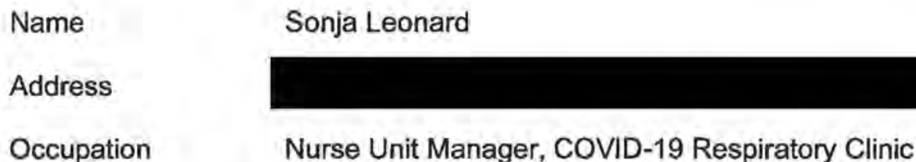
Statement of SONJA LEONARD

RFS-TAS-056

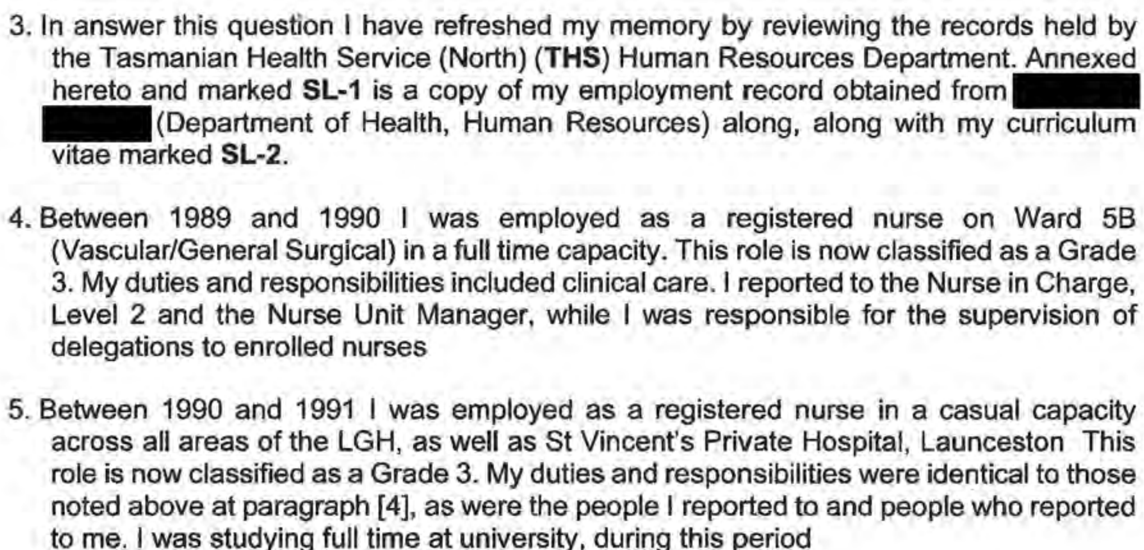
Name	Sonja Leonard
Address	
Occupation	Nurse Unit Manager, COVID-19 Respiratory Clinic

1. I, make this statement in response to Notice RFS-TAS-056 issued on 23 May 2022 by the President of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, the Honourable Marcia Neave AO.

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

2. I commenced employment at the Launceston General Hospital (**LGH**) in February 1986 as a student nurse. This was the commencement of my hospital training to become a Registered Nurse. I undertook my examinations for the Nursing Board of Tasmania on 23 and 24 February 1989 and gained Nursing Registration on 16 March 1989,

Q2. Outline the role(s) you have held at the Launceston General Hospital, including in respect of each role a brief description of (a) the duties and responsibilities of the role (b) the period in which you held the role (c) whether the role still exists (d) which area/department of Launceston General Hospital the role operated or operates in (e) who reported to you and to whom you reported (f) whether you had any personal performance measures, key performance indicators or financial outcomes in relation to how you or your team responded to child sexual abuse, safeguarded children to kept children safe, and (g) whether you held or were required as part of those roles to hold any qualifications or credentials (including any registration to work with vulnerable people).



3. In answer this question I have refreshed my memory by reviewing the records held by the Tasmanian Health Service (North) (**THS**) Human Resources Department. Annexed hereto and marked **SL-1** is a copy of my employment record obtained from (Department of Health, Human Resources) along, along with my curriculum vitae marked **SL-2**.

4. Between 1989 and 1990 I was employed as a registered nurse on Ward 5B (Vascular/General Surgical) in a full time capacity. This role is now classified as a Grade 3. My duties and responsibilities included clinical care. I reported to the Nurse in Charge, Level 2 and the Nurse Unit Manager, while I was responsible for the supervision of delegations to enrolled nurses

5. Between 1990 and 1991 I was employed as a registered nurse in a casual capacity across all areas of the LGH, as well as St Vincent's Private Hospital, Launceston This role is now classified as a Grade 3. My duties and responsibilities were identical to those noted above at paragraph [4], as were the people I reported to and people who reported to me. I was studying full time at university, during this period

6. Between 1991 and 1992 I was employed as a registered nurse on Ward 4K (Paediatrics). This role is now classified as a Grade 3. My duties and responsibilities were identical to those noted above at paragraph [4], as were the people I reported to, however in addition to those noted I also supervised Mothercraft nurses on Ward 4K.

7. In April 1992, I was promoted to Clinical/Community Nurse in a permanent part time capacity. At the time this was classified as a Level 2 position however following the introduction of an updated industrial agreement it was grandfathered to a Grade 4 position. While the records from Human Resources indicate that this promotion occurred in 1990, a review of my resume and personal records suggests it occurred in 1992. My duties and responsibilities included more complex clinical care, and at times I worked as the nurse Incharge of shifts. I reported to the Nurse Unit Manager. I was responsible for the supervision of delegations to student nurses, enrolled nurses and Mothercraft nurses, and when acting as the nurse Incharge, other registered nurses on shift at that time.

8. From October 1999 until November 2008, I was employed as a permanent part time Clinical Nurse on Ward 4K (Paediatrics). My duties and responsibilities were identical to those noted above at paragraph [7], as were the people I reported to and people who reported to me. During this time, I at times acted as the Nurse Unit Manager, including between:

    a. 8 August 2004 and 13 August 2004 (fixed term, part time)

    b. 11 May 2005 and 17 May 2005 (fixed term, part time)

    c. 27 August 2007 and 31 August 2007 (fixed term, part time)

    d. 13 October 2007 and 10 November 2007 (fixed term, part time)

    e. 29 June 2008 and 9 August 2008 (fixed term, full time)

9. From 4 November 2008 to 17 September 2017, I was employed as the Nurse Unit Manager on Ward 4K (Paediatrics) on a permanent, full-time basis. My duties and responsible included the management of the business unit, recruitment, staff management, rosters, human resources, strategic development, sleep study service, development of the Paediatrics Outpatient Service and support of the Eating Disorder Service. I have been provided with a copy of the statement of duties for the Nurse Unit Manager Role as at August 2008, which I annex and mark **SL-3**. As Nurse Unit Manager, I reported to the Nursing Director of Women's and Children's Services (**WACS**) as well as the Executive Director of Nursing (**EDON**). My direct reports included all staff employed on Ward 4K and Paediatric Outpatients, being Mothercraft nurses, enrolled nurses, registered nurses, Grade 4 and Grade 5 staff, the Educator, the Clinical Nurse Specialist, operational staff, sleep study technicians, play therapists and administrative staff. During this time, I held full time, fixed term roles as:

    a. The Assistant Director of Nursing for WACS between 5 September 2011 and 16 September 2011.

    b. Nursing Director of WACS between 11 January 2015 and 7 February 2015 and 25 December 2016 and 21 January 2017.

10. Between 18 September 2017 and 27 January 2018, I was employed across two roles, being the Nurse Unit Manager on Ward 4K (Paediatrics) on a permanent, part time basis and the Nurse Unit Manager on the Queen Victoria Maternity Unit. I was required to be

"offline" to participate in the research, planning and development of the 4K redevelopment with the Project Team. I was required to work 0.53 FTE on the 4K redevelopment project for this period to enable due consideration of the redevelopment issues. During this period I worked 0.47 in the Nurse Unit Manager Ward (Paediatrics) and 0.53 in the notional role of Nurse Unit Manager on the Queen Victoria Maternity Unit, to allow time to research, plan, develop the plans/ requirements of the 4K redevelopment plan. I reported to The Co-Directors of WACS, (Ms Janette Tonks and) the Capital works, Project Manager , and the Business manager for WACS . Vacating the Nurse Unit Manager 4K position allowed the 0.53 FTE backfill for the period. The Nurse Unit Manager role was covered by Mr Michael Sherring between 24 September 2017 and 18 November 2017 and by between19 November 2017 – 14 January 2018

11. Since 28 January 2018, I have held a permanent full-time position as the Nurse Unit Manager on Ward 4K (Paediatrics). My duties and responsibilities were identical to those noted above at paragraph [9], as were the people I reported to and people who reported to me. Since this time, I have also acted at the Nursing Director of WACS between:

    a. 25 February 2018 and 10 March 2018

    b. 24 June 2018 and 4 August 2018

    c. 3 October 2018 and 20 October 2018

    d. 29 September 2019 and 19 October 2019

12. Since 21 December 2020 I have been seconded to work as the Nurse Unit Manager of the COVID-19 Respiratory Clinics at Nursing Services. I report professionally to the THS (North) Nursing Director Pandemic Preparedness and Response ( ) and operationally to the Operations Manager of State-wide testing clinics, . My direct reports are all staff employed to provide testing services in the clinic - Specimen collectors, Assistants in Nursing, Administrative staff, Enrolled Nurses, Registered Nurses. Indirect reports include the external contractors - traffic management staff.

13. Each of the above roles remain in existence, albeit under slightly different nomenclature.

14. I am not aware and do not recall having any personal performance measures, key performance indicators or financial outcomes in relation to how me or any of my reports referred to above responded to child sexual abuse, safeguarded children or kept children safe.

15. At all relevant times, I have held the qualifications and/or credentials required for my employment. This includes being registered with the Nursing Board of Tasmania, now APHRA, and obtaining a working with vulnerable people registration following its implementation in May 2016.

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

16. In 1994 I obtained a Bachelor of Health Science in Nursing from the University of Tasmania. The Bachelor of Health Science offered a speciality stream called Child and Family Health which if completed led to registration with the Nursing Board of Tasmania. This qualification is equivalent to the current Bachelor of Nursing with a Graduate

Diploma in Child Health Nursing. Annexed hereto and marked **SL-4** is a copy of my transcript from the University of Tasmania.

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

17. I am currently on a secondment at the Emergency Operations Centre where I am employed as the Nurse Unit Manager of the COVID-19 Respiratory Clinics. I am responsible for managing the COVID-19 testing clinic in Launceston. My duties and responsibilities include the management of the business unit, recruitment, staff management, rosters, human resources, strategic development, policy review, infection prevention and control education. The unit provides Covid 19 PCR testing service delivery for the North of Tasmania including, Government Managed Quarantine Facilities, mobile testing clinics, outbreak testing and outreach testing.

