Launceston General Hospital Community Recovery Initiative

Co-Chairs' Report

Elizabeth Daly
Malcolm White

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Acronyms

CEO	Chief Executive Officer
CMHW	Community, Mental Health and Wellbeing
CoI	Commission of Inquiry
DoH	Department of Health
KPI	Key Performance Indicator
LGH	Launceston General Hospital
NGO	Non-government Organisation
TAFE	Technical and Further Education
TasCOSS	Tasmanian Council of Social Service
THS	Tasmanian Health Service
UTas	University of Tasmania

About the authors of this report

The Community Recovery independent Co-Chairs

Elizabeth Daly, OAM
BEd, MEd, Fellow University Tasmania

Elizabeth Daly has had an extensive career within the Department of Education as Principal, Northern District Superintendent, Senior Superintendent - Early Years, and Director of Education. Elizabeth has also acted as Children's Commissioner and has worked with a number of NGOs including the Smith Family and Colony 47.

Elizabeth has extensive board experience having served on the boards of UTas Alumni, Tasmanian Early Years Foundation, TasDance, Youth Futures, Royal Flying Doctor Service, and Child Health Association Tasmania.

Elizabeth has also been involved with a variety of community projects including Youth Transitions Taskforce, Launceston Safer Communities Partnership and the Northern Area Taskforce.

Elizabeth currently co-chairs the Tasmanian B4 Coalition, a collective impact, government funded project which aims to connect with and engage organisations, business and the general community, in supporting the development and wellbeing of Tasmania's youngest citizens. The B4 Coalition promotes a deeper understanding of the importance of the early years particularly in relation to brain development as it relates to getting the best start in life.

Elizabeth is also the chair of the Thrive Group Education and Care Services. Thrive provide long day care, after school, vocational care and family day care across Tasmania.

Malcolm White

Malcolm's career has spanned telecommunications, electronic engineering and vocational education and training. Malcolm taught at the Launceston Institute of TAFE in the 1980s, then after a return to industry, re-joined in 1998 and was appointed Chief Executive of TAFE Tasmania in 2005.

In 2013 Malcolm joined TAFE Directors Australia including a period as Acting CEO. After concluding this role in 2017 Malcolm continued as Chair of a national scholarship foundation for TAFE students until 2021.

Malcolm joined the board of the Royal Flying Doctor Service Tasmania in 2005 and apart from a two-year break in 2010/11 has served on the board, mostly as Chair, until the current time. He is currently a director of Royal Flying Doctor Service Australia and served as Acting CEO of Royal Flying Doctor Service Australia for a period in 2019.

Background

The *Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings* (CoI) was established on 15 March 2021 by Order of the Governor of Tasmania. The CoI is independent and is equivalent to a Royal Commission including the power to call witnesses and compel the production of documents from the Tasmanian Government.

It was established to inquire into the adequacy and appropriateness of the Tasmanian Government's responses to allegations and incidents of child sexual abuse in institutional settings, including the Department of Health (DoH) and the Tasmanian Health Service (THS) at the Launceston General Hospital (LGH).

The hearings listened to testimony from a number of victim survivors and staff of incidences of child sexual abuse occurring at the LGH.

At the time of the CoI hearings, anecdotal evidence suggested the community in the northern region had lost trust in the LGH.

While the DoH has responsibility for continuous improvement across its systems, processes, operations and culture to prevent child sexual abuse, it recognises that there was an urgent need to proactively rebuild the community's trust in the LGH immediately to ensure the community had confidence in using the public hospital. The DoH is not waiting for the conclusion of the CoI to do this. As it is imperative the Tasmanian community has confidence in its health institutions, the DoH decided to initiate a recovery process.

The DoH approached us, as experienced and known members of the northern region community, to oversee the recovery initiative as independent co-chairs. We both have deep ties to the community; we feel we understand the people and the region. We were keen to be involved in repairing the community's relationship with the LGH.

It was agreed that at least initially our involvement would be on a voluntary basis. The reason for this was that we could be seen as completely independent and could not be seen as potentially compromised. It was recognised that this may need to be re-assessed if the recovery process became too intensive for a voluntary arrangement.

