



# REPORT OF CASE STUDY NO. 27

The response of health care service providers and regulators in New South Wales and Victoria to allegations of child sexual abuse

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The response of health care service providers and regulators in  
New South Wales and Victoria to allegations of child sexual abuse

March 2016

CHAIR

The Hon. Justice Peter McClellan AM

COMMISSIONERS

Professor Helen Milroy



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# Preface

## The Royal Commission

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The Letters Patent provided to the Royal Commission require that it ‘inquire into institutional responses to allegations and incidents of child sexual abuse and related matters’.

In carrying out this task, we are directed to focus on systemic issues but be informed by an understanding of individual cases. The Royal Commission must make findings and recommendations to better protect children against sexual abuse and alleviate the impact of abuse on children when it occurs.

For a copy of the Letters Patent, see Appendix A.

### Public hearings

A Royal Commission commonly does its work through public hearings. A public hearing follows intensive investigation, research and preparation by Royal Commission staff and Counsel Assisting the Royal Commission. Although it may only occupy a limited number of days of hearing time, the preparatory work required by Royal Commission staff and by parties with an interest in the public hearing can be very significant.

The Royal Commission is aware that sexual abuse of children has occurred in many institutions, all of which could be investigated in a public hearing. However, if the Royal Commission were to attempt that task, a great many resources would need to be applied over an indeterminate, but lengthy, period of time. For this reason the Commissioners have accepted criteria by which Senior Counsel Assisting will identify appropriate matters for a public hearing and bring them forward as individual ‘case studies’.

The decision to conduct a case study will be informed by whether or not the hearing will advance an understanding of systemic issues and provide an opportunity to learn from previous mistakes, so that any findings and recommendations for future change which the Royal Commission makes will have a secure foundation. In some cases the relevance of the lessons to be learned will be confined to the institution the subject of the hearing. In other cases they will have relevance to many similar institutions in different parts of Australia.

Public hearings will also be held to assist in understanding the extent of abuse which may have occurred in particular institutions or types of institutions. This will enable the Royal Commission to understand the way in which various institutions were managed and how they responded to allegations of child sexual abuse. Where our investigations identify a significant concentration of abuse in one institution, it is likely that the matter will be brought forward to a public hearing.

Public hearings will also be held to tell the story of some individuals which will assist in a public understanding of the nature of sexual abuse, the circumstances in which it may occur and, most importantly, the devastating impact which it can have on some people’s lives.

A detailed explanation of the rules and conduct of public hearings is available in the Practice Notes published on the Royal Commission's website at:

[www.childabuseroyalcommission.gov.au](http://www.childabuseroyalcommission.gov.au)

Public hearings are streamed live over the internet.

In reaching findings, the Royal Commission will apply the civil standard of proof which requires its 'reasonable satisfaction' as to the particular fact in question in accordance with the principles discussed by Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336:

... it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal ... the nature of the issue necessarily affects the process by which reasonable satisfaction is attained.

In other words, the more serious the allegation, the higher the degree of probability that is required before the Royal Commission can be reasonably satisfied as to the truth of that allegation.

## Private sessions

When the Royal Commission was appointed, it was apparent to the Australian Government that many people (possibly thousands) would wish to tell us about their personal history of child sexual abuse in an institutional setting. As a result, the Commonwealth Parliament amended the *Royal Commissions Act 1902* to create a process called a 'private session'.

A private session is conducted by one or two Commissioners and is an opportunity for a person to tell their story of abuse in a protected and supportive environment. As at 26 February 2016, the Royal Commission has held 4,874 private sessions and more than 1,485 people were waiting to attend one. Many accounts from these sessions will be recounted in later Royal Commission reports in a de-identified form.

## Research program

The Royal Commission also has an extensive research program. Apart from the information we gain in public hearings and private sessions, the program will draw on research by consultants and the original work of our own staff. Significant issues will be considered in issues papers and discussed at roundtables.

## This case study

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In Case Study 27, the Royal Commission into Institutional Responses to Child Sexual Abuse examined the experiences of a number of patients in health care services in New South Wales and Victoria.

The public hearing was held from 6 May 2015 until 15 May 2015 in Sydney.

The scope and purpose of the public hearing was to inquire into:

1. The experience of a number of patients of health care services in New South Wales who were sexually abused as children in:
  - a. private medical practices
  - b. public hospitals.
2. The experiences of a number of complainants who made complaints against a medical practitioner to the New South Wales Health Care Complaints Commission and the then Medical Board of New South Wales.
3. The systems, policies, practices and procedures for receiving, investigating and responding to complaints against medical practitioners of child sexual abuse of:
  - a. the New South Wales Health Care Complaints Commission
  - b. the Medical Council of New South Wales
  - c. the Royal North Shore Hospital, Northern Sydney.
4. The experience of an outpatient who alleges child sexual abuse by a psychologist at the Royal North Shore Hospital, Northern Sydney, in the late 1960s.
5. The systems, policies and procedures of the Northern Sydney Local Health District and New South Wales Ministry of Health for preventing, detecting and responding to child sexual abuse.
6. The experience of an inpatient who alleged child sexual abuse by a volunteer at The Royal Children's Hospital, Melbourne, Victoria, in the early 1980s.
7. The response of The Royal Children's Hospital, Melbourne, Victoria, to an allegation of child sexual abuse made against a hospital volunteer.
8. The systems, policies and procedures of The Royal Children's Hospital, Melbourne, Victoria, for preventing, detecting and responding to child sexual abuse.
9. Any related matters.

## Executive summary

In Case Study 27, the Royal Commission considered child sexual abuse set in the context of medical consultations, in both private practice and public hospitals, by health professionals and hospital volunteers.

Medical practitioners, health professionals and hospitals are responsible for improving and maintaining the health of their patients. Patients, who are in a vulnerable state of illness, place their trust in health care providers. Patients, and the parents of child patients, place such trust in medical practitioners that they permit those medical practitioners to view and touch intimate parts of the patient's anatomy. Patients permit these acts because of the close nature of the health practitioner – patient relationship and because they believe that a health practitioner is acting in pursuit of a higher purpose of assisting the patient with his or her illness or injury and not out of personal sexual gratification.

Children often follow instructions from health care providers without question and the private one-on-one nature of therapy places children in a vulnerable position.

The public hearing was divided into three parts. The first part examined the experiences of seven patients who were abused by a medical practitioner, Dr John Rolleston, in private medical practices or at the Royal North Shore Hospital (RNSH). The second part of the case study heard the experience of an outpatient, Mr Terence Kirkpatrick, who alleged child sexual abuse by a psychologist at the RNSH in the late 1960s. The third part heard the experience of an inpatient who alleged sexual abuse as a child by a volunteer at The Royal Children's Hospital, Melbourne (RCHM), in the early 1980s.

The Royal Commission examined the responses of the relevant regulatory agencies, hospitals and health practitioners to the allegations of child sexual abuse.

### Child sexual abuse by medical practitioner Dr Rolleston in New South Wales

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#### Health care regulators

The New South Wales Health Care Complaints Commission (HCCC) is a state statutory authority responsible for receiving and assessing complaints about health care services and facilities. It acts to protect public health and safety by resolving, investigating and prosecuting complaints. The HCCC operates in a complex co-regulatory relationship with health professional councils for the relevant health professionals.

The Medical Council of New South Wales is the relevant health professional council responsible for any complaints or notifications received against registered medical practitioners. The HCCC and the Medical Council (health care regulators) together investigate complaints against registered medical practitioners.

## Allegations against Dr Rolleston

From 1992, the health care regulators received allegations concerning a registered medical practitioner, Dr Rolleston, sexually abusing teenage boys.

In 1969, Dr Rolleston started working as a general practitioner in a private practice in St Ives, Sydney (the St Ives practice). He left private practice in late 1979 to work as the Medical Director of the Accident and Emergency Department at the RNSH.

Between 1983 and early 1987, Dr Rolleston moved into private practice again at Whalan in western Sydney (the Whalan practice). Between October 1990 and February 1993, Dr Rolleston was employed in various hospitals in Sydney. After that he worked in Broken Hill in New South Wales. Between 1993 and early 1997, Dr Rolleston was the Director of Medical Services at the Broken Hill Hospital. From 1997, he established and worked as a principal in the Broken Hill Medical Centre.

In 2009, Dr Rolleston was arrested and in 2011 he was convicted of offences relating to the period when he worked at the St Ives practice, the RNSH and the Whalan practice.

## Complaints handling

### Processes and practices

On 13 July 1992 and 18 September 1992, the Medical Board (the predecessor to the Medical Council) file noted two telephone calls by a male caller alleging Dr Rolleston sexually abused him as a teenager. The Royal Commission did not find evidence of any steps that the Medical Board took to deal with the allegations documented in the file notes. This was not a satisfactory response on the part of the Medical Board. The starting point for an effective response to any complaint is to maintain an accurate record system appropriate for the task.

On 13 August 1998, AWC made a complaint to the HCCC outlining the sexual abuse by Dr Rolleston at the RNSH and seeking assistance. AWC's complaint remained with the HCCC until the file was closed on 19 November 2001. It is apparent that between 1998 and 2001 there was a lengthy delay in the HCCC's investigation of AWC's complaint against Dr Rolleston. There was no reasonable explanation for the unacceptable delays. The inevitable conclusion is that the organisation lacked proper management processes and practices.

On 4 and 19 November 1998, the HCCC discussed AWC's complaint with the Medical Board. The Medical Board made no link between the complaint against Dr Rolleston in 1998 and the 1992 telephone calls. The system the Medical Board had in place did not log the calls as a 'complaint' in the complaint database as it should have done.

### Termination of AWC's complaint

The HCCC has available to it a statutory discretion to discontinue dealing with a complaint where:

- there is a delay of more than five years, and
- the complainant does not have a sufficient reason for having delayed making the complaint.

The HCCC relied on this statutory discretion in discontinuing the investigation of AWC's complaint even though AWC did in fact give an adequate explanation for taking so long to make his complaint. The HCCC accepted that AWC gave a sufficient reason for the delay and that the statutory discretion was not available to terminate the complaint.

The HCCC's decision to terminate its investigation of AWC's complaint was wrong because it did not adequately take into account:

- that the allegations were of serious criminal offences
- that Dr Rolleston was at that time practising medicine in Broken Hill
- that the HCCC knew of evidence that came within the 'categories of evidence that may corroborate an allegation of sexual misconduct' as set out in the *HCCC Practice Manual – Investigations (2001)* (HCCC Practice Manual)
- that AWC had given sufficient explanation for the delay in making the complaint
- the need to protect patients from the risk of predatory activity by Dr Rolleston.

The HCCC notified Dr Rolleston of AWC's allegations against him, but Dr Rolleston did not respond. The HCCC incorrectly took into account Dr Rolleston's failure to respond as a reason to terminate its investigation.

### Referral to NSW Police and Director of Public Prosecutions

The HCCC did not refer AWC's complaint to NSW Police or the New South Wales Office of the Director of Public Prosecutions (ODPP) even though the HCCC's governing legislation expressly permitted it to do so.

HCCC's engagement with AWC had the effect of discouraging him from taking the matter to the police. This was contrary to the HCCC Practice Manual, which stated that the HCCC staff should not discourage complainants from going to the police.

## Credibility of AWC and Dr Rolleston

In 1975, Dr Rolleston was convicted of offences relating to the pharmaceutical provisions of the *National Health Act 1953* (Cth). In 1986, Dr Rolleston was convicted of offences under the *Health Insurance Act 1973* (Cth). In terminating its investigation of Dr Rolleston and assessing his and AWC's credibility, the HCCC gave no consideration to those previous criminal convictions. This failure contributed to the HCCC's error in deciding to terminate the investigation.

## Communication with complainants

On 9 May 2003, AWH approached the HCCC and made a complaint that his brother (AWO), his sister and he had been sexually abused by Dr Rolleston. AWH also told the HCCC that he and his family had mental health issues.

On 11 November 2003, an officer of the HCCC wrote to AWH asking for specific details about all the incidents of child sexual assault that AWH could recall. The letter asked for the dates, locations and details of what occurred during the relevant consultations with Dr Rolleston and asked AWH to provide this information with a supporting statutory declaration within 14 days of the date of the letter. AWC said the level of technicality, procedures and processes the HCCC was asking of him in that letter was overwhelming, and he did not provide the supporting statutory declaration.

We are satisfied that in 2003 the HCCC's approach to AWH was insensitive given the nature of the allegations being made against Dr Rolleston and AWH's personal circumstances – in particular, his mental health issues, which he had disclosed to the HCCC.

Further, when a complainant such as AWH was not able to, or did not, provide a statutory declaration, an alternative was to report the matter to the police. When the matter was serious and risks to others were real, as in AWH's case, this was the obvious course to take.

## Termination of AWH's complaint

AWH suffered a nervous breakdown in 2004 and was committed to a mental health service in Tweed Heads, New South Wales, to ensure he did not commit suicide. AWH did not engage with the HCCC again until 2006.

AWH again engaged with the HCCC on 10 July 2006. The HCCC's investigation officers were instructed not to interview AWH in person, to ask AWH to put his complaint in writing and to deal with AWH expeditiously. The HCCC did not help AWH in making his complaint against Dr Rolleston in 2006. The response of the then Commissioner of the HCCC, Mr Kieran Pehm, to AWH's situation was insensitive and inappropriate.

On 19 September 2006, the HCCC Investigation Report concerning AWH's complaint recommended the investigation be terminated for lack of corroborative evidence. The Investigation Report did not record the existence of the two other complainants (AWO and AWC). The HCCC incorrectly failed to consider the improved likelihood of proving AWH's complaint based on evidence of other similar reports against Dr Rolleston.

### Section 66 Inquiry

By November 2006, the Medical Board had knowledge of complaints against Dr Rolleston from AWC, AWH and his brother AWO. The Medical Board did not exercise its statutory powers to protect the public under section 66 of the *Medical Practice Act 1992* (NSW) and, in failing to do so, prolonged the period in which Dr Rolleston continued to practise with unconditional registration, giving him access to children.

On 8 April 2008, the Medical Board Conduct Committee met and discussed the possibility of convening an inquiry into the complaints that Dr Rolleston had assaulted males patients when they were children (a Section 66 Inquiry). This same committee met again on 13 May 2008. At the time, the Medical Board did not exercise its powers under section 66 of the Medical Practice Act and continued to prolong the period in which Dr Rolleston continued to practise.

A Section 66 Inquiry was convened on 23 June 2009. On that date action was taken to place conditions upon Dr Rolleston's registration. Between November 2006 and June 2009, Dr Rolleston continued to practise medicine without appropriate conditions on his registration, placing children at risk. Given the powers the Medical Board has under the Medical Practice Act, this was a significant failure to act to protect other children who may have been at risk of assault by Dr Rolleston.

### Reporting

Another former patient of Dr Rolleston, AWB, reported offences by Dr Rolleston at the RNSH. In 2005, AWB was referred to Ms Julie Blyth – a social worker with the RNSH sexual assault unit. Patient notes prepared by Ms Blyth record that AWB made several disclosures concerning Dr Rolleston abusing AWB at both the St Ives practice and the RNSH. In 2005 there was no requirement at the RNSH to report historical child sexual abuse to any manager or hospital personnel and no internal procedure for doing this. AWB's disclosure that sexual abuse had occurred at the RNSH was not reported to a senior manager.

A number of survivor witnesses referred to disclosures made to health professionals, including medical practitioners, either before or after they made contact with health care regulators. The reporting obligations of medical practitioners in cases of historical child sexual abuse under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) are not well understood by medical practitioners. Medical practitioners clearly require further education and training to ensure

that reporting obligations are acted upon. The medical practitioner is a key person in the early identification and reporting of child abuse incidents.

## Allegations of child sexual abuse at the RNSH by a psychologist

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In 1967, Mr Kirkpatrick, who was 11 years old at the time, was referred to Mr Frank Stuart Simpson – a psychologist at the CJ Cummins Unit of the RNSH. In the late 1960s, the CJ Cummins Unit, informally known as the Roundhouse, was an outpatient facility located on RNSH premises. Mr Simpson introduced ‘play therapy’ as a treatment for Mr Kirkpatrick’s asthma. Mr Kirkpatrick said that Mr Simpson sexually abused him under the guise of that ‘play therapy’. Mr Simpson abused Mr Kirkpatrick in the same manner on every consultation.

At one point Mr Simpson tried to get Mr Kirkpatrick to meet with him away from the RNSH, but he was unsuccessful. After that, Mr Kirkpatrick disclosed the abuse to his parents. After this disclosure Mr Kirkpatrick never went back to see Mr Simpson.

In or around 1983, Mr Kirkpatrick discussed the abuse with his parents. Mr Kirkpatrick said that his father told him that he had reported the matter to the Child Health Centre in Ryde (Ryde CHC) and the CJ Cummins Unit. His father said he was told the RNSH would take care of the matter. He was also discouraged from going to the police to spare Mr Kirkpatrick from ‘interrogation and all those distressing things’. After Mr Kirkpatrick’s father made the complaint, he told Mr Kirkpatrick that he did not hear any more about the complaint.

The North Sydney Local Health District (NSLHD) was not able to locate any records of the notification by Mr Kirkpatrick’s father to the CJ Cummins Unit or the Ryde CHC. If any record was kept of the notification, it no longer exists and may have been destroyed.

## Allegations of child sexual abuse at The Royal Children’s Hospital, Melbourne, by volunteers

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AWI, a former inpatient of the RCHM, gave evidence of her sexual abuse by volunteers in the early 1980s. AWI was admitted for chronic asthma and was placed in Ward 8 East of the RCHM, where she was introduced to volunteers. AWI said that she was abused by two volunteers during her stay at the RCHM.

On 15 December 1997, AWI made allegations of child sexual abuse by email to Dr John de Campo, the Chief Executive Officer of the Women’s & Children’s Health Care Network, which incorporated the RCHM and the Royal Women’s Hospital between 7 July 1997 and October 2000.

Shortly after AWI made those allegations, Victoria Police documents identified the alleged

perpetrator as Mr Harry Otto Pueschel, who had been at the RCHM for many years. Victoria Police believed that potentially there would be a number of victims. RCHM staff never confronted Mr Pueschel with AWI's allegations.

In her email of 15 December 1997, AWI asked Dr de Campo to commission an investigation to find out if the alleged perpetrator was still working with children. The RCHM did not conduct an internal investigation of the allegations that AWI made about child sexual abuse that occurred in the early 1980s. Further, it did not investigate the screening process of Mr Pueschel or the management processes within the RCHM to see if they could be improved to prevent the situation from recurring.

On 21 January 1998, Dr de Campo provided a letter to Mr Pueschel terminating his services as a volunteer. The letter of dismissal from Dr de Campo did not state all of the reasons for the dismissal and did not refer to the fact that AWI had made serious allegations of child sexual abuse. In terminating the services of Mr Pueschel as a volunteer in the manner the hospital did, it left open the possibility that Mr Pueschel could work elsewhere as a volunteer.

Even though Mr Pueschel's services were terminated in January 1998, on 1 July 1999 the Auxiliaries Office of the RCHM wrote to the Network Executive Director stating that Mr Pueschel had accessed the ward area by saying that one of the Auxiliaries Office staff had given him permission to do this. Mr Pueschel was able to access the RCHM ward area after his dismissal because there was no adequate system in place at the RCHM to prevent him from doing this.

There are no documents evidencing Mr Pueschel's termination as a member of the RCHM Auxiliaries following the Auxiliaries Office's letter of 1 July 1999 or following AWI's allegations against Mr Pueschel. RCHM also did not conduct an internal investigation on Mr Pueschel's return to the RCHM ward in 1999 or to find out whether there was any risk to any children in the ward.

# 1 Child sexual abuse by medical practitioner

## Dr John Rolleston

This section of the report examines allegations of child sexual abuse made against Dr John Rolleston at the Royal North Shore Hospital (RNSH) in Sydney, New South Wales, and in private medical practice in New South Wales. It also examines the processes of the relevant health care regulators and the RNSH in dealing with those allegations.

Dr Rolleston obtained his medical qualifications in 1967. Following this, he was employed at Sutherland Hospital and then at Mona Vale Hospital as a Resident Medical Officer.

In 1969 Dr Rolleston commenced as a general practitioner in St Ives, Sydney (the St Ives practice), and continued at that practice until late 1979. In that year, Dr Rolleston left that practice to commence as the Medical Director of the Accident and Emergency Department at the RNSH, where he remained until mid-1983.

Between 1983 and early 1987, Dr Rolleston was in private practice at Whalan in western Sydney (the Whalan practice). Between October 1990 and February 1993, Dr Rolleston was employed in various hospitals in Sydney. After that he worked in Broken Hill in New South Wales. Between 1993 and early 1997, Dr Rolleston was the Director of Medical Services at the Broken Hill Hospital. From 1997, he established and worked as a principal in the Broken Hill Medical Centre.

In 2009, Dr Rolleston was arrested and in 2011 he was convicted of offences relating to the period when he worked at the St Ives practice, the RNSH and the Whalan practice.

### 1.1 New South Wales health care regulators

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The health care regulators relevant to the first and second parts of the public hearings are:

- the New South Wales Health Care Complaints Commission (HCCC)
- the Medical Board of New South Wales.

#### New South Wales Health Care Complaints Commission

The HCCC was established in 1993 pursuant to the *Health Care Complaints Act 1993* (NSW) (HCC Act). The primary purposes of the HCCC are to :

- receive and assess complaints
- investigate and prosecute serious complaints
- resolve complaints.

The protection of the health and safety of the public is the paramount consideration.<sup>1</sup> The jurisdiction is protective and not punitive.

## Co-regulatory relationship with Medical Board of New South Wales

The HCCC operates in a complex 'co-regulatory' relationship with the health professional councils (previously boards) of the relevant health professions. In the case of a complaint about a medical practitioner, the relevant co-regulator is currently the Medical Council of New South Wales. Before July 2010, it was the Medical Board of New South Wales.

## Registration of health practitioners

Since July 2010, registration of health practitioners is national and determined by the relevant national registration board. The Australian Health Practitioner Regulation Authority (AHPRA) provides administrative support to the registration boards. There are currently 14 national registration boards, including for medicine, psychology, and nursing and midwifery.

## Complaints about health professionals

Complaints about health professionals may be made to the HCCC. Complaints about medical practitioners may also be made to the Medical Council. The HCC Act requires the HCCC to notify all complaints about medical practitioners to the Medical Council as soon as practicable.<sup>2</sup> The Medical Council has a similar responsibility to notify the HCCC if they receive the complaint.<sup>3</sup>

## Complaints assessment process

Once the HCCC receives a complaint, it is required to assess the complaint.<sup>4</sup> The purpose of the assessment is to decide whether a complaint should be:

- investigated
- conciliated
- referred to the Secretary of the Ministry of Health
- referred to another person or body.

The HCCC may decide not to investigate the complaint.<sup>5</sup> 'Another person or body' referred to above may include the police if it appears that the complaint (or part of it) raises issues which require investigation by the other person or body.<sup>6</sup>

The HCCC must carry out its assessment within 60 days of receiving the complaint.<sup>7</sup> However, if the HCCC has required the complainant to provide further particulars of the complaint,<sup>8</sup> that time frame extends to within 60 days after the date by which the HCCC specified that those particulars were to be provided.<sup>9</sup>

## Investigation of complaints

After the HCCC has made its assessment as to how the complaint should be dealt with, it is required to consult with the Medical Council before any action is taken.<sup>10</sup> If either the Medical Council or the HCCC considers a complaint should be investigated, it must be investigated.

When a complaint is referred for investigation, it is investigated by the HCCC. Division 5 of Part 2 of the HCC Act gives the HCCC powers to obtain documents and other information to assist in its investigation. At the conclusion of the investigation, and after a practitioner is given the opportunity to respond to the outcome that the HCCC proposes, the HCCC is required to again consult with the Medical Council before deciding what action to take.<sup>11</sup> Although the decision about whether to investigate a complaint is shared by the HCCC and the Medical Council, the decision on the appropriate action to be taken after investigation is one for the HCCC, irrespective of the Medical Council's opinion.

## Disciplinary proceedings

One outcome of an investigation is that the HCCC may refer a complaint to its Director of Proceedings to consider prosecuting the complaint before a disciplinary body.<sup>12</sup> Before making a decision, the Director of Proceedings must consult with the relevant Medical Council, although the Director of Proceedings makes the final decision.

If a decision is then made to prosecute a complaint, the role of the HCCC is effectively that of a prosecutor of a complaint before the New South Wales Civil and Administrative Tribunal (NCAT). For medical practitioners, this was formerly before the Medical Tribunal of New South Wales.<sup>13</sup>

## Powers of the HCCC under the HCC Act

When the HCC Act was enacted in 1993, Part 2 Division 5 set out the relevant powers of the HCCC to investigate complaints. In 2005, as a result of the New South Wales Special Commission of Inquiry into the Campbelltown and Camden Hospitals and its examination of the HCCC's handling of complaints, the HCCC was given increased powers through amendments to the HCC Act.<sup>14</sup> One of these was the power to compel the production of documents and information from third parties.<sup>15</sup>

At the same time, the amendments to the HCC Act removed the previous legislative barrier of requiring a statutory declaration from a complainant before an investigation could commence.<sup>16</sup>

At the public hearing, two former commissioners of the HCCC gave evidence: Professor Marilyn Walton, who served as Commissioner from July 1994 to December 1999; and Ms Amanda Adrian, who served as Commissioner from June 2000 to December 2003. The Commissioner of the HCCC in office at the time of the public hearing, Mr Kieran Pehm, also gave evidence. Mr Pehm commenced as Deputy Commissioner of the HCCC in April 2004 and was appointed Commissioner in April 2005.<sup>17</sup>

## Medical Council of New South Wales

The Medical Council of New South Wales is the relevant health professional council responsible for any complaints or notifications received concerning registered medical practitioners who nominate their principal place of practice as New South Wales. It was established on 1 July 2010 with the commencement of the National Registration and Accreditation Scheme for health professionals.

### Functions and powers

The Medical Council has broad statutory functions and powers to protect the health and safety of the public. The power to take immediate and urgent action to suspend or place conditions on the registration of the health practitioner lies with the relevant health professional council under section 150 of the *Health Practitioner Regulation National Law (NSW)* (the National Law). The powers contained in section 150 are enlivened when the Medical Council 'is satisfied it is appropriate to do so for the protection of the health or safety of any person or persons ... or if satisfied the action is otherwise in the public interest'. Before July 2010, this power, for medical practitioners, was found in section 66 of the *Medical Practice Act 1992 (NSW)* (now repealed).

The test enlivening the powers to take urgent action contained in section 66 was in different terms before 1 October 2008.<sup>18</sup> Before that date it required satisfaction 'that such action is necessary for the purpose of protecting the life or the physical or mental health of any person'.

### Compliance monitoring

The Medical Council is also responsible for monitoring health practitioners' compliance with conditions of registration.<sup>19</sup>

Professor Peter Procopis was President of the Medical Council at the time of the public hearing. He gave evidence for the Medical Council and for the previous Medical Board. Professor Procopis was appointed Chair of the Medical Board's Conduct Committee in 1999, Deputy President of the Medical Board in 2004 and President of the Medical Board (and then Medical Council) in 2005.<sup>20</sup> The Medical Council advised in written submissions that Professor Procopis's term as President ended on 30 June 2015.

### Mandatory reporting

When the National Law came into effect in July 2010, it brought with it mandatory reporting requirements for health practitioners, employers and education providers when they have a reasonable belief that a practitioner had engaged in 'notifiable' conduct.<sup>21</sup> This belief must have been formed in the course of their practise of the profession.<sup>22</sup>

‘Notifiable’ conduct includes sexual misconduct in connection with the practise of the practitioner’s profession and conduct that places the public at risk of harm. The notification is to be made to AHPRA. It is then forwarded to the HCCC and is deemed to be a complaint.

Before the introduction of the National Law, mandatory reporting obligations of medical practitioners, or other health practitioners, were introduced in 2008 through an amendment to the *Medical Practice Act 1992* (NSW) (now repealed). This amendment made it mandatory for health practitioners to report sexual misconduct when they had a reasonable belief that another medical practitioner had engaged in sexual misconduct in connection with the practise of medicine.<sup>23</sup>

Additionally, the *Child Welfare Act 1939* (NSW), amended in July 1977, introduced a mandatory requirement for prescribed persons, including medical practitioners and other health care professionals, to notify where they had reasonable grounds to suspect that a child had been assaulted, ill-treated or exposed. This provision was repealed in 1988 and replaced with the mandatory obligation in the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (the Children and Young Persons Act), which required health care professionals to notify when they had reasonable grounds to suspect that a child had been sexually assaulted.

Currently, the mandatory obligations for health care professionals, including psychologists and medical practitioners, to notify when there are reasonable grounds to suspect that another health professional is engaged in sexual misconduct towards a child is supported by both the National Law and section 27 of the Children and Young Persons Act. The Children and Young Persons Act requires professionals who deliver health care services to children, or with managerial responsibilities for children, to notify when they have reasonable grounds to suspect that a child, or a class of children, is at risk of significant harm.<sup>24</sup>

In relation to the first part of the hearing, a number of Dr Rolleston’s former patients and survivors made disclosures of their child sexual abuse to numerous health practitioners.

## 1.2 Experiences of former patients of Dr Rolleston

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Seven former patients of Dr Rolleston gave evidence before the Royal Commission of their experiences of child sexual abuse and having their complaints dealt with by New South Wales health care regulators (HCCC and the Medical Board). We also heard of the impacts of the abuse on their lives, including serious effects on their mental health, employment and relationships. Dr Rolleston was convicted of offences in relation to each of these seven former patients.

