rudeness where there is no real harm. Level 2 is where it gets a bit worse, it's maybe bullying behaviour that's one-off and where there is some harm but it's not at the level where you need to take formal HR disciplinary action.

Now, Level 3 is where the behaviour is such that it's so egregious or it's repeated in such a way that really this person requires a formal warning and disciplinary action needs to be documented because we may want to take some performance management action, then the triage team would then refer those cases formally to the HR team to

follow up. Otherwise it's Level 1 and 2 to get dealt with informally through the messaging process.

In the history of the Ethos Program we've never had a Level 4 which, as you say, is something so serious that you might want to suspend or terminate a person's employment.

Q. How would the program respond if you had a particular employee who had received a series of Level 1 or Level 2 messages which had been dealt with through that informal messaging conversation but there was evidence or reason to believe that they were not changing their behaviours in response?
A. That's a great question, because one of the reasons why the Ethos Program has been designed in the way that it has been is to create a level of trust with our people such that we tell them that the Ethos Program is a positive, constructive program to change culture where, if you get feedback to reflect on we do - it sits separate to any form of HR processes. We do not keep a record of it anywhere and it does not tally against you, so we specifically tell people we do not count Ethos messages, we will not use any Ethos messages against you in any form of disciplinary action, and this is to emphasise the fact that this a system that's meant to be positive, it's meant to help people change their behaviour.

But as you say, though, what happens for those people who get multiple Level 1s or 2s; now, there is a triage team and the triage team does consist of people from HR and so there will be visibility of this. Now, as I said, we will not be able to use those multiple messages against a person's performance management, but there is that ability, as I was saying, to escalate any of those messages up to HR anyway. So, there is a capacity to potentially tick one of those complaints and to change it to become formal to get the complainant to put in a formal complaint to HR, and so, there is that capacity to actually take that forward and to treat that more seriously if we need to.

Q. You speak in your statement, Professor Loh, about - you took a survey in 2017/18 which provided you with a baseline measure of complaints or messages and you've recently conducted or gathered data which is currently being analysed, I understand you haven't got the findings of that analysis, but are you able to tell the Commissioners about any reflections you have, anecdotal or

otherwise, on the impact that Ethos has had in terms of a speak up culture?
A. Yeah, sure. So, as you said, Macquarie University has just finished an evaluation of the program, they did a baseline survey and it repeated it four years later and we have got the data and outcomes of that analysis now, it's in a draft paper that we are submitting for publication, but the great news is that we found a 25 per cent reduction in bullying and inappropriate behaviour which is a statistically significant drop.

One of the things - and that study is not just quantitative looking at the numbers, but also they have also done a series of interviews and, there are really three things that we found that we think have led to the program being successful: (1) the fact that we've had high engagement and trust with staff, and that's as I've described because we've used peers as messengers, we ensure that the messengers are private and secure and we ensure that there's a system to weed out any misuse of the system such as vexatious complaints.

Number 2, it's nonjudgmental, we call it a messaging system not a reporting system, we use terms that the feedback will be a reflection rather than negative reports.

Thirdly, it's inclusive, it's open to all staff, not just doctors or clinicians, which is different to some of the other systems as well.

Q. Thank you. I think you say in your statement that it's only about a third of the complaints - sorry, the messages that are entered into the system are entered anonymously; is that right?
A. That's correct, yes.

Q. Most people are reporting - is that a lower incidence of confidential or anonymous reports than you expected?
A. I don't know, to be honest, that there was any expectation around the system. I suppose you are right in a sense that, if you create a system that allows people to remain anonymous you would think that a lot of people would use that system anonymously, but in one sense we were pleasantly surprised that people felt that they were able to identify themselves and be confident that their identity remain - that their identity would be kept in confidence and separate from the people that they're complaining

about, which is the way we are running it. The people who get complaint about or receive feedback about do not - they never find out who the complainants are.

COMMISSIONER BROMFIELD: Q. Professor Loh, with the people, the peers who give the feedback, is there any guidance for them if they give feedback, say, for example, about a boundary violation and the person they're giving feedback to doesn't demonstrate any reflection or doesn't demonstrate any insight that that behaviour was actually a boundary violation; is there kind of guidance for what they ought do then?
A. Yeah, that is a fantastic question actually. Their role, and this is why the training for messengers is intense, it's over two days and repeated once every year, we actually give them refreshers because, as you can imagine, giving feedback can be potentially stressful and you need particular skills to do it effectively. And in the cases where they give feedback and it appears that the recipient lacks insight, they don't have the capacity to reflect or they refuse to accept any responsibility, then it is possible because there is - the message is to inform a team ready to peer review, ready to share the concerns, so there is the capacity for them to kind of go back and catch up with the other messengers when they do have that and talk about it and talk about what to do.

I think this is the key and this is where there is tension; the idea is that you give the recipient the opportunity to reflect and then you leave it as this, because you're not meant to follow up, you're not meant to say, "Oh, you know, you need more training", so it is what it is. If we have made the decision, the decision is a message, then given and then we move on, but I think in the back of the mind if they have concerns there is that ability to potentially speak confidentially with the rest of the team and potentially escalate it up to the triage team. We do have to do that very carefully because we do want to maintain the integrity of the system and that it is meant to be constructive.

But to your question we have had an experience where there are individuals who have difficulty in accepting responsibility for their behaviour, in which case then, you know, we will have to think about ways of dealing with that without damaging the integrity of the process forward.

MS NORTON: Q. Professor Loh, you've been - as I understand it the genesis of the program was in relation to confronting workplace behaviours. The question that Commissioner Bromfield just asked was in relation to a concern of a slightly different nature, by which I mean not in the interpersonal issue as between colleagues but the potential for a boundary breach - excuse me, I withdraw that - a concern about a boundary breach which might involve a patient. Now, plainly child sexual abuse complaints are not complaints that would be appropriate to be dealt with through Ethos, but I'm interested to know whether you think that a program like Ethos might have a role to play in providing an opportunity for people to report lower level boundary breaches; for example, perhaps overhearing a colleague call a child patient, you know, "baby-girl" or "sweetheart" or something like that, something that might raise a concern in a colleague but that's not of such magnitude that a formal report would be made. Do you think there's a role for the messaging system in that sort of a circumstance?
A. I think there needs to be a system, whether it's a messaging system like Ethos, or whatever it is, for such potentially inappropriate behaviour to be escalated somehow. When it comes to boundary breaches, if anything like that gets into the Ethos system something like that will get escalated and it would most likely be dealt with formally through the HR process. You know, without going to specific cases that would be what would be expected and that would be what would happen. And, just like in organisations - just like other organisations, you know, there are - potentially staff can behave sometimes in inappropriate manners and if it's serious enough, especially when it comes to boundary breaches, whether it's between staff and myself and staff and the patients, those get treated very seriously and will get escalated to a formal investigation.

Q. Thank you. I will ask, just for context, have you had experience yourself in dealing with allegations of child sexual abuse against practitioners at any of the hospitals that you've had governance roles in? Do you speak from a position of experience when you talk about responses?
A. I mean, without identifying the organisation --

Q. No.
A. -- yes. Unfortunately in this world there are people who end up working as health professionals who breach

boundaries and I have been involved in cases like that and they are taken very seriously and the police get involved and AHPRA get involved and they are dealt with.

Q. One final question. Going back to my previous question about the appropriateness of something like the Ethos Program for I think what I termed as low level boundary breaches which is, I should say, probably quite problematic language on my part and I apologise. Is it your evidence that there really is no such thing as a boundary breach that is low level? Are all boundary breaches of concern and ought be taken seriously?
A. If you ask my opinion, my answer will be, yes. There is no place for boundary breaches in Health. Health professionals are trained very early on about boundaries and about maintaining professional lines between themselves and their colleagues and their patients, and so, any hint of a boundary breach should be taken very seriously I would expect and be followed up. In my experience a practitioner who has breached boundaries once is at a high risk of repeating the behaviour, and so, therefore, they need to be followed up from that point of view.