The Recovery Plan

An initial project plan was developed by the DoH to understand and map out how to meet the objectives of the Recovery Initiative, what resources would be required, and the timeframe of project delivery. The project plan was intended as a guiding document only, and we were given complete control to alter any aspect of the project plan including upscaling or downscaling the response as the Initiative progressed.

The provisional plan the DoH provided us set the recovery out into four stages:

1. **Listening to the community.**

2. **Recommend actions for the Department after listening to the community.**

3. **Work with the Department as it responds to the recommendations.**

4. **Review the Department's response.**

This report covers the first two stages of the plan, with this report being stage 2.

The Launceston General Hospital Community Recovery Initiative has three main objectives:

1. **Learn from the community –** for the Department to gain a deeper understanding of the northern region community's concerns, and have those concerns inform its efforts to improve the LGH's systems, processes and culture to prevent child sexual abuse from happening again.

2. **Restore community confidence –** to rebuild the northern region community's confidence in the LGH as a trusted public institution.

3. **Build community capacity –** through this process, aim where possible or appropriate to build ongoing capacity, strength and resilience within the northern region community.

As previously mentioned, both the staging and objectives were intended to be an initial framework and the DoH has made clear that we had the ability to adjust as the Initiative progressed.

Similarly, the scope of the project was limited to the LGH, however, after an initial conversation the DoH agreed that if we found during the process the need to make any recommendations broader than the LGH that we could make such recommendations.

It is important to stress this initiative is focussed on recovery and is forward looking. We are not investigating for liabilities and finding fault. Legal actions and recommendation are also outside the scope of this recovery initiative.

Listening to the Community

The target audience for this stage is the general population of Northern Tasmania as the potential patients of the LGH. The aim of this stage is to hear and understand the concerns of the northern region community in relation to child sexual abuse at the LGH, as raised at the CoI hearings.

The DoH commenced by offering an initial set of Community Forums. The forums were advertised in the media both print and social media multiple times as well as on the Department's website. The forums were initially designed by the DoH to be "Town Hall" in style with a capacity of up to 80 community members each.

Despite a reasonable level of advertising, contacting neighbourhood houses, consumer groups and asking TasCOSS to ask their network to pass onto interested clients, only 26 people expressed an interest in attending.

All but two were within the immediate Launceston region, with none being from the remainder of the northern region. Of the two from outside of Launceston, one was from the northwest of the State and one was from the south.

Details of the planned forums were sent to all interested people - 15 confirmed they planned to attend and 13 actually attended. Of those that communicated they were interested but could not attend, we offered to variously meet either separately, meet through video or phone call, or provided the option of providing a written submission to us. Each was contacted multiple times but many did not respond. Two people did take up the offer of a separate meeting.

Most of the attendees were either current or previous LGH staff or representatives of services or consumer groups. Two service groups asked that we engage with them further and it was proposed we work with them to provide a couple of "kitchen table" sessions with a representative group of the people they represented. To date these have not progressed as one service communicated it no longer thought it appropriate and the other service has been contacted multiple times but has not provided any further response.

Due to the relatively low numbers at each forum, we decided to change the format to be less formal and more "around the table". The forums were comprised of a 60 minute formal component where we heard from the community but importantly had a minimum of 30 minutes post-forum for attendees to come and speak to us one on one to allow for those reticent to talk in front of others. A support person was also present to provide support for anyone who needed to withdraw should they become distressed.

In the forums we sought community suggestions as to what they believed to be important to rebuild their trust in the LGH to ensure government decisions could be relevant, responsive and meaningful. We would at this point like to express our deep gratitude to those that gave up their time to talk to us and provide their thoughts and suggestions.

As Co-Chairs we led the forums, with support from nationally recognised psychological recovery expert Dr Rob Gordon. Dr Gordon advised on the agenda for the forums and guidelines for running the forums. Of particular note he stressed the forums needed to stay forward looking and not become debriefing sessions which risked being retraumatising. The formal component of the forums included a presentation from Dr Gordon on the nature of trauma and its effect on a community. Dr Gordon is a Clinical Psychologist; he was Clinical Director of the Victorian Department of Human Services Critical Incident Stress Service for 19 years and provides training and services to a wide range of health, welfare, and other human service agencies for trauma and stress in the workplace. He has worked in large and small, human and natural disasters since the Ash Wednesday fires in 1983 throughout Australia and New Zealand. He was also an expert witness at the CoI.

