PUBLIC

THE PARLIAMENTARY JOINT SESSIONAL COMMITTEE MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON FRIDAY 22 NOVEMBER 2024

RECOMMENDATIONS OF FINAL REPORT OF THE COMMISSION OF INQUIRY

The public hearing commenced at 9.00 a.m.

Hon JACQUIE PETRUSMA MP, MINISTER FOR HEALTH WAS CALLED AND EXAMINED.

CHAIR (Ms Forrest) - Welcome, minister, to that side of the table, having recently been a member of this Committee. We welcome you back in the capacity as Minister for Health. Before we start the hearing, I note that we will have to take a short break in the committee proceedings. The Legislative Council has a quorum call, which will occur at 9.30 a.m. When the bells ring, we'll stop the feed and we'll head out. We'll be back within about 10 minutes, probably a bit less. That's for anyone watching who wants to follow along.

As you're aware, minister, this is an open and public hearing. It is broadcast and transcribed by Hansard. I encourage members to make sure they're using their microphones when they're speaking so it can be accurately recorded.

Everything you say before the committee is covered by parliamentary privilege. That may not extend beyond the room. If there's anything of a confidential nature you wish to share with the committee, you can make that request. Otherwise, it is all public. I'll ask the other people at the table take the statutory declaration shortly.

Before we start, I'd like to make this statement, as I have in previous committee hearings.

I recognise that during these public hearings we will discuss highly sensitive matters that have deeply impacted the lives of some Tasmanians, particularly children. This may trigger trauma for committee members, ministers, departmental officers and members of the community. I also acknowledge the victim/survivors who bravely share their experiences with the commission of inquiry and thank them for their courage.

I remind all those on both sides of the table to keep this in mind and to take a trauma-informed approach to questions being asked and responses being given.

I also encourage anyone impacted by the content matter of this hearing to make contact with the support services that are available. These include the statewide Sexual Assault Support Line on 1800 697 877 or 1800 SUPPORT, Lifeline, the 24-hour crisis support line 131 114, the Tasmanian Lifeline from 8:00 a.m. to 8:00 p.m. 1800 984 434, 13YARN, a support service for Aboriginal and Torres Strait Islander people 139 276, and Relationships Australia Tasmania from on 9 a.m. to 5 p.m., Monday to Friday 1300 364 277.

Minister, having said that, I invite you to introduce the members of your team. I will then ask them to make the statutory declaration. I will then ask you to provide an opening statement if you wish. We have limited time, so I encourage responses to questions, and our questions, to be quite short and succinct so we can get through all the recommendations.

Mrs PETRUSMA - Thanks, Chair. I introduce at the table Dale Webster, secretary, Department of Health; Michelle Searle, acting deputy secretary, Community Mental Health and Wellbeing, Department of Health; and Ian Thomas, chief risk officer, Department of Health.

Mr DALE WEBSTER, ASSOCIATE SECRETARY, **Mr IAN THOMAS**, CHIEF RISK OFFICER and **Ms MICHELLE SEARLE**, DEPUTY SECRETARY, COMMUNITY, MENTAL HEALTH AND WELLBEING MADE THE STATUTORY DECLARATION, AND WERE EXAMINED.

Mrs PETRUSMA - Good morning. I thank the committee for the invitation and welcome the opportunity to appear at the inquiry today alongside the secretary, acting deputy secretary, and the chief risk officer.

Institutional child sexual abuse has caused enormous harm to many Tasmanians. To all survivors of child abuse who shared your personal experiences through the commission of inquiry, and to all those who spoke out on behalf of others to ensure their voices were heard, we thank you all for your strength and courage. Our state is deeply indebted to you for your bravery in coming forward in speaking to the commission in the hope that this abuse and injustice that you have suffered never happens again.

On behalf of the government, and as the new Minister for Health, we are deeply committed to ensuring that all necessary measures are taken to safeguard our children and young people in healthcare settings. The commission of inquiry report is a serious and tragic account of failures that must and will be fixed.

Any child sexual abuse is a deeply distressing matter, but when it's within the healthcare system, it not only compromises the trust and safety of vulnerable individuals, but also undermines the core values of our healthcare system. It is our collective responsibility as leaders to acknowledge and to be accountable for past failures and to take decisive action to prevent such harm from ever happening again. That's exactly what we're doing and why we're here today.

The Department of Health and the Tasmanian government are all very committed to implementing all of the commission's recommendations. The Department of Health is the lead agency for two interim commission of inquiry actions, and 24 of the commission of inquiry's final recommendations, including 13 short-term recommendations.

The interim actions and short-term recommendations were all delivered by 1 July 2024, including the two interim actions completed, 26 and 27. The completed short-term recommendations include 15.1, 15.3, 15.4, 15.5, 15.8, 15.11, 15.12, 15.13, 15.14, 15.16, 15.18, 15.7 and 15.20.

In my area of responsibility, the department has a further seven medium-term recommendations to deliver by 1 July 2026 as well as the longer-term recommendation to deliver by 1 July 2029. The medium-term recommendations are 15.2, 15.6, 15.10, 15.15, 15.17, 15.19, and 16.6, with 15.10 already complete. It will be an ongoing response.

The longer-term recommendation is 15.9. My colleague, minister Jaensch, in his capacity as Minister for Mental Health and Wellbeing, is responsible for recommendations 9.24, 12.20

and 12.21. The department is confident that we will deliver these as scheduled as we have done with interim actions and short-term recommendations. Work has commenced on delivering them all.

I would like to briefly expand on the Child Safe Governance Review that was delivered in December 2022, with 92 recommendations on strengthening child safety governance and a focus on the handling of serious misconduct such as child sexual abuse. I would like to thank those who participated in the Child Safe Governance Review, including the independent co-chairs. They are highly credentialed experts, staff and union representatives, and importantly, victim/survivors, who played an incredibly important role through the lived experience expert reference group.

Some key actions that have occurred in response to the recommendations of this review include mandating child safeguarding training for all Department of Health staff, volunteers, contractors and students. Over 15,500 people have completed this training in the initial round and annual refresher training requirements now commenced as of January this year. This is very important, not just for the workplace, but it also means we have an increased awareness of child safety in our communities as well. It also makes it easier for staff to raise concerns about children and young people's wellbeing, by basing full-time child safeguarding officers in each region of the state and updating the department's safety reporting and learning system with new child safeguarding notification type.

The recommendations of the Child Safe Governance Review have largely been implemented, with just a very small number of recommendations connected to longer-term systemic and cultural changes that are in progress. The Department of Health has received a total of $44.5 million funding in the 2024-25 State Budget for the continued implementation of the broader Health portfolio commission of inquiry-related activities.

CHAIR - Are there any overarching questions anyone wants to ask? I will move to the individual recommendations. Thanks for the summary of what's completed, minister. If we go through them briefly, each one that is completed, and hopefully the ones that are in train, if you like, we need more -

Mrs PETRUSMA - Would you like Mr Webster to provide an opening statement as well?

CHAIR - If he has anything further to add, he's welcome to.

Mr WEBSTER - Covered it.

CHAIR - Covered it? Okay. As I understand, 15.1 is the first of yours, which is the short-term one that's been completed in July 2024.

Ms WEBB - Where were the interim ones? Could we possibly ask a question about the interim ones? I know they are completed, but it just -

CHAIR - Some of those are too, but yes.

Mrs PETRUSMA - The two interim actions? The two interim actions were number 26, undertaking a Child Safe Governance Review of the Launceston General Hospital, its human

resources department. Number 27 was the establishment of the central statewide Complaints Management Oversight Unit, which is responsible for reviewing reports of inappropriate behavioural misconduct by Department of Health employees. Did you want further information on both of those?

Ms WEBB - No, I wanted to ask a question about 27, the second one that you mentioned, about the complaints handling mechanism or the oversight unit. That's now been in place for a period of time. I'm interested to hear about how that's functioning in terms of the complaints coming through and how it compares to the systems that were in before. Just so we can get a sense of its functionality and improvement, I hope, on what was in place before. Have you got data?

Mrs PETRUSMA - Yes, because the complaints one is also related to recommendation 15.16, so we can cover it more there if you prefer.

Ms WEBB - That is fine. We can leave it until then if you would like to. It was separately listed as an interim. I wanted to - but we can leave it until - was it 15.6?

Mrs PETRUSMA - Chair, 15.16 is responding to complaints and concerns, where we can cover it more robustly in -

Ms WEBB - We can roll it on the end, if you like. That is fine.

CHAIR - Yes, put it in there because it would make sense for reporting.

Ms WEBB - No problem.

CHAIR - Cassy, did you have one?

Ms O'CONNOR - Yes.

CHAIR - If it can be referred to another one, we will do that, but just ask your question.

Ms O'CONNOR - To the interim action on the Child Safe Governance review at the Launceston General Hospital's HR department - what were the findings and outcomes of that review?

Mrs PETRUSMA - I probably can't table mine, but I actually have the implementation status of the 92 recommendations, as well as the eight Launceston General Hospital Community Recovery Initiative in their status. I can indicate there are only just a very few that are still in progress. Most of them have been completed.

Ms LOVELL - Is that a public -

Mrs PETRUSMA - It is on the website, but would you like us to table a fresh copy?

CHAIR - You can table it. We haven't got it for our records. If you have a copy that you are happy to -

Mrs PETRUSMA - Mine has got scribble all over it.

CHAIR - That is right. We will take the secretary's, that might be tidier.

Mr WEBSTER - To explain the document we just tabled - the document actually is 100 recommendations, even though the Governance Advisory Panel only made 92. That's because at the same time we ran a community relations - or community recovery exercise. The panel that did that, made up of Elizabeth Daly, who's the former Children's Commissioner, and Malcolm White, who's the chair of RFDS, made a further eight recommendations. We combined them with the 92 and monitor them as one set.

The Chair and Deputy Chair of the Governance Advisory Panel were Professor Deb Picone, a former Director General of New South Wales Health, and Karen Crawshaw, a former General Counsel of New South Wales Health, a lawyer. They stayed on for 12 months after the panel finished its work.

The process we went through is that we had to satisfy them that we had completed the action before it got the tick in that report. You'll see that everything is actually completed, but there are a number of the recommendations that you'd never complete because they're an ongoing thing that we need to do. That report is a summary provided to us, if you like, by the Independent Chair and co-chair making sure that we actually follow through on the actions.

Ms O'CONNOR - Okay. Are the recommendations of the review, to your mind, the outcomes of that review? What did the review determine in terms of the child safety of the organisation, and in identifying some of the really serious failings that have brought us to this point?

Mr WEBSTER - Through the minister, it made a number of things. The first of those was that the clinical leadership team of the LGH needed to change and we needed to restructure how we were responding in that particular hospital. That we needed a child safety and wellbeing framework, that was a recommendation of the CI as well. That we actually needed to train our staff in their obligations under child safety and, particularly, there were reporting obligations. That we enhance the leadership, for instance, to ensure that we had multidisciplinary input to enhance the role of the Director of Allied Health and make them part of the leadership team, so that we had more than just doctors and nurses as part of the team. The changing of a few of the structures - we had large clinical groups and they recommended that we split them and therefore we had leadership closer to the frontline, if you like.

In the report, it's also around communication and how we were communicated across our hospital. The work led to development of values for the LGH, which have then been adopted by the Department of Health. It led to the establishment of a Child Safety and Wellbeing Service within the Department of Health, which was matched to a COI requirement. It basically said that we needed to change how we operated at the hospital level. It was targeted at the LGH, but the department has taken that as a criticism of the entire network and changed how we've operated the Department of Health as a whole, in line with the recommendations.

Ms O'CONNOR - Can I ask, just finally, has that led to changes in clinical leadership across the health service?

CHAIR - This will be picked up in some of the other recommendations, I think. Will it?

Ms O'CONNOR - Yes, but it just - I mean, I'm happy to move on, but now that we understand that that review led to systemic statewide changes, did we see the movement of clinical leadership in the process?

Mrs PETRUSMA - When you look at the recommendations in the document, you actually see quite a few different positions we've moved and changed. They're quite well-detailed in that report of 100. You'll see quite a few different changes in there.

Mr WEBSTER - We changed the structure so that we split north from north-west. We actually had leadership in the north-west as well as in the north. Therefore, people could focus more on their local region. You'll see from our organisational chart that the leadership of our three regional hospital and primary care areas has significantly changed since 2021 when the original panel was set up. At the LGH, the Chief Executive, the Executive Director of Operations and Performance, the Executive Director of Allied Health, Executive Director of Nursing, and the Executive Director of Medical Service have all been employed since 2021.

Ms LOVELL - Can I clarify for people who might be watching the proceedings that that report is available on the Department of Health website.

Mr WEBSTER - That's right.

