

PRIVILEGED AND CONFIDENTIAL

REPORT OF THE INDEPENDENT REVIEW OF GRANTS OF LEGAL ASSISTANCE UNDER EMPLOYMENT DIRECTION 16 TO PUBLIC OFFICERS APPEARING BEFORE *THE COMMISSION OF INQUIRY INTO THE TASMANIAN GOVERNMENT'S RESPONSES TO CHILD SEXUAL ABUSE IN INSTITUTIONAL SETTINGS*

Sam Tatarka OAM

24 March 2025

An independent review into whether there are appropriate grounds to require any Public Officers, who received a grant of legal assistance pursuant to Employment Direction No. 16 *Indemnity and Legal Assistance* in the course of the *Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings*, to reimburse the Crown for reasonable costs and expenses.

The following table* provides information on why parts of the ED16 Review Report have been redacted.	
SCHEDULE OF REDACTIONS	
Redaction Overlay Code:	Meaning/Reason:
RC – 1	Redactions to protect the identity of individuals such as victim-survivors, people with lived experience, or complainants.
RC – 2	Redactions to protect the identify of individuals, made consistently with the determinations of the Commission of Inquiry (Col). That is, if the Col determined it was not appropriate to identify the individual – that position has been preserved in the ED16 Review Report.
RC – 3	Redactions to protect the integrity of ongoing legal and administrative processes. Specifically, the identity of individuals who are still subject to ongoing processes are redacted.
No overlay code/blank	All other redactions that do not have an overlaid code redact information that is protected by law.

**This table and all redactions are not part of the original ED16 Review Report.*

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EXECUTIVE SUMMARY OF FINDINGS

In relation to 15 of the 18 Public Officers covered by this report, I recommend that no action be taken by the Crown to seek reimbursement for legal assistance provided pursuant to Employment Direction No. 16. These 15 Public Officers are:

- Ms Jacqui Allen
- RC - 2
- Ms Fiona Atkins
- Dr Stephen Ayre
- Ms Kathy Baker
- Ms Helen Bryan
- RC - 2
- Mr Gino Fratangelo
- Ms Madeleine Gardiner
- Mr Matthew Harvey
- Ms Claire Lovell
- Ms Kathrine Morgan-Wicks
- Mr Michael Pervan
- Ms Elizabeth Stackhouse
- Ms Janette Tonks

In relation to each of these 15 Public Officers I have found, on the basis of the Inquiry Report and the other evidence and materials with which I have been provided, that for the purposes of this Independent Review:

- A: I was not satisfied that the Public Officer had engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I was not satisfied that the Public Officer had engaged in conduct, including omissions, that did not arise in the course of their public office;
- C1: I was satisfied that the Public Officer had not been found guilty of an offence;
- C2: I was satisfied that the Public Officer was not currently subject to criminal investigations or proceedings;

- D1: I was satisfied that the Public Officer had not engaged in misconduct of a kind that would warrant their dismissal, or the revocation by a Professional Registration Authority of their professional practice rights or registration;
- D2: I was satisfied that the Public Officer was not currently subject to an inquiry into professional misconduct, and that they had not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I was not satisfied that in providing evidence to the Commission of Inquiry, the Public Officer acted unreasonably, or that they intentionally or recklessly failed to make full and frank disclosure of relevant matters.

In relation to **Dr Peter Renshaw**, I recommend that the Crown take action to seek reimbursement for legal assistance provided pursuant to Employment Direction No. 16. This recommendation is based on my consideration of the Inquiry Report and the other evidence and materials with which I have been provided in relation to Dr Renshaw's conduct, on which basis the following two of the six criteria in relation to recovery under ED16 have been met:

- A: I am satisfied that Dr Renshaw engaged in conduct, including omissions, demonstrating a lack of good faith; and
- E: I am satisfied that in providing evidence to the Commission of Inquiry, Dr Renshaw acted unreasonably, or that he intentionally or recklessly failed to make full and frank disclosure of relevant matters.

In relation to **Mr James Bellinger** and **Mr Patrick Ryan**, I have found that the Crown has a prima facie entitlement to seek reimbursement for legal assistance provided pursuant to Employment Direction No. 16. In relation to both Mr Bellinger and Mr Ryan, this finding is based on my consideration of the Inquiry Report and the other evidence and materials with which I have been provided, on which basis:

- A: I am satisfied that Mr Bellinger engaged in conduct, including omissions, demonstrating a lack of good faith; and
- A: I am satisfied that Mr Ryan engaged in conduct, including omissions, demonstrating a lack of good faith.

However, in relation to both Mr Bellinger and Mr Ryan, it is my recommendation that the Crown only exercise its right to make an order for reimbursement under ED16 if, after

carefully considering a range of matters identified in my reasons, the Crown is satisfied that it is reasonable in all the relevant circumstances to do so.

I will provide a supplementary report in relation to the remaining 9 Public Officers the subject of this Independent Review as soon as possible following completion of the relevant investigations and processes currently underway. Those Public Officers are not named in this Executive Summary as I consider it would be unreasonable to do so until any outstanding investigations are concluded and I have considered them in the context of concluding my review into the grants of aid given to them under ED16.

A: INTRODUCTION

Background to this Independent Review

On 15 March 2021, the Tasmanian Government established the *Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings* (“**Commission of Inquiry**”). The Commission of Inquiry was led by the Honourable Marcia Neave AO, with Commissioners Professor Leah Bromfield and the Honourable Robert Benjamin AM SC also presiding. Over more than two years, the Commission of Inquiry conducted over 150 consultations, received more than 95,000 documents and held nine weeks of hearings.

The Commission of Inquiry delivered its Report on 31 August 2023 (“**Inquiry Report**”), which included recommendations for sweeping changes to ensure that the government and its institutions are better able to prevent, identify, report and respond appropriately when concerns or allegations about child sexual abuse arise.

Numerous individuals who are, or were, employed by the Tasmanian Government as Public Officers¹ (sometimes also referred to as ‘State Servants’) were called to give evidence before the Commission of Inquiry.

The State Service recognises that Public Officers may be called to appear in legal proceedings or inquiries in relation to matters arising from their work, and that in some circumstances it is appropriate that these employees are provided with legal assistance and/or indemnity funded by the Crown. The policy specifying the circumstances in which such legal assistance and indemnity may be granted to a serving or former Public Officer employed under the *State Service Act 2000 (Tas)*, is titled Employment Direction No. 16 (“**ED16**”).

Pursuant to ED16, 27 Public Officers applied for and were granted funding for legal assistance in relation to their participation in the Commission of Inquiry. The total amount of legal assistance provided to these 27 Public Officers was \$1,017,698.55. The amounts of each individual’s share of the total varied from a minimum of \$1,440 to a maximum of \$468,845, with the mean grant being approximately \$39,000. However, the maximum grant was an outlier, with the next highest grant being \$85,333. With the maximum grant excluded from the group the mean grant was approximately \$22,000.

¹ “Public Officer” is defined in Employment Direction No. 16 as including Ministers, members of government acting on behalf of Ministers, statutory officers, and of particular relevance for this Independent Review, ‘state service officers and employees.’

The purpose of this Independent Review

The Commission of Inquiry made direct and indirect findings against, or made adverse comments in relation to the conduct of, a number of the 27 Public Officers who were provided with grants of legal assistance under ED16.

On 18 December 2023, this Independent Review was established by Attorney-General Guy Barnett MP, to inquire as to whether any of the 27 Public Officers who were granted assistance should be directed to reimburse the Crown pursuant to the framework established by ED16. Specifically, I have been tasked to inquire into, report on and make recommendations in relation to the following matters:

- Whether any of the Public Officers whose legal assistance was paid for by the Crown (and provided by external legal providers) in the course of the Commission of Inquiry did not act in good faith in carrying out his or her official or employment functions or duties, or in compliance with their obligations under the ED 16 policy framework;
- Whether it is reasonable for the Crown to seek a reimbursement of legal costs from any of the Public Officers identified above; and
- Any associated relevant matters.

I discuss in some detail below the relevant terms of ED16 for the purpose of this Independent Review, and the approach I have taken in formulating my recommendations to the Crown regarding whether reimbursement pursuant to the terms of ED16 should be sought.

Timing

It is now some 18 months since the Commission of Inquiry reported, and just over a year since this Independent Review was commissioned. It was not possible to complete the tasks I was assigned any sooner than has occurred due to the fact that the work couldn't begin in earnest until a number of further investigations and processes in relation to the conduct of Public Officers who are the subject of this Independent Review and triggered by the Inquiry Report had been completed. For reasons set out below, the recommendations of this Review are, to a significant extent, dependent on the outcomes of those post-Inquiry Report investigations and processes.

A number of those subsequent investigations and processes have only recently concluded and others remain in process. As a result, I have been asked to provide my report in relation to those Public Officers for whom all relevant investigations and processes are now complete, and to provide a later, supplementary report in relation to those Public Officers who remain subject to investigations and processes, once those are completed. This initial report delivers my findings in relation to 18 Public Officers, thus leaving 9 to be concluded in due course. I note that by email dated 19 August 2024 I delivered my recommendations in relation to Ms Kathrine Morgan-Wicks so that she was free to provide unhindered assistance in her role as Secretary of the Department of Premier and Cabinet.

Acknowledgements

As a consequence of the need to inquire into relevant police, disciplinary and other investigations and processes that have followed the Inquiry Report, I have requested and have been provided with a large volume of additional materials by the past and current Secretaries of the Justice Department and the Department of Premier and Cabinet, members of the Attorney-General's Office, by his Department, and by the Department of Premier and Cabinet. I take this opportunity to thank the Attorney-General, the members of his staff and the officers of the Tasmanian Public Service, including in particular Ginna Webster, Oliver Hinss, Courtney Ingham and Kristy Bourne, who have ably and rigorously assisted me in providing the necessary and in some cases very extensive materials for me to carry out my Independent Review in a manner that is as comprehensive, rigorous, and fair as possible to all those potentially affected.

I would also like to pay particular thanks to Dr David Blumenthal of the Victorian Bar who has ably assisted me in every aspect of the preparation and presentation of this review.

B: PRELIMINARY MATTERS

Relevant Provisions of Employment Direction No. 16

The specific policies setting out the terms of ED16 for the purposes of this Independent Review are:

- *Employment Direction No. 16: INDEMNITY AND LEGAL ASSISTANCE* including *Policy and Guidelines for the Grant of Indemnities and Legal Assistance to Public Officers of the State of Tasmania*,² and
- *Addendum to the Policy and Guidelines for the Grant of indemnities and Legal Assistance to Public Officers of the State of Tasmania (the Policy and Guidelines): Public Officers served with a notice to appear before the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings*.³

For simplicity, throughout this report I refer to both of these documents together as “ED16”, although if necessary I will refer specifically to the Addendum.

As alluded to above, ED16 recognises the fact that Public Officers may be subject to legal proceedings, inquiries or other investigations arising from their roles and that “[p]roviding legal assistance and indemnity to Public Officers is essential to the protection of the Crown’s interest, the fair treatment of its employees, and the effective management of an organisation.”

Under ED16, a Public Officer may request legal assistance (and indemnities) in respect of inquiries and investigations arising out of their acts or omissions done in good faith in the course of their public office. The Indemnity and Legal Assistance Panel (“**the Panel**”) considers such applications and determines whether or not to grant each such request by reference to the policies and conditions set out in ED16.

² https://www.dpac.tas.gov.au/__data/assets/pdf_file/0014/32441/Employment_Direction_no_16_-_Jul_2021-Indemnity_and_Legal_Assistance.pdf

https://www.dpac.tas.gov.au/__data/assets/pdf_file/0019/32185/Attachment_1_Policy_and_Guidelines_for_the_Grant_of_Indemnities_and_Legal_Assistance_to_PublicOfficers_of_the_State_of_Tasmania.PDF

³

https://www.dpac.tas.gov.au/__data/assets/pdf_file/0032/134798/FINAL_Addendum_to_Policy_and_G_nquiry_into_Child_Sexual_Abuse.PDF

The ED16 framework emphasises the ‘good faith’ of Public Officers as a condition of receiving legal assistance and that those Public Officers are acting within the scope and course of their employment, and not against the interests of the Crown:

Public Officers may be subject to legal claims/actions despite the fact that they are acting in good faith, within the scope of their duties or in the course of their employment. It is therefore necessary that they receive appropriate legal representation and be protected from personal liability as long as they are not acting against the interests of the Crown.⁴

I note that while ED16 provides for both legal assistance and indemnities, it is my understanding that indemnities would generally be provided to Public Officers exposed to potential liability in civil claims related to their employment. Indemnities of this kind would have no role to play for Public Officers appearing before a Commission of Inquiry. It appears to me that only legal assistance has been provided to the subjects of this Independent Review. In this regard, I note that Paragraph 3.11 of ED16, which deals specifically with inquiries and investigations, only refers to grants of legal assistance. It also incorporates a requirement of good faith in the following terms:

The Panel may grant legal assistance to a Public Officer in relation to the officer’s participation in an inquiry or investigation by a body other than a law enforcement agency where the Panel is satisfied that -

- a) the investigation or inquiry relates to the employment, office or official duties or functions of the Public Officer;
- b) it appears to the Panel that the Public Officer has acted in good faith;
- c) the matter giving rise to the inquiry or investigation for which the legal assistance is sought does not relate to a complaint by a Public Officer against another Public Officer; and
- d) it is in the interest of the Crown that the Public Officer be assisted.

In accordance with above I have referred throughout this report to the provision of ‘legal assistance’ under ED16.

⁴ ED16; 1. Introduction.

Basis for the Crown to seek recovery under ED16

Pursuant to Clause 3.20 of ED16, the Crown, through the Panel, may impose conditions on grants of legal assistance. The Crown may also seek reimbursement of any legal assistance granted in circumstances including:

- Where the conduct of the Public Officer in relation to which an indemnity or legal assistance was granted was not carried out in good faith;
- Where the conduct of the Public Officer in relation to which an indemnity or legal assistance was granted did not arise in the course of public office;
- Where the Public Officer is found guilty of an offence or crime constituted by or including the conduct in relation to which an indemnity or legal assistance was granted; and
- Where the Public Officer is found guilty of misconduct of a kind that would warrant the Public Officer's dismissal or the revocation by a Professional Registration Authority of the professional practice rights or the registration of the Public Officer.

In addition, Clause 3.21 of ED16, titled "Withdrawal of indemnity or legal assistance", provides that:

An indemnity or grant of legal assistance may be withdrawn or revoked if the Panel considers that -

- a) the Public Officer is not cooperating fully with the legal representatives appointed by the Crown to represent the Public Officer;
- b) the information provided by the Public Officer to support the indemnity and/or grant of legal assistance is found to be intentionally or recklessly incorrect or misleading;
- c) new information emerges which, if known to the Panel at the time of granting the application for indemnity or legal assistance would probably have led to the Panel to decide not to grant the indemnity legal assistance; or
- d) the Public Officer does not comply with the conditions of the grant of assistance.

If legal assistance is withdrawn the Crown may seek to recover any costs paid by the Crown to that time from the Public Officer.

Further, the notice requirements set in Clause 3.2 of ED16 state that:

If, in the course of any legal proceedings, inquiry or investigation, the Public Officer acts unreasonably, or intentionally or recklessly fails to make full and frank disclosure of relevant matters, an indemnity or legal assistance may be refused or withdrawn.

These requirements are reinforced by Clause 12 of the Addendum to ED16, which imposes a mandatory condition on all grants of legal assistance in relation to the Commission of Inquiry:

An indemnity or grant of legal assistance may be withdrawn in accordance with cl 3.21 of the [ED16] Policy and Guidelines. A condition of the indemnity or grant of legal assistance will be, in every case, that if, in the course of the provision of evidence, the PO acts unreasonably, or intentionally or recklessly fails to make full and frank disclosure or [*sic*] relevant matters, the indemnity or legal assistance may be refused or withdrawn.

I also note the following condition that was generally attached by the Panel to grants of legal assistance to the subjects of this Independent Review:

Should it become apparent to the Crown, or determined in the proceedings that [Public Officer] did not at a relevant time act in good faith, the indemnity will cease automatically and [Public Officer] will be required to reimburse to the Crown its reasonable costs and expenses incurred as result of the provision of this indemnity, including the legal representation provided to [Public Officer] and paid for by the Crown. The reasonableness of the costs or expenses so incurred will be determined by the Solicitor-General and that determination will be final and binding on [Public Officer].

I note that while this condition purports to operate ‘automatically’ should the Crown determine that a Public Officer in receipt of legal assistance did not act in good faith at a relevant time, the fact that the Attorney-General has commissioned this Independent Review indicates the Crown’s acceptance of the need for a more robust and nuanced process for determining whether to seek reimbursement under ED16. This process includes an element of reasonableness and discretion on the part of the Crown, even where a lack of good faith on the part of a Public Officer, including by a breach of the criminal law, has been established. It is my understanding that in this way this Independent Review effectively supports the above condition, by ensuring the Crown is properly and independently informed as to whether to seek reimbursement under ED16.

Potential bases for making a recommendation to seek reimbursement pursuant to ED16

In light of the grounds for seeking reimbursement under ED16 discussed above, I have considered, as relevant, the criteria listed in A – E below in determining whether to recommend that the Crown seek reimbursement for legal assistance paid in relation to each Public Officer subject to this Independent Review. I have incorporated my findings in relation to these criteria, as well as other relevant considerations, into my recommendations in relation to each Public Officer in Part D of this report.

A: Good faith

Condition: *In relation to the events that were the subject of investigation by the Commission of Inquiry, did the Public Officer act in good faith?*

As noted above, the term ‘good faith’ appears throughout ED16 as a requirement for legal assistance to be granted and maintained.

ED16 includes the following definition of ‘good faith’:

“good faith” when used in relation to the actions or omissions of a public officer means actions and omissions that are honest, sincere and reasonable, done or omitted to be done without any intention to harm the interests of the Crown. Further, without limitation, the following acts or omissions as referred to in section 49B of the *Civil Liability Act 2002* are, for the purposes of this policy, taken not to be acts or omissions in good faith –

- a) actions or omissions that constitute serious and wilful misconduct or a serious breach of a code of conduct applicable to the Public Officer;
- b) dishonest, fraudulent, or malicious actions or omissions of a Public Officer.

A number of the subjects of this Independent Review were also the subject of investigations into their conduct pursuant to the terms of Employment Direction No. 5 (“ED5”) in response to adverse findings of fact made in the Inquiry Report. The stipulation in note a) above is of particular relevance to the nature and general implications of the outcomes of these post-inquiry ED5 investigations as discussed in more detail below.

Taking into account the policies and definitions set out in ED16, in conducting this Independent Review I have treated conduct not being in ‘good faith’ to include:

- (i) Acts and omissions that were not honest, sincere and reasonable;
- (ii) Acts and omissions that were done or omitted to be done with an intention to harm the interests of the Crown;
- (iii) Acts or omissions that constitute serious and wilful misconduct or a serious breach of a code of conduct applicable to the Public Officer, which for the purposes of this Independent Review, is the Public Service Code of Conduct;
- (iv) Dishonest, fraudulent, or malicious acts or omissions of a Public Officer.

B: Conduct in the course of public office

Condition: *In relation to the events that were the subject of investigation by the Commission of Inquiry, was the Public Officer engaged in conduct that arose in the course of their public office?*

I am satisfied that in relation to each of the Public Officers who are the subject of this Independent Review, all relevant conduct that could form the basis of a recommendation to seek reimbursement pursuant to ED16 was carried out in the course of their public office.

C: Criminal findings

Condition C1: *Has the Public Officer been found guilty of an offence constituted by or including the conduct in relation to which legal assistance was granted?*

Condition C2: *Are criminal investigations or legal proceedings currently underway in relation to or including the conduct in relation to which legal assistance was granted?*

In relation to these two conditions, I have been informed by Tasmania Police, through the Commission of Inquiry Response Taskforce in the Department of Justice, that none of the Public Officers who are the subject of this Independent Review have been found guilty of offences, or are the subject of criminal proceedings, in relation to the findings of the Commission of Inquiry.

D: Professional misconduct findings

Condition D1: *Regarding the conduct in relation to which legal assistance was granted, did the Public Officer engage in misconduct of a kind that would warrant the Public Officer's dismissal or the revocation by a Professional Registration Authority of the professional practice rights or the registration of the Public Officer?*

Condition D2: Regarding the conduct in relation to which an indemnity or legal assistance was granted, is the Public Officer currently subject to an inquiry into misconduct of a kind that would warrant the Public Officer's dismissal or the revocation by a Professional Registration Authority of the professional practice rights or the registration of the Public Officer?

Consistent with my approach to other bases for recommending recovery under ED16, if no proceedings for professional misconduct have been conducted in relation to a Public Officer, I have not based my recommendations on speculation regarding the outcome of such theoretical proceedings. Where condition D2 arises, I consider that if there was not already a sufficient basis to recommend the Crown seek recovery from that Public Officer on one or more of the other bases outlined here, it would be necessary to wait for the outcome of any extant misconduct proceedings before making a recommendation in relation to that Public Officer.

