COMMISSION OF INQUIRY

INTO FORENSIC DNA TESTING IN QUEENSLAND

Brisbane Magistrates Court
Level 1/363 George Street, Brisbane

On Tuesday, 18 October 2022 at 9.30am

Before: The Hon Walter Sofronoff KC, Commissioner

Counsel Assisting: Mr Michael Hodge KC
Ms Laura Reece
Mr Joshua Jones
Ms Susan Hedge

<ALLAN RUSSELL McNEVIN, on former affirmation: [9.30am]

THE COMMISSIONER: Q. Mr McNevin, I was asking you yesterday about the change to the cleaning system.
A. Yes.

Q. What interested me was the adoption of TriGene as a method of cleaning, and bleach, and I wonder if you could assist me with how you came to that conclusion?
A. Yes. Can I make a correction to my evidence from yesterday?

Q. Of course you can.
A. Yesterday I referred to the end plugs or the bungs in the bone crushing box, that they were rubber, but they're actually metal.

Q. Yes, they are stainless steel, I think?
A. Yes. That was my mistake.

Q. Yes, that's all right. So what about the TriGene used for cleaning, and the bleach?
A. We've been using TriGene in the laboratory for some time, and we had been using a product called TriGene II and that was superseded by another product called TriGene Advance. I can't remember the exact details of why they changed their product, but they did. So we conducted Project #153 to look at TriGene Advance a bunch of other cleaning products. Project #153 showed that TriGene had worked quite effectively, along with Virkon and a couple of other cleaning products - bleach mainly, as well. So that was something that we had already had in use in the laboratory as a fairly routine thing.

Q. For what, what were you using it for?
A. For cleaning all sorts of things - instruments, like, machines, as well as various bits of equipment. Generally speaking, we used TriGene where we couldn't use bleach. Bleach is always our preferred option, and generally that involves the risk of corrosion and that sort of thing. So we had tested that using blood applied to plastic. The bone cleaning vials themselves are metal and plastic. I'm not sure if the plastic is the same that we tested - probably not. Whereas Project #148 was just looking at those bone cleaning vials. So when I was thinking we need to stop using Tergazyme, I was thinking to myself, well, we have this project, 148, that had been completed around the

same time as Project #153, and Project #148 had recommended that we clean these bone crushing vials using this special dishwasher cycle, so I thought, well, yes, we should use that, and why not just clean everything else the way we clean everything else in the laboratory? So that was kind of my thinking behind that decision-making process.

Q. I see.
A. And that's the process I then used to put forward to the rest of the management team.

Q. I understand that Ms Angelina Keller has a lot of experience in working with bones?
A. Yes, she does some of the sampling, yes.

Q. At this time, at the time that this new cleaning method was being considered by you, was she the one who had the most experience at FSS in working with bones?
A. I've not counted the number of bones that she's sampled versus the number other people have sampled, so --

Q. Well, what about compared with you? I think you hadn't done much work in that area --
A. For sure. I hadn't actually gone on the tools, as it were, to do the sampling myself.

Q. You were put into a position where I think you gave evidence that you studied some literature and some textbooks --
A. Yes.

Q. -- and other things. What was the position to which you were appointed that required you to do that study?
A. Well, I was the evidence recovery supervisor. So I supervise the evidence recovery team, and the evidence recovery staff, along with some staff outside of the evidence recovery team, did the bone sampling, amongst a whole bunch of other evidence recovery tasks.

Q. I see, and previously who was doing that?
A. Prior to me, being the evidence recovery supervisor, that was Luke Ryan. So we swapped roles.

Q. What about evidence recovery from bones - who was mostly doing that? Was that done by Luke Ryan's team?
A. Well, it was done by staff both within the evidence recovery team, so when Luke managed the team, that was the

case, and also when I managed the team, that was the case, but there were also another couple of other staff members outside of the evidence recovery team that also did some of the bone sampling as well.

Q. Who was that?
A. Angelina Keller was one of them, and another one was Allison Lloyd.

Q. As I understand it, with bones, it's necessary to handle the bone in a particular way to extract pieces of bone with a view to crushing them into powder, those pieces into powder, and then it is those powdered bones that become the sample that parts of which are then used for quantitation and amplification and so on; is that your understanding?
A. Yes, the bone powder goes on to a DNA extraction method in the analytical team, yes.

Q. When you were appointed, who was the person who was regularly doing the extraction of samples from bones that were received in the lab?
A. The DNA extraction or the sampling part?

Q. The sample extraction - the taking of the bone particles.
A. Yes, the chopping up and crushing?

Q. Yes.
A. That was done by Valerie Caldwell, one of my staff members in the evidence recovery; Abigail Ryan, another one of my staff members in evidence recovery; Janine Seymour-Murray was another one of my staff members; and then at that time I think Allison Lloyd and Angelina Keller were also - they were outside of the evidence recovery team; and I think at that stage Timothy Gardam was also still part of forensic DNA analysis, so he may have been doing some sampling.

Q. I see that you sent your proposal to the management team. You didn't send it to, for example, Mr Gardam, Ms Lloyd or Ms Keller?
A. Ms Lloyd was part of the management team, I believe.

Q. I see. What about Ms Keller and Mr Gardam - you didn't think it would be advisable to seek their views about changing the cleaning system used in connection with

bone extraction?
A. Well, I think at that time, Tim had actually left forensic DNA analysis.

Q. What about Ms Keller, had she left?
A. No, but I did talk to my own staff within evidence recovery who did the bone sampling.

THE COMMISSIONER: Ms Hedge isn't here, of course. Mr Hodge, can I see a copy of Project #153?

MR HODGE: Yes. It is [FSS.0205.0001.0001]. Commissioner, do you want a paper copy?

THE COMMISSIONER: I would, thank you. It might make things more efficient for this purpose.

Q. Could I just ask you about this sperm microscopy issue?
A. Mmm-hmm.

Q. I gather you were tasked with looking into it and developed that project because of your role in evidence recovery; is that right?
A. Yes.

Q. Had you had any experience in the examination of samples and interpretation of profiles specifically in relation to sexual assault cases?
A. Yes.

Q. When did you have that experience - at that time, I mean. We're talking about 2016, 2017.
A. Look, I can't remember exactly. I had gone through a process, when I was part of the analytical team as the analytical supervisor, to be trained in DNA reporting and reporting, case management of samples, you know, profile analysis, profile review and then on to the reporting aspects. And because I was a manager and, you know, I had to fit that training in around all sorts of comings and goings in the laboratory, the training was quite protracted, so I can't really think of a specific date, but I had undergone a certain level of reporting training prior to taking on the evidence recovery role, and, look, I can't recall off the top of my head exactly when I was signed off to report on sexual assault cases.

Q. But you were?
A. From memory, I think I was at the time that the sperm microscopy issue arose, but if I wasn't, it must have been around that time. I was certainly very familiar with all of the issues.

Q. We have seen evidence that the potential problem with the microscope slides used in the first instance arose in late 2015 and then arose again in early 2016, when Ms Wilson and Ms Reeves brought the matter to Mr Howes' attention, I think, and you must have become aware of it at about that time?
A. I'm not sure exactly, because --

Q. Well, you must have, because you were head of evidence recovery, weren't you?
A. Yes, but I don't know exactly what time they brought it to me.

Q. No, no.
A. Yes, so --

Q. Mr Howes or somebody must have brought it to your attention early in 2016?
A. Certainly prior to the - where it was mentioned first in the management team meeting, which I think - was that May or something we discussed yesterday?

Q. Yes.
A. So it must have been prior to that date, but exactly when and how it was presented to me I can't really recall. My - at that time, the general practice was, and I had a very good working relationship with my supervisor, Paula Brisotto, and also with my other colleagues that worked under Paula Brisotto, Luke Ryan and Kirsten Scott, so when they were acting for Paula, generally we tended to raise things to each other in person first, so that's why there probably isn't some sort of record.

Q. Yes, I understand.
A. It may have been raised in a way that was just kind of like, "Oh, some people have observed some things." "Oh, okay." You know, it may not have been a very well-formed idea and I might have said, "Well, I need more information." I think I talked about that yesterday, how one of my go-to things is --

Q. Now, I don't want to get into the rights and wrongs and rehash old history about that awful meeting. All right? So don't misunderstand me.
A. Mmm-hmm.

Q. I get the impression that, on the one hand, Ms Reeves was extremely concerned about it, but you were less concerned about it; would I be right?
A. Yes.

Q. Can you tell me why the lack of concern? I'm not criticising you for it. What I want to know is, it seems to me now that when some scientists come forward and say, "We may be missing samples here", that is a matter that would give rise to a sense of urgency in trying to find out whether that's happening and stopping it and, in due course, finding out why it has happened. But there doesn't seem to be a sense of urgency here, because nothing was done, really, until August, when you put forward the proposal for the project, and then it was worked on after that. So I'm interested in why, from your point of view, it didn't seem as urgent to you as it did to, for example, Ms Reeves, and I think Ms Rika, to be fair?
A. So if you just said to me, "We see more DNA in the differential slide than what's seen - or more spermatozoa on the differential slide than what we saw on the evidence recovery slide" --

Q. Well, we saw spermatozoa on the differential slide, when there were none on the --
A. I'm sorry, I'm just - how was it - how, from memory, it was presented to me --

Q. Oh, I see, how you understood it.
A. -- was that they were detecting more DNA on the differential lysis slide than the evidence recovery slide. And I wasn't - to me, that wasn't an unexpected finding, because when you did your initial immersion of the substrate, whether that was a piece of scraping from fabric or a swab or whatever, in some liquid in evidence recovery, that was in a larger volume than when you passed it through the initial stages of the DNA extraction process, where you then separate out the cellular epithelial fraction from the spermatozoa fraction. That spermatozoa fraction --

Q. I'm sorry to interrupt you. Can I summarise it this way: you understood the matter being raised was that there

were more sperm seen in the lysis stage than in the original microscope slide?
A. Yes.

Q. But that doesn't surprise you, because that's what you would expect, given the nature of the process in each case?
A. Yes, and that's what the very first stage of Project #181 kind of shows. And I should say that we didn't do nothing prior to the start of Project #181, because we did that data mining first to see if we could find some concrete examples.

Q. Yes.
A. So that was kind of the first step prior to the project, was looking for - can we sort of see what the size of this problem is? Are we talking about one or two isolated incidences or some sort of more regular occurrences?