Q. Thank you, I have just one more question. Last week the Commissioners heard from a number of different witnesses from the LGH current or former employees of the Launceston General Hospital who gave evidence that they felt they had had insufficient training in relation to boundary breaches and grooming behaviours. Would it surprise you that registered practitioners would not be well aware of the sorts of behaviours that constitute boundary breaches in 2022?
A. I would be personally surprised, yes; that's what I would say.

MS NORTON: Thank you, Professor Loh. Commissioners, I have no further questions, unless you do?

COMMISSIONER BROMFIELD: No further questions from me; thank you though.

PRESIDENT NEAVE: Thank you very much, Professor Loh, thank you.

SHORT ADJOURNMENT

PRESIDENT NEAVE: Ms Norton, before you begin I need to

make a restricted publication order.

MS NORTON: Thank you, Commissioner.

PRESIDENT NEAVE: Last week I explained that it will sometimes be necessary for the Commission to make an order which restricts the publication of certain information. The Commission is committed to being open and transparent, to respecting the preferences of victim-survivors and considering the impact that the evidence from these hearings may have on other investigations, legal proceedings and the wider community.

In order to protect the identity of certain people the Commission has decided to make a restricted publication order. We make this order because we are satisfied that the public interest in the reporting on the identities of certain people who may be discussed during this part of the hearing is outweighed by relevant legal and privacy considerations.

I will now briefly explain how the order will work. The order contemplates a use of a pseudonym in relation to a person who will be referred to as "Penny". The order requires that any information in relation to Penny's identity must be kept confidential. This means that anyone who watches or reads the information given by the next witness must not share any information which may identify Penny. This information is not limited to real names and may include other information which may identify these people, such as where they live or work. I make the order which will now be published.

I also remind everyone, including any journalists, that the restricted publication orders that the Commission has issued in previous weeks continue to apply. I encourage any journalist wishing to report on this hearing to discuss the scope of this and any previous order with the Commission's media liaison officer. A copy of the order will be placed outside the hearing room and is available to anyone who needs a copy.

Thank you, Ms Norton

MS NORTON: Thank you, President. Our next witness, our final witness for the day is Ms Claire Lovell, the Executive Director at Child Safety Services, and I'll ask

Ms Lovell to come up to the witness box.

<CLAIRE LOVELL, affirmed: **[3.35pm]**

<EXAMINATION BY MS NORTON:

MS NORTON: Q. Ms Lovell, can you state your full name, professional address and occupation for the transcript, please?
A. Yes. I'm Claire Lovell, I'm the Executive Director for Children and Family Services; that's within the division of Children, Youth and Families and the agency of Communities Tasmania.

Q. Thank you. I believe you have before you a statement that's been prepared by Mr Pervan, the Secretary of the Department of Communities; is that right?
A. Yes.

Q. There was originally a statement provided, it might have been undated - and I think, Commissioners, we've been provided with an updated statement earlier today. As I understand it there's only one substantive change and it's to paragraph 75. Are you familiar with this change, Ms Lovell?
A. No.

Q. It's paragraph 75, I understand the change is to the final line. There's a reference in the penultimate line to:

... policies, procedures or guidelines in place at the time in relation to information sharing ...

And then the words "regarding notifier identity" should be inserted. So, it will read:

... guidelines in place at the time in relation to information sharing regarding notifier identity with police.

And we can provide that final statement, Commissioners, but just for the purposes of the examination today.

Ms Lovell, the Commission issued a request for

statement to the Department of Communities in relation to the matters that we were hoping to explore today and, as I've said, Mr Pervan has provided a statement but you've come along as the witness. Were you involved in the preparation of Secretary Pervan's statement at all?
A. No.

Q. Do you know who was involved in the preparation of that statement? And the context for the question is, in paragraph 5 the Secretary says:

> *While this statement is made by me all opinions, analysis and material other than statements of fact are provided to me by senior practitioners within the Children, Youth and Families Division.*

Do you know who the senior practitioners are who assisted the Secretary to prepare his statement?
A. Yeah, I was aware of assistance being provided by the Director for Children and Family Services, Zaharenia Galanos. I also read drafts but didn't contribute to the preparation of this, so in reading those drafts I do understand the material that's been provided, yep.

Q. And, I assume that you've read the final version of the statement, yes?
A. Yes.

Q. And do you feel able to comment on the matters in that statement?
A. I'll do my very best.

Q. I'll invite you to do your best and if at any point you think a question that I ask of you would be better addressed to the Secretary or to one of the people who was more intimately involved in the preparation of his statement, then I'd invite you to say so.

Commissioners, we'll obviously in the coming weeks consider whether or not it would be necessary to ask Secretary Pervan or someone else from the department to come in a future hearing week to speak to the matters that Ms Lovell feels unable to address today.

PRESIDENT NEAVE: Thank you, Ms Norton, yes, we will.

COMMISSIONER BROMFIELD: Ms Lovell, as we go along today if there's areas where you perhaps were not involved in the preparation to come to a judgment call, we'd invite you to give your assessment based on your having almost a few decades of Child Protection experience, so to rely on your own professional judgment.
A. Yes, thank you, Commissioner.

MS NORTON: Q. Thank you, Ms Lovell. You've been in your current role since late 2021; is that right?
A. Yes, that's correct.

Q. And that's a relatively newly created role?
A. It is a newly created role. Just prior to that, though, I was Director for Children and Family Services since 2019.

Q. And you commenced, in a predecessor to the Child and Safety Services, I understand, in 2004 as a Child Protection Officer; is that right?
A. That's right.

Q. So, you have quite a long career in Child Protection?
A. Yes.

Q. Have you been watching or have you been briefed at all on the evidence that has been led over the course of the first week of the Health hearings?
A. No, I haven't been able to watch any directly because of my work, but I have been reading the transcripts each day.

Q. Okay, so you have some understanding, some level of familiarity?
A. Some.

Q. I will in due course speak to you about some of the case studies, and the case studies in particular where they involve a notification to Child Safety Services or its predecessor, and again, would just invite you to answer the questions to the best of your ability.

If I begin with some questions in relation to Child Safety liaison officers, are you familiar with the role of Child Safety liaison officers?
A. Yes, I am.

Q. Can you speak to the Commissioners about the purpose - I'm sorry, just so I don't forget, can I just have my instructor pass, via the clerk, pass to Ms Lovell a document that I may take her to in due course?
A. Thank you.

Q. Can you explain to the Commissioners the role and purpose of the Child Safety liaison officers, please?
A. Yes. So, Child Safety liaison officers are Allied Health professional Level 3, there are three in the state, they work for the Child Safety Service as Child Safety employees but they are co-located with four hospitals in the state, and they also co-locate back with the Child Safety Service, the Advice & Referral Line, and also I believe the non-government services which form the Advice & Referral Line, Baptcare and Mission Australia.

Q. What do you see as being the value-add, if you like, of the Child Safety liaison officers in providing that interface between Child Safety Services and hospitals?
A. Sure. The scope of their role is very large because we have many different connections between Children and Family Services and the hospitals, so they play a role in helping each of those services to understand the other service, how it operates, who to contact, in relation to which issues, what the relevant policies and procedures are for each of those services. They can support Child Safety involvement in a number of different areas in the hospital context, so particularly Women's and Children's, Emergency Department. In relation to child sexual abuse, if there needs to be an examination, they can assist to facilitate that.

Q. There's mention in Secretary Pervan's statement to the Child Safety liaison officers being able to give advice about boundary breaches and grooming behaviours. Do they have training in that area to your knowledge?
A. They have the same training as their colleagues in the Child Safety Service, so yes, they would be familiar with indicators of child abuse and neglect, and certainly grooming behaviours, yep.

Q. What's the advantages of having those liaison officers located on site within a hospital?
A. The advantages are that people know who they are, they know who to contact; I guess they're quite similar to the social workers who work within the hospital, that they're

on hand for advice.

Q. And presumably they have existing relationships as a result of being on site and a visibility?
A. Yeah, and I believe that they also capacity build with the social work team as well so that there's a larger group of people in any hospital who have an understanding of Child Safety matters.