Representatives from the DoH were also present including Mr Dale Webster, Deputy Secretary Community, Mental Health and Wellbeing, and Ms Jen Duncan, Director LGH Operations.

Although the number of attendees at the forums was fewer than anticipated, those who did attend, or submitted feedback via alternative avenues, were passionate, clearly affected and committed to wanting to see positive change at the LGH. Participants provided valuable suggestions for actions to be implemented by DoH to start rebuilding the community's trust in the LGH.

There were a number of strong recurring themes that were raised by participants suggesting these were the most important issues for the community including LGH staff. The consistency of these themes made the community forums a successful information gathering tool.

The recurring themes centred around:

1. A clear change in senior leadership at the LGH particularly focussed on senior leaders that presented at the CoI. There were also strong feelings that these leaders be seen to be made accountable and be seen to be removed and not allowed just "to retire ".

2. A transparent change in culture at the LGH to one which could broadly be described as an accountable or "just" culture. Common words were "ethical", "humble", "accountable" and "people focussed". Also expressed were perceived elements of the former and possibly current culture that needed to be changed; "comfortable", "entrenched" "bullying", "covering-up", "defensive".

3. A range of systemic suggestions that could be summarised as being focussed on aspects of trauma informed and safeguarding training and protocols for staff and management.

A full summary of suggestions from forums, meetings and submissions is listed below, with the community suggestions ordered by their scope (i.e. whether the suggestion was focussed at the LGH, best applied at a Departmental level or was more suitable as a whole-of-government approach).

In the interests of transparency, rather than summarise the community's thoughts and suggestions we have documented each meeting and submission:

Meeting One

Whole of Government

- Ensure there is a public campaign informing the community of the process (including contacts, etc.) for reporting suspected child abuse.

Whole of Agency

- Trauma informed training at Service Delivery points should be mandatory and embedded in the culture. This includes maintaining training as staff turnover.

- Psychometric testing of staff dealing with children and families in a service delivery environment.

- Testing of ability of staff working in service delivery environments on level of ability of written and verbal communication.

- Ensure proper use of Safety Reporting System. Minimise avoidance / lack of reporting.

- Clear protocol regarding rape and abuse claims originating within the DoH, which is not reliant on the DoH or key dependencies within the DoH.

- Initiate a KPI on staff turnover as an indicator of potential bullying in a workplace.

Launceston General Hospital

- Senior Managers from LGH that presented to the CoI must leave the organisation.

- LGH child safety officer's coverage must be adequate including at night and weekends – officers play an important internal role in creating a trauma-informed workplace.

- CULTURE – build culture of accountability, ethics, humility, service (client-focussed – holistic not just clinical). Remove bullying, defensive, cover-up culture.
- Premier and Secretary visit the Ward 4K staff.

- Children and vulnerable people – mandatory chaperone process. Review current chaperone policy and process with a safety and trauma informed lens.

Meeting Two

Whole of Agency

- Clear boundary of line between care and potential abuse behaviours including clear process of consent and consent training.

Launceston General Hospital

- Senior Managers from LGH that presented to the CoI must leave the organisation.
- Register of victim survivors held at LGH to inform service as part of trauma informed care.
- CULTURE – visible change of culture of accountability including performance appraisals, managers being “on the floor”.
- Rebuild peer trust within the LGH.
- Consideration on how to provide support for male LGH staff who have heightened sensitivity of public suspicion.

Meeting Three

Whole of Agency

- Formal management training for managers.
- Build protection of ALL vulnerable groups including children.
- Ensure there is protection of abuse “whistle-blowers”.

Launceston General Hospital

- Senior Managers from LGH that presented to the CoI must be removed from the organisation, and new external to LGH management recruited.
- Open and continuous communication to community of steps and changes made to address issues raised by the CoI.
- CULTURE – remove organisational siloes, visible change of culture build culture of accountability. trauma informed. client-focussed.
- Involve community in process and policy changes

Individual written response

Whole of Agency

- Secretary DoH should be removed.

Launceston General Hospital

- Senior Managers from LGH that presented to the CoI must be seen to be removed from the organisation.

Recommended actions

After considering all we have heard from the community, we feel we can now provide the DoH with a number of recommendations. It should be noted our role is to restore trust in the LGH, not make recommendations on restorative justice.