Q. So am I correct if I concluded that as it was presented to you, until August, the problem wasn't that samples might be being missed but that there was a suggestion that there was an inconsistency between the two steps, the original microscope and the lysis microscope examination in terms of quantity, and that from your point of view, that's not unexpected, so there wasn't any sense of urgency attached to it?
A. To be clear, I don't specifically remember how it was raised to me and exactly what context and the detail that I was provided in that, of it being raised to me, so that makes it a little bit difficult to be very specific about that. You have to also remember that we'd been using that procedure for quite some time, so you would think that if there had been some sort of systemic problem with that procedure, it would have arisen years previous, not, you know, some recent kind of development. So it didn't - we hadn't changed anything.

Q. Would that not have struck you as making it more serious, that if they're not seeing sperm under the microscope and maybe disposing of samples without further processing, but seeing sperm under the microscope after the D-lysis process has been undertaken and the process has been implemented a long, long time ago, there might be many samples that have been missed?
A. No, because it seemed to me that it was being raised as a recent issue, that it was only something that they had

observed of recent note, rather than something that they had been observing for some period of time, and so it seemed odd that you would suddenly notice something different in a procedure that had remained unchanged for quite some period of time.

Q. So --
A. So that's why - sorry, can I just --

Q. I'm sorry, you go ahead.
A. That's why my initial step was, well, let's get some more information before we go jumping at shadows. It turns out, yes, there were some examples we were able to find when we did that data mining, and that's what led to the project.

Q. So you recall that at that meeting there was a difference of opinion about the level of risk, or at least Ms Reeves was very anxious about matters and you were not as anxious, for the reasons you have just explained. Is it that you didn't appreciate or you didn't apprehend at the time or think at the time that there was much risk of losing valuable samples - that is, valuable for a particular case or investigation?
A. I don't - I don't really know. I think what maybe my response was, like, okay, we've identified it, we're moving forward, to just keep saying that there is a problem, when we were already starting down the process of moving forward, seemed a little bit redundant, I think.

Q. Yes, I understand.
A. Yes.

THE COMMISSIONER: Is there anything arising out of that, Mr Hunter?

MR HUNTER: No, thank you.

THE COMMISSIONER: Or anybody?

MS FREEMAN: Commissioner, I might have a few questions for Mr McNevin.

THE COMMISSIONER: Yes, you want to examine? Just excuse me a moment. There is nobody else? No. Yes, go ahead, Ms Freeman.

<EXAMINATION BY MS FREEMAN:

MS FREEMAN: Q. Mr McNevin, you have given some evidence this morning about Project #153.
A. Yes.

Q. I think it is still up on the screen there, so that's convenient. If you could just have a look at that, we can see on the front page there that it is dated April 2015?
A. Yes.

Q. Your evidence earlier was that you understood the outcome of that particular project was that TriGene was working efficiently and effectively in terms of cleaning instruments in the lab generally; is that right?
A. Yes, yes.

Q. If we could perhaps go to the final page of that document, please, Mr Operator, so page 12, the heading "5. Conclusions and Recommendations". Can you see that there, Mr McNevin?
A. Yes.

Q. It indicates there, doesn't it, that the findings of this project didn't show any indication that this new product, TriGene Advance, when used in the manner described - there was no discernible change between the outcomes when cleaning instruments. Is that the effect of what that concludes there?
A. In summary, yes.

Q. So the point of this project was to look at moving from TriGene II to TriGene Advance; is that right?
A. Yes, I think that was the --

Q. And as part of that process, you also tested - or the project looked at other possible alternatives; is that right?
A. Yes, we had a range of other chemicals that were there.

Q. Ultimately, the first recommendation there is to "Continue using TriGene Advance in the laboratory as a liquid decontaminant"?
A. Yes.

Q. The second point there, "Continue using 70% Ethanol to

remove any cleaning reagent residue" - can you just tell us, what is the role in this ethanol wiping part of this process?
A. Yes, so it's quite common in cleaning protocols, and we use it when we use bleach as well, so it's used to not just remove the residue of the cleaning agent, which may remain, but also a way of removing those breakdown products that the cleaning agent has resulted in, so it's broken down the DNA in the cells or bacteria, or whatever is present, and most of these things - sorry, the cleaning agents - I'll just use that word, sorry, the other word slipped my mind - also clean away those remnants as well in a mechanical action by wiping away, wiping clean. So you don't just leave the chemicals sitting on top; you wipe it away.

Q. So the person doing the cleaning would apply the TriGene or the bleach or the chemical agent that is being used to initially clean the instrument, and then they would physically wipe down the instrument with a solution of ethanol; is that right?
A. Yes, so you actually wipe with a wetted - quite wetted wipe with the cleaning agent, and then you use a wetted wipe with the 70 per cent ethanol after that. So it's a two-step process.

Q. Am I right in understanding that the chemical that is the bleach or TriGene or Tergazyme, whatever you are using, that destroys DNA but leaves fragments of it on the instruments; is that right?
A. Yes, that's kind of the difference between making something sort of sterile or disinfected versus what we need to do in our laboratory, in that a cleaning agent in a sort of a regular setting might be just sufficient to kill the virus, inactivate the virus, inactivate the bacteria, whatever, but because we also look for fragments of DNA, we need to go that little extra step of wiping away the remnants from that cleaning action.

Q. So the step of wiping the instrument or the equipment down with the 70 per cent ethanol is an important part of the cleaning process?
A. Yes, I believe so.

Q. Now, Project #153 was a project designed around experiments looking at blood on Petri dishes; is that right?

A. Yes, that's right.

Q. So blood on plastic?
A. Yes.

Q. The other project that you looked at when you were considering this cleaning process was Project #148?
A. Yes.

Q. That was different again, wasn't it --
A. Yes, it was --

Q. -- in that it was saliva and buccal cells on metal plugs being cleaned and seeing how the different products worked?
A. Yes.

Q. What was the significance for you in the sense that Project #148 involved saliva and buccal cells, if anything?
A. I guess implicit in both projects are that you have only really tested one biological source, and you have to then kind of extrapolate out to other biological sources - bone may be one, or semen or something else. So you don't - you don't have a - it's not a direct comparison. It's an indirect comparison.

Q. Is there anything about saliva or the properties of saliva that can make it difficult to clean compared to other biological material?
A. Well, it's posited in Project #148 that there are some proteins and things there that may make it sort of sticky or something like that. But, yes, each biological material is different, and much of the literature, when it - sometimes they test just free DNA, so they will get some extracted DNA in the form of a positive control material or something, and that gets cleaned away quite easily because it's not contained within a cellular biological fluid matrix. And so it's not always - all the different studies are not exactly necessarily the exact thing you're doing, and that may be because it's not necessarily practical to test the exact thing you're doing.

Q. And so in this case, neither of these projects tested the cleaning of bone fragments off equipment or metal or plastic?
A. Correct, yes.

Q. Is that because it's difficult to get enough bone samples to do the required testing to be able to understand the cleaning --
A. I think so, yes, that would be one element, predicting the amount of DNA in the bone as well, so trying to have some sort of control for your replicates of your test. There has already been some evidence about the need to control your variables, and also that the amount of DNA can vary along the length or in different areas of a piece of bone, and so if you are doing multiple sampling events, you may not necessarily have the same amount of DNA going into each test material, so it could be difficult to tease apart the differences between some cleaning agents and others if you are not necessarily controlling the amount of DNA you are depositing in the first place. That's why a lot of studies will use things like blood, because it's a readily available source, you can put a precise amount on a bunch of different things and carry out your cleaning then.

Q. Am I right in understanding that the process you undertook was to synthesise the results of Projects #148 and #153 and come up with a solution for the bone cleaning protocol that you needed to come up with?
A. Yes, we had this one project that, you know, showed that there was an effective method for cleaning these particular parts of the tools that we use, and then we had this other method that said, "Well, the method that you're using everywhere else in the laboratory is effective, so let's go with that."

Q. The first part of your answer there, you were talking about using the industrial dishwasher to clean --
A. Yes, just for the vials themselves, so that's the cylinder and the bungs and the impactor.

Q. And then the second aspect of it was using the TriGene to clean the other instruments?
A. Or bleach and ethanol as well. That was an option as well. So it was a combination of bleach and ethanol, and TriGene and ethanol.

Q. Plus the important step of wiping them down?
A. Yes, in another step.

Q. Finally, Mr McNevin, just in relation to Project #181 and the sperm microscopy issue, as I understand it, you were on leave from March to May 2016; is that right?

A. I'm sorry, I don't recall, but, yes --

Q. You can't recall. Okay, all right.
A. -- unfortunately, if there's evidence to show I was on holidays, I was.

Q. Do you recall taking leave in the first part of 2016?
A. How many years ago was that - six?

THE COMMISSIONER: I think there will be documents, Ms Freeman, and there is reference in minutes or emails about Mr McNevin being on leave at around that time.

MS FREEMAN: Thank you, Commissioner. I appreciate that.

Q. In any event, the issue was raised on 12 May 2016 in a management team meeting; is that right?
A. If that's what we have already discussed, yes.

Q. And it was at that point that you were tasked with the job of investigating the issue; is that correct?
A. I think that's - that's when we decided to do that retrospective data analysis first or looking at - well, I think it was both slightly retrospective and also slightly prospective, in that we went and got a bunch of unread differential lysis slides and read them.

Q. On 2 June 2016, you then actioned the initial request for an investigation into the issue; is that right?
A. The project, yes.

Q. That was what became Project #181?
A. Yes.

Q. We've heard the workaround was implemented from 8 August 2016; is that right?
A. Yes.

Q. So you're tasked in mid-May 2016 with investigating the issue. You do some initial data mining --
A. Yes.

Q. -- to see what the problem is; is that right?
A. Yes.

Q. Project #181 was established, or you initiated Project #181 on 2 June 2016?

A. Yes.

Q. And then the workaround was implemented on 8 August 2016?
A. Sounds right.

Q. So Project #181 ended up increasing in size and complexity as it went on, didn't it?
A. Yes.

Q. There were a number of phases or parts to it?
A. Yes.

Q. In terms of these projects that we've been hearing about in this inquiry, they are worked on by team members in addition to their usual workloads, aren't they?
A. Correct.

Q. You are not just working usually on one project at a time, are you?
A. Depends, but, yes, there are plenty of instances where you're working on multiple things, or certainly as a supervisor there might be various projects that you might have some involvement in across the laboratory, yes.

Q. That might be by virtue of your role as being the manager or the supervisor, which means you are on the management team?
A. Generally speaking, yes. The members of the management team are often involved in various projects, and then you might have a sort of a project team underneath you that would actually be doing the sort of on-the-tools work, and sometimes some of those might also be on another project, but more often than not, those people might be just dedicated to one project, but not always.

Q. And so your role in these projects would be in addition to all your other tasks and duties associated with your substantive position?
A. Yes.

MS FREEMAN: That was all that I had, thank you, Commissioner.