Q. In the statement it's said that - it's paragraph 8 of the Secretary's statement - that this role commenced at the Royal Hobart Hospital in 2007 but wasn't rolled out in other hospitals in the state until 2017. Do you know why there was such a delay between the rolling out in other hospitals?
A. I don't, I'm afraid. I believe that initially it was a pilot and that there was a review and it was determined that the position was successful and that it should be extended, but then there is a time delay that I can't account for other than perhaps it is similar to other reform activities related to Child Safety, that it can be overtaken by other reform activities.

Q. The statement also refers in a number of paragraphs to the fact that, while the liaison officers might provide advice about reporting obligations under the Act, the Children, Youth and Families Act, the statement makes very clear that it is a support and advisory role and that, where somebody, be it a patient or a staff member, raises a concern about child safety with the liaison officer, that doesn't constitute a mandatory report under the Act. Is that your understanding of the system?
A. Yes, that's my understanding.

Q. Is there potential for confusion there, do you think? And by that I mean, if you have, let's say, an upset parent who's very distressed because they think that a staff member at a hospital might have behaved inappropriately towards their child and they raise that concern with the person who is the Child Safety Service's Child Safety Liaison Officer; do you think there's the potential for that parent to think that they have made a report for the purposes of the Act?
A. I can only imagine that the liaison officers would be quite clear in any forum about how to make a report to the Advice & Referral Line or, as it used to be, the Intake Service. I doubt very much that they would ever intend - I

know that they would never intentionally be misleading; I doubt very much that they would allow somebody to believe that that's the case without trying to direct them to where they needed to make the call, which would be the Advice & Referral Line.

Q. Do the Child Safety Liaison Officers ever follow up to see whether - or is it their general practice or part of their role to follow up with the ARL to see if mandatory reports have in fact been made by parents or others?
A. That's something that I can't answer, I'm afraid, I don't know what they do in those circumstances, whether they would follow that up.

Q. Right, so that might come down to individual practice; you're not aware of there being --
A. I'm not aware, I'm sorry.

Q. If a Safety Liaison Officer is aware of a concern that a child might be at imminent risk and they are also aware that no report has been made to the ARL or they hold a concern about that, would they have their own mandatory reporting obligations under section 14 of the Act, that is, as somebody employed by the government agency that provides welfare services?
A. I think they would if they thought that nobody else - the person who should be making the notification had indicated that they weren't going to.

Q. Yes, thank you. What education or training do the liaison officers receive in relation to child safety? You've referred before in relation to grooming and boundary breaches, that they receive the same training that is common to - I don't know if it was to all Child Safety Officers. Is there additional training that they receive or specialisation for the liaison officer role?
A. I don't think there's anything unique to that role, but they are certainly trained in everything else that Child Safety staff are trained in, and that's something that's evolving, so we have our basic training that all staff have but in addition to that there are other training opportunities that continuously emerge and they will tap into that training as well.

COMMISSIONER BROMFIELD: Q. Ms Lovell, it notes in the statement that the role is required to work quite autonomously, being independently based within the

hospital. Are you aware of whether they're expected to have any level of experience, say, a number of years in practice, or whether that could be their first role in the agency?
A. They're an Allied Health Professional 3, so they are a senior social worker equivalent, so yes, I would expect that for them to be successful in obtaining that role, that they would be considered an experienced practitioner.

MS NORTON: Q. Do you consider it to be a specialised role or is it just one way in which a person in the role can deploy skills which are standard across other Child Protection officers of a certain seniority?
A. I think it's the latter. So, the Advice & Referral Line has a number of liaison positions attached to it, and while they do work in a particular context and they each have a different focus, they are all members of the Advice & Referral Line or the Child Safety Service if that's their base service.

Q. Last week the Commissioners heard evidence from the current Executive Director of Nursing at the Launceston General Hospital, you may have read the transcript but in case you haven't, the EDON, the current EDON gave evidence that she didn't know what the ARL was. In light of the fact that the Child Safety Liaison Officer has an educative role within the hospital in relation to child safety, is it a matter of concern to you that the most senior nurse within the hospital has never heard of the ARL?
A. It's a matter of concern to me, in that, it demonstrates a need for further education of staff, not necessarily education of staff by one Child Safety Liaison Officer, but in general. I think any service that has a role in working with children needs to make sure that its staff are informed about mandatory reporting responsibilities and how to discharge those responsibilities.

Q. In paragraph 25 of the statement, I'll just get you to open to that, just bearing in mind it's not your evidence, there's a reference to the Child Safety Liaison Officers having access both to CPIS and CARDI as well as the THS system. Do you know if those systems speak to one another? That is, if entries are inputted into each of those systems, do they create a consolidated chronology?
A. No, they don't. So, the two systems that do speak to each other or are in fact one system are CPIS and CARDI.

So, CARDI is a digital interface of CPIS.

Q. I see, so the Department of Communities' systems speak to one another but not THS?
A. Yes.

Q. So you've got siloed information as between the Department of Health and the Department of Communities?
A. Yes.

COMMISSIONER BROMFIELD: Q. Ms Lovell, what are the ARL - sorry, I've forgotten the names of all the databases, but my understanding is that the ARL has a database and, if it's accepted as a notification - and I know there's a different name for that now - it's then transferred into the Child Protection Information System. Have I got that right?
A. Yes. So, the CARDI is a digital interface of the Child Protection Information System, so the information system itself is where all of the information is stored about people. But then CARDI is used to - that's where the contacts are recorded, pulling the information out of CPIS to create a contact at the Advice & Referral Line, taking all of the relevant information and, as you say, then if that reaches - I'm loath to use the term "threshold" - if there is a need for further assessment of that based on the seriousness of what's being described and the risks to children, then an incident is created in CPIS and that incident is where the Tasmanian risk framework and that type of assessment begins.

Q. And so, if I were starting at the Child Protection end and pulling a chronology of all matters related to a particular person believed responsible, would I get all the information from the Advice & Referral Line and the Child Protection information?
A. Yes.

Q. I'd get both even though I started in the Child Protection System?
A. Advice & Referral Line staff can see all of the information that's in CPIS and CARDI; they have access to both systems and can see what's in there.

Q. But if you as a manager were pulling information, say, for example, for a statement and you pulled it from the Child Protection System, would that automatically pull from

the ARL or would you need to run a separate search?
A. ARL use both systems, so the majority of the information would come from CPIS, but then we can also have a look at what conversations have happened within CARDI that haven't reached that point of becoming an incident and collate the two together.

Q. I understand the ARL can do that, but if you were pulling - would it automatically pull or would you need to run two searches?
A. I'm sorry --

Q. As a manager, if you were wanting to pull a case history or all records about a particular person and you started with a search of Child Protection, would that give you everything or would you need to run a second search and look at the ARL? That's the bit I couldn't understand.
A. If I was a manager in ARL --

Q. No, if you're you?
A. Oh, me?

Q. Yes.
A. Me as me? I actually don't know. I know that we can get - we can see all of that information, I'm just not sure if it automatically comes into one search when we search by child or by any other person, or when we actually have to manually collate it.

COMMISSIONER BROMFIELD: Okay, thank you. Sorry, Ms Norton.

MS NORTON: No, not at all.

Q. Just going back to mandatory reporting and the example I gave about the evidence received last week about a senior member of nursing staff not being aware of the ARL, and I think your evidence in response was that there'd been a failure of education though not necessarily a failure of education on the part of the liaison officer.

In your view, who is responsible for educating staff about mandatory reporting obligations? Is that a responsibility that sits with the Department of Health or the Department of Communities or is it shared?
A. That responsibility sits with any service. It's not a responsibility of Communities Tasmania to educate every

workforce around mandatory reporting responsibilities. We do have some ARL resources available, we do have staff available, not just the liaison officers but other Advice & Referral Line staff who can do an in-service presentation, do a questions and answers-type session, but all services who work with children have a responsibility to make sure that staff understand their responsibilities.

Q. And so in the case then of staff of the Launceston General Hospital, that responsibility would sit with the Tasmanian Health Service presumably, on your evidence?
A. I believe so, in my view.