### AWF

AWF was a patient of Dr Rolleston between the ages of 13 and 20.<sup>25</sup> He saw Dr Rolleston at the private medical practice at 1 Sturt Place, St Ives (the St Ives practice). AWF is currently a medical practitioner himself.<sup>26</sup>

AWF also consulted Dr Rolleston at the St Ives practice between January 1970 and December 1972 when aged between 16 and 18 years.<sup>27</sup> He could not recall the medical reason for this consultation.<sup>28</sup>

During the consultation, Dr Rolleston told AWF he had to test his semen and instructed him to sit on the bed and masturbate to provide a sample.<sup>29</sup> AWF said that when he was unable to get an erection Dr Rolleston proceeded to masturbate him.<sup>30</sup> After he ejaculated, Dr Rolleston appeared to examine the 'sample' and said that the semen was 'ok'.<sup>31</sup>

AWF complied with Dr Rolleston's request because Dr Rolleston was a doctor and AWF trusted him.<sup>32</sup> AWF explained that, although he felt uncomfortable after the consultation, he trusted Dr Rolleston and thought that perhaps what Dr Rolleston had done was a normal medical procedure.<sup>33</sup>

AWF consulted Dr Rolleston on another occasion between 1 March and 30 June 1975 for a sore throat.<sup>34</sup> AWF was about 20 years old at the time of this consultation.<sup>35</sup> Dr Rolleston sexually abused AWF on this occasion in the same manner as in the earlier consultation.<sup>36</sup>

AWF completed a Bachelor of Medicine and Bachelor of Surgery in 1979.<sup>37</sup> During his studies, in or around 1976 to 1977 AWF said that he worked for one week with Dr Rolleston at the St Ives practice. During the time of this placement, AWF was not aware of any rumours of child sexual abuse in relation to Dr Rolleston.<sup>38</sup>

Around 1979 to 1980, AWF undertook an internship at the RNSH.<sup>39</sup> At that time, Dr Rolleston was employed in a senior position within the Accident and Emergency Department.<sup>40</sup> AWF said that, although by this time he was aware that the testing of a semen sample was not a recognised test for infection, he did not report his abuse to anyone at the RNSH.<sup>41</sup> AWF did not disclose his abuse because he was intimidated by Dr Rolleston as a more senior doctor and was concerned that reporting the abuse may impact upon his career at the RNSH.<sup>42</sup>

### **AWF discloses his abuse**

Around March 2011, AWF became aware through a media article that Dr Rolleston had been found guilty of 10 charges relating to child sexual abuse.<sup>43</sup> After reading this report, AWF began to search the internet for information about Dr Rolleston.

Around this time, AWF became aware of the chaperone conditions that the Medical Board had imposed upon Dr Rolleston's medical registration.<sup>44</sup> AWF believed that multiple and recurrent allegations of sexual abuse of unrelated adolescent males by a registered medical practitioner should have resulted in more than an eight-week suspension of medical registration.<sup>45</sup> Consequently, AWF decided to contact NSW Police.<sup>46</sup>

## Effects of abuse on AWF

AWF spoke about the impact of the abuse inflicted on him by Dr Rolleston. As a medical practitioner himself and in light of what Dr Rolleston did to him, AWF no longer addresses his perpetrator by his professional title of 'doctor'.<sup>47</sup> AWF has been periodically troubled and angry since he was abused.<sup>48</sup> He would occasionally make enquiries about Dr Rolleston's whereabouts, including by conducting online searches, but he found that he could not discuss the details of the sexual abuse inflicted on him by Dr Rolleston.<sup>49</sup>

## AWH

Dr Rolleston was the family general practitioner of AWH's grandparents, with whom AWH lived for intermittent periods as a child.<sup>50</sup> In 1973, when AWH was aged about 12 and living with his grandparents, he fell ill with the flu and saw Dr Rolleston at the St Ives practice. AWH's grandmother accompanied him, but she waited outside the consultation room while AWH went in with Dr Rolleston.<sup>51</sup> During the consultation Dr Rolleston masturbated AWH.<sup>52</sup>

AWH was abused on a second occasion, when Dr Rolleston made a home visit to AWH's grandfather. Dr Rolleston then saw AWH, who was in his bed suffering from the flu. Dr Rolleston again masturbated AWH.<sup>53</sup>

When AWH was speaking with his brother, AWO, about his own abuse in 1979, AWO confirmed that he too had been abused by Dr Rolleston on numerous occasions.<sup>54</sup>

## AWH discloses his abuse

In 2003, AWH made a complaint against Dr Rolleston to the HCCC. However, for reasons discussed below, the investigation of the complaint was discontinued later that year. AWH again contacted the HCCC in 2006 to pursue the matter.

In 2007, AWH disclosed his abuse to a general practitioner, Dr Peter Wynn, and informed him that Dr Rolleston remained in the medical profession and was working in Broken Hill, New South Wales. AWH also discussed the HCCC's investigation process with Dr Wynn. AWH could not recall what Dr Wynn said to him in response to his disclosure of child sexual abuse; however, he recalled the doctor prescribed him a medication plan that had worked well for him and that he continued to be on.<sup>55</sup>

## Effects of abuse on AWH

AWH gave evidence of the impact of the abuse on his life as a child and as an adult. Following the abuse, AWH did not understand what was sexually normal and abnormal conduct.<sup>56</sup> In his youth, soon after the sexual abuse by Dr Rolleston, AWH attempted suicide. He again attempted suicide in

his adulthood.<sup>57</sup> Dr Rolleston's conduct caused AWH distress over many years and has made him feel very insecure and uncomfortable about the safety of children.<sup>58</sup>

After he was abused, AWH developed and continued to have a deep distrust of doctors. AWH said that this distrust was so deep that in 2004, when he was in a mental health facility, he could not trust the doctors enough to seek the help he required.<sup>59</sup> AWH continues to have very strong emotions and reactions when he hears about paedophilia.<sup>60</sup>

## AWA

Dr Rolleston was AWA's family general practitioner. Between 1974 and 1976, when aged 15 to 17, AWA saw Dr Rolleston at the St Ives practice on three occasions, generally for treatment of common colds.<sup>61</sup> On each of the three occasions, Dr Rolleston sexually abused AWA.

On the first occasion, AWA's father remained in the waiting room when AWA went into the consulting room with Dr Rolleston. On the second occasion, AWA could not recall whether one of his parents was in the waiting room at the time.<sup>62</sup> On the third occasion, AWA was dropped off at the St Ives practice by his mother.<sup>63</sup> AWA recalled that all three instances of abuse were similar.

In describing the first occasion, AWA said Dr Rolleston asked him to 'Whip down to your tweedies', which he took to mean underpants.<sup>64</sup> Dr Rolleston put on latex gloves and masturbated him, saying the reason for this was to get some liquid from AWA's penis.<sup>65</sup>

AWA initially trusted Dr Rolleston because he assumed the behaviour was normal and because Dr Rolleston was a doctor.<sup>66</sup> AWA said that he grew more sceptical on the second occasion but that, by the third occasion, he knew Dr Rolleston's actions were not right and did not see Dr Rolleston again.<sup>67</sup>

### AWA discloses his abuse

AWA attempted to report his abuse after it happened. In 1977, AWA's final year of high school, he spoke with his brother about Dr Rolleston's abuse. His brother confirmed that he had also been abused by Dr Rolleston on one occasion.<sup>68</sup>

AWA gave evidence that later in 1977 he called the Medical Board stating Dr Rolleston's name and the nature of the abuse. However, AWA said that in this call he was threatened and told, 'If you try to make a complaint against one of our members, we will come down so hard on you, we will sue you so that your head will be so far up your arse, you won't see daylight for years'. At that time AWA thought he would leave the matter of Dr Rolleston and the abuse behind him, and at that point he did not follow through with making a complaint.<sup>69</sup>

However, there is evidence to suggest this telephone call may not have been made to the Medical

Board. In his evidence to the Royal Commission AWA stated he had initially thought that this 1977 telephone call was made to the Australian Medical Association (AMA).<sup>70</sup> The contents of emails that were sent from AWA to the HCCC on 19 and 24 April 2013 referring to the call confirm that, at least up until that time, AWA thought he had made the call to the AMA.<sup>71</sup>

The Medical Council submitted it was inherently unlikely that Medical Board staff would have acted in the way that AWA described and it relied upon evidence given by its President, Professor Procopis, to that effect.<sup>72</sup> However, the Medical Council does not contend that the abusive telephone call did not occur.

The Medical Council submitted that, on all the available evidence, it would be unsafe to find that an officer of the Medical Board, rather than the AMA, spoke to and threatened AWA. It submitted that, in any event, it is not necessary to make a finding in relation to this issue.

We accept the evidence of AWA that the abusive telephone call occurred. We also accept the submission of the Medical Council that it is not necessary to make a finding as to who AWA spoke to at that time. Whoever responded to AWA's call acted in an entirely inappropriate manner. It is important that anybody with responsibility to receive and respond to complaints has staff who are capable of and do respond appropriately to complainants.

AWA also told us that he had a friend whose father was a doctor. His friend's father, Dr William Barclay, was not AWA's treating doctor. In 1997 AWA spoke to Dr Barclay at his home. AWA recalled telling Dr Barclay of 'the problems with Dr Rolleston'; however, AWA was not sure if he had explicitly given details of the abuse. He also told Dr Barclay about the 1977 telephone call he had made in an attempt to report Dr Rolleston and the response he received. He stated that Dr Barclay did not seem surprised by that response.<sup>73</sup>

AWA said that Dr Barclay had told him, 'The best advice I can give is to drop your case because your life will be on hold for many years'. AWA understood that to mean that AWA should not press the matter, as it would be very difficult for him in terms of it being a complex and lengthy process. However, AWA also recalled Dr Barclay stating, 'If you really insist then I may be able to advise you on how to go about it'. AWA decided not to pursue the matter any further at that stage.<sup>74</sup>

Prior to the public hearing, the Royal Commission informed Dr Barclay of the public hearing and the evidence AWA was expected to give. Dr Barclay did not provide a response to the Royal Commission.

AWA told the Royal Commission that in 1991 he disclosed the abuse to his girlfriend, who was a nurse and who was at that time working at the same hospital as Dr Rolleston.<sup>75</sup>

## Effects of abuse on AWA

AWA gave evidence of the impact of the abuse by Dr Rolleston. He said that he felt a strong sense of guilt and shame that the abuse occurred three times before he finally said something.<sup>76</sup>

AWA developed a hostile attitude to authorities because of the responses he received when he attempted to report Dr Rolleston's abuse. AWA recalled being verbally threatened with legal action (in the 1977 telephone call) and felt in the dark about where to turn to.<sup>77</sup>

AWA described the impact of the abuse by Dr Rolleston:

[It is] like pulling a huge electromagnet throughout my life. During some parts of my life the electromagnet attracts even more issues ... As the electromagnet attracts more issues it became heavier and more difficult to pull around. I feel weighed down physically, emotionally and mentally. ... Moving forward, I am working towards turning off the power of this electromagnet.<sup>78</sup>

## AWG

Dr Rolleston was AWG's family doctor when Dr Rolleston was based at the St Ives practice. In about early 1976, when AWG was almost 15 years old, he consulted Dr Rolleston.<sup>79</sup> At the time AWG was exaggerating a sore throat to get out of going to school.<sup>80</sup>

AWG saw Dr Rolleston on his own. He believed his mother felt comfortable sending him to the St Ives practice alone, as Dr Rolleston was their trusted family doctor.<sup>81</sup>

During this consultation, Dr Rolleston felt around AWG's groin area.<sup>82</sup> AWG recalled that Dr Rolleston informed him he required a semen sample and instructed AWG to start masturbating himself.<sup>83</sup> When AWG was unable to do so, Dr Rolleston applied clear lubricant gel to his penis and began to rub it.<sup>84</sup> When AWG was still unable to get an erection, Dr Rolleston squeezed his penis and informed him that he would send the 'sample' off for tests.<sup>85</sup> AWG recalled thinking at the time that Dr Rolleston's actions were strange, but he trusted that, as the family doctor, Dr Rolleston's actions were a clinical necessity.<sup>86</sup>

## AWG discloses his abuse

On the afternoon of his sexual abuse by Dr Rolleston, AWG disclosed his abuse to members of his family. AWG spoke initially to his brother, who told him Dr Rolleston's actions were 'not right' and he ought to tell his mother.<sup>87</sup> AWG then told his mother, who told him that she would 'do something about it'.<sup>88</sup>

AWG understands that, on the day after he disclosed his sexual abuse to her, his mother informed Dr John Dowsett.<sup>89</sup> Dr Dowsett was their former family doctor, who had shared a practice with Dr

Rolleston.<sup>90</sup> AWG believes that his mother chose to speak with Dr Dowsett because he was a close family friend and former colleague of Dr Rolleston.<sup>91</sup> AWG said that Dr Dowsett told his mother it would be difficult to raise allegations and question the family doctor, as Dr Rolleston was a respected member of the community and it was unlikely that her word would be believed over Dr Rolleston's.<sup>92</sup> Dr Dowsett is now deceased.

Following AWG's mother's discussion with Dr Dowsett, she made an appointment with her gynaecologist, Dr Ian Truskett.<sup>93</sup> AWG believes that his mother trusted Dr Truskett because he was her gynaecologist and a senior medical professional.<sup>94</sup> AWG said that, after his mother outlined his experiences with Dr Rolleston, Dr Truskett responded: 'Don't worry about it. I'll take care of it.'<sup>95</sup> AWG said he was not aware of any subsequent actions that Dr Truskett took in response to this disclosure.<sup>96</sup>

Prior to the public hearing, the Royal Commission informed Dr Truskett of the public hearing and the evidence AWG was expected to give. Dr Truskett did not provide a response to the Royal Commission.

At the public hearing AWG was shown two handwritten notes prepared by staff members of the Medical Board dated 13 July 1992<sup>97</sup> and 18 September 1992<sup>98</sup> which appear to record two telephone calls that AWG made to the Medical Board.<sup>99</sup> AWG said he has never contacted the Medical Board about his abuse by Dr Rolleston and cannot explain how his details came to be recorded on the file notes.<sup>100</sup>

In around 2009, AWG approached NSW Police about his abuse by Dr Rolleston. However, he did not make a complaint at this time.<sup>101</sup> In about July 2009, AWG says his mother read in a newspaper article that Dr Rolleston had been arrested.<sup>102</sup> After reading this article, AWG said he contacted NSW Police to offer his assistance. He made a statement on 23 July 2009.<sup>103</sup>

The HCCC wrote to AWG around 27 November 2009 informing him the Medical Board had forwarded his complaint against Dr Rolleston to the HCCC.<sup>104</sup> As he had not contacted the Medical Board previously, AWG did not understand what was meant by the letter.<sup>105</sup> AWG believed the letter provided no information about the role of the HCCC.<sup>106</sup>

Although AWG has no recollection of contacting the Medical Board, it is apparent from the sequence of events that some person must have done so. It could have been Dr Truskett.

### **Effects of abuse on AWG**

AWG spoke about the impact of the sexual abuse upon him and in particular the impact on his role as a parent. He told us that his ability to trust people has been diminished.<sup>107</sup> As a father of three sons, AWG is unable to leave his sons alone with any men. The distrust has impacted on his neighbours, friends and family and the social relationships AWG's sons have with men.<sup>108</sup> AWG said, 'In my mind every man is a potential paedophile'.<sup>109</sup>

## AWB

Dr Rolleston was AWB's family doctor. AWB was abused by Dr Rolleston on five occasions in the St Ives practice and at the RNSH.

In 1978, when he was 14 years old, AWB's mother took him to the St Ives practice for a consultation with Dr Rolleston. Dr Rolleston said to his mother, 'It may be better if you wait outside, given AWB is now 14 years old'. From then on, his mother waited for him in the reception area outside the consultation room.<sup>110</sup>

In around 1978 Dr Rolleston started to touch AWB inappropriately.<sup>111</sup> AWB did not remember the date of the first abuse; however, he remembered that in about April 1979 he had a cluster of appointments with Dr Rolleston arising from a foot injury. He recalled that the abuse occurred before this cluster of appointments.<sup>112</sup>

Between about 1978 and 1979, AWB was seen by Dr Rolleston at the St Ives practice and was abused on three occasions.<sup>113</sup> On each occasion Dr Rolleston asked him to lie on his back, undo his pants and lift up his bottom to allow Dr Rolleston to pull down his pants and underpants. Dr Rolleston said words to the effect, 'I have to test for infection'. Dr Rolleston then got some gel, applied the gel to his penis and used his hand to rub his penis up and down. After a few minutes AWB ejaculated. Dr Rolleston got a piece of litmus paper, dabbed it onto the semen and studied the paper.<sup>114</sup>

On the first occasion Dr Rolleston said to AWB, 'You silly boy, I only need a little fluid'.<sup>115</sup> At some point after this occasion, AWB remembered Dr Rolleston saying words to the effect, 'You stupid boy, look what you have done' when he ejaculated.<sup>116</sup> AWB said Dr Rolleston scolded him in the same way after each occasion of abuse. AWB believed the insult and humiliation was some sort of insurance policy for Dr Rolleston, as it lessened the prospect of AWB talking about the incident to anybody.<sup>117</sup>

AWB was abused on two further occasions at the RNSH when Dr Rolleston changed from private practice.<sup>118</sup> AWB and his mother visited Dr Rolleston at the RNSH, where AWB was taken through the Accident and Emergency Department to a small treatment room.<sup>119</sup> His mother waited outside for him in Dr Rolleston's office.<sup>120</sup> AWB did not remember having his name registered at the emergency register on either occasion.<sup>121</sup>

On the two occasions at the RNSH, AWB recalls he was on a bed in the treatment room, where a privacy curtain was drawn.<sup>122</sup> Dr Rolleston put gel on his penis for the stated purpose of 'testing for infection'.<sup>123</sup> Dr Rolleston rubbed AWB's penis up and down for a few minutes and then AWB ejaculated.<sup>124</sup> Dr Rolleston looked at the seminal fluid and appeared to check it for infection.<sup>125</sup>

As AWB became older, from about 17 to 20 years of age, he thought about what happened and realised it was not right.<sup>126</sup> However, he did not think to disclose the abuse to anyone because Dr Rolleston was a trusted doctor in the community and particularly because of his mother, who thought very highly of Dr Rolleston. When he was growing up, AWB was taught to respect authority – particularly someone with such high standing in the community as a doctor.<sup>127</sup>

## AWB discloses his abuse

The first time AWB disclosed his abuse was to his wife in around 2001, soon after they met. In 2001, at a party, AWB heard that Dr Rolleston was practising as a doctor in Broken Hill.<sup>128</sup> AWB said he made various attempts from this time to contact professional organisations.

In 2002 to 2003, AWB telephoned the Medical Board, which he felt did not get him anywhere.<sup>129</sup> During 2004, AWB made further calls to the Medical Board, the AMA, the New South Wales Department of Community Services (DOCS) and 'possibly the HCCC'. AWB felt he was 'met with similar types of responses' and that he was generally given the 'brush off'.<sup>130</sup>

The Royal Commission sought documents from the Medical Council in relation to AWB. No documents were produced recording a telephone call from AWB.

On 4 November 2005 AWB went to the Hornsby Police Station to report his abuse. He subsequently assisted with the police investigation against Dr Rolleston.<sup>131</sup>

AWB also told the Royal Commission that his local general practitioners, Dr Steve Thackway and Dr John Proctor, both became aware that he had a drinking problem and had been abused by Dr Rolleston when he was young.<sup>132</sup> He recalled telling Dr Thackway directly about his abuse. AWB said he thought Dr Proctor may have found out through his patient file.<sup>133</sup> AWB cannot recall either Dr Thackway or Dr Proctor telling him who he should report the abuse to.<sup>134</sup>

Prior to the public hearing, the Royal Commission informed Dr Thackway and Dr Proctor of the public hearing and the evidence AWB was expected to give. On the first day of the hearing, each of the doctors made an application for a non-publication order in relation to their names and any other information that might identify them. The Chair declined to make the orders sought, stating that the starting point in the Royal Commission was that, as far as possible, all evidence ought to be publicly available unless there is a very good reason.<sup>135</sup> However, the Chair indicated that leave would be granted to the doctors to respond to AWB's statement, including by providing a statement if they chose to.<sup>136</sup> Dr Thackway and Dr Proctor did not provide a response to the matters outlined in AWB's statement.

AWB recalled that, around 22 April 2004, he went to the St Ives practice and met with Dr Roger Stone – a former colleague of Dr Rolleston.<sup>137</sup> When AWB went to see him, he discussed Dr Rolleston's abuse of him at the St Ives practice and at the RNSH on the pretext of testing for infection.<sup>138</sup> AWB told Dr Stone that he was unsure of what to do but wanted to discuss it with him. He also discussed the possibility of speaking to Dr Pollitt, who was another doctor within the practice.<sup>139</sup> AWB did not recall receiving any direction from Dr Stone about what he should do or any guidance on referral to appropriate medical institutions or the police.<sup>140</sup>

In November 2005, when AWB later visited Dr Stone to pick up some medical records, he recalls that Dr Stone said to him, 'you know you were a lot older than you said and thought you were at the

time’ – that is, he was 14 years old and not 12 years old when the abuse first occurred. AWB left the meeting feeling angry at what he interpreted as a suggestion he had been complicit in Dr Rolleston’s actions because AWB had been older. AWB felt Dr Stone was discouraging him from taking the matter further.<sup>141</sup>

Dr Stone gave evidence at the public hearing. He did not recall the meeting with AWB in November 2005 or the conversation about AWB’s age.<sup>142</sup> Dr Stone said that the only reason he would have for discussing AWB’s age would have been to assist AWB in getting dates correct and to enable correlation with past documented consultations with Dr Rolleston.<sup>143</sup> Dr Stone said:

I am very sad to see that AWB felt his discussion with me in April 2004 was not helpful and that he felt he received no advice from me when I felt I had made it clear that I believed him, felt the behaviour was totally unacceptable but that it was his decision whether to pursue it.<sup>144</sup>

In around 2005 or 2006 AWB disclosed the abuse to his older sister, who was a medical doctor.<sup>145</sup>

AWB was an impressive witness and we accept his evidence in relation to Dr Thackway and Dr Proctor. However, we cannot say whether he correctly understood Dr Stone’s intentions when they spoke.

### Effects of abuse on AWB

AWB spoke about the impact the abuse by Dr Rolleston had on his secondary education and career progress. He was supported by a loving family and support network.<sup>146</sup> Although AWG showed excellent academic performance until year 10 in high school, from the time of the abuse his scholastic performance tailed off rapidly.<sup>147</sup> AWB’s teachers noticed the drop in performance. However, AWB felt unable to speak to his parents, teachers, siblings or peers about what Dr Rolleston had done to him.<sup>148</sup> AWB attributed his inability to communicate the abuse to the way Dr Rolleston berated him at the end of each sexual assault – saying, ‘You stupid boy, look what you have done’.<sup>149</sup>

AWB failed to gain tertiary entrance, unlike his siblings, and started working in retail cadetships.<sup>150</sup> He was alcohol dependent for 30 years.<sup>151</sup> AWB spoke of the impact on his confidence as an adolescent and young adult, which inhibited meaningful or functional relationships.<sup>152</sup> AWB did not have a functional relationship until the age of 38.<sup>153</sup> AWB was diagnosed with post-traumatic stress-related depressive disorder.<sup>154</sup> AWB said that, as an adult, when AWB saw Dr Rolleston on the streets of Mosman the impact was profound.<sup>155</sup> On one occasion AWB found himself walking behind Dr Rolleston and agonised about whether to follow and confront him. While doing that, he suffered a physiological reaction, his heart raced and he felt nauseated.<sup>156</sup>

## AWC

On 24 July 1979, when AWC was 15 years old, he went to the RNSH Accident and Emergency Department with his grandmother. He had had an accident in the playground at school and was seeking treatment, having hurt his coccyx bone.<sup>157</sup>

On arrival at the Accident and Emergency Department, AWC and his grandmother were taken to see a doctor. At the time, AWC did not know the doctor's name but later discovered the doctor he saw was Dr Rolleston.<sup>158</sup> Dr Rolleston took him into a small office and closed the door.<sup>159</sup> Dr Rolleston asked him to jump up on the bench, lie on his side and take his pants down.<sup>160</sup> Dr Rolleston then took hold of his shorts, removed them completely from one leg and then removed his underwear in the same manner.<sup>161</sup> Dr Rolleston then said to AWC, 'we have to check to see if you have blood in your semen and we have to see if you have blood in your anus'.<sup>162</sup>

AWC felt alarmed at this stage, but when Dr Rolleston put on a latex glove he believed Dr Rolleston was going to perform a medical procedure.<sup>163</sup> Dr Rolleston then started to stroke AWC's penis with the hand without the glove and then moved the gloved hand between AWC's legs and put one of his fingers into his anus. Dr Rolleston then stopped masturbating AWC and said to him, 'masturbate yourself' and 'tell me when you are going to come'.<sup>164</sup> AWC ejaculated into Dr Rolleston's gloved hand and Dr Rolleston said to him: 'No, there is no blood in your semen and no blood in your anus. That's the important thing. You're fine. Just rest.'<sup>165</sup> AWC left the room feeling unsure whether what happened to him was a normal or 'appropriate' medical procedure.<sup>166</sup>

### AWC discloses his abuse

AWC started to speak about his abuse by Dr Rolleston around 1997. He could not remember the first person he spoke to about his abuse but did recollect that he spoke to a small group of people in a short period of time.<sup>167</sup> The group included his mother, sister, girlfriend, best friend, medical practitioner, a psychiatrist and a psychologist.<sup>168</sup>

Between 1997 and 1998, AWC made a series of telephone calls to the RNSH Medical Records Unit attempting to find out more about his abuse.<sup>169</sup> AWC was told there was a medical record of his visit to the RNSH and, based on that record, the date was 24 July 1979.<sup>170</sup> AWC tried to obtain the name of the doctor who had abused him and was told it was either 'Rolleto' or 'Rollerto', but they were not sure of the spelling of his name.<sup>171</sup> During a different telephone call he was told that his patient record had notes to the effect that the doctor had performed a rectal examination on him.<sup>172</sup>

In August 1998, AWC made a complaint to the HCCC. AWC told the Royal Commission of the processes he went through before the HCCC terminated his complaint on 17 November 2001 – just over three years after he made the complaint. The HCCC's handling of AWC's complaint is discussed below. AWC was deeply disappointed with the HCCC's decision to terminate the complaint in 2001 and with the HCCC's investigation of Dr Rolleston over this time period.<sup>173</sup>

On 24 October 2006 the Medical Board contacted AWC and advised him that his complaint was being reviewed in light of other complaints against Dr Rolleston and was being referred to the HCCC for investigation. AWC thought this process with the HCCC and the Medical Board was the most circular he had ever encountered.<sup>174</sup> AWC also told the Royal Commission of the process with the HCCC after they reopened his complaint and made contact with him in January 2007 – approximately eight years after he made his initial complaint to the HCCC.

Around January 2008, AWC was contacted by NSW Police. AWC was told that NSW Police were investigating Dr Rolleston and he agreed to give support to the investigation.<sup>175</sup>

As an adult, AWC disclosed his abuse to a number of health practitioners. Around 1997, when AWC was 33 years old, he went to see Dr Malcolm Parmenter.<sup>176</sup> AWC made the appointment to discuss the abuse. AWC went into detail about Dr Rolleston's test for internal bleeding and he asked whether what Dr Rolleston had done was an appropriate medical procedure. Dr Parmenter responded: 'No. You have been 100% sexually abused. You should do something about it.'<sup>177</sup>

Dr Parmenter said to AWC that the accident he had in the playground was a bruised coccyx bone. He said this was very common and was known to be painful, and that ordering an x-ray was the appropriate medical test. Looking for blood in his semen was not the appropriate medical procedure.<sup>178</sup> AWC asked Dr Parmenter how he would go about doing something about his abuse. Dr Parmenter gave AWC the phone number for the HCCC and said, 'You need to make a complaint'.<sup>179</sup>

On 13 February 1998, when AWC was 34 years old, he consulted a psychiatrist, Dr Lisa Lampe, about anxiety and panic attacks.<sup>180</sup> AWC said he informed Dr Lampe about his sexual abuse at the RNSH in explicit detail.<sup>181</sup> AWC does not remember Dr Lampe telling him to make a complaint or speak to the police about the matters he discussed with her.<sup>182</sup>

Prior to the public hearing, the Royal Commission informed Dr Lampe of the public hearing and the evidence AWC was expected to give. A legal representative for Dr Lampe appeared at the Royal Commission on the first day of the hearing. The Chair informed Dr Lampe's legal representative that, if the doctor thought it necessary to respond to AWC's statement, she would be granted leave to do so.<sup>183</sup> Dr Lampe did not provide a response.

Around 1998, when AWC was 34 years old, he consulted a registered psychologist and a clinical hypnotherapist, Ms Simonette Gow.<sup>184</sup> AWC saw Ms Gow in relation to anxiety, panic attacks and personal problems, and he said he gave her a 'detailed and explicit' description of the abuse.<sup>185</sup> AWC does not recall receiving any guidance from Ms Gow.<sup>186</sup>

## Effects of abuse on AWC

AWC gave evidence of the impact of the abuse by Dr Rolleston. As a 15-year-old, AWC felt too traumatised and embarrassed to speak about the abuse. The abuse was AWC's first sexual

experience and it made AWC concerned about whether he would become homosexual despite not wanting to be.<sup>187</sup> AWC felt angry and resentful towards his mother and father for not protecting him from a sexual predator like Dr Rolleston.<sup>188</sup>

Following the abuse, AWC suffered from panic attacks and was unable to sit for the Higher School Certificate.<sup>189</sup> The panic attacks continued to increase until AWC sought treatment from different psychiatrists and psychologists. The abuse impacted on AWC's relationships with girlfriends and on his acceptance of sexual advances from partners.<sup>190</sup> AWC wanted to start a family when he was in his thirties but was unable to do this because of his anxiety and depression.<sup>191</sup>

## AWD

In 1984, when he was 13 years of age, AWD visited the Whalan practice. This is where AWD's family doctor had previously worked and, at that time, where Dr Rolleston conducted his practice. AWD attended alone and saw Dr Rolleston, complaining of a sore throat. AWD wanted a medical certificate to explain an absence from school that day.<sup>192</sup>

During the consultation Dr Rolleston asked AWD to remove his clothes, inspected AWD's groin area and then fondled and masturbated him.<sup>193</sup> When Dr Rolleston told AWD he required a fluid sample, AWD said he felt very uncomfortable. He told Dr Rolleston that he did not 'really want to do that today'.<sup>194</sup> Dr Rolleston then booked AWD a further appointment and told him a fluid sample could be obtained on the next visit. AWD left the practice in tears and did not return for another appointment with Dr Rolleston.<sup>195</sup>

AWD said he felt unable to disclose the abuse to his family at the time.