THE COMMISSIONER: Q. That raises a problem for me, Mr McNevin. Did I understand you to say that Project #148 relating to the vials, which found that TriGene was almost

useless in cleaning them, was something that you discounted because the substance that was applied containing DNA was saliva?
A. No, not solely on that information.

Q. On what other information?
A. TriGene's used elsewhere and it was a common cleaning agent that had been used in other laboratories, so --

Q. For what?
A. For cleaning DNA, forensic - for decontaminating various things within a forensic laboratory. I haven't actually seen any reference to anything other than bleach and ethanol when I was looking for some information about cleaning of bone instruments in particular. There seemed to be a paucity of information out there about what other people were doing. So it's more that Project #148 came up with an unusual finding, and it's sort of acknowledged in Project #148 that that finding is unusual.

Q. How did it do that? Let's see --
A. I think it says - towards the end of the project, where it says - it acknowledges that the finding in the project is inconsistent with other findings in this laboratory, under the discussion under the Ballantyne paper, I believe, towards the end.

Q. Yes. Could this document be put up, please, [WIT.0003.0456.0001 at 0019]. That's the beginning of the "Summary & discussion". If you would read that, we will go over the page when you are ready.
A. I believe it's on that page there. It refers to the results as being "surprising" in the second sentence. So the authors are already acknowledging that they weren't expecting that TriGene would not work. And then approximately halfway down the paragraph, it's a little hard to count, but it says:

> *This result also conflicts with other testing at this laboratory using whole blood dried onto petri dishes, where it was found that TriGene Advance and Virkon are the most effective cleaning agents.*

About halfway down that paragraph.

Q. Yes, I see that.

A. So the project's - so the way I read it - yes.

Q. So you have a report that says TriGene is almost useless, and you have a report that says TriGene is quite useful?
A. Yes.

Q. So you chose to go ahead using TriGene?
A. Well, really, this report is the only report that I'd come across that said that --

Q. But what's its status as a report? I don't understand. I'm not blaming you. I just want to understand the status of reports in the lab, because for an outsider, you understand --
A. Yes, yes.

Q. -- you've got two conflicting reports. You appear to favour one report, the one with which you were involved, number 153, over the other. Why?
A. I don't think it was really about necessarily favouring one report over the other, because I took what this report found and I --

Q. 148?
A. Yes, and said, okay, well, in this instance, cleaning of these particular components of the bone cleaning process - let's use the findings that this report recommended.

Q. I see. So you decided to use the recommended method in accordance with Project #148, the washing machine - the dishwasher?
A. For the tools that 148 tested.

Q. But for other bone analysis equipment, bone extraction equipment, you decided to use TriGene because it had worked well, as you found, in Project #153?
A. It's not just TriGene but also bleach and ethanol that are appropriate as well, and bleach and ethanol is the more default cleaning agent that we would use in the laboratory.

Q. Could Project #153 be put up on the screen, please, [FSS.0205.0001.0001_R at 0005_R]. If you look through the paragraphs under "Sample preparation", maybe you can help me with it.
A. Yes.

Q. So do I understand the experiment to be this: you get a clean Petri dish, which is a circular dish about one centimetre deep made of glass; is that right?
A. Made of plastic.

Q. Sorry?
A. Made of plastic.

Q. All right. And that has been cleaned, so it has nothing in it; is that right?
A. It's purchased clean, yes.

Q. Yes, it's clean. The dish is then contaminated by putting some blood on it?
A. Yes.

Q. Then you clean the blood off using each of the substances you were testing - in this case, TriGene; right?
A. And the others, yes.

Q. And then you wipe the surface again with ethanol?
A. Yes.

Q. And then you see if it's clean, and you find that it's clean?
A. Yes, you sample that to detect any residual --

Q. You take a swab off it to see if you can get any DNA, and you find you have no DNA?
A. Yes.

Q. So how do you know it was the TriGene that removed the DNA, and not the ethanol?
A. I guess we didn't test the ethanol just by itself, but it's not really --

Q. So how do you know?
A. It's not really an accepted cleaning protocol.

Q. But you have a report that says TriGene is useless - that's 148 - and then you use two cleaning agents on a Petri dish and you say the first one you used is effective. How do you reach that conclusion?
A. Okay, so when I say we used "TriGene is effective", that is shorthand for "TriGene followed by 70 per cent ethanol" in the protocol as described within that project.

I don't believe that any anyone would just use 70 per cent ethanol and use it an effective cleaning agent.

Q. Would use what?
A. Just 70 per cent ethanol as an effective cleaning agent.

Q. Yes, so --
A. So I don't think it's thought of as a cleaning agent. It's more of a clean-up after you have done the cleaning agent.

Q. I see. But you tested it as a cleaning agent in this experiment, didn't you?
A. Well, as an adjunct to using - you use the cleaning agent, and then you clean the cleaning agent, as it were, and that's the protocol I then proposed.

Q. Wouldn't you use the same experiment to test TriGene and also ethanol, so that you get results for it, or am I wrong about that?
A. Sorry? I have misunderstood your question.

THE COMMISSIONER: No, it doesn't matter. It doesn't matter.

Anything arising out of that, Ms Freeman?

MS FREEMAN: No, thank you.

THE COMMISSIONER: Anybody else? Mr Hodge, do you have any re-examination?

MR HODGE: I do have some questions.

THE COMMISSIONER: I will tender Project #153 as exhibit 93. I will mark it as exhibit 93.

EXHIBIT #93 PROJECT #153 REPORT

MR HODGE: I should say, I am told the live stream has been up and down this morning; the video hasn't been working; the audio was working; the audio is cutting in and out; but I am assuming we'll just continue because there will be a recording of it available.

THE COMMISSIONER: As long as we're getting a transcript,

that's the important thing.

MR HODGE: Thank you.

<EXAMINATION BY MR HODGE:

MR HODGE: Q. Mr McNevin, I want to start with this question of the --

THE COMMISSIONER: Sorry, just to explain, Mr McNevin, Ms Hedge isn't here, so Mr Hodge is re-examining.

Sorry, go ahead.

MR HODGE: Thank you, Commissioner.

Q. I want to just start with this issue about 148 and 153 and some questions that you were asked by your counsel, Ms Freeman.
A. Mmm.

Q. When you made the recommendation to change the cleaning method in relation to bone, did you go back and read the reports for Project #148 and 153?
A. I don't think I went back and read 153, because I was kind of more familiar with that project, because - it doesn't matter why, but I was just more familiar with that project.

148 - I'm not sure if I initially did. I do remember my first response was to task one of my staff members to go and dig out that project and have a read and then talk to me about it. I think - I more than likely did. Whether I read it in depth or I just looked at the recommendations I can't quite recall exactly. I'm not sure. I might have just gone back and read the recommendations. I might have read the whole project. I can't remember, I'm sorry.

Q. In terms of how you came to send out the email which we looked at yesterday - and I might just bring that up. Could we bring up [WIT.0040.0077.0001 at 0257]. You see, just if we can trace this through, this is a chain of emails from you and from your witness statement, and if we go through to what is I think the third page of that document, it should be 0259.
A. Mmm-hmm.

Q. This seems to be the email or the chain of emails that has led to the issue being raised; is that right?
A. Yes. So Michael had raised it to me, said, "How come we're still using Tergazyme? That's not good." He had come and spoken to me in person, from what I can sort of piece together from the emails, and so I'd said to him, "Look, can you" --

Q. Sorry, please keep going.
A. That's okay. So Michael had I think had a conversation with me, and so that's when I had said to him, you know, "Can you just put that in an email for me, so that then I can then action it." That was probably twofold. Sometimes I liked to use my email as kind of like a to-do list, so I didn't forget to do things, but also it looks like it was a Friday afternoon and it was probably likely that I might have forgotten if we had come Monday, so I thought by putting it in an email, then I could then action it after the weekend. That was probably why I did it in that way in this instance.

Q. The issue that he was raising with you in the first place as to the existing cleaning method - what did you understand that to be?
A. It was more an issue with the chemical we were using, the Tergazyme, that it wasn't really suitable for storage where we were storing it, and the way we were just kind of flushing it down the drain wasn't the right thing to be done, and then we had issues with what to do with the empty packaging. It looks like those are the three main points that he raised with me.

Q. Did you find out whether there was any scientific reason why you were using Tergazyme in the first place?
A. It was unclear as to why we were - I did sort of recall having some conversations with a couple of my staff members who did the bone processing, and I said, like, "So how do we use it? Why do we use that, anyway?", and it was unclear exactly why. It might have been that that was a method that was imported from external to our laboratory. I don't believe that we had carried out any specific testing, like, way back in the day to say that this was the best method. It was just a method that we had imported along with some other methods, as far as I understand.

Q. Did you go back at the time, in 2019, to try to find out why it was that it had been used?

A. I knew previously that there were no sort of records around that, that we had no previous validations of those sorts of cleaning agents and cleaning protocols. And even just the whole bone sampling protocol, I knew that there was no validation extant around that whole protocol, that that had sort of arisen at a time previous to my arrival at forensic DNA analysis.

Q. Did you come to understand, though, at some point that it might have been the method that was used in the mortuary?
A. I think it was posited that that may have been a reason, yes. But of course the mortuary is a little bit different to the DNA lab.

Q. Tell me if I'm right about this: the way, then, in which this proceeds under the course of a week, as I have understood the various evidence you have given, is you have a conversation with one of your subordinates about potential problems with the use of the current chemical?
A. Michael's not my direct report, no.

Q. I'm sorry, you have a conversation with somebody else in the lab?
A. With another staff member.

Q. And that conversation is not about the effectiveness of the chemical in cleaning things, but it's about other consequences, disposal and things like that?
A. Yes, yes.

Q. And so you then raise a question with Ms Brisotto, who is your superior, about making a change; is that right?
A. Can we scroll up to the next part of the email? I'm assuming that's what that next bit says.

Q. Yes, if we go to the next page, if we go up, you can see at the bottom of the email chain, you say to Ms Brisotto:

> *Given some issues with using/disposing of Tergazyme as outlined ... should we implement the alternative protocol using the dishwasher as outlined in Proposal#148 ...*

A. Yes, so I had obviously recalled that at a time

previous we had done this other validation where we'd had this alternative cleaning method available that was there to be used, and given that we had an alternative method that could be used, why not use it?

Q. Then she responds - and you see this email at the top of the page - and says:

Anything that removes a [workplace health and safety] risk is worthwhile ...

A. Yes.

Q. Just tell me if I'm right, but there wasn't a conversation in between this, where she said to you, "What sort of validation have you done about the effectiveness of this for cleaning all of the equipment in relation to bone"?
A. No, no, because I had said to her, you know, "We're using Tergazyme. Should we get rid of it?"

Q. Yes, for reasons unrelated to the effectiveness of the cleaning?
A. Yes, pretty much exactly as that email trail says, yes.