Q5. Identify whether, at any time during the course of your employment at Launceston General Hospital, you were offered, received or delivered training in one or more of the following areas

(a) Mandatory reporting and notifications and related information sharing

18. I am unable to find a record that confirms that I undertook training in respect of mandatory reporting and notifications and related information sharing, however I recall participating in training regarding child safety. I do not recall when this occurred, and I do not recall if it involved training in respect of mandatory reporting and notifications and related information sharing. I believe it predominately concerned issues surrounding parents and guardians.

(b) Voluntary reporting and notifications

19. I have no recollection of being offered, receiving or delivering training in respect of voluntary reporting and notifications, and I am unable to find a record of any such training.

(c) Professional conduct in the workplace/codes of conduct

20. I recall that in or around 2009 the Human Resources team ran a series of education sessions that related to the State Service Code of Conduct and professional conduct more generally. I believe that these education sessions were offered to all nurses working on Ward 4K.

21. I note that my resume, annexed above, indicates that in 2013 I undertook training facilitated by the Integrity Commission on State Service Code of Conduct.

(d) Reporting misconduct or potential misconduct of staff members.

22. My resume reflects that in 2013 I undertook training facilitated by the Integrity commission on the topics of State Service Code of Conduct, Conflict of interest and Misconduct .

(e) Professional boundaries with patients

23. My resume reflects that in 2010 I received/attended training on the Australian Nursing and Midwifery Accreditation Council Professional boundaries.

(f) Informed consent processes for paediatric patients and their parents/guardians

24. I recall receiving training regarding consent processes; however I do not recall when this occurred or how such training was delivered. I am unable to find a record that confirms that I undertook training.

(g) Chaperoning or guiding intimate care for paediatric patients

25. I have no recollection of being offered, receiving or delivering training in respect of chaperoning or guiding intimate care for paediatric patients, and I am unable to find a record of any such training.

(h) Provision of health care to a paediatric patient with a disability

26. I have no recollection of being offered, receiving or delivering training in respect of the provision of healthcare to a paediatric patient with a disability, and I am unable to find a record of any such training.

(i) complaint and grievance processes when the complaint was made by a patient or family member of a patient.

27. I have no recollection of being offered, receiving or delivering training in respect of the complaint and grievance processes when the complaint was made by a patient or family member of a patient, and I am unable to find a record of any such training.

(j) complaint and grievance processes when the complaint was made by a staff member

28. I recall that in or about 2009 all staff on Ward 4K were offered and received training surrounding how to lodge a grievance. I believe that this training was organised by Human Resources and that independent facilitators were engaged, however I now do not recall who ultimately provided the training.

(k) identifying and responding to child sexual abuse, including grooming behaviours and child exploitation material

29. Between commencing at the LGH and 2020, I do not recall being offered, receiving or delivering training in respect of identifying and responding to child sexual abuse, including grooming behaviours and child exploitation material, and I am unable to find a record of any such training.

30. In or around February/March of 2020, the Nursing Director of WACS and the Clinical Educator of Ward 4K arranged education sessions relating to identifying and responding to child sexual abuse. I recall that it included training about the personality traits that a predator, or a person who was grooming a child, would have. In addition to attending this training, I was responsible for supporting its delivery by supporting the attendance of Ward 4K staff and arranging payment for their time to attend the educational sessions. It was acknowledged during these sessions that the training for staff relating to child sexual abuse was lacking. Annexed hereto and marked **SL-5** is an email attaching an invite to these education sessions.

(l) storing and dispensing of controlled drugs

31. I have no recollection of being offered, receiving or delivering training in respect of the storing and dispensing of controlled drugs, and I am unable to find a record of any such training.

32. The only information I recall receiving about the storing and dispensing of controlled drugs was when an updated policy was implemented and distributed amongst staff.

(m) record keeping and information management as it relates to either:

(i) storing and dispensing drugs;

33. I have no recollection of being offered, receiving or delivering formal training in respect of (m)(i), and I am unable to find a record of any such training. Informally, when medication audits were undertaken by the pharmacist or chart reviews were undertaken of the dangerous drugs register, the results would be presented to me as Nurse Unit Manager. The pharmacist and I would review the results and identify any gaps or errors and together with the Clinical Nurse Educator develop an education plan if required. Results were subsequently presented to staff at unit meetings for awareness and education.

(ii) recording complaints or grievances made by either staff, patients or family

members of patients, or

34. I have no recollection of being offered, receiving or delivering training in respect of (m)(ii), and I am unable to find a record of any such training.

(iii) the Safety Reporting and Learning System

35. In respect of (m)(iii), I recall undertaking general training provided in the Safety Reporting and Learning System (**SRLS**) system however do not believe it related specifically to record keeping and information management. I have refreshed my memory by reviewing my resume, which indicates that I completed three training sessions on the SLRS. These were 2014, 2016 and 2020 I recall undertaking these training sessions in person. By referring to my resume and to a 2014 timetable, I now recall that in 2014 I received training for managers, covering Clinical and work health and safety events, reports and actions. In 2016 I received training in the SRLS Risk register Module Training. In 2020 I again received training in the SRLS involving the reporting of Risk events and investigation of Risk. I do not now recall specifically what this training involved. A copy of my resume is annexed above as SL-2. Annexed hereto and marked **SL-6** is a copy of the timetable from 2014.

Q6. If you gave or received feedback on the adequacy or otherwise of the training mentioned in your response to paragraph 5, provide high-level explanation of the feedback you gave/or received (and to whom or by whom it was given) and any steps you took in response to or as a result of that feedback.

36. I do not recall receiving feedback on the adequacy of the training referred to above.

37. I do not recall providing receiving feedback on the adequacy of the training referred to above.

38. In or around 2019 I provided feedback to Ms Emily Sheppard, the Branch Secretary of the ANMF, to the effect that it would be beneficial for union representatives to receive education on the grievance process. I provided this feedback as I did not think any training had been provided to union representatives and was of the belief that they would be better prepared for the role if they had been provided this training.

39. Prior to speaking with Ms Sheppard, an ANMF representative had identified that they had not received any onboarding education for the role. As a result, in 2009 education was provided to all Ward 4K staff, including myself, on the grievance processes.

40. I recall that after 2014, following the implementation of SRLS, that the Clinical Nurse Educator and Quality Improvement Nurse received feedback regarding reports made by Ward 4K staff on the SRLS. The feedback suggested that the reports being made lacked the information that was required to follow up and investigate complaints. As a result, the Clinical Nurse Educator at the time, Mr Michael Sherring, was requested by myself to provide education to the staff of Ward 4K on how to properly submit an SRLS, including as to submitting the required information, the person affected, and a severity assessment. Subsequent to this, requests were made to [redacted] in his role as Quality improvement Nurse to address the components of entering a SRLS event.

41. Late in 2019, Ms Annette Whitmore, a nurse on Ward 4K, provided feedback to the Director of Nursing, Ms Janette Tonks, and myself during a group meeting with Ward 4K staff. This feedback was to the effect that the staff on Ward 4K did not have regular education and training in relationship to grooming behaviours, and if they did, their awareness would be improved.

42. As a result of this feedback, Ms Tonks asked Mr Sherring to explore potential educational opportunities for Ward 4K staff which led to the education sessions referred to above at paragraph [30].

Q7. As far as you understood, during the relevant period what were the policies, procedures, codes or guidelines which applied to or related to:

(a) mandatory reporting and notifications and related information sharing

43. *Children, Young Persons and Their Families Act 1997.*

(b) voluntary reporting and notifications

44. AHPRA Code of Conduct for Nurses

(c) professional conduct in the workplace/codes of conduct

45. State Service Code of Conduct, AHPRA Code of Conduct for Nurses, Nursing and Midwifery Board of Australia -Code of Ethics for Nurses

(d) reporting misconduct or potential misconduct of staff

46. State Service Code of Conduct, AHPRA Code of Conduct for Nurses, Tasmanian Integrity Commission,

(e) professional boundaries with patients

47. Nursing and Midwifery Board -Code of Ethics for Nurses, Conflict of interest Declarations, AHPRA - A nurses Guide to Professional Boundaries, AHPRA Code of Conduct for Nurses,

(f) informed consent processes for paediatric patients and their parents/guardians

48. Tasmanian Health Service Informed Consent Policy

(g) chaperoning or guidance relating to intimate care for paediatric patients

49. Tasmanian Health Service Chaperone Policy

(h) provision of health care to a paediatric patient with a disability

50. Nursing Code of Ethics, Nursing and Midwifery Board of Australia Registered Nurse standards for practice

(i) complaint and grievance processes when the complaint was made by a patient or family member of the patient

51. The Tasmanian Health Service (North) LGH feedback and complaints management protocol

(j) complaint and grievance process when the complaint was made by a staff member

52. Tasmanian Health Service and Department of Health Grievance Policy

(k) identifying and responding to child sexual abuse, including grooming behaviours and child exploitation material

53. Apart from Mandated reporting to Child Safety, as far as I understood, during the Relevant Period there were no policies, procedures, codes or guidelines which applied or related to identifying and responding to child sexual abuse, including grooming behaviours and child exploitation material.

(l) storing and dispensing of controlled drugs

54. Tasmanian Health Service S4 and S8 Medication Management Protocol, *Poisons Act 1971*

(m) record keeping and information management as it relates to either:

(i) Storing and dispensing drugs –

55. Tasmanian Health Service S4 and S8 Medication Management Protocol *Poisons Act 1971*

(ii) Recording complaints and grievances made by either staff, patients or family members of patients -

56. My understanding was that the recording of complaints from patients and families would be undertaken by the Quality and Patient Safety Service when they received a complaint. Resolution of complaints and grievances could be undertaken on an informal level and I understood that a recording of this could be achieved by file note or diary entry. Recording of formal grievances would be on the appropriate documentation/lodgement form and via formal processes. Management files were held by both managers and HR department. I have recently become aware of, but was not aware at the time, that there exists a 2022 Consumer Feedback and Complaint Management Protocol, which relates to the recording of complaints.

(iii) The Safety Reporting and Learning system

57. SRLS policy

Q8. Outline your role (if any) in developing, approving or implementing the policies, procedures, codes or guidelines identified in your answer to paragraph 7

58. In my role as Nurse Unit Manager, it was my role to implement current policies on Ward 4K by ensuring that staff were aware of the relevant policies and were complying with the expectations set out in those policies.

59. Generally speaking, Tasmanian Health Service and LGH policies were made by more senior staff within the organisation. As such, I do not recall being involved in the development or approval of any of the policies referred to above, other than the Professional Boundary - a guideline for nursing and midwifery staff working with children and their families: LGH Policy 6.13-09WACS. Annexed hereto and marked **SL-7** is a copy of this guideline from 2013.

60. To the extent that I was involved in the development of the Protocol, my role was to encourage staff on Ward 4K to contribute to its content. I recall that the idea behind the development of the Protocol was to create a collaborative statement which contained agreed values and expectations surrounding professional boundaries. To the best of my recollection, I believe that Mr Sherring was predominantly responsible for the drafting and completion of the Protocol.