Q. Yes, thank you. I'd like to ask you some questions about one of the case studies that was the subject of examination last week. Are you familiar at all with the case study in relation to Zoe Duncan?
A. Yes.

Q. You have in front of you a document, it's an Initial Inquiry Report that was prepared jointly by somebody from Child and Family Services and a nominee of the LGH; it was prepared in 2001 in response to Zoe Duncan's complaint. Is that a document you've seen before?
A. I have seen it before. I'm not overly familiar with every line, but yes, I'm aware of it.

Q. I'll just ask you some questions, I'm not going to put it on the screen, but I'll ask you some questions about it. That's a complaint that was made on 20 May 2001 in relation to - the nature of the complaint became more serious over time, but initially it was a complaint that a doctor in the Emergency Department, who we refer to as "Dr Tim", had behaved in an inappropriate way towards Zoe Duncan who was 11 at the time and, among other things, he had touched her breast, I think he tugged on her ear and he put his fingers inside her mouth. Are you familiar with that aspect of the allegation?
A. Yes.

Q. And then over the course of the next five or so weeks Ms Duncan made a number of further disclosures culminating in a disclosure of rape. Now, that complaint was reported immediately to the LGH but not notified to Children and Family Services for, I think it's a further nine days. Is a delay of that nature between first complaint of a doctor touching a patient's breast, tugging on their ear and

fingers in the mouth, would you expect a delay of nine days in reporting that to Child and Family Services?
A. I think it's best practice to report concerns of that nature as soon as they're observed or reported.

Q. Thank you. Once the allegations were referred to Children and Family Services they were investigated. It took just shy of four months for that investigation to be completed. Is that a standard timeframe or does that strike you as a particularly delayed report or is that a timeframe that you might expect for allegations of this nature?
A. I don't think there is any standard timeframe for completing an assessment, certainly one of that nature. I know that sexual abuse investigations are some of the most challenging and they can take quite a long time.

Q. Do you have experience yourself conducting investigations of that nature?
A. A long time ago, yes.

Q. Can you draw on your knowledge to the extent you're able: what would you see as being the key features of a rigorous investigation of an allegation of that kind?
A. Working alongside Tasmania Police would be particularly important. Making --

Q. When would you notify Tasmania Police of the allegation?
A. Straight away.

Q. Yes.
A. In many cases they would have notified us. So, working closely with them to determine the sequence and who has responsibility for which aspects and how we're going to communicate throughout the investigation. We would be wanting to make sure that we are assessing - that Tasmania Police tend to take the lead role in dealing with perpetrators or alleged perpetrators of abuse, whereas Children and Family Services are focused largely on the victim and protective adults for the victim who we can work with to keep them safe.

Q. Yes, you're coming at the same situation with different lenses?
A. That's correct. For a robust investigation as well something important to mention is making sure that we have

all of the information. This is a real challenge for us when we're dealing with sexual abuse, it remains a real challenge today. Sexual abuse is one of the most difficult things that we work with because of the secrecy surrounding it. It's not something where there's a summary of every incident that's happened; it's more likely that multiple services will have some pieces of relevant information that may have been at fairly - an observation which in and of itself wouldn't necessarily indicate sexual abuse. It's not until you piece together all of that information that you can identify a pattern and history and really appreciate how serious the matter might be and how great the risk to a child might be. It is still a challenge.

Q. I can understand that that would be a challenge in certain circumstances. It doesn't appear to have been an issue in this case and I'd like to test with you some of the key features of the CFS investigation.

Now, I'll just take you to a paragraph in the Secretary's statement to see whether you agree with it; it's paragraph 121. Having reviewed the steps taken, and I'll come in a bit more detail to what was done in the investigation. Sorry, it's actually paragraph 124. There's a statement that:

> *The steps taken are not considered appropriate or sufficient today. There was no engagement with Tasmania Police to report the alleged conduct. The young person was subject to multiple interviews and there appears to have been a reluctance by the hospital staff to report the incident.*

Have you reviewed this case study in sufficient detail to say whether or not you agree with those criticisms of the investigation?

A. Those criticisms sound reasonable if judged by today's standard. 2001 is prior to my experience in investigating child sexual abuse, and it does seem that it was an unusual policy at the time that the Child Protection Service, as it was then, would need to have completed an investigation and be satisfied that there was sufficient evidence before referring the matter to Tasmania Police. That hasn't been the policy through my time.

Q. Can you think of any reason why, from a child safety perspective, that policy might exist? Is there any way you can think of that that policy enhances child safety?
A. I don't think that enhances child safety. I think that that would cause a delay and it would cause a victim to repeat their story.

Q. One of the criticisms that is made in the ultimate report is that, by the time CFS spoke with Ms Duncan she had already - now, let me just get the reference - she had already spoken, I think, to six different people. Now, she'd spoken to - sorry, just bear with me - her parents understandably, her teacher, she'd spoken to Dr Renshaw at the hospital, a GP, somebody from SASS and a psychologist, and it was said in the report that by the time she came to be interviewed her account of her abuse had become contaminated.

Have you got any concerns about taking that view? Bearing in mind that at least three of those conversations were with a clinician or were therapeutic in nature, do you have any concerns regarding speaking about child sexual abuse or a disclosure of abuse with clinicians being regarded as something which compromises the veracity of a disclosure which contaminates the disclosure?
A. It could potentially, yeah.

Q. And, how so?
A. I guess we're assuming that all of those clinicians are people who understand the severity of what's being alleged and their duty of care to respond appropriately; that we could equally assume that those people may have responded in a way which reduced, that maybe it made her feel that next time she made a disclosure she was going to use slightly different terminology, so I'm not sure that I would describe it as contamination but I think it is risky for a child to have to repeatedly tell their story or any victim over and over again because each time they do that the person they tell the story to might reflect something back to them.

Q. In light of the evidence you've just given, would you agree that it really underscores the importance of a rigorous interview by an appropriately trained person as soon after disclosure as is possible?
A. Ideally, yes.

COMMISSIONER BROMFIELD: Q. Sorry, Ms Lovell, it's not always - the world doesn't always work the way we want it to in Child Protection, sadly. Children will often come having told their story to multiple people, particularly in light of incremental disclosures.

The assessment at the time really suggested that Zoe could not be considered credible evidence because she told six people between 20 May and 19 July. Do you think that's a fair assessment?
A. It was that person's assessment at the time. If that's me using today's standard I would think, no. Why should we stop someone making one more disclosure after they've already made it that many times, when that one disclosure might be the one that causes people to listen and protect them?

Q. And this was actually in the context of an interview. She'd never moved from her position that something bad happened to her, she increased the details of what happened to her, but she'd never contradicted herself. Do you think it was a fair assessment that she was not a credible witness in that context?
A. No.

Q. No. No, I don't think so either --
A. No.

COMMISSIONER BROMFIELD: But thank you.

MS NORTON: Q. In paragraph 130 of Mr Pervan's statement he refers to the interviewing of the alleged person believed responsible, that's Dr Tim, as being questionable. Do you know what's meant by the statement in that paragraph, Ms Lovell?
A. Sorry, paragraph 130, was it?

Q. 130.
A. No, I don't know what that means.

Q. It's evident from the document that you have in front of you, and I'll take you to page 8 of that document. This is the interview with Dr Tim. It takes place on 24 August 2001, and I'll just note that that is three months after the original disclosure of abuse, and a little bit less time but over two months since the Child and Family Services investigation commenced. Would you expect an

alleged perpetrator to be interviewed in a more timely way than that?
A. Yes, and I'd expect them to be interviewed by police, not by a Child Safety Officer.

Q. Yes. One of the things that is quite shocking about the account of the interview with Dr Tim on pages 8 and 9 is that Dr Tim, who had been told around the time of the original complaint, had not been informed that by this stage Zoe had made a very clear disclosure of rape, and he maintained during the interview with Child and Safety Services, it's apparent from this document, that he did not want to know about the nature or content of the additional allegations. Is that a feature that you're aware of from your prior reading of this statement?
A. No.