## AWD discloses his abuse

AWD first disclosed the abuse in 1997 or 1998 to a girlfriend.<sup>196</sup> In 1999, AWD disclosed the abuse to his sister. The following day he was admitted to hospital with suicidal ideation.<sup>197</sup> Hospital records note AWD's disclosure of abuse by a family doctor at a young age.<sup>198</sup> Although the notes do not record Dr Rolleston's name, AWD gave evidence he was confident he would have disclosed Dr Rolleston's name.<sup>199</sup>

Over the next few weeks after his hospitalisation, mental health workers from the Blacktown City Mental Health Service visited AWD at his home.<sup>200</sup> During this time, AWD said he made further disclosure of abuse. AWD ultimately filed a complaint with NSW Police in 2012.<sup>201</sup>

## Effects of abuse on AWD

AWD spoke of the impact the sexual abuse by Dr Rolleston had on him. Before the abuse AWD had been an A-grade student and played state soccer.<sup>202</sup> The year after the abuse, AWD's grades dropped and he quit soccer and school.<sup>203</sup>

AWD had trouble seeing doctors following the abuse. In or around 2000, after a suicide attempt, AWD was taken to hospital and attended to by a male doctor. AWD became extremely angry and uncontrollable.<sup>204</sup> Similarly, in 2011, when AWD had a heart attack, he suffered extreme pain for several hours at home before seeking help and self-medicated for as long as possible, as he wanted to avoid doctors and hospitals.<sup>205</sup>

Following the abuse, AWD started using drugs and alcohol to cope with stress.<sup>206</sup> Dr Rolleston's abuse of AWD created problems in AWD's personal relationships and ability to be sexually intimate with a partner.<sup>207</sup> AWD suffered from depression and suicidal tendencies and continues to find it difficult to accept assistance from medical health professionals.<sup>208</sup>

## 1.3 Dr Rolleston's professional history

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As outlined above, Dr Rolleston practised as a medical practitioner at the St Ives practice from 1969 to late 1979 and then was Medical Director of the Accident and Emergency Department of the RNSH from 1979 to mid-1983. It was during his time at the St Ives practice and at the RNSH that Dr Rolleston perpetrated the majority of the child sexual abuse that was to form the basis of the later convictions leading to his imprisonment.

Between 1983 and early 1987, Dr Rolleston was in general practice at the Whalan practice. He sexually abused AWD there in 1984.

### Criminal convictions: 1975 and 1986

In 1975 Dr Rolleston was convicted by the Court of Petty Sessions in New South Wales of nine offences relating to obtaining payments by making false statements and writing false prescriptions contrary to provisions of the *National Health Act 1953* (Cth). These offences occurred in 1971 and 1972.<sup>209</sup>

In April 1986, Dr Rolleston was convicted in the New South Wales District Court of 12 counts of issuing false documents capable of being used in relation to an application for a payment under the *Health Insurance Act 1973* (Cth).<sup>210</sup> These offences, commonly known as Medifraud, involve false claims being made for services.<sup>211</sup> Dr Rolleston was fined a total of \$17,000. He was also sentenced to a one-year term of imprisonment; however, pursuant to section 20 of the *Crimes Act 1900* (NSW) (now repealed), he was released from this term of imprisonment upon paying a sum of money for security and a penalty and was on a good behaviour bond for a period of five years.<sup>212</sup>

## Medical Tribunal hearing and conditions on registration: 1987 and 1990

On 27 February 1987, following a hearing before the then Medical Tribunal, Dr Rolleston was found guilty of professional misconduct (based on his Medifraud convictions) and his name was removed from the Register of Medical Practitioners.

In 1990, Dr Rolleston successfully applied to the Medical Tribunal to have his name restored to the register. However, the Medical Tribunal ordered that his registration be subject to conditions, including that Dr Rolleston could only practise within the hospital system and could not practise privately for a period of two years.<sup>213</sup>

The Medical Tribunal referred to Dr Rolleston's previous conviction for the 1971 and 1972 offences and stated there could be 'no doubt that there was moral turpitude involved'.<sup>214</sup> However, the Medical Tribunal noted that there is 'no dispute that he is a competent and caring medical practitioner'.<sup>215</sup> Of the more recent offences triggering the deregistration, the Medical Tribunal stated, 'what [the offences] clearly demonstrated was a cavalier attitude on the part of Mr Rolleston to his moral and legal obligations under the *Health Insurance Act*'.<sup>216</sup>

Between October 1990 and February 1993, Dr Rolleston was employed in various hospitals in Sydney and thereafter in Broken Hill.

## Removal of conditions on registration: 1993

In February 1993, the conditions on Dr Rolleston's registration were removed and from this time he was able to work as a general practitioner in private practice.

Between 1993 and early 1997, Dr Rolleston was the Director of Medical Services at the Broken Hill Hospital. From 1997 he established the Broken Hill Medical Centre and worked there as a principal.

## Inquiry into complaints of child sexual abuse: 2009

In June 2009 Dr Rolleston was called to appear at an inquiry convened by the Medical Board in accordance with section 66 of the *Medical Practice Act 1992* (NSW) (the Section 66 Inquiry).<sup>217</sup> These proceedings were convened in relation to the complaints by AWC, AWH, AWB and AWO.

On 23 June 2009, the delegates to the Section 66 Inquiry decided that, pending a full investigation of the allegations, it was appropriate to impose conditions on Dr Rolleston's registration. Those conditions prohibited Dr Rolleston from providing any medical services to patients between the ages of 11 and 18 years and required that a chaperone be present at all times during his provision of medical services to any patient aged between 0 and 10 years.

Dr Rolleston denied each of the allegations at the time.<sup>218</sup>

On 3 July 2009, Dr Rolleston was arrested by police and charged with 11 counts of indecent assault in the 1970s against four males between 11 and 15 years of age.

### Breach of chaperone conditions and further inquiry: 2010

In January 2010, the Medical Board wrote to Dr Rolleston about significant discrepancies between the entries recorded in his monthly chaperone logs and data supplied by Medicare Australia regarding medical services he rendered to patients aged 18 years or younger.<sup>219</sup> The information suggested that he had consulted with four patients aged between 11 and 18 years, which raised concern about a breach of the condition relating to age restrictions on patients. The data also suggested that he had consulted with 22 patients aged 10 years or younger.

A further Section 66 Inquiry was held on 25 March 2010. Dr Rolleston accepted he was in breach of his conditions.<sup>220</sup> He stated, however, that all patients had been properly chaperoned and that the only errors were in the paperwork. Dr Rolleston was unable to explain why there had been so many errors in the relevant period. Furthermore, Dr Rolleston asserted that in some cases the patient was just short of 19 years of age and in other cases the patient had been incorrectly billed as having consulted him rather than a colleague and these had been honest mistakes.

The Section 66 Inquiry was also told that in early July 2009 Dr Rolleston had been arrested and charged over a number of indecent assaults.<sup>221</sup> When asked for clarification on the current situation in relation to criminal charges, Dr Rolleston's legal representative informed the delegates that a total of 13 patients were implicated (with some suggestion the correct number was 14) and that Dr Rolleston had been charged with 40 separate charges under two sections of the *Crimes Act 1900* (NSW). The delegates set out the names of the 14 patients, including AWC, AWB, AWH, AWG, AWO and AWA.

The delegates observed that 'the charges are of an extremely serious nature and relate directly to professional standards and to the public's expectation of medical professionals who hold positions of particular trust'.<sup>222</sup> The delegates considered that the suspension of Dr Rolleston's registration was appropriate and necessary. The suspension of Dr Rolleston's registration took effect from the date of that Section 66 Inquiry (25 March 2010).<sup>223</sup>

### Trial and conviction for child sexual abuse: 2011

On 1 April 2010 the Director of Proceedings of the HCCC determined to prosecute a complaint in respect of AWH, AWO, AWC and AWB. However, having regard to the further investigations that the HCCC was undertaking and the criminal charges that were then before the courts, the Director of Proceedings decided to defer the filing of the complaint with the Medical Tribunal until the investigations were concluded.<sup>224</sup>

On 21 February 2011 Dr Rolleston stood trial in the District Court of New South Wales on 11 counts

of indecently assaulting male patients below the age of 18 years pursuant to section 81 of the *Crimes Act 1900* (NSW) (now repealed).

Before the proceedings commenced, an application to the court was made on behalf of Dr Rolleston for a stay of proceedings. The basis of this application was predominantly the long delay in bringing the proceedings, which was said to have produced a significant prejudice to Dr Rolleston, and that any trial of the doctor would necessarily be unfair.<sup>225</sup>

As part of its consideration of the prejudice of delay issue, the court was invited to have regard to the fact that AWC had made a complaint to the HCCC as early as 1998, that AWH had provided a statement to the HCCC in May 2003 and that AWO had made a statement to the HCCC in August 2007.<sup>226</sup> This stay application was not successful and the trial went ahead.

On 8 March 2011 Dr Rolleston was convicted on 10 of those 11 counts. Included in those counts were the indecent assaults perpetrated upon AWG, AWO, AWB and AWC.<sup>227</sup>

Dr Rolleston faced a further indictment and pleaded guilty on 5 May 2011. The indictment contained seven counts of indecently assaulting a male below the age of 18 years, also pursuant to section 81 of the *Crimes Act 1900* (NSW) (now repealed). The assaults perpetrated upon AWH and AWA were included in this indictment.<sup>228</sup>

On 6 July 2011 Dr Rolleston was convicted in relation to each of the 17 offences and sentenced to a total of four years imprisonment with a non-parole period of 18 months.<sup>229</sup>

At this time, Dr Rolleston admitted an additional 10 offences in a 'Form 1' and these were taken into account under section 33 of the *Crimes (Sentencing Procedure) Act 1999* (NSW). Those additional offences included assaults perpetrated upon AWH and AWA.<sup>230</sup>

### Further charges: 2012

On 2 November 2012 in the District Court of New South Wales, Dr Rolleston pleaded guilty to a further four counts on indictment under section 81 of the *Crimes Act 1900* (NSW) (now repealed). On 9 November 2012, Dr Rolleston was convicted in relation to each of the four offences and sentenced to a total of 14 months imprisonment.

At this time, Dr Rolleston admitted additional offences in a 'Form 1', which included an offence perpetrated against AWF.

### Deregistration: 2013

Following these criminal convictions, the HCCC complaint against Dr Rolleston was successfully prosecuted in the Medical Tribunal.<sup>231</sup>

On 17 May 2013 the Medical Tribunal decided that, firstly, Dr Rolleston's registration was to be cancelled; and, secondly, he was precluded from reapplying for registration for four years. At the time of the hearing, Dr Rolleston gave an undertaking in the form of a statutory declaration to the HCCC that he would never seek to be re-registered as a medical practitioner.<sup>232</sup>

### Further charge: 2013

Following the Medical Tribunal hearing, an additional charge was laid under section 78Q of the *Crimes Act 1900* (NSW), being an act of gross indecency with a male under 18 years. The offence had been committed upon AWD at the Whalan practice on 7 October 1984. Section 78Q had replaced section 81, which had been repealed from 8 June 1984.<sup>233</sup> Mr Rolleston was convicted and sentenced on 17 December 2013.<sup>234</sup>

The cumulative effect of the sentences imposed meant that Mr Rolleston's total sentence was set to expire on 23 June 2015.<sup>235</sup>

## 1.4 Communications between NSW Police and the HCCC

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### HCCC referral of complaints to NSW Police

Commissioner Pehm gave evidence that, where the HCCC received a complaint of child sexual abuse, it is usually in relation to a health practitioner in the course of practising in a health profession. However, he stated there may be allegations of child sexual abuse where the abuse has not occurred in the conduct of the alleged perpetrator's profession, in which case it would be appropriate for the HCCC to refer the complaint to NSW Police.<sup>236</sup>

In relation to the current practices between HCCC and NSW Police, Commissioner Pehm stated that, where there is a complaint to the HCCC raising serious criminal matters, the HCCC refers the complaint to the police and encourages complainants to go to NSW Police (if they had not already done so).<sup>237</sup> Commissioner Pehm gave evidence that a complication or uncertainty arises where a complainant does not want to go to the police and in deciding whether the HCCC should refer a matter to NSW Police without the complainant's consent.<sup>238</sup> Commissioner Pehm identified decision-making on this issue as one of the areas where potentially the HCCC can make improvements.<sup>239</sup>

### NSW Police procedures for handling complaints against health professionals

Detective Sergeant Grant Slade of NSW Police gave evidence in the public hearing. Detective Sergeant Slade has worked with the police Sex Crimes Squad and Child Abuse Squad and at the time of giving evidence was officer in charge of the Royal Commission Referral Team attached to the Sex Crimes Squad.

Detective Sergeant Slade explained that referrals to NSW Police from the HCCC or the Medical Council in relation to child sexual abuse complaints or allegations made against a health practitioner are dealt with by assessing the information and determining whether the complainant is willing to provide a statement, in the same manner as any other such complaint received by NSW Police.<sup>240</sup>

If a complaint is made to the NSW Police and the complainant makes a statement, a criminal investigation commences, in which event NSW Police may make enquiries of the HCCC and the Medical Council.<sup>241</sup> If NSW Police become aware that a complainant to the HCCC or the Medical Council is unwilling to contact NSW Police, they assess whether to initiate contact with the complainant.<sup>242</sup>

Where the HCCC informs NSW Police that an alleged perpetrator continues to work as a medical practitioner but the complainant does not wish to speak to NSW Police, consideration is given to whether NSW Police should initiate contact.<sup>243</sup> Generally NSW Police do not 'cold-call' victims of historical sexual assault due to the potential harm that may be caused (such as re-traumatisation), which is believed to outweigh any benefit that may flow to an investigation.<sup>244</sup> An exception is made when an individual has been identified who may be able to provide information relevant to a current investigation and it is necessary to follow that line of enquiry to avoid compromising the investigation or prosecution. In such circumstances, NSW Police approach the individual as a witness who could assist the investigation.<sup>245</sup>

## NSW Police investigation of Dr Rolleston

Detective Senior Constable Arron Ferguson of NSW Police gave evidence in relation to the police investigation of Dr Rolleston. Detective Senior Constable Ferguson was the officer in charge of the investigation. The investigation commenced in late 2007 after AWH, AWB and AWC came forward to report their abuse.

Detective Senior Constable Ferguson said that, during the course of investigation and prosecution of Dr Rolleston, NSW Police communicated with the HCCC to determine the status of HCCC proceedings against Dr Rolleston, to notify the HCCC of additional complaints known to NSW Police and to obtain relevant information for the police investigation, including medical records.<sup>246</sup> NSW Police and the HCCC were able to share this information under a memorandum of understanding (MOU) between the two agencies.<sup>247</sup>

## 1.5 Complaints to the Medical Board: 1992

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There is a file note of the Medical Board dated 13 July 1992 which records a telephone inquiry from a 'male person' alleging he had been sexually abused by Dr Rolleston as a teenager. The caller was referred to the Complaints Unit – the predecessor of the HCCC.<sup>248</sup>

A further file note dated 18 September 1992 from the Medical Board records a call from a male, purporting to be AWG, in relation to Dr Rolleston sexually abusing him as a 14-year-old 17 years earlier.<sup>249</sup> The caller stated he wished to make a complaint against Dr Rolleston. The caller was advised to put his complaint in writing and that Dr Rolleston was conditionally registered.<sup>250</sup>

AWG told the Royal Commission he had never contacted the Medical Board regarding his abuse by Dr Rolleston and could not explain how his name came to be recorded in the file notes.<sup>251</sup>

The Royal Commission sought documents and requested a statement from the present Medical Council concerning the response of the Medical Board to AWG's allegations in 1992. No documents were produced by the Medical Council disclosing any steps taken to deal with the allegations documented in the 1992 file notes. Professor Procopis accepted in his evidence that the two file notes of the male person alleging child sexual abuse by Dr Rolleston were filed 'somewhere'.<sup>252</sup>

Professor Procopis also accepted that, in hindsight, this was probably not a satisfactory response on the part of the Medical Board.<sup>253</sup> This is plainly the case. The starting point for an effective response to any complaint is to maintain an accurate record system appropriate for the task.

The Medical Board's file note dated 18 September 1992 records Dr Rolleston was conditionally registered.<sup>254</sup> The conditional registration was imposed because of Dr Rolleston's convictions for Medifraud. Professor Procopis gave evidence that Dr Rolleston's 'financial problems' were likely to have been thought of as a separate issue to the allegations of child sexual abuse but that 'it certainly may have been seen or should have been seen as an indication that Dr Rolleston was not an honest, straightforward medical practitioner'.<sup>255</sup>

We accept the evidence of Professor Procopis that the Medical Board should have regarded Dr Rolleston's conditional registration in this way. It was a consideration that was relevant to the integrity of the current complaint.

## 1.6 AWC's complaint to the HCCC: 1998

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On or around 13 August 1998, AWC made a complaint to the HCCC.<sup>256</sup> The complaint was a handwritten letter outlining the nature of the sexual abuse by Dr Rolleston and the reason for his consultation with Dr Rolleston at the RNSH. He disclosed the name of the doctor as being 'Doctor Rolleto or Rollerto'. AWC asked for assistance in lodging a complaint because he had been unable to obtain the doctor's precise name from the RNSH.<sup>257</sup> The HCCC recorded AWC's complaint on file 98/0035 and stated that the complaint was received on 13 August 1998.<sup>258</sup>

At the relevant time, section 22 of the HCC Act required the HCCC to carry out an assessment of the complaint 60 days after receiving the complaint or 60 days after the date on which the complainant provided further particulars of the complaint.

## HCCC's handling of AWC's complaint

### Assessment

The HCCC assessed AWC's complaint from 13 August 1998.<sup>259</sup> During this assessment phase, AWC provided a statutory declaration in relation to his complaint by 23 October 1998.<sup>260</sup> The HCCC delayed the assessment of AWC's complaint because the name of the medical practitioner could not be identified with precision.<sup>261</sup>

On 4 November 1998, the HCCC consulted the Medical Board to ascertain the name of Dr Rolleston.<sup>262</sup> On 11 November 1998, the Assessment Committee of the HCCC assessed the suitability of the complaint for investigation.

The Assessment Committee also requested that the Legal Division of the HCCC advise of the suitability of the complaint for referral to police and the obligations to report sexual abuse to DOCS or other organisations (such as the Office of the Director of Public Prosecutions (ODPP) and NSW Health).<sup>263</sup> There was no response to this request from the Assessment Committee.<sup>264</sup>

On 25 November 1998, the HCCC wrote to Dr Rolleston advising him of the complaint by AWC, which alleged inappropriate behaviour of a sexual nature during an examination at the RNSH in July 1979.<sup>265</sup> The letter did not require a response from Dr Rolleston.

### Investigation

The first steps in the investigation of AWC's complaint commenced on 17 September 1999. On that date the HCCC wrote to Dr Rolleston seeking a response within 28 days to a number of questions.<sup>266</sup>

On 26 April 2000 AWC contacted the HCCC about his complaint.<sup>267</sup> The HCCC returned his call on 1 May 2000 and discussed with him the possibility of the matter not proceeding.<sup>268</sup> It was not until this same day – 1 May 2000 – that the HCCC sought a response from Dr Rolleston to the earlier letter of 17 September 1999.<sup>269</sup>

On 6 and 22 June 2000 the HCCC received a response to its 1 May 2000 request from Dr Rolleston's lawyers, United Medical Protection.<sup>270</sup> The letter of 22 June 2000 informed the HCCC that Dr Rolleston strongly denied that he had acted improperly in any way. It also submitted that the HCCC should not proceed with the complaint given the lengthy delay in bringing the complaint, which had placed Dr Rolleston in an impossible position in which to defend himself. As part of this submission, it was stated that Dr Rolleston had no recollection of the consultation and that he was now prejudiced in seeking out possible witnesses. It was also noted that it appeared that the complainant had not made a complaint to any other persons at the time.

There is no record in the investigation file of any further investigation steps that the HCCC took in relation to AWC's complaint.

## Termination of investigation

On 28 September 2001 an officer of the HCCC finalised an Investigation Report on the complaint.<sup>271</sup> The report concluded that the conduct was very serious and would ordinarily result in disciplinary proceedings. However, given the long delay, it was stated that Dr Rolleston was not able to adequately participate in his own defence other than to deny the conduct. Ultimately, the report observed that after 22 years there was no longer a public interest in taking disciplinary action and recommended that no further action be taken. The report also recommended that no referral be made to DOCS or the ODPP for the same reasons.

Following this and further consultation with the Medical Board,<sup>272</sup> the decision was made to terminate the investigation of the complaint and the file was closed on 19 November 2001.<sup>273</sup>

## Delays in handling of AWC's complaint

AWC told the Royal Commission of the delays in the handling of his complaint and correspondence from the HCCC. AWC made the complaint to the HCCC on 13 August 1998<sup>274</sup> and was informed by letter on 10 May 1999<sup>275</sup> that the HCCC had assessed the complaint as suitable for investigation. AWC said that during this time 'I had assumed that the HCCC were investigating my complaint'.<sup>276</sup>

Following this letter, AWC received no contact from the HCCC until 1 May 2000 – a period of 12 months. AWC did not recall receiving any further contact from the HCCC again over the subsequent eight months.<sup>277</sup> AWC recalled that 'I was given no explanation for the delay in communicating with me about my complaint'.<sup>278</sup>

Commissioner Pehm<sup>279</sup> and Professor Walton accepted that the HCCC's delay in its assessment and its investigation of AWC's complaint was unacceptable.<sup>280</sup> Of the lack of any action on file in the period leading up to 30 July 2001, Commissioner Pehm stated, 'There is no reasonable explanation for this delay on the file and it is clearly regrettable that such a lengthy delay occurred'.<sup>281</sup>

On the day that the public hearing commenced – 6 May 2015 – and before being called to give evidence, Professor Walton was interviewed by ABC News.<sup>282</sup> Professor Walton was quoted as saying:

When I was the Director of the Complaints Unit and the Health Care Complaints Commissioner, there was no evidence of wanting to conceal complaints or not investigate complaints that should be investigated. Indeed, it was the opposite.

Professor Walton was taken to this quote in the course of the public hearing, where the following exchange took place:

Q. This morning you have had the opportunity to have regard to all of the documents that went to and fro with Mr [AWC] and the Health Care Complaints Commission. You have read the statement of Mr [AWC] and had a chance, before the hearing today, to review those documents and reflect. Having done that, do you stand by that statement or do you wish to modify it in any way?

A. Thank you. At that time, I was unaware of Dr Rolleston's predatory behaviours and, indeed, the delays within the Health Care Complaints Commission when I was there. Clearly, if I've given any false hope to anyone, I really regret that. Yes.<sup>283</sup>

More specifically in relation to AWC, Professor Walton stated:

I give him my apologies for that delay at the time that I was the Commissioner. It clearly was very distressing to him.<sup>284</sup>

AWC also gave evidence that:

The speed at which the HCCC looked at my complaint still makes me feel upset and angry today. I went to the HCCC asking for help in 1998, they managed to have Dr Rolleston deregistered as a doctor in 2013 after he had already been convicted ... Having the HCCC working at that pace is a danger to the public.<sup>285</sup>

It is apparent that between 1998 and 2001 there was a lengthy delay in the HCCC's investigation of AWC's complaint against Dr Rolleston. There was no reasonable explanation for the delay. The delay was entirely unacceptable. The inevitable conclusion is that the organisation lacked proper management processes and practices.

## AWC's complaint and 1992 allegations to the Medical Board

The HCCC discussed AWC's complaint with the Medical Board on 4 November 1998<sup>286</sup> and 19 November 1998.<sup>287</sup> The documents do not record a link being made between AWC's complaint and the 1992 allegations made to the Medical Board in relation to AWG.

In its submission the Medical Council accepts that, when the complaint against Dr Rolleston was made in 1998, no link was made to the 1992 telephone calls. The system in place did not identify any association between them. The system in place did not log the calls as a 'complaint' in the complaints database. It should have.

## HCCC discretion to discontinue investigation

AWC was sexually abused when a child in July 1979<sup>288</sup> and reported the abuse to the HCCC in August 1998.<sup>289</sup> The HCCC noted the 19-year period was 'extensive' and that 'the Commission prima facie has a discretion to discontinue dealing with the complaint under section 27(1)(f)'.<sup>290</sup>

At the relevant time, section 27(1)(f) of the HCC Act provided:

Following the assessment, the Commission may discontinue dealing with a complaint (or any part of a complaint) for any one or more of the following reasons:

(f) the complaint (or part) relates to a matter which occurred more than 5 years before the complaint was made and the complainant does not have a sufficient reason for having delayed the making of the complaint;

Section 27(1)(f) contains two limbs: one relates to the matter occurring more than five years before the complaint was made and the other relates to whether the complainant does not have a sufficient reason for having delayed the making of the complaint. Both limbs must be satisfied before a complaint may be discontinued on this basis.

With respect to the decision as to whether to discontinue the investigation, Commissioner Pehm accepted that AWC had in fact provided an adequate explanation for taking so long to make his complaint. The Commissioner also accepted that, as the explanation provided 'sufficient reason' for the delay, the discretion under section 27(1)(f) was not available.<sup>291</sup> This is undoubtedly correct.

## Termination of AWC's complaint

### Public interest

In October 1998, shortly after AWC made his complaint, an HCCC file note records the seriousness of the allegations, 'which, depending upon a number of factors yet unknown, may make it appropriate in the public interest to investigate the complaint'.<sup>292</sup>

On 28 September 2001, the HCCC noted in its Investigation Report that 'the countervailing public interest considerations in the hearing and determination of serious complaints concerning medical practitioners ... have much less weight in the circumstances of this case than would ordinarily be the situation'.<sup>293</sup> This was said to be because the Medical Tribunal jurisdiction was 'concerned primarily with a practitioner's present fitness to practice'. This observation is at odds with the fact that Dr Rolleston was then practising in Broken Hill.<sup>294</sup>

The Investigation Report concludes with an observation on the seriousness of this allegation but

noted that, as the ‘practitioner is unable to adequately participate in his own defence, other than to make a stark denial’, the issue is raised ‘of the competing public interest in protecting the interests of the practitioner and maintaining confidence in the administration of justice’.<sup>295</sup>

Commissioner Pehm accepted that, given Dr Rolleston was a practising medical practitioner, it was not sensible for the HCCC to have stated that there was no public interest in taking action.<sup>296</sup> This is obviously the case. The Investigation Report reflects a serious lack of understanding of the interests which the law is designed to protect. In the case of sexual assault the defence of the alleged perpetrator will be a denial, ‘stark’ or otherwise. The reasoning processes in the Investigation Report did not appear to have been informed by consideration of the interests of patients. It should have been a priority for more consideration of the action to be taken in respect of the serious allegations.

### Corroborative evidence

The HCCC Investigation Report also referred to the lack of corroborative evidence as being a reason to terminate the complaint. It reported ‘The difficulties in proving a complaint of professional misconduct given the lack of corroborative evidence and the denial of any misconduct by Dr Rolleston’.<sup>297</sup>

In 2001, the HCCC’s policies and practice surrounding what constitutes ‘corroborative evidence’ were set out in *HCCC Practice Manual – Investigations (2001)* (the HCCC Practice Manual).<sup>298</sup> The HCCC Practice Manual set out a number of ‘categories of evidence that may corroborate an allegation of sexual misconduct’, including:

- a. evidence of opportunity;
- b. the medical condition of the complainant;
- c. the distressed condition of the complainant at relevant times; and
- d. lies told by the identified practitioner.<sup>299</sup>

Former Commissioner Ms Adrian gave evidence that these factors were matters that an officer of the HCCC ought to have regard to.<sup>300</sup> Ms Adrian referred to the meaning of ‘evidence of opportunity’, which she assumed ‘goes to the fact that the medical practitioner or the health practitioner met with the client alone’.<sup>301</sup> Ms Adrian also affirmed that factors that an officer of the HCCC ought have had regard to included the distressed condition of the complainant at relevant times,<sup>302</sup> including distress at the time of making the allegations.<sup>303</sup>

The HCCC knew of the following matters in 2001 when determining to terminate the investigation into AWC’s complaint:

- the HCCC’s recorded evidence of opportunity:
  - Dr Rolleston was at the RNSH as Medical Director of the Accident and Emergency Department<sup>304</sup>
  - AWC attended the RNSH and saw Dr Rolleston alone<sup>305</sup>
  - Dr Rolleston performed a rectal examination<sup>306</sup>
- AWC’s apparent distress in speaking about the child sexual abuse by Dr Rolleston<sup>307</sup>
- Dr Rolleston’s previous history of fraud and deceit, including convictions for such offences.<sup>308</sup>

Commissioner Pehm was shown AWC’s medical record<sup>309</sup> and he gave the following evidence:

Q. If I could have document 1 displayed, document 1 records the Royal North Shore Hospital’s patient record of my client. On that record, it has the date, 24 July 1979, and then there’s some writing, and it says that ‘landed on lower back, very painful’, and underneath the document it says that there is ‘PR’?

A. Yes.

Q. Would you agree with me that in the documents that have been produced by the HCCC there is no consideration by employees of the HCCC that this document could possibly amount to corroboration insofar as it records that there has been a rectal examination in the context of a lower back complaint?