Q. Then if we go to the first page of that email, .8817, you then send an email saying:

Alrighty,

I'll do all the right comms as soon as practical.

A. Yes.

Q. If we then go to the document which is [FSS.0001.0056.8823], this is another chain of emails between you and Ms Brisotto. If we just start with the earliest email in time, so, operator, if you can bring up the bottom of page .8824 and then effectively the top two-thirds of page .8825. So you were sending an email to her --
A. Yes.

Q. -- on 18 June, which is basically that afternoon, after you have said you will do the comms --

A. Yes.

Q. -- which is the wording that you're proposing to send around?
A. Yes.

Q. And that's going to go to the management team to approve?
A. Yes.

Q. You say in that email:

For some time Tergazyme has been used as a cleaning agent in the preparation of bone & teeth samples ...

Then you say it has been brought to your attention that there are issues storing it, and then you have your draft recommendations, which are:

Implement the cleaning of the bone crushing equipment using the dishwasher as per --

and that's just a typo, it should be "Proposal #148", and then --

Use bleach and/or TriGene followed by 70% ethanol to clean the remaining equipment in line with other Evidence Recovery laboratory equipment.

A. Mmm.

Q. Just tell me if I'm right: what then happens is you get an email back from Ms Brisotto later that afternoon, so we see that beginning at the bottom of page .8823, and she just tracks some changes in red?
A. Yes.

Q. She fixes some typos in your email?
A. Yes.

Q. If we then go up to the top of that first page, we see you email her back on the Friday and say:

Not sure who decided Tergazyme was the best cleaning agent, it's just been part of the

process for such a long time.

And then there is a reference to some conversations where you have been told it's been used in the mortuary?
A. Yes, so that must have been where I said earlier I sort of recall having a conversation with some staff.

Q. And presumably - you tell me if I'm right - I understand you say there are differences in terms of human tissue between your lab and the mortuary --
A. No, I was just meaning that there's more a different sort of purpose.

Q. Difference in purpose?
A. Yes. They're really interested about, you know, being very clean from a safety point of view because they have got large quantities of biological material, and we're a little bit more concerned more with ensuring that our laboratory hasn't got - hasn't got small quantities of DNA. So it's a little bit different.

Q. I understand. That then leads to the email which you saw yesterday, which is [FSS.0001.0056.8821]. This is then the email where you send it to the team, that final version of what you have crafted with Ms Brisotto?
A. Yes.

Q. And, again, I just want to confirm, from when you raised this issue with Ms Brisotto to when you send this email to your team, neither of you discuss the idea that perhaps you should either investigate why you were using that chemical to clean bone differently from other places in the lab; is that right?
A. Other than the conversation that was included in the email trail.

Q. Where you say you don't know?
A. Yes.

Q. And neither of you discuss the idea that perhaps you should validate, test, do any kind of experiment to check whether it was a good idea to make this change; that's right?
A. Correct, based on those reasons that we've outlined in that email.

Q. Yes. Tell me, sitting here now, today, do you, with

hindsight, think that was an error in process?
A. Well, again, one of the difficulties is you're still extrapolating from sources of information on a process that you are highly unlikely to test as you actually do it. So it's unlikely for you to be able to sample a whole bunch of bones and use different cleaning agents on those to see how you go. So there seems to be a lot of focus on just these two projects, but, you know, it's not an out-there idea to use TriGene followed by ethanol or bleach followed by ethanol as a cleaning protocol. You know, whether it's TriGene or Virkon or whatever, these are commercial products, and the use of bleach and ethanol - bleach followed by ethanol as a cleaning regime is quite a standard sort of protocol that's used throughout forensic laboratories to clean, you know, lots of different things.

THE COMMISSIONER: Q. What sort of things do you use bleach to clean in the lab?
A. The lab. So the walls, the bench, sampling equipment, keyboards, mouses - all sorts of things.

Q. And here you have at the top of the first paragraph on the document on the screen:

> *... Tergazyme has been used ... to clean the parts of the bone crusher that come into contact with the exhibit, and all of the manual handling tools such as chisels and the like.*

A. Mmm.

Q. So then at the end, what you recommend is using the dishwasher to clean the vials in accordance with Project #148 and otherwise to use TriGene, bleach and ethanol to clean other parts of the bone crusher that come into contact with the exhibit and all of the manual handling tools such as chisels and the like; is that right?
A. Yes.

Q. And so how is TriGene used and how is bleach used and how is ethanol used to clean those tools?
A. Okay, so the ethanol is just used after you use either the bleach or the TriGene - oh, you mean those specific tools?

Q. Mmm.

A. Using the same sort of ways that they would have been cleaning them previously. I guess I didn't really think of a specific method, in that there were staff - the staff that were in my team that were doing the bone sampling were familiar with using these chemicals to clean throughout the laboratory and had cleaned other examination instruments, you know, forceps and things --

Q. And the people who clean the instruments, are they scientists or are they staff who are --
A. Yes, scientists, my scientists.

Q. -- scientists?
A. Yes.

Q. It's just that in the email that you sent - or, rather, the change procedure that you instituted, if I can find it.
A. Is this around the dishwasher, Commissioner?

Q. Yes, where you say, "Here is the change that we're making now."
A. So one thing I wasn't actually super clear on was whether the scientists would give the bone vial bits to the operational officers to run the dishwasher and they would give them back, or whether the scientists would go and fire up the dishwasher themselves. That was something I hadn't actually nutted out and left it to the scientists to discuss that with the operational officers themselves, the exact sort of fine process of that.

MR HODGE: Operator, can you do this for me: I want to eventually bring three documents up on the screen, so can we start by moving that email from Mr McNevin to one side of the screen.

Q. You definitely read Project #148; is that right?
A. Well, at the time that I signed off on the project, yes, so back when it was initially done. With respect to sort of proceeding to this implementing it, I may have only just gone and quickly read the recommendations. I can't remember whether I went back and reread the whole project from start to finish.

Q. Can we bring up 148, which is [WIT.0003.0456.0001]. For the moment, let's bring that up slightly bigger, so it's possible for that to be read, so maybe make that half

of the screen, thank you. Then can we go to page - in the PDF version, it should be page 8 of the document - page 7 of the document, page 9 of the document. Maybe just go to the one that has page 1 at the bottom. Thank you. There are multiple page 1s, I think. Go to the one that has the heading "Abstract" at the top. Perfect. I just want to understand, would you have read the abstract?
A. Subsequent to the email or are you talking about back when the project was done? I mean, look, I've read it, yes.

Q. At some time, you read it?
A. Yes, yes.

Q. If we just zoom in on the second-last paragraph on that page, you see it says:

Any suitable cleaning protocol must not damage the stainless steel components of the crushing vials by causing rusting or pitting.

A. Mmm-hmm.

Q. You understood that any damage to stainless steel components was going to be significant?
A. Mmm-hmm.

Q. I'm sorry, you're saying "mmm-hmm". You need to answer out loud.
A. I'm sorry, yes. My apologies, yes. Yes, yes, I understood.

Q. And you understood that at the time when you were making this recommendation?
A. Yes.

Q. So did you turn your mind at the time to the question of whether any of the cleaning products you were saying were going to be used might damage steel components?
A. That's why I was looking at TriGene, because that's why we use TriGene elsewhere in the laboratory to - because we have other instruments that are more sensitive to corrosion, so you use something alternative to bleach. I think I've already covered that in evidence.

Q. I just want to try to understand this, though. This

is your recommendation that you would use bleach and/or TriGene followed by 70 per cent ethanol?
A. As appropriate.

Q. What does that mean?
A. Well, the assumption is that all of the people receiving that email, including my staff, understand why we use TriGene in some circumstances and bleach in others, so there is an implicit understanding amongst the laboratory staff about which would be the more appropriate chemical to use for whatever thing you're cleaning.

Q. Which were the components that you had in your mind would be used for TriGene rather than for bleach?
A. The metal components.

Q. But why not just say that in your email?
A. Sorry, but it seemed pretty obvious to me when I was writing the email, I guess. My apologies if it's not obvious to anyone else, but - and I also assume that for any of the laboratory staff, that would be fairly obvious as well, because, like I said, that's the way we do things across multiple areas of the laboratory. So it's not an unusual or foreign concept to them. So for the staff that work in the laboratory day in, day out, that would be - I believe it would be pretty obvious, anyway.

THE COMMISSIONER: Q. Isn't that the kind of thing you would put into a document?
A. That would go into an SOP.

Q. "Do not use bleach on metal instruments"?
A. That would probably go into a standard operating procedure, yes.

Q. But when you issue your change management, "Use bleach and/or TriGene followed by 70 per cent ethanol as appropriate to clean the remaining equipment", isn't the notion that you do not use bleach for metal instruments something that is fundamental to the new process that you are introducing?
A. I think, Commissioner, because it's that fundamental to laboratory processes, it's a given, would be my thinking in my mind.

Q. Lots of things are given that are in the instructions in the form of standard operating procedures and other

directions to staff - lots of them are given. Truck drivers are told not to get into a cabin without having three points of contact. That's a given. But they are told it, as you are in your lab. You are not suggesting that the absence of that instruction in the change management entry can be explained because you take it that everybody knows - everybody who is going to wash a steel instrument knows shouldn't use bleach, are you?
A. Can I just clarify something, Commissioner?

Q. Yes.
A. Are you referring to the spreadsheet?

Q. No, I'm referring to --
A. To the email?

Q. Yes, I guess it's the spreadsheet. It is the change management register.
A. Yes, so that spreadsheet doesn't really contain a lot of detail. It's not meant to provide any kind of fine detail. It's meant to just provide us with a reference of, like, a timeline as we have gone through and changed things.

Q. So it is a note. I understand.
A. It's more like a notation in that respect.

THE COMMISSIONER: You go ahead, Mr Hodge.

MR HODGE: Q. I just then want to try to understand the process of reasoning in your head. You say, at the time, you turned your mind to the fact that there were metal instruments that were going to be used, and therefore you would say bleach and/or TriGene --
A. Mmm.

Q. -- thinking everyone would understand you were to use TriGene on the metal instruments?
A. Certainly all the staff in my team, I thought, yes.

Q. But you say this is a positive thought you had at the time?
A. That was the thought I had at the - I believe that - well, I can't remember exactly what I was thinking, you know, three years ago. But from - as I sit now, thinking about what I probably was thinking, then yes.

Q. And the way in which you reasoned was there was Project #148 that had determined that the most appropriate method for cleaning of the bone crusher vials was a particular method?
A. Yes.