Q. Or this report?
A. No.

Q. Ultimately, Dr Tim's denial of allegations which he ultimately didn't have particulars of, because he didn't want them, was accepted over Ms Duncan's clear and consistent disclosures. Do you have any concerns about the acceptance of Dr Tim's denial over Zoe's disclosures in those circumstances?
A. Yes, I do.

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

Q. And would you agree that you really couldn't place much weight on a denial of allegations where the person denying them doesn't even know what they are?
A. You can't normally place a lot of weight on the denial of allegations that relate to child sexual abuse because I'm not sure that I've ever come across a case where someone's admitted straight-up to sexually abusing a child, so asking someone whether they have or haven't is pretty

unlikely to result in the truth.

Q. As I understand it, based on this report, interviews were conducted by the Child and Family Services officers with Mr and Mrs Duncan, with the doctor, Dr Tim, with [redacted], a GP, with Zoe, and that's it. So, no other staff from the hospital who were working that night were interviewed, and it appears that Dr Renshaw who initially dealt with the complaint at the hospital was not interviewed. Does that strike you as a rigorous investigation process?
A. Not by today's standard.

Q. Well, by any standards?
A. I struggle with this because I can't imagine a time where this type of approach would have been used.

Q. Yes.
A. I have to believe it happened because it's here in black and white in front of me, but I'm really struggling to imagine a scenario where a Child Safety Officer is leading an investigation like this rather than police. So I can only imagine where police are taking the lead and police are looking for witnesses, because finding witnesses is probably the most effective way to ascertain whether something's happened or not.

Q. And, would you agree that it's particularly important where you've got a serious allegation of this nature by a child in Zoe Duncan's case and a denial by the perpetrator, you've got literally a he said/she said scenario: in those circumstances witnesses are particularly important, would you agree?
A. I'd agree.

Q. And so, would you expect at a minimum that other nurses working on the ward at that shift, and doctors, might be interviewed?
A. Yes, but what I'm still struggling to understand is what the role of the Child Safety Officer would have been in doing even what they did, let alone interviewing, doing the job of police and interviewing other staff on a ward or anybody else; it seems so far out of scope for the role of the Child Safety Officer.

Q. And having regard to the skillset and the training of Child Safety Officers?

A. And the scope of their assessments.

Q. Yes.
A. I mean, the primary scope for Child Safety Officers, it tends to be, rightly or wrongly, abuse in the context of a family. There are exceptions to that and the Child Safety Service certainly have a role and responsibilities in abuse that happens in other contexts, but they don't take over and step into the scope of Tasmania Police when it comes to investigating allegations of institutional abuse. They'd support that investigation, they'd provide information, they'd certainly support the victim, but they wouldn't be stepping in and interviewing witnesses in that way.

COMMISSIONER BROMFIELD: Q. What year did you commence practice, Ms Lovell?
A. 2004.

Q. Can I draw your attention to paragraph 123 of Mr Pervan's statement?
A. Which number, sorry?

Q. 123 in response to Question 21.
A. Yes.

Q. It reads:

> *It appears from the available material that the investigation or assessment [that being the investigation or assessment by Child Protection] was consistent with procedures in place at that time.*

The case was not substantiated on the materials available. On the evidence in front of you, do you feel that was a reasonable assessment on the balance of probabilities?
A. No, it sounds like it was - well, I don't know whether it was done in accordance with policy and procedure at that time because I don't know what they were - I'm going by how they were described in this report, this notion that a Child Safety Officer must be the first to investigate and then refer to Tasmania Police, so I can only assume that that was the policy at the time. But it seems very unusual, it doesn't seem that it resulted in a substantiation which, to me, would - that matter would be

substantiated. The threshold for substantiation currently is very low; we only need to believe that a child may have been harmed to substantiate, so it sounds like the threshold was either much higher in 2001 or that there was an error.

Q. And on the material in the document in front of you, as an experienced practitioner, your assessment on the balance of probabilities, could you just tell me that again?
A. On the balance of probabilities I would say that she was sexually abused; she's repeatedly made a clear disclosure, there's nothing to say that that hasn't happened. It doesn't mean that there's enough proof there for charges or convictions, but certainly for child safety and our substantiation there's certainly enough there by today's standard to substantiate, yeah.

Q. So, for the Duncan family, and this is one of many investigations that still stand where the Duncan family and Zoe were told that their allegation was unsubstantiated, do you feel that the Department of Child Protection has any role now in making any kind of amends or reaching out to the Duncan family in relation to the assessment that Zoe was lying?
A. I'm struggling to hear what you're saying: I'm piecing together the last - the majority of it, I just need that last little bit.

Q. The Department of Communities, is there any role for the Department of Communities now in reaching out to the Duncan family? This is still, for the Duncan family, a case that was not substantiated and it's one of many institutions that did not substantiate.
A. Yes, there is a role for us and there's a role for me in acknowledging that, that what happened - it appears to me what happened wasn't right. It appears to me that Zoe Duncan was sexually abused and that this investigation didn't substantiate that, whereas I believe that it should have. That's a very poor outcome for that family, for Zoe and her family, and for that I'm extremely sorry that that was their experience. I'm so sorry that that happened.

COMMISSIONER BROMFIELD: Thank you. Sorry, Ms Norton.

MS NORTON: Thank you, Commissioner.

Q. I'd like to move on from the Zoe Duncan case study to consider some notifications that the department received in relation to Griffin. Are you familiar with the notification received in November 2011?
A. Yes.

Q. Now, there was an issue in relation to that notification and I'll just take you to ground you in the statement of Secretary Pervan. It's dealt with at around paragraph 62. That was a referral that came to Child Safety Services from the police, it was - no, I don't think that's right, I think that's incorrect. It came to Child and Family Services and the police made enquiries of the Child Protection Officer for information about the notifier so that they could further investigate that notification. The Child Safety Officer that they dealt with said that they were unable to provide the notifier's details. Is that consistent with your understanding of the law or the department's policies at the time, that is, in 2011?
A. I believe that the policies and the legislation were confusing to staff at the time and I do remember that --

Q. Confusing?
A. Very confusing, so we had an Act which at that time didn't include police as an information sharing entity and we had a lot of - but we also had policies that talked about or that required us to report, make referrals to Tasmania Police when we'd become aware of a matter which potentially involved a criminal offence. The two things didn't work well together: the Child Safety Officers were certainly very hesitant, at best, to provide notifier information because they probably heard more of - more information about how that was prohibited under the Act and there were cases where they had been reprimanded for providing information about notifiers.

Q. Reprimanded within the department?
A. Yeah, certainly; even for providing information which caused somebody to guess the identity of a notifier, so at that time that was really the guidance that was given: protect notifier identity at all costs.

Q. Right, and I think you said earlier that there was ambiguity in the position under section 16 of the Act, and it sounds as though there was a policy that sat below the Act and the policy position was, don't provide notifier information?

A. Yes.

Q. Was that policy position set out in the memorandum of understanding. There were a number of memoranda of understanding with the police, I think going back to 2001 although I might be wrong about that; was that policy reflected in those documents?
A. I don't think so. I think at that time it was a very high level memorandum of understanding and I don't think it went into that detail.

Q. Yes. And it seems in this case, on the Secretary's statement, that there was a disagreement between the police and the Child Safety Officer. The police were of the opinion that notifier information could be provided and the Child Safety Officer, obviously acting under the policy you've described, was of a different opinion. Are you aware of or do you think it would have been appropriate for that Child Safety Officer to speak to her superiors to clarify the position? I say "her", I don't know if it was a female; to speak to their superiors?
A. Yes, unless that team leader also shared the view that that information couldn't be provided. So, I didn't work in the northern office, but certainly in the southern office where I was based this was an issue that was causing confusion.

Q. It sounds like there was a problem with the legislation, that is, that the legislation wasn't clear. Do you know if the Department of Communities ever sought legal advice about the proper interpretation of section 16?
A. I don't know what legal advice the department sought, I'm sorry. I know that it was rectified through amendment to the legislation later.