A. Yes.

...

Q. But the point is that no one turned their mind to the fact that part of my client’s story was corroborated by the contemporaneous notes that were in the possession of the HCCC by at least September 1999.

A. That’s right.<sup>310</sup>

## Delay

In deciding to terminate the investigation, the HCCC gave weight to the fact that the abuse occurred some 22 years before and that AWC had not complained until 1998 – 19 years after the abuse. The HCCC initially recognised the reasons for this delay in a memorandum by an officer of the HCCC, which included the environment AWC grew up in and that he had ‘simply attempted to shut it out of his mind’.<sup>311</sup>

The HCCC’s Investigation Report recommended that AWC’s complaint be terminated on the basis of ‘a real possibility’ of a permanent stay of proceedings ‘given the delay in making the complaint

[which] is not the fault of the practitioner'.<sup>312</sup> The Investigation Report provided an assessment of the legal position in relation to the complaint and identified 'delay' as a relevant consideration in deciding whether to take action.<sup>313</sup> It concluded that, in the matter of AWC, 'there has clearly been substantial delay in the making of the complaint'.<sup>314</sup> The Investigation Report further acknowledged: 'delay is not sufficient, by itself, to render a complaint an abuse of process. It must also be demonstrated that the relevant delay has caused actual prejudice to the medical practitioner concerned.'<sup>315</sup>

Commissioner Pehm conceded that, depending on the sufficiency of the reason for the delay, section 27(1)(f) may not operate.<sup>316</sup> The Commissioner at the relevant time, Ms Adrian, gave evidence that the delay in the making of the complaint was 'entirely explainable'.<sup>317</sup>

## Conclusions

We are satisfied that the HCCC's decision to terminate its investigation of AWC's complaint did not adequately take into account:

- that the allegations were of serious criminal offences
- that Dr Rolleston was practising medicine in Broken Hill at that time
- that the HCCC knew of evidence that came within the 'categories of evidence that may corroborate an allegation of sexual misconduct' as set out in the HCCC Practice Manual
- that AWC had given a sufficient reason for the delay in making the complaint
- the need to protect patients from the risk of predatory activity by Dr Rolleston.

Having regard to these matters, the decision to terminate the investigation was wrong.

## Dr Rolleston's response to the allegations

On or around 22 June 2000, Dr Rolleston's insurer, United Medical Protection, wrote to the HCCC on behalf of Dr Rolleston providing a response to the allegations that AWC raised.<sup>318</sup> The letter indicated that, while Dr Rolleston accepted the writing in AWC's patient notes as his own, he had no recollection of the consultation whatsoever and strongly denied that he acted in any way improperly towards AWC. United Medical Protection submitted that the HCCC should not proceed with the complaint, as Dr Rolleston was placed in an impossible position in which to defend himself.

The Investigation Report prepared by the HCCC on or around 28 September 2001 noted the HCCC had decided to terminate the matter pursuant to section 39(1)(e) of the HCC Act.<sup>319</sup> The Investigation Report accepted the United Medical Protection submission that, given the delay in making the complaint, Dr Rolleston was prejudiced in his capacity to respond to the allegations.<sup>320</sup> The Investigation Report stated that one of the reasons for terminating the investigation was 'the difficulties in proving a complaint of professional misconduct given the lack of corroborative evidence and the denial of any misconduct by Dr Rolleston'.<sup>321</sup>

Commissioner Pehm gave the following evidence:

THE CHAIR: Q. Can I understand this paragraph a little more. The report identifies you record this at the beginning of subparagraph (j) that this was a serious allegation, and it plainly was, and if proven would result in disciplinary proceedings: so much is clear. At this stage, it is a complaint in relation to a practitioner who is still practising, with the potential for risk to other children. Was that, in your view, a relevant factor?

A. Yes.

Q. At that

A. Yes.

Q. It is then said:

‘... given the long delay, Rolleston was not able to adequately participate in his own defence other than to deny ...’

When you have an allegation of a doctor abusing a child in the consulting room and there are only the two of them present, will there be any other action that the doctor can take, other than to deny?

A. Other than to deny? No. Well, he can admit, but

Q. Admit, yes, but if he’s going to defend, there is very unlikely to be anything else, whatever the time be, that

A. Well, unlikely there would be any medical records, yes.

Q. Well, making the assumption that there is a record that the patient was there in the first place

A. Mmm.

Q. which you would expect?

A. You would expect the doctor to deny it, yes.

Q. But there is little else the doctor can do or say in aid of the denial?

A. That’s right.<sup>322</sup>

On 1 May 2000 an officer of the HCCC contacted AWC and explained that the complaint might not proceed because no response from Dr Rolleston had been received.<sup>323</sup> On this, Commissioner Pehm gave the following evidence:

THE CHAIR: Q. But could I ask you this. I'm a lawyer, so maybe that's the problem, but how could it ever be? If you have a complaint but you haven't had a response from the person complained about, that that is a reason to discontinue an investigation; it defies belief?

A. Yes, I agree.<sup>324</sup>

It is clear the HCCC was wrong to take into account that Dr Rolleston failed to respond to the allegations of child sexual abuse as a reason to consider terminating AWC's complaint.

## Referral to NSW Police and the ODPP

The HCCC Practice Manual states:

certain types of sexual conduct constitute offences under the *Crimes Act 1900*.  
Complainants should always be advised that they can report the matter to the police ...  
The Commission should not discourage people from going to the police or seeking legal advice.<sup>325</sup>

On 11 November 1998, the HCCC's Assessment Committee requested its Legal Division to advise on the suitability for referral to the police and on obligations to report sexual abuse to DOCS or other organisations.<sup>326</sup> No documents containing legal advice responding to this request have been produced by the HCCC.<sup>327</sup> We are satisfied that no legal advice was given.

A file note prepared by an HCCC officer dated 12 September 2001 stated the officer believed:

[The HCCC] practice in the past has been to make such a referral [to the ODPP] when we believe the matter may warrant institution of a prosecution ... As the matter involves an alleged sexual offence the views of the victim are of great importance, accordingly I suggest the victim be contacted and told where we are at, explain we have the option of referring to DPP and ask him what this views are.<sup>328</sup>

There is no evidence of any person contacting AWC about referral to police or ODPP following this file note.<sup>329</sup>

The Investigation Report dated 28 September 2001 in relation to AWC's complaint records a decision of the HCCC not to refer AWC's complaint to the ODPP and DOCS.<sup>330</sup> The Investigation Report states the reasons for the decision were the same as the reasons given for the decision to terminate the investigation. In summary, these were:

- lack of public interest in pursuing the investigation
- significant delay in the complainant coming forward
- lack of corroboration.<sup>331</sup>

On or around 28 September 2001, an HCCC officer telephoned AWC to inform him of the recommendations contained in the Investigation Report.<sup>332</sup> During that conversation, the officer is recorded in a file note as informing AWC that he would recommend that the complaint not be referred to the police or DOCS ‘for the same reasons outlined above and the difficulties in proof’.<sup>333</sup> The officer asked AWC if he had considered contacting the police. AWC said that he might and asked why the HCCC would not make such a referral.<sup>334</sup> The file note indicated that the officer ‘again stated the reasons’.<sup>335</sup>

At the relevant time, section 26 of the HCC Act expressly permitted the HCCC to refer a complaint to another person or body following an assessment that the complaint raised issues which required investigation by another body. Currently, section 99B(1)(f) of the HCC Act permits the HCCC to disclose information to police if the HCCC suspects that the information relates to an offence that may have been committed.

Commissioner Pehm told the Royal Commission that the HCCC’s failure to refer AWC’s complaint to NSW Police was not because it was uncertain about its statutory powers to refer the complaint but because there was no evidence that the HCCC had turned its mind to referring the complaint.<sup>336</sup>

In relation to the file note of the HCCC officer who telephoned AWC, Commissioner Pehm conceded that it provided a record not only that the HCCC would not be referring the matter to the police but also that the HCCC discouraged AWC from going to the police.<sup>337</sup> Ms Adrian concurred.<sup>338</sup>

The evidence is clear that, in 2001, the HCCC did not refer AWC’s complaint to the NSW Police or the ODPP in circumstances where section 26 of the HCC Act at that time permitted the HCCC to do so.

The effect of the HCCC’s engagement with AWC was to discourage him from taking the matter to the police. This was contrary to the HCCC Practice Manual, which stated that the HCCC staff should not discourage people from going to the police.

## Credibility of AWC and Dr Rolleston

### AWC

From at least as early as October 1998, the HCCC found AWC to be ‘an entirely credible person who was providing a truthful and uncoloured account of the examination which was performed upon him’.<sup>339</sup> In 2001 this credibility continued to be acknowledged.<sup>340</sup> By 2007, when AWC’s complaint was being revisited, an Investigation Report dated 3 April 2007 summarised the reasons for termination in 2001. They did not include the credibility of AWC.<sup>341</sup>

On 23 February 2009 the HCCC briefed senior counsel to provide advice with respect to the merits of filing a complaint against Dr Rolleston in the Medical Tribunal and in particular on the issue of delay. The advice was sought in relation to the complaints of AWH, AWC and AWO.<sup>342</sup>

Senior counsel advised that the HCCC should hold a conference with the complainants. The HCCC held a conference with AWC on 4 May 2009.<sup>343</sup>

Following this conference, senior counsel advised the HCCC that AWC impressed ‘as a careful and credible witness’.<sup>344</sup>

### Dr Rolleston

As to Dr Rolleston’s credibility, in 1975 he was convicted of nine offences relating to pharmaceutical provisions of the *National Health Act 1953* (Cth).<sup>345</sup> A later Medical Tribunal stated that there was ‘no doubt that there was moral turpitude involved’ in the offence.<sup>346</sup>

Further, in 1986 Dr Rolleston was convicted on 12 counts under the *Health Insurance Act 1973* (Cth) in relation to Medifraud.<sup>347</sup> In 1990, the Medical Tribunal deemed these offences as ‘clearly [demonstrating] ... a cavalier attitude on the part of Mr Rolleston to his moral and legal obligations under the *Health Insurance Act [1973 (Cth)]*’.<sup>348</sup>

The HCCC knew of these matters from the time of identifying Dr Rolleston as the subject of the complaints.<sup>349</sup>

Commissioner Pehm gave evidence that, in assessing Dr Rolleston’s credibility, the HCCC gave no consideration to Dr Rolleston’s previous criminal convictions.<sup>350</sup> Ms Adrian’s evidence was ambiguous on this point.<sup>351</sup> However, Ms Adrian accepted that the fact that Dr Rolleston’s criminal convictions could impact on his credibility is not clear from the notes kept by the HCCC.<sup>352</sup>

### Conclusions

We are satisfied that in 2001, when making its decision, the HCCC failed to adequately consider the credibility of both Dr Rolleston and AWC. It should have done so. This failure contributed to the error in deciding to terminate the investigation.

## 1.7 AWH’s complaint to the HCCC: 2003

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On 9 May 2003, AWH made a complaint against Dr Rolleston to the HCCC.<sup>353</sup> AWH made his complaint by email. The HCCC gave the email file number 03/01056.<sup>354</sup> AWH provided the name of the medical practitioner and the place where he was abused. He asked whether Dr Rolleston was still in medical

practice. AWH stated that he, his brother and his sister were abused by Dr Rolleston.<sup>355</sup> He later accepted with the benefit of hindsight he knew only of his own and his brother's abuse and that, based on that knowledge, he had (wrongly) assumed that his sister had also been abused by Dr Rolleston. AWH disclosed in his original email that he and his family had mental health issues and queried whether those were related to Dr Rolleston's abuse of his family and him.

## HCCC's handling of AWH's complaint

### Assessment

The HCCC assessed AWH's complaint from 9 May 2003 to 16 July 2003. During this time, the Medical Board was consulted<sup>356</sup> in relation to suitability for investigation,<sup>357</sup> Dr Rolleston was notified<sup>358</sup> and it was agreed that both AWH and his brother, AWO, would provide statements.<sup>359</sup> HCCC officers attempted to arrange to see AWO and AWH at AWH's home in Murwillumbah in northern New South Wales.<sup>360</sup>

At the time the HCCC assessed AWH's complaint, the HCCC had knowledge of the previous complaint that AWC had made against Dr Rolleston. On 11 November 2003, for example, an officer of the HCCC prepared a file note and referred to AWC's complaint in 1998, noting it had been terminated.<sup>361</sup> Officers of the HCCC were also present at a Medical Board meeting on 9 December 2003, where the minutes from that meeting disclose the committee 'noted its concern at the serious nature of the allegations against Dr Rolleston, and that there was a previous complaint against Dr Rolleston of a similar nature'.<sup>362</sup>

### Investigation

The HCCC investigated AWH's complaint from September 2003 to March 2004. During this time, the HCCC was unsuccessful in its attempt to see AWH and AWO in Murwillumbah.<sup>363</sup> AWH asked the HCCC if he could provide the information by letter or by email. AWH was advised that he could do so and to contact the HCCC investigation officer handling his complaint.<sup>364</sup>

AWH suffered a nervous breakdown in 2004 and was committed to a mental health service in Tweed Heads, New South Wales, for a period of two weeks to ensure he did not commit suicide.<sup>365</sup> AWH did not engage with the HCCC again until 2006, after which the complaint was assessed for investigation.<sup>366</sup>

### Statutory declaration and reporting to police

At the time AWH made his initial complaint in May 2003, the HCC Act required any complaint that was assessed for investigation to be supported by a statutory declaration from the complainant.<sup>367</sup>

This requirement was removed from the HCC Act in 2005.

On 25 June 2003 an officer of the HCCC spoke to AWH. During that conversation, AWH told the officer that he had not been to the police about the matter.

On 15 September 2003, an officer of the HCCC spoke to AWH and again asked whether AWH had spoken to the police or whether he intended to do so. AWH said that he had not and thought that a statute of limitations applied. The officer told AWH that there was no statute of limitations applicable to child sexual assault matters as long as the alleged offender was still alive.<sup>368</sup> On 23 September 2003, in a conversation between AWH and the HCCC officer, AWH said that he did not intend to contact police and confirmed that AWO had said that he would contact the HCCC.<sup>369</sup>

Commissioner Pehm accepted that, even though the HCCC officers raised the issue of reporting to the police, it was not done in a positive or encouraging manner.<sup>370</sup> As previously mentioned, from 2001 the HCCC Practice Manual required complainants to be advised that they can report the matter to the police and that the HCCC should not discourage people from going to the police or seeking legal advice.<sup>371</sup>

## Termination

On 11 November 2003, an officer of the HCCC wrote to AWH and sought all the specific details about all the incidents of child sexual assault that AWH could recall.<sup>372</sup> The letter requested all the dates, locations and details of what occurred during the relevant consultations with Dr Rolleston and asked for those details to be returned to the HCCC within 14 days of the date the letter was written.<sup>373</sup>

Of this letter AWH said:

This was a very frustrating experience for me. The HCCC correspondence was happening at a time in my life when I was mentally very upset. I had around this time attempted to commit suicide and was experiencing suicidal thoughts all the time. The level of technicality, procedures and processes the HCCC was asking from me was overwhelming to me.<sup>374</sup>

These comments by AWH at the time of the public hearing are consistent with AWH's first email complaint of 9 May 2003 to the HCCC, where he stated that he and his family suffered from mental health issues. He had queried whether those issues were related to Dr Rolleston's abuse of his family and him.

After not receiving a response from AWH to the 11 November 2003 letter, on 10 December 2003 the HCCC called AWH and informed him that, as the HCCC had not received a statutory declaration or any other particulars about the complaint from him, the investigation would be terminated or discontinued.<sup>375</sup>

## Conclusions

We are satisfied that in 2003 the HCCC's approach to AWH was insensitive given the nature of the allegations being made against Dr Rolleston and AWH's personal circumstances – in particular, his mental health issues, which he had disclosed to the HCCC.

On the issue of referral to the police, Commissioner Pehm gave the following evidence:

Q. Again, in a situation like that where there is a sort of statutory roadblock to an investigation within the Health Care Complaints Commission, again, it might be appropriate at that point for them to be referred to the police?

A. Yes.<sup>376</sup>

In relation to AWH's complaint, Professor Procopis gave evidence that, because a statutory declaration had not been obtained from AWH by December 2003, the Medical Board had no alternative but to agree to the HCCC's recommendation that the investigation of AWH's complaint be discontinued. Later in his evidence Professor Procopis clarified what he meant by 'no alternative':

I think that the 'no alternative' mentioned was no alternative as far as pursuing the complaint through the health care complaints system – that as there was no statutory declaration, which was required by law then, that the Commission could not do anything further from the point of view of referring it to a further investigation or Tribunal, because of the law about the statutory declaration.

So that 'no alternative' refers to that, but I agree with you, there are other alternatives such as referring to the police, which was not done, either by the Commission or the Board at the time.<sup>377</sup>

Commissioner Pehm and Professor Procopis are plainly correct. When a complainant was not able to, or did not, provide a statutory declaration, an alternative was to report the matter to the police. When, as in the present case, the matter was serious and risks to others were real, this was the obvious course to take.

## 1.8 AWH resumes his complaint to the HCCC: 2006

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On 10 July 2006, AWH contacted the HCCC again by email.<sup>378</sup> The email referred to his earlier complaint and advised that he had suffered a nervous breakdown in 2004.<sup>379</sup> However, he said he was now in better health and wanted to pursue the complaint again, even if it meant going to the police to have Dr Rolleston investigated. In his email AWH asked for advice on what he had to do now.<sup>380</sup>

## HCCC's handling of AWH's resumed complaint

### Assessment

The HCCC assessed AWH's complaint from 10 July 2006 to 17 July 2006. As part of this process, the HCCC consulted with the Medical Board, resulting in this recommendation: 'Given the desire of the complainant to proceed with this matter that a revised assessment be made for investigation.'<sup>381</sup>

### Investigation

The HCCC resumed its investigation of AWH's complaint on 2 August 2006. AWH's file was allocated to an HCCC officer.<sup>382</sup> The HCCC officer sought advice from Mr Scott Schaudin, the Director of Investigations, and Commissioner Pehm on progressing the investigation. In particular, the officer said that he did not see a telephone interview with AWH as an option because of the nature of the complaint and because two officers would be required to travel to Queensland to take a statement.<sup>383</sup>

On 9 August 2006, the HCCC officer confirmed with the Medical Board that Dr Rolleston was still registered as a medical practitioner in New South Wales.<sup>384</sup> On the same day, Commissioner Pehm responded to the HCCC officer: 'The conduct is very old. I don't see the need for a trip to Queensland given his failure to attend the last meeting arranged. Why can't he set out the details of the complaint in writing?'<sup>385</sup>

On 11 August 2006, the HCCC officer wrote to AWH requesting further information about his complaint.<sup>386</sup> The letter advised that before the HCCC would commence its investigation it needed further information on nine separately identified paragraphs. The HCCC asked for a reply within 21 days.

On 30 August 2006, AWH emailed the HCCC expressing his deep distress since receipt of the HCCC letter, particularly in relation to the request for detail such as times, dates and type of clothing worn.<sup>387</sup>

On 18 September 2006, the HCCC officer acknowledged AWH's email and responded:

Thank you for your response to the Commission's request for information. I apologise for the delay in acknowledging your email, but I have been on three weeks annual leave. The Commission will consider the information you have provided ...<sup>388</sup>

Commissioner Pehm accepted that this was not an adequate response and gave the following evidence:

Q. [Referring to the AWH's reaction to the HCCC email] Do you have anything to say about that response?

A. Well, I can understand I understand why he was devastated by it. It's very cold, clinical, unresponsive and sort of, 'Don't call us, we'll call you'. It is completely inadequate and made no attempt to communicate with him in any meaningful way.<sup>389</sup>

In our opinion this was a correct assessment of the situation.

### Assisting complainants

In an HCCC internal memorandum dated 3 August 2006, the officer noted:

I perceive great difficulties with this file. It's a complaint about a very historical sexual assault. There is an IR [Investigation Report] in the file that [HCCC officer] wrote indicating potential difficulties. I'm in full agreement with [the HCCC officer]. We should go through the process. But we shouldn't dilly dally about it. We have to put the allegation to the Doctor. I can predict his response but I'll leave it to the investigation. The passage of time is a serious difficulty here. The complainant alludes to what I can most neutrally say are emotional problems. This should be dealt with appropriately and expeditiously.<sup>390</sup>

AWH told the Royal Commission that 'It was and still is my strong opinion that the HCCC did not want to help me and wanted to discourage me from pursuing my complaint'.<sup>391</sup>

Commissioner Pehm gave the following evidence:

THE CHAIR: Q. By this stage, about eight years of delay has been the Health Care Complaints Commission

A. Yes. I mean, it's very badly I mean, it's I mean, one thing I tried to do Scott Schaudin was the Director of Investigations at the time was to give direction to investigation officers and unfortunately, that's the directions that they got.

DR BENNETT: Q. So Mr [AWH] was pretty spot on, wasn't he?

A. Yes.

Q. Further down in that paragraph 32, Mr Pehm, you have said:

From my review of the records, the investigation officer emailed me on that date noting he did not consider a telephone interview as an option given the nature of the complaint and welcomed any direction. I responded asking why Mr [AWH] couldn't put his complaint in writing and that I didn't see the need to arrange a further meeting given his failure to attend ...

I have seen what you have said there, but would you like to say something about that?

A. Yes, it's completely to my discredit, and I have it's completely contrary to everything I was trying to do in the Commission, so it there is no excuse for it and it wasn't an appropriate response. I suppose, to give it some context, you will see I responded very quickly to the email. Part of the problem with the Commission was delays, and I developed a practice of trying to keep things moving and getting decisions made. I also say in that email, 'I'm not familiar with this file'. I was on leave when that matter was assessed for investigation, so I wasn't aware of it, but it's not it's indefensible. It just doesn't take any adequate account of the circumstances of [AWH]'s position and there is no excuse for it.

Q. At paragraph 33 you said: 'On 11 August 2006 the HCCC wrote to Mr [AWH] requesting further information about his complaint. The letter advised that before the HCCC could commence its investigation further information was required in relation to nine separate identified points. A reply paid envelope was enclosed as well as a blank authority allowing the HCCC to obtain medical records. Reply was sought within 21 days'.

A. Yes.

Q. Again, given what you have just said

A. Well, again, it's a completely inadequate response, and I heard Mr [AWH]'s evidence on the position that put him in and the onus it put on him to do the investigation for us, to get all that information together, and again, how discouraging that was for him, and it's an inadequate and inappropriate way to handle a matter like this.<sup>392</sup>

Commissioner Pehm stated, 'Having reviewed these documents, it is clear to me that my response was insensitive to Mr AWH's situation and that arrangements should have been made to interview him personally at this point'.<sup>393</sup>

We are satisfied that in 2006 the HCCC did not assist AWH in making his complaint against Dr Rolleston. Commissioner Pehm's response to AWH's situation was insensitive and inappropriate.

## Termination

On 19 September 2006, an Investigation Report was prepared which recommended that the investigation be terminated, as the information that AWH provided would not be sufficient to allow Dr Rolleston to provide an informed response other than a bare denial. The Investigation Report stated, 'There is a lack of corroborative evidence available that would assist the Commission in proving a complaint of professional misconduct against Dr Rolleston to a high standard required'.<sup>394</sup>

Commissioner Pehm conceded that in the investigation of allegations of child sexual abuse the only evidence that investigators are likely to get from the alleged perpetrator is a bare denial and 'again, to our discredit, we left it at that at that time'.<sup>395</sup>

Commissioner Pehm also conceded that, in circumstances where there were two other survivors, that should have prompted further investigation of AWH's complaint in 2006.<sup>396</sup> The HCCC Investigation Report dated 19 September 2006 did not record the existence of the two other complainants (AWO and AWC).

It is clear that the HCCC did not consider the improved likelihood of proving AWH's complaint based on evidence of two further reports of similar conduct on the part of Dr Rolleston. The HCCC was wrong in not taking into account the previous complaint against Dr Rolleston by AWC in 1998.

## Medical Board's review of complaints: 2006–2009

### Medical Board powers regarding complaints against medical practitioners

In 2006, the Medical Board had powers under section 66 of the *Medical Practice Act 1992* (NSW) (now repealed) to take immediate action to suspend or place conditions on the registration of a medical practitioner to protect the life, physical health or mental health of any person.<sup>397</sup> The Medical Board was not required to consult with the HCCC before exercising these statutory powers.<sup>398</sup>

By November 2006, the Medical Board had knowledge of complaints against Dr Rolleston from AWC, AWH and AWH's brother AWO. The Medical Board informed the HCCC that the Conduct Committee viewed the 'allegations with great concern which warrant a thorough investigation'.<sup>399</sup> The Medical Board indicated that Dr Rolleston 'may be guilty of unsatisfactory professional conduct and/or professional misconduct and is not of good character'.<sup>400</sup> The Medical Board also knew that Dr Rolleston was at that time working without conditions on his registration given that the conditions imposed on his registration in 1990 had been removed in February 1993.<sup>401</sup>

Professor Procopis gave evidence that, in contrast with the HCCC, the Medical Board had the power to do things immediately and to act very quickly.<sup>402</sup> When asked why, at this time, the Medical Board did not use its powers under section 66 of the Medical Practice Act, Professor Procopis responded:

I think that that is the big mistake that the Medical Board made with some of these cases, that we didn't exert our powers for a section 66, in those days, soon enough. ... with hindsight, I think that should have been done, because he, as you say, was still practising and it therefore would be possible that he was still engaging in this behaviour with other young people.

Now, although we have no evidence that that in fact occurred and there certainly was a more than slight possibility that it could have occurred, and I think that would have – should have been enough to warrant a section 66 inquiry.<sup>403</sup>

We are satisfied that in November 2006 the Medical Board did not exercise its powers under section

66 of the *Medical Practice Act 1992* (NSW) and, by not doing so, prolonged the period in which Dr Rolleston continued to practise with unconditional registration, giving him access to children.

### **HCCC referral to the Medical Board for inquiry**

On 2 April 2008 the Medical Board received a faxed letter from the HCCC confirming that their investigation of the complaints of AWC, AWH and AWO had been finalised and that the HCCC had recommended that the matters be referred to the Director of Proceedings.<sup>404</sup>

On 8 April 2008, the Medical Board Conduct Committee met and discussed the possibility of a Section 66 Inquiry. The committee resolved 'to discuss the possibility of action pursuant to section 66 of the MPA 1992 with the [HCCC] at the Consult meeting of 22 April 2008' and noted the HCCC may be in possession of corroborative material.<sup>405</sup>

There was no statutory requirement for the Medical Board to consult with the HCCC before deciding to hold a Section 66 Inquiry.<sup>406</sup>

The minutes from a Conduct Committee meeting of 13 May 2008 state: 'The Board requested the [HCCC] provide further evidence if available which may assist the Board in determining whether action under section 66 was warranted.' No follow-up date was set to trigger further action if the HCCC did not respond.

In relation to the delay in making a decision to conduct a Section 66 Inquiry, the Medical Council submitted that, while it accepts without qualification the facts as they are now established, it is a different thing entirely to find that in November 2006 and April 2008 it would then have been in a position to take action as it did in June 2009. This submission is in contrast to the evidence of Professor Procopis.

We accept the evidence of Professor Procopis on this issue. We are satisfied that in April 2008 the Medical Board did not exercise its powers under section 66 of the *Medical Practice Act 1992* (NSW) and, by not doing so, prolonged the period in which Dr Rolleston continued to practise with unconditional registration and had access to children.

### **Section 66 Inquiry**

It was not until 27 May 2009, the following year, that the Medical Board wrote to its delegates with respect to whether section 66 proceedings should be convened based on a complaint by AWB. AWB had by that time also made a complaint against Dr Rolleston, in addition to AWG, AWC, AWH and AWO.

When asked about the fact that a year had passed without the Medical Board making a decision, Professor Procopis stated:

Completely unacceptable, I agree. Somehow – I cannot explain it. Somehow that got overlooked and, as I said earlier, my regret is that a section 66 action had not been taken much sooner.<sup>407</sup>

A Section 66 Inquiry was convened on 23 June 2009. On that date action was taken to place conditions upon Dr Rolleston’s registration.

### **A significant failure to act**

From 2006 Dr Rolleston continued to practise medicine without appropriate conditions on his registration, placing children at risk. Having regard to the power given to the Medical Board to protect children, this was a significant failure to act to protect children who may have been at risk of assault by Dr Rolleston. Although we know of people who have reported sexual abuse by Dr Rolleston when they were children, it is reasonable to assume that others were abused who have never come forward.

## 1.9 The HCCC’s current systems, policies and procedures

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Commissioner Pehm gave evidence that since 2004 the HCCC has undergone ‘major’ changes, including procedural reform and implementation of ‘an efficient’ case management system and database.<sup>408</sup> Commissioner Pehm’s evidence referred to improvements to the HCCC practices and website, including:

- changes to the case management system and improvement to an electronic tagging system<sup>409</sup>
- efforts to improve customer service
- changes to the contact with and explanations provided to complainants.