CHAIR - Whereabouts? I find that I've been looking for stuff on this website for some time and you tend to circle back. If you could have a clear description as how to get to it for people to find it.

Mr WEBSTER - We will table a link once we get it. How's that? I don't have my computer open.

Mrs PETRUSMA - I googled it, for what it's worth.

CHAIR - If you just go on the website and look, it's quite a tortuous process.

Ms LOVELL - It's not easy to navigate.

Mrs PETRUSMA - Would you like us to email you the link, Chair? Would that be the easiest?

CHAIR - Email it to the secretary. That would be helpful.

Mr WEBSTER - It's a long URL, so we'll do that.

CHAIR - Email it to the secretary.

Mrs PETRUSMA - We'll email it to the secretary.

CHAIR - Are we okay to move on then to the next - then we go to 15.1, which is completed. Did you want to add anything to that, minister? I know it is completed.

Mrs PETRUSMA - To show proof of completion, I'm happy to table the Policy Framework 2024-29 and the Implementation Plan 2024-29. That shows the work that has been

done in regards to the safeguarding reforms and recommendations. The framework outlines the background, context and further details of the broader child safety reform and review environment within the Department of Health, which addresses requirements 15.1(a), (b), and (c) of the recommendations.

The Implementation Plan captures accountability status and time frames for the implementation of all recommendations of the commission of inquiry and other child safety reviews, which addresses requirements 15.1 (d), (e), and (f) of the recommendations. They cover all the recommendations of 15.1.

CHAIR - They're a bit easier to find on the website. No other questions on that? Otherwise, we'll move to 15.2, which is a medium-term, I think we call it?

Mrs PETRUSMA - Do you mind if we do - that's alright.

CHAIR - We're just working through in numerical order. It makes it a bit easier for our reporting.

Mrs PETRUSMA - Recommendation 22 is to be completed by July 2026. This is implementing the National Principles for Child Safe Organisations. The Department of Health's Child Safety and Wellbeing Framework outlines the department's approach to the implementation of the National Principles for Child Safe Organisations and Tasmanian child and youth-safe standards. The implementation is supported by our Child Safety and Wellbeing Policy which articulates the department's commitment and obligations to creating and maintaining a child safe organisation, and explains key features of the department's approach to meeting the National Principles in the Tasmania Child and Youth Safety Framework. A Child Safety and Wellbeing Service has also been created to oversee the implementation of the framework and its related policy framework.

It is in progress. I do have quite a lot more information that I could read out, but if there's maybe specific questions in regards to this - we can table the documents soon. I'll table the Child Safety and Wellbeing Framework.

Ms O'CONNOR - What does all that mean in practical terms? In terms of implementing the national principles across the health service in practical terms, in real terms, what has changed and where?

Mr WEBSTER - I think the first thing is that we established a Child Safety and Wellbeing Service. A group of, if you like, dedicated staff across the network - and critical to those is in fact a group. They've changed their name recently, but I'll call them by their old name, which is child safeguarding officers. They are staff with expertise who actually sit in our regions alongside our CEs to monitor the education efforts in the regions, but also support the chief executives with advice about child safeguarding issues and things like that. They also are liaison point with child safety liaison officers, who are DECYP staff who also sit within our hospital network to be the liaison point between child safety and health, should a child in out-of-home-care, or coming into contact with child safety, need a health service. So, as a part of that, is there. The Child Safe Service also then has staff.

We have changed our approach with our safety learning and reporting system. One of the things we learned from the governance advisory panel and repeated in the commission of

inquiry was that staff felt that to make a complaint you needed evidence. It was almost like you didn't report unless you could make a judgment that you felt they'd done something. We've tried to change it to reporting without judgment. In other words, we don't use the word 'complaint', we use the word 'concern'. If you've got a gut feeling, put it in the safety reporting and learning system so that we can pick that up. It might be a series of those gut feelings come together to say we should be doing something about culture, or we should be doing something to report this to working with children or indeed, you know, there is a professional boundary breach that we should be dealing with through AHPRA. That change to how we will report is really important first step.

Ms O'CONNOR - Who is reporting and who do they report to precisely? It's all THS staff?

Mr WEBSTER - All Department of Health staff, including the THS, can use that to report. It goes through to two spots. Our central complaints monitoring and oversight unit can see it, but our Child Safety Service can also see it. Then another thing that was set up under this banner is in fact what is a standing governance advisory panel that's aimed at children. We've set up a panel of five people made up of - the chair is a social worker, we have a psychologist on that panel, we have a lawyer, we have the CEO of Child Safe Victoria, and we have a lived experience of a younger person who's been through out-of-home-care in their earlier life.

They form what we call our child advisory panel. There are panels set up under the THS act to advise the secretary, and they get the reports that are coming through, they're monitoring that at their meetings. I also have the ability to refer a matter for investigation by that panel. They're also doing things like site visits to have a look at how we're doing at the local level. Child Safety and Wellbeing Service is more than just staff. It's this independent group as well, that look at what we're doing and give advice direct to me. This roams across a few recommendations, the Child Safety and Wellbeing Service also set up our child and young persons advisory group that give us feedback.

CHAIR - Do those two groups interact with each other?

Mr WEBSTER - Yes.

CHAIR - That panel talks to the children themselves to get their perspectives, yes?

Mr WEBSTER - That's right. In addition to that, we do ad hoc activities. For instance, in our school holidays earlier this year we had some children come in and do play activities around what made them feel safe in a hospital setting so that we could do that. Last year in putting together our materials -

CHAIR - If we could just - sorry, I know you're in mid-flight, Mr Webster. We need to suspend the hearing for a moment and we'll be back in about 10 minutes.

The public hearing suspended from 9.26 a.m. to 9.36 a.m.

CHAIR - Apologies for that interruption mid-sentence, Mr Webster, but if you'd like to continue.

Mr WEBSTER - What you'll find in the framework that we tabled is that we wrote that before as part of the government's advisory panel recommendations. We revisited after the COI and we've gone through and embedded the national principles in our framework through that. Just to wind up on that, part of it is not just staff reporting and staff having concerns. We want to actually hear directly from children and parents. With our website, at the bottom of every page now is actually a report of concerns link. Across our hospitals proactively in our Wombat Wards, which is what they are called in the north, and Penguin Ward in the south, we have the My Say, Our Voices booklet, which, through the minister, we can table - which is a way of children communicating not just in words but with drawings. All the drawings that are in that book came from children who attended one of our sessions to give us feedback about what it meant to be safe in our hospitals. In fact, the Penguin and Wombat Ward idea is coming from those same panels.

The other thing, just to wind up, is a summary of the learnings that we got from the sessions that we did with children and young people in 2023-24, which again, we can table. It is a document done to summarise the activity over that 12 months. We'll do that each 12 months. We're making sure we're following through on the learnings that we get from our young people as part of the framework.

CHAIR - Just on that, Dale, with this booklet, were these children who were engaged in that, children who had been in hospital, or were they just random children that you asked to participate?

Mrs PETRUSMA - When you read through it you'll see the children in hospital who are saying things like what ice cream flavours they'd like to see -

CHAIR - You've lost your copy, you want one back?

Mrs PETRUSMA - No, that's alright, I have mine here. It talks about ice cream, what they like about in hospital, what's the good, what's the bad. You know, that was boring, needles are not good, nose tubes suck. It's what they suggest for the adolescent ward. It's actually an interesting read when you have a look through it.

CHAIR - These were children who had been in hospital?

Mr WEBSTER - Children and young people with experience of our health services, not just hospital, but other services. The idea of this booklet is to encourage very young children to give us feedback not just in words, but drawing their own pictures of their experience and things like that as well.

Ms LOVELL - Is this given to all children who come into those wards now?

Mr WEBSTER - Yes.

Mrs PETRUSMA - The youngest who participated in it was Felix, who was four, and ranged up to Alex who was 17. But yes, a wide range of children and young people actually helped develop the resource.

CHAIR - Have their views about what's good and what they'd like been taken on board?

Mr WEBSTER - Yes. Things like they didn't want to call it a paediatric ward, it doesn't mean much for children to call something a paediatric ward. Changing the name of the wards was part of that. At the LGH, we have looked at the adolescent area and how we can reconfigure that, the request to have their own access to some food during the day and things like that. We take it on board and try to adjust what we are doing.

Mrs PETRUSMA - Chair, so that we can continue to hear from children and young people about how we can improve our services, we do have these up around wards. They are also given these handouts so that they can draw and write in their own words or in a picture how further we can improve services as well.

CHAIR - Can they raise complaints through this sort of mechanism too, or concerns? Like, if a child was feeling unsafe they could draw it, write it down and give it to a staff member?

Mr WEBSTER - Yes, that's the idea of it. They have many different mechanisms, not just a QR code and an official government form, but you can do a drawing, you can say a few words and give it back to us.

Ms LOVELL - What's the process if they do fill out something? How quickly are they monitored or checked for that sort of thing? What happens then?

Mr WEBSTER - As I said before, those would then go into our child safety and our central complaints, so that both are monitoring them. Depending on severity, by the way, we then also report externally from those mechanisms. The follow-up is straight away. We get back to the hospital as well to make sure they are involved in what needs to be done as well. There is that central oversight to make sure we are doing it from our two units, and then the local effort as well.

CHAIR - I will go to Cassy. I think she has a question on this area.

Ms O'CONNOR - Thank you. Cecily Rosol, my colleague who's unwell today, has referred me to a statement put out by the Australian Nursing and Midwifery Federation in relation to the Wombat Ward from May-June this year. They were really concerned that members were raising child safeguarding issues, related to the care of patients with mental health issues, that were going repeatedly - according to the ANMF - unheard. It related to the environment and the fact that voluntary patients to the Wombat Ward were being secluded. That's only a few months ago, so what's changed?

Mr WEBSTER - Through you, minister, we might want to go in camera for this. This is about an individual.

Mrs PETRUSMA - Right, can we go in camera for this one, please, Chair?

CHAIR - We can. It's probably best to do it now and then come back out.

Mr WEBSTER - Just to explain - because of the small number, this will identify an individual.

CHAIR - That's fine. You make that request because it identifies an individual. If we could ask you to step out of the room while the committee deliberates, we will just stop the feed.

The public hearing suspended from 9.43 a.m. to 9.54 a.m.

CHAIR - Thank you, minister, we will come back out into public session and note that the matter was discussed in camera. I wonder if you or the secretary are happy to provide some context for the public record.

Mr WEBSTER - Thanks, Chair. For the public record, we heard the concerns of our staff and the concerns summarised by the ANMF in the media release, and responded with information and training to our staff in that area so they understood what we were doing, and that resolved the issue.

CHAIR - And there were no further complaints?

Mr WEBSTER - No further issues raised.

CHAIR - I've got a question of this particular area. In terms of putting in place - and some of this works fantastic and it's really great, particularly for engaging with young people - what measures are you taking to actually measure the changing culture for staff who were concerned about raising a complaint without evidence, or without something concrete, rather than just raising a concern? That, I expect, would be able to be demonstrated in some manner. How are you measuring that and what are we seeing in terms of comfort in raising concerns?

Mrs PETRUSMA - Chair, we will be going into 15.3, which is the Cultural Improvement Program next.

CHAIR - If you cover it there, I'm happy to wait till then.

Mrs PETRUSMA - I think cultures best come under that one.

Ms LOVELL - My question might come under that one as well. I was interested particularly in regard to the framework, which is very comprehensive. What work has been done around education and training of staff?

Mrs PETRUSMA - There has been a rollout of child safeguarding mandatory training to all workers, including staff, contractors, students and volunteers. The mandatory training is an annual requirement for all workers.

Ms LOVELL - What does that training look like? Is it like an online course? Is it face-to-face? How long is it?

Mrs PETRUSMA - I think it's online, but I think they have been looking at different methods as well of conducting the training, considering that there are different literacy levels, just to make it easier for some people to do the training. I'll ask the secretary to provide more information.

Mr WEBSTER - It is an online package that we put together with an external provider. I've forgotten the name of the external provider. It will come to me. We also identified that there are large parts of our workforce that don't actually have access to a computer on a daily basis. We did things like set up kiosks around the network, so that staff who didn't regularly have access to computers could go to the kiosk if they were comfortable using the online materials. We also then ran face-to-face sessions, which was the same material but delivered face-to-face for those who, for computer literacy or indeed English literacy, didn't feel comfortable using the online materials. There was face-to-face training available to them. This is an ongoing role of our child safeguarding officers, to monitor if people actually have access to the materials in an understandable way and if not, do that face-to-face training.

In addition to that, myself, as the then deputy secretary responsible, alongside the then secretary and the then chief risk officer, also went round and did grand rounds - which is just another way of saying staff meetings - in each of our hospitals to raise awareness of the training and to make sure people knew that they need to do it. We also followed that up with very careful monitoring, as in ticking people off a list to make sure they'd actually done the training to get to -

Ms LOVELL - Has everyone done the training now?