Q9. Outline any views you held or hold on the adequacy of these policies and procedures, including whether they were effectively implemented and adhered to.

61. In respect of mandatory reporting, in my view the responsibility of nursing staff to report their concerns was not widely understood. It appeared to me that in practice, nursing staff would often discuss their concerns with another staff member, such as a social worker, but fail to then report those concerns to Child Safety Services. If I became aware that nursing staff had held a concern for a patient but had not reported it to Child Safety Services, I took the opportunity to speak to that staff member, provide education about their responsibilities and reiterate that if they had a concern, they should always report it.

62. As to the adequacy of policies relating to the reporting of misconduct, as Nurse Unit Manager I found it very challenging to obtain information from Ward 4K staff as it related to poor conduct or poor performance. In my view, the staff who worked on Ward 4K were protective of their long-term friendships and they tended to respect the decisions of certain more senior members of staff. Ward 4K had a culture of bullying that made staff reluctant to report poor conduct or performance due to the impact that would have on their personal and professional relationships with colleagues. While from a managerial perspective the ability to identify and address poor performance became easier after nursing allocation was changed from a team nursing structure to one where every patient was allocated a nurse, nursing staff remained reluctant to report poor conduct.

63. In my experience the policies regarding the lodging of a grievance were not consistently adhered to. Particularly where a grievance was lodged and the outcome was not satisfactory to the staff member lodging the grievance, the escalation of the matter to the next tier of management did not occur in a timely manner.

64. In respect of the policies surrounding the storing and dispensing of controlled drugs, in my experience these were generally adhered to. However, I understand that there was an SRLS event where discharge medication that had been delivered in the late afternoon by the pharmacist was found to be missing from the Ward 4K drug room when nursing staff were preparing the patient for discharge. I am unable to verify the date that this incident took place, however having spoken to [redacted] I understand it is likely to have occurred prior to 2007. Upon investigation, it was determined that the nursing staff working the late and night shifts had been wedging the swipe card access door open with a towel to prevent it from slamming and waking up nearby patients and families.

The event was logged, investigated (including by Tasmania Police) and ultimately processes were changed to ensure that appropriate control measures were in place regarding the safety of controlled medications.

Q10. What is your understanding of when and how to report a concern of child sexual abuse or other child abuse to Child Safety Services? Who do you understand is responsible for making that report?

65. My understanding is that any person who holds a concern for the safety of a child is required to report that concern to Child Safety Services. As a nurse, I know that I am a mandatory reporter and am required to make a report when I hold such a concern.

66. At the LGH, when a person holds a concern regarding the safety of a child, they could contact the Child Safety Liaison Officer at the LGH, or if they are not available, they would go directly to Child Safety Intake Services. When making a report, I understand that we provide information about the identity of the child, the identity of any person whose behaviour or conduct we are concerned about, and details of that behaviour or conduct.

Q11. What is your understanding of when and how to report a concern about a practitioner's conduct to a professional or regulatory body (including the Australian Health Practitioner Regulation Agency)? Who do you understand is responsible for making that report?

67. My understanding is that any person who holds a concern about a practitioner's conduct should lodge a complaint with the relevant regulatory body, and that this can be done by contacting the regulatory body online. Whilst I previously believed you could only make a complaint if you had evidence to support the complaint, I now understand, [redacted], that a concern alone is enough to lodge a complaint.

Q12. What is your understanding of when and how to make a complaint under the Health Practitioner Regulation National Law (Tas) 2010 and the Health Complaints Act 1995 (Tas)?

68. I have no knowledge or experience with this process.

Q13. What is your understanding of when and how to report a concern about inappropriate conduct to Tasmania Police? Who do you understand is responsible for making that report?

69. I understand that if a person is concerned that a crime has been, or is at risk of being, committed, or if a person is at risk of harm, a report to Tasmania Police should be made.

70. A report should be made by the person who holds that concern or by a person who has been provided information regarding that concern.

Q14. What is your understanding of when and how to report reportable conduct to the Registrar appointed pursuant to section 11 of the Register to Work With Vulnerable People Act 2013 (Tas)? Who do you understand is responsible for making that report?

71. I have no knowledge or experience with this process.

Q15. Are there other notifications you are aware of that are relevant or required to be made in your role, including when and to whom voluntary notifications can be made?

72. I am not aware of any other notifications that a relevant or required to be made in my role, and I have no knowledge or experience with the process of voluntary notifications.

Q16. Explain the incident management systems that were in place during your time at Launceston General Hospital, including how incidents were reported, recorded and investigated. Include in your answer the time periods for which each system applied.

73. During my employment with the LGH, I recall there being three reporting processes. These were a handwritten triplicate incident report book, the Electronic Incident Management and Reporting System (**EIMS**) and the Safety Reporting and Learning System (**SRLS**). For the purpose of answering this question, I have spoken to ████ ████ regarding the dates EIMS and SRLS were implemented.

74. Prior to the introduction of the EIMS, there was an incident report book. The event was handwritten on the first of triplicate pages and provided to the Nurse Unit Manager to review and investigate.

75. In or around 2006, EIMS was implemented. To the best of my memory, the EIMS was an electronic reporting process however I cannot not recall how incidents were recorded or investigated.

76. In or around March 2014, the SRLS was implemented. The SRLS was an electronic reporting system designed to record actual and near miss safety events. Unlike the EIMS, the SRLS used risk assessments and had the ability to attach documents with actions and feedback requirements. It was designed as tool for learning and improvement, rather than lodgement of incidents that had occurred

77. An event could be logged on the SRLS via a program that was installed on each computer within Ward 4K. Who would be advised of the event and who would have access to review the event on the SRLS would be determined by the nature and location of the incident.

78. The Nurse Unit Manager and Nursing Director for Safety and Quality had oversight of all events logged on the SRLS. Events logged in Paediatrics automatically fed to the Nursing Director of WACS and the Quality and Practice Improvement Nurse (later name change to Clinical Nurse Consultant – Practice Development). Other staff may have had access to the files depending on their role in the organisation, or if they had been provided access to action items relating to the event. As the Nurse Unit Manager, I would receive a notification when an event was logged on Ward 4K and could then access the event on the SRLS desktop icon on a computer.

79. After receiving a notification, I would review the event to see what had occurred and determine whether I was the person responsible for the event or there was a more appropriate person who should become the file owner. Similarly, the event may have been identified in 4K, however, location of the event, may have been another department. If I came to the view that another person was better situated to be the owner of and investigate the event, I would change the file owner to the appropriate person and notify them by email. If I was the person responsible for the event, I would review the information provided and determine whether we needed further information to be able to progress the investigation.

80. Once I was satisfied that sufficient information was provided, I would seek feedback from those involved in the event as well as relevant specialist staff to better understand what had occurred. If it appeared that further education was needed to support a change in practice, either with an individual person or a group, this would be arranged with the

Clinical Nurse Educator. Often the undertaking of the investigation and discussion with the employees involved provided the opportunity for any education required.

Q17. Detail any training you have received in relation to using the Safety Reporting and Learning System, and the frequency of this training.

81. For the purposes of answering this question, I have had reference to my resume, a copy of which I have annexed above.

82. Since commencing at the LGH, I have received the following training in relation to the SRLS.

    a. SRLS Manager training was provided in March 2014 when SRLS was implemented as the new tool for Incident Management. The training covered managing Clinical as well as, WH&S Events, Reports and Actions

    b. SRLS Risk Register Module Training, THS Risk Management Policy in 2016. To the best of my memory, this training concerned logging organisational risks and vulnerabilities onto the risk register.

    c. SRLS Reporting Risk events and investigation of risk in 2020. I believe that this training concerned residual risk ratings, however, do not know recall the specifics.

83. I have also received training in respect of the EIMS in 2007 and 2009. I have no independent recollection of these training sessions.

84. To the best of my knowledge, there is no required frequency to SRLS training, other than on commencement for new employees to the organisation.

Q18. Explain your understanding of the Safety Reporting and Learning System, including

(a) what it is designed to record

85. The SRLS is designed to record safety events that have impacted or have the potential to impact on the safe delivery of care to the patient

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

86. Once an event is logged, numerous staff have access to the file depending on the location, severity and assessment code however a file owner is automatically allocated in the background permissions and reporting/management pathway. The file owner will review the file and make any necessary corrections to the Severity Assessment Classification (**SAC rating**), identifications and level of harm to ensure it accurately reflects the events described. Before progressing with the review of the SRLS, the system requires the person to answer, with a yes or no response, whether the responses have been changed. The responsible person will, if necessary, seek further information by contacting the person who logged the event and other relevant staff and/ or reviewing relevant documents. Once all information is received, the matter will be discussed with senior nursing staff, specialist staff, those involved with a view to determining what the outcome/recommendations should be. Prior to closing the event on the SRLS, the file owner should provide feedback to the person who logged the event and review the residual risk rating.

(c) whether reports can be edited, changed or deleted by staff, and if so by whom and how, and

87. I do not believe that you are currently able to delete/reject an event from the SRLS, however previously there was capacity for a line manager to reject an event logged in the SRLS. I do not recall when the ability to reject an event was disabled/removed.

88. Reports can be edited by staff who have SRLS permissions. To my knowledge, these people include the Nurse Unit Manager, the Quality and Clinical Improvement Nurse, the Clinical Nurse Educator, and the Nursing Director of WACS. The Nursing staff of the Patient Safety and Quality Unit at the LGH can edit a report. In relation to a WHS event, the Injury Management Coordinator can edit a file.

(d) how edits to a report in the Safety Reporting and Learning System can be identified by others

89. My understanding is that each time a person accesses, updates or modifies an SRLS event, that activity is recorded in the event with the name of the user, the date and a time stamp. I do not have knowledge of how the SRLS records the detail of what was modified. It is my understanding that it only records the name of the user who edited the record and the date and time that the edit occurred.

Q19. Outline your experience (if any) using the Safety Reporting and Learning System, including:

(a) whether you have used it to report any concerns of child sexual abuse or inappropriate behaviour towards a child by any person (including staff, other patients or visitors)

90. I do not recall using the SRLS to report concerns of child sexual abuse or inappropriate behaviour towards a child.

(b) if you made a report of child sexual abuse or inappropriate behaviour towards a child, whether you (i) received any feedback or response connected with your report, or (ii) had (or have) any concerns about how the report you made was handled

91. Not applicable

(c) if you are or have been responsible for respondent to a report of child sexual abuse or inappropriate behaviour towards a child, outline the general steps you have taken (or would take) to investigate and respond to the report, including

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

92. The circumstances in which I might alter a report would include when assessing and correct the SAC rating, where the location or name of a person was incorrect, and to correct spelling mistakes.