### Training

Commissioner Pehm said the HCCC now offers support to staff in contact with trauma victims. This currently includes resilience training and support. Commissioner Pehm stated the HCCC now has an experienced psychologist to specifically provide training to staff to assist with dealing with trauma victims.<sup>410</sup>

### Communication with complainants

A number of survivors gave evidence of feeling confused by the HCCC correspondence.<sup>411</sup> Commissioner Pehm accepted that the survivors’ evidence was justified and the HCCC letters were very bureaucratic.<sup>412</sup>

Commissioner Pehm said that the current practice within the HCCC is to send with the correspondence ‘fact sheets’ drafted in plain English to explain to HCCC complainants the processes at each stage; what terms mean; how long things are expected to take; and when they can expect to be contacted again. The plain English fact sheets were introduced in 2012 as a result of general feedback the HCCC had received about poor and unresponsive communication.<sup>413</sup>

## Providing information to police

In relation to the referral of matters to the police, Commissioner Pehm stated that the HCCC entered into an MOU with NSW Police in April 2005.<sup>414</sup> The MOU was intended to facilitate the exchange of information between the parties and assist with separate or joint investigations by the parties of health service providers.<sup>415</sup>

Commissioner Pehm also stated that the mechanism under section 99B of the HCC Act, introduced in 2008, had enabled the HCCC to share information and provide information to the police more regularly. Section 99B gave the Commissioner a discretion to disclose information at any time rather than waiting for the end of a particular stage in the investigation.<sup>416</sup>

## 1.10 AWB’s disclosure to the RNSH: 2005

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In 2005, Ms Julie Blyth was a social worker with the RNSH sexual assault unit. In October of that year, AWB was referred to her by a psychologist who was treating him.<sup>417</sup>

Patient notes prepared by Ms Blyth record that AWB that made several disclosures concerning Dr Rolleston abusing AWB at both the St Ives practice and the RNSH.<sup>418</sup> AWB said that Ms Blyth encouraged him to contact the police and that she provided AWB with a contact card for a NSW Police detective at the Hornsby Police Station.<sup>419</sup>

After disclosing his abuse to the RNSH, AWB said that he did not receive a phone call or any other contact from the RNSH, other than from Ms Blyth, concerning his abuse while he was a patient at the RNSH.<sup>420</sup>

Ms Blyth provided two statements to the Royal Commission outlining her recall of her contact with AWB, as well as her understanding of the policies and practices within the RNSH on handling allegations of child sexual abuse.<sup>421</sup>

Ms Blyth stated that, when AWB disclosed the sexual abuse he had suffered as a child, she was aware that the Sexual Assault Services Policy and Procedures Manual (Adult) (the Sexual Assault Services Manual)<sup>422</sup> applied to her.<sup>423</sup>

Under the Sexual Assault Services Manual, reports by adults of sexual abuse committed against

them as children were categorised with the lowest priority. However, this did not mean that historical sexual abuse victims were not supported.

Ms Blyth understood her obligations to include providing the victim with the support and information necessary to make an informed decision on whether they wished to make a complaint to the police, the HCCC, the Medical Board or other appropriate authority.<sup>424</sup> In her statement, Ms Blyth set out her understanding that there was no internal requirement or procedure at the RNSH to report historical child sexual abuse to any manager or hospital personnel.<sup>425</sup>

Ms Blyth understood that her reporting obligation in respect of recent assaults by current NSW Health employees was to notify NSW Police, even where the client did not wish to make a notification.<sup>426</sup> In that regard, Ms Blyth's evidence was that current complaints of sexual assault against persons who were NSW Health employees at the time of the complaint were required to be reported to the Chief Executive (CEO) of the North Sydney Local Health District (NSLHD), who would then report to the appropriate authorities such as the NSW Police, the Staff Records Management Unit of NSW Health and the HCCC.<sup>427</sup>

## 1.11 Current RNSH practices and policies on internal reporting

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Adjunct Associate Professor Vicki Taylor, the current CEO for the NSLHD, gave evidence at the hearing, as did Dr Mary Foley, Secretary of the New South Wales Ministry of Health. The Ministry of Health develops policies and policy documents for NSW Health that are of state-wide application, including within Local Health Districts (LHDs) and thus hospitals within those LHDs such as the RNSH.<sup>428</sup>

Professor Taylor said that the Sexual Assault Services Manual was one of a number of policies that the RNSH worked within.<sup>429</sup> Relevantly, section 1.8 of that manual relates to allegations of sexual assault by a NSW Health employee. It states:

Any Sexual Assault Service staff member who is made aware of an allegation of sexual assault where the alleged assailant is an employee of the Area Health Service will report the allegation immediately to the Chief Executive Officer of the Area Health Service.

In relation to a circumstance where the allegations concern the RNSH but where the alleged perpetrator is no longer an employee of the RNSH, Professor Taylor said that RNSH staff are encouraged to use the Mandatory Reporter Guide,<sup>430</sup> established in 2010, which contains a flow chart to assist with reporting decision-making.<sup>431</sup> The Mandatory Reporter Guide was not available at the time AWB disclosed his abuse to Ms Blyth.

In a circumstance where the allegations are of sexual assault by a NSW Health employee (a medical practitioner) and the RNSH staff member is not aware whether the alleged perpetrator is actually working in that area health service, Dr Foley also gave evidence that the staff member should give consideration to the Mandatory Reporter Guide.<sup>432</sup>

Where the patient making the allegation of child sexual abuse is aware that the medical practitioner is still working somewhere in the New South Wales public health care services, Dr Foley said the staff member receiving the report ought to follow the procedures set out in the Sexual Assault Policy or the Child Protection Guidelines on what to do when the perpetrator may be an employee of NSW Health.<sup>433</sup> So much is obvious.

### RNSH practices and policies on receiving, investigating and reporting complaints

Professor Taylor gave evidence of the current policies and practices that relate to receiving, investigating and reporting complaints of child sexual abuse that has occurred at the RNSH. One requirement of a mandatory reporter engaged with NSW Health is that they must report to the Child Protection Helpline where they have reasonable grounds to suspect that a child under 16 years of age or a class of children is at risk of significant harm.<sup>434</sup> While the legislative requirement is for mandatory reporting in respect of a child<sup>435</sup> (defined as a person under 16 years of age), the Ministry of Health policy requires health workers to report where the reporting threshold is met in relation to both children and young people. A young person is someone aged at least 16 years but who is under the age of 18 years.<sup>436</sup>

Where the allegation concerns a clinician, there are specific policies which apply to that allegation, including Child Related Allegations, Charges and Convictions against Employees (Child Related Allegations Policy);<sup>437</sup> and Managing Misconduct.<sup>438</sup> The policies require the employee who is made aware of the allegation to record the details of the allegations, notify their manager and notify the Child Protection Helpline.<sup>439</sup>

The NSW Notification Requirements Checklist (November 2014)<sup>440</sup> outlines that historical allegations of child sexual abuse could be reported to the police. If the issue relates to a current concern about a young person or a class of young persons then the Mandatory Reporter Guide sets out a decision tree flow chart to assist with decision-making on reporting options.<sup>441</sup> The New South Wales Department of Family and Community Services (DFCS) will notify the employer of the reportable conduct investigation. The head of the agency (in this case, the CEO of the LHD) is required to notify the New South Wales Ombudsman of any reportable allegation or conviction.

The Royal Commission will be reporting in due course on practices and policies in complaint handling across all institutions.

### Information sharing between NSW Health and other public agencies

Dr Foley gave evidence that, if a child is found to be at risk of significant harm, it must be reported. If it involves alleged criminal activity, the matter is referred to the Joint Investigative Response Team (JIRT).<sup>442</sup> JIRT involves a collaboration between NSW Police, DFCS and NSW Health in the investigation of child abuse, including child sexual abuse.<sup>443</sup>

If the risk of significant harm to a child is judged by NSW Health workers to be below the threshold for mandatory reporting, they are also encouraged to contact the NSW Health Child Wellbeing Units to enable the matter to be noted in the WellNet System that operates between agencies and is maintained by the Child Wellbeing Units.<sup>444</sup>

There are three Child Wellbeing Units in New South Wales providing support to health workers across NSW Health. The units are aligned with three child health networks that NSW Health has developed to provide for services planning and referral pathways between groupings of LHDs across local and specialist referral children's health services.<sup>445</sup> It is also the role of the Child Wellbeing Units to guide health workers as to whether notification needs to be made outside the LHDs.<sup>446</sup>

Child protection legislation provides for notification to be made without consent (although health workers are encouraged to let children and families know).<sup>447</sup> The information sharing between agencies enables a bigger picture to be obtained and assists in early intervention.<sup>448</sup>

### Training offered to NSW Health employees

Dr Foley told the Royal Commission that policies are developed within NSW Health in a number of locations and they are primarily developed or overseen by the New South Wales Ministry of Health, although other entities can also develop policies.<sup>449</sup> Once policies are distributed to the LHDs, the LHDs are responsible for ensuring that health workers are aware of them. At the Ministry level and from a state-wide point of view, the Ministry also facilitates the process through training.<sup>450</sup> Training is primarily done online and is supplemented by specialised face-to-face training.<sup>451</sup>

NSW Health is able to monitor staff training through their payroll system, which links training information and enables the Ministry of Health to ensure that staff are undertaking essential training.<sup>452</sup>

Following the release of new policies, staff are encouraged to contact the author of the implementation plan (a lead member of staff), the Child Protection Service within the LHD or the Child Wellbeing Unit if they have any concerns or are unsure of how they should comply with or apply a policy.<sup>453</sup> The Child Protection Service for the NSLHD is located at the RNSH.<sup>454</sup>

## 1.12 Reporting obligations of health practitioners, including medical practitioners

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### Disclosures to health practitioners

The evidence that survivor witnesses gave to the Royal Commission referred to a number of disclosures made to health professionals, including medical practitioners, either before or after they made contact with New South Wales health care regulators.

Dr Stone gave evidence at the hearing about AWB's disclosure of child sexual abuse to the St Ives practice. Dr Stone said he had been oblivious to the fact that such abuse had taken place in another office at the practice. Dr Stone's response to AWB included providing a copy of AWB's medical file to AWB, assistance with the police investigation and being a witness for the criminal proceedings against Dr Rolleston in 2011.<sup>455</sup> Dr Stone said more generally that, having read AWB's statement, 'I very much regret that AWB did not see me as benevolent, helpful, nor as sympathetic to his situation as I felt I was'.<sup>456</sup>

Dr Stone told the Royal Commission of his understanding of mandatory obligations for medical practitioners – namely, if there is evidence of current abuse of a child, there is a requirement for that to be reported.<sup>457</sup> Dr Stone was unclear as to the obligation when an adult reported that they were abused as a child.<sup>458</sup>

## Medical Council

Professor Procopis gave evidence that the Medical Council had a specific role to educate medical practitioners on their mandatory obligations under the National Law in New South Wales.<sup>459</sup> He also referred to the mandatory reporting obligations under the Children and Young Persons Act to report to DOCS where there are grounds to suspect that a child is at risk of harm.<sup>460</sup>

The Children and Young Persons Act also refers to circumstances where a class of children is at risk. Professor Procopis gave evidence that he expected the vast majority of doctors would not know how this provision might apply when an adult reports they were sexually abused when they were a child.<sup>461</sup>

The State of New South Wales submitted that there is insufficient evidence to support a conclusion that doctors generally do not understand the mandatory reporting requirements; rather, they do not understand the more specific issue of reporting of historical child abuse where the reporter believes or knows that the alleged perpetrator is still engaged in professional work involving access to children. In this, the Children and Young Persons Act contains the relevant law.

We accept this submission. We are satisfied that the reporting obligations of medical practitioners in relation to historical child sexual abuse under the Children and Young Persons Act are not well understood by practitioners. Further education and training of medical practitioners is clearly required. The medical practitioner is a key person – and there are, of course, others – in the early identification and reporting of child abuse incidents.

## 2 Allegations of child sexual abuse at the Royal North Shore Hospital by a psychologist

This section of the report examines the experience of an outpatient, Mr Terence Kirkpatrick, who alleged child sexual abuse by Mr Frank Stuart Simpson at the RNSH in the late 1960s. It also examines the response of the RNSH and the Child Health Centre in Ryde, New South Wales (Ryde CHC), to Mr Kirkpatrick's allegation.

### 2.1 The Royal North Shore Hospital

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The RNSH is a public hospital within the legal control,<sup>462</sup> governance<sup>463</sup> and financial support of NSLHD.<sup>464</sup> It is one of the LHDs in the Sydney metropolitan region. The NSLHD is constituted as an LHD under section 17 of the *Health Services Act 1997* (NSW) and has the functions specified in section 10 of that Act, which include conducting and managing public hospitals under its control.<sup>465</sup> The NSLHD has a board comprising appointed board members. The CEO of the RNSH is accountable to the board of the NSLHD.<sup>466</sup>

The NSLHD also has responsibility and accountability for managing all aspects of hospital and health service delivery for its district under a service agreement between the Secretary of the Ministry of Health and the NSLHD CEO and board pursuant to section 126(2)(a) of the *Health Services Act*.<sup>467</sup>

NSW Health policy documents are issued by the Ministry of Health. The NSLHD is required to comply with NSW Health policy directives in relation to health and child safe policies.<sup>468</sup>

#### CJ Cummins Unit, Royal North Shore Hospital

In the late 1960s, the CJ Cummins Unit, informally known as the Roundhouse, was an outpatient facility located on the same premises as the RNSH.<sup>469</sup> It is now an adult mental health inpatient unit located in Building 34 at the RNSH.

### 2.2 Experience of Mr Terence Kirkpatrick

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In 1967, when Mr Kirkpatrick was around 11 years of age, he consulted Dr Spencer at the Ryde CHC for treatment of his asthma. At that time, Mr Kirkpatrick's asthma was identified as being of psychosomatic origin.

In March of that year, he also attended the CJ Cummins Unit of the RNSH, where he was seen by Mr Simpson, a psychologist.<sup>470</sup> Mr Kirkpatrick saw Mr Simpson alone while his mother waited outside the consulting room in the waiting area.<sup>471</sup> Mr Kirkpatrick saw Mr Simpson five times during the period from mid-March 1967 to mid-March 1968.

Mr Kirkpatrick said that Mr Simpson abused him under the guise of 'play therapy', which Mr

Simpson introduced as a treatment for Mr Kirkpatrick's asthma.<sup>472</sup> During the 'play therapy', Mr Simpson made Mr Kirkpatrick sit back in a chair, said words to the effect of 'relax, close your eyes', made Mr Kirkpatrick dress up, photographed him and made him perform oral sex. Mr Simpson abused Mr Kirkpatrick in the same manner on every occasion that Mr Kirkpatrick saw him.<sup>473</sup>

Documents produced by the NSLHD, which included contemporaneous clinical notes and reports, record that Mr Kirkpatrick was seen by Mr Simpson between May 1967 and March 1968.<sup>474</sup> Professor Taylor accepted that a number of consultations took place between Mr Kirkpatrick and Mr Simpson, who identified himself in those notes as a psychologist.<sup>475</sup> However, no employment records relating to Mr Simpson were located for production. While no record of destruction of the employment records was found, Professor Taylor said they were presumed to have been destroyed given their age.<sup>476</sup>

## 2.3 Mr Kirkpatrick discloses his abuse

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### Complaint to the RNSH and Ryde CHC

At one point Mr Simpson unsuccessfully attempted to get Mr Kirkpatrick to meet with him away from the RNSH at the Lane Cove National Park.<sup>477</sup> At that time, Mr Kirkpatrick disclosed to his parents that Mr Simpson has sexually abused him.<sup>478</sup> After this disclosure Mr Kirkpatrick never went back to see Mr Simpson.

In or around 1983, Mr Kirkpatrick again discussed the abuse with his parents. Mr Kirkpatrick said that his father told him that he had reported the matter to the Ryde CHC and the CJ Cummins Unit. His father said that he was told the RNSH would take care of the matter. He was also discouraged from going to the police to spare Mr Kirkpatrick from 'interrogation and all those distressing things'.<sup>479</sup> After Mr Kirkpatrick's father made the complaint, he told Mr Kirkpatrick he did not hear any more about the complaint.<sup>480</sup>

Professor Taylor said that the NSLHD had not been able to locate any records of the notification by Mr Kirkpatrick's father to the CJ Cummins Unit or the Ryde CHC.<sup>481</sup> In relation to this issue, Professor Taylor gave the following evidence:<sup>482</sup>

Q. And you then heard the evidence of Mr Kirkpatrick that his father made contact with Ryde Community Health Centre and the Cummins Unit in 1968 to report the abuse?

A. Correct.

Q. You've indicated in your statement that the Local Health District has not been able to produce any records in relation to that notification?

A. That's correct.

Q. Is it the case that if those records existed, they might have been destroyed?

A. Yes, they could have been destroyed. The other possibility is that there wasn't a written record kept of that contact.

Q. And have you any reason to doubt Mr Kirkpatrick's evidence that, in fact, his father did make a report to the hospital and the Ryde Health Service?

A. I have no reason to doubt it, but in the absence of being able to find proof, I'm just stating the honest situation there. He could well have contacted us, but unfortunately we do not have a written record.

## Disclosure to NSW Police

Mr Kirkpatrick recalled that, between September 1992 and March 1993, he attended a Salvation Army Sexual Assault Counselling Unit at Concord, where he disclosed his abuse in a counselling session and was advised to report the abuse to NSW Police. At the time Mr Kirkpatrick did not feel emotionally strong enough to do so.<sup>483</sup>

However, on or around 8 September 1993, Mr Kirkpatrick made a call to the NSW Police and recorded a complaint as an anonymous caller.<sup>484</sup> Mr Kirkpatrick had not initially intended to make the call anonymously, but during the call he grew increasingly anxious. He began to doubt himself in relation to what he was doing and whether it was going to become public that he was a victim of sexual abuse.<sup>485</sup> He said that it would have assisted him at the time to have discussed his options with NSW Police and to have known what NSW Police could and could not do if he remained anonymous.<sup>486</sup>

## 2.4 Impact of the abuse on Mr Kirkpatrick

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Mr Kirkpatrick described the time of the abuse as a very distressing period for him. Even as a child he had a sense that what was happening was wrong, but he did not have the understanding to know just how or why it was wrong and what to do about it.<sup>487</sup> The abuse shattered his sense of safety and trust as well as the confidence he had in himself and the world around him. He described how the overwhelming sense of bewilderment and helplessness he felt as a child has carried through to his adulthood.<sup>488</sup>

Mr Kirkpatrick explained how his relationship with his mother was impacted as a consequence of the abuse. His mother, acting on the advice of health professionals, forced him to go to see Mr Simpson despite his protestations; this broke his trust in her.<sup>489</sup> Mr Kirkpatrick has continued to have

trust issues in relationships and finds it difficult to share much of himself with other people. Mr Kirkpatrick continues to have strong emotions of guilt, shame and embarrassment associated with his experience of abuse. He did not share his abuse with his children until three years ago, when he found himself too distressed to speak and wrote a letter to tell them about his abuse.<sup>490</sup>

Mr Kirkpatrick's mechanism for coping with the abuse of the past was to keep busy and distracted to refrain from facing the abuse.<sup>491</sup> The coping mechanism of never slowing down, not being at home and playing competitive sports throughout his life impacted on his marriage and ex-wife.<sup>492</sup>

## 2.5 RNSH policies for child safe practices: 1968–1981

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The documents produced to the Royal Commission did not include any child safe policies in force during the period 1968 to 1975. The current CEO of the NSLHD, Professor Taylor, stated that in 1967 and 1968 the RNSH did not have clear policies on child protection and child safety.<sup>493</sup> Professor Taylor also gave evidence that at the time the RNSH had no policies specifically directed to protecting children from the risk of child sexual abuse.<sup>494</sup>

The earliest document produced to the Royal Commission in relation to reporting or notification obligations where there is belief that a child has been sexually assaulted is the Services for Victims of Sexual Assault – Policy and Procedural Guidelines, dated July 1981,<sup>495</sup> which set out the mandatory obligations of doctors to notify the New South Wales Department of Youth Community Services (DYCS) under section 148B of the *Child Welfare Act 1939* (NSW).<sup>496</sup>

## 2.6 Current RNSH policies for child safe practices

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### Reporting sexual assault

#### **Child Related Allegations Policy and Managing Misconduct policy**

Professor Taylor gave evidence about the RNSH Child Related Allegations Policy<sup>497</sup> and the Managing Misconduct policy,<sup>498</sup> which apply to the investigation of complaints or allegations made against a health professional or health worker within the hospital.<sup>499</sup>

The Child Related Allegations Policy provides that employees have an obligation to report their awareness of a child-related allegation. Reports of child sexual abuse must ultimately be reported to the CEO, who is then responsible for notifying the New South Wales Ombudsman. The obligation to report to the CEO is limited to allegations involving current employees of the relevant LHD (and was therefore not applicable to Ms Blyth, as Dr Rolleston was not a current employee at the time of the report).<sup>500</sup>

Professor Taylor also told the Royal Commission that, where an alleged perpetrator is not an employee of the RNSH, staff are encouraged to use the Mandatory Reporter Guide<sup>501</sup> to lead them through the reporting process. If it becomes clear that there is risk of significant harm to a child or a class of children then a report must be made to the Child Protection Helpline and to the CEO.<sup>502</sup>

Other obligations of the CEO when reports on child sexual abuse allegations against an employee are received include:

- conducting an immediate risk assessment of further or ongoing harm to children
- notifying NSW Police where an allegation involves possible criminal conduct<sup>503</sup>
- notifying DFCS where there is a reasonable belief that a child or class of children is at risk of harm.

If the conduct being assessed or investigated would constitute a serious criminal offence, the Child Related Allegations Policy provides that the employee should be suspended pending investigation and a decision should be made as to disciplinary action. Although there is a NSW Health policy concerned with managing misconduct of NSW Health staff, any disciplinary action contemplated against NSW Health staff in respect of a child-related allegation, charge or conviction is to be assessed using the procedure under the Child Related Allegations Policy discussed above.

## Sexual Assault Services Manual

Sexual assault services are provided by all New South Wales area health services. The services offer specialist expertise to people who have experienced sexual assault. The Sexual Assault Services Manual<sup>504</sup> contains the policies for the functions of New South Wales Health sexual assault services.<sup>505</sup>

Professor Taylor gave evidence that the Sexual Assault Services Manual is 'one of a number of policies that we work within'. Section 1.9 concerns reporting to the police. It provides that, where an adult who experiences sexual assault presents to a sexual assault service, the staff member from the sexual assault service will discuss with the person the steps involved in making a complaint to NSW Police.<sup>506</sup>

The Mandatory Reporter Guide leads staff through the reporting process. If it becomes clear there is risk of significant harm to a child or a class of children then a report must be made to the Child Protection Helpline and to the CEO.<sup>507</sup> Professor Taylor told the Royal Commission that the difficulty for staff in reporting to NSW Police is where the adult patient reporting the abuse feels uncomfortable about involving NSW Police.<sup>508</sup>

## Other policies and training

The Child Wellbeing and Child Protection Policies and Procedures for NSW Health<sup>509</sup> requires child protection training for health workers, which the LHDs are responsible for providing. Every new employee that commences with the LHD is required to undertake two hours of training on receiving and responding to reports of child sexual abuse.<sup>510</sup> Furthermore, employees working specifically with children are offered a full-day training program.<sup>511</sup>

In addition to training, the RNSH policy is to bring policies to the attention of staff via email as well as to ensure that managers are responsible for drawing the attention of their staff to new policies, particularly those relevant to a group of staff<sup>512</sup>

## Safety and security for children

Safety and welfare issues in respect of care of children in NSW Health services are dealt with in the policy on Safety and Security of Children and Adolescents in NSW Acute Health Facilities (Safety and Security Policy).<sup>513</sup> That policy outlines the necessary non-clinical aspects of safety and security of children that area health services must address, including:

- designated safe beds for children, which are easily observed and supervised at all times<sup>514</sup>
- accommodating children admitted to acute health facilities separately from adult patients
- separating bathroom or recreational facilities used by children and adult patients
- mandatory child-related screening of employees, and ensuring staff receive education and training in the protection of children and young people
- the requirement that staff avoid being alone with paediatric patients in situations that involve intimate procedures.

In respect of the security of children and adolescents in hospital, the Safety and Security Policy provides that area health services must ensure guidelines are in place that address security issues, including:

- the need to identify custodial parents/guardians
- authorisation for removal of children from the ward
- Care of Children under Orders in a ward or hospital.

## Employment screening and supervision

Pre-employment and ongoing screening of health professionals working at the RNSH<sup>515</sup> occurs in accordance with various policy directives. These include the policies on Recruitment and Selection of Staff of the NSW Health Service<sup>516</sup> and Employment Checks – Criminal Record Checks and Working with Children (WWC) checks.<sup>517</sup> The relevant policies provide the framework in which:

- identity checks, WWC checks and referee checks are conducted for all applicants
- WWC checks are mandatory for all NSLHD staff, regardless of whether they are in child-related work<sup>518</sup>
- registration of medical practitioners must be verified through AHPRA. Where practice conditions are imposed, the NSLHD reports those medical practitioners to the Ministry of Health and notification is also made to other relevant bodies and the CEO
- the registration status of health professionals is checked on an ongoing basis and, in accordance with the NSW Health Code of Conduct, it is the obligation of health professionals to disclose if they are charged or convicted of a serious offence.

In respect of psychologists, Professor Taylor also gave evidence that all psychologists must be registered with the Psychology Board of Australia and proof of current registration is checked during the NSLHD recruitment process.<sup>519</sup>

The Principal Psychologist engaged at the NSLHD is responsible for providing professional and clinical guidance to psychologists within the LHD.<sup>520</sup> Supervision of psychologists is provided through their clinical units, and the Principal Psychologist assists and facilitates organisation of supervision and professional development.<sup>521</sup>

### One-on-one contact between health professionals and children

Professor Taylor said it was considered a matter of clinical judgment whether a child was seen by a health professional on a one-on-one basis. Relevant factors cited included the age of the child, the presenting problem, diagnosis and the nature of the workplace.<sup>522</sup>

Specifically in relation to psychologists, Professor Taylor told us it was considered a part of a health professional's duty of care to conduct a thorough assessment and that establishing a therapeutic relationship with a child or adolescent in which he or she feels understood and heard was a key part of psychological practice, assessment and treatment. She said that, for the purpose of comprehensive psychological assessment and treatment, it was therefore standard clinical practice for a child, particularly a child over five, to be seen individually if it is clinically indicated. Children younger than five may also be seen individually if indicated.<sup>523</sup>

Professor Taylor also stated that any one-on-one consultation would be in combination with the child being seen with their parents, in family therapy or in group therapy sessions as indicated.<sup>524</sup>

Professor Taylor also reported that, in the recently rebuilt RNSH facility, children would now be assessed and treated in rooms which have viewing windows.<sup>525</sup>

## 3 Allegations of child sexual abuse at The Royal Children’s Hospital, Melbourne, by volunteers

This section examines allegations of child sexual abuse by volunteers at The Royal Children’s Hospital, Melbourne (RCHM), including Mr Harry Otto Pueschel, in the early 1980s. The allegations were made by AWI, a former inpatient of the RCHM. The section also examines the RCHM’s response to AWI’s allegations.

### 3.1 The Royal Children’s Hospital

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The RCHM is a major specialist paediatric hospital in Victoria. It provides a full range of clinical services, tertiary care and health promotion and prevention programs for children and young people.<sup>526</sup> The RCHM cares for and treats children from Victoria as well as from other Australian states and other countries.<sup>527</sup> In particular, the RCHM provides the Victorian Forensic Paediatric Medical Service (with Southern Health and Victorian Institute of Forensic Medicine) assessment and care for abused, assaulted and neglected children and adolescents.<sup>528</sup>

In the 1980s, the RCHM was located at Parkville, Victoria. In 2011, the new RCHM opened on an adjoining site, also in Parkville. Since that time the RCHM has operated as a public–private partnership under the state government’s Partnerships Victoria model.<sup>529</sup> The public sector (RCHM) operates the hospital and provides all core clinical services, while the private sector (Children’s Health Partnership) provides finance, design, construction and maintenance of the new hospital building.<sup>530</sup>

The RCHM has within its premises the Gatehouse Centre, where children who have suffered physical or sexual abuse are taken and cared for by persons with the relevant skills and expertise.<sup>531</sup>

#### External governance

As a public hospital, the RCHM’s relationship with the Victorian Department of Health & Human Services (DHHS) and Victorian public health services is governed by the *Health Services Act 1988* (Vic).<sup>532</sup> The Act lists it as a public health service and prescribes its powers and duties.<sup>533</sup>

Victorian public health services are independent legal entities established as incorporated statutory authorities under section 65P of the Health Services Act. Positioned at arm’s length from the government, they have a separate legal status and are not part of the Crown.<sup>534</sup>

Public health services are governed by a board of directors, the members of which are appointed by the Governor-in-Council on the recommendation of the Minister for Health.<sup>535</sup> As part of the devolved governance model, under the provisions of the Health Services Act public health services are subject to governance and contractual arrangements with the Minister and the Secretary of the department.<sup>536</sup>

The DHHS has a role in monitoring the performance of public health services, with expectations articulated primarily in the Statement of Priorities or service agreements. The Victorian health

services performance monitoring framework is the key source of information about how the DHHS monitors the performance of health services and works with them to improve performance.<sup>537</sup>

Dr John de Campo was the CEO of the Women's & Children's Health Care Network (WCHCN).<sup>538</sup> Dr de Campo gave evidence in the public hearing.

Professor Christine Kilpatrick is the current CEO of the RCHM and has held that position since 18 August 2008. Professor Kilpatrick also gave evidence in the hearing.<sup>539</sup>

## Internal governance

The RCHM has its own board of management. The RCHM board is appointed by the government but governs the RCHM. The RCHM is constituted as a separate legal entity.<sup>540</sup> The RCHM board has to coordinate and work with governments and within their budgets, but the RCHM board has control and management over what occurs within the RCHM.<sup>541</sup> The RCHM board is significantly dependent on the CEO to ensure that matters are attended to promptly and adequately.<sup>542</sup>

## Volunteers

The Volunteer Service of the RCHM supplements the hospital's ordinary services to its patients.<sup>543</sup>

Volunteers assist in many areas of the RCHM. Assignments include assisting in casualty departments, manning administration and enquiry desks, conducting tours of the hospital, assisting in the general clinic area by directing quiet play and entertaining children, delivering daily educational feedings for infants to the wards, assisting in compiling historical registers of patients treated and escorting patients to their areas of appointment.<sup>544</sup> Records of volunteers are kept by the RCHM and include the volunteer register and files. There are detailed guidelines for RCHM volunteers.<sup>545</sup>

## RCHM Auxiliaries

The RCHM Auxiliaries is a fundraising arm of the RCHM and its role is mostly based outside of the RCHM. For example, there may be fundraising arms in Melbourne or in regional centres like Ballarat.<sup>546</sup> The administrative base of the Auxiliaries Office is physically located at the RCHM address on Flemington Road in Parkville, Victoria. Correspondence from the Auxiliaries Office is written on RCHM letterhead.<sup>547</sup>

The Auxiliaries Coordinator is responsible for coordinating the different fundraising objectives. The Auxiliaries Coordinator was responsible for coordinating the multiple community-based auxiliaries for the RCHM. The Auxiliaries Coordinator would not have access to or knowledge of the RCHM volunteer file or register.<sup>548</sup>

## 3.2 Experience of AWI

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AWI, a former inpatient of the RCHM, gave evidence at the public hearing about her sexual abuse by volunteers in the early 1980s.