Mr WEBSTER - We got to 100 per cent as at a point in time. Then it becomes part of our - what we call our Tier 1 Mandatory Training. It sits alongside things like hand hygiene and everyone in the network has to do it every 12 months. The name of the organisation was Child Wise.

CHAIR - We'll go to 15.3.

Mrs PETRUSMA - Thank you, Chair, 15.3 is the Cultural Improvement Program. This recommendation is complete. We do see that our people are the greatest assets in our health system. We want them to be in a workplace of choice where they all feel valued and staff are recognised and individuals feel empowered to make positive changes and are given opportunities for growth.

To address recommendation 15.3, the department has introduced its One Health Culture Program Strategy, known as One Health, designed to drive cultural improvements, supporting staff to work together, learn, collaborate, and problem solve, share risk, and empower and respect each other. It is about building a better working environment that supports employees to work together to improve the health and wellbeing of Tasmanians.

One Health has five focus areas: leadership accountability; building a capability; workplace values and behaviours; health, safety and wellbeing; and systems and processes. It brings together all the various cultural wellbeing and non-clinical development initiatives already underway across the department. I can table for you the One Health Cultural Program and Strategy document as well as the first annual report.

CHAIR - Going back to the question I asked previously then, minister. There may be some information in that first report, but I am interested to understand how you are monitoring and measuring a change in behaviour. Particularly, knowing what some of the barriers, perceived or actual, were to reporting in the past.

Mrs PETRUSMA - The annual report does help to measure change as well. The annual report does talk about progress and other things.

Mr WEBSTER - You will see in the strategy document, when you have a look at it, there are actually a number of KPIs that were built into that. These monitor our performance in the state service survey, for instance. Are we improving across the categories in the state service survey? Also other areas about levels of reporting and those sorts of things. There are a number of KPIs.

The first January report looks at, if you like, actions, because we didn't have a baseline. The second annual report, which will come out in the next few weeks - the delay there has been the TSS survey has only just been published. It gives us the opportunity to compare performance last year against this year for the first time in an annual report. We are busily trying to put that together now, so that we can actually see that.

The KPIs are about making sure that the strategy isn't just a series of actions, you know, 'Do leadership training, do -' but, in fact, that we actually see some improvements in our network as we go .What I can say is that, across the establishment of our complaints, et cetera, network, for the first time we are actually able to monitor the number of complaints across it. Previously, complaints went to the area where you were complaining about. If you had a complaint about the Launceston General it went to the Launceston General. There was no central oversight of how many complaints were going where.

CHAIR - Is that all complaints related to health, or child safety complaints as a separate -

Mr WEBSTER - All complaints now going to health go through this central complaints mechanism.

CHAIR - With matters related to child safety, are they, somehow, flagged and prioritised? Some of the complaints you'll get are someone's delay to care and things like that, which are still important, but perhaps not as critical as attending to promptly.

Mr WEBSTER - That's why, also, we have the Child Safety and Wellbeing Service. That gives the priority to making sure we are reacting to those child safety complaints and they are getting that priority. Secondly, that we are reacting to, if you like, the gut feels. You know, five or six staff have a gut feeling that something's wrong, and our child safety service is making sure that they are connecting those dots and we are responding to that as well.

CHAIR - If a complaint was raised through the health complaints portal, not through the child safety one, is it automatically flagged and referred?

Mr WEBSTER - Yes. We independently flag that as well, outside of the agency.

Mrs PETRUSMA - If you read the actual strategy itself, there are performance measures and indicators for each action area. In the annual report, you'll see how they have been assessed as complete, underway or et cetera. Keeping in mind that another annual report will be coming out in the next few weeks.

CHAIR - Can you provide the committee with the next annual report once it's available? Assuming it will be before we are back to hear from you again?

Mrs PETRUSMA - Once it's available.

Member - Did you want to add?

Mr WEBSTER - There was one category that has just been passed to me, in the TSS survey in 2023, 'I'd be confident approaching my manager to discuss concerns and grievances' - 78 per cent were confident, that has gone up to 79 per cent. A slight change there, but, we need to keep monitoring that and obviously. It would be nice to have that in the nineties, really. That is the sort of monitoring that are in the KPIs, so we are tying it back to the TSS.

Ms WHITE - That was going to be my question. It was about that recommendation, (f)ii which is:

> (ii) To empower staff to feel safe and supported, to raise concerns about colleagues with their leaders

That was an obvious problem, that whistleblowers weren't able to raise those issues, but that sounds like you're identifying a way to measure that directly. It would be good to see it much higher, as I think that's been a significant failure across health from the evidence we heard through the commission of inquiry.

What other feedback are you receiving beyond the survey from staff about how comfortable they feel raising concerns about their colleagues?

Mr WEBSTER - Through the safety reporting learning system, normally if you put in a patient safety report, it will flag with your direct manager and others depending on the level of the rating. We rate them from SAC 1 down to 4 -

Ms WHITE - What does SAC mean?

Mr WEBSTER - I knew you were going to ask me that.

CHAIR - It's a [inaudible] event, isn't it?

Mr WEBSTER - Yes. Anyway, they're rated from 1 to 4. If it's a 1, that, in fact, besides your manager getting that, it will actually flag to every level up to me.

Ms WHITE - That's the most serious?

Mr WEBSTER - That's the most serious. So I get every SAC 1 across the network flags on my email so that I can monitor. That is death or near miss type of level of patient safety. Obviously, you lodge that, everyone in the network can see that you've done that.

Ms WHITE - When you do lodge that, does it identify you as the person who lodged it?

Mr WEBSTER - That's right.

Ms WHITE - It does. Is there a way to make it anonymous?

Mr WEBSTER - That's what I was going to say. With the child safety we have actually made it anonymous and the reporting is through to the central teams, so that you don't have that same fear of the issues. 'Severity Assessment Code' is SAC.

Mrs PETRUSMA - In regard to that, I will table 'Do you have a complex or sensitive complaint', which goes through how they can do things anonymously. Also, how do we go in reporting concerns of inappropriate behaviour. These are throughout the hospital in different areas and stuff.

Ms WHITE - Posted up on the notice boards?

Mrs PETRUSMA - And in toilets. It so that we can encourage our staff to actually make anonymous complaints and to report up.

Ms WHITE - Coming back to my question then, so you're doing a survey to get feedback from staff. Are there other ways for you to understand how staff feel about these new processes?

Mr WEBSTER - Kath, and now I as secretary, are doing regular sessions in our hospitals so we get that direct feedback loop. The second part of it is making sure that - and this is the advisory panel that I spoke about, the standing advisory panel under the act - the purpose of their on-site visits is they can then gauge and get feedback. We're trying to create as many opportunities for feedback that aren't the traditional structures of feedback. The purpose of having child safeguarding officers out there in the network is, instead of being someone who's come from central office, they're actually working in the hospital on a day-to-day basis and hopefully picking up the feedback as well.

It's hard. You've got to break down the traditional methodologies because I feel, and I'm sure Kath felt this, if I go out there it's like a royal visit. People stop what they're doing and things. So it's not -

Ms WEBB - It's sanitised.

Mr WEBSTER - It's sanitised, exactly. It's better that other people are giving me feedback about what's going on, as well as me spending time out there.

Ms WEBB - A lot of these look really positive. Certainly, even when you look at the different departmental websites, the Department of Health has the clearest and most thorough information about making reports of complaints or concerns. Congratulations on that.

On that data you shared from the survey about the two in 10 who aren't necessarily confident to report something to their manager, what do you do then to find out about why that is? Like in the circumstances where there are particularly, I suppose, whether it's systemic issues or whether potentially it's, I guess, person-based issues - because presumably that's your next level of improvement. If you want it to be up in the 90s instead of 79, how do you understand that figure then?

CHAIR - Assuming it's anonymised, the feedback.

Ms WEBB - That's right, so what's the next step beyond receiving that data, which is useful?

Mr WEBSTER - I think that's where the One Health Culture strategy kicks in. We change the way we're operating in terms of accountability, our leadership training, those sorts of things, to encourage people to better understand what we're doing.

When you think about it, in our health service, people get promoted because they're a good doctor, a good nurse. It's the thing that happens in technical or professional areas. The promotion is based on your skill setting, your technical area, rather than your leadership skills. Part of the One Health Culture is we need to provide leadership training. We need people in leadership roles or management roles to be leaders. Having the training there is part of it. Encouraging it through the mandatory training that we offer, which is the reporting.

The last thing is acknowledging that we have 20 per cent who aren't comfortable. Having the anonymous portal is really important. If that was 100 per cent 'feel comfortable', you wouldn't need an anonymous portal. You have to recognise that if you've got 21 per cent who are uncomfortable, give them another method. That is really the key to that. Then try to get that confidence by changing the way we operate through leadership training and those sorts of things.

Ms WHITE - I'd imagine, too, that they'd be members of unions. They might raise their complaints through their union so they could protect themselves from being the person who raised the issue. How are you engaging the unions in the work that you've just described for the committee?

Mrs PETRUSMA - I've met with the unions since being minister and taken on board their concerns. I attended the HACSU conference. I even said to the people there that they can email me anytime as well, which some have. I'm happy to take those on board. If they wish to be anonymous, we've handled those issues anonymously. I'll ask the secretary to provide further information.

Mr WEBSTER - The first thing is that our Governance Advisory Panel that set up our framework included the unions. We actually had Emily, Lara, I don't think it was Tim, but it might have been Tim, and Thirza on that panel, that input to the framework. There's knowledge within the unions. Then there's just that encouragement of, we need to know about these things. As you know, unions will raise them. The minister meets with them regularly. I don't think there's a week goes by that I'm not talking to three of the four that I just named. A bit less time that I spend with Thirza, but the other three I'll probably talk to most weeks and formally meet with them monthly so we can get that feedback from them, which is an important loop.

I sort of mentioned, it was a pity it went through the media, but it was actually good to get that feedback from the ANMF, because it really did reinforce that we needed to do a bit more about the communication. For the first eight weeks of that, we were very focused, patient-centred if you like, and forgot about the fact that you've got these other feedback loops you have to do.

Ms O'CONNOR - Minister, this is also a question from Cecily Rosol. Recommendations 15.3 and 15.5, obviously which we'll get to shortly, relate to culture and accountability within health, and specifically call out the need for holding senior executives and managers

accountable to respond appropriately to the actions of their staff. The government's response indicates on page 57 that this has been completed. I'm sure you'd agree that cultural change is not a task that is ever completed.

The responses from 23 September, all DoH staff, including members of DoH's Senior Executive, have child safety documented as an accountability in their statement of duties. How is this accountability documented in the statement of duties? How is it measured in the annual performance review? Are there specific key performance indicators that need to be addressed? How is this accountability documented in the statement of duties?

Mrs PETRUSMA - I'll just start off, I'll just say that because it's complete, as we outlined at the start, a lot of these are ongoing, of course, too. What was required has been completed, but they're ongoing. Quite a number of recommendations will be ongoing. I'll ask the secretary to the accountability.

Mr WEBSTER - Through you, minister. The One Health Culture Program is a 10-year program. In saying it's completed - in the Governance Advisory Panel, you'll see there's a dot next to it that says, 'First step completed, but ongoing'. The statements of duties for everyone in health were changed with an insertion around child safety. I might have to pass to the deputy secretary to actually tell you the exact wording of that.

Ms O'CONNOR - That would be helpful.

Mr WEBSTER - It's then built into the PDAs, but there's also a statement of commitment. If you join the health executive, you actually have to sign a statement of commitment around child safety. The other issue is that in our health executive, we actually have a separate meeting that is only on child safety. We don't actually have it as an item at a regular meeting. We have a separate meeting so we can focus on child safety at that meeting. I think the additional thing is that the rules around mandatory training apply to all our health executives across the board.

The final thing before I hand to Michelle is that, from July this year, there are now what we call monthly accountability meetings where each of the members of our health executive are sitting down with the secretary, and previously the associate secretary was involved, and we work through accountability issues such as people, risk, finance and these type of issues, complaints, et cetera. We've taken, if you like, the first part of the culture program leadership and accountability to the level of, 'We need monthly accountability meetings from the executive to the secretary'. Within our hospitals and primary care division, that flows down that each of the executives below our chief executives also has a monthly accountability meeting with the chief executive to inform the meeting that then occurs with the secretary.

Ms SEARLE - We did update all our statements of duties, as the secretary has discussed. Really, that is so that all of them have under key accountabilities and responsibilities, that we champion a child-safe culture that upholds the national principles of child-safe organisations. The department is committed to the safety, wellbeing and empowerment of all children and young people, and expect all employees to actively participate in and contribute to our rights-based approach to care, including meeting all mandatory reporting obligations.