Q. Ultimately.
A. Yes.

Q. Yes. Even in its unamended state section 16 permits notifier information to be provided to the police by the department with the consent of the notifier. It doesn't seem that in this case consent was sought. Do you think that was a missed opportunity? Do you think that the Child Safety Officer might have done more to try and provide this notifier information to the police?
A. I think that was a missed opportunity, but I've also looked at - I can see a lot of problems with the policy of

the day. It was certainly very scant on information for the Child Safety Service around what to do in relation to institutional abuse, particularly adults reporting their own abuse. At best, it allowed discretion by a team leader to determine what to do with that information, it was very, very light on. It wasn't until 2016 that there was a procedure in its own right that had a reasonable level of information about what to do in these circumstances. I think I agree it was a missed opportunity and there was another way to interpret the Act as well at the time and that was to look at the "authorised officer" definition.

Q. Yes, because it does strike me, and we don't need to get into a legal discussion about it, but is your evidence that there's potentially some scope in 16(a) for the provision of that information to police?
A. For a Child Safety Officer who is or was brave enough to liberally interpret a piece of legislation themselves to do something that they thought was right at the time, yes. That would be my interpretation of it because I would think it doesn't make sense to not provide police with the information that they need to conduct an investigation, so I'd be looking for a way to do that, but then I was a confident practitioner and always thought, well, I'll do what I think's right, that's my duty of care, and I'll apologise for it later if I need to, but not all brand new practitioners would be like that. Some who might have just been reprimanded for disclosing a notifier's details may not have been so brave. So, yeah, it was a problem with the legislation and the policy at the time.

Q. It sounds like the evidence you've just given is that, in that situation of ambiguity, you would have taken an approach that was focused on child safety. Is it your concern that the policy directive within the department was not appropriately concerned with child safety in that situation?
A. I think the policy was lacking and the policy has evolved, but it's not until we've looked back after there's been an adverse event that we realise how deficient our policy is; it's not until we look at case studies that we realise and adjust it. So, our policy people don't sit and read through policies looking for gaps and problems every day: we don't know there are problems until there are problems.

Q. In a situation where you have a notification of that

kind, if the information available to you suggests that - or to the Child Protection Officer assessing the notification - suggests that there might be other children at risk because, for example, they live with the person against whom the notification is being made, what would be your standard practice in relation to those other children at risk? Would you make separate notifications in relation to them?
A. Yeah, so the practice today is to make notifications for all children who may be at risk.

Q. And when did that practice come in?
A. There has been variations on it. So, previously it was that multiple unrelated children would be attached to one notification or they can be done separately, completely separately.

Q. And if similarly the information available to you suggested that the subject of that notification had access to children, say through their work, would you take any steps in response to that information?
A. Yes, that happens now.

Q. What steps?
A. Now we do that, yeah. So, now we would be entering a notification about those children potentially straight away, otherwise we may have to - we may engage with Tasmania Police first if we think it's such a large group of children that we're going to need to use a taskforce approach, so that has happened.

MS NORTON: Yes, thank you. Commissioners, I'm mindful of the time, I do have some other matters in the case studies that I was hoping to explore with Ms Lovell, but before I bat on I should just --

PRESIDENT NEAVE: Yes, thank you, Ms Norton, we should do that, yes.

MS NORTON: Yes, thank you.

Q. Can I ask the operator to pull up on the screen a document, TDCT.0003.0006.0003. Thank you. This is a notification, I'll give you a paragraph reference: it's paragraph 83 in the statement. It's a 2013 notification to the department. Is this a notification that you're familiar with based on your review of documents thus far?

A. Paragraph 83?

Q. It might be perhaps 82, paragraph 82.
A. Yes.

Q. I'll take you through this document because there are some features of it that I would like to bring to your attention and then I'd like to ask you some questions about it.

If we can go to the second page, please. And you'll see, this is a young - no, the date of birth's gone, I can tell you this is a 15-year-old young person. You can see at the bottom of the page that the alleged offender is Mr Griffin.

Over the page, at the top, it says "Prior reported concerns - under the heading, "Relevant prior convictions/matters pending and warnings", there's a prior reported concern in 2009, "No convictions recorded"?
A. Yes.

Q. Would you expect the Child Protection Officer assessing this notification to make enquiries about those concerns that had previously been reported to police?
A. Yes, unless the information had come from police and already outlined what those matters were, yes, that would be relevant.

Q. And would you expect, if further enquiries had been made or further details were available, would you expect to see those details there?
A. If they were available, yes, I would expect to see them there.

Q. Now, I don't know for sure, but based on the information available to the Commission this seems likely to me to be a reference to a report made in 2009 that Griffin had been "up-skirting" girls on the Spirit of Tasmania. If that information was available to you, would you regard that as relevant to assessing this notification?
A. Yes.

Q. And would you have included that information at that spot in the form or somewhere else in the form?
A. It wouldn't be here in the form but it would be - yeah, it would be in part of our case note records where

we've done follow-up and we would be asking questions about anything relevant, any prior offending or concerns of relevance, that would also be included in the risk assessment.

Q. I should just say, I should have said at the outset, I'll begin at the end which is to say that the assessment of this notification was ultimately that the notification was closed and it was assessed as being low risk. Sorry, there was a low risk of future harm. So, we've noted that there are some prior reported concerns, then there's no further detail but it seems likely that it's an allegation of up-skirting of teenage girls.

I think it's fair to summarise the concerns that were reported as having come from a concerned adult in relation to the young person and they were backed up by a mental health worker who was privy to some of the concerns and details, and that mental health worker assessed the behaviours as involving potential grooming. I'm just looking at what information is there, I might just leave it at that, but would you agree that an assessment by a mental health care worker that the perpetrator's behaviour involved grooming behaviours would be a concerning assessment?
A. Yes, I would think that concerning behaviours are concerning and relevant for an assessment regardless of who's observed them or reported them.

Q. There's also a statement in the description or the basis for concerns, and again, this comes from the mental health practitioner, who felt that the man, that is Griffin, was acting unethically with young girls and was inappropriate. Is that also some concerning information for you if you were in the position of an assessor?
A. Yes.

Q. There's also reference in this document to - and it's slightly further down, the end of that top box:

According to the RP Griffin works in the Children's Ward at LGH. He is also a medical officer and sports trainer for state netball.

So, the significance of that, would you agree, is that this is somebody who has access to children professionally

and through an extra - or a hobby, if we refer to the netball in that way?
A. Yes.

Q. The response, if I can just summarise it: there was a conversation with the person who made the report and also with the young person in question and I think it's fair to summarise the conversation with the young person in question as the key message being that she ought take steps to protect herself from the situation. Based on your understanding of this notification, does that sound accurate to you?
A. Based on my understanding of practice at that time, that sounds like a conversation that would have happened.

Q. At that time?
A. At that time, yes.

Q. So, was it standard practice at that time in response to concerns about grooming behaviours with a young person to place the responsibility for Child Protection on that young person?
A. I don't know that that was the intention; I think it was standard practice at that time to defer to Tasmania Police and, if they indicated that it wasn't likely to result in charges, I think that Child Safety felt unable to do very much more with the matter, but before they closed off they had a tendency to - we had a tendency to try and do one or two more things that we thought might make the situation safer. So, that was the mindset at the time, so some of those things that we used to do to try and make things safer, they're not considered good practice anymore: they're things like going and telling victims of family violence that they really ought to stay away from the offender, it's victim-blaming type stuff. The intention though is to try and use our authority to caution someone against continuing particular unsafe behaviour. We'd also follow it up with a formal letter with a similar sort of caution. It's not good practice, it's very unlikely that it's going to bring about any change or achieve any safety in the majority of cases.

I think what we're seeing is a desperate act by a service that feels that they can't do anything meaningful; that they don't have authority to do anything meaningful because there's unlikely to be proof. I think we've progressed - I know we've progressed from there.

Q. Yes. What would you do, applying current best practice, what would your response be to this complaint?
A. Current best practice now, I think that hearing from a victim-survivor about their experience and what would have helped them really resonated with me, and that's actually taking the time to build a relationship with them, to build enough rapport that they might be in a position to disclose; to not relying on one interview, noting that it might take them multiple opportunities and that might be a gradual disclosure. Providing them with enough information about sexual abuse for them to actually take away and process and talk to their own support people and then the opportunity to come back.