As a child, AWI suffered from chronic asthma<sup>549</sup> and had been admitted to RCHM on a number of occasions for treatment and management of asthma. From about May to October 1981, when AWI was 12 years old, AWI was admitted to Ward 8 East of the RCHM, which was predominantly occupied by patients who were being treated for asthma and cystic fibrosis.

As an inpatient in Ward 8 East, AWI was introduced to two volunteers – AWK and Mr Pueschel. AWI would go to the playroom, where she would be met by Mr Pueschel. AWI said that in the playroom Mr Pueschel would touch her over her clothing on her breasts and stroke up and down over her breasts. AWI said that she could feel Mr Pueschel was erect.<sup>550</sup> This occurred a few times a week during the nurses' handover while she was in Ward 8 East of the RCHM.<sup>551</sup> AWI said the molestation by Mr Pueschel only ceased when AWI was moved from the ward after contracting a golden staph infection.

AWI said she was also sexually abused by a young male volunteer one evening when the patients from Ward 8 East were sent to play games in the section of the RCHM that was for physiotherapy and outpatient consultations. During a game of 'sardines', the volunteer had said, 'you have to be really quiet because of the game. We can't have other people hearing us'. The volunteer pulled her body close to him and touched her genitals. The volunteer had his hands over his erection and tried to penetrate AWI with his fingers until he ejaculated.<sup>552</sup> AWI was unable to name the volunteer.

### AWI discloses her abuse

In 1984, when AWI was 16 years old, she telephoned the RCHM intending to report her abuse. AWI was put on hold. During the waiting time, AWI lost her confidence and hung up on the call.

In 1985, AWI spoke of her abuse to Antioch – a Catholic youth group of peers – and then to her family. She was encouraged to report the abuse. In 1997, AWI reported the abuse by Mr Pueschel to the then CEO of the RCHM, Dr de Campo, by email.

### Impact of the abuse on AWI

AWI said that the sexual abuse at RCHM has given her a long-term fear of hospitals, obtaining medical treatment and dealing with medical staff. At the age of 17, AWI had an accident in the city and an ambulance was called. AWI was so fearful of being treated in a hospital setting that she insisted on her friend staying with her.<sup>553</sup> As an adult, when AWI walked into the RCHM for work purposes, it triggered an anxiety attack for AWI.<sup>554</sup>

The sexual abuse at RCHM resulted in AWI being self-conscious and having intimacy issues with men throughout her life.<sup>555</sup> The relationship with her family, particularly with her father and mother, has also been awkward, and showing natural physical affection is difficult.<sup>556</sup> AWI has had trouble sleeping at night and has suffered from bouts of depression, frustration and anger in the past.<sup>557</sup> AWI suffered a mental breakdown following the death of her father. Her anxiety became extreme, with regular uncontrollable panic attacks and outbursts of hot sweats.<sup>558</sup>

AWI has had thoughts about committing suicide and has at times written various suicide notes documenting her haunting memories. It was only with an extended period of hospitalisation that AWI's medications managed to bring the suicidal thoughts and anxiety under control.<sup>559</sup>

AWI hoped that as a consequence of the Royal Commission's inquiry she would be able to look forward to the future and a life of good memories instead of having the past haunt her.<sup>560</sup>

### 3.3 AWI reports her abuse to the RCHM

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On or around 15 December 1997 AWI sent an email to Dr de Campo.<sup>561</sup> In the two-page email she:

- sought assistance and support from the RCHM in dealing with the child sexual abuse that occurred 16 years earlier
- asked the RCHM to commission an investigation to find out if the alleged perpetrator was still working with children or whether charges had been pressed by any other victims
- set out her suspicion that there was at least one other female victim
- disclosed that the alleged perpetrator was identified by the first name 'Harry'
- stated that he frequented the ward with another man, AWK.

In this email, AWI asked the RCHM to 'respect my confidence and FIND this man to ensure that he is no longer working with children/adolescents'. AWI gave her email address and contact phone number for further communications. She did not provide her full name but wrote that she would be happy to provide it over the telephone. AWI provided the names of hospital staff members she recalled working at the RCHM at the time.

### 3.4 RCHM's handling of AWI's complaint

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#### Dr de Campo's emails

In an undated email, likely to have been sent between 15 and 16 December 1997, Dr de Campo replied to AWI.<sup>562</sup> His email informed AWI that an investigation had commenced with 'very senior staff, including experts in the area' and that having her full name would be of some assistance.

On or about 17 December 1997 AWI wrote back to Dr de Campo.<sup>563</sup> The email informed Dr de Campo that AWI ‘wanted some revenge’ and felt ‘strong and confident enough’ to ‘put the wheels in motion’. AWI disclosed her full name to assist with the investigation and stated that she hoped that the RCHM had by this time identified ‘Harry’ and started a thorough investigation. AWI reiterated, ‘I will be happy to assist you in any way to try and track down the man in question and if you have any questions I will try to answer’. In this email, AWI identified further members of the hospital staff during her time as an inpatient of the hospital.

On or about 17 December 1997 Dr de Campo wrote to AWI and stated, ‘The full name of Harry is being investigated. I hope that the clinical staff will know more. I will keep you posted’.<sup>564</sup>

On 24 December 1997 a Victoria Police document entitled Child Exploitation Squad – Information Report (the Information Report) recorded a telephone call from an informer from the Gatehouse Centre, RCHM.<sup>565</sup> The document stated the name of AWI as the complainant of indecent assault by a volunteer she knew as ‘Harry’. It also noted the Gatehouse Centre contact had been asked to attempt to have AWI meet investigators from the Victoria Police.

While the Information Report stated the suspect’s name as Harry Otto Pueschel, it also recorded the following:

‘HARRY’ has not yet been positively identified but all information tends to point towards a current serving volunteer at the hospital. Given that this person has been at the hospital for many years the potential for numerous victims is high. At this stage, the following suspect has been stood down from the hospital. This person has not been informed of the reasons for his [suspension].

On or around 24 December 1997 Dr de Campo emailed AWI and advised her to contact him.<sup>566</sup> There is no record in this email of the request from Victoria Police that the RCHM should attempt to have AWI meet police investigators. There is no record in this email that Mr Pueschel had been identified or stood down.<sup>567</sup>

On 19 January 1998 Dr de Campo emailed AWI.<sup>568</sup> There is no record in this email of the request from Victoria Police that the RCHM attempt to have AWI meet police investigators. There is no record in this email that Mr Pueschel had been identified or stood down. The email stated, ‘I don’t believe there is any prospect of court action [and] the associated publicity because identification and proof are very difficult’.<sup>569</sup>

### AWI requests an internal investigation

In the email of 15 December 1997, AWI asked Dr de Campo to ‘commission an investigation to find out if he is still working with children or in any event to let me know if someone else has ever pressed charges against him’.<sup>570</sup> To assist Dr de Campo, AWI also provided the names of the ‘play

specialist', Pat, and a senior nurse, Sister Lawrence.<sup>571</sup> AWI also identified a psychologist named Sarah, Dr Landau and Dr Phelan as persons whom she recalled from the RCHM at the relevant time.<sup>572</sup> The RCHM produced no documents recording Dr de Campo or any other person from the RCHM speaking to staff about AWI's allegations.

Dr de Campo accepted that he never put AWI's allegations of child sexual abuse to Mr Pueschel.<sup>573</sup> Dr de Campo accepted that there was no evidence at all that RCHM staff ever confronted Mr Pueschel with the allegations.<sup>574</sup>

Dr de Campo told the Royal Commission that at no time during his tenure as CEO did the RCHM investigate the events that took place in 1981. Further, no investigation was made of the screening process of Mr Pueschel and there was no investigation of what management processes within the RCHM could be improved to prevent the situation from recurring.<sup>575</sup>

Dr de Campo told of his own uncertainty over whether he had made any searches or investigations to find out whether there were any other children who may have reported abuse by 'Harry' during the 1980s.<sup>576</sup>

We are satisfied the RCHM did not conduct an internal investigation of AWI's allegations of child sexual abuse that occurred in the early 1980s.

### RCHM's dismissal letter to Mr Pueschel

On 21 January 1998, Dr de Campo provided a letter to Mr Pueschel terminating his services as a volunteer.<sup>577</sup> The letter made no reference to allegations of child sexual abuse made against Mr Pueschel. The letter gave the following reasons for terminating Mr Pueschel's services as a volunteer:

- 'giving of a significant gift to a patient and personal involvement with patients and/or families'
- 'printed personalised cards which have been handed out at the hospital'
- 'prior to the Christmas break you failed to record your departure time and return your identification badge'
- 'having regard to the aforementioned breaches of the Volunteer Service guidelines, I must advise that your services as a volunteer attending the Hospital will not be required in the future'.

In his evidence to the Royal Commission, Dr de Campo accepted that AWI's allegations related to serious criminal conduct<sup>578</sup> and that they were 'substantial, serious and significant'.<sup>579</sup>

The Victoria Police Information Report indicates that, at least by 24 December 1997, the RCHM was aware of the identity of the suspected perpetrator.<sup>580</sup> However, Mr Pueschel's termination letter on 21 January 1998 made no reference to AWI's allegations.<sup>581</sup>

Dr de Campo told the Royal Commission that he signed Mr Pueschel's termination letter on 21

January 1998 and that the reason it made no reference to the allegations by AWI<sup>582</sup> was that he 'assumed' the letter sought not to 'tip off' Mr Pueschel.<sup>583</sup>

Dr de Campo accepted that, in terminating the services of Mr Pueschel as a volunteer in the manner the hospital did, it left open the possibility that Mr Pueschel could work elsewhere as a volunteer.<sup>584</sup>

We are satisfied that Dr de Campo's letter of dismissal of Mr Pueschel did not state all of the reasons for the dismissal and made no reference to AWI's serious allegations of child sexual abuse being a reason.

### Mr Pueschel returns to the RCHM ward

Despite Mr Pueschel's dismissal in January 1998, it came to the attention of the hospital that he had been able to access the ward area of the hospital again by July 1999.

On 1 July 1999, Ms Sally Watson, Auxiliaries Coordinator of the RCHM Auxiliaries Office, wrote to Mr Tony Browne, Network Executive Director. In the letter she referred to a telephone call from Ms Griffiths, the Volunteer Coordinator, who said:

[I am] rather concerned that Harry had accessed the ward area by stating that he had been given permission by one of my staff. This being not true, and due to Harry's history, which is obviously not conducive to understanding his boundaries within the hospital I have taken the matter in hand on the auxiliary side of things.<sup>585</sup>

Further, Ms Watson informed Mr Browne she had spoken to the head of the Auxiliaries and advised that 'when she is contacted by Harry, to say that the auxiliary isn't doing anything at the present time, and that if there are any problems with his persistent manner to refer him to me'.<sup>586</sup>

The evidence before the Royal Commission did not disclose how long Mr Pueschel had remained on the ward or the circumstances in which he left or was otherwise removed.

Dr de Campo accepted that after 21 January 1998 Mr Pueschel was back at the RCHM and that Mr Pueschel had accessed a hospital ward area by stating he had been given permission.<sup>587</sup> Dr de Campo told the Royal Commission that these facts were not known to him during his tenure as the CEO.<sup>588</sup> Dr de Campo said that he first became aware of this issue when the Royal Commission provided him with documents to assist with the preparation of his statement.<sup>589</sup> He said he had no recollection of Mr Browne discussing the letter dated 1 July 1999 with him. Dr de Campo was the CEO in and around July 1999.<sup>590</sup>

We are satisfied Mr Pueschel was able to access the RCHM ward area after his dismissal and that there was no adequate system in place to prevent that access. It is obvious that this should not have been allowed to happen.

The RCHM did not produce any documents to the Royal Commission recording Mr Pueschel being

terminated as a member of the RCHM Auxiliaries following the letter of 1 July 1999 or AWI's allegations against Mr Pueschel.

Furthermore, the RCHM produced no documents to the Royal Commission recording any investigation being conducted regarding the ward Mr Pueschel may have accessed and whether there was any risk to children in the ward in or around July 1999.<sup>591</sup> Dr de Campo was asked whether there was any investigation to find out who he had accessed on the ward or if there were any risks to children on the ward. Dr de Campo said that there had not been.<sup>592</sup> We are satisfied that no investigation was conducted and no such risk assessment was made. They should have been.

## Victoria Police

A Victoria Police Information Report records a request by police investigators on 24 December 1997 to the Gatehouse Centre informer, 'to attempt to have AWI meet investigators from this office'.<sup>593</sup>

Documents produced by the RCHM do not record the Victoria Police request being communicated to AWI.

We are satisfied that, in circumstances where Dr de Campo accepted the allegations made by AWI related to serious criminal matters requiring a police investigation<sup>594</sup> and given the significant role the RCHM and the Gatehouse Centre have in assisting children who have been sexually abused, the RCHM staff ought to have appreciated the significance and importance of this request to initiate and progress the Victoria Police investigation.

We are also satisfied there were a number of early opportunities available to the RCHM to inform AWI of the request from Victoria Police to have AWI contact them, including in correspondences dated on or around 17 December 1997, 24 December 1997 and 19 January 1998.

The evidence before the Royal Commission indicates the RCHM informed the police at an early stage about the allegations that AWI made. However, we are satisfied the RCHM failed to convey to AWI the request from the police, at an early opportunity, to have AWI contact them about the allegations of child sexual abuse.

## RCHM's representations to AWI

Dr de Campo accepted that, in his email to AWI on 24 December 1997, he did not inform AWI that Mr Pueschel had been identified and stood down. When viewed in retrospect, Dr de Campo said he should have informed AWI.<sup>595</sup>

In Dr de Campo's email to AWI on 19 January 1998 he wrote, 'I don't believe there is any prospect of court action and the associated publicity because identification and proof are very difficult'.<sup>596</sup> In his evidence at the hearing, Dr de Campo accepted that it was not correct on 19 January 1998, when

sending the email, that the identification of Mr Pueschel was difficult. He gave the following evidence:

Q. Now, Doctor, it's simply not right, is it, that identification is difficult in this case?

A. No, I don't think so. On reflection, I don't think so.

Q. To suggest that identification was difficult in this case misrepresents the situation to AWI, doesn't it?

A. It is said in a context, like everything. You will recall that in her earlier letters, which we've already discussed, she was hesitant about moving forward. That sentence balances the one before it, I think. The sentence before is, 'We have involved the police' – so that might have been concerning to AWI. It turns out it was good for her, but it might have been concerning. I couldn't judge that, obviously. The second sentence is like a balance to that. We've gone to the police, that might be worrying her. The balancing sentence is the one you have just read out. It's to give a balanced reply to a person I have never seen, who I'm not sure which things will worry her and which things won't worry her, but I need to convey information so that it is balanced and not – it is of course different if you are talking with someone, but in a delicate situation, I wanted to give a balanced reply so that she doesn't think one thing or the other and, as we know, she didn't see it anyway, but that is, I think, the reasonable purpose of that email, again, taken as a whole, not word by word.<sup>597</sup>

In relation to Dr de Campo's statement that 'I don't believe there is any prospect of court action',<sup>598</sup> Dr de Campo accepted that as a medical practitioner he was not in a position to give AWI legal advice on the prospects of a criminal prosecution or the success of any civil litigation.<sup>599</sup> Dr de Campo gave the following evidence:

Q. And you would agree, in saying in this email, 'I don't believe there is any prospect of court action', that might have been discouraging AWI to take any action in relation to the police or courts?

A. It may have been, but you will see that I wanted to visit – I wanted her to speak to me about other matters and this email. So whilst we are examining it sentence by sentence, the email stands as a whole in my mind and I – as you have pointed out, I am not a lawyer, but, taken as a whole, it was an engaging email to say, 'Can I meet you? This is where we are up to.' It wasn't meant to be a summary, but an engagement and 'I want to meet you' email.

Q. So do you agree that stating, 'I don't believe there is any prospect of court action', et cetera – do you agree that that is a discouragement to AWI to pursue those avenues?

A. Taken by itself, yes.<sup>600</sup>

We are satisfied that Dr de Campo's email to AWI of 19 January 1998 was not correct. The identification of Mr Pueschel was not difficult.<sup>601</sup> Dr de Campo's comments to AWI concerning potential for court action were inappropriate when Dr de Campo was not professionally qualified to give AWI legal advice on the prospects of a criminal prosecution or the success of any civil litigation.<sup>602</sup> He should not have done so.

While Dr de Campo accepted that the comments made to AWI were incorrect, he did not accept that they misrepresented the situation. He said that his statements were motivated by a concern not to worry AWI and that he wanted to provide her with a balanced reply.<sup>603</sup> We do not accept this explanation.

We are satisfied that Dr de Campo represented incorrectly to AWI that the identification of the alleged perpetrator/volunteer was a difficult matter.

We are also satisfied that Dr de Campo was wrong to tell AWI that he did not believe there was 'any prospect of court action'.

## 3.5 Overview of RCHM's current policies, practices and guidelines

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### Recruitment, screening, Working with Children checks, health and mental wellbeing checks for volunteers

The RCHM Application to Volunteer form<sup>604</sup> requires prospective volunteers to provide their personal details, referee details, work experience and availability. The application form also requires applicants to declare their acceptance of Conditions of Becoming a Volunteer, which are set out in the application. Those conditions include the ability to maintain professional boundaries, a willingness to acquire a Victoria Police check and a willingness to acquire a WWC check.

Volunteer applications are assessed against the RCHM Volunteer Application Assessment form, which sets out the items to be assessed in each volunteer application. The first stage considers the application received and a score system is applied to determine whether the applicant proceeds to an interview. The interview stage also uses a score system (considering matters such as 'demonstrated people skills and teamwork' and 'demonstrates a capacity to follow our values of respect, integrity, excellence and unity') to determine whether the applicant is invited to training.<sup>605</sup> The RCHM Volunteers Visiting Program (VVP) Procedure requires the Volunteer Coordinator to keep all details on a database.<sup>606</sup> Interested volunteer groups approved for the VVP enter into a Volunteer Service Agreement, which outlines the relationship between the RCHM and the relevant Volunteer Group and provides that the Volunteer Group must notify RCHM if it becomes aware of anything which may impact on the appropriateness of a particular visiting volunteer, including any criminal investigation or charges.<sup>607</sup>

The Volunteer Handbook<sup>608</sup> lists the volunteers' rights and responsibilities. Volunteers are required to register at the beginning and end of each shift and it is mandatory for volunteers to wear an identity badge and lanyard at all times while in the hospital. The same procedure also applies to Visiting Volunteers, as set out in the VVP Procedure.<sup>609</sup> RCHM staff are required to be aware of the Volunteer Groups that should be in attendance in their area on any particular day and to refuse access to any Visiting Volunteer not approved for attendance.<sup>610</sup>

The Agreement Visiting Volunteers Program<sup>611</sup> sets out guidelines for the VVP and individual volunteers, and expectations of volunteers, including that they must wear photo identification at all times and boundaries are to be exercised with patients and their families.

For all staff, students, volunteers, observers, contractors and honorary appointments, a National Police Record Check and a WWC check are required before commencing employment at the RCHM. Under the VVP Procedure, interested Volunteer Groups approved for the VVP enter into a Volunteer Service Agreement.<sup>612</sup>

### Use of badges, record of wards visited and volunteer register

All staff (including volunteers) and authorised visitors must wear identification badges on an RCHM lanyard displaying the employee/volunteer's photo, name, position, department and employee number at all times on RCHM premises.<sup>613</sup>

The Security procedure<sup>614</sup> also outlines the access levels at RCHM. The hospital has adopted an open-door policy for general access areas across the hospital for all staff. Wards are open to the public during business hours (7 am to 7 pm). The majority of visitors to the hospital, including the general public, do not require security access. The majority of staff have general-level access, with access to high-risk areas provided only to staff specifically credentialed to work in specified risk areas.

### Supervision and management of volunteers on hospital premises

The Professional Boundaries Procedure<sup>615</sup> applies to all employees, students and volunteers. It sets out limits which protect the boundaries between the power of the RCHM staff and the patient's vulnerability. The Code of Conduct (Policy)<sup>616</sup> specifies the behaviours expected of employees and volunteers, based on the hospital's values of unity, respect, integrity and excellence. The code specifies the responsibility of employees and volunteers to abide by applicable legislation, the Code of Conduct and the RCHM policies and procedures.

## Handling of child sexual abuse complaints and child safe practices

### Incident and complaints reporting

The Incident Reporting and Management (Procedure)<sup>617</sup> and the Critical Incident Review Process (Procedure)<sup>618</sup> require all incidents, including complaints, to be reported through Victorian Health Incident Management System (VHIMS) within 24 hours of occurrence. Managers will be notified of all incidents reported by staff under their management, and the managers are to review all incidents within two working days.

The Consumer Feedback Procedure<sup>619</sup> identifies VHIMS as the reporting system on which a complaint, compliment or enquiry is to be entered within 48 hours of receipt.

The Open Disclosure (Procedure)<sup>620</sup> provides for an open, consistent approach to communicating with patients, families and carers following a clinical incident. It includes expressing regret for what has occurred as early as possible, keeping the patient and their family informed and providing feedback on investigations and steps taken to prevent an event from recurring.

### Misconduct

The Performance Management and Disciplinary Procedure<sup>621</sup> defines misconduct as a wrong or improper act that usually involves something more than a mere error of judgment or innocent mistake, including a failure to act in accordance with required standards of behaviour. Serious misconduct includes serious, significant breaches of RCHM policy, including the Code of Conduct. Under the procedure, managers make a preliminary assessment where a complaint about an employee is made.

Where an investigation is required, the matter is reported to the divisional Executive Director. In cases of serious misconduct, the RCHM may elect to summarily dismiss an employee.<sup>622</sup> If serious misconduct is alleged, an employee may be stood down pending a meeting with the employee. In that meeting the employee is asked to respond to a written outline of the allegations.

RCHM is expected to make a decision on whether to dismiss the employee or to take other action within 48 hours following the meeting with the employee. The RCHM provides the employee with its written decision, which is to be placed on the employee's file.

In the case of complaints of serious misconduct against medical practitioners, this procedure provides that RCHM must conduct an investigation and allow the practitioner an opportunity to be heard by the board.<sup>623</sup>

## Vulnerable children

The Vulnerable Children Policy<sup>624</sup> governs the RCHM's provision of services to vulnerable babies, children and young people at risk of harm by abuse or neglect and to their families. The policy deals primarily with the clinical management of child patients who may have suffered from child abuse or neglect. In relation to mandatory notification to Child Protection Services, the policy refers to the legislative requirements under the *Children, Youth and Families Act 2005 (Vic)* (CYFA). Professionals other than those mandated under the CYFA are encouraged to notify Child Protection Services when the professional believes that a child is in need of protection and to notify Child FIRST when there are concerns about a child's wellbeing.

The policy notes that all the RCHM departments are required to make a coordinated response, and clear and accessible procedures and guidelines are available to inform decision-making and facilitate referral. This policy is supported by the Vulnerable Children – RCHM Procedure for Suspected Child Abuse<sup>625</sup> and Vulnerable Children – Management of Known Sex Offenders at RCHM.<sup>626</sup>

The RCHM Handbook Child Abuse and Neglect<sup>627</sup> defines the type of abuse children can be subjected to and includes a direction regarding mandatory reporting to Child Protection Services if there are reasonable grounds to believe a child is at risk of sexual abuse.

## Supervision and monitoring

The Supervision and Movement of Inpatients across the RCHM and Access to Inpatient Areas (Procedure)<sup>628</sup> provides generally for the access of guardians and visitors to inpatient areas, the supervision and monitoring of patients by clinical staff, and the transfer of unaccompanied patients between RCHM departments.<sup>629</sup>

## Suspected child abuse

The VFPMS Guidelines for Forensic Evaluation of Suspected Child Abuse<sup>630</sup> set out procedures and priorities to assist decision-making in clinical situations when child abuse and neglect are suspected. The guidelines outline that 'at risk children' are considered in four categories:

1. physical harm / non-accidental injury
2. sexual harm / sexual abuse
3. neglect
4. vulnerable child / at risk of abuse.

The guidelines recognise that these risk categories may coexist.<sup>631</sup> The VFPMS – How to Refer<sup>632</sup> sets out the procedures to refer suspected physical and sexual abuse to the VFPMS.

## Mandatory reporting and notification

The GACE Assessment Policy<sup>633</sup> governs the assessment of patients presenting to the Gatehouse Centre and details the processes that Gatehouse Centre staff must observe when engaging with external agencies. The policy notes that the Gatehouse Centre works collaboratively with Victoria Police and DHHS Child Protection in relation to mandatory reporting.<sup>634</sup>

The policy provides, firstly, that Gatehouse Centre staff are to notify DHHS Child Protection of information they become aware of in the course of clinical services which may impact upon the safety of children, young people and families. It notes that clinical reports may be provided to DHHS Child Protection on issue of a subpoena for court proceedings.<sup>635</sup>

The Notification to DHS [Department of Human Services] – Child Protection Policy (Gatehouse Centre)<sup>636</sup> records the processes for notification of suspected child abuse or neglect to DHHS Child Protection under the *Children and Young Persons Act 1989* (Vic) (now repealed). The policy indicates that the Gatehouse Centre supports the need for all professionals to consider notification, whether mandated or not, where there is a belief that a child or young person is or may be in need of protection from sexual abuse or physical injury which results from abuse or neglect.

The Procedure for Referral between VFPMS and Gatehouse Centre (Draft) (Work practice/ protocol)<sup>637</sup> is currently in active trial. The RCHM consults with VFPMS and the Gatehouse Centre on child sexual abuse allegations or complaints. In its present form, it applies to referrals between VFPMS and the Gatehouse Centre in respect of children referred to the RCHM in relation to sexual assault or sexual abuse.

## Information exchange and communication

The MOU between DHHS and the RCHM<sup>638</sup> acknowledges that the child's best interests and their professional responsibilities will guide information exchange and ongoing communication, with due reference to the family's privacy rights and relevant legal obligations. It notes the preferred practice is for DHHS Child Protection to obtain parental consent for release of medical information about a child; however, it also notes that the release of information by the RCHM to DHHS Child Protection in accordance with CYFA does not constitute a breach of privacy/confidentiality.

## 4 Systemic issues

This case study provided the Royal Commission with insights into systemic issues within its Terms of Reference in the area of institutional response to concerns and allegations about incidents of child sexual abuse.

In particular, the systemic issues arising from this case study were:

- Understanding the scope and impact of child sexual abuse.
- What health settings are particularly vulnerable to offending and why?
- What environments encourage or facilitate offending?
- Arrangements within the health care services and health care regulators to facilitate and receive reports or disclosures of child sexual abuse or concerning conduct; and to apply the outcomes of investigations to systems improvement.
- Arrangements within health care services and health care regulators to report incidents to external agencies.
- Arrangements within health care services and health care regulators to respond to victims and their families, and to the relevant community.
- Arrangements within health care services and health care regulators to respond to those accused of child sexual abuse.
- Arrangements within health care services and health care regulators to respond to historical claims of child sexual abuse.
- The health care regulatory regimes scope of reporting obligations in the health care regulatory regimes framework for reporting to external agencies and information exchange between the relevant bodies.

# APPENDIX A: Terms of Reference

## Letters Patent dated 11 January 2013

ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth:

TO

The Honourable Justice Peter David McClellan AM,  
Mr Robert Atkinson,  
The Honourable Justice Jennifer Ann Coate,  
Mr Robert William Fitzgerald AM,  
Dr Helen Mary Milroy, and  
Mr Andrew James Marshall Murray

GREETING

WHEREAS all children deserve a safe and happy childhood.

AND Australia has undertaken international obligations to take all appropriate legislative, administrative, social and educational measures to protect children from sexual abuse and other forms of abuse, including measures for the prevention, identification, reporting, referral, investigation, treatment and follow up of incidents of child abuse.

AND all forms of child sexual abuse are a gross violation of a child's right to this protection and a crime under Australian law and may be accompanied by other unlawful or improper treatment of children, including physical assault, exploitation, deprivation and neglect.

AND child sexual abuse and other related unlawful or improper treatment of children have a long-term cost to individuals, the economy and society.

AND public and private institutions, including child-care, cultural, educational, religious, sporting and other institutions, provide important services and support for children and their families that are beneficial to children's development.

AND it is important that claims of systemic failures by institutions in relation to allegations and incidents of child sexual abuse and any related unlawful or improper treatment of children be fully explored, and that best practice is identified so that it may be followed in the future both to protect against the occurrence of child sexual abuse and to respond appropriately when any allegations and incidents of child sexual abuse occur, including holding perpetrators to account and providing justice to victims.

AND it is important that those sexually abused as a child in an Australian institution can share their experiences to assist with healing and to inform the development of strategies and reforms that your inquiry will seek to identify.

AND noting that, without diminishing its criminality or seriousness, your inquiry will not specifically examine the issue of child sexual abuse and related matters outside institutional contexts, but that any recommendations you make are likely to improve the response to all forms of child sexual abuse in all contexts.

AND all Australian Governments have expressed their support for, and undertaken to cooperate with, your inquiry.