Within our professional development templates we have updated those so that there are sections in there where they can reflect on the care values so that we embed the care values as

part of our everyday working. Also for executives, there is a section around how we are implementing the commission of inquiry recommendations, and how we're implementing child safety across our organisation. There is that extended level of accountability for executives.

We do have our Aspire leadership program, which is obviously out of the One Health program. That was really part of picking up the desire around improving leadership accountability across the organisation, noting that a number of our senior leaders do step up into executive roles. It's not just about having us as being accountable, it's the next level down as well, and so that we're embedding that across the organisation.

Ms O'CONNOR - Thank you for that. How is that accountability measured in your annual performance review?

Ms SEARLE - We do have an annual performance development discussion, but obviously, as the secretary's commented on, we do have regular discussions through health executive in relation to child safety. We have quarterly updates from the child safety and wellbeing team that provide updates in relation to the trends that they are seeing and the work that they are doing. We also do have ongoing discussions, as you would through any management, with the secretary on the progress.

Ms O'CONNOR - Thank you. Are there specific KPIs that need to be addressed as part of these statements of duties, and form part of the performance review discussion?

Mr WEBSTER - They will vary from executive to executive. Obviously - chief people officer for instance, that's Michelle's usual role, which is why she was able to give that comprehensive answer - are around, basically, do we have the process in place, have you completed the task on this? Those sort of things. Importantly, the COI health executive goes through the individual Governance Advisory Panel recommendations that are ongoing, but also the COI recommendations, to say 'What are we doing in this space?' That's the measuring body, if you like, where we get the reports on our performance in this space.

Ms O'CONNOR - Is it undertaken individually?

Mr WEBSTER - Sorry, yes.

Ms O'CONNOR - When there is an annual performance review?

Mr WEBSTER - Yes.

Ms O'CONNOR - Okay, so there is a way to measure?

Mr WEBSTER - That's right. The performance development and assessment documentation has KPIs built against each one. They will be different for each health executive, depending on their role in the organisation. Then, at the end of - in fact, every six months rather than every 12 months, but 12 months formally; six months informally - we go back and say 'What's your performance against those KPIs? Have you achieved them? What's your progress if you have not achieved them?' Those sorts of things. They are designed for each executive.

Ms O'CONNOR - Thank you for that. In the government's response on page 58, there is mention of an update to the performance and development discussion template, 'To help

managers support employees to understand their responsibilities relating to child safety, mandatory reporting, confidentiality and cybersecurity'. It links to the document from within the PDF. The link redirects to the DoH intranet and requires a login to access. What's in the template?

Mrs PETRUSMA - I can table both of those if you'd like.

Ms O'CONNOR - Okay, thank you.

Mrs PETRUSMA - I am tabling the performance and development discussions and overview, as well as the performance and development agreement report templates.

Ms O'CONNOR - Why wouldn't those sorts of documents be more publicly accessible?

Mrs PETRUSMA - Probably because they are internal to the department, but I will ask the secretary.

Ms O'CONNOR - People should be able to find these sorts of things, though.

Mr WEBSTER - Reflecting on it, as you ask the question, we have no reason why they wouldn't actually be on the public website, other than, our public website is incredibly large and incredibly hard to navigate. I can tell you that our internal website is almost as large and is almost as hard to navigate. We will work out a way to get them up there attached to the child safety space of the website. There is no reason why they are not public documents, other than that they are a form that we use internally and the form section is on the intranet rather than internet.

CHAIR - Thanks. We will move then to 15.4. This is one that is marked as completed on the website. Is there anything you need to add on that, minister, or are you happy to go to the next?

Mrs PETRUSMA - No, it is completed. It is completed through the One Health Culture Program, and the St Vincent's Health Australia's Ethos program. It is designed to remove barriers to speaking up, by providing an avenue which is fast, fair and transparent. The department is mirroring the themes of that program when developing its own activities as part of the One Health Culture Program. I could extensively go into it, but it's -

CHAIR - Are there any other questions on that one?

Ms O'CONNOR - Is that strategy publicly available? The One Health Culture strategy?

Mrs PETRUSMA - Yes, we tabled that.

Ms O'CONNOR - Is it on the website publicly available now?

Mr WEBSTER - Yes.

Ms O'CONNOR - Again, this well-thought-out question is from Cecily Rosol - is there any specific information about the comparison of the One Health Culture strategy or model in

relation to the Ethos program? What sort of gaps were identified in the One Health Culture strategy, when compared to the Ethos program?

Mrs PETRUSMA - As I outlined to the committee, just a second ago, the department is mirroring the themes of the Ethos program when developing zone activities as part of the One Health Culture Program. For example, the department is implementing activities similar to the Ethos program through CARE chats, a style of communicating which challenges directly, in a compassionate way. The CARE chats model, which aims to support employees in addressing behaviour across the workforce, through proactive communication, is focused on both patient and staff safety. The CARE chats model supports staff to seek out conversations focused on accountability with compassion, to identify and address unprofessional behaviours.

Phase one of CARE chats has developed an evidence-informed communication tool to foster an organisation-wide feedback culture. It involves, training the organisation using the tool through training CARE chats champions, who will train other colleagues. It is informed by the research undertaken by Macquarie University into the Ethos program.

Also, there is another - mirroring the Ethos program, through activities like the Speaking Up for Safety Program and the Speaking Up for Safety Framework. I can go into quite extensive detail. We'll table the CARE chats reference guide.

Mr WEBSTER - Just to explain CARE - it stands for Compassionate, Accountable, Respectful, and Excellent. It was developed by our staff at the LGH as part of the work we did post the Governance Advisory Panels. The agency's adopted the LGH's values because around 2500 staff across the LGH contributed to the process of developing the CARE values, so we've just adopted those for the agency.

CHAIR - We'll go to 15.5. Again, this one's marked as completed. We have touched on some of these things -

Mrs PETRUSMA - I was going to say, Chair, basically about everything that I would have said to you has been already discussed this morning. Probably one thing that hasn't been talked much about is that we do have checks and balances in place to safeguard children and young people through the recruitment processes, such as the necessary employment checks and essential requirements. They've been strengthened by providing specific reference to child safety and wellbeing when actually advertising for positions. People, when they're applying for the position, know upfront that that is a requirement of the role as well. That's probably just the only -

CHAIR - Before any new staff member is on-boarded, they would have had to have done the training before they could actually step into the hospital setting?

Mr WEBSTER - Within the first few days - as part of tier 1, for instance, doctors as part of, might not get this right, credentialing, not accreditation, credentialing, tier 1 happens, if you like, in the first half day of their employment.

CHAIR - That's included, the training and necessary requirements?

Mr WEBSTER - That's right, yes. Mandatory child safety training is now seen as tier 1. It sits alongside hand hygiene, basic lifesaving, that sort of thing.

Mrs PETRUSMA - Also, duty statement, selection criteria, and referee checks demonstrate that children and young people are valued and respected. The department's committed to child safety and wellbeing and understanding of children's development needs and culturally safe practices. It's made very clear by the department that we do emphasise our commitment to child safety and wellbeing when advertising, recruiting and screening staff and volunteers, the way through.

CHAIR - On that matter, minister, when referee checks are done, are those questions specifically asked of the referees, if they can vouch for the person's awareness of child safety matters, as you've outlined?

Mrs PETRUSMA - That's what is indicated in here.

Mr WEBSTER - That's what we expect. I can't vouch for every referee check, but that's what's expected because that's what's built into the statement of duties. When I do a referee check, that's what I'm asking.

CHAIR - Any questions on 15.5? If not, we'll go 15.6. This one's the medium-term in progress. Minister, did you want to update us on how that is progressing?

Mrs PETRUSMA - This is supporting health services to become child-safe organisations. This is outlined a lot on what we discussed under 15.2. The Department of Health has developed a Child Safety and Wellbeing Framework, which we've tabled today, to implement the National Principles for Child Safe Organisations. If you've got any specific questions, because a lot of what is under this one has actually been discussed through our Cultural Improvement Program and the systems in place.

CHAIR - This is one that's never really going to end, isn't it?

Mrs PETRUSMA - Yes.

CHAIR - In terms of monitoring and making sure that compliance is occurring.

Mr WEBSTER - Through you, minister. The next big step in this one is - and we've met with the National Safety and Quality Commission in Healthcare, I think that's what they it call these days, but the national commission that sets the accreditation standards for hospitals. There is an accreditation standard too, under patient safety, which would include child safety, but the commission is now working on additional actions under that priority two, that are specific to child safety. In the future, we'll have to demonstrate all of what we're talking about today to keep our accreditation.

Ms O'CONNOR - What tools will be used to measure staff consistency and compliance with the National Principles for Child Safe Organisations?

Mr WEBSTER - This is one we've spent a lot of time working our way through. You can build KPIs around some of them, but a lot of them are about attitudinal change or behaviour change. It really is monitoring the feedback that we're getting from children, parents, et cetera. Are we seeing consistently the same comments around our network or are we seeing changes in those comments? That's why the Child Safety and Wellbeing Service is an ongoing service.

It's also why the previous secretary set up a standing advisory panel to be independent, to monitor, spend time in the network, but also get the reports and give us feedback. As I said also, they have the ability to do an independent investigation.

All those things are really important. I think the other thing is that in addition to the survey that's done generally across the state service, we need to be building our own individual surveys that pick up, if you like, the non-state-service-y things of health, that's not really a good term, is it? Health sits in the health sector as well. We need to be judging how we're performing as a health service, not just as a State Service. In our hospital network we have a survey called In Sync. We're rolling that out, and we've got to do that across our network, not just in hospitals because obviously other services come in contact with children as well.

Ms O'CONNOR - Can I ask, through that process, is there a way to measure how staff are applying those national child safe organisations principles? I take on board how complex it is to measure, but also if you have mandatory training that's updated each year to be able to be certain that staff understand what they need to understand, how is that captured?

Mrs PETRUSMA - I had completed the unit myself, but when I had to do it, it was - I assume you are still at current - you had to pass certain quizzes along the way to show that you were taking in the knowledge and skills.

Mr WEBSTER - Ultimately, this is why I have met with the national accreditation body to say we need it built into the standards. Then we will have independent snap audits that are questioning us about, 'Are you still implementing this?' The national principles should be seen as a minimum standard, like we have in all other areas of health. We've got to meet the minimum standards. Just like we do with hand hygiene, we've got to do surveys to show that our staff are not just understanding hand hygiene, they're actually using it as they pass through doors and things like that.

That's the important work, and why we're saying this is ongoing is we actually need to build that into our accreditation standards, so that we can actually then start measuring it from that perspective. What I would say to you is that we've got imperfect measures at the moment around KPIs, and get the training done, and those sorts of things. Once we're actually building it into our accreditation, it will become a much better and more rigorous independent look at our performance.

CHAIR - It's also more visible once it's there. You won't get an accreditation if you don't comply.

Mr WEBSTER - That's right. The way the accreditation works is that there are eight accreditation standards, then under those is a number of actions. If you get not-mets then basically your accreditation is in jeopardy, and you get a certain number of days to fix them. If you get met with requirements you get a certain number of days to fix them. If they continue, you can then jeopardise your accreditation. Become a very public thing, if we fail the standards into the future. As I said, it's already built into accreditation standard two, but we're asking them to actually call out additional actions that align with national principles so that we've got further judgement of how we're doing.

Ms WEBB - Sends the right message, doesn't it, to include it there?

Mr WEBSTER - Yes.

CHAIR - Is it more explicit in the assessment?

Mr WEBSTER - That's right. At the moment it's all-encompassing with patient. We want to call it out and say how we are doing on child safety.

CHAIR - Anything else on that one? If not, we will go to 15.7. Which, we have talked a little bit about this one as well. This is the Young Persons Advisory group. I will invite you to give some overview, minister, but I am interested in how these young people are actually appointed.

Mrs PETRUSMA - There are expressions of interest. They met for the first time in October 2023. The inaugural Children and Young People Advisory Group Membership was established following an expression of interest process, open to young Tasmanians aged 12 to 18 years of age. Expressions of interest were encouraged from a mixture of age, gender and representation from a range of backgrounds. This included young Tasmanians with the experience of using Tasmanian Government Health services, such as our public hospitals; Aboriginal and Torres Strait Islander young people; young people with disability; young carers; young Tasmanians with refugee and/or migrant backgrounds; young Tasmanians from rural/regional or remote areas; young people with experience of homelessness and out-of-home-care; young people from low-income backgrounds and LGBTIQA+ young people.

We also had the support of community sector organisations, including the Office of the Commissioner for Children and Young People and the Youth Network of Tasmania who supported the expression of interest process. Several organisations and other jurisdictions also assisted the Child Safety and Wellbeing Service to establish the Children and Young People Advisory Group as well. This support included sharing learnings from their own children and youth participation models and informing the development of the Children and Young People's Advisory Group's foundational documents, such as the terms of reference. These documents have been endorsed by members.