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

93. Human Resources, my line manager, the staff named as witnesses, the person named in the event as having undertaken the behaviour and/or conduct, the child and the child's parent(s). Prior to consulting with relevant witnesses, I would also consider consulting with persons with experience in conducting interviews where there had been allegations of child sexual abuse and/or inappropriate behaviour towards a child.

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

94. Whether a report could be substantiated or not may not be able to be determined through internal investigations and therefore would need to be reported to Child Safety Services, AHPRA and Tasmania Police.

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

95. The person making the report, the person named in the report, the child involved, and the parent(s) of that child. Reporting back with HR and my line Manager in determining the outcome of the investigations.

Q20. Where were controlled drugs stored in Ward 4K and how were they secured?

96. When I commenced employment on Ward 4K, controlled drugs were stored in a double locked cupboard (**DD cupboard**) in a secured drug room. The secured drug room most recently had a swipe card access, which was activated by an ID badge card reader. Approval was required from the Nurse Unit Manager to advise LGH security prior to ID badge being activated. Prior to this, I can't recall if the drug room was locked with a key

97. The nurse in charge was required to carry keys that would unlock the DD cupboard. These were referred to as the "red keys" as they were on a long red lanyard.

98. When a nurse required access to the controlled drugs, they would need to ask the nurse in charge to open the DD cupboard. If the nurse in charge was available, they would open the room and DD cupboard themselves, but otherwise they would give the keys to a registered nurse who would/should return them afterwards. Due to workflow and ward activity, it was not always practical for this to occur.

99. At some stage, the DD cupboard was replaced with a metal safe that required a single swipe card to enter (**DD safe**). After discussing this with [redacted], I understand this occurred in early 2014. Prior to this time, the access to the secured drug room also changed so it could only be accessed with a single swipe card. I do not remember when this occurred. A further approval has to be sought and obtained from LGH security to access the DD safe, in addition to the approval referred to above at paragraph [96].

100. The exception to the above was that there was one vial of diazepam left out of the DD cupboard/safe. This was done to allow rapid access in the event of an emergency. This vial was stored in the secured drug room and was accounted for in the daily checks. Occasionally, if there was a child with unstable seizures, the vial would be stored in that child's room on a high shelf above the bed so it could be readily accessed. When the vial was being stored outside of the secured drug room, it would be accounted for in the daily check as well as on each shift change.

Q21. How were controlled drugs dispensed in and around Ward 4K?

101. Before controlled drugs were removed from the DD cupboard/safe, the medication order would need to be charted and two nurses would then need to access the DD cupboard/safe. One of these nurses was required to be a registered nurse.

102. The two staff members would access the DD cupboard using the red keys (or in the case of the DD safe, using a swipe Staff ID card - unique to each staff member and traceable.

103. One nurse would write up the details of the drug, the amount, the person being supplied and the dose, and would verify the amount that should be remaining in the cupboard. While this was happening, the other nurse drew the medication and showed the other the drugs in stock in the cupboard and what was being taken out. Together the two nurses would calculate the dose, confirm the dose and verify the amount of drug remaining and placed in the secure storage. This would be documented in the dangerous drug register and signed by both nurses. Any medications not given to the patient would be discarded in the drug room and documented on the drug chart and the dangerous drug register.

104. The medication and drug chart are checked again with the patient and parent at the patient's bedside in the presence of two nurses, and following administration, the two nurses would sign the drug chart to verify the administration to the patient.

Q22. Was there any system in place to record when controlled drugs were removed from storage or dispensed in Ward 4K? How were these records maintained and reconciled?

105. Controlled drugs that were removed from storage or dispensed in Ward 4K were recorded on the dangerous/controlled drug register. This recorded ward stock, discharge medication and any medications brought by the patients that were classified as controlled drugs. (S8 and S4D)

106. On a daily basis there would be a reconciliation and check of the dangerous drug stock to ensure that the count was correct. This was undertaken by two staff at the start of the late shift, who would then verify that the reconciliation was undertaken and confirm whether it was correct or whether there was a discrepancy. If there was a discrepancy this was to be raised with the nurse in charge and/or the Nurse Unit Manager, lodged on the SRLS and investigated. Overtime, this reconciliation was required to be undertaken three times per day at the change of shifts. The Controlled drug register was required to be stored and accessible for 2 years

107. In addition to the daily reconciliation, the ward pharmacist would undertake an audit of the dangerous drug register on a quarterly basis, or more regularly if there had been a discrepancy. I understand that there was recently a recommendation that this audit now be completed by the Nurse Unit Manager.

Q23. Was it possible for nurses to remove controlled drugs from Launceston General Hospital premises without detection? If yes, explain how this was possible. If no, explain the process in place to ensure that this did not occur.

108. In circumstances where the secured drug room door was not securely closed, and when discharge medications containing controlled drugs were not secured (as stated above at paragraph [64]), it would have been possible for nurses to have removed controlled drugs from the LGH without detection.

109. Further, when access to the controlled drugs was possible through use of a set of keys, it would have been possible for nurses to remove controlled drugs without detection.

110. The introduction of a single swipe card access to the DD safe has made the likelihood of removing controlled drugs without detection marginally more difficult. The activity of who is accessing the DD safe is traceable, however, there is no formal, structured reporting process that I am aware of that provides a report on the activity of the safe. It is unlikely that a nurse could remove controlled drugs from the DD safe without detection, but not impossible. Since the requirement to have monitoring cameras

installed in the drug rooms, with direct view of the DD cupboard and the person accessing the cupboard, it is unlikely that controlled drugs could be removed without detection. From my understanding, the barrier to a two-card swipe for the DD cupboards/safe (and therefore 2 nurses to access the safe in unison) in the LGH was the requirement for an extensive IT upgrade.

111. Once controlled drugs are removed from the DD safe, the risk of the controlled drugs being removed from the LGH without detection is reduced through checking the drug administration at the patient's bedside in view of the patient, their parents and another nurse.

Q24. Respond to paragraphs 20 to 23 again but with reference to the storage, handling and dispensing of antihistamines, antibiotics, sedatives and pain killers.

112. Antihistamines, antibiotics, sedatives and pain killers were stored in the secured drug room on Ward 4K. Over time, time sedatives (S4D) came to be stored in the DD safe.

113. As with controlled drugs, the medication order for antihistamines, antibiotics, or pain killers would need to be charted before they are dispensed. Two nurses then check the order, confirm the dose calculations are correct, and dispense the medications. The medication and drug chart are checked again with the patient and parent at the patient's bedside in the presence of two nurses, and following administration, the two nurses would sign the drug chart to verify the administration to the patient. As sedatives are a controlled drug, (S4D) the process to be followed is as stated at paragraphs [102] to [104] above.

114. I do not recall there being a formal reconciliation system in place to record when antihistamines, antibiotics, or pain killers were removed from storage. Pharmacy staff would undertake restocking of the general drugs including antihistamines, antibiotics, and painkillers. Sedatives were managed by the Pharmacist on the dangerous drugs register as previously described. The only system that records when antihistamines, antibiotics, and painkillers were dispensed that I am aware of is a patient's drug chart which recorded the administrating of those medications.

115. As the secured drug room can be accessed via a single swipe card, there is the potential for these medications to have been removed by a staff member without detection. I understand the monitored cameras have been installed in the secured drug room in recent years which may reduce the risk of this occurring, however I do not believe I am qualified to comment on the effectiveness of this in deterring or preventing the unauthorised removal of medications.

Q25. Have you ever worked with Mr Griffin and if so, in what capacity?

116. I have worked with Mr Griffin since he started his employment on Ward 4K. I believe this was in 2001. I have since confirmed these dates with [redacted], whose email is annexed hereto and marked **SL-8**.

117. I was initially Mr Griffin's colleague, however, became his manager when I was appointed the Nurse Unit Manager in November 2008. I remained Mr Griffins manager until August 2019, however, note that between 19 November 2017 and 29 May 2018 Mr Griffin was not working on Ward 4K due to being seconded to the Ashley Youth Detention Centre.

Q26. How would you describe your relationship with Mr Griffin?

118. I would describe the relationship as that of work colleagues. In the early years of his employment on Ward 4K, Mr Griffin and I had a professional relationship. Over time, following further conversations, this developed into a friendly professional relationship.

Q27. Describe any contact you had with Mr Griffin outside of work, including whether Mr Griffin ever visited your home or other properties you owned or rented, the nature of any such visits, whether he brought any children with him during those visits, and the nature of your and his relationship with those children.

119. I had limited contact with Mr Griffin outside of work.

120. I had some contact with Mr Griffin through text messages, which I would describe as being friendly banter and conversations about our shared interest of

121. Through attending some of the same work-related dinners and functions, Mr Griffin met my husband. They developed a friendly relationship as they both shared an interest in motor sports.

122. I recall one occasion where Mr Griffin visited our family beach house in . I cannot recall the date, but I believe it was around Easter in 2013 or 2014.

123. I did not invite Mr Griffin over. I recall that his family was camping at the local caravan park and believe he told me he would come over to look at the renovations my family had recently made to the house.

124. When he arrived, Mr Griffin had a child with him, who he introduced . He introduced her as "Tiff", who I believe to be Tiffany Skeggs, and explained that the other children were busy either with other people or other activities and she had essentially "tagged along". I am unsure of her age, but I recall that she looked as if she was a pre-teen. I do not recall her speaking very much, but I don't remember her appearing unsettled or anything.

125. Mr Griffin looked around the house, stayed for a cup of tea with my husband and me, and then left. I think he was there for approximately one hour.

126. I have not had, and do not currently have, a relationship of any kind of Miss Skeggs. I recall that years later Mr Griffin described his relationship with her as a "father figure", however I do not now remember why he told me this. .

127. I recall another occasion where Mr Griffin parked in the driveway of our home to pick something up from us. I remember there being children in the car, but I did not know who they were. I have very little clarity around this memory.

128. I recall an occasion when my husband and I saw Mr Griffin's caravan in – he was setting up his campsite. He was in the company of While I believe this may have been in late 2018, I cannot say for certain when this occurred.

129. I do not recall any other occasions where I had contact with Mr Griffin outside of the workplace.

Q28. Do you have knowledge of or did you observe Mr Griffin doing any of the following during the Relevant Period?

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

130. Not that I am able to recall.

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

131. On 15 January 2009, I received a letter of complaint from Senior Psychiatric Registrar [redacted]. Annexed hereto and marked **SL-9** is a copy of this letter. In this letter [redacted] explained that there was an incident where Mr Griffin had attended a weekly multi-disciplinary team meeting concerning one of his patients whilst Mr Griffin was on annual leave. [redacted] stated that Mr Griffin had been concerned to see the patient in [redacted]. The letter explained that the patient had [redacted] and that in [redacted] Mr Griffin had undermined the psychiatrically informed behaviour management plan.

132. I understood from [redacted]'s letter that he had also reported his concerns to the Clinical Director of Mental Health Services North, [redacted]. I believe that I also notified Human Resources and the Nursing Directors of WACS on 15 or 16 January 2009.