E: Conduct of the Public Officer while providing evidence to the Commission of Inquiry

Condition E: In the provision of evidence to the Inquiry, did the Public Officer act unreasonably, or intentionally or recklessly fail to make full and frank disclosure of relevant matters?

This condition, which relates to each Public Officer's conduct in giving evidence to the Commission of Inquiry itself, rather than to the subject matter of its investigations, is imposed by Cl 3 of ED16 and Cl 12 of the Addendum to ED16.

Seriousness and nature of contraventions of conditions taken into account

I note that contravention of one or more of conditions A – D above does not necessarily indicate that action for reimbursement of legal assistance provided under ED16 will be reasonable or appropriate. Rather, in formulating my recommendations I have carefully considered the seriousness and nature of any contravention, with reference to the conditions imposed by ED16 and its Addendum, particularly contraventions of the State Service Code of Conduct. I discuss this further below in the context of investigations carried out under ED5.

In this context I also note that ED16 provides that even a criminal contravention by a Public Officer provided with legal assistance does not necessarily indicate that reimbursement should be sought, and that there are also degrees of culpability in relation to revocation of professional practice rights. Cl 3.20 of ED16 states:

Before seeking reimbursement of legal costs the following consideration applies:

- a) In the case of an offence, the Crown – on advice from the Panel - may take into account the nature of the offence, any mitigating circumstances and the severity of the sentence imposed.
- b) In the case of revocation of professional practice rights the Crown may take into account whether the Public Officer's practice rights have been revoked or fully or partially suspended and the length of period of any suspension and the impact that may have on the Public Officer's ability to continue his or her public sector employment. In some cases a partial revocation of practice rights, such as a requirement to practise supervised, may not warrant a total reimbursement of legal assistance costs.

Recovery under ED16 not to be understood as punitive measure

A Commission of Inquiry is not a court of law. It is an executive inquiry, the primary purpose of which is to investigate systemic issues of significant importance to the State. Commissions of Inquiry are not usually established to look specifically for the proverbial 'rotten apples' as a police taskforce or professional regulatory body might, although such individuals will often be identified in the course of its processes. As an executive body, a Commission of Inquiry cannot punish identified rotten apples, as a court is empowered to do. Rather, the primary purpose of a Commission of Inquiry is to inquire into systemic issues impacting the health of the apple tree, or of the orchard, as the case may be.

In conducting this Independent Review I have been concerned to ensure that the Crown's power to order the reimbursement of legal assistance granted is not used to punish Public Officers who the Commission of Inquiry may have found to have failed in aspects of their duties. This is particularly the case because, as the Inquiry Report makes clear, many of the identified failures by Public Officers occurred in the context of long-standing and ubiquitous systemic failings in protecting young persons from sexual abuse, and which were the primary focus of the Commission of Inquiry.

As I read ED16, and related conditions attached to grants of legal assistance authorised by the Panel, the purpose of the claw-back provision is to ensure a degree of accountability under the policy designed to ensure the fair treatment of Public Officers who become engaged in legal proceedings as a consequence of matters arising in the course of their employment by the Crown.

Further, it seems clear that the policy objective of the reimbursement policy under ED16 is to ensure that a Public Officer be required to return taxpayer funds provided to fund their legal representation in a range of circumstances that effectively vitiate that Public Officer's right to receive legal assistance from the Crown, including in circumstances where

a Public Officer has not acted in good faith by committing serious breaches of the State Service Code of Conduct, or has significantly breached relevant professional standards.

I have taken a similar approach where a Public Officer is found to have misled the Commission of Inquiry itself. It is axiomatic that Public Officers working in a flawed system may well have engaged in conduct that arises from, and that perpetuates, those systemic flaws. Uncovering the systemic flaws driving poor conduct and outcomes, and using the opportunity to learn from them in order to avoid further harm, are key reasons for establishing Commissions of Inquiry, such as the present one.

Accordingly, where Public Officers admit fault, and engage fully and truthfully with the Commission of Inquiry to support its investigative work, it is important to ensure they are not punished for their candour. Complete honesty and cooperation on the part of those who were part of a flawed system is a vitally important step in ensuring systemic flaws are identified and remediated.

In contrast, a lack of good faith in engaging with the Commission of Inquiry can undermine the work of the Inquiry, is inimical to the public good, and is precisely the kind of conduct that is rightly identified in the ED16 policy framework as a basis to abrogate a Public Officer's right to state-funded legal assistance.

Standard of Proof and the Briginshaw principle

In making findings on which I have based my recommendations, I have applied the civil standard of proof, which requires proof 'on the balance of probabilities'. This is the same standard of proof applied in most civil inquiries, including by the Commission of Inquiry itself and in the subsequent investigations pursuant to ED5, to which I often refer.

In applying this standard of proof, I have also applied the Briginshaw principle (*Briginshaw v Briginshaw* (1938) 60 CLR 336), which requires that the degree of probability required to make any given finding increases proportionately with the gravity of that finding. In the context of this Independent Review, because of the gravity of the matters I am bound to consider and the consequences of any recommendation I might make as a result, I have required a high standard of probative evidence in order to be satisfied of such circumstances on the balance of probabilities.

Consideration of the impact of an order for reimbursement pursuant to ED16, reasonableness and the requirements of procedural fairness

In formulating my recommendations to the Tasmanian Government, I have been mindful of the purpose of this Independent Review in ensuring the proper accountability of Public Officers who were provided with legal assistance pursuant to ED16. Where Public Officers have breached the conditions for being provided with legal assistance set out in ED16, particularly in relation to acting in good faith and engaging with the Commission of Inquiry in a cooperative and truthful manner, the basic requirements of accountability may support a recommendation that the Crown seek reimbursement for any legal assistance paid.

However, I have also been mindful of the potential adverse financial and other impacts on Public Officers of an order to reimburse the Crown for legal assistance provided pursuant to ED16. Many of those criticised in the Inquiry Report may have already undergone significant hardship, including being publicly identified and criticised in the course of the Commission of Inquiry, in the media, and in some cases, in the Tasmanian Parliament. Some individuals have had their employment as Public Officers terminated or their careers shortened as a consequence of conduct identified through the Commission of Inquiry, which may in and of itself impose considerable financial hardship on both the individual and, depending on their circumstances, their families.

In addition to financial hardship, any public disclosure of an order to reimburse legal assistance funding, while of potential benefit to the public in terms of ensuring a high degree of transparency and accountability with respect to the operation of ED16, may also have the effect of increasing the public opprobrium an individual has already been subjected to as consequence of the findings of the Commission of Inquiry and subsequent public commentary.

I am required to balance the need for proper accountability pursuant to ED16 with the potential hardship that such accountability may cause by the Terms of Reference of this Independent Review. Specifically, I interpret the Terms of Reference as requiring me to consider not only whether the Crown has proper grounds to seek reimbursement of legal costs from any Public Officer pursuant to ED16, but also, to consider whether it is **reasonable** to seek such reimbursement.

In addition to the potential hardship that may be caused to a Public Officer by the making of an order to reimburse the Crown, some of the determinations on which I have based my recommendation, despite being based on prior findings of fact, are in some respects novel with respect to the specific matters found, such as a lack of good faith constituted by a serious breach of the Code of Conduct.

Procedural Fairness

Without wanting to unduly add delay or complexity to any process of reimbursement the Crown may seek pursuant to ED16, I recommend that if the Crown accepts a recommendation to seek reimbursement from a Public Officer for legal assistance received pursuant to ED16, the Crown should first write to that individual setting out a summary of my findings, and inviting that individual to respond within 21 days (or such other time as is considered reasonable by the Attorney-General) with respect to the findings themselves and whether they believe that an order for reimbursement of legal assistance would cause them particular hardship that the Crown should consider prior to making such an order.

In relation to ensuring that the requirements of procedural fairness are met in relation to any order to a Public Officer for reimbursement of legal assistance, I also note that Clause 3.23 of ED16 provides that:

Nothing in this policy affects the right of a Public Officer to apply to the Cabinet for legal assistance or an indemnity or to seek a declaration or other relief from a court of competent jurisdiction in the event an indemnity or legal assistance is refused or withdrawn.

I also note that some Public Officers received relatively small sums of legal assistance, in a number of cases amounting to less than \$10,000. In assessing the ‘reasonableness’ of any recommendation to seek reimbursement I have focussed on the policy framework of ED16, and I have not sought to make any threshold assessments of the commercial efficacy and practicality of seeking reimbursement of relatively small sums of legal assistance. This is a matter the Crown may choose to address in considering whether to act on my recommendations.

C: PROCESS OF THE INDEPENDENT REVIEW

Inquiry Report

The Inquiry Report formed the starting point for my work on this Independent Review. I take this opportunity to acknowledge the Commissioners and all who assisted them for their rigorous and tireless examination of what is complex and harrowing subject matter. I also acknowledge and recognise the hundreds of victim-survivors and their families who so courageously provided evidence of the suffering and the injustice they have endured, and that many continue to endure.

In reading the Inquiry Report, I focussed particularly on findings of fact made in relation to the 27 subjects of this Independent Review.

At my request I was also provided with access on a confidential basis to , Case Study 1 of Volume 6, Chapter 14, which at the time of the Independent Review was subject to a Restricted Publication Order. I reviewed this Case Study to determine whether it contained any findings or outcomes relevant to this Independent Review.

While reading the Inquiry Report, I was cognisant of the fact that the Commissioners had made clear that compliance with the requirements of sections 18 and 19 of the Commissions of Inquiry Act had the practical effect of constraining the capacity of the Commissioners to make adverse findings against a number of witnesses.

Consistent with this position, a review of the Commission's findings indicates that the Commissioners have, with some notable exceptions, often attributed the actions and omissions that resulted in the sexual abuse of children in the institutions under investigation primarily to systemic factors, rather than directly to misconduct by specific – or at least, specifically identified – individuals. The Commissioners state:

Most often, we found that people made bad decisions or failed to respond to child sexual abuse effectively because of the flawed systems they worked in. This often made it hard to single out any one individual for an adverse finding, even when we felt their response was poor. However, we have made some findings that relate to the actions of individuals, particularly in the case study on James Griffin in Chapter 14, where we consider the conduct of those individuals could not be blamed on a systemic failure alone.⁵

⁵ Inquiry Report, Volume 1, p.25.

The Commissioners also state:

We heard arguments that any adverse comment about an individual's behaviour could constitute misconduct (for example, because it was a breach of the very broad State Service Code of Conduct). This interpretation made it difficult and, in some cases, impossible for us to make some of the findings we might otherwise have made.

...

As a result, we had to make some difficult decisions about how we wrote our report and framed our findings. This involved balancing the public interest in holding individuals and systems to account with the public interest in prioritising effort and funding to tangible changes to protect children... Most of our findings relate to systemic failures by the State.⁶

Reliance on findings in the Inquiry Report

I note that Section 21 of the Commissions of Inquiry Act states that "Evidence given by a person before a Commission is not admissible in subsequent legal proceedings other than proceedings against that person under this Act." I am satisfied that this Independent Review does not satisfy the requirement of a 'legal proceeding' for the purposes of section 21, and that accordingly I am able to rely on findings of fact made in the Inquiry Report in assessing whether an individual has complied with the conditions imposed by ED16.

That being said, while the Inquiry Report provides important context and a starting point for my work, I have sought out and examined a wide range of additional materials, as outlined below in conducting this Independent Review.

Additional materials relied on

Notwithstanding the constraints described by the Commission of Inquiry in relation to making adverse and misconduct findings against individuals, the findings of fact detailed in the Inquiry Report formed the basis for a range of referrals, investigations and other processes in relation to a number of the Public Officers who are the subject of this Independent Review. The Commissioners note in the Inquiry Report that as at February 2023, 92 State Servants had been suspended due to allegations of child sexual abuse, that 38 of those state servants were suspended following the establishment of the Inquiry,⁷ and that the Commission had made some 230 referrals to 'appropriate authorities' in relation to more than 100 individuals, under section 34A of the Commissions of Inquiry Act.⁸

While factual findings made by the Commission of Inquiry provided a necessary starting point for this Independent Review, I have made only one recommendation that the Crown

⁶ Inquiry Report, Volume 1, pages 25 – 26.

⁷ Inquiry Report, Volume 1, page 4.

⁸ Inquiry Report, Volume 2, page 13.

should seek recovery based solely on these factual findings. That recommendation is in relation to Dr Renshaw, for the reasons set out below. In relation to all other subjects of this review, in determining whether to make recommendations for the Crown to seek reimbursement for legal assistance provided under ED16, I have relied on the outcomes of referrals, investigations and other processes carried out during and subsequent to the Commission of Inquiry, including the following:

- The content and outcome of referrals pursuant to section 34A of the Commissions of Inquiry Act into relevant conduct of any of the 27 Public Officers subject to this Independent Review;
- The outcome of any criminal investigations and processes in relation to relevant conduct of any of 27 Public Officers subject to this Independent Review;
- The outcome of any independent ED5 investigations into potential breaches of the Code of Conduct in relation to relevant conduct of any of the 27 Public Officers subject to this Independent Review, and determinations made by departmental secretaries and other senior departmental officers in response to those completed investigations (including the circumstances surrounding any decision to discontinue or not to commence an ED5 investigation due to the resignation from the State Service of a subject of this Review); and
- Miscellaneous independent inquiries into individuals and matters identified in, and adjacent to, matters identified in the Inquiry Report.

This additional material was provided to me in tranches throughout the conduct of this Independent Review, some of it as it became available as post-Inquiry Report investigations were completed.

I outline briefly below each of the categories of additional materials I've relied on as they are relevant to this Independent Review.

Applications for Indemnity and Legal Assistance pursuant to ED16, and the Determinations by the Indemnity and Legal Assistance Panel

The application for legal assistance made by each Public Officer under ED16 provides details of the subject matter of their involvement in the Commission of Inquiry.

A determination was then made by the Panel whether to grant each application, and if granted, that determination included notification of any matters and conditions attached to that grant. Each determination granting legal assistance includes a confirmation of the presumed good faith of the Public Officer on which the grant is contingent, stating that: “On the basis of the material provided, the Panel has determined that [Public Officer] appears to have acted in good faith at all times.”

Referrals pursuant to section 34A of the Commissions of Inquiry Act

Section 34A of the Commissions of Inquiry Act empowers a Commission of Inquiry to refer individuals believed to have contravened the law to law enforcement and regulatory authorities, including the Attorney-General, the Director of Public Prosecutions, and authorities or persons responsible for the administration or enforcement of the relevant law. Section 34A also provides a wide range of further referral powers, including in circumstances where a Commission obtains information or evidence in relation to a person that relates, or may relate, to the safety and protection of children.

The Inquiry Report states that the Commissioners made some 230 referrals to Tasmanian and other government authorities in relation to over 100 individuals under s.34A of the Commissions of Inquiry Act.⁹

In response to a request by me for information about any section 34A referrals made with respect to the Public Officers who are the subject of this Independent Review, the Tasmanian Government confirmed that only two of the 27 Public Officers were referred under section 34A: [REDACTED] and [REDACTED]. I deal with the content, outcomes and implications of those s.34A referrals under the respective sections dealing with those individuals in Part D of this report.

I also note that concerns had been raised in public regarding whether the Commission had made all the section 34A referrals it deemed appropriate, or whether it felt constrained from making some referrals by legal strictures imposed by the Commission of Inquiry Act, time constraints or other factors. I have been provided with an exchange of correspondence between Premier Rockliff, Attorney-General Barnett and the Commissioners, in which the Commissioners confirm (in their private capacities given the Commission had concluded at the time of the correspondence) that they were confident that the Commission of Inquiry had made all referrals it was legally required to make.

⁹ Inquiry Report, Chapter 1, page 13.

Investigations pursuant to Employment Direction No. 5 (“ED5”)

ED5 established procedures for the investigation and determination of whether an employee of the Tasmanian Government has breached the State Service Code of Conduct (“**Code of Conduct**”). Investigations under ED5 are commenced when the head of an agency appoints an investigator in writing, informing them of matters including the scope of the investigation, the allegations to be investigated, and the requirements of a written report.

ED5 investigations appear to be carried out in broad compliance with the requirements of procedural fairness. The employee subject to the investigation is informed that the investigation is being carried out, the name of the investigator, the allegations against them, and of their right to engage a person to assist them through the process. Other measures of procedural fairness include that the employee has a right to present their version of relevant events to the investigator, an obligation for the investigator to provide their findings and reasons to the employee, and a right for the employee to appeal against a range of sanctions that may be imposed if a breach of the Code of Conduct is found.

In response to factual findings made by the Commission of Inquiry, ED5 investigations were carried out into many of the subjects of this Independent Review. The outcomes of these investigations are of particular significance to the formulation of my recommendations. This is in part because the definition of good faith in ED16 (as cited above) stipulates that actions or omissions that constitute serious and wilful misconduct or *a serious breach of a code of conduct applicable to the Public Officer* are, for the purposes of ED16, taken *not* to be acts or omissions in good faith.

I am also satisfied that the ED5 investigations provide a further layer of procedural fairness for Public Officers subject to a potential order for reimbursement of legal assistance pursuant to ED16. This is because the independent investigators carry out their own inquiries, and make findings of fact independently of those made by the Commission of Inquiry, and include an opportunity for the Public Officer to engage.

Not all breaches of State Service Code of Conduct indicate a lack of ‘good faith’

Not all breaches of the Code of Conduct identified by an ED5 investigation are necessarily indicative of a lack of good faith for the purposes of seeking reimbursement under ED16. As noted above, the definition of ‘good faith’ in ED16 references ‘**serious**’ breaches of a code of conduct applicable to a Public Officer, rather than **any breach** of an applicable code of conduct.

Section 9 of the *State Service Act 2000 (Tas)* sets out the terms of the State Service Code of Conduct as follows:

- (1) An employee must behave honestly and with integrity in the course of State Service employment.
- (2) An employee must act with care and diligence in the course of State Service employment.
- (3) An employee, when acting in the course of State Service employment, must treat everyone with respect and without harassment, victimisation or discrimination.
- (4) An employee, when acting in the course of State Service employment, must comply with all applicable Australian law.
- (5) For the purpose of subsection (4),
Australian law means –
 - (a) any Act (including this Act) or any instrument made under an Act; or
 - (b) any law of the Commonwealth or a State or Territory, including any instrument made under such a law.
- (6) An employee must comply with any standing orders made under section 34(2) and with any lawful and reasonable direction given by a person having authority to give the direction.
- (7) An employee must maintain appropriate confidentiality about dealings of, and information acquired by, the employee in the course of that employee's State Service employment.
- (8) An employee must disclose, and take reasonable steps to avoid, any conflict of interest in connection with the employee's State Service employment.
- (9) An employee must use Tasmanian Government resources in a proper manner.
- (10) An employee must not knowingly provide false or misleading information in connection with the employee's State Service employment.
- (11) An employee must not make improper use of –
 - (a) information gained in the course of his or her employment; or
 - (b) the employee's duties, status, power or authority –in order to gain, or seek to gain, a gift, benefit or advantage for the employee or for any other person.
- (12) An employee who receives a gift in the course of his or her employment or in relation to his or her employment must declare that gift as prescribed by the regulations.
- (13) An employee, when acting in the course of State Service employment, must behave in a way that upholds the State Service Principles.
- (14) An employee must at all times behave in a way that does not adversely affect the integrity and good reputation of the State Service.
- (15) An employee must comply with any other conduct requirement that is prescribed by the regulations.
- (16) For the purposes of this section, a reference to an employee includes a reference to an officer and a reference to State Service employment includes a reference to an appointment as an officer and an arrangement made under section 46(1)(a).

Some ED5 investigations into the conduct of subjects of this Independent Review concluded that breaches of section 9(2) of the Code of Conduct occurred, however, a lack of care and diligence in employment does not necessarily indicate to me a 'serious' breach constituting a lack of good faith for the purposes of ED16.

Similarly, a number of Public Officers have been investigated for a possible breach of section 9(14) of the Code of Conduct. Even where such a breach has been substantiated, I have taken a narrow view of whether engaging in conduct that 'adversely affects the integrity and good reputation of the State Service' can constitute a 'serious' breach of a code of conduct for the purposes of ED16. As noted above, the Inquiry Report attributes causation in large part to identified systemic problems in the State Service. In light of this, holding individual Public Officers who were employed by, and often trained within, the State Service accountable for conduct that is at least in part referable to identified systemic flaws within that Service requires a high threshold to be reached. In my view, a 'serious' breach of section 9(14) would require conduct by a Public Officer that cannot be explained by reference to the systemic problems identified.

In contrast to the example above, where ED5 investigators concluded that significant breaches of sections 9(1) or 9(10) occurred, indicating a lack of honesty on the part of the Public Officer, I have been more inclined to find such breaches are of a sufficiently serious nature as to form the basis of a recommendation to the Crown to seek reimbursement of legal assistance paid under ED16. This is particularly the case where significant sanctions are imposed on that Public Officer for a proven breach, including dismissal from the State Service.