CHAIR - Great, thank you.

Ms WEBB - On that, I was wondering if the purpose and objectives and the documentation around that are publicly available? Around the advisory group, I mean.

Mrs PETRUSMA - I think we actually did table -

Ms WEBB - You gave us that?

Mrs PETRUSMA - Yes, that's the reference, but I don't know if we gave you the 'Have Your Say' - that's how we first of all advertised. Actually, no, I think you got -

CHAIR - We got that one.

Mrs PETRUSMA - There's the terms of reference.

CHAIR - I don't think we got that.

Mr WEBSTER - The answer is yes.

Ms WEBB - Is it publicly available? Thank you. It says there that it's going to be reported on as part of the department's annual report. That has begun being reported on in the annual report for this year?

Mrs PETRUSMA - Yes.

Mr WEBSTER - The comments of the annual report were drawn from the learnings document that we tabled a bit earlier.

Mr STREET - Can I just briefly ask, Chair, it is probably a question for Dale. One of the problems when I was Community Services minister with setting up these advisory groups and asking for young adolescents is that it's very difficult to get a broad cross-section of adolescents onto that. They tend to end up being self-selecting because they are adolescents who are interested in public policy and the issues that are being discussed. How confident are you that you have a broad cross-section on this advisory group, to provide the information that is necessary?

Mr WEBSTER - My confidence is higher than in previous experience because we worked with organisations to find people for us, rather than, just allow people to self-select. It is still not that high because, again, within those organisations you get that level of self-selection. This is why we decided that, alongside the panel, which is the recommendation, we would have these ad hoc groups, where we are just looking at groups of our patients giving us feedback. That sort of broadens out the feedback.

The second thing is, it is very hard for five- or six-year olds to be part of a panel. How do you get their feedback? Again, the ad hoc groups supplement that process. You're right, getting a youth advisory panel that is broadly representative is incredibly difficult. Our approach was to do that, but have these other processes to supplement it.

Mr STREET - Thank you.

Ms O'CONNOR - How is the department undertaking age-appropriate engagement with children, to be sure their voices are being heard?

Mrs PETRUSMA - As we've outlined, there've been several health organisations in other jurisdictions assisting like the learnings from their own children, youth participation models and forming the development and how we do support the children. Also, we've had the support of other community sector organisations including WhyNot and the office of the commissioner for children helping us. We also have a special Child Safety and Wellbeing Services Secretariat. They are consulted at least four times a year, and they're supported and provided with opportunities to present their views. They're provided other supports.

Ms O'CONNOR - Before then, how is that feedback from young people captured? I mean, there's an argument there that, for transparency and a better functioning health service, you would make that feedback publicly available de-identified as well. How do you capture and act on feedback from children and young people who are within that system? You probably have some really important insights? That's one thing. How does it work into system change?

Mr WEBSTER - From that, it builds up into an annual report to health executive, the learnings from these engagements, so that we're picking up through that, which then translates into our annual report, so that we're publicly doing that.

Really important is designing the interaction in the first place correctly. I think you put it in your question quite - I'm not going to go out and do a session with children. I'm probably pretty good with my grandson, but I don't see myself as an expert in getting children to open up. It is actually getting people who have that skillset to run sessions rather than assuming that we can do it, or our nurse unit manager can do it, or whatever. In the ad hoc sessions, we make sure that the leadership that's doing that is appropriate to that. We get people in to do that.

The other thing is, we're not experts in interpreting those drawings if people are giving us feedback in drawings. Again, going back to child psychologists to say, 'What sort of feedback should we draw from this?', those sorts of things.

We're trying to make sure that we're capturing it in a way that it's meant to be captured, rather than an adult way. I think that's really important, because even reading something like this, we'll put an adult interpretation on it. It really is important that we continue to go back to the young people and children to check what we're saying.

Ms O'CONNOR - That's right. But also to demonstrate listening and results. For example, in the book that you've given us about spaces, the guidance to government from children and young people is about the visual environment that they're within. 'It's boring', is one of the observations. There could be an art gallery or art room, nicer rooms, outdoor sensory garden, a herb garden. This is direct advice to the Health department. Have any of those ideas being picked up and implemented?

Mr WEBSTER - The outdoor space at the LGH was opened -

Mrs PENTLAND - A few weeks ago, I think.

Mr WEBSTER - Yes, it might have been the previous minister as I look at this, minister.

Mrs PETRUSMA - I've visited. It's beautiful.

Mr WEBSTER - That's the first thing. In the Mersey redevelopment, our paediatric outpatients - we're not allowed to call it a playground - we've got an outdoor space attached to that now, based on this feedback. Just two examples, but the picking up of -

CHAIR - Burnie's already had the outdoor area. Burnie's always had it. It was part of the design for the hospital.

Mr WEBSTER - The fact that, for the children's part of it, we're calling them Wombat in the north and north-west and Penguin in the south is a response to that. If you go into the Wombat Ward in Launceston, there's now a magnificent mural as you walk into the ward that is around indigenous animals. I didn't get that term right, but you know what I mean. In fact, a lot of our staff are now wearing the non-THS standard - they're out of the blues and into Wombat scrubs or individual scrubs. Those sorts of things. They're just little examples.

Ms O'CONNOR - What about the Royal?

Mr WEBSTER - At the Royal, they've now got the Penguin mural because they're the Penguin Ward.

Mrs PETRUSMA - The Royal Hobart paediatric ward, since when I worked there, it's chalk and cheese now. It's just beautiful when you come there.

CHAIR - Is there an outdoor play area?

Mrs PETRUSMA - Yes, there is a development of a bit of an outdoor - I think they actually had to crane in a new playground Kindergym thing, a few weeks ago. I saw that too.

Mr WEBSTER - RHH were working on the outdoor space, which we don't call playground.

Mr STREET - Three Sundays back they craned the playground in, because I was stuck for 15 minutes in Campbell Street, in traffic.

Mrs PETRUSMA - I was a bit amazed how they managed to get this playground up where it was.

Mr WEBSTER - Minister, we don't call them playgrounds, they are outdoor spaces.

Mrs PETRUSMA - Yes, alright. I would like to table some different items here, Chair. Stickers and everything else, what we're doing to keep our young people safe and as well -

CHAIR - These are on the wards, are they? In the children's wards?

Mrs PETRUSMA - That's right. Also, the learnings from the Young Tasmanians document, that we did table near the start - it does talk about other initiatives that the department has done. Whether, going to Agfest, where they handed like 3000 sticker and 800 colouring in handbooks and 500 feedback forms. They're trying to get actively out in the community as well to hear from the children. You will see pictures of kids at Agfest, colouring in and wearing hospital outfits and everything else. They're really trying to [inaudible] all around Tasmania as well.

Ms O'CONNOR - That is encouraging.

Mr WEBSTER - Just to wind that up, then actually doing what we're hearing. We are trying to make sure we're implementing what we're being asked for.

CHAIR - Is there wi-fi in the spaces now?

Mr WEBSTER - I haven't checked it but I'm told there is.

Mrs PETRUSMA - Yes, I did see that in there.

CHAIR - Alright.

A member - Giraffes?

CHAIR - No giraffes. You can't have giraffes, it said, not real ones.

Ms LOVELL - You can't bring in a giraffe.

CHAIR - That's right. Unless it's a small toy one. My grandson would want to bring his toy giraffe in. Recommendation 15.08, if we are ready to move on. That one is also completed. I think you have provided a lot of information already on this. Is there anything else you wish to add that you haven't?

Mrs PETRUSMA - Just to table the Patient and Child Safety leaflet, that's one we haven't tabled. This captures information relating to the rights of patients and their family or carers in our health services, as well as information on how to raise a complaint or concern both internally and externally. The leaflet provides patients with high level information, but also links them to a web page, where they can find more detailed information and contact information. This is being provided to all patients or a carer or family member who admitted to one of our services. The department collects feedbacks on the leaflet from staff, consumers and consumer groups and is making several improvements, particularly in regard to accessibility of the information.

CHAIR - That was my question, it was that this is reviewed and updated, subject to feedback from staff as well as patients and children?

Mrs PETRUSMA - Considering staff also have other methods to do it anonymously, but it's -

Mr WEBSTER - We have, in each of our hospital areas, community and consumer engagement committees, that are chaired independently by members of the community, that look at these materials. The one we have just tabled is the adult version of the child Your Say, if you like. It matches.

Mrs PETRUSMA - I can outline where a lot of the documents are throughout the health service.

CHAIR - That would be great.

Mrs PETRUSMA - The 'My Say, Our Voices' book is throughout the Tasmanian Health Services but the 'How Did We Go?' poster is displayed across hospitals and health services, including in outpatient waiting areas and inpatient family tea rooms. The reporting child safety concerns, posters and handouts are in outpatient waiting areas, inpatient family tea rooms and staff areas. 'It's Always Okay to Speak Up' posters are displayed next to all child and adolescent inpatient beds with a QR code to information on the Department of Health website about child safety and wellbeing. The statewide complaints management framework, reporting concerns of inappropriate behaviour poster is displayed in inpatient family tea rooms, also with a QR code. The 'Me and My Health Journey' booklet which provides an alternative way for children to provide feedback including through drawing, also includes a QR code to link to the 'How Did We Go' form.

CHAIR - There's a lot of information being provided, yes, to be commended.

Ms WHITE - It's almost like she was a member of this committee before she was the minister.

Mrs PETRUSMA - I'm trying to show there's been a lot of fantastic work done in the Department of Health. I commend them for all their efforts, because it's been outstanding.

CHAIR - Moving on to 15.9. This one is a longer-term one, if you like, with the timeframe 1 July 2029. Did you want to provide any information on that? This is a continuous improvement monitoring recommendation, I guess.

Mrs PETRUSMA - This is in progress. It's the children and young people's sense of safety. The Department of Health is enhancing a mechanism to gather feedback from young Tasmanians about their experiences. Again, it incorporates a lot of what we've tabled today, but also to further strengthen the ways the community, including young Tasmanians, can raise safety concerns. There is also a new online form for members of the public to raise any concerns, including child safety concerns, about health workers. As we said before, we're promoting the statewide complaints management. We've already talked about the SRLS.

I think we've talked about most of the initiatives. We talked about the workshops and safety and feedback tools and surveys. We've outlined most of that. That is still in progress, but a lot of what we're doing is incorporated in that point. Secretary, is there anything else?

Mr WEBSTER - Probably we would get towards the end of this one and mark it as complete once the Standard 2 of the National Standard is amended, as we've suggested to the national body, because then we've got independent oversight.

CHAIR - On this, there's the 'How Did We Go' forms and things like that that fit into part of this, the feedback mechanism, if you like. Obviously, a four-year-old or a five-year-old is not going to be able to read this. They can see the pictures. Obviously, they probably can't read this 'How Did We Go' or 'How Do We Keep Children and Young People Safe'. Are the parents encouraged to engage with that and also to help their child to engage? It's often the children who are most vulnerable who are the ones who can't speak up for themselves.

Mr WEBSTER - Yes. That's exactly it, and also the ad hoc sessions that, are you know, actually sitting down and just having a drawing session about any of - the giraffe pictures are sort of an example of that. It's really important that you engage in a way that not just the parents interpret what the child wants, that the child gives us direct feedback. On an ongoing basis, we encourage the parents to help the children do the drawing et cetera. Then those ad hoc sessions we're running every now and then give us that more direct route of feedback.

CHAIR - Recommendation 15.10. You're ahead of schedule on this one, by the look of it.

Mrs PETRUSMA - Yes, Chair. On this one we actually are complete, but this is an ongoing one as well. Again, well done to the Department of Health for completing this one, but it will be ongoing. It's under the new Child Safety and Wellbeing Framework, that we will continue to take initiatives to strengthen our engagement young Tasmanians and hear their ideas on how to improve its services to children and young people.

As I outlined before when I talked about the children and young people advisory group, that we do have a mixture of age, gender and representation from a wide range of backgrounds in regards to this to make sure that we do represent children and young people who are Aboriginal children, children from culturally diverse backgrounds, children with disability, children with mental illness and children who identify as LGBTIQA+, et cetera.

CHAIR - On this one, minister. With the consultation with the Aboriginal community, obviously, say, a person from the north-west, a member of CHAC perhaps, may or may not access services in that region, they may need to come to Hobart for services, or other parts of the state. How do you ensure that their cultural needs are also recognised within another health setting? It may have been more intense consultation with the local community in the local hospital area, but perhaps when they have to travel outside that region?

Mrs PETRUSMA - Our future focus will include building further on our engagement with Aboriginal children, young people and relevant service providers throughout the state, whether through standalone consultations to ensure that children, young people feel safe and supported in an environment that they are familiar with. So this is an ongoing body of work too to ensure - but there is an Aboriginal health reference group too in the department.