We can't expect just to spring somebody with one visit and for them to tell us all about what's happening, particularly knowing what we know about people who perpetrate sexual abuse and the myths that they create and the confusion and the guilt that they place on their victims. We need to tread very carefully and create circumstances where victim-survivors feel enabled to disclose and know that they're going to receive support.

Q. Thank you. In addition to the Child Protection Officer having a conversation with the young person, there was also a conversation with the perpetrator. Are you familiar with the content of that conversation at all based on your review of the materials?
A. Yep.

Q. Would you agree with this characterisation: it was really in the nature of a conversation where the message was that there had been an over-reaction to his behaviours, they'd been misinterpreted, and he ought be more careful in future?
A. Yeah, I perceive that in the same way, that possibly the Child Safety Officer didn't believe that but knowing that there was not enough evidence to take the matter any further, I think that was their way of cautioning him and trying to disrupt the behaviour; that's one thing that it may have been.

Q. On the final page - I've taken that document down, but on the final page it's assessed as low risk of future harm and it is closed. Having regard to the key features of the notification I've just taken you to, that is, grooming

behaviours reporting by a concerned adult and a mental health professional, a vulnerable 15-year-old, police concerns on record regarding up-skirting, and the only action taken was a conversation with both parties about how to protect themselves; I'd invite you to comment on whether there's anything about that situation that strikes you as giving rise to a low risk of future harm?
A. I don't think that's a low risk of future harm. I think that they overlooked the pattern and history; if they had have seen that, even followed up on that one matter or located more information that we had on file, I think they would have seen that there was a pattern of this, it wasn't a once-off incident that was misunderstood.

So, I think that they - they either underestimated the likelihood of future harm or potentially it's a form of confirmation bias which isn't necessarily a cognitive action of the officer involved, it can actually be systemic as well; it can actually be a way of justifying the closure of a matter, where you know that you can't do anymore or you feel that you can't do anymore with it in order to accept the next matter that's waiting for assessment.

I don't think that's right, I think that's very wrong. I think that it should have been - I think the information should have been gathered and that was an oversight. I think that in an ideal world there would have been more done, but I think for its time that seems to me that that's the type of practice that people were engaging with, quite possibly driven as much by necessity as anything else rather than - yes, driven by necessity.

Q. Having regard to the various contributing factors that you've just described, would you agree that the fact that this notification wasn't taken more seriously was a system failure?
A. I would always consider systemic factors as well as individual factors. I think we're very quick to look at case studies like this and place responsibility onto individuals without thinking of the system that they're working in at that time.

At that time there was an enormous amount of pressure to work quickly, to complete investigations within a certain time frame; to make sure that we didn't have unallocated and a backlog being created. Senior staff even had Service Level Agreements that were more to do with the

speed of an investigation than the outcome. Still today there's more key performance indicators about things like that, the speed of an assessment being completed, rather than the outcome. I don't think it was child-centric practice and that concerns me.

Q. If you were assessing the risk of harm presented by this notification today, how would you assess the risk of harm? You've said it wasn't low; where would you place it?
A. Today I would hope that we have a lot more information at hand because today we would be working this jointly with Tasmania Police, so we would be able to see everything that they can see. So, we would have seen that he had more of a history, pattern and history certainly factors into our assessment of the likelihood of future harm.

Today we also know a lot more about sexual abuse and the manipulation that occurs, we don't automatically assume that, because it's denied, it didn't happen. So, I think that today it would be assessed quite differently to what it was then in 2013.

Q. Having regard to the evidence that you've just given, including in relation to the role of systemic factors in the response to this particular notification and as a senior member of the department who's giving evidence today, is there any reflection that you would like to offer to the young person to whom this notification relates and the adults who made the notification on her behalf?
A. For me to speak, what I would say to her today about her experience?

Q. Yes.
A. I'm sorry, I don't know how much I can say without disclosing people's identities, so I'm finding it very hard to choose words --

Q. Yes?
A. -- because I know information that I'm not sure that the public knows.

Q. Of course.
A. So --

Q. Are you able to offer a general reflection, bearing in mind the reflection that you offered Zoe Duncan's family?
A. Are we allowed to name who this person is that I'm

speaking to in the same way that I was able to say what I would say to Zoe Duncan's family?

Q. I'll just wait for an answer on that. There is no restrictive publication order.

PRESIDENT NEAVE: You can. In this case there is no restricted publication order in relation to the particular young person that we're talking about.

MS NORTON: I think it's fine to name the young person.

PRESIDENT NEAVE: Yes, she can name her.

MS LOVELL: Well, this person is an adult now, so if you could name that person first?

MS NORTON: Ms Skeggs.

COMMISSIONER BROMFIELD: The person in the notification is Ms Skeggs.
A. Thank you. I was very, very moved by Ms Skeggs's statement. I found it incredibly brave and it's something that influenced me more than - than most things that I've heard in all of my 18 years of working in Children and Family Services in its various forms. She described a level of detail which I think can only improve all of our understanding about child sexual abuse and the manipulations that occur for children, the difficulty that they have understandably as children in being able to recognise what's happening for them and to be able to reach out to adults.

She described that somebody had talked about Griffin's behaviour as "textbook": I don't think that there is a textbook on child sex offenders. I think that these people - each individual is different, each of their individual victims is going to be different, so the scenarios that they create are always going to be different, and I think the most powerful learning comes from people like Ms Skeggs who can really describe what it's like to be in that and how much control is exerted over them and what the challenges are in being able to get help from the adults who should protect them.

We should have protected Ms Skeggs and we didn't protect her, and for that I barely - it's hard to find

words to say how sorry I am: I'm deeply sorry.

MS NORTON: Q. Thank you, Ms Lovell. I have just one final case study that I would like to ask you about. It's the case study in relation to a child known as "Lillian", using that pseudonym. Now, it's dealt with in the statement at around paragraph 104. It's also been the subject of evidence at the beginning of the Commission's hearings in week 1.

Lillian's mother gave evidence during that week. Based on the information I've given you thus far are you familiar with this case study at a high level of detail?
A. A very high level of detail. The only information I have on this matter is what is in Secretary Pervan's statement.

Q. Yes, and if I could perhaps just go to the relevant paragraph. It appears that there was a call from Ms Donohue to the Child Safety Service in relation to concerns she had about the treatment that Lillian was receiving at the Launceston General Hospital.

Now, in Secretary Pervan's statement her concerns are referred to as concerns about the appropriateness of the medical treatment that she was receiving, and that is true, that was an element of the concern. However, I'd like to just read to you a short excerpt from the transcript of when Ms Donohue gave evidence in week 1. She said this:

When I rang Child Safety they said, "Oh, okay, well, we'll send someone along to your meeting".

And this was a meeting that she was having with representatives of the hospital, another department and Child Safety Services. So, Child Safety said they'd send someone along to the meeting that you're having:

And they sent someone along, and yeah, she was present at the meeting and, yeah, when I was [there] ... I mentioned [Lillian's] injury on her vagina and it was completely dismissed by the paediatrician [another person at the meeting] and everyone else was shocked, but yeah, nothing became of that.

Now, based on the file note of the review in Secretary Pervan's statement there is no reference in there to a concern being raised at the meeting about an injury to Lillian's vagina. I know you weren't at the meeting: have you reviewed the file notes?
A. No.

Q. Would it be a matter of concern for you if an allegation of that kind was raised at the meeting and not recorded in Child Safety Service's notes?
A. It should have been recorded in the notes if that was discussed at the meeting, yeah.

Q. And is it a matter of concern for you that that serious allegation which Ms Donohue has given sworn evidence about doesn't appear in the records that this Commission is aware of that have come from the Department of Communities?
A. It sounds like there's missing detail from our records.

Q. Missing serious detail, would you agree?
A. It may be now known as serious but to the person in the meeting at the time not having any awareness that they were dealing with a potential sexual abuse matter, perhaps they didn't realise how serious it was.