Where there has not been an independent ED5 investigation to determine whether breaches of the Code of Conduct in fact occurred, I have been reticent to conclude that findings in the Inquiry Report that indicate a lack of 'good faith' are sufficient to base a recommendation to seek reimbursement pursuant to ED16. Similarly, where the Inquiry Report makes adverse findings concerning a Public Officer, but there has been no subsequent independent investigation into the impugned conduct by a body such as the police or a professional standards organisation, I have been reticent to conclude those findings indicate a lack of 'good faith' sufficient to base a recommendation to seek reimbursement pursuant to ED16.

In contrast to the fairly constrained approach outlined above, I have taken a less lenient view where Public Officers were found by the Commission of Inquiry to have engaged in conduct that is conspicuous because it indicates failings that are not primarily referable to the systemic problems identified in the Inquiry Report. This is particularly the case where the conduct of a Public Officer appears to involve a degree of dishonesty, carelessness as to the truth, or other failings indicative of a lack of good faith as the term is generally understood. This is particularly the case where a lack of good faith has effectively been

confirmed by a subsequent independent investigation under ED5, and a determination that a serious breach of the Code of Conduct related to integrity has occurred. In such circumstances I have concluded that the demonstrated lack of good faith engaged in by those Public Officers is of a kind that justifies a recommendation to seek reimbursement under the terms of ED16.

In summary, in formulating my recommendations I have considered the implications of any findings from ED5 investigations, taking into account the nature and severity of any breach of the Code of Conduct, and any other relevant circumstances.

Where ED5 investigations have been recommended, but not commenced due to the resignation of the Public Officer

There are a number of individuals who are the subject of this Independent Review who would have been referred for investigation under ED5 but who resigned prior to these investigations occurring. The Public Service advice is clear; no ED5 investigation can take place if the subject is no longer a Public Officer. Nevertheless, the inability to carry out an ED5 is a matter of record and if that person re-applies to work in the State Service, the frustrated ED5 investigation may then be pursued.

The threshold for commencing an ED5 investigation is fairly low, requiring only that the decision-maker is satisfied there are “reasonable grounds to believe that a breach of the Code [State Service Code of Conduct] may have occurred”.¹⁰ Accordingly I place no weight on the fact that a particular ED5 was made otiose by the resignation of the person concerned.

Criminal processes

As noted above, ED16 provides for reimbursement of legal assistance provided where a Public Officer is convicted of an offence or crime constituted by or including the conduct in relation to which an indemnity or legal assistance has been granted. The Tasmanian Government has confirmed that none of the 27 subjects of this Independent Review are subject to criminal proceedings in relation to conduct for which they were provided with legal assistance under ED16.

¹⁰ ED5, Clause 8.1.

Reports of other independent reviews following the Commission of Inquiry

Since the Commission of Inquiry reported in August 2023, there have been several further independent reviews conducted into matters arising from the Inquiry Report and matters related to the circumstances of the Inquiry. I have closely examined the reports of three of these independent inquiries that are relevant to this Independent Review, and have referenced them where their findings are relevant to the individual assessments in Part D of this report. The independent inquiry reports I considered were:

- **The Bartlett Report.** On 10 September 2021, then Premier Gutwein appointed Ms Melanie Bartlett to carry out an *Independent Review into Processes Conducted by the Department of Communities Tasmania* in response to the Complaints made by RC - 1 [REDACTED], who was a Clinical Practice Consultant working at AYDC. RC - 1 [REDACTED] complaints concerned workplace bullying, assault and sexual harassment, and had been the subject of an [REDACTED] Ms Bartlett's report was provided to Premier Gutwein on 22 October 2021.
- **The Bowen Report.** On 23 September 2021, Premier Gutwein appointed Mr Peter Bowen to carry out an inquiry into a complaint made by RC - 1 [REDACTED], a Clinical Practice Consultant working at AYDC, regarding the conduct of Mr Pervan, the then Secretary of the Department of Communities Tasmania. Mr Bowen provided his report on 30 March 2022.
- **The Blake Review.** In around November 2023, Former Tasmanian Auditor-General, Mike Blake AM, was commissioned by the Tasmanian Government to carry out an independent assessment of concerns raised by the Commission of Inquiry in respect of actions by selected past or present Heads of Agencies. Mr Blake reported to Premier Rockliff on 28 March 2024, and provided an Addendum to his report on 16 June 2024, concluding that none of the departmental Secretaries and acting departmental Secretaries appearing before the Commission of Inquiry breached, or potentially breached, the Tasmanian State Service Code of Conduct.

D: FINDINGS AND RECOMMENDATIONS IN RELATION TO PUBLIC OFFICERS THE SUBJECT OF THIS INDEPENDENT REVIEW

Listed below are the 27 Public Officers who were provided with legal assistance under ED16, and who are the subject of this Independent Review. As noted in Part A, this report delivers my findings in relation to the 18 Public Officers in relation to whom all relevant investigations and processes following the Commission of Inquiry are complete. Their names are bolded in the list below. I will provide a supplementary report in relation to the remaining 9 Public Officers as soon as possible following completion of the relevant investigations and processes currently underway regarding those officers.

1. **Ms Jacqui Allen**
2. **RC - 2**
3. **Ms Fiona Atkins**
4. **Dr Stephen Ayre**
5. **Ms Kathy Baker**
6. **Mr James Bellinger**
7. **RC - 3**
8. **Ms Helen Bryan**
9. **RC - 3**
10. **RC - 2**
11. **RC - 3**
12. **Mr Gino Fratangelo**
13. **Ms Madeleine Gardiner**
14. **Matthew Harvey**
15. **RC - 3**
16. **RC - 3**
17. **Ms Claire Lovell**
18. **RC - 3**
19. **Ms Kathrine Morgan-Wicks**
20. **Mr Michael Pervan**
21. **Dr Peter Renshaw**
22. **Mr Patrick Ryan**
23. **RC - 3**
24. **Ms Elizabeth Stackhouse**
25. **Ms Janette Tonks**
26. **RC - 3**
27. **RC - 3**

References to case studies in relation to events at Launceston General Hospital

Volume 6 of the Inquiry Report focusses on the safety of children and young people in the Tasmanian Health Service. The overwhelming evidence received in relation to child sexual abuse in the Tasmanian Health Service related to allegations of abuse at Launceston General Hospital (“LGH”). Accordingly, LGH was a primary focus of the Commission of Inquiry with respect to the Tasmanian Health Service, and Chapter 14 of the Inquiry Report presents three case studies that examine events at LGH. References to the following case studies are used where relevant in my reasons below:

- Case Study 1 examines a complaint made by an individual receiving a health service at LGH. It is subject to a restricted publication order.
- Case Study 2 examines a complaint made in 2001 by an eleven-year-old patient named **RC - 1**, and by her parents, alleging that **RC - 1** was sexually abused by a former doctor employed at LGH referred to by the pseudonym Dr Tim.
- Case Study 3 examines in detail the evidence received about sexual abuse perpetrated by James Griffin over almost twenty years that he was employed as a nurse on the paediatric ward at LGH, commencing in 2001.

SUBJECT 1: MS JACQUELINE ALLEN

Determination pursuant to ED16

On 24 August 2022, the Panel issued a determination under ED16 to grant an application made by Ms Jacqueline Allen for indemnity and legal assistance in relation to the Commission of Inquiry. [REDACTED]

[REDACTED]

I am satisfied on the basis of documents I have seen that such an application was made on or about 18 July 2023 and approved shortly thereafter. Ms Allen received a total of \$10,500 in legal assistance pursuant to the Panel's July 2023 determination.

From July 2020, Ms Allen was the Assistant Director, Safety, Wellbeing & Industrial Relations, which was part of the People and Culture Division of the Department of Communities. In that role she reported to the then Director of People and Culture. Ms Allen resigned on 20 January 2023.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Ms Allen for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

Ms Allen was a witness before the Commission of Inquiry primarily in its examination of children in youth detention at AYDC. Ms Allen was not specifically identified as a subject of any adverse findings of fact in the Inquiry Report, but two of the findings in Case Study 7 of Chapter 11 had relevance to Ms Allen as a senior employee of the Department at the relevant time. The first relevant finding was that:

Finding—The Department did not take appropriate steps to manage risk, make appropriate notifications and progress investigations against Ira, Lester and Stan

(all pseudonyms), which left children and young people at Ashley Youth Detention Centre at potential risk of harm.¹¹

Notably, in relation to the above finding the Commission of Inquiry suggested that the deficiencies arose primarily from systemic problems rather than the failure of particular Public Officers:

At various points between 2019 and 2020, it became clear to the Department that there were serious allegations of child sexual abuse made against Ira, Lester and Stan. We consider these allegations were not treated with the seriousness, urgency and care that was warranted. This had the effect of delayed reporting to relevant bodies and delayed disciplinary action, including the removal of staff from the Centre while a proper disciplinary process was conducted. These delays placed detainees at potential risk of harm in one of the highest risk environments for sexual abuse.

We consider these delays were a result of:

- limited understanding of the range of behaviours that constitute child sexual abuse
- concerns about privacy and sharing information with appropriate authorities
- deficient record keeping
- a corporate loss of knowledge of the Abuse in State Care Program
- a failure to consider the cumulative effect of allegations
- inadequate risk management strategies, including retaining staff on site, inappropriately relying on staff being in non-operational roles, not informing managers about potential risks and deferring action awaiting police direction
- conservative and narrow disciplinary processes, which ultimately gave preference to employee rights at the expense of child safety considerations.¹²

A range of systemic problems are also identified as the primary causes behind the other adverse finding of fact that indirectly impacted Ms Allen as a senior departmental officer at the relevant time.¹³ That finding was:

Finding—The Department failed to adequately consider the safety of detainees and place appropriate weight on public interest considerations in relation to Ira, Lester and Stan until 8 November 2020.¹⁴

In a Minute to Secretary Tim Bullard dated 9 August 2024, the Department for Education, Children and Young People concluded that there were no reasonable grounds to believe that Ms Allen may have breached the Code of Conduct in relation to any of the

¹¹ Inquiry Report, Volume 5 (Book 2) Chapter 11, page 202.

¹² Inquiry Report, Volume 5 (Book 2) Chapter 11, page 202.

¹³ Inquiry Report, Volume 5 (Book 2) Chapter 11, pages 203 - 218.

¹⁴ Inquiry Report, Volume 5 (Book 2) Chapter 11, page 218.

Commission of Inquiry's findings. Secretary Bullard agreed with that conclusion, and also agreed that should Ms Allen seek re-employment, a further assessment of the matters relating to the two findings above might be undertaken prior to her re-employment.

There is no suggestion that in providing evidence to the Commission of Inquiry, Ms Allen unreasonably, or intentionally or recklessly failed to make full and frank disclosure of relevant matters. To the contrary, the Commission of Inquiry specifically thanked Ms Allen for her cooperation, stating that:

... despite her short tenure at the Department, Ms Allen provided us with a large amount of documentary evidence in response to our requests for information. This included in relation to events that occurred before her commencement at the Department and with which she was not involved, and often where we had not been provided with those documents in response to other requests. We were grateful for her efforts in this regard.¹⁵

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Ms Allen engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Ms Allen engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that Ms Allen has not been found guilty of an offence;
- C2: I am satisfied that Ms Allen is not currently subject to criminal investigations or proceedings;
- D1: I am satisfied that Ms Allen has not engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that Ms Allen is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and

¹⁵ Inquiry Report, Volume 5 (Book 2) Chapter 11, page 96.

E: I am not satisfied that in providing evidence to the Commission of Inquiry, Ms Allen acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 2: RC - 2

Determination pursuant to ED16

On 22 November 2022, the Panel issued a determination under ED16 to grant an application made by RC - 2 for indemnity and legal assistance in relation to the Commission of Inquiry.

RC - 2 was the Chief People Officer at the Department of Health.

RC - 2 received a total of \$1,440 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from RC - 2 for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

RC - 2 was not called to give evidence before the Commission of Inquiry, however she provided evidence by way of a witness statement, which was considered and discussed in the Inquiry Report in the context of case study 3 in relation to LGH. RC - 2 is not named in the Inquiry Report, and is identified therein as 'the former Chief People Officer'.

There is only one finding in the Inquiry Report that relates to RC - 2 conduct. That finding relates to RC - 2 role in dealing with a referral to the Integrity Commission by RC - 1, a member of the LGH staff, regarding the response of certain LGH managers to concerns raised about Mr Griffin's conduct. Following an investigation of the complaint titled Project Greystone, the Integrity Commission determined that the matter should be referred back to Ms Morgan-Wicks, as Secretary of the Department of Health, for investigation.

On 2 December 2019, the Integrity Commission's letter and report was referred by Secretary Morgan-Wick's office to RC - 2, who had commenced as Chief People Officer at the Department of Health a few weeks earlier, and who had previously worked in the Department's human resources area. The Inquiry Report states that:

In line with standard practice, the former Chief People Officer allocated the complaint to Mr Bellinger, as then Human Resources Manager, for investigation....

We consider it should have been obvious to the human resources team that allocating the complaint to Mr Bellinger—or indeed to anyone within that team—was inappropriate given their direct involvement in the management of some of the complaints about Mr Griffin (which the complainant took specific issue with). Mr Bellinger had been directly involved in responding to various complaints about Mr Griffin’s behaviour over the years and played a central role in the hospital’s management of more recent staff concerns about how Mr Griffin’s conduct had been managed.

The former Chief People Officer told us they had no reason to believe there was any conflict of interest in Mr Bellinger investigating the complaint forwarded by the Integrity Commission and would have expected either the human resources team or Mr Bellinger to have notified them if there was.¹⁶

In evidence before the Commission of Inquiry, several witnesses agreed that the matter should not have been sent to the human resources team at the hospital because of the potential conflict of interest this raised, though some indicated this was only clear with the benefit of hindsight.

One of the findings in the Inquiry Report in relation to this matter is notable for its focus on the decision of the Integrity Commission to refer the matter back to the Department of Health, rather than **RC - 2** conduct. The finding states:

Finding—The Integrity Commission should have ensured **RC - 1 complaint to them was robustly and independently reviewed**

Although we accept that there may be instances where it is appropriate to refer a complaint back to a principal officer of a public authority for investigation, this should only occur in circumstances where the referring agency, in this case the Integrity Commission, is satisfied that:

- the public authority tasked with the review has adequate processes in place to ensure complaints are robustly and independently investigated
- the referring agency has adequate processes in place to maintain a close level of oversight and scrutiny over an authority’s investigation, to ensure it is robust and independent

¹⁶ Inquiry Report, Chapter 14, page 225.

We note that **RC - 1** complaint to the Integrity Commission did not name human resources staff as subjects of the complaint. However, we consider the Integrity Commission should have been attuned to the risks that could arise in referring the complaint back to the Department, including that it may be investigated by those who had previously been involved with complaints about Mr Griffin's conduct. The Integrity Commission should have set guiding parameters for the Department to avert this, such as specifying that the complaint should not be investigated by those previously connected to the management of complaints involving Mr Griffin.¹⁷

The finding in the Inquiry Report pertaining more directly to **RC - 2** includes the following:

Finding—James Bellinger did not conduct a proper investigation into James Griffin's complaints history and misled the Secretary of the Department and the Integrity Commission

...

It was inappropriate for Mr Bellinger and other hospital human resources staff to undertake the review. Mr Bellinger had a direct conflict of interest in the matter, given that he and other human resources staff were involved in managing complaints about Mr Griffin. An investigation should have ideally been undertaken by a person entirely independent of the hospital, but most certainly not by its own human resources team.

...

We are unclear what, if any, scrutiny Mr Bellinger's superiors in the human resources team applied to this review, noting they recalled only seeing the final letter to the Integrity Commission. We are of the view that Mr Bellinger was not closely supported or supervised by senior managers in the task of responding to the Integrity Commission, which demonstrated an absence of concern by senior leaders about the seriousness of the complaint. This lack of scrutiny enabled the response prepared by Mr Bellinger to the Integrity Commission to contain inaccurate and misleading information.

RC - 2



In reviewing **RC - 2** conduct in relation to the above finding, the Department of Health determined that there was not a sufficient basis to believe that a breach of Code of

¹⁷ Inquiry Report, Chapter 14, page 227.

Conduct may have occurred, and accordingly no ED5 investigation should take place. I have seen no evidence to suggest otherwise, and can see no basis to recommend the Crown seek reimbursement from RC - 2 in relation as a consequence of the matters noted above.

There is no suggestion that in providing evidence to the Commission of Inquiry, RC - 2 unreasonably, or intentionally or recklessly failed to make full and frank disclosure of relevant matters.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that RC - 2 engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that RC - 2 engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that RC - 2 has not been found guilty of an offence;
- C2: I am satisfied that RC - 2 is not currently subject to criminal investigations or proceedings;
- D1: I am satisfied that RC - 2 has not engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that RC - 2 is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, RC - 2 acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 3: MS FIONA ATKINS

Determination pursuant to ED16

On 8 August 2022, the Panel issued a determination under ED16 to grant an application made by Ms Fiona Atkins for indemnity and legal assistance in relation to the Commission of Inquiry.

Ms Atkins commenced employment at AYDC as a Youth Worker in 2000. She was subsequently promoted to a range of more senior roles at AYDC, including as Operations Coordinator, Operations Manager, Assistant Manager, Manager Custodial Youth Justice, and from July 2023, Director Youth Detention.

Ms Atkins received a total of \$12,599 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Ms Fiona Atkins for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

Many of the findings in the Inquiry Report relate to systemic failings and a culture that enabled abuse of children in detention, and the Commission of Inquiry made no adverse findings or findings of misconduct against Ms Atkins personally. However, several matters examined by the Commission of Inquiry related to the conduct of Ms Atkins in the course of her employment as a Public Officer in several roles she held at AYDC between 2002 and 2009. The matters identified in the Inquiry Report concerning Ms Atkins were:

- Case Study 2: Harmful sexual behaviours – that resulted from the Serious Events Review Team's review of an incident involving an individual referred to as 'Henry', that occurred on 7 August 2019;
- The use of isolation with reference to an incident involving the roof that occurred in December 2019;

- The use of isolation and the management response to an incident involving the roof in March 2020;
- Commentary on bullying and other unprofessional behaviour at AYDC, in relation to which Ms Atkins was identified as a subject, rather than a perpetrator, of those behaviours by members of the management group.

A detailed review of the findings in relation to Ms Atkins in the Inquiry Report was carried out by the Department for Education, Children and Young People. The review concluded that none of the findings revealed conduct that could form the basis of a reasonable belief that Ms Atkins may have breached the Code of Conduct. The Secretary of the Department, Mr Tim Bullard, agreed with this conclusion, and determined not to order an ED5 investigation into whether Ms Atkins had breached the Code of Conduct in relation to the findings in the Inquiry Report.¹⁹

Notably, Secretary Bullard also concluded Ms Atkins had, to the extent she was aware of incidents, made appropriate reports to Tasmania Police, and generally acted appropriately by escalating matters as required in compliance with relevant procedures.

[REDACTED]

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[REDACTED]

Determination not to carry out investigations under Employment Direction No. 5 (“ED5”)

On 19 February 2024, Secretary Bullard determined not to commence an ED5 investigation into Ms Atkins’ conduct on the basis that he did not have reasonable grounds to believe that a breach of the Code of Conduct may have occurred. This determination was made following consideration of the following matters:

- The findings of the Commission of Inquiry in relation to Ms Atkins noted above;
- Statements made to the Commission of Inquiry by Ms Atkins and others, AYDC records including incident reports, employment records, search and use of force records and registers, complaint forms and records and AYDC policies and procedures;

- [REDACTED]

[REDACTED]

[REDACTED]

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Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Ms Atkins engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Ms Atkins engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that Ms Atkins has not been found guilty of an offence;

- C2: I am satisfied that Ms Atkins is not currently subject to criminal investigations or proceedings;
- D1: I am not satisfied that Ms Atkins engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that Ms Atkins is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Ms Atkins acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 4: DR STEPHEN AYRE

Determination pursuant to ED16

On 12 June 2022, the Panel issued a determination under ED16 to grant an application made by Dr Stephen Ayre for indemnity and legal assistance in relation to the Commission of Inquiry.

Dr Ayre was the Chief Executive at the Launceston General Hospital between 2004 and 2008.

Dr Ayre received a total of \$44,250 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Dr Ayre for legal assistance provided to him pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

The Commission of Inquiry made adverse comments concerning Dr Ayre relating to:

- Case Study 1: Restricted Publication – Finding 32;
- Case Study 3: James Griffin – Finding 63.

However, the Commission of Inquiry made no adverse findings or findings of misconduct against Dr Ayre personally.