One thing we feel we should make clear and found was important, was to sometimes inform participants that witnesses to the CoI, including government employees were afforded certain protections.

These can be found on the Commission's website:
https://www.commissionofinquiry.tas.gov.au/hearings/witness-information

In summary they are that:

Witnesses have rights and protections under the Commissions of Inquiry Act 1995 (Tas). If you are called as a witness, the Act provides that:

- ***your employer cannot prejudice or dismiss you;***
- ***others cannot try to prevent you from providing evidence to the Commission; and***
- ***others cannot punish you or cause you damage, loss or disadvantage because you provide evidence to the Commission.***

This means that punitive action such as termination of employment against any witness based on their testimony is illegal.

Our recommendations, after listening to the community, are made in respect of Leadership, Communication, and Training and Protocols.

We recognise that our recommendations complement the work already underway by the DoH around cultural change, the commitment to implementing the National Principles for Child Safe Organisations, and the restructure of senior LGH leadership.

Leadership

The recurring theme in every conversation and view we heard was that professional standards of care and leadership had been breached and people who were in positions of responsibility must be held to account.

The breaches of care have resulted in consequences, some severe, some very severe, long term and life changing for the victims of child sexual abuse, their families, and affecting also LGH staff generally and the wider community. We heard that accompanying these breaches were many omissions. These omissions, which centred on leadership, also had consequences, some severe.

It was the overwhelming view of meeting and forum attendees that those senior staff in leadership and management positions at the LGH must be held to account. They referred to breaches of care and the risk of further breaches. Further, the view at our forums and the meetings with individuals was that tangible actions must be taken to restore confidence in leadership and to significantly improve organisational culture in respect of management and administration at the LGH.

We are mindful that certain protections have been afforded people who made statements to the CoI. Furthermore, our role is forward-looking and it is in this respect that we make our recommendations. However, we must be clear in our observations, that without exception the meeting and forum attendees asserted a requirement that leaders who failed in their duties be held to account. To not meet this criterion will, in our view, lead to the risk of an overall failure assessment of restorative trust actions from those we heard from and, more generally, for those whom the DoH seeks to restore a trusting relationship.

Recommendation 1. Tangible and timely actions to be taken to restore confidence in senior leadership at the LGH. We see the need to put in place a new management team.

We note that actions in respect of leadership renewal are already underway, furthermore we noted a high level of confidence, while not universal, that the senior leadership of the DoH are committed to addressing the significant issues at the LGH that led to the CoI, our forums, and to the recovery process.

Views we heard about the management culture at LGH that contributed to the incidence of child sexual abuse included ‘entrenched’, ‘comfortable’, ‘defensive’ and ‘cover-up’.

Recommendation 2. The immediate work of a new management team at the LGH is cultural change that focusses on patient outcomes in an environment where the committed staff of the LGH are supported to do their best work. This culture must support performance, accountability, safety of staff and patients and an openness to addressing incidents, accidents and near misses.

Communication

The structure of our forums allowed both formal and informal time for participant consultation. The informal time where participants were able to talk with the Deputy Secretary, DoH and Director Operations, LGH proved to be particularly valuable. There was general appreciation of the opportunity to exchange views and particularly the honesty and frankness of these discussions. We heard stories of outstanding care and of dedicated and committed staff at the LGH.

While it is understandable that stories about past events, particularly as told through the statements made to the CoI featured and continue to feature in the media, we believe it is important to communicate the many positive stories at the LGH.

While not making any judgement as to the current levels or effectiveness of communications at the LGH, our view is that significantly increased communication is a key to restoring trust.

We see it as important to build the brand of the LGH with an emphasis on community ownership and pride. It is vital to communicate effectively with the public and to staff, noting the form of communication will be different for each audience.

Everyday there is very good work being performed at the LGH. It is important to tell these stories to the public across various media platforms.

By the nature of its work and the significant pressures on a public hospital, some of the communications to the public and to staff will be about difficult issues and about improvements that are needed. We believe both the public and staff will respond positively when they feel they have an opportunity to share in the problems and share a role in supporting 'their' hospital.

Staff also have a particular interest in communication that is relevant and transparent.

The opportunity for staff to have a chat with senior managers or occasionally encounter them in a workplace is seen as valuable from the perspective of staff members and executives.