Mr WEBSTER - I think that is one of the issues, that you want to have your local services culturally relevant and culturally respectful to the local area, and then services delivered statewide. It is about us actually making sure that we're culturally respectful in all parts of the network in a broad sense. To help us build on that we're about to appoint a chief Aboriginal health advisor, because we need to work better with community to make sure that we are respectful.

As the minister said, we meet with all the local providers at both locally and at a statewide level. This is an area where it's us still building to make sure that we're not just doing it at that local level, that we're acknowledging, if you like, cross-regional respectfulness, as such. I would say that again through reference groups we get that feedback, but also we believe it's really important that we actually have a voice within the department, which is why we're going down the avenue of a chief Aboriginal health advisor.

Ms O'CONNOR - Many LGBTIQA+ young people have difficulties at home. They might not be comfortable disclosing to their parents their sexuality, and they might be more comfortable indeed talking to health professionals, counsellors and the like. What policies does the department have in place to make sure appropriate and inclusive care is provided for LGBTIQA+ young people, and that their confidentiality and privacy is respected?

Mrs PETRUSMA - The department has been engaging with one of our key stakeholders, Working It Out, to discuss health access issues for young LGBTQA+ Tasmanians, to make sure that all our initiatives are being progressed through consultation with community and youth sector experts, especially in this area. I'll ask the secretary to add further.

Mr WEBSTER - We're very pleased to launch, last week, our LGBTQA+ action plan that we've developed with our community and with our reference group over the last three years, to get to that point. That's us going forward, we recognise we've got room in the space.

Importantly, in the space that you're talking about, from last year - and this is an ongoing program - we are funding Working It Out to have lived-experience Health Navigators - long statement -

Ms O'CONNOR - In the hospitals?

Mr WEBSTER - No, someone from within Working It Out who can actually help them navigate, help their peers, LGBTIQA+ young people, navigate their way through a health system and support them in that. That's a supplement to the other services that Working It Out has now been providing for about a decade around counselling, et cetera.

We recognise that it's really difficult when you might not have the support of adults to go through the process to navigate the health system. Having those health navigators, but more importantly, lived-experience health navigators to help the young people through our system is one of our biggest initiatives in recent times. Also making sure, in terms of our reference group, in response to feedback from the members of that reference group, we've just doubled the size of the reference group to pick up more community representatives, more lived experience representatives so that -

Ms O'CONNOR - More diversity?

Mr WEBSTER - And more diversity, exactly. Given it's LGBTIQA+, we needed to actually have a greater number at the table. We've doubled the size of our community members on our reference group to better get that feedback.

Ms O'CONNOR - I don't know if the term is, 'clinically', but, in practice, if a young person discloses something they can't talk to their parents about, that is their sexuality or gender identity, to a healthcare worker within the system, what policies are in place to make sure the privacy of that young person is respected? It's a difficult space, obviously, but there is a privacy issue here.

Mr WEBSTER - The starting principle is that that is confidential information to the patient. There isn't that automatic share right to parents of mature adolescents. The mature adolescent is the patient in that sense and it's their information. That's our starting principle. There are some provisions around safety of the patient and things that might see us sharing, but that's the first principle that is reinforced through our privacy policies. Our medical information is the medical information that belongs to the person, and a mature adolescent is seen as adult within that policy. That's a really important principle.

I think that the other thing I didn't mention there is that, over the last few years, we've developed what we call our LGBTIQA+ Champions Network, which now has 60 of our clinicians who wear identification within the network to provide advice to fellow clinicians as well as to the public about issues to do with community. That's an important network of our staff that are identified across the network to support, as well and make sure that -

CHAIR - Members of the community themselves.

Mr WEBSTER - They may be members of the community, they might just supportive of community, but they've identified as wanting to be part of a network to get training and understanding that can help the rest of the clinicians also understand what's going on, et cetera.

Ms O'CONNOR - They're allies.

Mr WEBSTER - Allies, exactly. We, in fact, invite our Champions to listen in on the reference group meetings as well. The reference group is co-chaired by the secretary and a member of community.

CHAIR - We'll go then to 15.11. This was phase 1, if you like, early recommendation, in regard to reviewing and consolidating policies and procedures, et cetera. Minister, did you want to provide any further evidence of the work done here, or anything to add?

Mrs PETRUSMA - Yes, thanks, Chair. This recommendation, Review of Policies, Procedures and Protocols is complete, but it's also ongoing. It was a multi-stage Child Safety Policy Review Project established in January 2024. Stage 1 has met short-term deliverables against these recommendations by ensuring review of key child safeguarding policy documents, identifying other child safety-related policies, and establishing a process for ensuring those policies are reviewed in line with the Tasmanian Child and Youth Safe Standards.

Further stages of the project will continue to build on the findings and work of Stage 1. The project has also ensured that policy governance templates and Department of Health now include a statement requiring all policies relating to children and young people to be consistent with the department's Child Safety and Wellbeing Policy. The policy governor's framework makes a clear commitment to the review of government's documentation as part of the policy life cycle. The policy and practice guidelines have been or will be updated in line with changes and frameworks, et cetera.

Ms O'CONNOR - I have one from Cecily. Thank you for that, minister. Cecily Rosol has asked me to ask, point 4 recommends the department publish its policies, procedures and protocols for child safety on its website. Cecily - and this is from a few weeks ago - found the Department of Health, Child Safety and Well-Being Policy, The Child Safety and Wellbeing Framework and How to Report a Safeguarding Concern, but beyond that, at that time she couldn't see other policies, procedures or protocols.

How many policies, procedures and protocols does the Department of Health have for child safety? For example, would the support person policy be relevant here? When will it and other relevant child safety policies, procedures and protocols be published on the department website to promote transparency?

Mr WEBSTER - The support person policy would be relevant, and I'll come back to that. We have 3500 policy documents on a system called the SDMS. I haven't got a clue what SDMS stands for.

Ms O'CONNOR - Something management system.

Mr WEBSTER - Document management system. I don't know what the S stands for.

Mr THOMAS - Strategic.

Mr WEBSTER - Strategic Document Management System. SDMS has 3500 documents on it, and is, in my view, almost as impenetrable as our website to find things on. We have, in fact, a project underway to replace SDMS, which will then allow us to put our documents up in the public way. As you imagine, if we put 3500 documents on our website -

CHAIR - It'd probably crash it.

Mr WEBSTER - Yes, exactly, so we've got a lot of work to do here. In the support person space that you mentioned, is that this was a policy that was particularly targeted by the Governance Advisory Panel in one of their recommendations. The old policy in this space was called a chaperone policy and was a very old policy. In fact, it had its objective of protecting the clinicians.

CHAIR - Correct. That's exactly what it was for.

Ms O'CONNOR - That's how we got here.

Mr WEBSTER - It's been replaced with a support person policy. This has actually now been updated a couple of times, but the idea is around when someone is in a vulnerable position, not just children, within the health services, that they have a right to have support persons with them so that they feel safe -

CHAIR - Of their choosing?

Mr WEBSTER - Of their choosing, so they feel safe in our environment. That was a significant and major change to our policy framework. As I said, the recommendation of the Governance Advisory Panel and Professor Picone and Ms Crawshaw made sure that we did it before they finished their work. We've revisited since then to update it further.

CHAIR - In terms of ensuring that children aren't left alone, locked in an emergency department or somewhere like that. I mean, parents have to go to the toilet perhaps, even if it's only for a short period. How is that managed now?

Mrs PETRUSMA - That is under recommendation 15.14. Chair, do we want to?

CHAIR - We'll leave it there. Cassy, do you have anything else on that line?

CHAIR - No. I mean, we'll probably need an update at some time on that transparency project.

CHAIR - We'll do that next, as we continue our work. If we can go to 15.12, this is another completed -

Ms WEBB - We've covered a bit of it here.

CHAIR - We have, yes.

Mrs PETRUSMA - The Department of Health has developed, of course, what we've talked about here, the Child Safety and Wellbeing Framework and Policy, but also Statewide Complaints Management Framework and a Professional Conduct Policy, which outlines the

responsibilities as mandatory reporters under several acts, including the Children, Young Persons and Their Families Act 1997, the Health Practitioner Regulation, National Law (Tasmania) Act, the Registration To Work With Vulnerable People Act, the Child and Youth Safe Organisations Act and to Tasmania Police, of course, if there's a reasonable belief that our employees are engaged in criminal conduct.

To reiterate, the staff are not required to seek authorisation before making a mandatory notification, but largely we have covered most of the elements of this recommendation already.

Ms WEBB - Is this where the - I think there's an MOU that you have with AHPRA. Does that sit in this space in this recommendation? Can you give an update on how that is functioning?

Mrs PETRUSMA - A memorandum of understanding was signed in September 2023 between the Department of Health and AHPRA to support sharing of information relating to sexual misconduct by health practitioners. Under the MOU, AHPRA and the department will share information regarding alleged boundary violations by department employees as soon as possible, and is allowed by law, enabling early action to protect Tasmanians. This action will strengthen the information-sharing arrangements and increase community trust in keeping children safe in our health system. Also, the department has collaborated with AHPRA to provide information sessions to staff across all regions on mandatory reporting in April 2024.

Ms WEBB - Because it was an issue, that staff apparently didn't know that they could report to AHPRA, I think that was something identified in the commission.

Mrs PETRUSMA - That's why they've done the information sessions, to remind staff that they can now do that.

Ms WEBB - What level of confidence do you have now that all staff do understand that they are able to do that and will do it readily when necessary?

Mr WEBSTER - I think the second part of it is that as part of your reregistration each year, you now acknowledge that you have obligations as well. AHPRA changed its process end, and came through the COI. The important thing is that the department wasn't always aware when AHPRA had investigations on foot and what they were about. The MOU establishes the sharing of information between AHPRA and the department so that we have greater awareness, we don't have 100 per cent awareness because of legislative differences, but greater awareness. If someone reports to AHPRA and they commence an investigation, we will normally, in most circumstances, find out about that directly from AHPRA as soon as it's started rather than as happens in the past when it becomes a public issue later on.

Ms WEBB - There's generally no time lag between if they've commenced some sort of investigation based on the complaint, that the department's made aware?

Mr WEBSTER - These days we're finding it's almost straight away that they're telling us. We don't have problems with the time lag. I'll just give you an example, there was a circumstance where someone appealed a suspension from AHPRA, and that's how the Department found out that there was an investigation. That's where we've come from, to now AHPRA telling us when they start the investigation, rather than us finding out from public websites of what's going on.

Ms WEBB - The MOU stands, and is it revisited at any point or reviewed at any stage? What's the plan going forward then based on that MOU that was established last year?

Mr WEBSTER - It was signed in September last year and has a 12-month review cycle. It stands subject to, and we just revisited every 12 months.

Ms WEBB - Is there any suggestion that there's legislative reform that's required to address any of the information-sharing matters?

Mr WEBSTER - There are some Commonwealth privacy principles as well as state privacy principles, but mostly they've been overcome through the MOU.

CHAIR - Is there anything else on that? We will go to 15.14.

Mrs PETRUSMA - 15.13?

CHAIR - Oh sorry, yes. I jumped ahead. I was reading that one.

Mrs PETRUSMA - This is complete. The Department of Health has developed a professional conduct policy which is underpinned by the One Health values, and other work being undertaken with the One Health Culture Program. The policy ensures that department workers, whether employees, contractors, subcontractors, volunteers and students understand the behaviours that are considered unacceptable, including concerning conduct, misconduct or criminal conduct, and their reporting obligations.

Extensive consultation occurred in development of the Professional Conduct Policy, including with the internal subject matter experts throughout 2024, and the policy has been shared across other agencies who are developing their own similar policies, including Department of Justice and DECYP, as well as, with SSMO, who have responsibility for whole-of-government conduct recommendations. Formal consultation with unions and staff commenced on 7 June 2024, and concluded on 21 June 2024. It was endorsed by the health executive in June 2024 and is supported by a lot of the other resources that we have discussed today. I can table a copy of the professional conduct policy for the committee.

Ms O'CONNOR - Thanks for that. This, in a way, is where the rubber hits the road. It is one thing to have a policy, so there's a document there. But in terms of setting out those expectations of behaviours, reporting, accountability - in practical terms, how is this being applied and measured?

Mrs PETRUSMA - To support implementation, the current HR essentials training has been updated to appropriately capture any changes relevant from the revised workplace behaviour and grievance policies. Recommendation 20.2 does state that the Tasmanian government should introduce legislation or other binding mechanism to ensure that a breach of a departmental professional conduct policy may be taken to be a breach of the State Service Code of Conduct, without needing to assess whether a separate provision of the code has been breached. Such a breach does not have to be accompanied by a lawful and reasonable direction for there to be a breach of the Code of Conduct. Further legislative reform to the State Service Act will form part of delivery for the phase 2 recommendations, and have been addressed in the Professional Conduct policy that I have just tabled.