Investigations under Employment Direction No. 5 ("ED5")

Following consideration of the adverse comments regarding Dr Ayre's conduct noted above, the then Secretary of the Department of Health, Ms Kathrine Morgan-Wicks, determined that Dr Ayre's actions did not provide a sufficient basis for determining that he may have breached the Code of Conduct, and that no further action would be taken.

Accordingly, Dr Ayre was not the subject of any ED5 investigation in relation to the conduct the subject of his grant of legal assistance under ED16.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Dr Ayre engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Dr Ayre engaged in conduct, including omissions, that did not arise in the course of his public office;
- C1: I am satisfied that Dr Ayre has not been found guilty of an offence;
- C2: I am satisfied that Dr Ayre is not currently subject to criminal investigations or proceedings;
- D1: I am not satisfied that Dr Ayre engaged in misconduct of a kind that would warrant his dismissal, or the revocation by a Professional Registration Authority of his professional practice rights or registration;
- D2: I am satisfied that Dr Ayre is not currently subject to an inquiry into professional misconduct, and that he has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Dr Ayre acted unreasonably, or that he intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 5: MS KATHY BAKER

Determination pursuant to ED16

On 31 August 2022, the Panel issued a determination under ED16 to grant an application made by Ms Kathy Baker for indemnity and legal assistance in relation to the Commission of Inquiry.

At times relevant to the Commission of Inquiry, Ms Baker held the role of Executive Director, Capability and Resources in the Department of Communities (a role reclassified and retitled in September 2021 to Deputy Secretary, Corporate Services). For a brief period Ms Baker also served as the Acting Secretary of that Department.

Ms Baker received a total of \$18,375 in legal assistance pursuant to the Panel's determination.

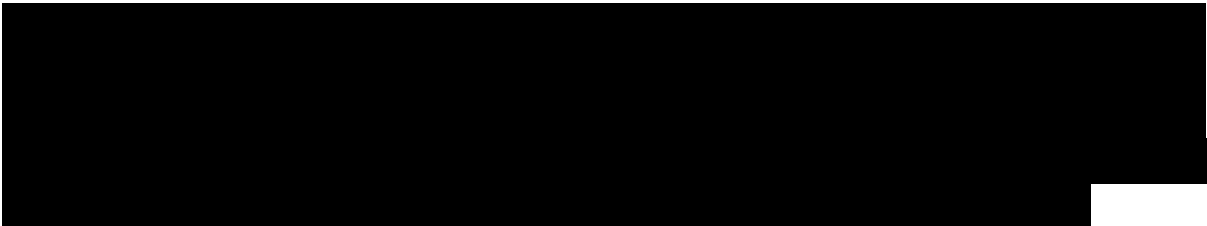
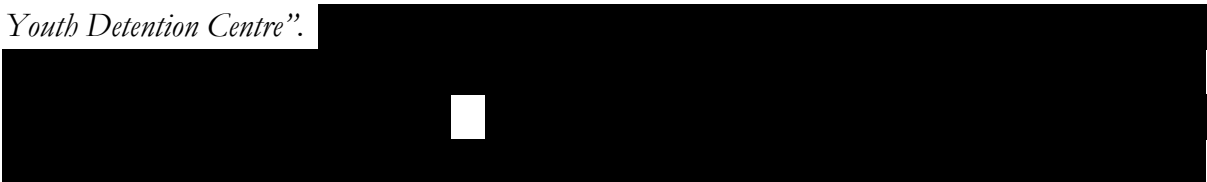
Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Ms Baker for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

Ms Baker provided evidence in relation to a range of matters pertaining to AYDC. The primary matter examined by the Commission of Inquiry that made findings regarding Ms Baker's conduct is set out in Chapter 11, "*Case Study 5: A response to staff concerns about Ashley Youth Detention Centre*".



[REDACTED]

[REDACTED]

In particular, the Commission of Inquiry found:

Finding—The Department should not have conducted the Preliminary Assessment and this reflects systemic problems

We were concerned by the lack of evidence provided to our Commission of Inquiry about the appropriate allocation of the Preliminary Assessment, including the extent to which the State considered the appropriateness of Ms Clarke and Ms Baker's involvement in the Preliminary Assessment.

Ms Clarke and Ms Baker were involved in processes that were under direct consideration in the Preliminary Assessment. These processes included initiating, conducting or directing the scope of investigations relating to **RC - 1** complaints regarding Lester and (in Ms Clarke's case) responding to allegations of harmful sexual behaviours at the Centre. Each had a personal interest in demonstrating the suitability of Ms Honan's (and, by extension, theirs and the Department's) response to **RC - 1** reports. In that context, we consider there are serious questions about whether Ms Clarke and Ms Baker had actual, potential or perceived conflicts of interest such that they should not have been allocated or conducted the Preliminary Assessment.

As described above, Ms Clarke contended that the question of her and Ms Baker's conflicts 'goes to who else would have been in a position' to conduct the Preliminary Assessment. We disagree that no other person was suitable to undertake the Preliminary Assessment. We were not convinced that an independent reviewer, such as a Secretary from another Department or the Head of the State Service, could not have been appointed to undertake this task. More objective reviewers may have been better placed to identify systemic concerns and to divert them for consideration appropriately (beyond the narrow forum of the disciplinary action against Ms Honan).

These problems reflect systemic matters we have observed elsewhere. The absence of clear direction and policy guidance relating to preliminary assessments raises

the risk of conflicts of interest not being recognised and understood. We are not confident the process for initiating and conducting a preliminary assessment was well understood because:

- the complaint was forwarded to Ms Clarke by the Office of the Solicitor-General
- Ms Clarke and Ms Baker were allowed to conduct the Preliminary Assessment without apparent acknowledgment or management of their actual, potential or perceived conflicts of interest.

We do not consider the Preliminary Assessment should have been structured in this way...²¹

Also relevant to Ms Baker, the Commission of Inquiry made the following findings of fact:

Finding—The delay in the Preliminary Assessment was not acceptable and risked exposing children to ongoing harm.²²

Finding—The Preliminary Assessment was, at least in part, a quasi-investigation into the substantive reports made by RC - 1 (a pseudonym) about child sexual abuse by staff, due to a lack of clarity about preliminary assessments.²³

Finding—The Preliminary Assessment gave a false impression of the adequacy of the Department's response to reports made by RC - 1 about child sexual abuse by staff.²⁴

The Commission of Inquiry ultimately concluded that there were a number of concerning elements (including broad cultural failures) in the Department's response to RC - 1 September 2021 complaint, and that these elements explained systemic deficiencies in attitudes and responses to allegations of failures by departmental staff to protect children in detention from abuse.

[REDACTED]

[REDACTED]

²¹ Inquiry Report, Volume 5 (Book 2) Chapter 11, pages 97-101.

²² Inquiry Report, Volume 5 (Book 2) Chapter 11, pages 104-108.

²³ Inquiry Report, Volume 5 (Book 2) Chapter 11, pages 108-110.

²⁴ Inquiry Report, Volume 5 (Book 2) Chapter 11, pages 110-120.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Blake Review

I also note that because Ms Baker served for a short period relevant to the Commission of Inquiry as the Acting Secretary of the Department of Communities, she fell within the

scope of the Blake Review. That Review found that Ms Baker had not engaged in conduct that potentially breached the Code of Conduct.²⁵

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Ms Baker engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Ms Baker engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that Ms Baker has not been found guilty of an offence;
- C2: I am satisfied that Ms Baker is not currently subject to criminal investigations or proceedings;
- D1: I am not satisfied that Ms Baker engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that Ms Baker is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Ms Baker acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

²⁵ Blake Review, pages 9; 20.

SUBJECT 6: MR JAMES BELLINGER

Determination pursuant to ED16

On 24 June 2022, the Panel issued a determination under ED16 to grant an application made by Mr James Bellinger for indemnity and legal assistance in relation to the Commission of Inquiry.

At times relevant to the Commission of Inquiry, Mr Bellinger held the role of Human Relations Consultant at LGH, becoming the manager of the HR team at LGH in late 2016. In this latter role he was also a member of the Senior Executive Team at LGH. Mr Bellinger resigned effective 15 September 2023.

Mr Bellinger received a total of \$1,830 in legal assistance pursuant to the Panel's determination.

Recommendation

The Crown has a prima facie entitlement to seek reimbursement from Mr Bellinger for legal assistance provided to him pursuant to Employment Direction No. 16. However, it is my recommendation that the Crown only make an order for reimbursement under ED16 if, after carefully considering the matters identified in my reasons below, the Crown is satisfied that it is reasonable in all the relevant circumstances to do so.

Reasons

Inquiry Report

In Case Study 3 of Chapter 14, which examined matters pertaining to the sexual abuse perpetrated by James Griffin while employed as a nurse at LGH, the Commission of Inquiry made three adverse findings of fact against Mr Bellinger personally, and fourteen further adverse findings that relate to Mr Bellinger's conduct within the hospital system.

The first adverse finding of fact specifically identifying Mr Bellinger was as follows:

Finding—Luigino Fratangelo and James Bellinger received a disclosure of child sexual abuse from RC - 1 relating to James Griffin in 2011 or 2012.²⁶

²⁶ Inquiry Report, Chapter 14, page 113.

This finding is among the most serious against Mr Bellinger, because it places him at the meeting in which a critically important disclosure by **RC - 1** in 2011 or 2012 was made. The finding was the basis of adverse findings with respect to Mr Bellinger's subsequent conduct in the Inquiry Report, however, the Commission of Inquiry was somewhat equivocal in making this critical finding, stating that:

We consider, on the balance of probabilities, that both Mr Bellinger and Mr Fratangelo were present at the meeting with **RC - 1** and Mr Millar in 2011 or 2012, in which she disclosed childhood sexual abuse by Mr Griffin. We are more confident in Mr Fratangelo's presence but consider there is enough evidence to find that Mr Bellinger was also present. We base this conclusion on the strength and consistency of Mr Millar's evidence (including a variety of documents we reviewed, not all of which have been described for legal reasons), Mr Bellinger's actions in 2019 when **RC - 1** disclosure again became known (discussed further in Section 5), and because we found Mr Millar to be a more credible witness than Mr Bellinger.

As discussed further below, the ED5 investigation into an allegation based on this finding concluded, on the balance of probabilities, and applying the Briginshaw standard, that the allegation was *not* substantiated. If Mr Bellinger did not, in fact, attend the meeting above with **RC - 1** in 2011 or 2012, this has implications for some of the adverse findings and comments regarding Mr Bellinger's subsequent conduct in the Inquiry Report. I return to this matter in my discussion below.

The second adverse finding of fact identifying Mr Bellinger in the Inquiry Report was:

Finding—James Bellinger did not conduct a proper investigation into James Griffin's complaints history and misled the Secretary of the Department and the Integrity Commission

As we have outlined above, Mr Bellinger appeared to undertake a cursory 'review' of complaints relating to Mr Griffin in November 2019. Mr Bellinger's reference to his various 'reviews' was confusing, but **what is clear to us is that there was no meaningful review at any stage**. Mr Bellinger told us that his November 2019 review was limited to complaints that were addressed with Mr Griffin, which resulted in **RC - 1** disclosure in 2011 or 2012 being excluded. Further, this review does not appear to have been recorded and was not communicated to anyone else other than through verbal assurances that responses were appropriate. His subsequent reviews in response to the Australian Nursing and Midwifery Federation's concerns and the Integrity Commission relied on this inadequate review.

...

In a statement to us, Secretary Morgan-Wicks said that before hearing Mr Bellinger's evidence at our Commission of Inquiry she was not aware that he had been informed, in October 2019, of the complaint that **RC - 1** made about Mr Griffin. Secretary Morgan-

Wicks said that had she been made aware of **RC - 1** disclosure, she would have immediately started an internal investigation, rather than waiting until October 2020. **She agreed that Mr Bellinger's draft response was misleading to both her and to the Integrity Commission.**²⁷ [Emphasis added.]

The finding that Mr Bellinger failed to conduct a rigorous and comprehensive review of James Griffin's complaints history at LGH, with the result that inaccurate and misleading information was subsequently provided to Secretary Morgan-Wicks and to the Integrity Commission, could in and of itself be indicative of a lack of good faith for the purpose of ED16, even without a serious breach of the Code of Conduct being determined with reference to that finding.

However, with respect this finding, the Commission of Inquiry also noted that:

We are unclear what, if any, scrutiny Mr Bellinger's superiors in the human resources team applied to this review, noting they recalled only seeing the final letter to the Integrity Commission. We are of the view that Mr Bellinger was not closely supported or supervised by senior managers in the task of responding to the Integrity Commission, which demonstrated an absence of concern by senior leaders about the seriousness of the complaint. This lack of scrutiny enabled the response prepared by Mr Bellinger to the Integrity Commission to contain inaccurate and misleading information.²⁸

This is a significant observation, indicating that during an unfolding crisis that should have involved the most senior levels of management, Mr Bellinger appears to have been acting without adequate supervision. In addition, aspects of Mr Bellinger's conduct that formed the basis of this finding (though not the finding itself) were the subject of an ED5 investigation, which found that some of the alleged failures by Mr Bellinger in this context were not substantiated. I return to this matter in my discussion below.

The third adverse finding specifically identifying Mr Bellinger in the Inquiry Report relates to a conflict of interest that Mr Bellinger failed to manage when he took a statement from Mr Millar regarding the meeting he had with **RC - 1** in 2011 or 2012:

Finding—James Bellinger should not have taken the statement from Stewart Millar

We are concerned that Mr Bellinger took the statement from Mr Millar about **RC - 1** disclosure in 2011 or 2012 given our finding that Mr Bellinger was at the meeting with **RC - 1** when she made the disclosure.

²⁷ Inquiry Report, Chapter 14, pages 239-241.

²⁸ Inquiry Report, Chapter 14, page 240.

Even on Mr Bellinger's evidence that he was not at the meeting, when asked by the former Director of Employee Relations to obtain a statement from Mr Millar, Mr Bellinger should have flagged his likely conflict of interest and declined to be involved. Mr Bellinger was a member of the human resources team. It was not appropriate for him to have any involvement in Mr Millar's statement. Even on the most favourable interpretation of Mr Bellinger's evidence, at the point Mr Millar named Mr Bellinger as being at the meeting, he should have reported this to his manager and ceased involvement. Mr Bellinger conceded that somebody else should have taken the statement.

We are concerned about Mr Bellinger's decisions regarding **RC - 1** 2011 or 2012 disclosure, including:

- not alerting anyone within the hospital or Department to **RC - 1** disclosure when Detective Senior Constable Hindle enquired about it on 11 October 2019, despite his evidence that it would be his usual practice to do so
- not including **RC - 1** disclosure in any of his various reviews of Mr Griffin's prior complaints history, including the response to the Integrity Commission.

These decisions contributed to our finding that he was present at the 2011 or 2012 meeting.²⁹

I agree with the view of the Commission of Inquiry that even if Mr Bellinger was not at the meeting with **RC - 1** in 2011 or 2012, once Mr Millar identified him as being present, Mr Bellinger should have recognised he had a conflict of interest, reported this to his manager, and ceased further involvement. If Mr Bellinger was in fact at the meeting with **RC - 1** the implications regarding his conduct are far more serious, as outlined in the commentary to the finding above, and in relation to subsequent findings against Mr Bellinger.

The Inquiry Report makes some 14 further findings of fact that are adverse to Mr Bellinger, but which do not name him. However, in relation to some of those findings, the extent to which they impugn Mr Bellinger's conduct is to some extent referable to whether or not he attended the meeting with **RC - 1** in 2011 or 2012, and may therefore have failed to act on his knowledge of a serious and credible allegation regarding Mr Griffin's earlier sexual offending. For example, the Commission of Inquiry made the following further findings that do not name Mr Bellinger, but which would significantly impugn his professional conduct if he was present at the meeting with **RC - 1**:

²⁹ Inquiry Report, Chapter 14, pages 259 – 260.

Finding—Launceston General Hospital failed to respond appropriately to RC - 1 disclosure of abuse by James Griffin in 2011 or 2012, leaving children exposed to potential risk for eight years

RC - 1 disclosure of her sexual abuse by Mr Griffin to the hospital in 2011 or 2012 reflected a level of risk for the hospital of a significance that cannot be overstated. The failure to take any action in response to this disclosure failed to reduce the very significant risks Mr Griffin posed to paediatric patients on the ward for another eight years (and that those risks may have continued beyond this period had another victim-survivor, RC - 1, not reported her abuse by Mr Griffin to police in 2019).

That a meeting occurred between RC - 1, Mr Millar and at least one representative of the human resources team is not contested. As described earlier, we consider the meeting most likely happened in 2011 or 2012. Launceston General Hospital was given credible information that Mr Griffin had a history of perpetrating child sexual abuse and was provided with an opportunity to prevent other potential risks to children, but did not act. The hospital did not even record the information to provide future weight or context to interpreting Mr Griffin's behaviour, which at that time included multiple allegations of 'boundary breaches' involving inappropriate non-medical contact with child patients.³⁰

Finding—Launceston General Hospital did not have adequate processes to ensure the meeting with RC - 1 was recorded and that record was retained

We could not determine whether a record of the meeting was not taken or was lost or destroyed. However, it is concerning to us that the human resources representatives who attended the meeting would not document a meeting of this nature, sensitivity and significance.

A disclosure of this kind, which describes child sexual abuse at the hands of a person employed on a paediatric ward, is a disclosure that should be treated with the utmost concern and urgency. The disclosure warranted a clear and accurate record being taken of the discussion and escalation to senior managers to determine appropriate action and ensure children on the ward were safe. Responding to the disclosure required care, concern and steps taken to ensure RC - 1 had appropriate support, particularly given that she often had to encounter Mr Griffin at the hospital. Failure to take action was a missed opportunity to protect children and young people in the hospital from further abuse by Mr Griffin. It also meant that this information was not considered when subsequent complaints against Mr Griffin arose.³¹

³⁰ Inquiry Report, Chapter 14, page 112.

³¹ Inquiry Report, Chapter 14, page 114.

Finding—The human resources team failed to escalate information they received on 11 October 2019 about RC - 1 2011 or 2012 disclosure

As we have described above, the call to Mr Bellinger from Detective Senior Constable Hindle on 11 October 2019 should have been a catalyst for immediate and urgent action from Mr Bellinger and other members of the human resources team. We consider that the human resources team, including Mr Bellinger, should have taken steps to ensure Mr Daniels and Secretary Morgan-Wicks were advised of the request and its implications for the hospital.

The information that human resources staff held about RC - 1 disclosure should have been escalated given it indicated that the hospital had known about Mr Griffin's potential offending from that time. This includes fully informing the Secretary of the query human resources staff received from Detective Senior Constable Hindle about RC - 1 disclosure—and describing what was known about that disclosure. We understand that for Mr Bellinger in particular, given his attendance at the meeting at which the disclosure was made, acknowledging such a fundamental error of judgment is confronting. However, the implications of mishandling RC - 1 disclosure should have been acknowledged at the earliest opportunity.³²

In addition to the findings set out above, the Inquiry Report includes a number of further adverse findings of fact that relate to Mr Bellinger's professional conduct in the context of Case Study 3. After considering these findings, Secretary Morgan-Wicks endorsed a Departmental Minute dated 27 November 2023 stating that the additional findings suggested that Mr Bellinger failed in various ways in his professional duties, including in properly acquitting his responsibilities to escalate concerns regarding James Griffin, to manage the concerns appropriately, and/or report Mr Griffin's conduct to an appropriate health practitioner's registration authority. The relevant findings include:

Finding—Launceston General Hospital's response to RC - 1 2017 Safety Reporting and Learning System complaint did not comply with the requirements of a State Service Code of Conduct investigation.³³

Finding—Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin Collective failure in relation to Mr Griffin.³⁴

Finding—The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct.³⁵

³² Inquiry Report, Chapter 14, page 199.

³³ Inquiry Report, Chapter 14, page 139.

³⁴ Inquiry Report, Chapter 14, page 160.

³⁵ Inquiry Report, Chapter 14, page 161.

Finding—Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem.³⁶

Finding—Launceston General Hospital had no clear system, procedures or process in place to report complaints about James Griffin to external agencies.³⁷

Finding—The response of Launceston General Hospital to revelations about James Griffin’s offending was passive and ineffective.³⁸

Finding—Launceston General Hospital did not have clear accountabilities for child safety.³⁹

Finding—The lack of a coordinated and transparent response by Launceston General Hospital increased feelings of mistrust among hospital staff.⁴⁰

Finding—Launceston General Hospital’s human resources team should not have been involved in the request or preparation of a statement from Stewart Millar regarding RC - 1 disclosure.⁴¹

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

³⁶ Inquiry Report, Chapter 14, page 162.

³⁷ Inquiry Report, Chapter 14, page 165.

³⁸ Inquiry Report, Chapter 14, page 174.

³⁹ Inquiry Report, Chapter 14, page 176.

⁴⁰ Inquiry Report, Chapter 14, page 210.

⁴¹ Inquiry Report, Chapter 14, page 259.

[REDACTED]

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Mr Bellinger resigned effective 15 September 2023.