133. As I was going on leave that day, I emailed [redacted] to advise that [redacted], who would be Acting Nurse Unit Manager in my absence, would address the complaint. Annexed hereto and marked **SL-10** is a copy of my email to [redacted] and his response.

134. I understand that around this time [redacted] also raised a concern that in the week commencing [redacted] January 2009, he observed Mr Griffin giving an [redacted]-year-old patient a cuddle on a recliner chair in her room. He noted that the patient had been visibly upset [redacted] and accepted Mr Griffin's actions as being caring and consoling. I understand that this patient was the same patient being cared for by [redacted] referred to above at paragraph [131]. Following [redacted]'s complaint, [redacted] made a retrospective file note relating to Mr Griffin's conduct. Annexed hereto and marked **SL-11** is a copy of this file note signed by [redacted].

135. Having reviewed my records, I understand that the following steps were taken:

   a. On 21 January 2009, [redacted], along with [redacted] (Human Resources) and Ms Sue McBeath (Nursing Director of WACS) met to discuss the complaint concerning Mr Griffin. Annexed hereto and marked **SL-12** is a copy of a file note taken of this meeting.

   b. Following receipt of the complaint at paragraph [131] Mr Sherring made a retrospective file note relating to Mr Griffin's conduct. Annexed hereto and marked **SL-13** is a copy of this file note signed by Mr Sherring dated 21 January 2009.

   c. A letter was sent to Mr Griffin by [redacted] in which he confirmed the expectations in respect of professional boundaries. I have located a draft letter from [redacted], which I understand to be this letter. It is undated. Annexed hereto and marked **SL-14** is a copy of this draft letter.

136. As a result of the conduct complained of, a protocol for staff on Ward 4K relating to professional boundaries was developed. This development was done in a group forum that included Mr Griffin. I believe this occurred in or around mid-2009.

137. On or around 2 November 2015, raised concerns with about Mr Griffin overstepping professional boundaries with a psychiatric patient. I was not working at the time the concern was raised, and only became aware of this concern after finding it in a handwritten note left at work. I do not specifically recall what the complaint related to, however my diary note suggests that I subsequently spoke to Mr Griffin regarding the complaint on 4 November 2015 and directed him not to sit on a patients bed or hug patients. Annexed hereto and marked **SL-15** is a copy of a handwritten note left for me by , along with my diary note of speaking to Mr Griffin on 4 November 2015.

138. I observed Mr Griffin frequently greet familiar patients with a hug, including standing side by side with patients and hugging them. From my observations children and parents reacted positively to these gestures. The staff witnessing these hugs did not respond negatively to this. Notwithstanding this, I had directed Mr Griffin to desist from this behaviour as in my view it was not a professional manner in which to greet patients. I do not recall the date or time that I directed Mr Griffin to desist from this behaviour, however having reviewed the file note annexed above at paragraph [137] I believe it was in 2015 around the same time that I spoke to him following on from 's complaint.

139. I also understand that a report was made by the previous Nurse Unit Manager, , where he was cautioned by her when he kissed a child on the forehead and was directed not to continue such behaviours. I am not aware of the circumstances surrounding this report.

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

140. In or around March 2017, a patient raised her discomfort with being called "babe and sweetheart". This came to my attention after a Child and Adolescent Mental Health Services, Social worker, raised it with me and Mr Sherring on March 2017. I believe it was also documented in the patient notes.

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

142. To the best of my knowledge, the patient concerned was a child . and was staying at the LGH while . Her care required twice weekly multidisciplinary meetings, and from a case management point of view her care and treatment was labour intensive.

143. Given the complex needs of this patient, I recall discussing the complaint with Mathew Harvey at Human Resources, Mr Sherring, the broader Ward 4K staff, social workers, staff from Child and Family Services and the Child and Adolescent Mental Health Services, her paediatrician and Ms Tonks.

144. I subsequently discussed the matter with the patient and following her feedback and request, I determined that male staff would not care for this patient overnight, and Mr Griffin would not care for the patient at all.

145. Mr Griffin was subsequently sent a letter dated [redacted] regarding maintaining professional, therapeutic relationships with his patients and reiterating that using pet names was inappropriate. Annexed hereto and marked **SL-16** is a copy of this letter.

146. A further concern was raised by a [redacted] student completing their placement on Ward 4K, which was brought to my attention on [redacted] via email. Annexed hereto and marked **SL-17** is a copy of an email sent to Mr Sherring which I was copied into.

147. I understand that this complaint was dealt with by Mr Sherring. Annexed hereto and marked **SL-18** is an email from Mr Sherring outlining the steps he undertook as a result of that complaint.

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

148. On 16 April 2013 [redacted] approached me and told me that the mother of a patient had spoken to her and asked if Mr Griffin could be told not to visit her or her child. When asked the reason, she was told that there were "family issues" and that she did not want to elaborate further.

149. [redacted] advised that a few hours later, the mother had said she had just had a conversation with a family member, who asked if the mother had requested a nurse not to visit as that family member had been contacted by someone at the hospital and asked questions. Annexed hereto and marked **SL-19** is a copy of a file note I made after speaking with the mother. [redacted] subsequently sent me an email providing further detail, a copy of which is annexed and marked **SL-20**.

150. I subsequently met with Mr Griffin, along with Mr Sherring, to discuss what had happened, which resulted in Mr Griffin being sent a letter concerning an alleged breach of confidentiality. Annexed hereto and marked **SL-21** is a copy of this letter, which was edited by a member of Human Resources.

151. In or around July 2019, [redacted] reported a concern to [redacted] after having heard Mr Griffin making inappropriate conversation with a paediatric patient. [redacted] subsequently raised this with me. I contacted [redacted] and asked her to come and see me to discuss the concerns. On 22 July 2019, [redacted] and I met to discuss her concerns and I requested a written statement from her.

152. After meeting with [redacted] on 22 July 2019, I verbally reported the matter to Ms Tonks and Mr Harvey.

153. [redacted] subsequently sent me an email with further information regarding Mr Griffin's conduct, which I forwarded to Ms Tonks and Mr Harvey. I understand that on 7 August 2019 Mr Harvey forwarded the email chain to Mr James Bellinger and [redacted]. Annexed hereto and marked **SL-22** is a copy of this email chain.

154. After forwarding [redacted]'s statement to Ms Tonks and Mr Harvey on the 7 August 2019, I had no further involvement in the matter and am unsure how it was ultimately resolved.

155. My only other knowledge of Mr Griffin telling paediatric patients that they could contact him after hours or when off-duty is the incident referred to above at paragraph [131] and Safety Event ID 52489 that occurred in 2017 and is referred to below at paragraphs [191] to [204]

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

156. When allocating nurses to patients, as far as possible I would ensure that procedures involving intimate engagement with paediatric patients, such as intimate care or showering, were done by nurses of the same gender as the patient. If I became aware intimate engagement was required and these considerations had not been accounted for, I would re-allocate a more appropriate staff member to care for that patient.

157. In my view, Mr Griffin, as well as other staff, did not always demonstrate an awareness of procedures involving intimate engagement with paediatric patients. By this, I mean that if there had been an inappropriate allocation made, he would not raise the issue and request that it be changed.

(f) using his mobile phone while on shift

158. Mr Griffin did use his mobile phone while on shift, as did many of the staff on Ward 4K. His use of his mobile phone did not concern me, as I believed that all staff were completely professional in the use of their mobile phones.

(g) giving his mobile phone number to paediatric patients

159. On 11 January 2009, I had a discussion with [redacted] regarding Mr Griffin providing his telephone number to a patient. I recall being told that Mr Griffin had offered it and said he would come back to work to sit with the distressed patient if needed. Annexed hereto and marked **SL-23** is a handover memo from [redacted] and [redacted] that relates to this concern.

160. As a result of this conversation, I met with Mr Griffin and directed him not to give out his mobile phone number, clearly detailing that having contact with patients outside of work hours was not acceptable. I also met with the patient's mother who advised me that she had already deleted the phone number from her child's phone. Annexed hereto and marked **SL-24** is a copy of my diary note from February 2009 which relates to my discussion with Mr Griffin.

161. I do not recall whether I reported this incident to my supervisor. I understand that the conduct in issue was also considered at the same time and in the same manner as the complaints outline above at paragraphs [131] to [135].

162. In his letter of 15 January 2009 annexed above [redacted] also complained that there was an incident where Mr Griffin had given his mobile phone number to a patient with the expectation that they could contact him when he was outside the LGH. The steps that were taken following receipt of this complaint are outlined above at paragraphs [131] to [135].

163. I am not sure whether the patient referred to in [redacted]'s letter of complaint is the same patient referred to above at paragraph [159].

164. On 11 February 2009, I met with Mr Griffin to discuss the complaint. Annexed hereto and marked **SL-25** is a copy of my diary entry from this date as well as a separate set of handwritten notes.

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

165. My only knowledge of incidents concerning Mr Griffin telling paediatric patients that they could contact him after hours or when off-duty are those referred to above at paragraphs [131] and [159]

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

166. My only knowledge of incidents relating to Mr Griffin telling paediatric patients that they could contact him after hours or when off-duty are those referred to above at paragraphs [131] and [159]

(j) having contact with paediatric patients after they were discharged from hospital

167. In February 2009, Mr Griffin approached me to advise me that he was intending to "give away" a previous patient at their wedding. I told Mr Griffin that this concerned me. The reason it concerned me was it appeared to be an unusually close relationship for a nurse to have with an ex-patient.

168. I recall that there was a limited number of days before the wedding and that around that time my direct manager, Ms McBeath, was away or unavailable. As I was unsure of how to proceed, I discussed my concern with Ms Helen Bryan, the EDON. Ms Bryan advised that Mr Griffin could attend the wedding, however it would be inappropriate for him to act in the capacity in which he "gave her away".

169. I subsequently met with Mr Griffin on 25 February 2009 to discuss the matter and explain what I had discussed with Ms Bryan. Mr Griffin told me that he would not be "giving away" the patient at her wedding. Annexed hereto and marked **SL-26** is a copy of the letter dated 2 March 2009 sent to Mr Griffin following our meeting on 25 February 2009.

170. In or around May 2009, I recall receiving an email from Mr Griffin at my personal email address. It was also sent to a number of Ward 4K staff, as well as someone I recognised as being a previous patient of Ward 4K. Although I was of the understanding that Mr Griffin was friends with the patient's mother, I felt that it was not appropriate to be communicating with the patient via email. I subsequently met with Mr Griffin and requested him not to send me personal emails, and to not communicate with current or discharged patients. Annexed hereto and marked **SL-27** is a copy of the email sent from Mr Griffin.

171. I was also aware of Mr Griffin having contact with a patient outside of work hours, where that patient would visit his house and go away caravanning with his family. However, this relationship did not concern me as I understood that the patien .