Q. And therefore you would recommend that for the bone crusher vials?
A. Yes.

Q. And you wouldn't recommend that for the other equipment?
A. Well, it's not that that other method might not be useful. It just seemed that we'd done this particular project to clean these particular things; it had a recommendation that we should use it. We hadn't been implementing it, because we still had lots of leftover of the old chemical, so why not implement that now, that is, the recommendation from that project. So it seemed kind of like - this is what I'm sort of - like I said, I can't remember exactly what I was thinking three years ago, but the gist of it would have been that we had this project; it tested this particular cleaning method, and it was suitable for replacing the use of this chemical that we now have decided we wanted to get rid of out of the laboratory, so why not implement that recommendation as it stood in that project.

Q. Yes, which is the first part of your dash?
A. Yes.

Q. But my question is, when it then came to the second part of your dash, which is all of the other equipment, why is it that you decided to recommend bleach and/or TriGene, given that (a) you knew bleach wasn't appropriate to use on metal equipment, and (b) you had read Project #148 and you knew that TriGene, when it had been used, had not been effective at cleaning away bone fragments?
A. No, because we didn't test bone fragments in Project #148; we tested saliva. Bone cleaning vials.

THE COMMISSIONER: Q. Do you regard Project #148 as determining that the dishwasher is good for getting rid of DNA in saliva but that it didn't test - you couldn't infer anything else from that project?
A. Oh, no. You know, that cleaning protocol might actually work for lots of things. I don't actually know.

Q. Wasn't the purpose of the test, if it had any purpose, to determine what cleaning agent would be best for getting rid of DNA in the vials?
A. I think it was just looking more just for an alternative protocol because they had previously been using an autoclave, and so they wanted to come up with a new protocol.

Q. Yes, an alternative protocol in order to determine what would get rid of DNA on the vials?
A. Yes.

Q. Not DNA in saliva but DNA from whatever source?
A. Yes, saliva was the biological --

Q. Yes, it was the medium, it happened to be the medium they used?
A. Yes, yes.

Q. So it was an experiment to determine what alternative protocol might be good at getting rid of DNA on the vials to ensure they are not contaminated?
A. Yes.

Q. So Mr Hodge's question is: why not use the dishwasher to clean all bone-crushing equipment that can fit into the machine?
A. I don't see why you couldn't.

Q. Why didn't you? Yes, I can't see any reason you couldn't, either, but I'm asking you why you didn't recommend it?
A. Because we had these other cleaning protocols that were used for all these other things, it seemed pretty straightforward that we would just implement those.

MR HODGE: Q. Tell me, though, if my understanding is right: 148 was a project that studied the effectiveness of a cleaning method on the equipment that you were making a recommendation about?
A. On the specific equipment that I made the recommendation about, and then I said, "Let's follow that cleaning protocol for that specific bit of equipment."

Q. And 153 was not a project about the cleaning of the equipment that you were making a recommendation about?

A. It was a more generic project to --

Q. Sorry, it was not a project about the cleaning of the equipment that you were making a recommendation about?
A. Well, there was no project to cover the equipment other than the bone crushing vials. There had been no project that covered anything other than the bone crushing vials.

Q. Is the answer to my question, "Yes, that's right", that Project #153 was not a project testing the cleaning of the equipment that you were making a recommendation about?
A. Well, can I be a little bit more specific? Because when you talk about equipment, there's two sets of equipment that I'm referring to in the email. There's one set of equipment, which is the bone crushing vials, which Project #148 covers, and then there's the remaining equipment, which no project covers. So 153, yes, doesn't cover either of those sets of equipment.

THE COMMISSIONER: Q. So the answer to Mr Hodge's question is, yes, 153 does not relate to any of the equipment with which you were concerned?
A. Yes, so we only have a project that covers a small portion of the equipment.

Q. No, we're just talking about 153.
A. Sorry, yes.

Q. 153 concerned plastic Petri dishes and not any of the equipment with which you were concerned when you were considering to change the cleaning protocol?
A. Yes.

MR HODGE: Q. 153 is about cleaning blood from a plastic Petri dish?
A. That's the experiment method under test, yes.

Q. And you were making a recommendation about cleaning equipment that included stainless steel equipment and bone powder or fragments?

THE COMMISSIONER: And steel equipment. It's not stainless steel.

MR HODGE: And steel equipment, sorry, you are quite right.

Q. Is that right?
A. Things other than the bone crushing vials, yes.

Q. Not plastic Petri dishes?
A. Well, it involved cleaning all sorts of things that were used in that laboratory. I'm not sure if they used - I think they used - oh, the Petri dishes are probably disposable, so, yes, probably wouldn't clean the Petri dishes, no.

Q. Did you have any idea what the equipment was?
A. Yes.

Q. So you turned your mind to it?
A. Yes.

Q. And you thought, "I don't have any project that evaluates the effectiveness of different cleaning products on this particular equipment, so I'll just use the one that we came up with for blood on plastic Petri dishes"; is that fair? I'm just trying to understand. Is there any more reasoning than that?
A. Well, you're kind of missing out on the whole milieu of the fact that it's a pretty well-accepted cleaning protocol that is used across a wide range of laboratory equipment and across a wide range of laboratories. So it doesn't - it's not like it's just something I've, you know, just sort of thought up in the moment. That's the way it sounds like your question is asking me. But it's not something I just thought up in the moment. It was something that was, you know, well used and well developed.

THE COMMISSIONER: Q. But your confidence in adopting the findings you made in Project #153 was based upon your view that TriGene and bleach and ethanol were being used and have been used generally, and in your view effectively, elsewhere in the laboratory and, to your knowledge, in other laboratories for cleaning purposes?
A. Yes.

Q. But the question remains that - sorry, Mr Hodge, you go ahead.

MR HODGE: No, no.

THE COMMISSIONER: Q. The problem as I see it,

Mr McNevin - and you may not be able to help me with this - is that to the extent that you had projects to rely upon, Project #148, which was published a month after 153, said, as you pointed out, that the most striking result is that TriGene Advance was very ineffective - I'm changing the words, but that's what it means --
A. Mmm.

Q. -- and this result conflicts with other testing using whole blood dried on to Petri dishes, where it was found that TriGene was very effective, and it cites Project #148.

So the writers of this report, in considering the use of TriGene to clean bone crushing equipment, bone extraction equipment, have identified that their conclusion that TriGene is very ineffective is in conflict with an earlier experiment relating to plastic Petri dishes, and then they conclude that it may be that no one cleaning agent will be suitable for all cleaning tasks. So that reads to me like a warning that you have to do these things piece by piece; what's good for a plastic Petri dish may not be good for other instruments.

As I understood your evidence earlier, you were very conscious of the content of Project #153 because you were involved in it, but was I right in understanding that you had asked one of your colleagues to have a look at 148 and come back to you with a summary of it, or did you read it?
A. Look, I can remember that was the first step I definitely - the first step I said was, "Can you go and dig out that project and have a bit of a read", and then I'm sure I probably would have at least read the recommendations. Whether I went back and read the whole project or not I can't really recall.

THE COMMISSIONER: All right, thank you.

MR HODGE: Q. To your knowledge, has anyone since you made the recommendation raised with you the question of whether this should be tested or evaluated?
A. No.

Q. Have you had any further discussions about it with Ms Brisotto?
A. No.

MR HODGE: Then I wanted to move to a different topic,

Commissioner --

THE COMMISSIONER: Yes.

MR HODGE: -- which is something that came out of the questions that Mr Hunter asked.

Q. Do you recall Mr Hunter asked you yesterday afternoon some questions about the Options Paper and your feedback on the Options Paper - sorry, feedback on the draft of Project #184?
A. Yes, yes, yes.

Q. I can take you to the email, but you remember, that was the email where you had the emoji smiley face and the emoji sad face.
A. Yes, yes.

Q. Do you remember whether you were aware at the end of 2017 or the beginning of 2018 about what feedback had been given by other members of the management team?
A. Probably not. I probably wasn't aware.

Q. Do you recall whether you were aware of any controversy over Project #184 or resistance from members of the management team?
A. I might have been vaguely aware. I can't really remember. I mean, sorry, that was quite a while ago.

Q. Do you recall Amanda Reeves or Kylie Rika raising issues with the conclusions in the draft Project #184 paper?
A. I don't really have a memory of that, no. It seems - I mean, it's a little bit hard, because I've already heard some evidence and things, so I don't know what's now --

THE COMMISSIONER: Q. You don't know what you know now and what you knew then?
A. Yes, exactly.

Q. Just do your best, Mr McNevin.
A. Yes, I don't really - I don't really remember clearly, no.

MR HODGE: Q. Do you recall whether you knew why Project #184 had not come back to the management team for sign-off?

A. I remember - in preparation of my statement, I remember seeing that there was something that was discussed in a management team meeting. I don't know if I had conversations outside of that, I certainly don't - really being fully aware of the ins and outs of all of that, just that that was what was happening. Now, whether someone discussed it with me prior to the management team or not, I have no way of remembering that.

Q. I now want to ask you about another topic. You gave some evidence this morning, I think in answer to a question the Commissioner asked you, about the issue in relation to sperm microscopy.
A. Mmm.

Q. I might have misunderstood, but I thought that the evidence you gave the Commissioner was to the effect that you hadn't realised that the issue was sperm not being detected; you thought the issue was just a difference between the number of sperm heads being seen using diff lysis and the number of sperm heads seen using the ordinary microscopy evidence recovery method?
A. So I actually don't really remember exactly how it was raised to me. My sort of vague recollection is that there was a difference between the two. And maybe if you consider that if you had an evidence recovery slide where you had no sperm detected and you only had one or two detected on a differential lysis slide, that would fit within the paradigm of, you know, a small difference between the two. So maybe if I wasn't provided with a lot of information, maybe that's why my recollection is a little bit more vague. Look, I actually don't really remember how it was raised to me, so I can't really make a clear comment on what was said to me, so therefore what my level of alert was.

Q. I thought - and I might have misunderstood - that the evidence that you were giving to some questions your counsel Ms Freeman was asking was to the effect that in about May 2016 you had undertaken a data analysis and determined the difference between the number of sperm being able to be seen using the evidence recovery slide versus the diff lysis slide?
A. I can't remember exactly the timeline, but there was - it was probably between those two management team meetings when I went away and did that extra work. Oh, look, I can't even remember whether it - how long it took to do

that extra work, so whether we had kicked it off prior to May or subsequent to the management team meeting in May. I can only - it's so long ago, I can only really go on what sort of emails and management team meeting minutes and documents that I can find with dates on them. So I can't remember exactly that timeline of how we went about it, except that my sort of overall memory is that it was raised to me that there was a difference, I said, "Let's get some data", so we got some data and went down the path in the project.