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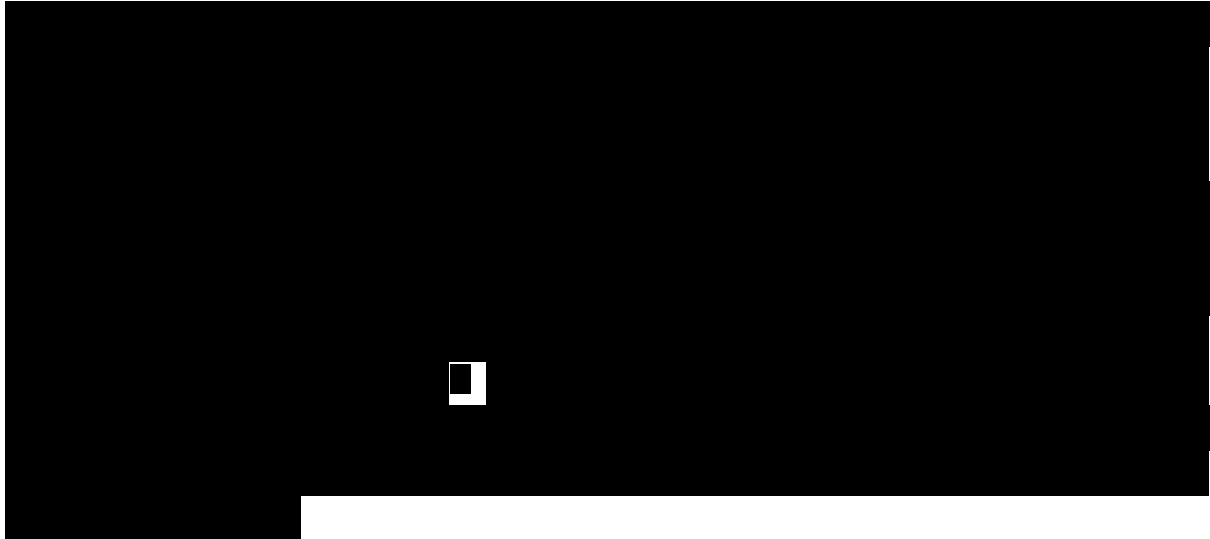
Secretary Morgan-Wicks determined that had Mr Bellinger not resigned from the State Service, she would have commenced an investigation into the numerous adverse findings of fact against him in the Inquiry Report. Mr Bellinger was advised of this in a letter dated 5 October 2023, and informed that a record would be kept of those findings, and that an ED5 investigation might be commenced if he again sought employment with the State Service.

[REDACTED]

[REDACTED]

However, in the context of the many other findings against Mr Bellinger in Case Study 3, whether or not it can be established that Mr Bellinger was at the meeting with **RC - 1** in 2011 or 2012 is not determinative of whether or not Mr Bellinger acted in good faith for the purposes of ED16.

In particular, I note that several of the adverse findings against Mr Bellinger relate to his failure to communicate the fact of **RC - 1** disclosure to the Secretary or to the Integrity Commission *after* he was informed of that disclosure by Detective Senior Constable Hindle in October 2019.



As made clear throughout this report, not all breaches of the Code of Conduct necessarily indicate a lack of good faith. However, where a senior Public Officer has displayed a serious and repeated lack of care and diligence in breach of section 9(2), as well as failures to appropriately manage conflicts of interest as required by section 9(8), it is open to me to find that such serious breaches of the Code of Conduct constitute a lack of good faith for the purposes of ED16. This is particularly apt in relation to Mr Bellinger's conduct, which I find was conspicuous in demonstrating professional failings by him that in many cases were not primarily referable to the systemic problems identified in the Inquiry Report.

For example, in relation to Mr Bellinger's failure to conduct a comprehensive review of complaints made about Mr Griffin, the Commission of Inquiry states:

Of significant concern was that Mr Bellinger's review failed to consider and reflect all available material relevant to complaints about Mr Griffin. Mr Bellinger admitted that **RC - 1** complaint to the hospital—which, on his evidence, he became aware of from Detective Senior Constable Hindle on 11 October 2019—was not included in his review. This is a striking omission. Mr Bellinger sought to justify the omission by explaining that his review was limited to complaints that were addressed with Mr Griffin. He accepted, in retrospect, that the limited scope of the review was not appropriate and that **RC - 1** disclosure should have been included. However, he denied that his failure to include **RC - 1**

⁴³ Inquiry Report, Chapter 14, page 239.

RC - 1 disclosure in his review was an attempt to cover up that the disclosure was first made to the hospital in 2011 or 2012.⁴⁴

That being said, in relation to the related finding that Mr Bellinger “did not conduct a proper investigation into James Griffin’s complaints history and misled the Secretary of the Department and the Integrity Commission”, the Inquiry Report noted that:

We are unclear what, if any, scrutiny Mr Bellinger’s superiors in the human resources team applied to this review, noting they recalled only seeing the final letter to the Integrity Commission. We are of the view that Mr Bellinger was not closely supported or supervised by senior managers in the task of responding to the Integrity Commission, which demonstrated an absence of concern by senior leaders about the seriousness of the complaint. This lack of scrutiny enabled the response prepared by Mr Bellinger to the Integrity Commission to contain inaccurate and misleading information.⁴⁵

This is a significant observation, indicating that during an unfolding crisis that should have involved the most senior levels of management, Mr Bellinger may have been acting without adequate support and supervision. Nevertheless, a more focussed eye on Mr Bellinger himself would tend to suggest that he may well have taken advantage of the lack of close supervision and support in order to mask the deficiencies in his own conduct.

In relation to the more general findings in the Inquiry Report regarding the failings of staff and systems in relation to Mr Griffin’s offending, the following observations by the Commission of Inquiry at the end of Case Study 3 suggest that while individuals, such as Mr Bellinger, certainly failed to properly fulfill their professional responsibilities, the failures that enabled Mr Griffin to offend with such impunity for so long, and with such devastating effect, were often collective in nature:

Despite considering the documents and other evidence relevant to Mr Griffin for some months, we struggle to come to terms with the enormity of the collective failure by a range of institutions—including Launceston General Hospital, Child Safety Services and Tasmania Police—that characterises their responses to the risks Mr Griffin posed. These collective failures enabled a motivated sexual predator to repeatedly groom, harm and abuse vulnerable young patients and other children with whom he had contact.⁴⁶

Whether Mr Bellinger’s failures were referable primarily to the general systemic failures at LGH, or were so egregious that they indicate a lack of good faith for the purposes of ED16, has been a very difficult matter to determine on the evidence before me. This is

⁴⁴ Inquiry Report, Chapter 14, page 220 (footnotes omitted).

⁴⁵ Inquiry Report, Chapter 14, page 240.

⁴⁶ Inquiry Report, Chapter 14, page 260.

particularly so given that because of Mr Bellinger's resignation, no ED5 investigation could be carried out into the specific findings against him in the Inquiry Report.

Conclusions

The most significant finding against Mr Bellinger which *would* have indicated a lack of good faith was that he was present at RC - 1 disclosure in 2011 or 2012. This finding has significant implications for interpreting Mr Bellinger's subsequent conduct, and the Commission of Inquiry appeared to strongly suggested that Mr Bellinger sought to deliberately cover up the fact of his attendance at RC - 1 critical disclosure, as well as the fact of the disclosure itself. However, as noted above, this key finding was not substantiated [REDACTED], indicating that while many of the findings against Mr Bellinger's subsequent conduct with a bearing on RC - 1 disclosure show that he acted with a lack of care and diligence, I cannot be satisfied that Mr Bellinger was acting with dishonest intent in relation to his presence at the meeting with RC - 1.

Notwithstanding the finding above, the other unsubstantiated findings [REDACTED] and the mitigating factors relating to the broader context of Mr Bellinger's professional failings, I consider that the number and significance of the findings made against Mr Bellinger in the Inquiry Report, [REDACTED] demonstrate that he repeatedly and seriously breached his obligation to act with care and diligence under section 9(2) of the Code of Conduct. In addition, the findings in the Inquiry Report show that Mr Bellinger failed to disclose and avoid two significant conflicts of interest as required by section 9(8) of the Code of Conduct. I find that the serious and repeated breaches of the Code of Conduct by Mr Bellinger constitute a lack of good faith for the purposes of ED16.

Moreover, on the basis of the finding in the Inquiry Report that "Mr Bellinger did not conduct a proper investigation into James Griffin's complaints history and misled the Secretary of the Department and the Integrity Commission", [REDACTED] I find that Mr Bellinger acted in a manner that was not 'honest, sincere and reasonable', amounting to a lack of good faith for the purposes of ED16.

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am satisfied that Mr Bellinger engaged in conduct, including omissions, demonstrating a lack of good faith;

- B: I am not satisfied that Mr Bellinger engaged in conduct, including omissions, that did not arise in the course of his public office;
- C1: I am satisfied that Mr Bellinger has not been found guilty of an offence;
- C2: I am satisfied that Mr Bellinger is not currently subject to criminal investigations or proceedings;
- D1: I am not satisfied that Mr Bellinger engaged in misconduct of a kind that would warrant his dismissal, or the revocation by a Professional Registration Authority of his professional practice rights or registration;
- D2: I am satisfied that Mr Bellinger is not currently subject to an inquiry into professional misconduct, and that he has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Mr Bellinger acted unreasonably, or that he intentionally or recklessly failed to make full and frank disclosure of relevant matters.

Reasonableness

Although I have found that the Crown has a prima facie right to recovery of the legal assistance paid to Mr Bellinger pursuant to ED16, I note that the amount of legal assistance he received was \$1,830. Whether it is reasonable to seek to recover this sum from Mr Bellinger will depend on the Crown's assessment of the cost any recovery process against what might be recovered, in the context of the value of any educative or other purpose the Crown may have to seek recovery, including demonstrating accountability under the ED16 policy framework. I am not in a position to advise on these matters, but I recommend that the Crown only seek to exercise its right to recover against Mr Bellinger if it is satisfied it is reasonable to do so in these or any other relevant circumstances.

SUBJECT 7: RC - 3

A recommendation and reasons regarding RC - 3 grant of legal assistance will be provided in a supplementary report following completion of all relevant investigations and processes.

SUBJECT 8: MS HELEN BRYAN

Determination pursuant to ED16

On 12 April 2023, the Panel issued a determination under ED16 to grant an application made by Ms Helen Bryan for indemnity and legal assistance in relation to the Commission of Inquiry.

Ms Bryan was the Director of Nursing at LGH in the period 2001-2007 and the Executive Director of Nursing for Northern Tasmania from May 2011.

Ms Bryan received a total of \$15,300 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Ms Helen Bryan for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

The Commission of Inquiry made no direct adverse findings or findings of misconduct against Ms Bryan personally. However, the Commission of Inquiry made a number of adverse comments about or concerning Ms Bryan's conduct in relation to Case Study 3 at LGH.

While Ms Bryan's conduct, and in particular, her omissions to act, are discussed in a number of the findings in Case Study 3, none of these findings appear to me to constitute allegations of sufficient gravity against Ms Bryan personally to make a recommendation for the Crown to seek reimbursement of the legal assistance granted to Ms Bryan pursuant to ED16.

For example, the Inquiry Report notes that Ms Bryan agreed that there was a "complete failure of senior leadership to respond appropriately to Mr Griffin's conduct"⁴⁷. However, the Inquiry Report also states:

⁴⁷ Inquiry Report, Ch 14, page 173.

Much of the leadership of the hospital was noticeably absent from the response to Mr Griffin's offending. We did not receive evidence (or meeting minutes) to suggest this issue was regularly discussed by hospital leadership. The then Chief Executive, Eric Daniels and then Executive Director of Nursing, Helen Bryan, in particular, were not referenced by witnesses to our Inquiry, and their names did not often appear in the documents we reviewed relevant to the hospital's response to Mr Griffin's offending. In their evidence to us, they appeared to have little knowledge of the situation; it seemed that they learned the extent of Mr Griffin's offending from *The Nurse* podcast and from our hearings.

The practical effect of their absence from the response is that the evidence we received focused more on the conduct of those who were directly involved, including many who were significantly more junior than those tasked with the hospital's governance.⁴⁸

The Commission of Inquiry also found that "Leadership at Launceston General Hospital was dysfunctional and this compromised its collective response to revelations about James Griffin."⁴⁹ The Commission of Inquiry went on to say:

Former Executive Director of Nursing, Ms Bryan, described having 'very little involvement with the allegations relating to Mr Griffin' after 31 July 2019, despite Ward 4K being within her area of responsibility. She indicated that Dr Renshaw and the human resources team managed the response. She conceded that she should have been involved, given Mr Griffin was a nurse, but she described feeling 'disconnected' and 'not included in the process'.⁵⁰

In this context, the Commission of Inquiry noted Ms Bryan's admission that she had "probably omitted to properly fulfil her responsibilities", but accepted her evidence that she had been excluded from some key meetings.⁵¹

A lack of knowledge and engagement on the part of senior staff in relation to Mr Griffin's offending, including Ms Bryan, clearly indicates serious systemic failings at LGH. However, it does not in itself suggest a lack of good faith on the part of Ms Bryan, nor does it indicate any another basis for recommending that the Crown seek reimbursement under ED16.

Ultimately, the Commission of Inquiry observed that the failures that enabled Mr Griffin to offend for so long were systemic and collective, extending beyond the leadership team at LGH:

⁴⁸ Inquiry Report, Ch 14, page 172.

⁴⁹ Inquiry Report, Ch 14, page 175.

⁵⁰ Inquiry Report, Ch 14, page 175.

⁵¹ Inquiry Report, Ch 14, page 175.

Despite considering the documents and other evidence relevant to Mr Griffin for some months, we struggle to come to terms with the enormity of the collective failure by a range of institutions – Including Launceston General Hospital, Child Safety Services and Tasmania Police – that characterises their responses to the risks Mr Griffin posed. These collective failures enabled a motivated sexual predator to repeatedly groom, harm and abuse vulnerable young patients and other children with whom he had contact...⁵²

I note that these comments are consistent with the general comments in the Inquiry Report about the nature of systemic failures across Tasmanian government institutions, referenced in Part C of this report.

Determination not to carry out investigations under Employment Direction No. 5 (“ED5”)

On 30 November 2023, the then Secretary of the Department of Health, Ms Kathrine Morgan-Wicks, determined that no ED5 investigation into Ms Bryan’s conduct could occur because she had resigned from the State Service in May 2023. Had Ms Bryan not resigned, Ms Morgan-Wicks determined that she would have directed an ED5 investigation into Ms Bryan’s conduct, and specifically, whether her conduct might have breached sections 9(2) and 9(14) of the Code of Conduct.

Secretary Morgan-Wicks further determined that the State Service Management Office would be notified of the situation in relation to Ms Bryan, and that if Ms Bryan sought employment with the State Service in the future, an investigation of the matters noted above pursuant to ED5 would need to be carried out and its outcomes considered prior to confirming her re-employment.

[REDACTED]

[REDACTED]

[REDACTED]

⁵² Inquiry Report, Ch 15, page 260.

[REDACTED]

[REDACTED]

[REDACTED]

On the evidence before me, which is essentially limited to the Inquiry Report, I am unable to conclude on the balance of probabilities that Ms Bryan's conduct constituted breaches of the Code of Conduct of sufficient gravity to indicate a lack of good faith, and that would thereby constitute grounds to seek reimbursement of legal assistance provided pursuant to ED16. Similarly, on the evidence before me I am unable to conclude on the balance of probabilities that Ms Bryan's conduct in relation to the findings in the Inquiry Report would provide a basis for the revocation of her practice rights or registration as a nurse.

I also note there is no suggestion that in providing evidence to the Commission of Inquiry, Ms Bryan unreasonably, intentionally or recklessly failed to make full and frank disclosure of relevant matters.

⁵³ See Section 49B, *Civil Liability Act* 2002.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Ms Bryan engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Ms Bryan engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that Ms Bryan has not been found guilty of an offence;
- C2: I am satisfied that Ms Bryan is not currently subject to criminal investigations or proceedings;
- D1: I am not satisfied that Ms Bryan engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that Ms Bryan is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Ms Bryan acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 9: RC - 3

A recommendation and reasons regarding RC - 3 grant of legal assistance will be provided in a supplementary report following completion of all relevant investigations and processes.

SUBJECT 10: RC - 2

Determination pursuant to ED16

On 14 March 2023, the Panel issued a determination under ED16 to grant an application made by RC - 2 for indemnity and legal assistance in relation to the Commission of Inquiry.

RC - 2 was the Director of Employee Relations at LGH.

RC - 2 received a total of \$10,636.37 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from RC - 2 for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

RC - 2 was not called to give evidence before the Commission of Inquiry, however she provided evidence by way of a witness statement, which was considered and discussed in the Inquiry Report. RC - 2 is not named in the Inquiry Report, and is identified only as 'the former Director of Employee Relations' at LGH.

There is only one finding in the Inquiry Report that relates to RC - 2 conduct. That finding relates to RC - 2 role as Manager of the Commission of Inquiry Response and Reform team at the Department of Health:

Finding—Launceston General Hospital's human resources team should not have been involved in the request or preparation of a statement from Stewart Millar regarding RC - 1 disclosure

The Department's Commission of Inquiry Response and Reform team (where the former Director of Employee Relations worked at this time) was responsible for providing our Commission of Inquiry with all relevant documentation from the Department, including in relation to RC - 1 disclosure.

Because **RC - 1** disclosure was made to the hospital's human resources team, it should have been clear to the Department's Commission of Inquiry Response and Reform team that the hospital's human resources team should not have been involved in documenting anything connected to **RC - 1** disclosure, nor gaining statements from other human resources team members.

Furthermore, it was reasonably foreseeable to the Department's Commission of Inquiry Response and Reform team that Mr Bellinger and Mr Millar would be witnesses at our Commission of Inquiry and that there may have been a point of contention in their differing recollections of who was present at **RC - 1** disclosure, and that greater care to not compromise the evidence before our Inquiry should have been taken.⁵⁴

The Inquiry Report also includes the following statement regarding **RC - 2** conduct and her acknowledgement that it was an error for her to request a staff member of the human resources team to obtain a statement from another staff member of that team:

The former Director of Employee Relations told us that it was not their expectation that Mr Bellinger would discuss Mr Millar's recollection with him and draft Mr Millar's statement himself, only that he would request that Mr Millar provide a statement. They said that they only became aware that Mr Bellinger had prepared the statement himself when they received a copy and saw that Mr Millar's name was misspelt. They acknowledged that they should not have asked Mr Bellinger to obtain a statement from Mr Millar.⁵⁵

In reviewing **RC - 2** conduct in relation to the above finding, the Department determined that there was not a sufficient basis to believe that a breach of Code of Conduct may have occurred, and accordingly that no ED5 investigation should take place. I have seen no evidence to suggest otherwise, and can see no basis to recommend the Crown seek reimbursement from **RC - 2** in relation to the matters noted above.

Further, and consistently with **RC - 2** candour noted in the Inquiry Report above, there is no suggestion that in providing evidence to the Commission of Inquiry, **RC - 2** unreasonably, or intentionally or recklessly failed to make full and frank disclosure of relevant matters.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

⁵⁴ Inquiry Report, Chapter 14, page 259.

⁵⁵ Inquiry Report, Chapter 14, page 258.

- A: I am not satisfied that **RC - 2** engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that **RC - 2** engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that **RC - 2** has not been found guilty of an offence;
- C2: I am satisfied that **RC - 2** is not currently subject to criminal investigations or proceedings;
- D1: I am not satisfied that **RC - 2** has engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that **RC - 2** is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, **RC - 2** acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 11: RC - 3

Determination pursuant to ED16

A recommendation and reasons regarding RC - 3 grant of legal assistance will be provided in a supplementary report following completion of all relevant investigations and processes.

SUBJECT 12: MR GINO FRATANGELO

Determination pursuant to ED16

On 24 June 2022, the Panel issued a determination under ED16 to grant an application made by Mr Gino Fratangelo for indemnity and legal assistance in relation to the Commission of Inquiry.

Mr Fratangelo commenced employment as a Public Officer with the Department of Health in 2000, and from 2004, including at times relevant to the Commission of Inquiry, Mr Fratangelo worked as a Human Relations Consultant at LGH. He retired on 8 March 2019.

Mr Fratangelo received a total of \$6,442.50 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Mr Fratangelo for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

In his role as a Human Relations Consultant at LGH from 2004, Mr Fratangelo's conduct was examined by the Commission of Inquiry in relation to Case Study 3. Ultimately, the Inquiry Report made six findings of fact against Mr Fratangelo, several stemming from the finding that in 2011 or 2012, he received a disclosure from an employee at LGH, **RC - 1** that she had been sexually abused by James Griffin when she was a child.