Q29. Did you observe anything else about Mr Griffin that concerned you, including in relation to his interactions with paediatric patients and/or children and young people generally? Please explain your answer

172. There were a few occasions in which I had to speak to Mr Griffin about poor clinical decisions regarding paediatric patients. I recall that on one occasion he . There was a clear care plan in place and he had deviated from that. Annexed hereto and marked **SL-28** is a copy of my diary note from when I spoke to Mr Griffin regarding this matter.

Q30. In relation to any concern you did hold about Mr Griffin, did you report those concerns to anyone at Launceston General Hospital?

173. Not applicable.

Q31. In respect of any report made by you to anyone at Launceston General Hospital, what process was followed after you made your report? In your answer, explain

(a) how your report was recorded

174. Verbal reports were made to the Nursing Directors of WACS and the EDON as previously noted. I also made written notes in my work diary, of relevant extracts have been annexed.

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

175. As referred to above, I had conversations with the Nursing Directors of WACS and the EDON as well as members of Human Resources.

(c) what actions were taken by your supervisor and/or Launceston General Hospital management

176. Other than previously stated, I do not recall what if any action was taken by my supervisor and/or LGH management.

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

177. The only actions taken against Mr Griffin are the ones I have referred to above.

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

178. Other than previously stated, I do not recall what if any response was given by LGH executives.

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

179. I held no concerns and had no complaints regarding my supervisor or LGH Management, to the contrary I looked to them for advice, direction and guidance in these matters

(g) was the process that followed consistent with your understanding of the relevant complaints and grievances process?

180. Yes, it was my understanding that meeting with staff, providing education and direction/ directives were the first steps in resolving complaints and grievances.

181. The staff who raised these concerns did not seek feedback, information on outcomes or advise that they were not satisfied with the outcome of the process.

Q32. In relation to any concern you did hold about Mr Griffin, did you or someone else from Launceston General Hospital report your concern to (a) the Department of Health and/or the Secretary of the Department of Health (b) a Minister of Ministerial Office (c) a professional or regulatory body (including the Australia Health Practitioners Regulatory Agency) (d) Child Safety Services (e) the Department of Justice and/or the Registrar to Work with Vulnerable People, and/or the Consumer, Building and

Occupational Services business unit within the Department of Justice (f) Tasmania Police and/or (g) any other office, agency or organisation.

182. I did not report any concerns to any of the above bodies, and I am not aware of whether any other person did.

Q33. If reports were made to any organisation listed in paragraph 32, detail (a) who made the report (b) how the report was made (c) when the report was made (d) any responses received to the report (including when those responses were received), and/or (e) the outcome of the report

183. Not applicable.

Q34. Did the fact that Mr Griffin was the delegate of the Australian Nursing & Midwifery Federation impact your response to concerns you held in relation to him? If yes, explain how and why this was the case.

184. The fact that Mr Griffin was a ANMF delegate did not influence my response to any concerns I held, or concerns raised with me about him.

Q35. Did anyone raise a concern about Mr Griffin with you, including the behaviours outlined in paragraph 28?

185. On ██ November 2009 I met with the mother of a patient following a complaint relating to Mr Griffin. She told me that she felt uncomfortable with Mr Griffin being around her child as other staff had described him as being a "womaniser" and a "sleaze". I now do not recall whether she was directly told this by staff, or whether she overheard staff talking about it. She said something to the effect of "you've got men working here looking after children, and bad things happen we all know that". Annexed hereto and marked **SL-29** is a copy of my diary note of this conversation.

186. As outlined in my diary note, I subsequently spoke to Ms McBeath. My recollection of this conversation was that Ms McBeath said the complaint would be noted but that there was no need to progress the matter. I believe the reason for this was because the patient was due to be discharged shortly after the concern was raised.

187. I am not aware of any action taken by LGH management or executives nor am I aware of the concern being reported to any of the organisations noted at question 32.

188. All other concerns raised with me about Mr Griffin have been outlined in my previous answers.

Q36. Was the process that followed the raising of the concern consistent with your understanding of the relevant policies, procedures, codes and guidelines?

189. Yes. It was my understanding that at first instance complaints could be dealt with informally rather than always making a formal report. This would involve discussing the matter with the complainant and the person being complained of, providing appropriate directions and further education.

190. Whenever I met with patients or their parents who had raised a concern, I would ask them whether they wanted to go through the formal feedback process or whether they would like me to deal with it directly. If they were content to proceed with their concern at the informal level, that is how I would proceed.

Q37. In reference to the Safety Recording and Learning System report (Safety Event ID 52489, reference number REF 52300) lodged on 29 August 2017 in relation to concerns about Mr Griffin's behaviour (see copy of report at Annexure C), answer the following questions:

(a) What involvement did you have in responding to this report? Include in your response any action taken to investigate the report.

191. The substance of this report was first raised with me in an email from Mr William Gordon on 26 August 2017 at 10:54 p.m. On 28 August 2017, I forwarded the email from Mr Gordon to Mr Harvey. Annexed hereto and marked **SL-30** is a copy of these emails.

192. I was allocated as the file owner of the SRLS event. While I do not have an independent recollection of receiving a notification, I subsequently reviewed the event, assessed the risk, and sought further information from the people named in the report. As part of seeking further information, I sought responses from [redacted], [redacted], [redacted], [redacted], and [redacted]. Annexed hereto and marked **SL-31** is a copy of a statement I received from Mr Gordon.

193. On 4 September 2017 I wrote to Mr Griffin to receive his account and response to the allegations. Annexed hereto and marked **SL-32** is a copy of this letter and covering email.

194. On 6 September 2017, I received an email from Mr Griffin attaching his response to the complaint. Annexed hereto and marked **SL-33** is a copy of the email and response received.

(b) Did you alter or update the report in any way? If yes, state the nature of the alteration/update and the reason why you made it?

195. Responses I received from the above people were received in my email. I copied and pasted the content of the emails into the progress notes to create a contemporaneous record of information relevant to the event.

196. I am not able to recall if any other changes were made to the SAC rating, the location, or the people involved, nor do I recall if I altered or updated the report in any other way.

(c) did you grant any other staff member access to the report? If yes, state the staff member(s) to whom such access was granted and the reason why access was granted.

197. I am unable to recall whether I granted access to any other staff member.

198. The record appears to indicate that [redacted] granted file access to Mr Harvey on 4 September 2017. From memory, I believe I tried to make Mr Harvey the file owner but was unable to.

(d) Are you aware of any other Launceston General Hospital staff member changing any details of the report, after it was lodged on 29 August 2017? If yes, please identify the staff member who made the change and state the nature of the change.

199. Not that I am aware of.

(e) to your knowledge, what was the outcome of the report? Include in your answer the relevant decision makers, reasons for the outcome and the persons who were informed of it.

200. After receiving Mr Griffin's response, on [redacted] I provided a copy to Mr Harvey. We discussed the challenge of the situation and came to the conclusion that the inappropriate communication did not occur in the course of Mr Griffins employment and the event should be closed.

201. Mr Harvey drafted a letter to Mr Griffin advising him of this outcome, which I signed and provided to Mr Griffin on [redacted]. Annexed hereto and marked **SL-34** is a copy of this letter and covering email.

202. Notwithstanding this, I also spoke with Mr Griffin to direct him not to care for the patient in [redacted]. At this time I recall reiterating the requirement that he maintain professional boundaries.

203. In respect of feedback given to Mr Gordon, this was done verbally, after the event was closed. The feedback had not yet occurred at the time the file was closed. Given this was a matter specific to Mr Griffin, it was not discussed at the weekly team meeting.

(f) would the outcome have been different had the report expressly stated that the comments made by the patients concerning Mr Griffin were sexual in nature?

204. Yes, I believe so, as I think that that would have been really clear evidence that Mr Griffin had overstepped professional boundaries.

Q38. Do you have any concerns or complaints about how any concerns were responded to by your supervisor and/or Launceston General Hospital's management team and/or executives? Were you directed (formally or informally) to take particular actions that you did not agree with? If so, please detail

205. No.

Q39. Did the fact that Mr Griffin was a Ward 4K Australian Nursing & Midwifery Federation Delegate impact your response to concerns raised by others in relation to him? If yes, explain how and why this was the case.

206. No, the fact that Mr Griffin was a ANMF representative did not impact my response.

Q40. Do you consider the action you took in response to concerns raised by others in relation to Mr Griffin was adequate? Please provide reasons. To the extent that you now consider your actions to have been inadequate, state what action you would take now and why.

207. At the time of the complaint, I considered the actions I took in response, when taking into account the nature of the complaint and the way Mr Griffin responded to the complaint, to be adequate. I believe that I followed the principles of natural justice and procedural fairness.

208. However, with the benefit of hindsight I believe that the outcome, being further education on maintaining professional boundaries, was most generous to Mr Griffin. If I was to deal with the complaint again now, I would have reported the concerns to the relevant authority and encouraged staff to do the same.

209. With the benefit of hindsight, I believe that the complaint should have been managed with a more robust referral of the concerns to AHPRA and that there was a failure, both on behalf of myself as well as other staff, to identify Mr Griffin's grooming behaviours.

Q41. Prior to 31 July 2019, were you aware of any allegation that Mr Griffin had engaged in child sexual abuse or had had an inappropriate relationship with a child or young person (whether or not a paediatric patient of Launceston General Hospital)? If yes, state the nature of each such allegation and when and how you became aware of it.

210. Prior to 31 July 2019 I was not aware of any allegation that Mr Griffin had engaged in child sexual abuse or had had an inappropriate relationship with a child or young person.

Q42. Did you have any concerns about any conduct similar to that described in paragraph 28 in relation to other staff members at Launceston General Hospital? Please answer paragraphs 30 to 33 in relation to each such staff member

211. Not that I can recall.

Q43. Did anyone raise concerns with you in relation to other staff members at Launceston General Hospital? Please answer paragraphs 35 to 38 and 40 in relation to each such staff member.

212. In respect of using mobile phones and providing mobile phone numbers to patients, passed on concerns to me, raised by , directly with in relation to using her mobile phone whilst on shift in June of 2020. This was reported to Ms Tonks and Mr Harvey.

213. The concerns raised by were related to an allegation that a patient on the ward had obtained 's personal mobile number.

214. I recall that was reluctant to make a complaint to me as valued friendship with and was concerned that making a complaint would negatively impact their personal and professional relationship. After a number of conversations with , I advised that I had no course of action, other than to act on the information that had been provided to me.

215. I met with on 7 July 2020 to discuss two matters, being the management of schedule 4 and schedule 8 drugs and the professional boundaries relating to mobile phone usage and not sharing personal information with patients. At this time clarified with me that did not share mobile phone number but had airdropped a photo to a patient.

216. I recall that further education was provided and the expectations surrounding the use of mobile phones were put into a formal letter to which resolved the matter. I have been able to locate two documents relevant to this matter, annexed hereto and marked **SL-35**.