Ms O'CONNOR - When you say reforms to the State Service Act, in broad terms, what are the amendments? I know you are not the Premier.

Mrs PETRUSMA - What I just read out as part of recommendation 20.2. In regards to breaches of professional conduct policies will be a breach of the State Service Code of Conduct, et cetera. But the secretary will -

Ms O'CONNOR - Those breaches, the change to the way that is dealt with, will be an amendment to the State Service Act? When are we likely to see that?

Mrs PETRUSMA - That would come under the Premier.

Mr WEBSTER - To explain it, at the moment under this policy, we would have to call out someone's behaviour in one sense to give them a lawful and reasonable direction to comply, as a step. Or, we would have to say that behaviour is a breach of this provision of the State Service Code of Conduct. It becomes a process, and then we'll have to do a separate investigation to show that, et cetera.

The recommendation the minister read out from the commission of inquiry is that instead of having to prove the individual element, it applies to this part of the Code of Conduct, or they breached the lawful and reasonable direction from the secretary. Prima facie, it is accepted that they know there is the policy and they have professional conduct requirements. If they then breach those, then you have a prima facie breach of the State Service Act. You then go through the State Service Act process. It's really shifting it, so you don't have to do preliminary steps to apply the policy.

Ms O'CONNOR - Okay. Has that been consulted with CPSU and unions and the like? I imagine they would want to be part of any discussion about how this is rolled out.

Mrs PETRUSMA - Our professional conduct policy, that formal consultation with unions and staff commenced on 7 June and concluded on 21 June 2024. That changed that recommendation 20.2, which does come under the Premier. That is part of a phase 2 recommendation. So that'll be part of -

Ms O'CONNOR - 2026?

Mrs PETRUSMA - Yes, 1 July 2026. That will be coming under the Premier. I have no doubt that unions will be consulted as part of that.

Ms O'CONNOR - Will there be changes to the ED5 process? In Estimates, we were given some sort of flowchart of how that would change. That's all still in train 2?

Mr WEBSTER - There have been some changes to ED5, but you would expect that if that amendment to the State Service Act passes Parliament, there would have to be further amendment because ED5 would have to align with the act.

Ms O'CONNOR - Thank you.

CHAIR - We can follow up with the Premier next year, too. Any other questions on that one? If not, we'll go to 15.14. I think we've probably covered that. This is about the former chaperone policy.

Mrs PETRUSMA - Chair, just to assist with this one. I'm very happy to table the support person policy for the committee. That has replaced the former chaperone policy in December 2023.

Since the original policy was released, it has been continued to be refined and improved. This revised version of the policy was endorsed by the THS executive in August 2024. The policy's purpose is to guide healthcare workers providing examinations, procedures, and intimate personal care, especially to vulnerable patients. The policy intends to safeguard vulnerable patients while minimising additional work or impact on patient flow through the health system.

The support person policy does require a support person to be offered for the provision of intimate personal care for all patients. It requires a support person to be present for all intimate examinations and procedures, for all examination procedures, and intimate personal care provided to vulnerable patients at any time a patient requests they be present.

CHAIR - How does a patient know that's their right? Particularly if they're a young person.

Mr WEBSTER - That's, again, through posters, through encouraging staff to make sure you are offering these rights at all times. Again, this standard applies in this space as well. Again, getting independent assessment. Are we applying our support person policy correctly?

CHAIR - Anything else on that one? I think we have covered that a little bit earlier as well. We'll go to 15.15. Is that medium-term 1 in progress, minister? I won't read it out. I'll let you speak to it.

Mrs PETRUSMA - This one is in progress. There is a minimum mandated child safeguarding training requirement for all Department of Health staff that we've outlined. It's implemented for all Department of Health staff, volunteers, students, and contractors to increase awareness of child safeguarding, including when and how to raise safety concerns for children and young people. In 2023, child safeguarding training compliance reached 98 per cent for Department of Health staff. February 2024 saw the rollout of an updated annual training course. Ongoing compliance monitoring is occurring.

As of February 2024, all Department of Health staff, volunteers, students, and contractors are required to complete an annual 30 to 45 minute mandatory course called the Fundamentals of Safeguarding Children and Young People Training. All new staff are required to complete the training at commencement, with volunteers, students, and contractors without a network account training via health learning online.

The Heart Health Executive Analytics Reporting Tool Dashboard enables tracking of staff completion of the mandatory trial safeguarding training. This dashboard can be viewed by health leaders and has reporting capacity to ensure compliance with mandatory training requirements across services.

CHAIR - How will that be reported then? I'm just interested in how and when, I guess.

Mr WEBSTER - This will become part of our HR dashboard suite. The HR dashboard that we're developing so that we can actually report all this sort of data, so it's publicly aware of where we're at with these sorts of things. At the moment, there is internal sort of data that's provided within - obviously, have to declare it as part of any accreditation process, but we want to actually have it on our website as part of our dashboards.

CHAIR - When we talk about contractors, is this any contractor? A contractor who may be a plumber coming in to fix a plumbing problem. Do they have to as well?

Mr WEBSTER - Where they're part of a regular contract of maintenance and those sorts of things, then, yes. It might be a one-off contractor, but then they'll have to be supervised on site if they're not having gone through this process.

CHAIR - They have to have someone watching them all the time, effectively?

Mr WEBSTER - If they're not part of our regular crew, then yes, they'll have to be supervised as part of it.

CHAIR - Any questions from any other members on that? No, 15.16.

Mrs PETRUSMA - Thank you, Chair, 15.16 is complete, responding to complaints and concerns, but of course it will be ongoing as well. The department is committed to an integrated and consistent approach. To achieve this, fostering a positive, open and transparent complaints management culture is key.

The Statewide Complaints Management Framework and policy is being developed to assist staff to manage complaints in the Department of Health. The framework was released in August 2023 and aims to improve the awareness of all staff regarding the department's trauma-informed approach to managing complaints and concern. It is founded on a 'no wrong door' approach for making a complaint or registering a concern. To support the complaints framework, a simple online form has been created and is easily accessible for staff and members of the public to make a complaint about concerns of inappropriate staff behaviour.

The model is guided by the following principles: it is to be trauma informed, promoting and protecting safety, respectful and confidential treatment, accessible information and processes, clear and regular communication, taking ownership, timeliness, transparency, fairness and natural justice. A Statewide Complaints Management Oversight Unit has been created to support the consistent triage and oversight of complaints management in the Department of Health. I'm happy to table the Statewide Complaints Management Framework.

CHAIR - As a user, if I was to make a complaint, and I was not seeking to be anonymous, what confidence do I have that my complaint's being seen, responded to in terms of the confidence in the system?

Mr WEBSTER - The first step is the acknowledgement of that by our Statewide Complaints Management Oversight Unit, and then they provide a feedback loop. There are unfortunately some constraints in feedback, but we try to - I'll just go to that, for instance, ED5 processes, you can't actually give chapter and verse feedback, but we'll give feedback on

progress of that process. Part of the unit's role is to keep that feedback loop going with the complainant in that sense.

CHAIR - If a person who made a complaint about an individual that proved to have some substance to it, they would be informed that it was being progressed? Would you at least know that?

Mr WEBSTER - Yes. They'd be informed of that; we've got process steps. So they might not be informed that we've commenced an ED5 on a particular individual, but we've commenced an investigation. That might be how we frame that.

CHAIR - If it's dismissed as not requiring further assessment, the person who made the complaint would be notified of that as well?

Mr WEBSTER - That's right, yes. Just for completeness, but it also may be moved in if it's something that would require a root cause analysis or open disclosure or even in some circumstances an apology from the senior member of the agency. All those things wouldn't be done by the complaints management unit, they would be done by the appropriate part of the agency. The feedback loop might actually move from the unit to whoever is in charge of that part of the process.

Ms O'CONNOR - This question is asked on behalf of Cecily. The Statewide Complaints Management Framework on the Department of Health website says that people will receive an acknowledgement of their complaint within five working days, but there's no timeframes listed for a final response. These are available on pages 5 and 6 of the policy document and page 18 of the framework. Where is it shown that a person should be updated about their complaint every 35 working days. Is that in the document? I haven't had a chance to look at the one you've tabled. The point of the question here is about accessibility so that people understand what to expect from the department, so they're not left sort of hanging with uncertainty?

Mrs PETRUSMA - So what was the question again in regards to 35?

Ms O'CONNOR - The question is about making sure that people who lodge a complaint understand - or making sure the department is clear with people who lodge a complaint that there will be an update every 35 days.

Mr WEBSTER - It's in the matrix, which is in the policy. That actually spells out the 35 days there. We need to check what's on the website to make sure that that's the document that's on the website. The policies are from SDMS, which I explained before, whereas the framework is something we've put up publicly. It may be that we've missed out in the public document the 35 days that's in the actual internal document.

Ms O'CONNOR - It sounds like you have missed it out, rather than may have missed it out, given that this is the public document, when people make complaints through that framework. Perhaps we could have a commitment today that that information will be put into the framework that's publicly available?

Mr WEBSTER - Absolutely. The matrix of that - and we don't have the end date because as you can appreciate you've been around the ED5s and they take forever - but we need to spell

that out. There's a matrix that's in the policy that we need to make sure is in the back of the framework.

Ms O'CONNOR - Another one, there's a 'no wrong door' approach referred to in the policy, but the statewide complaints management web page refers to SCMOU, the Statewide Complaints Management Oversight Unit having a -

CHAIR - So many acronyms.

Ms O'CONNOR - I know - having a 'one front door' approach. I understand these mean the same thing, I guess, as the SCMOU will triage and refer as necessary, and complaints made in other ways should also be triaged and sent to this as necessary. The two different ways of describing the same thing is potentially confusing, don't you think? 'No wrong door' is quite different from 'one front door'. Could this be clearer? And a link included on the statewide complaint management page to both the SCMOU web page and the complaint form to make it easier to find out how to make a complaint?

CHAIR - The question is, could it be made clearer?

Ms WEBB - Described consistently.

Ms O'CONNOR - Described consistently. Exactly.

Mr WEBSTER - Yes, and I've just been pointed out that the 35 days is in the framework, so it is on the website.

Ms O'CONNOR - Good. Thanks. Has the Statewide Complaints Management Oversight Unit been established?

Mrs PETRUSMA - Yes.

Ms O'CONNOR - Does it have a web page or contact details, or its internal -

Mr WEBSTER - Every page of the website has the link that takes you effectively to the complaint form that takes you to SCMOU.

Ms O'CONNOR - Thank you.

CHAIR - The only one that's worse than Health is Energy, in terms of acronyms.

Recommendation 15.17, that one's in progress. Minister, did you want to outline what's happening there?

Mrs PETRUSMA - That's right. This is in our child-related incident management directorate. A lot of this is in regards to SCMOU, the unit that has been created. I appreciate a lot of what I have here has already been talked about. I wonder if the secretary's got anything else that he feels needs to be added to this, because we have outlined most of what is happening to this.

Mr WEBSTER - Just to reinforce that link to the child safety service as well, so that it does have a child safety as well as general complaints flavour.

CHAIR - Any other questions? We've covered quite a degree of that.

Recommendation 15.18, this one's also completed. Not sure if you've tabled all the relevant documents to this one about open disclosure process for patients who experience child sexual abuse.

Mrs PETRUSMA - Yes, the Department of Health services have open disclosure processes in place. Online open disclosure training, as well as trauma-informed training is available to all staff. The department's open disclosure policy has also now been reviewed and updated. The Department of Health is committed to supporting victim/survivors of child sexual abuse, including through trauma-informed open disclosure whereby there is frank and open discussion with victim/survivors about what happened to them. Open disclosures include an apology, an opportunity for the person to talk about their experience and ask questions, and an explanation of the steps being taken to prevent abuse happening again.

The Department of Justice has also developed a resource for use by government agencies titled 'Apologising to Victim/Survivors of Institutional Child Sexual Abuse'. This resource provides guidance to agencies on the delivery of an institutional apology to victim/survivors of child sexual abuse. This resource will complement our existing agency open disclosure processes. I can table the open disclosure policy document too.

Ms O'CONNOR - Is that publicly available?

Mr WEBSTER - This is the strategic document management system process again. It will be publicly available once we can overcome the issues we have in that system.

Ms O'CONNOR - Okay. I guess it's difficult to put a time frame on that, is it?

Mr WEBSTER - The process is underway. We are hopeful that that would be up this year, if not early in 2025.

Mrs PETRUSMA - It's why we're spending an extensive amount of money in IT in the Health department to try to get a lot of things underway in department.

CHAIR - Is that part of that $44 million?