The specific findings of fact in the Inquiry Report that were in 2023 identified by the Department of Health as being findings against Mr Fratangelo are:

- Launceston General Hospital failed to respond appropriately to **RC - 1** disclosure of abuse by James Griffin in 2011 or 2012, leaving children exposed to potential risk for eight years;
- Luigino Fratangelo and James Bellinger received a disclosure of child sexual abuse from **RC - 1** relating to James Griffin in 2011 or 2012;
- Launceston General Hospital did not have adequate processes to ensure the meeting with **RC - 1** was recorded and that record was retained;
- Launceston General Hospital failed to manage the risks posed by James Griffin;

- The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct;
- The response of Launceston General Hospital to revelations about James Griffin's offending was passive and ineffective.⁵⁶

Following an analysis of these findings, the Department of Health concluded that Mr Fratangelo appeared to have failed to properly carry out his role, including by generally failing in his obligations to manage the complaints relating to James Griffin appropriately, including by escalating complaints and reporting complaints to an appropriate health practitioner's registration authority.

On 28 November 2023, the then Secretary of the Department of Health, Ms Morgan-Wicks, considered her Department's advice, as summarised in the paragraphs above, and determined that the findings against Mr Fratangelo in the Inquiry Report may have constituted a breach of the following sections of the Code of Conduct:

- Section 9(2): An employee must act with care and diligence in the course of State Service employment.
- Section 9(14): An employee must at all times behave in a way that does not adversely affect the integrity and good reputation of the State Service.

However, Secretary Morgan-Wicks determined that because Mr Fratangelo had retired from the State Service in March 2019, she could not order an ED5 investigation into his conduct, nor determine any sanction that would apply if breach was substantiated, including termination of his employment. However, she noted that had Mr Fratangelo remained a Public Officer, she would have directed an ED5 investigation into whether his conduct might have breached sections 9(2) and (14) of the Code of Conduct.

Secretary Morgan-Wicks further determined that the matters above would be noted in the records maintained by the Department, and would be considered if Mr Fratangelo sought future engagement as an employee, contractor or volunteer. In the event Mr Fratangelo sought future employment with the State Service, Secretary Morgan-Wicks determined that a condition precedent of his re-employment would be an investigation of the matters noted above pursuant to ED5.

[REDACTED]

[REDACTED]

⁵⁶ Inquiry Report, Chapter 14, Case Study 3.

[REDACTED]

[REDACTED]

Despite the seriousness of the failure to respond appropriately to RC - 1 disclosure, I note that in relation to the finding that “Launceston General Hospital failed to respond appropriately to RC - 1 disclosure of abuse by James Griffin in 2011 or 2012, leaving children exposed to potential risk for eight years,” the Commission of Inquiry contextualised that failure within the systemic shortcomings of the LGH generally. The Inquiry Report states:

That a meeting occurred between RC - 1 Mr Millar and at least one representative of the human resources team is not contested. As described earlier, we consider the meeting most likely happened in 2011 or 2012. Launceston General Hospital was given credible information that Mr Griffin had a history of perpetrating child sexual abuse and was provided with an opportunity to prevent other potential risks to children, but did not act. The hospital did not even record the information to provide future weight or context to interpreting Mr Griffin’s behaviour, which at that time included multiple allegations of ‘boundary breaches’ involving inappropriate non-medical contact with child patients.

We could not identify a specific hospital or departmental policy in place at the time for responding to allegations of child sexual abuse about a staff member. We consider it unlikely

[REDACTED]

that any policies would have guided the human resources team to manage RC - 1 disclosure in the way it did.⁵⁹

Accordingly and despite the seriousness of the findings against Mr Fratangelo in the Inquiry Report, and the substantiation of the finding that he attended the critical meeting with RC - 1 in which she disclosed her abuse by Mr Griffin, on the evidence before me I am unable to conclude on the balance of probabilities that Mr Fratangelo's conduct constituted breaches of the Code of Conduct of sufficient gravity to indicate a lack of good faith, and that would constitute grounds to seek reimbursement of legal assistance paid pursuant to ED16. In arriving at this conclusion I note that the issue is finely poised, however it is consistent with the view I have taken about others who were not the subject of ED5 investigations because they had left the State Service before such an investigation could commence.

I also note that in his evidence before the Commission of Inquiry, Mr Fratangelo reported that he was unable to recall the critical meeting with RC - 1, but conceded he may have been present. In the absence of an adverse finding against Mr Fratangelo with respect to the veracity of his evidence, and acknowledging that RC - 1 disclosure occurred approximately a decade prior to the Commission of Inquiry and that Mr Frantangelo retired in 2019, I cannot infer from Mr Fratangelo's lack of recall when providing evidence that he was deliberately withholding information from the Commission of Inquiry.

[REDACTED]

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Mr Fratangelo engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Mr Fratangelo engaged in conduct, including omissions, that did not arise in the course of his public office;
- C1: I am satisfied that Mr Fratangelo has not been found guilty of an offence;

⁵⁹ Inquiry Report, Chapter 14, page 112.

- C2: I am satisfied that Mr Fratangelo is not currently subject to criminal investigations or proceedings;
- D1: I am satisfied that Mr Fratangelo has not engaged in misconduct of a kind that would warrant his dismissal, or the revocation by a Professional Registration Authority of his professional practice rights or registration;
- D2: I am satisfied that Mr Fratangelo is not currently subject to an inquiry into professional misconduct, and that he has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Mr Fratangelo acted unreasonably, or that he intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 13: MS MADELEINE GARDINER

Determination pursuant to ED16

On 27 July 2022, the Panel issued a determination under ED16 to grant an application made by Ms Madeleine Gardiner for indemnity and legal assistance in relation to the Commission of Inquiry.

Ms Gardiner was formerly the Manager, Professional Services and Policy, at Ashley Youth Detention Centre (“AYDC”)

Ms Gardner received a total of \$32,500 in legal assistance pursuant to the Panel’s determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Ms Gardiner for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

On 21 November 2024, I was advised by the Department of Premier and Cabinet that there was no information responsive to my requests for information from relevant agencies regarding any criminal, civil, disciplinary or other investigations or proceedings against Ms Gardiner in response to the findings of the Commission of Inquiry. I was also advised that while there were references to Ms Gardiner in the Inquiry Report on the basis of her former employment at the AYDC, there were no adverse commentary or findings regarding Ms Gardiner in the Inquiry Report.

Consistent with the above advice, I note that the Inquiry Report details a number of formal objections that Ms Gardiner made to decisions of other AYDC staff which, in her view, compromised the safety of vulnerable young people in that facility. The Inquiry Report commends Ms Gardiner’s diligence in identifying risks and advocating for the safety of vulnerable young people,⁶⁰ and details the manner in which she escalated matters where appropriate.⁶¹ The Inquiry Report also describes how Ms Gardiner sought to instigate training to improve the awareness and skills of AYDC staff regarding harmful sexual behaviours and how they should be managed,⁶² as well as other reforms to procedures. In

⁶⁰ Inquiry Report, Volume 5 (Book 1) Chapter 11, pages 189 – 190.

⁶¹ Inquiry Report, Volume 5 (Book 1) Chapter 11, pages 191 – 192.

⁶² Inquiry Report, Volume 5 (Book 1) Chapter 11, pages 192 – 193.

conclusion, it appears that far from being one of the Public Officers participating in and at times perpetuating the culture and systemic practices that placed vulnerable young people detained at AYDC at risk, Ms Gardiner made a concerted effort to change the flawed culture and systems she observed.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Ms Gardiner engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Ms Gardiner engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that Ms Gardiner has not been found guilty of an offence;
- C2: I am satisfied that Ms Gardiner is not currently subject to criminal investigations or proceedings;
- D1: I am satisfied that Ms Gardiner has not engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that Ms Gardiner is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Ms Gardiner acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 14: MR MATTHEW HARVEY

Determination pursuant to ED16

On 24 June 2022, the Panel issued a determination under ED16 to grant an application made by Mr Matthew Harvey for indemnity and legal assistance in relation to the Commission of Inquiry.

Mr Harvey was employed by the Department of Health and Human resources from 2006. From 2014 to 2018 he worked as a Human Resources Advisor, and was promoted to the role of Human Resources Consultant from 2018 to 2022.

Mr Harvey received a total of \$13,352 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Mr Harvey for legal assistance provided to him pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

The Commission of Inquiry made adverse comments concerning Mr Harvey's conduct at LGH in Case Study 3: James Griffin. However, the Commission of Inquiry made no adverse findings or findings of misconduct against Mr Harvey personally.

Investigations under Employment Direction No. 5 ("ED5")

The Department of Health gave consideration to carrying out an ED5 investigation into Mr Harvey's conduct, however it was determined by the then Secretary of that Department, Ms Kathrine Morgan-Wicks, that in light of his more junior role and level of experience (as compared with Mr James Bellinger, to whom Mr Harvey reported), Mr Harvey's actions did not provide sufficient basis for determining that he may have breached the Code of Conduct. I respectfully agree with Ms Morgan-Wicks' conclusion.

Accordingly, Mr Harvey was not the subject of any ED5 investigations in relation to the conduct the subject of his grant of legal assistance under ED16.

Mr Harvey resigned from the State Service in May 2023.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Mr Harvey engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Mr Harvey engaged in conduct, including omissions, that did not arise in the course of his public office;
- C1: I am satisfied that Mr Harvey has not been found guilty of an offence;
- C2: I am satisfied that Mr Harvey is not currently subject to criminal investigations or proceedings;
- D1: I am not satisfied that Mr Harvey engaged in misconduct of a kind that would warrant his dismissal, or the revocation by a Professional Registration Authority of his professional practice rights or registration;
- D2: I am not satisfied that Mr Harvey is currently subject to an inquiry into professional misconduct, or had been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Mr Harvey acted unreasonably, or that he intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 15: RC - 3

A recommendation and reasons regarding RC - 3 grant of legal assistance will be provided in a supplementary report following completion of all relevant investigations and processes.

SUBJECT 16: RC - 3

A recommendation and reasons regarding RC - 3 grant of legal assistance will be provided in a supplementary report following completion of all relevant investigations and processes.

SUBJECT 17: MS CLAIRE LOVELL

Determination pursuant to ED16

On 9 February 2023, the Panel issued a determination under ED16 to grant an application made by Ms Claire Lovell for indemnity and legal assistance in relation to the Commission of Inquiry.

Ms Lovell was the Executive Director, Children and Family Services within the former Department of Communities

Ms Lovell received a total of \$22,245.46 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Ms Lovell for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Ms Lovell provided evidence to the Commission of Inquiry in relation to its examination of children in out of home care, and in relation to children in health services.

On 21 November 2024, I was advised by the Department of Premier and Cabinet that there was no information responsive to my requests for information from relevant agencies regarding any criminal, civil, disciplinary or other investigations or proceedings against Ms Lovell in response to the Commission of Inquiry. I was also advised that there were no adverse comments or findings made about Ms Lovell in the Inquiry Report.

I note that the Inquiry Report details significant failings by Child Safety Services to respond appropriately to a complaint by **RC - 1**, a 15-year-old victim of Griffin's abusive conduct. **RC - 1** made her complaint in May 2013. The Commission of Inquiry details multiple failings by Child Safety Services in handling the complaint,⁶³ summarised in the following finding:

Finding—Child Safety Services should have taken further steps to assess the risk James Griffin posed in 2013 when concerns were again reported about him

⁶³ Inquiry Report, Chapter 14, pages 119 – 122.

Upon receiving the notification, Child Safety Services should have taken more steps to assess the risk Mr Griffin posed to **RC - 1** and others – particularly given Child Safety Services’ knowledge about his opportunities to offend in several settings, including in his professional role. Child Safety Services should have:

- taken **RC - 1** mother’s concerns seriously particularly given her close relationship with her daughter and the fact that she directly witnessed some of the concerning behaviour;
- undertaken a records check for any information to suggest Mr Griffin had previously been the subject of a notification—this would have raised the prior notification in 2011 from the head of an organisation who reported that two people had disclosed to them that Mr Griffin had abused them as children;
- engaged with **RC - 1** in person and in a location that was child-centred and created a sense of safety to disclose—if **RC - 1** did not disclose, she should have been reassured and given the steps for who to contact if she wanted to talk in the future
- sought more information regarding the 2009 notification to Tasmania Police about Mr Griffin to inform its risk assessment process, noting that, in 2011, Child Safety Services had received information about child abuse allegations involving Mr Griffin⁶⁴

Notwithstanding the above criticisms of the manner in which Child Safety Services dealt with **RC - 1** complaint, there is no indication from the Inquiry Report or from any subsequent investigations or processes by the Department of Communities indicating there is a basis upon which to recommend that the Crown seek recovery of legal assistance provided to Ms Lovell pursuant to ED16. Notably, I have received no indication that an ED5 investigation was contemplated into potential breaches of the Code of Conduct by Ms Lovell.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Ms Lovell engaged in conduct, including omissions, demonstrating a lack of good faith;

⁶⁴ Inquiry Report, Chapter 14, pages 122 – 123.

- B: I am not satisfied that Ms Lovell engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that Ms Lovell has not been found guilty of an offence;
- C2: I am satisfied that Ms Lovell is not currently subject to criminal investigations or proceedings;
- D1: I am satisfied that Ms Lovell has not engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that Ms Lovell is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Ms Lovell acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 18: RC - 3

A recommendation and reasons regarding RC - 3 grant of legal assistance will be provided in a supplementary report following completion of all relevant investigations and processes.

SUBJECT 19: MS KATHRINE MORGAN-WICKS

Determination pursuant to ED16

On 21 March 2023, the Panel issued a determination under ED16 to grant an application made by Ms Kathrine Morgan-Wicks for indemnity and legal assistance in relation to the Commission of Inquiry.

Ms Morgan-Wicks was at times relevant to investigations by the Commission of Inquiry the Secretary of the Department of Health.

Ms Morgan-Wicks received a total of \$28,000 in legal assistance pursuant to the Panel's determination.

Recommendation

On 19 August 2024, I wrote to the Attorney-General, the Hon Guy Barnett, recommending that no action be taken by the Crown to seek reimbursement from Ms Morgan-Wicks for legal assistance provided to her pursuant to Employment Direction No. 16 and provided my reasons for that recommendation.

Reasons

My assessment of Ms Morgan-Wicks was conducted in advance of the assessments of the other 26 individuals subject to this Independent Review. This was necessary because at the time this review commenced, Ms Morgan-Wicks was the Secretary of the Department of Premier and Cabinet, and in that role had been referred to me by the Attorney-General's Department as my primary contact for providing information regarding relevant regulatory, disciplinary and other governmental processes relating to Public Officers the subject of this Independent Review. Accordingly, it was important to ensure that Ms Morgan-Wicks could carry out her duties free from any suggestion of conflict of interest in being both a senior source of information within the Tasmanian Public Service in support of this Independent Review, and at the same time being a subject of that Review.

I have not reproduced the reasons for my recommendation to the Attorney-General set out in my letter of 19 August 2024, but I note those reasons were also informed by the considerations outlined in Parts A, B and C of this report. In summary, on the basis of the information I reviewed, including the Inquiry Report, the Blake Review, and the exchanges between the General Counsel of the Commission of Inquiry and Counsel for Ms Morgan-Wicks, I concluded there was no basis for the State of Tasmania to seek reimbursement

from Ms Morgan-Wicks for the legal assistance provided to her pursuant to ED16. In particular, I concluded that there were no indications that Ms Morgan-Wicks had acted other than in good faith in relation to all examined conduct and in providing evidence to the Commission of Inquiry, or that she would be conflicted in providing information in relation to this Independent Review.

I also noted the following observation by the Commission of Inquiry in relation to Ms Morgan-Wicks, given in the context of the examination of Mr Griffin's offending at LGH (Case Study 3):

Secretary Morgan-Wicks came to our hearings to listen and accept responsibility. **She stood out as one of the few senior witnesses to genuinely appreciate the scale of the catastrophe that was the hospital's response to revelations of Mr Griffin's offending and that the task ahead of rebuilding community trust will be enormous** [emphasis added]. Her willingness to be accountable was as appropriate as it was heartening. It was clear to us that Secretary Morgan-Wicks was not only poorly advised, but also misled."⁶⁵

Conclusions

For the sake of completeness, I note here that on the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above and discussed in my letter to the Attorney-General of 19 August 2024, for the purposes of this Independent Review:

- A: I am not satisfied that Ms Morgan-Wicks engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Ms Morgan-Wicks engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that Ms Morgan-Wicks has not been found guilty of an offence;
- C2: I am satisfied that Ms Morgan-Wicks is not currently subject to criminal investigations or proceedings;

⁶⁵ Inquiry Report, Chapter 14, page 263.

- D1: I am satisfied that Ms Morgan-Wicks has not engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that Ms Morgan-Wicks is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Ms Morgan-Wicks acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 20: MR MICHAEL PERVAN

Determination pursuant to ED16

On 31 August 2022, the Panel issued a determination under ED16 to grant an application made by Mr Michael Pervan for indemnity and legal assistance in relation to the Commission of Inquiry.

Mr Pervan was the Secretary of the Department of Communities (and its predecessor, the Department of Health and Human Services), from May 2014 to October 2022, with a gap between July 2018 and September 2019.

Mr Pervan received a total of \$468,844.99 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Mr Pervan for legal assistance provided to him pursuant to Employment Direction No. 16.

Reasons

In his role as a departmental secretary, Mr Pervan had significant responsibilities in relation to matters investigated by the Commission of Inquiry, including for children in out of home care (Chapter 8) as well as for the health, safety and welfare of young people held at AYDC (Chapter 11), through a memorandum of understanding with the Department of Health and for children in health services (Chapter 14).

While this review is independent of previous inquiries, I have been concerned to ensure I do not replicate the work of the numerous inquiries already undertaken. This is particularly important in the case of Mr Pervan, who in addition to extensive scrutiny by the Commission of Inquiry, has been the subject of several subsequent inquiries, all of which have exonerated him from engaging in misconduct of a kind that could constitute grounds for seeking reimbursement pursuant to ED16. I will only briefly outline the subject matter and determinations made by each of these inquiries.

Inquiry Report

Mr Pervan provided extensive evidence to the Commission of Inquiry across many of its areas of investigation. While numerous findings were made about failings by state

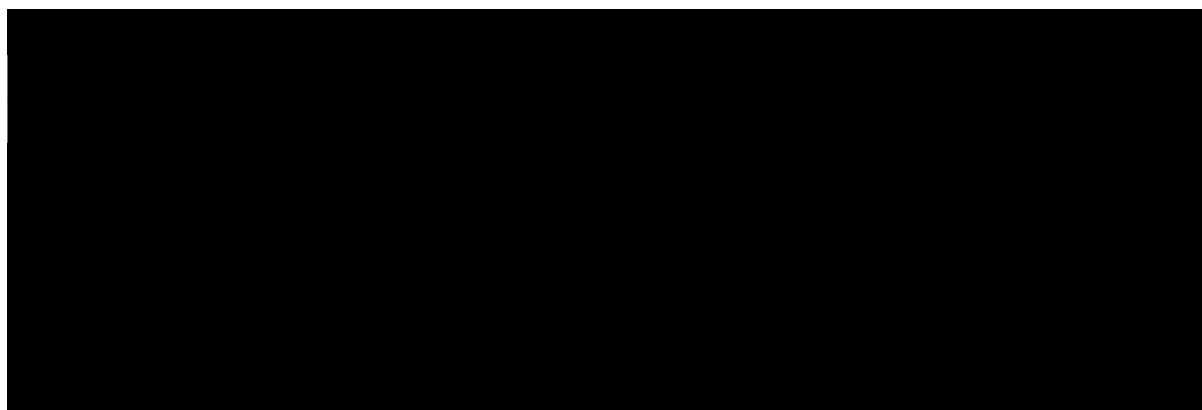
institutions, no adverse findings or findings of misconduct were made against Mr Pervan personally. Moreover, and consistently with the tenor of the findings discussed in my comments in Part C of this report, adverse findings in the Inquiry Report relevant to Mr Pervan's conduct are referable primarily to identified systemic failings that were entrenched beyond any one government department, so that Mr Pervan can reasonably be seen as essentially being a participant in a flawed system, albeit a senior one. For these reasons, I am not satisfied that the Inquiry Report makes findings against or relating to Mr Pervan which indicate he engaged in conduct indicating a lack of good faith, or which constitutes other grounds to seek recovery under ED16. This finding is consistent with the finding of the Blake Report, discussed immediately below.

Blake Report

In around November 2023, former Tasmanian Auditor-General, Mike Blake AM, was commissioned by the Tasmanian Government to carry out an independent assessment of concerns raised by the Commission of Inquiry in respect of actions by selected past or present Heads of Agencies. Mr Blake was directed to inquire into whether any departmental secretaries, including Mr Pervan, potentially breached the Code of Conduct.⁶⁶ Mr Blake's report to Premier Rockliff on 28 March 2024 concluded that none of the departmental Secretaries appearing before the Commission of Inquiry, including Mr Pervan, breached, or potentially breached, the Code of Conduct.