NOW THEREFORE We do, by these Our Letters Patent issued in Our name by Our Governor-General of the Commonwealth of Australia on the advice of the Federal Executive Council and under the Constitution of the Commonwealth of Australia, the *Royal Commissions Act 1902* and every other enabling power, appoint you to be a Commission of inquiry, and require and authorise you, to inquire into institutional responses to allegations and incidents of child sexual abuse and related matters, and in particular, without limiting the scope of your inquiry, the following matters:

- a. what institutions and governments should do to better protect children against child sexual abuse and related matters in institutional contexts in the future;
- b. what institutions and governments should do to achieve best practice in encouraging the reporting of, and responding to reports or information about, allegations, incidents or risks of child sexual abuse and related matters in institutional contexts;
- c. what should be done to eliminate or reduce impediments that currently exist for responding appropriately to child sexual abuse and related matters in institutional contexts, including addressing failures in, and impediments to, reporting, investigating and responding to allegations and incidents of abuse;
- d. what institutions and governments should do to address, or alleviate the impact of, past and future child sexual abuse and related matters in institutional contexts, including, in particular, in ensuring justice for victims through the provision of redress by institutions, processes for referral for investigation and prosecution and support services.

AND We direct you to make any recommendations arising out of your inquiry that you consider appropriate, including recommendations about any policy, legislative, administrative or structural reforms.

AND, without limiting the scope of your inquiry or the scope of any recommendations arising out of your inquiry that you may consider appropriate, We direct you, for the purposes of your inquiry and recommendations, to have regard to the following matters:

- e. the experience of people directly or indirectly affected by child sexual abuse and related matters in institutional contexts, and the provision of opportunities for

them to share their experiences in appropriate ways while recognising that many of them will be severely traumatised or will have special support needs;

- f. the need to focus your inquiry and recommendations on systemic issues, recognising nevertheless that you will be informed by individual cases and may need to make referrals to appropriate authorities in individual cases;
- g. the adequacy and appropriateness of the responses by institutions, and their officials, to reports and information about allegations, incidents or risks of child sexual abuse and related matters in institutional contexts;
- h. changes to laws, policies, practices and systems that have improved over time the ability of institutions and governments to better protect against and respond to child sexual abuse and related matters in institutional contexts.

AND We further declare that you are not required by these Our Letters Patent to inquire, or to continue to inquire, into a particular matter to the extent that you are satisfied that the matter has been, is being, or will be, sufficiently and appropriately dealt with by another inquiry or investigation or a criminal or civil proceeding.

AND, without limiting the scope of your inquiry or the scope of any recommendations arising out of your inquiry that you may consider appropriate, We direct you, for the purposes of your inquiry and recommendations, to consider the following matters, and We authorise you to take (or refrain from taking) any action that you consider appropriate arising out of your consideration:

- i. the need to establish mechanisms to facilitate the timely communication of information, or the furnishing of evidence, documents or things, in accordance with section 6P of the *Royal Commissions Act 1902* or any other relevant law, including, for example, for the purpose of enabling the timely investigation and prosecution of offences;
- j. the need to establish investigation units to support your inquiry;
- k. the need to ensure that evidence that may be received by you that identifies particular individuals as having been involved in child sexual abuse or related matters is dealt with in a way that does not prejudice current or future criminal or civil proceedings or other contemporaneous inquiries;
- l. the need to establish appropriate arrangements in relation to current and previous inquiries, in Australia and elsewhere, for evidence and information to be shared with you in ways consistent with relevant obligations so that the work of those inquiries, including, with any necessary consents, the testimony of witnesses, can be taken into account by you in a way that avoids unnecessary duplication, improves efficiency and avoids unnecessary trauma to witnesses;

- m. the need to ensure that institutions and other parties are given a sufficient opportunity to respond to requests and requirements for information, documents and things, including, for example, having regard to any need to obtain archived material.

AND We appoint you, the Honourable Justice Peter David McClellan AM, to be the Chair of the Commission.

AND We declare that you are a relevant Commission for the purposes of sections 4 and 5 of the *Royal Commissions Act 1902*.

AND We declare that you are authorised to conduct your inquiry into any matter under these Our Letters Patent in combination with any inquiry into the same matter, or a matter related to that matter, that you are directed or authorised to conduct by any Commission, or under any order or appointment, made by any of Our Governors of the States or by the Government of any of Our Territories.

AND We declare that in these Our Letters Patent:

**child** means a child within the meaning of the Convention on the Rights of the Child of 20 November 1989.

**government** means the Government of the Commonwealth or of a State or Territory, and includes any non-government institution that undertakes, or has undertaken, activities on behalf of a government.

**institution** means any public or private body, agency, association, club, institution, organisation or other entity or group of entities of any kind (whether incorporated or unincorporated), and however described, and:

- i. includes, for example, an entity or group of entities (including an entity or group of entities that no longer exists) that provides, or has at any time provided, activities, facilities, programs or services of any kind that provide the means through which adults have contact with children, including through their families; and
- ii. does not include the family.

**institutional context:** child sexual abuse happens in an institutional context if, for example:

- i. it happens on premises of an institution, where activities of an institution take place, or in connection with the activities of an institution; or
- ii. it is engaged in by an official of an institution in circumstances (including circumstances involving settings not directly controlled by the institution) where you

consider that the institution has, or its activities have, created, facilitated, increased, or in any way contributed to, (whether by act or omission) the risk of child sexual abuse or the circumstances or conditions giving rise to that risk; or

- iii. it happens in any other circumstances where you consider that an institution is, or should be treated as being, responsible for adults having contact with children.

**law** means a law of the Commonwealth or of a State or Territory.

**official**, of an institution, includes:

- i. any representative (however described) of the institution or a related entity; and
- ii. any member, officer, employee, associate, contractor or volunteer (however described) of the institution or a related entity; and
- iii. any person, or any member, officer, employee, associate, contractor or volunteer (however described) of a body or other entity, who provides services to, or for, the institution or a related entity; and
- iv. any other person who you consider is, or should be treated as if the person were, an official of the institution.

**related matters** means any unlawful or improper treatment of children that is, either generally or in any particular instance, connected or associated with child sexual abuse.

AND We:

require you to begin your inquiry as soon as practicable, and

require you to make your inquiry as expeditiously as possible; and

require you to submit to Our Governor-General:

first and as soon as possible, and in any event not later than 30 June 2014 (or such later date as Our Prime Minister may, by notice in the *Gazette*, fix on your recommendation), an initial report of the results of your inquiry, the recommendations for early consideration you may consider appropriate to make in this initial report, and your recommendation for the date, not later than 31 December 2015, to be fixed for the submission of your final report; and

then and as soon as possible, and in any event not later than the date Our Prime Minister may, by notice in the *Gazette*, fix on your recommendation, your final report of the results of your inquiry and your recommendations; and

authorise you to submit to Our Governor-General any additional interim reports that you consider appropriate.

IN WITNESS, We have caused these Our Letters to be made Patent  
WITNESS Quentin Bryce, Governor-General of the Commonwealth of Australia.

Dated 11th January 2013  
Governor-General  
By Her Excellency's Command  
Prime Minister

## Letters Patent dated 13 November 2014

ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth:

TO

The Honourable Justice Peter David McClellan AM,  
Mr Robert Atkinson,  
The Honourable Justice Jennifer Ann Coate,  
Mr Robert William Fitzgerald AM,  
Dr Helen Mary Milroy, and  
Mr Andrew James Marshall Murray

GREETING

WHEREAS We, by Our Letters Patent issued in Our name by Our Governor-General of the Commonwealth of Australia, appointed you to be a Commission of inquiry, required and authorised you to inquire into certain matters, and required you to submit to Our Governor-General a report of the results of your inquiry, and your recommendations, not later than 31 December 2015.

AND it is desired to amend Our Letters Patent to require you to submit to Our Governor-General a report of the results of your inquiry, and your recommendations, not later than 15 December 2017.

NOW THEREFORE We do, by these Our Letters Patent issued in Our name by Our Governor-General of the Commonwealth of Australia on the advice of the Federal Executive Council and under the Constitution of the Commonwealth of Australia, the *Royal Commissions Act 1902* and every other enabling power, amend the Letters Patent issued to you by omitting from subparagraph (p)(i) of the Letters Patent “31 December 2015” and substituting “15 December 2017”.

IN WITNESS, We have caused these Our Letters to be made Patent.

WITNESS General the Honourable Sir Peter Cosgrove AK MC (Ret'd), Governor-General of the Commonwealth of Australia.

Dated 13th November 2014  
Governor-General  
By Her Excellency's Command  
Prime Minister

## APPENDIX B: Public hearing

<b>The Royal Commission</b>	Justice Peter McClellan AM (Chair) Justice Jennifer Coate Mr Bob Atkinson AO APM Mr Robert Fitzgerald AM Professor Helen Milroy Mr Andrew Murray
<b>Commissioners who presided</b>	Justice Peter McClellan AM (Chair) Professor Helen Milroy
<b>Date of hearing</b>	6 May – 15 May 2015
<b>Legislation</b>	<i>Royal Commissions Act 1902</i> (Cth) <i>Royal Commissions Act 1923</i> (NSW) <i>Evidence (Miscellaneous Provisions) Act 1958</i> (Vic)
<b>Leave to appear</b>	AWA AWC AWD AWH Dr Roger Stone Dr Stephen Thackway Dr Lisa Lampe Dr John Proctor Julie Blyth Health Care Complaints Commission Medical Council of New South Wales State of New South Wales New South Wales Police North Sydney Local Health District Western Sydney Local Health District John Rolleston AWI State of Victoria Royal Children’s Hospital Melbourne

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**Legal representation**

Dr H Bennett, Counsel Assisting the Royal Commission

A Kernaghan of Kernaghan & Associates, appearing for AWA

A Kernaghan of Kernaghan & Associates, appearing for AWD

M Kumar, instructed by George Newhouse of Shine Lawyers, appearing for AWC

Joanne Gallagher, appearing for AWH

P O'Brien of O'Brien Solicitors, appearing for Dr Roger Stone

K Keogh of TressCox Lawyers, appearing for Dr Stephen Thackway

A Harris of Andrew Harris & Associates, appearing for Julie Blyth

W Hunt, instructed by A Kohn of Makinson d'Apice Lawyers, appearing for Health Care Complaints Commission

M McCulloch SC, instructed by F Menniti of Curwoods Lawyers, appearing for Medical Council of New South Wales

M Windsor SC with G Wright, instructed by R Kelly of Crown Solicitors Office, appearing for the State of New South Wales

M Windsor SC with G Wright, instructed by R Kelly of Crown Solicitor's Office, appearing for North Sydney Local Health District

I Fraser of Crown Solicitor's Office, appearing for New South Wales Police

I Fraser of Crown Solicitor's Office, appearing for Western Sydney Local Health District

S Hall appearing for John Rolleston

I Fehring, instructed by A Olver of Ryan Carlisle Thomas, appearing for AWI

K Judd QC, instructed by M Tisler of Landers and Rodgers, appearing for State of Victoria

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	K Judd QC, instructed by M Tisler of Landers and Rodgers, appearing for Royal Children’s Hospital Melbourne
	D Fagan SC, instructed by R Ottley of Swabb Attorneys, appearing for Amanda Adrian
<b>Pages of transcript</b>	539 pages
<b>Summons to Appear issued under <i>Royal Commissions Act 1902 (Cth)</i></b>	20 summonses
<b>Notice to Produce documents issued under <i>Royal Commissions Act 1902 (Cth)</i> and documents produced</b>	34 notices, producing approximately 3,539 documents
<b>Summons to Produce documents issued under the <i>Royal Commissions Act 1923 (NSW)</i> and documents produced</b>	18 summonses, producing approximately 8,970 documents
<b>Summons to Produce documents under the <i>Evidence (Miscellaneous Provisions) Act 1958 (Vic)</i> and documents produced</b>	3 summonses, producing approximately 21 documents
<b>Number of exhibits</b>	31 exhibits consisting of a total of 591 documents tendered at the hearing
<b>Witnesses</b>	<p><b>AWA</b> Survivor witness</p> <p><b>AWB</b> Survivor witness</p> <p><b>AWC</b> Survivor witness</p> <p><b>AWD</b> Survivor witness</p> <p><b>AWF</b> Survivor witness</p> <p><b>AWG</b> Survivor witness</p> <p><b>AWH</b> Survivor witness</p> <p><b>AWI</b> Survivor witness</p> <p><b>Detective Sergeant Grant Slade</b> New South Wales Police</p>

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**Detective Senior Constable Arron Ferguson**

New South Wales Police

**Dr Roger Stone**

Retired medical practitioner, St Ives practice

**Kieran Pehm**

Commissioner, Health Care Complaints Commission

**Professor Peter Procopis AM**

President, Medical Council of New South Wales

**Terence Kirkpatrick**

Survivor witness

**Adjunct Associate Professor Vicki Taylor**

CEO, North Sydney Local Health District

**Dr Mary Foley**

Secretary, New South Wales Ministry of Health

**Dr John de Campo**

Former CEO, Royal Children's Hospital

**Professor Christine Kilpatrick**

Current CEO, Royal Children's Hospital Melbourne

**Professor Merrilyn Walton**

Former Commissioner, HCCC (1994–2000)

**Amanda Adrian**

Former Commissioner, HCCC (June 2000 –  
December 2003)

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# Endnotes

- 1 *Health Care Complaints Act 1993* (NSW) s 3(2).
- 2 *Health Care Complaints Act 1993* (NSW) s 10.
- 3 *Health Practitioner Regulation National Law* (NSW) (2009 No 86a) s 144G.
- 4 *Health Care Complaints Act 1993* (NSW) s 19.
- 5 *Health Care Complaints Act 1993* (NSW) s 20(1).
- 6 *Health Care Complaints Act 1993* (NSW) s 26(1)(b).
- 7 *Health Care Complaints Act 1993* (NSW) s 22(a).
- 8 *Health Care Complaints Act 1993* (NSW) s 21.
- 9 *Health Care Complaints Act 1993* (NSW) s 22(b).
- 10 *Health Care Complaints Act 1993* (NSW) s 12.
- 11 *Health Care Complaints Act 1993* (NSW) s 39(2).
- 12 *Health Care Complaints Act 1993* (NSW) s 39(1)(a).
- 13 *Health Care Complaints Act 1993* (NSW) s 90B(1); Transcript of K Pehm, Case Study 27, 8 May 2015, 14219:40–7.
- 14 Exhibit 27-0013, ‘Statement of Kieran Pehm’, Case Study 27, STAT.0554.001.0001\_R at [14].
- 15 *Health Care Complaints Act 1993* (NSW) s 34A (version effective 1 March 2005).
- 16 Exhibit 27-0013, ‘Statement of Kieran Pehm’, Case Study 27, STAT.0554.001.0001\_R at [14].
- 17 *Ibid* at [1].
- 18 *Medical Practice Act 1992* (NSW) s 66 (version effective 1 July 1993 to 1 October 2008).
- 19 Transcript of K Pehm, Case Study 27, 8 May 2015, 14220:40–7.
- 20 Exhibit 27-0017, ‘Statement of Professor Peter Procopis’, Case Study 27, STAT.0559.001.0001\_R at [2]–[5].
- 21 *Health Practitioner Regulation National Law 2009* (NSW) Part 8, Division 2.
- 22 *Health Practitioner Regulation National Law 2009* (NSW) s 141(1).
- 23 *Medical Practice Act 1992* (NSW) s 71A (version effective 1 July 1993 to 1 October 2008).
- 24 ‘Risk of significant harm’ is defined at s 23 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).
- 25 Exhibit 27-0007, ‘Statement of AWF’, Case Study 27, STAT.0550.001.0001\_R at [11].
- 26 *Ibid* at [8].
- 27 *Ibid* at [13].
- 28 *Ibid*.
- 29 *Ibid* at [14].
- 30 *Ibid* at [17].
- 31 *Ibid*.
- 32 *Ibid* at [14].
- 33 *Ibid* at [18].
- 34 *Ibid* at [19].
- 35 *Ibid*.
- 36 *Ibid* at [20].
- 37 *Ibid* at [8].
- 38 *Ibid* at [21].
- 39 *Ibid* at [22].
- 40 *Ibid*.
- 41 *Ibid*.
- 42 *Ibid* at [23].
- 43 *Ibid* at [24].
- 44 *Ibid* at [25].
- 45 *Ibid* at [28].
- 46 *Ibid* at [29].
- 47 *Ibid* at [10].
- 48 *Ibid* at [32].
- 49 *Ibid* at [33].
- 50 Exhibit 27-0005, ‘Statement of AWH’, Case Study 27, STAT.0549.001.0001\_R at [11].
- 51 *Ibid* at [13].
- 52 *Ibid* at [15].
- 53 *Ibid* at [17].

54 Ibid at [19].  
55 Ibid at [53]–[55].  
56 Ibid at [79].  
57 Ibid.  
58 Ibid at [80].  
59 Ibid at [81].  
60 Ibid at [82].  
61 Exhibit 27-0002, ‘Statement of AWA’, Case Study 27, STAT.0543.001.0001\_R at [11]–[12].  
62 Ibid at [16].  
63 Ibid at [17].  
64 Ibid at [14].  
65 Ibid at [15].  
66 Ibid at [19].  
67 Ibid.  
68 Ibid at [20].  
69 Ibid at [22]–[24].  
70 Ibid at [25].  
71 Exhibit 27-0001, Case Study 27, HCCC.0001.005.0948\_R; Exhibit 27-0001, Case Study 27, IND.0266.001.0039\_R.  
72 Transcript of P Procopis, Case Study 27, 8 May 2015, 14295:21–33.  
73 Exhibit 27-0002, ‘Statement of AWA’, Case Study 27, STAT.0543.001.0001\_R at [26]–[29].  
74 Ibid at [30]–[32].  
75 Ibid at [41].  
76 Ibid at [83].  
77 Ibid at [84].  
78 Ibid.  
79 Exhibit 27-0003, ‘Statement of AWG’, Case Study 27, STAT.0551.001.0001\_R at [10].  
80 Ibid.  
81 Ibid at [11].  
82 Ibid at [14].  
83 Ibid.  
84 Ibid at [15].  
85 Ibid.  
86 Ibid at [16].  
87 Ibid at [19].  
88 Ibid at [20].  
89 Ibid at [23].  
90 Ibid at [8].  
91 Ibid at [23].  
92 Ibid.  
93 Ibid at [24].  
94 Ibid.  
95 Ibid.  
96 Ibid at [25].  
97 Exhibit 27-0001, Case Study 27, MCN.0001.005.0015\_R.  
98 Exhibit 27-0001, Case Study 27, MCN.0001.005.0016\_R.  
99 Exhibit 27-0003, ‘Statement of AWG’, Case Study 27, STAT.0551.001.0001\_R at [26].  
100 Ibid at [28].  
101 Ibid at [29].  
102 Ibid at [30].  
103 Ibid at [31].  
104 Exhibit 27-0001, Case Study 27, HCCC.0001.009.0917\_R.  
105 Exhibit 27-0003, ‘Statement of AWG’, Case Study 27, STAT.0551.001.0001\_R at [32].  
106 Ibid.

107 Ibid at [39].  
108 Ibid.  
109 Ibid.  
110 Exhibit 27-0004, 'Statement of AWB', Case Study 27, STAT.0546.001.0001\_R at [15].  
111 Ibid at [16].  
112 Ibid.  
113 Ibid at [17]–[21].  
114 Ibid.  
115 Ibid at [19].  
116 Ibid at [22].  
117 Ibid.  
118 Ibid at [23]–[25].  
119 Ibid at [24].  
120 Ibid.  
121 Ibid.  
122 Ibid at [26]–[27].  
123 Ibid at [27].  
124 Ibid.  
125 Ibid.  
126 Ibid at [29].  
127 Ibid.  
128 Ibid at [31]–[32].  
129 Ibid at [34].  
130 Ibid at [35].  
131 Ibid at [53].  
132 Ibid at [40].  
133 Ibid.  
134 Ibid.  
135 Transcript, Case Study 27, 6 May 2015, 14043:19–41.  
136 Transcript, Case Study 27, 6 May 2015, 14044:11–15.  
137 Exhibit 27-0004, 'Statement of AWB', Case Study 27, STAT.0546.001.0001\_R at [37].  
138 Ibid at [38].  
139 Ibid.  
140 Ibid.  
141 Ibid at [50].  
142 Exhibit 27-0012, 'Statement of Dr Roger Stone', Case Study 27, STAT.0564.001.0001\_R at [15].  
143 Ibid.  
144 Ibid.  
145 Exhibit 27-0004, 'Statement of AWB', Case Study 27, STAT.0546.001.0001\_R at [51].  
146 Ibid at [73]–[74].  
147 Ibid.  
148 Ibid at [76].  
149 Ibid.  
150 Ibid at [78].  
151 Ibid at [80].  
152 Ibid at [82].  
153 Ibid at [83].  
154 Ibid at [87].  
155 Ibid at [75].  
156 Ibid.  
157 Exhibit 27-0008, 'Statement of AWC', Case Study 27, STAT.0560.001.0001\_R at [10]–[11].  
158 Ibid at [13].  
159 Ibid at [14].  
160 Ibid.

161       Ibid at [15].  
162       Ibid at [16].  
163       Ibid at [17].  
164       Ibid at [17]–[18].  
165       Ibid at [20].  
166       Ibid at [23].  
167       Ibid at [30].  
168       Ibid at [30].  
169       Ibid at [45].  
170       Ibid.  
171       Ibid.  
172       Ibid.  
173       Ibid at [86].  
174       Ibid at [91].  
175       Ibid at [97].  
176       Ibid at [31].  
177       Ibid at [33].  
178       Ibid at [34].  
179       Ibid at [36].  
180       Ibid at [38].  
181       Ibid.  
182       Ibid at [39].  
183       Transcript, Case Study 27, 6 May 2015, 14044:16–46.  
184       Exhibit 27-0008, ‘Statement of AWC’, Case Study 27, STAT.0560.001.0001\_R at [41].  
185       Ibid at [41] and [44].  
186       Ibid at [43].  
187       Ibid at [107].  
188       Ibid at [108].  
189       Ibid at [109].  
190       Ibid at [111].  
191       Ibid at [113].  
192       Exhibit 27-0006, ‘Statement of AWD’, Case Study 27, STAT.0548.001.0001\_R at [11]–[12].  
193       Ibid at [16]–[27].  
194       Ibid at [20].  
195       Ibid at [23].  
196       Ibid at [26].  
197       Ibid at [27].  
198       Exhibit 27-0001, Case Study 27, NSW.2030.001.0036\_R.  
199       Exhibit 27-0006, ‘Statement of AWD’, Case Study 27, STAT.0548.001.0001\_R at [29].  
200       Ibid at [30]–[31].  
201       Ibid at [33]–[34].  
202       Ibid at [35].  
203       Ibid.  
204       Ibid at [36].  
205       Ibid at [37].  
206       Ibid at [39].  
207       Ibid at [40].  
208       Ibid at [42].  
209       Exhibit 27-0001, Case Study 27, AHP.0001.001.0134 at 0156; Exhibit 27-0001, Case Study 27,  
HCCC.0001.002.0889 at 0895.  
210       Exhibit 27-0001, Case Study 27, HCCC.0001.006.0555.  
211       Exhibit 27-0001, Case Study 27, HCCC.0001.006.0701.  
212       Exhibit 27-0001, Case Study 27, HCCC.0001.002.0889 at 0892.  
213       Exhibit 27-0001, Case Study 27, HCCC.0001.006.0701.

214 Ibid at 0702.  
 215 Ibid at 0705.  
 216 Ibid at 0705.  
 217 Exhibit 27-0001, Case Study 27, HCCC.0001.007.0073\_R.  
 218 Ibid at 0082\_R.  
 219 Exhibit 27-0001, Case Study 27, MCN.0001.005.0165\_R.  
 220 Exhibit 27-0001, Case Study 27, HCCC.0001.006.0723\_R.  
 221 Exhibit 27-0001, Case Study 27, HCCC.0001.007.0091\_R at 0101\_R.  
 222 Exhibit 27-0001, Case Study 27, HCCC.0001.006.0144 at 0149.  
 223 Exhibit 27-0001, Case Study 27, MCN.0001.006.0016.  
 224 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001 at [155].  
 225 Exhibit 27-0001, Case Study 27, NSW.0039.002.0207\_R at 0211\_R.  
 226 Ibid at 0214\_R.  
 227 Exhibit 27-0001, Case Study 27, HCCC.0001.007.0621\_R.  
 228 Ibid.  
 229 Exhibit 27-0001, Case Study 27, NSW.0039.003.0068\_R.  
 230 Ibid.  
 231 Exhibit 27-0001, Case Study 27, HCCC.0001.006.0144.  
 232 Exhibit 27-0016, Case Study 27, HCCC.0001.012.0663\_R; Transcript of K Pehm, Case Study 27, 8 May 2015, 14220:2–27.  
 233 Exhibit 27-0001, Case Study 27, NSW.0039.003.0017\_R.  
 234 Exhibit 27-0001, Case Study 27, NSW.0039.003.0005\_R; Exhibit 27-0001, Case Study 27, NSW.0039.003.0019\_R.  
 235 Exhibit 27-0001, Case Study 27, NSW.0039.003.0068\_R.  
 236 Transcript of K Pehm, Case Study 27, 7 May 2015, 14198:32–T14199:20.  
 237 Transcript of K Pehm, Case Study 27, 7 May 2015, 14197:36–47.  
 238 Ibid.  
 239 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [216].  
 240 Exhibit 27-0011, 'Statement of Detective Sergeant Grant Slade', Case Study 27, STAT.0565.001.001\_R at [19].  
 241 Ibid at [20].  
 242 Ibid at [21].  
 243 Ibid at [22].  
 244 Ibid at [23]–[24].  
 245 Ibid at [24].  
 246 Ibid at [48] and [50].  
 247 Ibid at [52].  
 248 Exhibit 27-0001, Case Study 27, MCN.0001.005.0015\_R. The Complaints Unit was the predecessor of the HCCC.  
 249 Exhibit 27-0001, Case Study 27, MCN.0001.005.0016\_R.  
 250 Ibid.  
 251 Exhibit 27-27-0003, 'Statement of AWG', Case Study 27, STAT.0551.001.0001\_R at [28].  
 252 Transcript of P Procopis, Case Study 27, 8 May 2015, 14276:10–20.  
 253 Ibid at 20–22.  
 254 Exhibit 27-0001, Case Study 27, MCN.0001.005.0016\_R.  
 255 Transcript of P Procopis, Case Study 27, 8 May 2015, 14275:38–14276:8.  
 256 Exhibit 27-0008, 'Statement of AWC', Case Study 27, STAT.0560.001.0001\_R at [46].  
 257 Exhibit 27-0001, Case Study 27, HCCC.0001.003.0310\_R.  
 258 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0004\_R.  
 259 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [20].  
 260 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0944\_R.  
 261 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0103\_R.  
 262 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0100; Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [20(l)].  
 263 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0923\_R ; Exhibit 27-0001, Case Study 27, HCCC.0001.013.0085\_R; Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [20(n)].

264 Transcript of K Pehm, Case Study 27, 7 May 2015, 14184:32–14185:4.  
 265 Exhibit 27-0001, Case Study 27, HCCC.0001.003.0340\_R ; Exhibit 27-0013, ‘Statement of Kieran Pehm’, Case Study 27, STAT.0554.001.0001\_R at [20(a)].  
 266 Exhibit 27-0001, Case Study 27, HCCC.0001.003.0342\_R; Exhibit 27-0013, ‘Statement of Kieran Pehm’, Case Study 27, STAT.0554.001.0001\_R at [21(a)].  
 267 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0073\_R; Exhibit 27-0008, ‘Statement of AWC’, Case Study 27, STAT.0560.001.0001\_R at [65].  
 268 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0073\_R; Exhibit 27-0008, ‘Statement of AWC’, Case Study 27, STAT.0560.001.0001\_R at [67].  
 269 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0075\_R.  
 270 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0061\_R; Exhibit 27-0001, Case Study 27, HCCC.0001.013.0057\_R; Exhibit 27-0013, ‘Statement of Kieran Pehm’, Case Study 27, STAT.0554.001.0001\_R at [21(e)–(f)].  
 271 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0863\_R.  
 272 Exhibit 27-0013, ‘Statement of Kieran Pehm’, STAT.0554.001.0001\_R at [22].  
 273 Exhibit 27-0013, ‘Statement of Kieran Pehm’, STAT.0554.001.0001\_R at [21]–[22]. Exhibit 27-0001, Case Study 27, HCCC.0001.013.0006; Exhibit 27-0013, ‘Statement of Kieran Pehm’, Case Study 27, STAT.0554.001.0001\_R at [22(d)].  
 274 Exhibit 27-0001, Case Study 27, IND.0267.001.0008.  
 275 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0144\_R.  
 276 Exhibit 27-0008, ‘Statement of AWC’, Case Study 27, STAT.0560.001.0001\_R at [63].  
 277 Ibid at [73].  
 278 Ibid.  
 279 Exhibit 27-0013, ‘Statement of Kieran Pehm’, Case Study 27, STAT.0554.001.0001\_R at [21(f)]; Transcript of K Pehm, Case Study 27, 7 May 2015, 14186:15–37.  
 280 Transcript of M Walton, Case Study 27, 15 May 2015, 14558:24–34.  
 281 Exhibit 27-0013, ‘Statement of Kieran Pehm’, Case Study 27, STAT.0554.001.0001\_R at [21(f)].  
 282 Exhibit 27-0029, Case Study 27, WEB.0041.001.0001.  
 283 Transcript of M Walton, Case Study 27, 15 May 2015, 14562:31–42.  
 284 Transcript of M Walton, Case Study 27, 15 May 2015, 14561:3–5.  
 285 Exhibit 27-0008, ‘Statement of AWC’, Case Study 27, STAT.0560.001.0001\_R at [116].  
 286 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0100.  
 287 Exhibit 27-0013, ‘Statement of Kieran Pehm’, Case Study 27, STAT.0554.001.0001\_R at [20(o)].  
 288 Exhibit 27-0001, Case Study 27, HCCC.0001.003.0310\_R.  
 289 Exhibit 27-0008, ‘Statement of AWC’, Case Study 27, STAT.0560.001.0001\_R at [46].  
 290 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0863\_R at 0868\_R.  
 291 Transcript of K Pehm, Case Study 27, 7 May 2015, 14182:30–14183:4.  
 292 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0103\_R.  
 293 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0863\_R at 0867.  
 294 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0923\_R.  
 295 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0863\_R at 0867.  
 296 Transcript of K Pehm, Case Study 27, 7 May 2015, 14193:31–40.  
 297 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0863 at 0868.  
 298 Exhibit 27-0001, Case Study 27, HCCC.0001.014.0238.  
 299 Ibid at 0363–0364.  
 300 Transcript of A Adrian, Case Study 27, 15 May 2015, 14577:12–14578:10.  
 301 Ibid at 28.  
 302 Ibid at 46.  
 303 Transcript of A Adrian, Case Study 27, 15 May 2015, 14578:4.  
 304 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0923\_R.  
 305 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0121\_R.  
 306 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0102\_R; Exhibit 27-0001, Case Study 27, HCCC.0001.013.0102\_T\_R; Exhibit 27-0001, Case Study 27, HCCC.0001.012.0863\_R at 0865; Transcript of K Pehm, Case Study 27, 8 May 2015, 14224:22.