Q. If we're just thinking it through, how likely is it that somebody came and said to you, "There's an issue that needs to be studied because we're getting a difference between the number of sperm that we're finding on evidence recovery slides and the number of sperm that we're finding on diff lysis slides"?
A. Well, things - over the course of my time as a manager looking after both the analytical team and then the evidence recovery team, people would sometimes raise things and you would look into them and then you would go back to them and they would realise that it actually wasn't the issue that they thought it was. So it wasn't necessarily given that someone brought something up, that it was going to be something that needed further investigation. And like I said, I don't - because I don't recall exactly how it was mentioned to me and what evidence I was given, I can't really comment on whether the information given to me should have caused me to do a certain set of actions straight away, because I can't remember what information was given to me.

Q. Assume for the moment that it was Mr Howes who raised the issue with you. Does that seem likely, that it would have been Mr Howes?
A. Not necessarily, no. He could have gone to whoever - because I want to say Paula, but I think at that time Paula was on maternity leave and some other people were acting in her role. So it would not be unexpected that Justin could have gone to the other team leader and said, "Look, can you have a conversation with Allan about this." So that wouldn't be an unusual scenario, either.

Q. I take it from what you're saying you accept that the information, or one step in the chain of the information coming to you, must have been Mr Howes?
A. Well, there seems to be some emails around that, so

I think that's pretty incontrovertible.

Q. I just want to understand, because you can see the difference, I'm sure, between, on the one hand, somebody coming to you and saying, "We seem to be getting different numbers of sperm heads when we do evidence recovery slides versus when we do diff lysis slides", and, on the other hand, somebody coming to you and saying, "You are getting zero sperm on evidence recovery slides for things that turn out to be semen." You can see the difference, can't you?
A. Yes.

Q. And you say you don't think it was the second issue that was raised with you; you think it was the first issue?
A. I don't know how it was phrased or what information was given to me, so I can't make a statement --

Q. But it has a substantial effect, doesn't it? You must see that it has a substantial effect that if, within your lab, for semen, samples are not being tested because an evidence recovery slide is showing no sperm heads, that that is a potentially significant issue in relation to sexual assault cases in Queensland; you can see that, surely?
A. And that's why we went and carried out all the work we did.

Q. But I just want to understand: do you say that was the issue that was presented to you, or do you say that the issue, as you recall it, that was presented to you was simply that there seemed to be different numbers of sperm heads being detected on evidence recovery slides as compared to diff lysis slides?
A. I don't really remember exactly how it was put to me, so I can't really make any statements either way. It was how many years ago - six years ago?

THE COMMISSIONER: Q. I guess the point that is being --
A. I can't quite remember.

Q. The point that Mr Hodge is driving towards is that if you were told that, "We're not seeing sperm on microscopy in the first instance, but that's wrong, there is sperm there, in some cases we've worked out that there is sperm there", and that some of your colleagues are anxious about evidence being discarded when it might have a conclusive effect in an investigation, that that would give rise, in

a rational person in your position, to a sense of urgency to get on top of this, to do something to ensure that evidence isn't being lost, and that on the other hand, if you were merely told that there seems to be a lack of balance between microscopy and diff lysis, well, that's another matter, as you said to me, that's something that you would expect and it wouldn't give rise to a sense of urgency.

So what is being put to you is, having regard to the effect upon you that this must have had if you had been told, "We are likely throwing away valuable evidence", that being the implication, and that you didn't have that sense of urgency - does that assist you in recalling what you were told? Alternatively, maybe you were told that, "We're losing evidence", or words to that effect, "because we're misreading microscopy slides or they're being badly prepared", and that didn't strike you as urgent. What do you say? Can you help me?

A. Again, it might have depended on what evidence was given to me. Was it just a single event which - you know, in the course of doing many hundreds and thousands of tests, you do get the odd result that doesn't quite fit what you would expect, or are we seeing something a little bit more, where there's - you know, I don't really know what information was given to me, so I can't really say whether I should have been more alarmed by the finding or should have not been. I'm sorry, but I - I find it hard to kind of provide a definitive response.

Q. No, that's all right. You can't remember, you say?

A. Yes, yes. It was a long time ago.

MR HODGE: Q. The reason I need to clarify this is because this morning, in answer to some questions that the Commissioner asked you, as I understood it, your evidence was that your appreciation or your understanding of the urgency and how urgent it was was due to your understanding that there were fewer sperm heads being detected on ER slides as distinct from no sperm heads? So I just want to understand, and you should take a moment to think about this: do you think that that statement, if I've understood your evidence from this morning, was correct, or do you just not know what you were told?

A. I believe that was around the conversation, where I had already previously stated that I couldn't remember how it was exactly presented to me, and it was just sort of

my sort of vague memory of that's the way it was presented to me, but I don't really remember. And so now that you're pushing me to be specific, yes, I can't be specific. I believe that that was the conversation, was it not, that it was about - you know, I've already stated that I couldn't clearly remember how it was raised to me and that I couldn't even remember who the person was that spoke to me.

Q. In any event, do you remember whether any more senior manager approached you in the first half of 2016 and said, "This is urgent. We have to do something about this"?
A. I don't really remember the timeline. That's the thing. I don't remember whether someone came to me and said --

Q. Let me ask you the question more generally - I will do it specifically. Do you remember Justin Howes approaching you at any stage and saying something to the effect of, "Allan, this is urgent. What are you doing about this?"
A. No. I don't remember that specific type of conversation, no.

Q. Do you remember him, even in a general way, raising or suggesting that this was something that ought to be resolved urgently?
A. I don't really remember. I know that we discussed it in the management team and certainly there was sufficient - there was sufficient impetus for us to go about, "Okay, let's look into this deeper." I remember that, because we did. That's what we did. We went and looked at some data and said, "Okay, is there a problem to investigate? Yes, there is. Let's investigate it."

Q. Do you remember Cathie Allen coming to you at any stage to speak to you about urgency?
A. Look, I don't remember - I don't think they would have come and spoken to me in a one-on-one sort of manner and, you know, in the way you're sort of positing it. It was probably in part of a management team meeting or something, part of the conversation.

Q. But you don't remember it, though?
A. No, I don't really remember. It was quite a while ago. Sorry, I - I don't remember.

Q. Again, looking back on it with hindsight and knowing

what you know now, does it surprise you that there was no urgency that was raised about this?
A. Again, I don't know exactly what information was provided to Justin, how many examples, whether those examples were over, you know, a period of thousands of samples or over a period of 20 samples. I really don't know how it sort of came about. I mean, I've seen that there's, you know, a few emails back and forth, but I don't - I haven't really looked into the detail of over what time period they were, what - you know, what was the context of, you know, was it one sample out of many in the one case, or these sorts of things. I don't really know exactly what the situation was, so I can't - you know, it's too long ago, I'm sorry. I don't really remember. I mean, I guess looking back on it, if you ask, did we act upon it fast enough, is that kind of maybe - I don't know. It's hard to look at things so distant and be certain about exactly the scenario that was given and the steps that you took at the time.

Q. When you look back at what happened in relation to Project #184 and the Options Paper and what you know now, does anything about that strike you as unusual?
A. You know, it obviously speaks to some of the interpersonal issues that were going around at the time.

Q. Project #184 speaks to interpersonal issues?
A. I'm talking about the --

Q. The DIFP process?
A. Yes.

Q. Project #184 is the Options Paper.
A. Looking at it now, isn't that what some other people seem to have raised already?

Q. Perhaps step back. Tell me if you agree with these things. You know that there was a project that was never brought to completion in accordance with the ordinary policies of the lab?
A. Yes, yes.

Q. And you know that there was a document that was presented to police, and you have seen that document?
A. Yes, yes.

Q. And you know that there was a process that was

implemented, which was the DIFP process?
A. Yes.

Q. It meant that samples within the DIFP range were not going to be - if they were priority 2 cases, they weren't going to be tested?
A. Yes, unless we were asked for - asked --

Q. If the police asked?
A. Yes, if the police had given us information to then go and do the work.

Q. So when you say given you information, you mean unless they asked you to go and --
A. Yes, provide us with a task or a request, yes. "Requested it" would have been a better choice of words.

Q. You know that the Commissioner put out an interim report and that the government has stopped that DIFP process?
A. Yes, yes.

Q. What I'm interested in understanding is, when you look back on that now, with the benefit of the information that you now know, does anything about that seem unusual to you in terms of how the lab was managed?
A. It's a rather broad - a rather big question. I guess I'd - I'd always assumed, rightly or wrongly, that there was that well-developed process of investigators looking at their DNA results and that they would have that information in the forensic-register to say that this could give you a result if you request further work on it, and that we would do that.

I mean, I was in a slightly different position, being especially in the evidence recovery role, where I was aware of exhibits that came in that were marked, and then they would go back because no testing was required, and then things would get reactivated, so this sort of to and fro of things didn't seem particularly unusual to me. You know, looking at how it's all played out in the end, it obviously didn't go so well. But as to the commentary on other people's responsibility and roles, it's a little bit hard for me to comment.

Q. You had experience - you were in the management team?
A. Yes, yes.

Q. You had lengthy experience with the management of the lab. My question is: looking back on it, does anything about the process seem unusual to you in terms of how the lab was managed?
A. I mean, it - I guess the idea of an Options Paper wasn't something that seemed to be too common, so that itself would be an unusual option, I guess.

MR HODGE: Commissioner, I don't have any further questions for Mr McNevin.

THE COMMISSIONER: Thank you. Thank you, Mr McNevin, for your assistance. You are free to go, and of course you are free to stay as well, if you wish.

<THE WITNESS WITHDREW

MR HODGE: Commissioner, do you want to take the morning adjournment now, and then I think Ms Reece is going to call a witness.

THE COMMISSIONER: Who is that?

MR HODGE: It is Therese O'Connor.

THE COMMISSIONER: Very well. We will adjourn until half past 11.

SHORT ADJOURNMENT

THE COMMISSIONER: Ms Reece?

MS REECE: Thank you, Commissioner. I call Therese O'Connor, who is in the witness box.

<THERESE O'CONNOR, affirmed: [11.38am]

<EXAMINATION BY MS REECE:

MS REECE: Q. Ms O'Connor, can you tell the Commission your current position?
A. My current position as of yesterday is principal adviser, people and performance, HR branch, Department of Health. Last week I was the acting principal employee relations adviser for the HR branch that looked after the former business units that formed Health Support

Queensland.

Q. In 2017, you were employed as a senior adviser within Statewide People and Performance?
A. That's correct.

Q. Part of the role there was in providing support to those various business units you have just spoken of?
A. That is correct.

Q. One of them was Forensic and Scientific Services?
A. As a business partner, yes.

Q. In April 2018, you worked as a human resources business partner?
A. That's correct.

Q. For Forensic and Scientific Services?
A. For Health Support Queensland, and the business that I supported was Forensic - FSS.