On 16 June 2024, Mr Blake submitted an addendum to his March 2024 report, following further consideration of relevant matters, including in particular the effect of purported constraints on the capacity of the Commission of Inquiry to make findings of misconduct against specific persons. Having reviewed that evidence, Mr Blake remained confident of the conclusions in his March report.

Bartlett Report



⁶⁶ The report was titled *Did any or all of six selected Secretaries potentially breach the Code of Conduct?*

[REDACTED]

[REDACTED]

The Bowen Report

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Mr Pervan engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Mr Pervan engaged in conduct, including omissions, that did not arise in the course of his public office;
- C1: I am satisfied that Mr Pervan has not been found guilty of an offence;
- C2: I am satisfied that Mr Pervan is not currently subject to criminal investigations or proceedings;
- D1: I am satisfied that Mr Pervan has not engaged in misconduct of a kind that would warrant his dismissal, or the revocation by a Professional Registration Authority of his professional practice rights or registration;
- D2: I am satisfied that Mr Pervan is not currently subject to an inquiry into professional misconduct, and that he has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Mr Pervan acted unreasonably, or that he intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 21: DR PETER RENSHAW

Determination pursuant to ED16

On 29 June 2022, the Panel issued a determination under ED16 to grant an application made by Dr Peter Renshaw for indemnity and legal assistance in relation to the Commission of Inquiry.

Dr Renshaw was the Executive Director of Medical Services at LGH during the period relevant to the Commission of Inquiry, and resigned effective 13 January 2023.

Dr Renshaw received a total of \$56,430.14 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that the Crown seek reimbursement from Dr Renshaw for legal assistance provided to him pursuant to Employment Direction No. 16.

Reasons in relation to Dr Renshaw's conduct as examined in Case Studies 1, 2 and 3 in Chapter 14 of the Inquiry Report

Dr Renshaw was the subject of numerous adverse comments in the Inquiry Report in relation to all three case studies concerning LGH. In particular, Dr Renshaw was the subject of an explicit finding of misconduct and of five explicit adverse findings of fact in relation to Case Study 2 and 3. These findings provide an ample basis for making my recommendation that the Crown seek reimbursement from Dr Renshaw under ED16. Accordingly, although I have considered all of the material in relation to Dr Renshaw in the Inquiry Report, it has not been necessary for me to set out in detail here all adverse findings that relate to Dr Renshaw's conduct as Executive Director of Medical Services at LGH.

Case Study 2

In relation to the complaint about Dr Tim, the Commission of Inquiry made the following findings:

Finding—Dr Peter Renshaw failed to comply with Launceston General Hospital’s protocol for reporting and management of cases of suspected child abuse.⁶⁷

Finding—Dr Peter Renshaw failed to comply with his mandatory reporting obligations in a timely manner, which impacted on the ability to gather evidence and future investigations.⁶⁸

Both of these findings constitute serious failures by Dr Renshaw in which he breached the relevant protocol and his legal obligations. They cannot be seen to be referable to systemic flaws at LGH as the protocol clearly provided a pathway that he chose to ignore. The explanations provided by the Commission of Inquiry in relation to each of the above findings go to the seriousness of these breaches, both in terms of the breach by Dr Renshaw of his professional and legal obligations, and of the gravity of the harm that may have flowed from these failures. I have set those comments out in detail here because notwithstanding the absence of an ED5 investigation into these findings and any resultant breaches of the Code of Conduct (discussed below), in Dr Renshaw’s case I have relied on the findings of fact made by the Commission of Inquiry in formulating my recommendation in relation to ED16.

In relation to the first finding above, that “Dr Renshaw failed to comply with Launceston General Hospital’s protocol for reporting and management of cases of suspected child abuse,” the Commission of Inquiry wrote:

On 19 May 2001, [RC-1] allegations were that Dr Tim had given her a hug, kissed her hand, said she was a pretty girl and that, if she were older, he would marry her. We note that Dr Renshaw gave evidence that when he was notified of [RC-1] initial allegations on 19 May 2001, he understood them to be ‘a professional boundary violation which could be, but may not have been, child sexual abuse’. On his own evidence, this was an allegation of potential child sexual abuse, which should have activated the Protocol and Guidelines in place at the time.

Dr Renshaw failed to comply with the Protocol and Guidelines in several respects. First, he did not contact the paediatric registrar about [RC-1] allegations. This was a missed opportunity to receive assistance from specialist staff.

Second, Dr Renshaw failed to comply with the Protocol because, contrary to what its Guidelines required, he spoke to [RC-1] about her allegations in circumstances where he did not have the statutory responsibility or authority for investigating whether abuse had occurred. Dr Renshaw’s file note indicates that he spoke with [RC-1] to ‘assess her story’. Dr Renshaw later described this as a brief assessment. In our view, however, Dr Renshaw’s meeting with [RC-1] constituted an ‘in depth’ interview under the Protocol because it extended beyond merely accurately recording ‘information volunteered by the child’ and involved Dr

⁶⁷ Inquiry Report, Chapter 14, page 60.

⁶⁸ Inquiry Report, Chapter 14, pages 61.

Renshaw assessing [RC - 1] ‘affect’. The Protocol specifically recommended against undertaking an ‘in depth’ interview. By this stage, the [RC - 1] [RC - 1] parents] had told Dr Renshaw that [RC - 1] had raised further allegations about Dr Tim touching her.

Although our view is that Dr Renshaw’s interview with [RC - 1] should not have taken place at all, we also highlight that Dr Renshaw did not have any training in child abuse or experience in interviewing children.

Third, Dr Renshaw failed to consult a senior colleague and consider making a report to Child Safety Services. The Protocol says: ‘Decisions about whether to refer, and where, must not be made in isolation. Discuss concerns you may have with an immediate senior colleague and follow the procedure ... below’. Having such a discussion may have resulted in a mandatory report being made to Child Safety Services earlier.

We consider that Dr Renshaw’s failure to comply with the Protocol—by failing to immediately alert the paediatric registrar of [RC - 1] allegations, his failure to discuss reporting to Child Safety Services with a senior colleague, and his subsequent interview of [RC - 1]—may have contributed to delaying [RC - 1] disclosure of more serious allegations against Dr Tim, including that he had raped her. Furthermore, the failure to comply with the Protocol meant that a forensic examination was never entertained as an option. Dr Renshaw told us that he considered ‘a forensic examination or detailed interview was simply not required’. This was a missed opportunity to collect forensic evidence that may have been relevant to [RC - 1] allegations.⁶⁹

In relation to the second finding, that Dr Renshaw “failed to comply with his mandatory reporting obligations in a timely manner, which impacted on the ability to gather evidence and future investigations”, the Commission of Inquiry wrote:

Ten days passed between [RC - 1] initial disclosures on 19 May 2001 and Dr Renshaw’s verbal report to Child Safety Services on 29 May 2001. During this time, Dr Renshaw received more information about [RC - 1] disclosures. On 21 May 2001, [RC - 1] told Dr Renshaw that Dr Tim had touched her on the breast, inserted a finger in her mouth, made comments about her appearance and expressed a desire to marry her. Taken together, this was an allegation of child sexual abuse.

At the time of [RC - 1] allegations, Dr Renshaw had mandatory reporting obligations (as a medical practitioner) under the *Children, Young Persons and Their Families Act 1997*. Specifically, under section 14 of the Act, he was required to report to Child Safety Services as soon as practicable if he knew or believed or suspected on reasonable grounds that a child had been abused. We are of the view that in the circumstances we have outlined, any professional would, on reasonable grounds, form a suspicion that child sexual abuse had occurred and make a mandatory report as required under the Act.

⁶⁹ Inquiry Report, Chapter 14, pages 60 – 61. Footnotes omitted.

Dr Renshaw could have reported the matter to Tasmania Police and Child Safety Services when he first became aware of it on 19 May 2001, but he should have reported it to these authorities after the RC - 1 raised the concern about Dr Tim touching RC - 1 on 21 May 2001. Compounding this, Dr Renshaw did not report the matter after speaking to RC - 1 in the afternoon of 21 May 2001 when she told him directly that Dr Tim had touched her on the breast, inserted a finger in her mouth, had made comments about her appearance and expressed a desire to marry her.

Dr Renshaw conceded that on 21 May 2001 he should have made a report to Child Safety Services.

Dr Renshaw was also contacted individually, after the initial allegations, by three separate parties (RC - 1 general practitioner, RC - 1 and Laurel House) before he made a report to Child Safety Services. It is significant that two professional parties and RC - 1 were expressing serious concerns about RC - 1 and her contact with Dr Tim.

Dr Renshaw's inaction had an adverse impact on later investigations. As discussed later in this case study, subsequent investigation reports from Child Safety Services and the Medical Council of Tasmania refer to Dr Renshaw's delay in reporting. They suggest that a more timely report and advice from Child Safety Services may have resulted in a clearer picture of what occurred while also preventing the potential contamination of RC - 1 story and reducing the emotional trauma for RC - 1⁷⁰

Case Study 3

Dr Renshaw was also the subject of three highly critical findings of fact in Case Study 3 in relation to James Griffin. I have reproduced parts of each below because these findings indicate very significant failures on the part of Dr Renshaw, and the Commission's findings have formed the factual basis on which I have based my recommendation. Each of the following adverse findings in Case Study 3 indicate to me that Dr Renshaw failed in his professional conduct in ways that are not explicable by reference to the systemic problems at LGH detailed at length in the Inquiry Report:

Finding—Dr Peter Renshaw misled the Chief Executive of Launceston General Hospital and the then Secretary of the Department by failing to fully and accurately convey information relating to James Griffin received from Tasmania Police on 31 July 2019

Dr Renshaw received two critical pieces of information that linked the police investigation into Mr Griffin to the hospital. These two pieces of information were the possibility that images found on Mr Griffin's devices were taken of patients in the hospital (whether they

⁷⁰ Inquiry Report, Chapter 14, pages 61 – 62.

were deemed child exploitation material or not) and the possibility of Mr Griffin's inappropriate contact with Penny, a patient of the hospital.

This information is relevant to the hospital's response to revelations about Mr Griffin's offending for the following reasons...

...

We find that Dr Renshaw misled Mr Daniels and then Secretary Pervan by failing to convey information fully and accurately to them about the police briefing on 31 July 2019. Dr Renshaw's initial briefing, which positioned Mr Griffin's offending as occurring entirely outside the hospital setting, set the tone for subsequent briefings to the Secretary.⁷¹

Finding—Dr Peter Renshaw should have escalated and acted on knowledge of RC - 1 disclosure to the hospital once advised about it by Tasmania Police on 29 October 2019

We consider that Detective Senior Constable Hindle told Dr Renshaw about RC - 1 disclosure on 29 October 2019. Dr Renshaw had a responsibility to tell the Department and the hospital executive, particularly the Chief Executive Mr Daniels, that there had been a significant failure of systems and processes at the hospital resulting in a paedophile continuing to work in a paediatric ward for several more years. Dr Renshaw, as part of the executive, should have been looking for ways to ensure similar failures did not reoccur. He should also have been ensuring that others were informed of the failures in systems and processes so they could support those affected and take their own actions to ensure similar failures were not repeated.⁷²

Finding—Dr Peter Renshaw misled the Secretary of the Department about James Griffin

Of all the Minutes to the Secretary, we consider the Minute of 5 November 2019 to be the most significant and the most misleading. ...

While the Minute gave the Secretary some sense of the seriousness of the situation and the distress of ward staff, it also conveyed that the hospital had no knowledge of the risk Mr Griffin posed to children until 31 July 2019. We consider the wording of what was included, combined with what was excluded, to have been calculated to give the impression to the Secretary that the hospital was not implicated in Mr Griffin's conduct. Secretary Morgan-Wicks agreed, telling us she felt that the wording of the Minute was designed to 'reassure me that there was nothing to see here in terms of the LGH'.

⁷¹ Inquiry Report, Chapter 14, pages 187 – 188.

⁷² Inquiry Report, Chapter 14, page 206.

Dr Renshaw conceded that ‘in retrospect’ the briefing was significantly deficient, although he qualified that the briefing was written in ‘good faith based on the information’ he had at the time and ‘there was no deliberate intent to mislead’. He said ‘it was just one of those situations where the amount of information we had was pretty well overwhelming’. Dr Renshaw later told us that he did not include some information in the briefing, because it was ‘unnecessary’ (in relation to Penny), did not ‘warrant advising the Secretary’ (in relation to the ‘corridor rumour’) or was ‘well known’ (in relation to Mr Griffin’s length of employment). This does not explain why Dr Renshaw did not include information about **RC - 1** disclosure when it was confirmed by Detective Senior Constable Hindle on 29 October 2019. Dr Renshaw also stated that he regretted his failure to pass on critical information, which contributed to the Secretary not taking appropriate steps in response to the allegations against Mr Griffin and in support of staff.

The concessions Dr Renshaw made were reluctant and highly qualified and we found his evidence on this Minute to be unconvincing. Overall, we consider that he attempted to minimise his responsibility by suggesting that the Department was taking the lead on coordinating investigations and that any enquiries he may have made to provide more comprehensive advice could have cut across the Department’s work. This position overlooks the obvious fact that the Office of the Secretary was relying on Dr Renshaw’s advice—as a senior executive who was receiving or had access to all material information—to inform her decisions on the need for and nature of further enquiries.⁷³

I have no hesitation in concluding that in aggregate, the five factual findings against Dr Renshaw in Case Studies 2 and 3, as set out above, indicate that Dr Renshaw did not act in good faith for the purposes of ED16.

In the absence of an ED5 investigation and any resultant departmental determination of breach of the Code of Conduct, I have *not* based my recommendation on the arm of the definition in ED16 (set out in Part B above) that a lack of good faith may be constituted by “acts or omissions that constitute serious and wilful misconduct or a serious breach of a code of conduct applicable to the Public Officer, which for the purposes of this Independent Review, is the Public Service Code of Conduct.” Rather, it is my view that the above findings demonstrate that Dr Renshaw did not act in good faith because he engaged in “acts and omissions that were not honest, sincere and reasonable”, particularly given the seniority of his role as the Executive Director of Medical Services at LGH and the gravity of the harm that he knew, or should have known, might flow to vulnerable patients from his failures to act with urgency, and to communicate with full and complete honesty, in strict compliance with his professional and legal obligations, in relation to critical information he received and that was the subject of the above findings.

⁷³ Inquiry Report, Chapter 14, pages 216 – 217.

It is also my view that some of Dr Renshaw's conduct in withholding information as set out in the above findings in relation to Case Study 3 was 'dishonest', and so was in breach of the fourth arm of the definition of 'good faith' set out in Part B of this report.

Finding of Misconduct

In the context of Case Study 3, the Commission of Inquiry also made a finding of misconduct against Dr Renshaw. He was the only Public Officer against whom a finding of misconduct was made. The finding was in the following terms:

Misconduct finding—Dr Peter Renshaw misled our Commission of Inquiry about his state of knowledge

Throughout Section 5, we have shown that Dr Renshaw withheld important information, particularly in briefings to the Chief Executive and the Secretary, that significantly and adversely affected their ability to make the best possible decisions to address Mr Griffin's conduct and its implications for staff, patients, the hospital and the broader community. That Dr Renshaw's briefings were factually inaccurate also hampered our Inquiry. We relied on accurate documentation and truthful statements to inform and shape our Inquiry, particularly in the lead up to our hearings. Dr Renshaw did not provide this when it was within his power to do so.

There were many instances during our Inquiry where witnesses forgot certain events or were confused by questions. We accept that giving oral evidence, in particular, is daunting and it can be easy to misspeak. We note this here to make explicit our inclination to give witnesses the benefit of the doubt.

We consider that **Dr Renshaw falls into a different category**. We consider that in view of the totality of his evidence, the evidence of others and relevant documents provided by other agencies, that **Dr Renshaw actively sought to mislead our Commission of Inquiry**.

...

As we have flagged elsewhere, we found Dr Renshaw to be an unhelpful witness. He was defensive and pedantic. Each of the concessions he made, once confronted by the evidence, had to be extracted from him during hearings. We consider that Dr Renshaw failed to accept responsibility for his failures. He did not demonstrate even a modicum of self-reflection during our hearings. Dr Renshaw's approach to our Inquiry frustrated many affected parties, particularly victim-survivors and their families, who were understandably seeking some acknowledgment, reflection and, indeed, apologies.

Dr Renshaw's omissions and fabrications amount to misleading our Commission of Inquiry. We do not make this finding lightly. Misleading a commission of inquiry undermines public trust and confidence in the process. Such an act by a senior state servant is unethical and unprofessional and brings the State Service into disrepute.

Under section 18 of the *Commissions of Inquiries Act 1995* ('Commissions of Inquiries Act'), we have the power to make a finding of misconduct. Section 3 of the Commissions of Inquiries Act defines misconduct as 'conduct by a person that could reasonably be considered likely to result in a criminal charge, civil liability, disciplinary proceedings, or other legal proceedings, being brought against that person in respect of the conduct'. Section 10 of the State Service Act outlines circumstances under which a State Service employee may be subject to disciplinary processes. This includes when an employee breaches the State Service Code of Conduct.

Dr Renshaw's conduct in misleading our Commission of Inquiry meets most, if not all, of these provisions and may be considered likely to result in disciplinary proceedings, which meets the definition of misconduct in the Commission of Inquiries Act. We make a finding of misconduct against Dr Renshaw.⁷⁴

The finding that Dr Renshaw misled the Commission of Inquiry provides a separate and sufficient basis for recommending the Crown seek reimbursement from Dr Renshaw pursuant to ED16, in addition to his demonstrated lack of good faith in relation to the subject matter of the inquiry outlined earlier in this section. Specifically, the above finding of misconduct against Dr Renshaw enlivens Clause 3.2 of ED16, which states that:

If, in the course of any legal proceedings, inquiry or investigation, the Public Officer acts unreasonably, or intentionally or recklessly fails to make full and frank disclosure of relevant matters, an indemnity or legal assistance may be refused or withdrawn.

The finding of misconduct also enlivens Clause 12 of the Addendum to ED16, which imposes the following mandatory condition on all grants of legal assistance in relation to the Commission of Inquiry:

An indemnity or grant of legal assistance may be withdrawn in accordance with cl 3.21 of the [ED16] Policy and Guidelines. A condition of the indemnity or grant of legal assistance will be, in every case, that if, in the course of the provision of evidence, the PO [Public Officer] acts unreasonably, or intentionally or recklessly fails to make full and frank disclosure or [sic] relevant matters, the indemnity or legal assistance may be refused or withdrawn.

Both of the clauses set out above are expressed as enlivening a discretion, rather than an obligation, to withdraw legal assistance. Given the seriousness of Dr Renshaw's conduct, both in terms of undermining public trust in the process of the Commission of Inquiry and by demonstrating unethical and unprofessional conduct that brings the State Service

⁷⁴ Inquiry Report, Chapter 14, pages 248 – 251 (emphasis added).

into disrepute, it is my recommendation that the Crown exercise its discretion to withdraw funding and seek recovery of legal assistance paid.

In constituting a breach of a condition of the grant of legal assistance in Clause 12 of the Addendum, the finding of misconduct against Dr Renshaw also enlivens Clause 3.21(d) of ED16, empowering the Crown to withdraw funding and to seek recovery of costs paid.

Lack of ED5 inquiry into the above findings

Dr Renshaw resigned from the Department of Health effective 13 January 2023, at a time when material for an ED5 investigation into the findings against him in the Inquiry Report was being prepared. Had the ED5 investigation been conducted it would have examined whether Dr Renshaw had breached section 9(1), 9(2), 9(10) and 9(14) of the Code of Conduct. As a consequence of Dr Renshaw's resignation, on 29 November 2023 the Secretary of the Department of Health, Ms Morgan-Wicks, determined that no ED5 investigation could proceed. Secretary Morgan-Wicks further determined that a record of the above matters would be maintained by the State Service, and that if Dr Renshaw again sought employment or engagement with the State Service, including as a volunteer, an ED5 investigation into his earlier conduct would be commenced.

Notwithstanding that an ED5 has not been carried out I am confident in my conclusions regarding Dr Renshaw's conduct and the recommendations I have made due to the very serious findings of fact made against Dr Renshaw personally by the Commission of Inquiry, which clearly indicate a lack of good faith as defined in ED16, and which show that in providing evidence to the Commission of Inquiry, Dr Renshaw intentionally or recklessly failed to make full and frank disclosure of relevant matters and actively sought to mislead the Commission.

As discussed in Part B above, I also note that sections 18 and 19 of the *Commissions of Inquiry Act* contains significant protections for persons against whom adverse findings and findings of misconduct may be made, which ensure that procedural fairness is accorded to any potential subject of such findings. I am satisfied that through these provisions, Dr Renshaw was accorded procedural fairness with regard to the findings upon which I have based my recommendation.