217. In May 2012 I was advised that on May 2012 had take a photo of patient in mobile phone. This was addressed with face to face, and deleted the photo at that time and demonstrated awareness that this was not appropriate behaviour. Annexed hereto and marked **SL-36** is a copy of my diary note relating to this matter.

218. With the support of my Manager and Human Resources I believe the process was consistent with the relevant policies, procedures, codes and guidelines. I had no concerns about the letter provided to and the overall response. I believe that the actions taken were adequate in the circumstances, including acting against the request of who originally raised the issue of concern and firmly requested no action be taken by either or myself.

219. A further incident related to having inappropriate conversations with a paediatric patient during night shift on July 2020.

220. The incident related to entering the patient's room while mother was sleeping after had decided to leave the workplace to go home. took the patient into the adolescent activity area, where proceeded to question behaviours and decision making in relation to diagnosis of . During this conversation, other staff overheard make comments along the lines of "I need to discuss this new attitude", "What's going on with you? Your behaviour has deteriorated, and you know what causes this" and "I want some answers". Further concerns were raised by staff that may have been under the influence of illicit drugs and/or alcohol at this time.

221. This matter was raised with me on July 2020. I sought more information from other staff present and then had a telephone call with . I subsequently sent a letter to seeking a response from in relation to the incident and help.

222. I reported the incident and concerns to Ms Tonks and Mr Harvey. I advised Ms Tonks that I was considering notifying AHPRA given was already subject to supervision by them due to health and that I was receiving limited information from and treating team. I also said how AHPRA had provided very limited information on 's health. We discussed the challenges of getting information from AHPRA and and sought to set up a meeting with Human Resources and to progress the situation and discuss .

223. Following and this meeting, and I met regularly over the next few months with the support of at Human Resources. was also aware of my thoughts regarding notifying AHPRA. As I left the role of Nurse Unit Manager on 12 November 2020, I was unable to complete this process.

224. I recall receiving complaints regarding having inappropriate and disrespectful communications with paediatric patients and their parents, in 2019 and 2020. Annexed hereto and marked **SL-37** are final determination letters relating to these complaints.

Q44. During the Relevant Period, were you aware of past allegations of child sexual abuse at Launceston General Hospital and how such allegations have been managed? If yes, did such awareness influence the action you took in response to concerns in relation to Mr Griffin or any person identified in answer to paragraphs 42 and/or 43 above.

225. I was not aware of any past allegations of child sexual abuse at the LGH, other than those relating to Mr Griffin which I became aware of on 1 August 2019.

Q45. What action was taken by Launceston General Hospital to identify and support any potential victim-survivors of child sexual abuse by Mr Griffin?

226. I am unaware of what, if any, action was taken by the LGH to identify and support any potential victim-survivors of child sexual abuse by Mr Griffin.

Q46. When did you first become aware of allegations that Mr Griffin engaged in child sexual abuse?

227. I became aware of the allegations against Mr Griffin from Ms Tonks on 1 August 2019. Ms Tonks advised me that Mr Griffins Working with Children Registration had been

revoked and that he was being investigated for potential crimes related to child sexual abuse.

Q47. Please explain how you have been impacted by the allegations about Mr Griffin

228. I have suffered both professionally and personally as a result of the allegations about Mr Griffin.

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Q48. What support was offered to you by Launceston General Hospital after the allegations about Mr Griffin were known to you?

235. The only support offered to me was that which was offered to all staff on Ward 4K.

236. The Social Work manager at the LGH, , offered to provide support generally to the staff on Ward 4K. However, after discussions with the manager of Allied Health, , Ms Helen Bryan and Mr Bellinger, it was determined that this would be a professional conflict of interest and that other external counselling services would be explored.

237. Following this decision, individual sessions were able to be arranged through the Employee Assistance Program or more opportunistic sessions were available with who was available on the ward.

Q49. Were any directions given to staff on Ward 4K regarding their ability to discuss the allegations against Mr Griffin and/or his death? If yes, outline the nature of the each such direction, who gave the direction, to whom the direction was given to and the reason the direction was given.

238. Human Resources directed staff to not discuss the allegations made against Mr Griffin due to ongoing police investigations. This direction was repeatedly provided when requests were made by staff for support and they asked to be allowed to discuss the allegations against Mr Griffin. I was led to believe that the direction was to protect the integrity of the investigation, and that it came about due to a recommendation of Tasmania Police. I recall that this recommendation was referred to by Mr Harvey, Mr Bellinger, Ms Tonks, Ms Bryan and Mr Peter Renshaw.

239. This direction was conveyed to me by Ms Tonks on 1 August 2019 when she advised me of the allegations against Mr Griffins. At this time, she told me not to discuss the matter with and , who were said to be aware of the events.

240. In respect of directions regarding Mr Griffins death, at the time of his death he was an inpatient at the LGH and was being treated for a number of days prior to his death. I believe that Mr Griffins died on or about 18 or 19 October 2019.

241. I received a text message from , who at the time was Acting Nurse Unit Manager of Ward 4K while I was Acting Nursing Director of WACS, that LGH staff were contacting Ward 4K staff as they had heard about Mr Griffins death. There was a suggestion that a group text message be sent to all Ward 4K staff to advise them of Mr Griffin's death. Both and I did not support this, and as far as we were aware his family had not announced his death. In my view, Mr Griffin as a patient was entitled to expect confidentiality and privacy surrounding his hospitalisation and it would not be appropriate to share the news of his death amongst the staff.

242. On 21 October 2019 at the 7:00 a.m. morning handover, I directed the staff of Ward 4K to not discuss the death due to patient confidentiality whilst acknowledging the challenges this would create given many of the staff were friends with Mr Griffin. I encouraged the staff to focus on their work as best they could and checked in with them individually to see how they were feeling and to offer them EAP counselling or one on

one meeting with me. I found this a very difficult path to navigate, so I sought direction and guidance from Ms Tonks, Mr Harvey and Mr Bellinger once they were at work later that morning. I was hoping to receive guidance on how to proceed and I recall that they supported this approach.

243. The staff I gave this direction to were Mr Gordon, .

Q50. What was the response of Launceston General Hospital's management team and/or executives to the allegations against Mr Griffin and/or his death? Did this response change over time? If so how and why?

244. When Tasmania Police were investigating Mr Griffin, we were instructed not to discuss the allegations given they were subject to an open and ongoing investigation. As the situation progressed so too did the response from the LGH management team. Once Mr Griffin had passed away, I remember there was more transparent communication.

245. In the week leading up to Mr Griffins death, there were some challenges and delays as both Ms Tonks and Mr Renshaw were on leave. I was acting as the Nursing Director for WACS in Ms Tonks' absence during the period 28 September 2019 to 20 October 2019, and was Acting Nurse Manager of Ward 4K. During this time, I met regularly with the Ward 4K staff with a HR representative, either Mr Harvey or Mr Bellinger, to provide what information we could, and offer individual debriefs and/or EAP counselling. This was a very difficult time.

246. Recognising the severity of the situation and that Ms Tonks was on leave, it was around this time that I requested that Ms Bryan attend Ward 4K to acknowledge the staff, the difficulties of the situation, and confirm that she would be available if staff needed her.

247. Further meetings were held with Ward 4K with Mr Renshaw and Ms Tonks on 30 October 2019 and again on 1 November 2019 to explain the information available and processes being taken. I recall that this was followed up with a second session with the staff in the WACS meeting room, however I am unclear when this occurred. At this time we were advised that an Open Disclosure process was being undertaken by the Director of Medical Services, and any images of children would be reviewed with the potential for identification by key Clinical Paediatric Staff.

248. Work was undertaken by the management and executive team on how to support the Ward 4K staff and a few areas had been identified. Education and mediation were identified by Human Resources and Ms Tonks as processes that would be used to support the staff of Ward 4K. Over time and towards mid 2020 there was more open dialogue and planning for moving forwards, including, but not limited to how to make Ward 4K safe for children and staff, as well as education on grooming and predatory behaviours. Annexed hereto and marked **SL-38** is a copy of a memo circulated to staff on Ward 4K.

249. During this time the Secretary of the Department of Health was visible on the ward and made herself accessible to staff to hear their concerns, and those of the community. I understand that the Secretary recommended in March 2021 that a Commission of Inquiry be established.

Q51. Did you consider the direction and/or response detailed in answer to paragraphs 49 to 50 to be appropriate or adequate? Please provide reasons for your answer.

250. Acknowledging the difficulties of the situation and topic of Child Sexual abuse, different relationships, supports, and individual life experiences, I have no experience or knowledge in what would constitute an adequate response.

251. I feel that my actions in seeking the support and direction of the Nursing Director of WACS and Human Resources in development of a response following Mr Griffin's death to ensure my actions were consistent with their expectations was appropriate. I was not in direct contact with the EDON, Ms Bryan, however, I understood she was in regular contact with the Nursing Director and Human Resources team.

252. I consider the decision to support individual debriefs as opposed to group debriefs was appropriate. In my experience, group debriefs lead to situations where not all staff members have the opportunity to be heard, the most vocal people direct the conversation, and the outcome is not always reflective of the views of all the staff. The preference for individual sessions to be offered to staff acknowledged that each person had their own experiences and relationship with Mr Griffin that should be discussed privately. The personal EAP sessions offered allowed a choice of provider which was seen to offer the best personal support for each individual staff member, while the sessions with [redacted] allowed convenient access for staff.

253. However, the direction for staff not to discuss the allegations again Mr Griffin was very difficult to support, and I was deeply challenged and conflicted by this, frequently requesting the ability for staff to talk about the topic and be offered support. The staff clearly needed the opportunity to talk and were struggling, however, I was unable to meet their needs, and support open conversations. The options of meeting with Ms Tonks, Human Resources, or myself one on one did not met the expectations of the staff.

Q52. To the extent that you were responsible for any direction or response detailed in answer to paragraphs 49 and 50, would you give the same direction or response today? If not, what would you do differently and why?

254. In learning of Mr Griffin's death and managing that information, in hindsight this could have been dealt with greater compassion and empathy. Noting the difficulties in meeting staff expectations and navigating this challenging situation, at all times I sought the guidance from the management and Human Resources team of the LGH. At this time, perhaps the support of a professional accredited mental health councillor would have better supported the staff needs.

Q53. Outline any supports you believe would have assisted you and other staff at Launceston General Hospital to recover and learn from the impact of the allegations about Mr Griffin?

255. In retrospect, I believe that the support offered to both the staff of Ward 4K and myself needed to be ongoing and easily available, and in a format that met our needs. I believe that we would have been assisted by:

   (a) Allowing time for 4K staff to grieve, discuss and adapt to the information and allegations against Mr Griffin and his subsequent death.

   (b) Further education on the grievance process, complaints process, reporting processes, professional boundaries

(c) The appointment of facilitators to develop and enhance team culture, to create ward values, education to support a zero tolerance to situations that could put children at risk.