Q. And in the capacity both in that earlier role as senior adviser, Statewide People and Performance, and in your role as a business partner, you worked with the DNA Analysis Unit at FSS?
A. That is correct.

Q. The original engagement with that business unit or that DNA Analysis Unit arose out of your role providing specialist HR advice to Queensland Health?
A. That's correct. I could elaborate?

Q. Yes.
A. My understanding is that Ms Amanda Reeves made a complaint to the director-general, including that she had made a public interest disclosure and she was receiving reprisals because of that. The director-general chose to - or requested Statewide People and Performance to actually manage the complaint on behalf of the department.

Q. You started managing that matter in about mid-2017?
A. That's correct.

Q. And then, at a later stage, that piece of work was overseen by your colleague, Shaun Mulholland?
A. Shaun was always involved with it, but he - the actual workload and the negotiations, et cetera, and meetings were

attended by Shaun.

Q. You weren't involved in, for example, setting up the Livingstones process?
A. No. That was Health Support Queensland that developed the terms of reference and engaged Livingstones.

Q. Similarly with the report which was obtained from the New Zealand lab?
A. That is correct. It was HSQ.

Q. You did then have some involvement in the engagement of workplace consultants, Workplace Edge?
A. In reflection, I've looked back through my records. I'm not sure that I actually had done quotes for Workplace Edge. My understanding is Workplace Edge was part of a standing arrangement offer that we have with the department, because Workplace Edge was directly engaged with HSQ - by HSQ, and I wasn't at HSQ at that time.

Q. So it wasn't the case that you got quotes from the companies which were then put forward to HSQ?
A. That's correct.

Q. You think your involvement --
A. Was later.

Q. -- didn't extend to that?
A. Pardon?

Q. It didn't extend to that?
A. No, it didn't extend to that.

Q. You became aware, though, that they had been engaged to do some work around the reintegration of Ms Amanda Reeves to her previous position?
A. That's correct.

Q. And you weren't involved in writing the terms of reference?
A. No, I was not.

Q. Your evidence is that you became aware that Workplace Edge developed a restructure of the DNA Analysis Unit?
A. That's correct.

Q. If I could ask that the witness be shown

[FSS.0001.0083.4017], Commissioner, this document was disclosed in the "Sperm Microscopy (Culture)" doc set. First of all, Ms O'Connor, are you familiar with this document?
A. Well, I have seen it, yes.

Q. If you could go to page 2, and, Mr Woolridge, if you could then enlarge that flow chart there, or the team chart?
A. Yes.

Q. This is the team chart. It reflects the people and the positions that you are familiar with --
A. That is correct.

Q. -- from that period of time?
A. Yes.

Q. And you see at the yellow headings there, or the yellow boxes, there are two team leaders?
A. That's correct.

Q. They were HP6s, weren't they?
A. I would have to look, but, yes, they're HP6s. The next level below are HP5s.

Q. And then everyone underneath in the white boxes are HP4 and below?
A. That's correct.

Q. You see from that chart there that perhaps in the light beige boxes, are those - they're the HP5s you have just referred to?
A. Yes, I have.

Q. And there are six of them?
A. Yes, that would be correct.

Q. Then if you go to page 6, Mr Woolridge, of the same document, if you could then again focus on the chart there. Do you recall seeing that this was a proposed organisational restructure?
A. In all honesty, I can't actually recall seeing it, but in all likelihood I would have seen it, definitely.

Q. Mr Woolridge, if you could then zoom out from that and then on to the text under "Implications". Ms O'Connor, it

notes there that the implications would be that there would be three new team leaders at the HP6 levels to lead the teams?
A. Yes.

Q. That would have been an additional HP6, wouldn't it?
A. I'm assuming - yes.

Q. But then there was to be a reduction in supervisors from the six HP5s that we saw in that first flow chart to five on this proposal?
A. That would be correct.

Q. Did you form a view as to what the implications were for this workplace from that proposed restructure?
A. Yes, I did.

Q. And what was that?
A. My view is that the organisational change was designed so that Amanda Reeves' HP5 position would be abolished.

Q. Did this restructure go ahead?
A. No, it did not.

Q. You were not involved in the decision-making, I understand, but you became aware that Workplace Edge - that the work didn't go ahead with them?
A. No, it did not.

Q. And that their recommendations shouldn't be acted upon?
A. That is correct.

Q. If I could ask that Ms O'Connor be shown [WIT.0004.1246.0001] --

THE COMMISSIONER: Did you want to tender the document that's on the screen?

MS REECE: Yes, thank you, Commissioner. I tender that document. That's the draft report of Workplace Edge - or draft review, I should call it.

EXHIBIT #94 DRAFT REVIEW OF WORKPLACE EDGE, BARCODED [FSS.0001.0083.4017]

MS REECE: Q. Ms O'Connor, can you see that at the top

of that email chain, there is an email from you to Kylie Rika?
A. That's correct.

Q. You tell her there, consistent with what we have just discussed, that you had been able to establish that Workplace Edge was not to be contracted again, that their recommendations shouldn't be acted upon?
A. That's correct.

Q. And that you had spoken to Michel Lok about that?
A. Yes.

Q. Did you then have some conversation with Cathie Allen about that, which is suggested perhaps in the final sentence?
A. I may or may not have had conversations with Cathie. I cannot recall.

Q. You do recall, though, during the rest of the time that you worked with FSS and the DNA Analysis Unit, that Ms Allen asked you multiple times something along the lines of, "When is the organisational restructure going to occur"?
A. That is correct, that is correct, and I believe that she was referring to the Workplace Edge proposed restructure.

Q. Did she specifically tell you what it was in particular that she was interested to implement?
A. No.

Q. And you advised her that that wasn't going to happen?
A. That is correct.

Q. When did you cease working at FSS?
A. There was - I ceased - technically I ceased working in FSS on 2 February 2019, but because of resourcing, I still supported them for at least four or five months after I had moved into a new position.

MS REECE: Commissioner, the document that is on the screen has already been provided, has already been tendered as part of Ms Kylie Rika's evidence, but it has been extracted and given a new number for ease of reference in the proceedings.

THE COMMISSIONER: I will mark it exhibit 95.

EXHIBIT #95 EMAIL CHAIN, BARCODED [WIT.0004.1246.0001]

THE COMMISSIONER: There was the earlier document that you showed Ms O'Connor with the organisational chart in it. Do you want to tender that?

MS REECE: The review?

THE COMMISSIONER: No - was that the review, was it? Was there only one document?

MS REECE: Just one document, yes. It had the original structure and the one that was in place, and then the proposed change.

THE COMMISSIONER: Thank you.

MS REECE: Thank you, Commissioner.

Q. At the time you sent that email, Ms O'Connor, that was after you started working in this business partner role that you have told the Commissioner about?
A. That is correct, yes.

Q. Your report as of April 2018, your direct report, was to Andria Wyman-Clarke?
A. I would have reported through to Andrew Riddell and then through to Andria.

Q. She was the general manager for HR?
A. That's correct.

Q. For HSQ?
A. That's correct, yes.

Q. Can you just explain briefly what your role became once you actually started working with that DNA Analysis Unit in that business partner role?
A. A HR business partner is there to provide expert or specialist advice in relation to HR issues, but it's an advice and supporting role, so if managers have queries, employees have queries, we can provide advice about how that matter should progress, we provide support to managers in resolving complaints, a wide range of HR and industrial issues.

Q. As part of that role, you were actually physically in the FSS campus for a couple of days a week?
A. For three to four days a week, I sat in the library.

Q. You replaced Mr Jade Franklin?
A. I believe Jade may have left before I commenced, and it may have been Helen Russell.

Q. In the interim?
A. In the interim, yes.

Q. You were doing the job, though, that he had previously done?
A. Similar, yes.

Q. While you were working in that role as business partner, do you recall there was an incident about potential disposal of confidential documents?
A. That's correct, yes.

Q. You have been given a copy of the transcript of what Ms Kylie Rika told the Commission of Inquiry about that particular incident?
A. Yes.

Q. While you don't remember whether or not you attended a meeting between Ms Rika and Ms Allen, do you think it's possible?
A. Yes, I think it's possible.

Q. When did you first become aware that there was a potential issue with a confidential bin?
A. It would have been either directly raised with myself or it would have been raised through my manager, Andrew Riddell. My understanding is that it was Amanda Reeves' last day of work, she had come in to clean up her desk and collect her personal belongings, that she had wheeled one of the confidentiality bins across to her desk and was emptying the contents of arch-lever folders into the confidentiality bin. Whilst she was doing that, there were three people standing around the bin talking. One of them was Kylie. I cannot recall who the other two people are. I can't recall who was actually throwing the documents into the bin or exactly - or if all four of them were throwing documents in the bin or whether it was just Amanda. I would have to pull out the file and dig --

Q. This wasn't something that you yourself saw; you were told about it?
A. No, definitely not.

THE COMMISSIONER: Q. But the bin you are talking about is the familiar bins that you see in some offices into which you throw documents that are to be destroyed confidentially by a service that comes to pick it up?
A. That's my understanding, sir.

Q. And generally they are locked for that purpose with a slot in the top, and you put the documents in and they --
A. Sometimes those bins are able to be unlocked, especially if you are emptying large quantities of documents into them.

Q. Yes. In any event, generally they are secure bins into which you put documents that you want to be destroyed in a secure manner?
A. That's correct. They are shredded and then burnt.

THE COMMISSIONER: Thank you.

MS REECE: Q. Do you recall speaking with Cathie Allen about this incident?
A. I have a vague recollection. I'm sure that Cathie would have spoken to me in relation to the event. My recollection is that Cathie wanted to take disciplinary action against all the participants. My advice was that there was insufficient evidence, insufficient evidence to support a disciplinary process at that point in time, that further information would need to be gathered, because we needed to know which person had actually thrown the confidential document into the bin and --

THE COMMISSIONER: Q. But what's wrong with throwing confidential documents into a confidential destruction bin? That's what it's for, isn't it?
A. It depends on what the document is. We've got archiving requirements within government. Certain documents must be retained for a certain period of time.

Q. So some have to be preserved?
A. Correct.

Q. And some of course - that's why the bin is there, some

you destroy?
A. That's correct.

Q. And what were these documents?
A. I cannot recall, and that's one of the things - that's part of the information that would need to have been gathered in identifying, if it was a confidential document, if that document was necessary to keep, because in the digital age we now keep scanned copies or the data may have been entered on the forensic-register, so whether that particular copy of the document - it could have been archived, saved elsewhere and been fine to --

Q. Do you have any recollection whether you were aware - whether Ms Allen told you what the complaint was, because it couldn't simply be putting documents into the confidential document destruction bin?
A. Throwing away confidential - disposing of confidential documents in the confidential bin.