307 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0121; Exhibit 27-0001, Case Study 27, HCCC.0001.012.0923;  
Exhibit 27-0001, Case Study 27, HCCC.0001.013.0054; Exhibit 27-0008, 'Statement of AWC', Case Study 27,  
STAT.0560.001.0001\_R at [78]; Transcript of A Adrian, Case Study 27, 15 May 2015, 14577:46.

308 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0923\_R; Exhibit 27-0001, Case Study 27,  
HCCC.0001.013.0100.

309 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0102\_R and HCCC.0001.013.0102\_T\_R.

310 Transcript of K Pehm, Case Study 27, 8 May 2015, 14224:14–42.

311 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0103\_R at 0104\_R.

312 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0863\_R at 0868\_R.

313 Ibid.

314 Ibid at 0866\_R.

315 Ibid.

316 Transcript of K Pehm, Case Study 27, 6 May 2015, 14182:30–14183:4.

317 Transcript of A Adrian, Case Study 27, 15 May 2015, 14586:8–12.

318 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0057\_R.

319 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0863\_R at 0869\_R.

320 Ibid.

321 Ibid.

322 Transcript of K Pehm, Case Study 27, 7 May 2015, 14189:45–14190:37.

323 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [21(b)]; Exhibit 27-  
0001, Case Study 27, HCCC.0001.013.0073\_R.

324 Transcript of K Pehm, Case Study 27, 7 May 2015, 14187:21–6.

325 Exhibit 27-0001, Case Study 27, HCCC.0001.014.0238.

326 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0923\_R at 0924\_R.

327 Transcript of K Pehm, Case Study 27, 7 May 2015, 14184:32–14185:4.

328 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0053\_R.

329 Transcript of A Adrian, Case Study 27, 15 May 2015, 14584:13–37.

330 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0863\_R at 0869\_R.

331 Ibid.

332 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0886\_R.

333 Ibid.

334 Ibid.

335 Ibid.

336 Transcript of K Pehm, Case Study 27, 8 May 2015, 14217:45–14218:6.

337 Transcript of K Pehm, Case Study 27, 7 May 2015, 14194:36–41.

338 Transcript of A Adrian, Case Study 27, 15 May 2015, 14589:34–6.

339 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0103\_R at 0104\_R.

340 Exhibit 27-0001, Case Study 27, HCCC.0001.013.0054\_T\_R.

341 Exhibit 27-0001, Case Study 27, HCCC.0001.003.0618\_R.

342 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [124].

343 Ibid at [126].

344 Exhibit 27-0001, Case Study 27, HCCC.0001.004.0221\_R at 0226.

345 Exhibit 27-0001, Case Study 27, HCCC.0001.007.0073\_R at 0078\_R.

346 Exhibit 27-0001, Case Study 27, HCCC.0001.006.0701 at 0702.

347 Ibid at 0555.

348 Exhibit 27-0001, Case Study 27, HCCC.0001.006.0701 at 0703.

349 Exhibit 27-0001, Case Study 27, HCCC.0001.012.0923; Exhibit 27-0001, Case Study 27, HCCC.0001.013.0100.

350 Transcript of K Pehm, Case Study 27, 8 May 2015, 14225:3–16.

351 Transcript of A Adrian, Case Study 27, 15 May 2015, 14566:15–36.

352 Ibid.

353 Exhibit 27-0001, Case Study 27, HCCC.0001.003.0356\_R; Exhibit 27-0013, 'Statement of Kieran Pehm', Case  
Study 27, STAT.0554.001.0001\_R at [26].

354 Exhibit 27-0013, 'Statement of Kieran Pehm', STAT.0554.001.0001\_R at [26].

355 Exhibit 27-0001, Case Study 27, HCCC.0001.003.0356\_R; Exhibit 27-0013, 'Statement of Kieran Pehm', Case  
Study 27, STAT.0554.001.0001\_R at [26].

356 Exhibit 27-0001, Case Study 27, HCCC.0001.002.0454\_R.  
357 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [26(c)].  
358 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0946\_R.  
359 Exhibit 27-0001, Case Study 27, HCCC.0001.002.0447\_R.  
360 Exhibit 27-0005, 'Statement of AWH', Case Study 27, STAT.0549.001.0001\_R at [28].  
361 Exhibit 27-0001, Case Study 27, HCCC.0001.002.0355\_R.  
362 Exhibit 27-0001, Case Study 27, MCN.0001.001.0033.  
363 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [28(e)]; Exhibit 27-0005, 'Statement of AWH', Case Study 27, STAT.0549.001.0001\_R at [32]–[37]; Exhibit 27-0001, Case Study 27, HCCC.0001.002.0442\_R.  
364 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0937\_R; Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [28(f)].  
365 Exhibit 27-0005, 'Statement of AWH', Case Study 27, STAT.0549.001.0001\_R at [41].  
366 Ibid at [42].  
367 *Health Care Complaints Act 1993* (NSW) (now repealed) s 23(3).  
368 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [28(b)]; Exhibit 27-0001, Case Study 27, HCCC.0001.001.0941\_R.  
369 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [28(c)].  
370 Transcript of K Pehm, Case Study 27, 7 May 2015, 14197:20–34.  
371 Exhibit 27-0001, Case Study 27, HCCC.0001.014.0238.  
372 Exhibit 27-0001, Case Study 27, HCCC.0001.002.0440\_R.  
373 Exhibit 27-0005, 'Statement of AWH', Case Study 27, STAT.0549.001.0001\_R at [38].  
374 Ibid at [40].  
375 Ibid at [39].  
376 Transcript of K Pehm, Case Study 27, 7 May 2015, 14200:2–7.  
377 Transcript of P Procopis, Case Study 27, 8 May 2015, 14286:22–14287:34.  
378 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0571\_R.  
379 Ibid.  
380 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [29].  
381 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0881\_R; Exhibit 27-0001, Case Study 27, HCCC.0001.001.0859\_R.  
382 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0854\_R.  
383 Ibid.  
384 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [32].  
385 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0854\_R.  
386 Exhibit 27-0001, Case Study 27, HCCC.0001.003.0448\_R.  
387 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0830\_R.  
388 Ibid.  
389 Transcript of K Pehm, Case Study 27, 7 May 2015, 14203:26–14204:39.  
390 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0857\_R.  
391 Exhibit 27-0005, 'Statement of AWH', Case Study 27, STAT.0549.001.0001\_R at [48].  
392 Transcript of K Pehm, Case Study 27, 7 May 2015, 14201:45–14203:13.  
393 Exhibit 27-0013, 'Statement of Kieran Pehm', Case Study 27, STAT.0554.001.0001\_R at [32].  
394 Exhibit 27-0001, Case Study 27, HCCC.0001.001.0820\_R at 0822\_R.  
395 Transcript of K Pehm, Case Study 27, 7 May 2015, 14205:34–14206:1.  
396 Transcript of K Pehm, Case Study 27, 7 May 2015, 14206:3–24.  
397 Transcript of P Procopis, Case Study 27, 8 May 2015, 14273:5–9.  
398 Ibid at 13–21.  
399 Exhibit 27-0001, Case Study 27, HCCC.0001.003.0749\_R.  
400 Ibid.  
401 Exhibit 23-0001, Case Study 27, HCCC.0001.006.0144 at 0147.  
402 Transcript of P Procopis, Case Study 27, 8 May 2015, 14303:40–14304:11.  
403 Transcript of P Procopis, Case Study 27, 8 May 2015, 14280:16–28.  
404 Exhibit 27-0017, 'Statement of Professor Peter Procopis AM', Case Study 27, STAT.0559.001.0001\_R at [78].

405 Exhibit 27-0001, Case Study 27, MCN.0001.001.0114\_R.  
 406 Transcript of P Procopis, Case Study 27, 8 May 2015, 14282:20–44.  
 407 Transcript of P Procopis, Case Study 27, 8 May 2015, 14284:46–14285:2.  
 408 Exhibit 27-0013, ‘Statement of Kieran Pehm’, STAT.0554.001.0001\_R at [15].  
 409 Transcript of K Pehm, Case Study 27, 8 May 2015, 14254:19–36.  
 410 Transcript of K Pehm, Case Study 27, 8 May 2015, 14242:4–30.  
 411 Exhibit 27-0002, ‘Statement of AWA’, Case Study 27, STAT.0543.001.0001\_R at [52] and [69]; Exhibit 27-0008, ‘Statement of AWC’, Case Study 27, STAT.0560.001.0001\_R at [63]; Exhibit 27-0004, ‘Statement of AWB’, Case Study 27, STAT.0546.001.0001 at [66]; Exhibit 27-0003, ‘Statement of AWG’, Case Study 27, STAT.0551.001.0001\_R at [32] and [34].  
 412 Transcript of K Pehm, Case Study 27, 7 May 2015, 14206:41–14207:19.  
 413 Transcript of K Pehm, Case Study 27, 7 May 2015, 14207:17–28.  
 414 Exhibit 27-0015, Case Study 27, HCCC.007.001.0014\_R.  
 415 Exhibit 27-0001, Case Study 27, HCCC.0006.001.0001.  
 416 Transcript of K Pehm, Case Study 27, 8 May 2015, 14255:19–28.  
 417 Exhibit 27-0004, ‘Statement of AWB’, Case Study 27, STAT.0546.001.0001\_R at [46].  
 418 Exhibit 27-0001, Case Study 27, NSW.2010.001.0027\_R.  
 419 Exhibit 27-0004, ‘Statement of AWB’, Case Study 27, STAT.0546.001.0001\_R at [52].  
 420 Ibid at [55].  
 421 Exhibit 27-0019, ‘Statement of Julie Blyth’, Case Study 27, STAT.0552.001.0001\_R; Exhibit 27-0020, ‘Further Statement of Julie Blyth’, Case Study 27, STAT.0552.002.0001\_R.  
 422 Exhibit 27-0001, Case Study 27, NSW.2047.008.0001.  
 423 Exhibit 27-0020, ‘Further Statement of Julie Blyth’, STAT.0052.002.0001\_R at [7].  
 424 Ibid at [8].  
 425 Ibid at [15].  
 426 Ibid at [14].  
 427 Ibid at [16]–[18].  
 428 Exhibit 27-0024, ‘Statement of Dr Mary Foley’, Case Study 27, STAT.0555.001.0001 at [31].  
 429 Transcript of V Taylor, Case Study 27, 11 May 2015, 14328:47–14329:3.  
 430 Exhibit 27-0033, Case Study 27, NSW.0055.001.0369.  
 431 Transcript of V Taylor, Case Study 27, 11 May 2015, 14329:25–14330:3.  
 432 Transcript of M Foley, Case Study 27, 11 May 2015, 14363:32–14364:19.  
 433 Transcript of M Foley, Case Study 27, 11 May 2015, 14364:39–14365:6.  
 434 Exhibit 27-0022, ‘Statement of Adjunct Associate Professor Vicki Taylor’, Case Study 27, STAT.0561.002.0001\_R at [34].  
 435 *Children and Young Persons (Care and Protection) Act 1998 (NSW) s 27.*  
 436 Exhibit 27-0001, Case Study 27, NSW.2047.006.0001; *Children and Young Persons (Care and Protection) Act 1998 (NSW) s 3.*  
 437 Exhibit 27-0001, Case Study 27, NSW.2047.017.0001.  
 438 Exhibit 27-0001, Case Study 27, NSW.2047.023.0001.  
 439 Exhibit 27-0022, ‘Statement of Adjunct Associate Professor Vicki Taylor’, Case Study 27, STAT.0561.002.0001\_R at [24].  
 440 Exhibit 27-0030, Case Study 27, WEB.0040.001.0001.  
 441 Exhibit 27-0021, Case Study 27, WEB.0037.001.0001.  
 442 Transcript of M Foley, Case Study 27, 11 May 2015, 14367:46–14368:13.  
 443 Exhibit 27-0024, ‘Statement of Dr Mary Foley’, Case Study 27, STAT.0555.001.0001 at [81].  
 444 Transcript of M Foley, Case Study 27, 11 May 2015, 14368:15–28.  
 445 Exhibit 27-0024, ‘Statement of Dr Mary Foley’, Case Study 27, STAT.0555.001.0001 at [77].  
 446 Transcript of M Foley, Case Study 27, 11 May 2015, 14369:17–41.  
 447 Transcript of M Foley, Case Study 27, 11 May 2015, 14368:41–14369:2.  
 448 Transcript of M Foley, Case Study 27, 11 May 2015, 14369:4–15.  
 449 Transcript of M Foley, Case Study 27, 11 May 2015, 14360:25–39.  
 450 Transcript of M Foley, Case Study 27, 11 May 2015, 14361:25–14362:4.  
 451 Transcript of M Foley, Case Study 27, 11 May 2015, 14361:44–14362:4.

- 452 Transcript of M Foley, Case Study 27, 11 May 2015, 14362:7–40.
- 453 Transcript of V Taylor, Case Study 27, 11 May 2015, 14330:17–26.
- 454 Transcript of V Taylor, Case Study 27, 11 May 2015, 14330:44–14331:10.
- 455 Exhibit 27-0012, ‘Statement of Dr Roger Stone’, Case Study 27, STAT.0564.001.0001\_R at [16]–[18].
- 456 Ibid at [19].
- 457 Transcript of R Stone, Case Study 27, 7 May 2015, 14171:7–13.
- 458 Ibid at 7–27.
- 459 Transcript of P Procopis, Case Study 27, 8 May 2015, 14291:46–114292:12.
- 460 Transcript of P Procopis, Case Study 27, 8 May 2015, 14293:1–25.
- 461 Transcript of P Procopis, Case Study 27, 8 May 2015, 14294:23–37.
- 462 Exhibit 27-0023, ‘Statement of Adjunct Associate Professor Vicki Taylor’, Case Study 27, STAT.0561.001.0001\_R at [16]–[21].
- 463 Ibid at [29]–[31].
- 464 Ibid at [19].
- 465 Ibid at [16].
- 466 Ibid at [21].
- 467 Ibid at [20].
- 468 Ibid at [33].
- 469 Exhibit 27-0018, ‘Statement of Terence Kirkpatrick’, Case Study 27, STAT.0553.001.0001\_R at [15].
- 470 Ibid at [17].
- 471 Ibid at [21].
- 472 Ibid at [22].
- 473 Ibid at [23].
- 474 Exhibit 27-0001, Case Study 27, NSW.2006.001.0015\_E.
- 475 Transcript of V Taylor, Case Study 27, 11 May 2015, 14333:30–6.
- 476 Exhibit 27-0023, ‘Statement of Adjunct Associate Professor Vicki Taylor’, Case Study 27, STAT.0561.001.0005\_R at [12]–[14].
- 477 Ibid at [25].
- 478 Ibid at [26].
- 479 Ibid at [29].
- 480 Ibid at [30].
- 481 Transcript of V Taylor, Case Study 27, 11 May 2015, 14335:17–34.
- 482 Transcript of V Taylor, Case Study 27, 11 May 2015, 14335:13–35.
- 483 Exhibit 27-0018, ‘Statement of Terence Kirkpatrick’, Case Study 27, STAT.0553.001.0001\_R at [31].
- 484 Ibid at [32].
- 485 Ibid at [33].
- 486 Ibid at [33].
- 487 Ibid at [36].
- 488 Ibid at [37].
- 489 Ibid at [38].
- 490 Ibid at [40].
- 491 Ibid at [41].
- 492 Ibid at [41].
- 493 Transcript of V Taylor, Case Study 27, 11 May 2015, 14335:36–14336:2.
- 494 Transcript of V Taylor, Case Study 27, 11 May 2015, 14347:4–8.
- 495 Exhibit 27-0001, Case Study 27, NSW.2009.001.0426.
- 496 A later circular, issued on 30 March 1984, on the Notification of Children at Risk (Exhibit 27-0001, Case Study 27, NSW.2009.001.0548) advised health workers that it was the policy of the Department of Health that obligations to notify DYCS applied to all health workers, despite that it was not a requirement under the *Child Welfare Act 1939* (NSW).
- 497 Exhibit 27-0001, Case Study 27, NSW.2047.017.0001.
- 498 Exhibit 27-0001, Case Study 27, NSW.2047.023.0001
- 499 Exhibit 27-0022, ‘Statement of Adjunct Associate Professor Vicki Taylor’, Case Study 27, STAT.0561.002.0001\_R at [24].

- 500 Ibid at [31].
- 501 Exhibit 27-0033, Case Study 27, NSW.0055.001.0369.
- 502 Transcript of V Taylor, Case Study 27, 11 May 2015, 14329:39–14330:4.
- 503 Exhibit 27-0021, Case Study 27, WEB.0037.001.0001, sets out a checklist of notification requirements of health workers, including immediate notification to NSW Police if there is alleged criminal conduct which may not be notifiable to the Child Protection Helpline – for example, child pornography and historical child sexual assault.
- 504 Exhibit 27-0001, Case Study 27, NSW.2047.008.0001.
- 505 Transcript of V Taylor, Case Study 27, 11 May 2015, 14328:47–14329:3.
- 506 Exhibit 27-0001, Case Study 27, NSW.2047.008.0001.
- 507 Transcript of V Taylor, Case Study 27, 11 May 2015, 14329:25–14330:3.
- 508 Transcript of V Taylor, Case Study 27, 11 May 2015, 14329:5–26.
- 509 Exhibit 27-0001, Case Study 27, NSW.2047.006.0001.
- 510 Transcript of V Taylor, Case Study 27, 11 May 2015, 14332:35–45.
- 511 Transcript of V Taylor, Case Study 27, 11 May 2015, 14333:6–15.
- 512 Transcript of V Taylor, Case Study 27, 11 May 2015, 14338:3–19.
- 513 Exhibit 27-0001, Case Study 27, NSW.2047.009.0001.
- 514 In this regard, Professor Taylor gave evidence that the majority of rooms where children receive treatment at the RNSH have viewing windows to provide visibility and maximise patient and staff safety without compromising patient privacy: Exhibit 27-0023, ‘Statement of Adjunct Associate Professor Vicki Taylor’, Case Study 27, STAT.0561.001.0001\_R at [70].
- 515 Ibid at [45]–[62].
- 516 Exhibit 27-0001, Case Study 27, NSW.2047.015.0001.
- 517 Exhibit 27-0001, Case Study 27, NSW.2047.016.0001.
- 518 Exhibit 27-0023, ‘Statement of Adjunct Associate Professor Vicki Taylor’, Case Study 27, STAT.0561.001.0001\_R at [51].
- 519 Ibid at [72]–[73].
- 520 Ibid at [74].
- 521 Ibid at [79]–[80].
- 522 Ibid at [65].
- 523 Ibid at [65].
- 524 Ibid at [65].
- 525 Transcript of V Taylor, Case Study 27, 11 May 2015, 14343:36–47.
- 526 Royal Children’s Hospital, *About the Royal Children’s Hospital*, [www.rch.org.au/rch/about/](http://www.rch.org.au/rch/about/) (viewed 1 June 2015).
- 527 Exhibit 27-0001, Case Study 27, RMH.0001.001.0247 at 0252.
- 528 Above n 526.
- 529 Ibid.
- 530 Ibid.
- 531 Transcript of C Kirkpatrick, Case Study 27, 13 May 2015, 14513:47–14514:11.
- 532 Exhibit 27-0001, Case Study 27, DHS.3143.001.0001 at 0006.
- 533 *Health Services Act 1988* (Vic) Schedule 5.
- 534 *Health Services Act 1988* (Vic) s 65Q; Exhibit 27-0001, Case Study 27, DHS.3143.001.0001 at 0006.
- 535 Exhibit 27-0001, Case Study 27, DHS.3143.001.0001 .0006.
- 536 Ibid.
- 537 Ibid.
- 538 Exhibit 27-0026, ‘Statement of John de Campo’, Case Study 27, STAT.0557.001.0001\_R at [1].
- 539 Exhibit 27-0027, ‘Statement of Professor Christine Kilpatrick’, Case Study 27, STAT.0556.001.0001\_R [1].
- 540 Transcript of C Kilpatrick, Case Study 27, 13 May 2015, 14484:38–44.
- 541 Transcript of C Kilpatrick, Case Study 27, 13 May 2015, 14519:27–34.
- 542 Transcript of C Kilpatrick, Case Study 27, 13 May 2015, 14519:36–41.
- 543 Exhibit 27-0001, Case Study 27, RMH.0001.002.0182 at 0189.
- 544 Exhibit 27-0001, Case Study 27, RMH.0001.002.0182 at 0207.
- 545 Transcript of J de Campo, Case Study 27, 12 May 2015, 14438:33–46.

- 546 Transcript of J de Campo, Case Study 27, 12 May 2015, 14439:1–11.  
547 Transcript of J de Campo, Case Study 27, 12 May 2015, 14441:27–30; Exhibit 27-0001, Case Study 27, RMH.0001.010.0006.  
548 Transcript of J de Campo, Case Study 27, 12 May 2015, 14439:38–14440:5.  
549 Exhibit 27-0025, ‘Statement of AWI’, Case Study 27, STAT.0558.001.0001\_R at [14].  
550 Ibid at [40].  
551 Ibid at [41].  
552 Ibid at [55]–[56].  
553 Ibid at [98].  
554 Ibid at [99].  
555 Ibid at [100].  
556 Ibid at [101].  
557 Ibid at [103]–[104].  
558 Ibid at [105]–[106].  
559 Ibid at [107].  
560 Ibid at [106].  
561 Exhibit 27-0001, Case Study 27, RMH.0001.010.0007\_R.  
562 Exhibit 27-0026, ‘Statement of John de Campo’, Case Study 27, STAT.0557.001.0001\_R at [21], Exhibit 27-0001, Case Study 27, RMH.0001.010.0013\_E at 0014\_E.  
563 Exhibit 27-0026, ‘Statement of John de Campo’, Case Study 27, STAT.0557.001.0001\_R at [22]; Exhibit 27-0001, Case Study 27, RMH.0001.010.0013\_E\_R.  
564 Exhibit 27-0026, ‘Statement of John de Campo’, Case Study 27, STAT.0557.001.0001\_R at [23]; Exhibit 27-0001, Case Study 27, RMH.001.010.0013\_E\_R.  
565 Exhibit 27-0001, Case Study 27, VPOL.0009.002.0016\_E\_R.  
566 Exhibit 27-0026, ‘Statement of John de Campo’, Case Study 27, STAT.0557.001.0001\_R at [27]; Exhibit 27-0001, Case Study 27, RMH.001.010.0010\_E\_R.  
567 Exhibit 27-0026, ‘Statement of John de Campo’, Case Study 27, STAT.0557.001.0001\_R at [27].  
568 Ibid at [29]; Exhibit 27-0001, Case Study 27, RMH.0001.010.0017\_E.  
569 Exhibit 27-0001, Case Study 27, RMH.0001.010.0017\_E.  
570 Exhibit 27-0001, Case Study 27, RMH.0001.010.0007\_R.  
571 Ibid.  
572 Exhibit 27-0001, Case Study 27, RMH.0001.010.0013\_E\_R at 0014.  
573 Transcript of Dr J de Campo, Case Study 27, 12 May 2015, 14415:21–30.  
574 Transcript of Dr J de Campo, Case Study 27, 12 May 2015, 14424:40–7.  
575 Transcript of Dr J de Campo, Case Study 27, 12 May 2015, 14446:19–14447:21.  
576 Transcript of Dr J de Campo, Case Study 27, 12 May 2015, 14446:19–14447:10.  
577 Exhibit 27-0001, Case Study 27, RMH.0001.010.0021\_R.  
578 Transcript of J de Campo, Case Study 27, 12 May 2015, 14411:21–30.  
579 Transcript of J de Campo, Case Study 27, 12 May 2015, 14416:33–41.  
580 Exhibit 27-0001, Case Study 27, VPOL.0009.002.0016\_E\_R.  
581 Transcript of J de Campo, Case Study 27, 12 May 2015, 14436:29–14437:16.  
582 Ibid.  
583 Exhibit 27-0026, ‘Statement of John de Campo’, Case Study 27, STAT.0557.001.0001\_R at [41(a)].  
584 Transcript of J de Campo, Case Study 27, 12 May 2015, 14431:31–8.  
585 Exhibit 27-0001, Case Study 27, RMH.0001.010.0006.  
586 Exhibit 27-0001, Case Study 27, RMH.0001.010.0006.  
587 Exhibit 27-0001, Case Study 27, RMH.0001.010.0006; Transcript of J de Campo, Case Study 27, 12 May 2015, 14443:12–17, 14444:10–13 and 14444:26–9.  
588 Transcript of J de Campo, Case Study 27, 12 May 2015, 14448:3–13.  
589 Ibid.  
590 Transcript of J de Campo, Case Study 27, 12 May 2015, 14450:6–15.  
591 Transcript of J de Campo, Case Study 27, 12 May 2015, 14448:3–32.  
592 Transcript of J de Campo, Case Study 27, 12 May 2015, 14448:3–13.  
593 Exhibit 27-0001, Case Study 27, RMH.0001.010.0006.

594 Transcript of J de Campo, Case Study 27, 12 May 2015, 14411:21–30.

595 Exhibit 27-0026, 'Statement of John de Campo', Case Study 27, STAT.0557.001.0001\_R at [27].

596 Exhibit 27-0001, Case Study 27, RMH.0001.010.0017\_E.

597 Transcript of J de Campo, Case Study 27, 12 May 2015, 14427:42–14428:21.

598 Exhibit 27-0001, Case Study 27, RMH.0001.010.0017\_E.

599 Transcript of J de Campo, Case Study 27, 12 May 2015, 14428:27–37.

600 Transcript of J de Campo, Case Study 27, 12 May 2015, 14428:39–14429:10.

601 Transcript of J de Campo, Case Study 27, 12 May 2015, 14427:33–45.

602 Transcript of J de Campo, Case Study 27, 12 May 2015, 14428:23–37.

603 Transcript of J de Campo, Case Study 27, 12 May 2015, 14427:47–14428:21.

604 Exhibit 27-0001, Case Study 27, RMH.0004.001.0230.

605 Exhibit 27-0001, Case Study 27, RMH.0004.001.0234.

606 Exhibit 27-0032, Case Study 27, RMH.1000.002.0170.

607 Exhibit 27-0001, Case Study 27, RMH.0004.001.0381.

608 Exhibit 27-0001, Case Study 27, RMH.0004.001.0372.

609 Exhibit 27-0032, Case Study 27, RMH.1000.002.0170.

610 Ibid.

611 Exhibit 27-0032, Case Study 27, RMH.1000.002.0174.

612 Exhibit 27-0001, Case Study 27, RMH.0004.001.0361.

613 Exhibit 27-0001, Case Study 27, RMH.0004.001.0358.

614 Exhibit 27-0001, Case Study 27, RMH.1000.003.0004.

615 Exhibit 27-0001, Case Study 27, RMH.0001.007.0363.

616 Exhibit 27-0001, Case Study 27, RMH.0004.001.0351.

617 Exhibit 27-0001, Case Study 27, RMH.0004.001.0450.

618 Exhibit 27-0001, Case Study 27, RMH.0004.001.0454.

619 Exhibit 27-0032, Case Study 27, RMH.1000.005.0013.

620 Exhibit 27-0001, Case Study 27, RMH.0004.001.0410.

621 Exhibit 27-0001, Case Study 27, RMH.0004.001.0416.

622 Exhibit 27-0001, Case Study 27, RMH.0004.001.0416 at 0421.

623 Ibid at 0422.

624 Exhibit 27-0032, Case Study 27, RMH.1000.005.0305.

625 Exhibit 27-0001, Case Study 27, RMH.0004.001.0393.

626 Exhibit 27-0032, Case Study 27, RMH.0001.001.0386.

627 Exhibit 27-0032, Case Study 27, RMH.0001.001.0162.

628 Exhibit 27-0032, Case Study 27, RMH.0006.001.0001.

629 It supersedes the Supervision of Unaccompanied Inpatient Child or Adolescent Procedure: Exhibit 27-0032, Case Study 27, RMH.1000.005.0283.

630 Exhibit 27-0032, Case Study 27, RMH.0004.001.0398.

631 Ibid.

632 Exhibit 27-0032, Case Study 27, RMH.1000.005.0291.

633 Exhibit 27-0032, Case Study 27, RMH.0004.001.0408.

634 Ibid at 0409.

635 Ibid.

636 Exhibit 27-0032, Case Study 27, RMH.1000.005.0085.

637 Exhibit 27-0001, Case Study 27, RMH.0005.001.0002.

638 Exhibit 27-0001, Case Study 27, RMH.0004.001.0428.



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