(d) Having greater accessibility to senior nursing and human resources staff.

Q54. With the benefit of hindsight, do you consider that you acted appropriately in relation matters outlined in your statement? If so, why? If not, what would you change or do differently?

256. Regretfully, with the benefit of hindsight, and knowing what we now know of the allegations against Mr Griffin, it is difficult to consider the actions in relation to complaints made about Mr Griffin adequate. Having said that if staff members were aggrieved at the perceived lack of action or feedback, from complaints then they are to be encouraged to take advantage of the formal grievance process, if they were not satisfied with the outcome. Open conversations and escalating any concerns to higher nursing management should have been further encouraged and should be made more accessible for staff. Had I been made aware of the allegations made against Mr Griffin, I would have supported the escalation of those concerns.

257. On reflection, and with the benefit of hindsight, were I to be dealing with the matters referred to above today, I would likely not deal with them on an informal basis and would make sure that any complaints that related to professional boundaries or staff conduct would be referred to a person independent of the work group to investigate.

Q55. Given your experiences at Launceston General Hospital, what do you think needs to change to make children safer from child sexual abuse whilst patients at Launceston General Hospital?

258. In my view, a project position supporting ongoing education and policy development related to child safety reviewing incidents and SRLS should be developed, which would include key performance indicators and reporting of the same to LGH management and HR, including auditing. Further, such a position would need to include all aspects of organisational service delivery at the LGH and not be confined to only Ward 4K and Paediatric Outpatients. All departments at the LGH should have a child safety focus and undertake audits/reporting against the same. It would be beneficial to have a consumer representative to represent children and their parents when such education and policies are developed.

259. Further education needs to be provided to each staff member to ensure they have a clear understanding of their responsibilities regarding the protection of children and the pathways available to report any concerns or provide any feedback. This education should focus on:

(a) Developing a strong culture of responsibility and accountability which would support staff to call out, identify and report all unacceptable behaviour.

(b) Emphasising a zero tolerance to behaviours that could place children at risk.

(c) Establishing a unified set of expectations and actions to be taken when concerns are identified.

260. A structured support and education programme to ensure that when new or updated policies are implemented, they are put into practice on each Ward. This should include

a process for supporting the wards/business units to embed the new policy requirements with a staged plan for education and training, as well as audits on compliance.

261. Locating the Child Safety Liaison Officer on Ward 4K and giving the role an increased scope to enable them to undertake auditing/reporting on key performance indicators on the wards.

262. An independent process should be created to allow staff, parents, children and others to make complaints against staff members.

263. I also believe that while we await the findings of the Commission of Inquiry, the findings and recommendations of the Victorian Government Response to the Royal Commission into Institutions responses to Child Sexual Abuse, July 2018 should be provided and implemented in all Tasmania institutions, including the LGH. When released, this report should have been provided to all Tasmanian institutions providing care to children, with the expectation of improving child safety. From this key performance indicators could have been developed and child safety policy and processes developed. These recommendations need to be supported by project positions, at a broader governmental /organisational level to be able to generate tools, audits, action plans that workplaces can easily implement these recommendations.

Q56. How do you think the health system's response to allegations of child sexual abuse can be improved?

264. Awareness of and implementation of recommendations from the Victorian Government Response to the Royal Commission into Institutional Responses to Child Sexual Abuse, whilst awaiting the report from the Commission of Inquiry.

Q57. What steps do you think Launceston General Hospital should take in an effort to rebuild community trust in Launceston General Hospital?

265. Media communications reporting the changes and improvements that have been implemented, including:

(a) New staff that have been appointed to leadership positions.

(b) The progress that is being made with implementing child safe strategies at the LGH

(c) The audit results from child safe audits

(d) Where feedback received from the community has been acted upon to identify and implement improvements.

266. Create an easier complaints process that parents and children are able to navigate when they wish to make a complaint against an LGH staff member.

267. Creating a mobile phone management policy for staff in all areas of the LGH to protect children and the vulnerable in the community.

Q58. Has anyone in a position of authority (whether or not employed by Launceston General Hospital) discouraged you from assisting this Commission? If yes, please outline in general terms the form the discouragement took.

268. No.

Q59. Have you refreshed your memory for the purposes of this statement by reviewing any documents or other records or by speaking to any other person (other than a lawyer assisting you with the statement)? If so:

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

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

269. As referred to above, I have refreshed my memory for the purposes of this statement by reviewing documents and speaking to other persons.

270. People I have spoken to include ████, who has undertaken searches for information and documents via Ms Janette Tonks, ████, Patient Safety and Quality and ████, Acting Pharmacy Manager., as well as the HR records and Page Up Records

271. To the best of my ability, I have annexed documents to which I have referred to this statement. Other documents I have referred to include:

Annexed hereto and marked:

Statement of Duties - '50004041 CNC-MANAGER 4K' dated 8 June 2005	**SL-39**
New Code of Professional Conduct for Nurses dated August 2008	**SL-40**
Handwritten Management notes titled "Notes Jim Griffin"	**SL-41**
Email signed statement from Leonard Sonja to Leonard Sonja on 21 January 2009 at 12:25 p.m. signed by ████	**SL-42**
Email from Ms Leonard to James T Bellinger dated 16 December 2020 forwarding email of 21 January 2009	**SL-43**
Diary note of 11 February 2009 showing a note of the Professional Boundaries follow up meeting	**SL-44**
Draft letter from Ms Leonard to Mr James Griffin following up after their meeting on 25 February 2009 dated 2 March 2009	**SL-45**
Diary note of 27 April 2009 showing a note of a discussion with Mr Griffin regarding professional boundaries on 28 April.	**SL-46**
Document "Jim Griffin referee report CONFIDENTIAL" dated 18 June 2009	**SL-47**
Diary note of 11 November 2009	**SL-48**
Diary note 1 May 2012	**SL-49**
Diary note of 21 May 2012	**SL-50**

Diary note of ■ November 2012 recording that a discussion was had with ■'s mother, ■ who was uncomfortable with Jim describing him as a 'womaniser / sleaze' and a discussion with Jim on ■ December 2012	**SL-51**
Statement of Duties - Nurse Unit Manager (NUM) - Paediatric Services dated December 2012	**SL-52**
Handwritten notes of Ms Leonard regarding 'social issues' of ■ dated ■ April 2013	**SL-53**
Email from ■ to Ms Leonard: "Incident 16/4/13"	**SL-54**
Draft letter from Ms Leonard to Mr Griffin titled 'Patient Confidentiality' dated 17 April 2013	**SL-55**
Forwarded email from Gino Fratangelo to Ms Leonard dated 18 April 2013 "FW: Jim Griffin Confidentiality 2013.doc" attaching edited letter	**SL-56**
Mental Health Progress Notes of ■ dated ■ March 2017	**SL-57**
Email from Ms Leonard to Mr Griffin "Jim Griffin – Professional Boundaries and Communication" sent 7 March 2017 attaching letter dated 6 March 2017	**SL-58**
Email response from Sonia Leonard to Mathew Harvey "FW Inappropriate conversations with Patients 4K" sent 28 August 2017	**SL-59**
Email from William Gordon to Ms Leonard: "Inappropriate conversations with Patients" sent 26 August 2017 – *at bottom of above*	**SL-60**
Statement documenting the events of 26 August 2018	**SL-61**
Safety Event Management Form completed by William Gordon dated 29 August 2017	**SL-62**
Email from Ms Leonard to Mr Griffin "Seeking response to SRLS August 26 2017" sent 4 September 2017 attaching the letter dated 4 September 2017	**SL-63**
Letter from Ms Leonard to Mr Griffin dated 4 September 2017	**SL-64**
Forwarded email from Mr Griffin dated 6 September 2017 attaching document "Response to SLRS Re date 26/8/2017"	**SL-65**
Email attaching letter from Ms Leonard to Mr Griffin regarding the final outcome to the SLRS dated 11 September 2017	**SL-66**
Diary note of 13 June 2019 noting a discussion with 'Jimbo'	**SL-67**
Email from Mr Mathew Harvey to ■ and Mr James Bellinger "FW: JG Incident Report – 18 July 2019" sent 7 August 2019	**SL-68**

Email from Ms Leonard to Mr Harvey and Ms Janette Tonks: "FW:JG Incident report – 18 July 2019" sent 7 August 2019	**SL-69**
Email of response from Ms Leonard to [redacted] "RE: Incident Report – 18 July" sent 7 August 2019	**SL-70**
Email from [redacted] to Ms Leonard: "Incident Report" sent 7 August 2019	**SL-71**
Diary note of 23 September	**SL-72**
Email from Ms Leonard to James Bellinger "FW: New Guy in Prison – email received" sent 16 December 2020	**SL-73**
Email from [redacted] to Ms Leonard forwarding email from Mr Griffin (which forwards email of [redacted] from 7 May 2020) sent 8 May 2020	**SL-74**
Email from Ms Leonard to James Bellinger: "Handover J Griffin.doc" sent 16 December 2020	**SL-75**
Statement of Duties - Nurse Unit Manager – COVID Respiratory Clinics dated August 2020	**SL-76**
Statement of Duties - Registered Nurse dated November 2012	**SL-77**
Statement of Duties - Nurse Unit Manager (NUM) Paediatric Services dated April 2021	**SL-78**
Statement documenting the events of [redacted] August 2018	**SL-79**
Email chain between [redacted] and Sonja Leonard: "RE: request for information for witness statement"	**SL-80**
25-09 Patient Examination by Medical, Nursing and Allied Health Staff at LGH	**SL-81**
S8-12 Patient Examination by Medical Nursing Allied Health Staff - Chaperone Procedure THO-N	**SL-82**
Tasmanian Health Service Protocol Document P16/000607: "Chaperone – Intimate Examinations"	**SL-83**
Tasmanian Health Service Protocol Document P2010/0580-001: "Chaperone – Intimate Examinations"	**SL-84**
Consent Policy	**SL-85**
THS Informed Consent Protocol	**SL-86**
THS Grievance Resolution	**SL-87**
Consumer feedback and Complaints Protocol	**SL-88**
S4 and S8 interim policy 2020	**SL-89**

Grievance Management Procedure effective 1 July 2014	**SL-90**
Email from [redacted] to Ms Leonard "RE: EIMS implementation ?" sent 17 June 2022	**SL-91**
Email from [redacted] to Ms Leonard "RE: S8 Drug safe access" sent 17 June 2022	**SL-92**
Email from [redacted] to Ms Leonard "Information from Page Up" sent 17 June 2022	**SL-93**

Q60. Is there further information you would like to provide to the Commission regarding Launceston General Hospital?

272. No.

Q61. Is there further information you would like to provide to the Commission regarding the Tasmanian Health Service (including any other hospital within the Tasmanian Health Service) and/or the Department of Health?

273. No

Name: Sonja Leonard

Date: 21 June 2022