Q. But would an injury to - and I'll give you some further detail, but the allegation was that some cream had been applied to the vagina and that there was then an injury to the skin on the vagina. Is that something that's ever not a serious concern?
A. It's something that we receive multiple reports of; not necessarily injuries to genital areas, but certainly rashes and the like are often raised with us.

Q. Yes, and if you --
A. If there was any indication whatsoever that the injury might have been of a sexual nature rather than a rash, yes, it should have been considered serious.

Q. Thank you, Ms Lovell. I'm grateful to you for the way that you've approached my questions this afternoon in circumstances where you haven't provided a statement. Commissioners, I have no further questions for - sorry, I do have one further question, if I could just have a second

just to read it?

You gave evidence earlier that you often don't know that an issue exists with the policy until something goes wrong. How often do Child Safety Service's policies get audited?
A. They're not audited.

MS NORTON: No further questions, Commissioners.

PRESIDENT NEAVE: I think Professor Bromfield has a question.

COMMISSIONER BROMFIELD: Q. Ms Lovell, thank you for your evidence today and for giving us your assessments based on your judgment as a practitioner. I actually wanted to ask you a question about some of the evidence that you gave during the Out-of-Home Care week, so I'm going to remind you of it.

It was in relation to the discussion of the care concerns and specifically care concerns that raised concerns about child sexual abuse; whether it be as a consequence of a carer's behaviour or harmful sexual behaviours.

During your evidence you said that it was such small numbers that there was scope for yourself and the Director to make decisions in those matters.
A. Yeah.

Q. I was reflecting on your evidence afterwards and it just occurred to me that I wasn't sure what "small numbers" were in the context of the Department of Child Protection compared to other contexts and I just wondered if you could give me any kind of estimate on how many care concerns you would have looked at in this year that had any allegations of sexual harm?
A. I think for the last full financial year there were nine matters of - there were nine substantiated care concerns, I believe - it was either six or nine in the last two years, I may have got them the wrong way.

PRESIDENT NEAVE: Q. That are substantiated?
A. That are substantiated, yes, but they don't all relate to - so they're not - so say if there's nine in the last year, it might be that one of those children was

sexually abused and that we opened notifications for all of the other children who may have been as a result of visiting or having an overnight stay in that foster placement, that sort of thing. So, with those ones we are actually looking at one case even though there's multiple children.

COMMISSIONER BROMFIELD: Q. And sorry, the financial year, do you mean the one that ended days ago?
A. Yes.

Q. Yes. And, would this Commission have all of those cases then, information about all of those cases?
A. Yes, I believe so, yep. So, at the moment we are - I wouldn't normally be looking at individual case matters but we're very conscious that we're between the old and the new at the moment. So, our old Care Concern policy is - it's not only out of date in terms of its practice but it describes teams and roles that no longer exist since the redesign, but it's not the right time to be - to write a new policy because we're just about to shift our practices entirely to fit with our new practice framework, so we're in an unusual zone at the moment where we really need to be providing more direct guidance to staff around the best approach.

Q. Ms Lovell, we might just confirm that we've got the information on all of the matters for this financial year just given that the evidence was a few weeks ago now for the Out-of-Home Care hearing.
A. We would very much like to give the correct figures. I do have some concerns about the data that has been presented and how that's been interpreted and that we might need to correct the record, so if I could take that on notice and provide the accurate figures relating to notifications and substantiations of abuse for children in Out-of-Home Care.

Q. And I think for these care concern matters the details of those cases as well, but that would be wonderful.
A. Yes.

PRESIDENT NEAVE: Q. I had one question. You did refer to performance requirements for caseworkers and you said, I think, at least back in 2013 that those performance requirements about completing assessments might have put pressure on people to proceed faster than perhaps they

should have done. Now, what are the sorts of performance requirements now that are contained in arrangements with caseworkers?
A. Yeah, so at the moment they still are - well, in my opinion we do still have some outdated performance requirements and they're stemming from the national indicators that we report on annually for report of government services, so some of these don't align well with our current model, and in particular the ones around what's viewed as an aspirational period of time to complete, to commence and complete investigations, those sorts of things. Whereas I think, if we are child-centric, that our work should take as long as our work takes particularly when we're dealing with child sexual abuse. I think it's more important that we set indicators around the types of activities that are a must for our practitioners and that we're focused on that and achieving good outcomes, more than saying that we should have dealt with the matter within 28 days; that seems arbitrary to me and not likely to result in good outcomes for everybody.

Q. So you're required to balance a number of competing considerations, aren't you? One is to ensure that perpetrators don't go on working in situations where more children could be harmed?
A. Yep.

Q. The concern that you complete matters for the sake of people who allege, or their parents who allege child sexual abuse, and getting it right?
A. Yep, yes.

Q. They're the three things that you have to take account of?
A. Yes.

Q. And do you think that the current performance indicators balance those requirements satisfactorily? I think from what you're saying they don't?
A. No, I don't think so, no. So, we are currently designing new practice expectations and they're the things that we want to measure our performance against and they really are making sure that we practice in a way which maximises the safety and wellbeing for all children, so making sure that they're consulted, included in their own decision-making and those sorts of things: slow practice. I don't think that fast practice, when we're dealing with

any abuse, but certainly not child sexual abuse is good practice; I think we risk missing things and I think we overlook the complexity and the sensitivity of these matters and the time it takes to engage people well and develop trust and enough safety for them to disclose.

PRESIDENT NEAVE: Thank you very much, Ms Lovell.

COMMISSIONER BROMFIELD: Sorry.

PRESIDENT NEAVE: One further question.

COMMISSIONER BROMFIELD: Q. You've opened up a new line for me. I appreciate the importance of good engagement in order to do a thorough investigation. Are there any risks from your perspective of not having timeframes for investigation that would need to be managed?
A. Any --

Q. Risks in not having?
A. Any risks in not having timeframes?

Q. Yes.
A. I think that we absolutely need to measure how long it is taking us, but more to make sure that what we're doing is still purposeful and that we haven't - that there's not something that's just drifting that we're not attending to. We do have a timeframe measure at the beginning that really concerns me, and that is that there seems to be a community expectation that as soon as we hear about child sexual abuse that we're going to jump straight in the car and go and attend to that on the same day, also known as a priority 1.

I have real concerns about that because, knowing what we do about sexual abuse, there's probably a whole lot of information that we're not aware of on the day that we receive that notification, and if we rush in like that I think we're probably only dealing with the tiniest little tip of the iceberg and we could actually do more harm than good.

So, what I hope for is that, when we have our multidisciplinary victim-survivor hubs running, that we will also have a better way of gathering all of that intelligence from multiple services, mapping it properly and working with our service partners to plan really how

we're going to approach this in a way that's most likely to achieve safety and good long-term outcomes, but I don't think that rushing out on the same day is going to do that.

Q. Also during the Out-of-Home Care week you talked about the struggles with workload and caseload numbers, vacancies. Is there a risk that, if we don't pay attention to time, that in that context we'll see case drift?
A. We are very aware of case drift, so that's something that our senior practitioners are monitoring really closely. So, a lot of our practice shift is about making sure that we're not allocating a case to one person and then leaving it there for them, but that as a group we're collectively looking at our response and its effectiveness live the whole time, so we're very, very aware of that and we can easily monitor that case activity.

Q. So, would you agree then that time is one of many factors that should be considered when looking at performance?
A. Sorry, I'm struggling hearing you, sorry, because of your microphone and your proximity to me.

Q. I think I've inched to the left as the weeks have gone on. Would you agree that time is one measure to be included amongst multiple measures when you're monitoring performance of the system?
A. Absolutely, yeah. So, I think that hearing from our service users about how effective our services are to them is probably number one in measuring effectiveness. There are other measures but I think that they're qualitative measures, they're harder to ascertain; I think it's very easy to look at time because that can be quantified in a report and I think it's very tempting for people to focus on that when it was probably the least important thing.

COMMISSIONER BROMFIELD: Thank you.

PRESIDENT NEAVE: Thank you very much, Ms Lovell, and we can adjourn.

AT 5.05PM THE COMMISSION WAS ADJOURNED TO TUESDAY, 5 JULY 2022 AT 10.00AM