Mr WEBSTER - No. It's a separate Digital Health Strategy uplift.

CHAIR - Part of HRIS, surely?

Mr WEBSTER - No, not part of HRIS. Part of Digital Health Strategy, $450 million to update our digital platforms.

Mrs PETRUSMA - It's a lot of dollars.

Ms WEBB - While you've mentioned the $44 million that's in this year's state budget for commission-related implementation, is there a way you can provide a breakdown of that to us

in terms of how it's being allocated across - I know it doesn't really fit into discussing it in one particular recommendation, but it's no doubt across a number.

Mrs PETRUSMA - There's $44.5 million over the next four years to the continued implementation of commission of inquiry initiatives, including $8.9 million for the ongoing operation of the Child Safety and Wellbeing Service and continued engagement with children and young people. There is $7.2 million for the ongoing operation of statewide complaints management, $8 million for the continued roll out of the department's One Health Culture program, $400,000 for ongoing engagement with the Launceston community to support recovery and restoration activities, and $20 million to continue the development of the Human Resources Information System to provide the foundation for a whole-of-government system.

CHAIR - Some of that is IT-related, some digital.

Mrs PETRUSMA - That's the Human Resources Information System, which we'll be using to gather one source of truth for an employee when they go through the system as well.

Ms WEBB - I think it was $20 million, or so, you said for that. Is that to be completed in this financial year, or is that going be an ongoing amount that needs to be completed across a number of years?

Mr WEBSTER - HRIS, which is a long-term Health goal, is also a whole-of-government project. It is funded in Health as a final two-year project, but is actually being coordinated by Department of Premier and Cabinet as a whole-of-government initiative. There will be an ongoing element to it. At the moment, through the commission of inquiry, we're funded for two years to get it up and running.

Ms WEBB - Are we in year one or year two of that?

Mr WEBSTER - We're in year one of that.

Ms O'CONNOR - What supports are available to affected people where the abuse is connected to Department of Health services?

Mr WEBSTER - Through the Governance Advisory Panel, back at that process, and then when the commission of inquiry was set up, both Department of Health and whole-of-government set up a number of processes to support victim/survivors. With the outcomes of the commission of inquiry, the coordination of that is moved to Premier and Cabinet. It varies on individual needs. For instance, some people are accessing private psychological services. We're funding those because they don't want to have that service from within the THS. Other people, it might actually be like connection with family and some funding to allow for that to occur. It's individualised. There is an interaction between staff at the moment within DPAC and the individuals to work out what supports they may need.

Ms O'CONNOR - How does that work?

Mr WEBSTER - To give a recent example of that, is that there is a number of people that are, if you like, acting as victim/survivor advocates across the state. The most recent example that I'm aware of, is one of those people rang me and made me aware of a circumstance where a couple of people were struggling. I then got in contact with the person in DPAC who

is, in fact, a mental health professional employed in DPAC, who then made the contact with the individuals to offer them the support.

Ms O'CONNOR - Thank you. That sounds really good for the person who knew to contact you and had your contact details. But if a complaint has been made by a person about it something that has happened in DoH, when you say that DPAC is in contact with that person, how does that work?

Mr WEBSTER - Sorry, I went down the COI route. Generally speaking, what will happen is through either the Statewide Complaints Management Oversight Unit or Child Safety, Department of Health will offer support to complainants and actually do it. If you like, it is the same process, but within Health. The COI has transferred from us to DPAC, specifically.

Ms O'CONNOR - Okay.

CHAIR - Are there any other questions?

Ms O'CONNOR - One last follow-up question. Are there wait times, as far as you know, for people who make those complaints through the open disclosure policy and the mechanisms that underpin that? Are there wait times for people to receive some support?

Mr WEBSTER - No, the support mechanisms will go in as required. They don't go into, if you like, the example I gave, where we actually made the referral off to a private service. We intersect with that private service to make sure they're ready to take the client, rather than just doing a referral and saying, 'You'll wait until someone contacts you'. It's actually more of a 'hot' referral. To make sure the support goes in immediately, rather than as part of a wait program.

CHAIR - We'll move to 15.19.

Mrs PETRUSMA - This is the critical incident response plan, which is in progress. We've talked a lot today about our One Health Culture Program. A key focus area of the culture program is health, safety and wellbeing, to ensure we have a workforce that understands and positively engages with worker and patient safety, adjusting or eliminating behaviours and practices as appropriate, a physically and psychologically safe workplace and wellbeing supports available to assist our people. This includes the development of a structured set of supports to assist our people if they are exposed to potentially traumatic events. This will be a part of our critical and cumulative incident response protocol, which will be a department-wide framework that links escalation pathways, reporting mechanisms and avenues of support. This will be done to ensure our processes are clear and incidents are being managed and escalated appropriately. To support development of the CCIRP a literature review has been undertaken by a senior psychologist within the department which recommends a peer-lead, trauma-responsive, and organisationally endorsed approach.

The research suggests both an immediate, psychologically first aid response and facilitator group reflection should be included to enable flexible, responsive support to staff. It's based on contemporary research. Work is continuing on the design of the protocol. This includes integration with the broader critical incident response processes. The CCIRP will be supported by our staff wellbeing program. In the meantime, all health employees, including those working within Ambulance Tasmania and the hospitals can access the department's EAP

program as well. Critical incident stress management is a long-standing program that utilises a dedicated team of 80 psychologists and 76 critical incidents stress management peers to manage the impact of critical incidents, for example on our Ambulance Tasmania workforce. They provide on-scene support, psychological support, follow-up assistance and advice to partners, families and friends.

Ms LOVELL - This is a phase 2 recommendation. Is that on track to be delivered on time?

Mrs PETRUSMA - Yes

Ms LOVELL - At that time, or any earlier do you think?

Mrs PETRUSMA - A lot of it has already been put in place, through the One Health Culture Program. But yes.

CHAIR - Are you confident there will be adequate services right in around the state to meet - not that you hope you need to use it too much, but that there won't be a delay in accessing that support, particularly the initial support.

Mr WEBSTER - We have to make sure there are initial responses. We have that broad responsibility in any emergency event for the for the state. It's the same resource pool that we'd pull into this as well.

CHAIR - Are you confident that we'll meet the more sometimes nuanced or challenging needs of a person who's traumatised by a sexual assault on a child, for example?

Mr WEBSTER - Yes, because it's, it's through that additional training. Ambulance Tasmania or the system set up by DPFEM which includes Ambulance Tasmania is a good model, but it needs to be adapted, which is why we haven't just switched over to that model. We're doing the research to make sure it's fit for purpose.

CHAIR - That will be all done before July next year? Okay, if members are okay with that one we'll move to 15.20.

Mrs PETRUSMA - This is complete, but it's an ongoing commitment. It's ongoing assistance for victim/survivors. We have already touched on it this morning. The Department of Health is committed to supporting victim/survivors of child sexual abuse including through trauma-informed open disclosure.

The Chief Executive of Hospitals North has also recently written to known victim/survivors associated with the Launceston General Hospital. The letter acknowledges the impact of the matters associated with the commission of inquiry on victim survivors, their families and loved ones. The letter offers victim/survivors the option of attaching a notification to their health record which will prevent them from having to unnecessarily retell their lived experience and ensure they can be provided with appropriate support. The letter also confirms if they have any issues or would like to discuss anything, they can contact the chief executive directly.

The department is also developing a number of initiatives aimed at supporting recovery and restoration in the Launceston community, which we briefly touched on this morning. The Department of Health has been providing holistic support to victim/survivors and witnesses of the commission of inquiry. As the secretary outlined before, these supports have now transitioned to be provided on an ongoing basis by the Department of Premier and Cabinet.

CHAIR - Are there any other questions on that? So, 16.6.

Mrs PETRUSMA - The increased availability of forensic medical examinations - this is in progress. Any allegation of sexual abuse is a serious matter that needs prompt, sensitive and coordinated responses from all services involved to minimise further trauma and ensure timely forensic medical examinations are available.

All children and young people presenting as victims/survives of sexual abuse are offered a forensic examination if the alleged abuse occurred in the previous 72 hours and beyond that, if deemed clinically appropriate. The clinical examination care of children suspected of having been sexually assaulted is highly specialised work. It requires specialist training, afterhours on-call work, preparation, medico-legal reports and court appearances. Additional funding has recently been provided for the purchase of new equipment that allows Forensic Science Services Tasmania to increase its evidence storage capacity for sexual assault evidence and other samples.

Recent state and national discussions have also identified need to support general community hospital paediatricians to undertake sexual assault examinations for children under the age of 15 years, due to the infrequency, the need for these examinations, the importance of providing a child-centred and trauma-informed approach and the need to be across legislation, regulations and any changes to these.

I can indicate that we do have staff that are appropriately trained and registered to conduct forensic medical examinations within each hospital, including at the Royal Hobart Hospital with the paediatric sexual assault service. This includes 11 consultants that can undertake examinations, report writing, and can be expected to be an expert witness when required. The adult sexual assault service, which includes a permanent clinical nurse consultant and a further two registered nurses are undertaking clinical training to undertake forensic examinations. The adult sexual assault service also includes an encore roster with four RNs with the relevant clinical training to undertake forensic examinations -

CHAIR - Is all in the south?

Mrs PETRUSMA - It is so far, but we have more in the north-west and everything else. One RN that possesses a law degree and masters in forensic and one RN that possesses their graduate certificate in forensics, and a medical GP with their graduate certificate in forensics. I can continue reading out the rest if you'd like to know.

CHAIR - It'd help to know from the other two regions, if you could.

Mrs PETRUSMA - I'll just finish off the south as well, because they also do help with the statewide service. There are also three appropriately trained and registered special forensic pathologists based at the Royal Hobart Hospital that provide a centralised statewide service

managing cases that are transferred by the Department of Justice to the Royal Hobart Hospital from the Launceston General Hospital in the north-west.

Also, at the Launceston General Hospital, we have the hospital's Sexual Assault and Family Violence Forensic Service, known as SAFE, which includes six CNCs who have completed the relevant postgraduate training to provide a response to alleged adult sexual assaults, and six general paediatricians that support the team when a paediatric patient presents to SAFE, or general paediatricians are provided with training and responding to alleged paediatric sexual assaults during their advanced training years.

In the north-west, we have the hospital's north-west Sexual and Forensic Examination, and Sexual Assault Medical Service, or SAFE and SAMS, which includes one general paediatrician that supports the team when a paediatric patient presents to SAFE and SAMS; and three visiting medical officers that have the appropriate training to support SAFE and SAMS.

Additionally, within the Tasmanian Health Service, there are several other paediatricians and gynaecologists outside of the sexual assault care teams who are trained in paediatric sexual assault examinations.

CHAIR - We don't have any specifically qualified nurses in that in the north-west?

Mr WEBSTER - We did, but unfortunately through their resignation, they're not there at the moment. But I can - and it might have been Ms Webb who asked a question in Estimates around this, that in the smaller, particularly in the north-west, we are concerned that the model becomes too reliant on individuals. You can see in Launceston and in Hobart, we have broader teams. We are effectively from this week working with TasPol about a different model for the north-west, and also for the west coast and the two islands. This would see a broader number of staff trained, but not specifically attached to a service, so that you're not reliant on one or two people in these smaller regions. We're working on that. It's early stages. At the moment we're quite concerned about our limitations in the north-west and we're even more concerned about limitations in the in the remote areas.

CHAIR - Like Circular Head? There is a hospital there

Mr WEBSTER - Again, it would be an example where it'd be good to actually have staff trained more broadly at Smithton, St Helens, the east coast, west coast, both islands. It's early stages of a discussion between Ms Searle and TasPol about creating a new model -

CHAIR - To cover the whole north-west region?

Mr WEBSTER - North-west and remote areas.

CHAIR - Right. That's all the recommendations that relate to your areas, minister.

Is there anything you want to say in closing or that we haven't mentioned that you'd like to at this point?

Mrs PETRUSMA - No. I thank the Chair and the committee members. We've really appreciated the time to appear before the committee to outline the extensive body of work that

the Department of Health has undertaken. I commend the secretary and the acting deputy secretary, the chief risk officer, but of course, there are many other people across the wider Department of Health who have been involved in putting all these resources together. Also, the children and young people who are part of our advisory group and all the other stakeholders as well. As you can tell, there's been a lot of work and time and effort being put into developing resources.

We do emphasise that these are living documents as well. At any time, we do appreciate feedback on these documents to make sure that they up to date. At any time, if any member, as has been pointed out today, picks up an omission or has any suggestions as to what other resources can be developed, or how the website can be improved, we do appreciate any suggestions and any feedback is always welcome.

Thank you, Chair.

CHAIR - Thank you very much, minister. Thank you for your appearance today.

THE WITNESSES WITHDREW.

The public hearing concluded at 11.55 a.m.