Recommendation 3. The LGH to develop a strong positive presence in the eyes of the public highlighting the many positives of the LGH and its people. Utilise a variety of media platforms. Enhance the feeling of ownership of the LGH by the community.

Recommendation 4. Communicate regularly and transparently with staff. Have avenues for two-way communication.

Recommendation 5. Senior managers visit workplaces regularly.

We heard from LGH staff in the forums that they would appreciate a visit from the Minister and Secretary to Ward 4K.

Recommendation 6. Minister and Secretary to visit Ward 4K at an appropriate time.

Training and Protocols

We heard about protocols, which if taken, may have prevented the events or decreased the opportunity for ongoing harm that was described at the CoI.

There is no doubt in our minds that a number of programs and protocols in this respect will shortly or already have been implemented at the LGH. These programs are designed to ensure all staff understand the requirement to guard against and to

report breaches of behaviour, in particular in respect of children and vulnerable people. Further, it is desirable that there is a greater understanding of trauma in its various forms.

While understanding the importance of not unthinkingly adding greater complexity and compliance burdens to staff as an inevitable response to an institutional failure, the importance of training, including induction training, in prevention and reporting of child sexual abuse is emphasised.

Moreover, induction training should emphasise the principles and cultural pillars of openness and transparency in respect of safety and improvement.

Recommendation 7. All staff to undergo training in their responsibility to prevent and report incidents of child sexual abuse and more generally in the principles and pillars of the LGH safety culture.

The importance of on-going staff 'refreshers' of requirements and principles of LGH safety culture, particularly in regard is child sexual abuse, is emphasised.

It is important in our view that these preventative measures and actions and protocols be communicated in general to the public as a component of restoring trust. This information should be made available and readily accessible in detail to parents and carers of children who are patients at the LGH.

Next steps

The next phase of our work as Co-Chairs is for the DoH to consider our Recommendations.

The initial Project Plan suggested the formation of a Local Area Recovery Committee. This was based on the expectation of a large and diverse range of community-led suggestions and recommended actions both internal and external to the LGH including possible community inclusion projects.

Our assessment is that the loss of trust in the LGH from a community perspective is not as wide spread as initially thought. The suggestions we have heard have been about internal changes needed within the LGH or DoH and for that reason we do not believe the Local Area Recovery Committee is of benefit or needed. As Co-Chairs we suggest that we continue as a committee of two liaising with the DoH and other relevant committees about how we may continue to support and assist the process of restoring trust.

It is noted that the Launceston City Council and the Launceston Chamber of Commerce have opportunities to participate in restoring the community confidence and trust in its major hospital. Opportunities to welcome new intakes of student doctors and interns to the city and celebrating such occasions of completion of studies of senior nurse practitioners. Such occasions enrich the city and as many of these people are from interstate, contributes to the economy and culture.

Recommendation 8. The Co-Chairs of the Launceston General Hospital Community Recovery Initiative approach the Launceston City Council and the Launceston Chamber of Commerce to consider:
1. Welcome to Launceston City for annual intakes of student doctors and interns.
2. Celebration of significant events such as the completion of Nurse Practitioner course.
3. Consider placing representatives of the new Senior Management Team on invitee lists for special occasions.

It is our intention to liaise with the DoH on its response to our recommendations and monitor the progress of actions.

We think it important that each of the attendees at our meetings and forums be informed in a general way of progress in our work.. We also believe the community should be provided with updates on actions that the DoH decides to put in place to restore trust.

We understand that the DoH will be responsible for establishing review processes, and developing protocols for identified longer-term structure and process changes.

Closing Comments

We feel it important to honour and acknowledge the work of people we met and heard from, particularly those closely affected by the actions and omissions associated with child sexual abuse at the LGH, who have worked tirelessly, some for many years, with the simple aim of ensuring that others do not have to go through the suffering they have endured.

We are satisfied that the DoH is committed to taking all necessary steps, in a timely fashion, to ensure that the required checks and balances are put in place so as to restore community trust that the institutional failures at the LGH as described to the CoI never happen again.

Appendix 1: Related Government Policy and Legislation

Department of Health Child Safety and Wellbeing Framework

State Service Act 2000

Criminal Code Act 1924 (section 105A – Failing to report the abuse of a child)

Children, Young Persons and their Families Act 1997

Registration to Work with Vulnerable People Regulations 2014