[REDACTED]

[REDACTED]

[REDACTED]

- 1 [REDACTED]
- 2 [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1 [REDACTED]
- 2 [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- I [REDACTED]
- I [REDACTED]
- I [REDACTED]

[REDACTED]

[REDACTED]

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above in relation to Chapter 14 of the Inquiry Report, for the purposes of this Independent Review:

- A: I am satisfied that Dr Renshaw engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Dr Renshaw engaged in conduct, including omissions, that did not arise in the course of his public office;
- C1: I am satisfied that Dr Renshaw has not been found guilty of an offence;
- C2: I am satisfied that Dr Renshaw is not currently subject to criminal investigations or proceedings;
- D1: I am unable to conclude whether Dr Renshaw's conduct as set out above would amount to misconduct of a kind that would warrant his dismissal, or the revocation by a Professional Registration Authority of his professional practice rights or registration. I am aware that notification of the misconduct finding and adverse findings of fact has been provided to the Australian Health Practitioners Regulatory Agency and to Working With Vulnerable People;
- D2: I am unable to be satisfied that Dr Renshaw is not currently subject to an inquiry into professional misconduct, and that he has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am satisfied that in providing evidence to the Commission of Inquiry, Dr Renshaw acted unreasonably, or that he intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 22: MR PATRICK RYAN

Determination pursuant to ED16

On 22 July 2022, the Panel issued a determination under ED16 to grant an application made by Mr Patrick Ryan for indemnity and legal assistance in relation to the Commission of Inquiry.

Mr Ryan was employed by the Department of Communities Tasmania as the Manager Custodial Youth Justice (usually described as the ‘Detention Centre Manager’) at AYDC from 3 January 2017 until July 2020.

Mr Ryan received a total of \$17,915 in legal assistance pursuant to the Panel’s determination.

Recommendation

The Crown has a prima facie entitlement to seek reimbursement from Mr Ryan for legal assistance provided to him pursuant to Employment Direction No. 16. However, it is my recommendation that the Crown only make an order for reimbursement under ED16 if, after carefully considering the matters identified in my reasons below, the Crown is satisfied that it is reasonable in all the circumstances to do so.

Reasons

Mr Ryan was an employee of the Tasmanian State Service from around 1988 until 2024, a career of some 36 years duration. At times relevant to the Commission of Inquiry, from 3 January 2017 until July 2020, Mr Ryan was employed by the Department of Communities Tasmania as the Detention Centre Manager at AYDC.

I note that Mr Ryan’s employment was transferred from the Department of Communities Tasmania to the Department of State Growth on 1 October 2022 under a machinery of government process. [REDACTED]

With respect to his role as Detention Centre Manager at AYDC, Mr Ryan was the subject of three sets of allegations in relation to three matters examined by the Commission of Inquiry. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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- [REDACTED]
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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1 [REDACTED]
- 2 [REDACTED]
- 3 [REDACTED]
- 4 [REDACTED]

[REDACTED]

- 1 [REDACTED]
- 2 [REDACTED]
- 3 [REDACTED]
- 4 [REDACTED]
- 5 [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

In a letter dated 29 July 2024, Secretary Limkin accepted Mr Ryan's resignation, and informed Mr Ryan that he would nevertheless proceed to impose the sanction of termination of employment, with a range of administrative consequences.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am satisfied that Mr Ryan engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Mr Ryan engaged in conduct, including omissions, that did not arise in the course of his public office;
- C1: I am satisfied that Mr Ryan has not been found guilty of an offence;
- C2: I am satisfied that Mr Ryan is not currently subject to criminal investigations or proceedings;
- D1: I am satisfied that Mr Ryan has engaged in misconduct of a kind that has led to his dismissal from the Tasmanian State Service;

D2: I am satisfied that Mr Ryan is not currently subject to an inquiry into professional misconduct, and that he has not been subject to an inquiry into professional misconduct that was discontinued; and

E: I am not satisfied that in providing evidence to the Commission of Inquiry, Mr Ryan acted unreasonably, or that he intentionally or recklessly failed to make full and frank disclosure of relevant matters.

On the basis of my findings above, it is clear that Mr Ryan has not acted in good faith in relation to matters for which legal assistance was provided under ED16. [REDACTED]

[REDACTED]

[REDACTED]

As noted in Part B above, I consider that breaches of the Code of Conduct that go beyond a lack of care and diligence by a Public Officer, such that they include an element of dishonesty, may be regarded as ‘serious’ for the purposes of the definition of ‘good faith’ in ED16.

On the basis of the clear breaches by Mr Ryan of the requirement of good faith imposed by ED16, I find that the Crown has a prima facie basis to order that Mr Ryan reimburse the State for the \$17,915 in legal assistance provided to him pursuant to ED16.

Reasonableness

As noted in Part A of this report, my Terms of Reference require that I consider not only whether a subject of this review failed to act in good faith and their other obligations under the ED16 policy framework, but ‘[w]hether it is reasonable for the Crown to seek a reimbursement of legal costs’. In the case of Mr Ryan, I am concerned that it may not in fact be reasonable for the Crown to seek reimbursement of legal assistance paid, and I recommend that the Crown give careful consideration to the following matters in determining whether it will pursue reimbursement from Mr Ryan.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

It is clear from the findings against him that Mr Ryan did not act in good faith in relation to certain matters investigated by the Commission of Inquiry, and that he has thereby breached the conditions of his grant of legal assistance under ED16. [REDACTED]

[REDACTED]

[REDACTED] Accordingly, I recommend that in determining whether it will order Mr Ryan to reimburse the Crown pursuant to ED16, the Crown first assess the accuracy of the matters raised by Mr Ryan, and consider the reasonableness of ordering reimbursement in light of the verified facts and my comments below.

If one accepts that Mr Ryan has been subjected to untrue and personally injurious public statements regarding his conduct, the harm that he has already borne as well as the further harm that might be reasonably anticipated from any subsequent publicity around an ED16 reimbursement order, should be taken into account in determining the reasonableness of the Crown ordering such reimbursement from Mr Ryan pursuant to ED16. I venture to say that if Mr Ryan's claims are of substance it would appear to me that in all the circumstances of the case that it would not be reasonable to do so.

[REDACTED] again it would appear to me in all the circumstances that it would not be reasonable to do so.

SUBJECT 23: RC - 3

A recommendation and reasons regarding RC - 3 grant of legal assistance will be provided in a supplementary report following completion of all relevant investigations and processes.

SUBJECT 24: MS ELIZABETH STACKHOUSE

Determination pursuant to ED16

On 14 March 2023, the Panel issued a determination under ED16 to grant an application made by Ms Elizabeth Stackhouse for indemnity and legal assistance in relation to the Commission of Inquiry.

Ms Stackhouse commenced working for the Tasmanian State Service as a member of the Northern Regional Health Board in 1991. Ms Stackhouse commenced as Chief Executive Officer of the LGH in 1998 and resigned in 2003.

Ms Stackhouse received a total of \$4,200 in legal assistance pursuant to the Panel's determination.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Ms Stackhouse for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

The Commission of Inquiry made a number of adverse comments about or concerning the conduct of Ms Stackhouse in relation to both Case Studies 2 and 3 at LGH.

Case Study 2

In Case Study 2, the Inquiry Report details numerous failures of LGH to properly consider and to mitigate the risk that an alleged abuser, Dr Tim [pseudonym], posed after allegations were first made by an eleven-year-old patient in his care, RC - 1 and her parents. The Inquiry Report details the many failures to properly, urgently or rigorously investigate those allegations, and the cascade of adverse consequences that flowed from those failures. Three of the findings in Case Study 2 directly concern the conduct of Ms Stackhouse in her role as Chief Executive Officer of the LGH. The first is:

Finding—Launceston General Hospital failed to consider and take active steps to stand down Dr Tim while RC - 1 allegations were investigated

At no time after [RC - 1] allegations were made or while subsequent investigations by Child Safety Services or Tasmania Police were underway was Dr Tim stood down from his employment at Launceston General Hospital.

...

Ms Stackhouse told us that she was not aware of any steps taken against Dr Tim while [RC - 1] allegations were being investigated. She said that ‘upon reflection’ Dr Tim should have been ‘stood aside while the allegation was investigated by an independent party, not a member of [Launceston General Hospital] staff’.

The failure of Launceston General Hospital to take steps to stand down Dr Tim while the matter was investigated meant that Dr Tim continued to work in the emergency department with no restriction on his ability to treat children. Launceston General Hospital failed to consider this risk and then failed to take steps to mitigate the risk. We received no evidence to suggest that consideration was given to this course of action...⁷⁸

Case Study 2 also examined failings in hospital policies. The Inquiry Report notes that Ms Stackhouse gave evidence that the hospital’s chaperone policy was largely implied at the time of [RC - 1] complaint, and that following investigations into [RC - 1] allegations a formal chaperone policy was drafted, as well as a revised protocol for reporting and managing suspected cases of child abuse and neglect, both of which were formally adopted by LGH in 2002.⁷⁹ In relation to these matters, the Commission of Inquiry found that:

Finding—Launceston General Hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after [RC - 1] May 2001 disclosure and not waited until June 2002.

Launceston General Hospital’s failure to formalise, implement and enforce a chaperone policy at the time of [RC - 1] disclosure affected [RC - 1] safety and the safety of other patients in the hospital’s care. It also meant there was no formal policy against which Dr Tim could have been sanctioned had this been pursued.

The hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after [RC - 1] May 2001 disclosures and not waited until June 2002 to do so.⁸⁰

The third finding in Case Study 2 relating directly to the conduct of Ms Stackhouse was in the following terms:

Finding—Launceston General Hospital failed in its overall response and did not offer appropriate support to [RC - 1] and her family

⁷⁸ Inquiry Report, Chapter 14, pp. 62-3.

⁷⁹ Inquiry Report, Chapter 14, p. 63.

⁸⁰ Inquiry Report, Chapter 14, p. 64.

Despite many communications occurring across institutions about RC - 1 allegations, at no time did Launceston General Hospital offer RC - 1 or her family any support. The RC - 1 recalled that when they did ask to access psychological support for RC - 1 they were told to make a request in writing to the chief executive officer of the hospital with the assistance of a lawyer. The RC - 1 ended up arranging their own support for RC - 1 and, for a period of time, made regular trips to Hobart until RC - 1 decided to stop these visits.

Ms Stackhouse conceded at our hearings that Launceston General Hospital's response to RC - 1 allegations was 'inadequate'. She said the response 'did not prospectively protect other children from harm'. She also said the matter was resolved 'in a manner that would not be considered appropriate today'. Ms Stackhouse apologised to RC - 1 family and acknowledged that the hospital had 'collectively let RC - 1 family down'.⁸¹

Case Study 3

The Inquiry Report includes the following finding of relevance to Ms Stackhouse in relation to Case Study 3:

Finding—Launceston General Hospital did not have clear accountabilities for child safety

Elizabeth Stackhouse, a former Chief Executive Officer of Launceston General Hospital, told our Commission of Inquiry that, during her time in the role between 1998 and 2003, the hospital did not have any strategic plans, performance measures or key indicators that directly or indirectly related to child safety, including allegations of physical or sexual abuse of children...

We saw no indication that one individual, committee or role-holder was responsible for ensuring child safety at the hospital. Ms Stackhouse could not recall whether there was a separate role-holder responsible for child safety during her tenure. She told us that patient safety generally, for adults and children, was monitored by the quality committee. ...

A shared responsibility for child safety should not be interpreted as a diffused responsibility in which no one is ultimately accountable.⁸²

Determination not to carry out investigations under Employment Direction No. 5 ("ED5")

On 30 November 2023, the then Secretary of the Department of Health, Ms Kathrine Morgan-Wicks, made two determinations in relation to the adverse findings relating to Ms Stackhouse in the Inquiry Report.

⁸¹ Inquiry Report, Chapter 14, page 76.

⁸² Inquiry Report, Chapter 14, pages 176 – 177.

First, Secretary Morgan-Wicks determined that there was not a sufficient basis to consider there may have been a breach of the Code of Conduct in relation to the following findings:

- Case Study 2: Launceston General Hospital should have formalised, implemented and enforced a chaperone policy as soon as practicable after RC - 1 May 2001 disclosure and not waited until June 2002.
- Case Study 3: Launceston General Hospital did not have clear accountabilities for child safety.

Second, Secretary Morgan-Wicks determined that in relation to the following findings in Case Study 2, the alleged conduct, if substantiated by an independent investigation, may constitute a breach of sections 9(2) and (14) of the Code of Conduct:

- Case Study 2: Launceston General Hospital failed to consider and take active steps to stand down Dr Tim while RC - 1 allegations were investigated
- Case Study 2: Launceston General Hospital failed in its overall response and did not offer appropriate support to RC - 1 and her family

However, in relation to these two findings, Secretary Morgan-Wicks determined that because Ms Stackhouse had resigned from the State Service in 2003 there could not be an ED5 investigation into her conduct. However, Secretary Morgan-Wicks determined that had Ms Stackhouse remained a State Servant, she would have directed an ED5 investigation into whether the conduct of Ms Stackhouse might have breached sections 9(2) and (14) of the Code of Conduct.

Secretary Morgan-Wicks further determined that the State Service Management Office would be notified of the situation in relation to Ms Stackhouse, and that if Ms Stackhouse sought employment with the State Service in the future, an investigation of the matters noted above pursuant to ED5 would need to be carried out and its outcomes considered prior to confirming her re-employment.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Accordingly, on the evidence before me, which in the absence of an ED5 investigation is essentially limited to the Inquiry Report, I am unable to conclude on the balance of probabilities that Ms Stackhouse's conduct in relation to the findings of the Commission of Inquiry constituted breaches of the Code of Conduct of sufficient gravity to indicate a lack of good faith, and that would thereby constitute grounds to seek reimbursement of legal assistance paid pursuant to ED16.

Furthermore, having carefully reviewed the findings of the Commission of Inquiry in relation to Ms Stackhouse, it seems clear that the context of those findings is one of significant and long-standing systemic failings and a defective culture of management at LGH, and more broadly across the Tasmanian Public Service, with the effect that vulnerable children were not properly protected from sexual abuse in government institutions. Unlike several other senior staff at LGH who are singled out and criticised by the Commission of Inquiry for engaging in misconduct that was conspicuous and additional to the systemic problems identified in the Inquiry Report, and that may therefore be indicative of a lack of good faith (as discussed elsewhere in this Report), it appears that Ms Stackhouse was essentially a participant in a long-established system that failed children and young people, rather than a primary cause of those failings.

I also note there is no suggestion that in providing evidence to the Commission of Inquiry, Ms Stackhouse unreasonably, or intentionally or recklessly failed to make full and frank disclosure of relevant matters.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Ms Stackhouse engaged in conduct, including omissions, demonstrating a lack of good faith;

- B: I am not satisfied that Ms Stackhouse engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that Ms Stackhouse has not been found guilty of an offence;
- C2: I am satisfied that Ms Stackhouse is not currently subject to criminal investigations or proceedings;
- D1: I am not satisfied that Ms Stackhouse has engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that Ms Stackhouse is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Ms Stackhouse acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 25: MS JANNETTE TONKS

Determination pursuant to ED16

[REDACTED]

On 14 March 2023, the Panel issued a further determination ED16 to grant the application Ms Tonks sought for indemnity and legal assistance, but in this second determination Ms Tonks was granted legal assistance to employ an independent legal practitioner. [REDACTED]

[REDACTED]

[REDACTED]

Ms Tonks commenced working at the LGH as a student nurse in 1976 and occupied a number of nursing positions until she was appointed Nursing and Midwifery Director, Women's and Children's Services (WACS) in August 2013. Ms Tonks resigned from the State Service in March 2023 after a career spanning 47 years.

Ms Tonks received a total of \$16,092 in legal assistance pursuant to the Panel's determinations.

Recommendation

I recommend that no action be taken by the Crown to seek reimbursement from Ms Tonks for legal assistance provided to her pursuant to Employment Direction No. 16.

Reasons

Inquiry Report

In Case Study 3, the Commission of Inquiry focussed primarily on the systemic failures that led to a failure by LGH staff to respond appropriately to multiple complaints about Mr Griffin's conduct over many years. In this context, the Inquiry Report includes a number of adverse comments about or concerning the conduct of Ms Tonks in her role at LGH. Notably, the primary purpose of the role of Nursing and Midwifery Director, WACS was to provide effective leadership and management across clinical streams at the hospital, including in paediatrics where Mr Griffin worked. The Inquiry Report includes seven findings that either directly criticise Ms Tonks' conduct, or which could, given Ms Tonks' leadership role, be understood as being critical of Ms Tonks' conduct, including the following findings:

- **Finding—Launceston General Hospital's response to RC - 1 2017 Safety Reporting and Learning System complaint did not comply with the requirements of a State Service Code of Conduct investigation;**
- **Finding—Launceston General Hospital failed to manage the risks posed by James Griffin;**
- **Finding—Launceston General Hospital leadership collectively failed to address a toxic culture in Ward 4K that enabled James Griffin's offending to continue and prevented his conduct being reported;**
- **Finding—Launceston General Hospital failed to consider the cumulative effect of complaints about James Griffin;**
- **Finding—The response of Launceston General Hospital to complaints about James Griffin suggested it was ultimately not concerned about his conduct;**
- **Finding—Leadership at Launceston General Hospital collectively failed to provide appropriate supervision and proactive oversight, which is a systemic problem;**
- **Finding—Launceston General Hospital did not have a robust system for managing complaints involving child safety.⁸³**

Following an analysis of these findings, the Department of Health concluded that these findings indicated that Ms Tonks appeared to have failed to properly carry out her role, including by generally failing in her obligations to manage the concerns relating to James Griffin appropriately, including the complaint by RC - 1 in 2017, or to escalate and report other complaints about Mr Griffin to an appropriate health practitioner's registration authority.

On 30 November 2023, then Department of Health Secretary Morgan-Wicks considered her Department's advice, as summarised in the paragraph above, and determined that in relation to the findings concerning Ms Tonks in Case Study 3, the alleged conduct, if substantiated by an independent investigation, may constitute a breach of the following sections of the Code of Conduct:

⁸³ Inquiry Report, Chapter 14, Case Study 3.

- Section 9(2): An employee must act with care and diligence in the course of State Service employment.
- Section 9(14): An employee must at all times behave in a way that does not adversely affect the integrity and good reputation of the State Service.

Secretary Morgan-Wicks determined that because Ms Tonks had resigned from the State Service in March 2023, there would not be an ED5 investigation into her conduct, but noted that had Ms Tonks remained a State Servant, Secretary Morgan-Wicks would have directed an ED5 investigation into whether her conduct might have breached sections 9(2) and (14) of the Code of Conduct.

Secretary Morgan-Wicks further determined that if Ms Tonks sought employment with the State Service in the future, an investigation of the matters noted above pursuant to ED5 could be commenced and its outcomes considered prior to confirming Ms 'Tonks' re-employment.

[REDACTED]

[REDACTED]

[REDACTED]

Furthermore, having carefully reviewed the findings of the Commission of Inquiry in relation to Ms Tonks, it seems clear that the context of those findings is one of significant and long-standing systemic failings and a defective culture of management at LGH, and more broadly across the Tasmanian Public Service, with the effect that vulnerable children were not properly protected from sexual abuse in government institutions. Unlike several

other senior staff at LGH who are singled out and criticised by the Commission of Inquiry for engaging in misconduct that was conspicuous and additional to the systemic problems identified in the Inquiry Report, and that may therefore be indicative of a lack of good faith (as discussed elsewhere in this Report), it appears that Ms Tonks was essentially a participant in a long-established system that failed children and young people, rather than a primary cause of those failings.

I also note there is no suggestion that in providing evidence to the Commission of Inquiry, Ms Tonks unreasonably, or intentionally or recklessly failed to make full and frank disclosure of relevant matters.

Conclusions

On the basis of the evidence and materials with which I have been provided, and taking into account the matters referred to above, for the purposes of this Independent Review:

- A: I am not satisfied that Ms Tonks engaged in conduct, including omissions, demonstrating a lack of good faith;
- B: I am not satisfied that Ms Tonks engaged in conduct, including omissions, that did not arise in the course of her public office;
- C1: I am satisfied that Ms Tonks has not been found guilty of an offence;
- C2: I am satisfied that Ms Tonks is not currently subject to criminal investigations or proceedings;
- D1: I am satisfied that Ms Tonks has not engaged in misconduct of a kind that would warrant her dismissal, or the revocation by a Professional Registration Authority of her professional practice rights or registration;
- D2: I am satisfied that Ms Tonks is not currently subject to an inquiry into professional misconduct, and that she has not been subject to an inquiry into professional misconduct that was discontinued; and
- E: I am not satisfied that in providing evidence to the Commission of Inquiry, Ms Tonks acted unreasonably, or that she intentionally or recklessly failed to make full and frank disclosure of relevant matters.

SUBJECT 26: RC - 3

A recommendation and reasons regarding RC - 3 grant of legal assistance will be provided in a supplementary report following completion of all relevant investigations and processes.

SUBJECT 27: RC - 3

A recommendation and reasons regarding RC - 3 grant of legal assistance will be provided in a supplementary report following completion of all relevant investigations and processes.