Q. But that's what it's there for.
A. It's there - so --

Q. What I mean is were you given to understand that the documents being thrown away ought not have been thrown away?
A. That's correct.

Q. I see.
A. I think the implication was that they were documents which should have been retained and only destroyed when they met the scheduling requirements.

THE COMMISSIONER: Thank you.

MS REECE: Q. When you say Ms Allen wanted to take disciplinary action, do you recall what it was that she wanted to do? How did she express that to you?
A. I'm pretty sure it was, "I want to discipline them."

Q. And you said "all of them". Amanda Reeves at that point, I understand, had left her employment at FSS?
A. She had left her employment with FSS. However, she still fell under - she was still an employee of Queensland Health, and there are legislative - under chapter 6 - part 5, chapter 6 of the Public Service Act, under the disciplinary provisions, you can actually refer a matter to

another CEO, and potentially that's the way the - another disciplinary process could be commenced.

Q. The advice that you gave Ms Allen was that you would need further information to provide advice --
A. That's correct.

Q. -- in order for - would it have been you who started a disciplinary process?
A. I would have - this is part of the support process. HR normally provides support in drafting the disciplinary notices to show cause. There's two processes. We obviously provide summary options and risk assessments in relation to all processes. We would develop the documents in draft form, and they would be escalated through to the delegate to review and sign.

Q. The process that was then followed was that a number of meetings were set up?
A. That's my understanding, that there were a number of meetings set up. I believe Andrew Riddell was meant to be involved in the meetings. But if Kylie believes that I was in the meeting, I assume that she was correct.

Q. Your view of this issue is that obviously there are these important rules around records management?
A. Yes.

Q. But your recollection is that you weren't given the detail of what had been disposed and why it was an issue?
A. There was insufficient information to be able to substantiate an allegation, because we couldn't tell who had thrown what confidential document in the bin.

Q. Did you become aware at any stage that Mr Csoban and Ms Allen had accessed the confidential bin and retrieved some documents?
A. I may have been aware of it. I cannot recall it, though.

Q. And that they retrieved a number of documents, which were then categorised and sent in an email to Andria Wyman-Clarke?
A. Again, I may have been aware of it. I cannot recall.

Q. Do you recall whether any further disciplinary action was taken against any of these individual staff members?

A. My understanding is that that matter did not result in a disciplinary process. With the human resource delegations, Paul Csoban would have had the delegation to commence a disciplinary process. However, at no stage did he approach me to commence a disciplinary process.

Q. Was Ms Reeves interviewed as part of that process, do you know?
A. No, she wouldn't have been.

Q. So it was just the three other scientists who were seen standing around?
A. I believe so.

Q. Again, you have been shown - I will just get the reference up, Commissioner. I'm sorry, Commissioner, it will take me a moment to get up this reference. I'm just going to ask you about some evidence Ms Rika gave. She says that she recalls bumping into you in the library some time after she had been interviewed by Ms Allen and, in her memory, you, and she speaks of a conversation that the two of you had. I'm just getting up the reference from the transcript itself, but do you recall that at the time, broadly, of this investigation or this incident, you worked in the library?
A. That's correct.

Q. And you do recall having a conversation with her, consistent with what she told the Commission?
A. Yes.

Q. But you don't actually recall bumping into her, as such?
A. No.

Q. Mr Woolridge, could you please bring up [TRA.500.010.0001 at 0110]. Ms O'Connor, can you see this is some transcript that you have been shown. Down at line 29, Ms Rika says:

> *... I did follow up with Therese O'Connor myself. I just said, "Look" - because I bumped into [her] in the library, and I just said to her ...*

Can you see that piece of text there?
A. Yes, I do.

Q. She asked you:

..."What's come of that meeting that I had, because that was a really stressful time for me and I'd really like an outcome or" ...

And Ms Rika says:

... that basically the answer to that question might be obvious in the sense that Paul Csoban was no longer employed as ED.

So that, on her evidence, is the response that you gave her to that question. Is that an accurate reflection of that conversation, to the best of your memory?
A. My recollection of the conversation is extremely limited, but I'm sure I would have said more. But it doesn't surprise me at all that I would have said that.

Q. While you were in that position - again I'm delineating the time when you were providing support around the Amanda Reeves complaint --
A. Yes.

Q. -- and then this period from early 2018 onwards, when you were the business partner - you would sit in the library, in your office, and many employees would come and speak to you confidentially, wouldn't they?
A. That's correct.

Q. They were about predominantly human resources issues?
A. Correct.

Q. Those people included Ms Rika, Ms Caunt, Ms Keller and Ms Quartermain?
A. That's correct.

Q. How did those meetings come about?
A. My understanding is Andria Wyman-Clarke provided them with my contact details. They would email me or phone me and ask for a meeting when they could get away. It was - they would always specifically request that the matter was confidential, that I was not to take any action in relation to what they were raising. It was more that they wanted HR to be aware of what was happening.

Q. Did they ever tell you why they didn't want you to take any further action in what they were raising with you?
A. They were fearful of Amanda Clark - sorry, they were fearful of Cathie Allen and, if they had made a complaint, they may be treated the same way as Amanda.

Q. Is that something they told you directly?
A. Yes.

Q. The types of issues they were raising with you also sometimes concerned scientific processes?
A. That is correct.

Q. You're not someone who has any scientific qualifications?
A. No, I definitely don't.

Q. Do you recall what those issues were that they were raising with you?
A. It was about the testing processes and the fact that it would have - testing processes, validity of the processes. One of the ones that stands out to me is - I think it's Angelique's [sic] conversation in relation to them creating a new bone extraction - DNA extraction process from bone. She is a recognised expert in those processes, and there was no consultation with her for the new process, and she had considerable concerns in relation to what was happening. I would have to dig out and refer to my notes about the specific details of it.

Fortunately, when John Doherty became executive director - he came up from the forensic lab down in Victoria Police. His background is actually a forensic scientist, so he does have a very strong understanding of DNA and the science all behind it. So I can remember one meeting that I had Kylie and Emma in my office talking, it was about the retesting of samples, and there was a view that Justin and Cathie were saying, "Don't retest samples." Because John - I knew John was in the building and available, so I actually went out and got him to come and meet with Kylie and Emma in my office to have a discussion about what their concerns were, so that they could have - air their views with somebody that could fully understand the science in relation to it.

Q. When you sat in that position, you also had staff come

to speak to you about flexible work arrangements?
A. That's correct.

Q. Do you recall how many staff might have come to you about that issue?
A. Not off the top of my head, no.

Q. Was it more than five?
A. Probably.

Q. Did those staff members work across the DNA Analysis Unit?
A. They would have worked across the DNA Analysis Unit; they would have also worked in the forensic chemistry unit as well.

Q. What was your understanding of the difficulties that they were having with flexibility in their work arrangements?
A. My understanding is that Cathie's view was that a person had to work full time and be present between 8.30 and 4.30; that when a court or a police officer called in relation to a DNA report, the person who had been writing the report and analysing the report had to be available to speak to the inquiry.

Q. Your understanding was that the difficulty they were having was in progressing their applications beyond Ms Allen?
A. That's correct.

Q. Who was the person who actually had the delegation to approve those arrangements at the time?
A. At that time, it probably would have been Ms Allen. Since 2008, there has been an amendment to the Industrial Relations Act where it's very, very clear, an employee's ability to apply for flexible working arrangements, and the delegation for that is with the executive director. So --

Q. Sorry, go on.
A. I was going to say, so if Cathie was extremely reluctant to approve any flexible work arrangement, whether it be because of health reasons, personal reasons, return from maternity leave, I would - I had monthly briefings with the executive director, and I would actually raise it at that point, during those meetings, and talk about the risks to the organisation.

Q. What was the risk as you perceived it? What was the risk you were advising about?
A. The right to work part-time, especially returning from maternity leave, it's enshrined in legislation and continues to be enshrined. People wanting part-time work, it should actually be encouraged. Quite often they are wanting it because they have an identifiable trait under the Anti-Discrimination Act, so the risk would be that we would have industrial disputes or discrimination claims made against the department, of which we would have little to no defence.

Q. What experience were you drawing on when you gave the executive director that advice?
A. At that point, I would have had 20 years' experience in industrial relations and HR.

Q. Does that include outside of the Department of Health?
A. Yes. I've had 15 years - I've worked 15 years with Together Queensland as an industrial adviser, or an industrial officer. I've then worked with the Department of Health in Metro North as a HR business partner and then in the history that you have already described. So it comes down to experience. I've faced very, very similar situations and it's just - it's one of those things that, as a HR practitioner, you're surprised that management actually ask you, that they're going to deny somebody coming back from maternity leave part-time. It's legislated. We have to comply with it.

Q. And this was one of the concerns that you --
A. I would have raised, yes.

Q. -- held about that workplace?
A. Absolutely, yes.

Q. Finally, Ms O'Connor, given your engagement with that workplace as a human resources professional, what is your view of the culture of that workplace?
A. It would be what we described as a toxic workplace.

Q. What do you mean when you say "toxic workplace"?
A. It's a very unhappy, very stressful, dysfunctional working place. They may be good with the science or the expertise that they do, but their actually working together and the management of issues was never appropriate, timely,

that there were underlying issues that had never been resolved, and when you get a work environment when these issues are allowed to fester and build, the emotional investment in that produces a lot of animosity between certain parties.

Q. What were the underlying issues, as you saw them?
A. My understanding is that it had actually started when the lab was first set up. We had some really good, brand-new scientists, including Cathie Allen and Amanda Reeves. When the managing scientist left, Cathie and Amanda both applied for the managing scientist role. Cathie was successful, and it's my understanding that from then, the working relationship between the two of them, and the personal relationship between the two of them, deteriorated significantly.

Q. Just to be clear, though, that's something that you must have been told by others?
A. That's correct.

Q. That's not something you were there for?
A. That's nothing that I - through the documents that I have read, I can categorically say they did not have a working relationship.

Q. Ms Reeves, at the time, held one of those HP5 supervising scientist roles?
A. That's correct, yes.

Q. And sat on the management team?
A. That's correct.

Q. Just one final question. This is going back to the flexible work arrangements. What impact was that having on that workplace at the time, from the point of view of morale?
A. It was extremely stressful for the people who were trying to make a work/life balance, you know, meet their personal needs and their family's needs as well as their working needs.

Q. And they were coming to you to express these concerns?
A. Yes.

MS REECE: Thank you, Commissioner. That's Ms O'Connor's evidence.

<EXAMINATION BY MR HUNTER:

MR HUNTER: Q. Ms O'Connor, I act for the Queensland Police Service. You said, speaking of the Workplace Edge report into the organisation, that you thought the restructure that was proposed in that report was designed to get rid of Ms Reeves?
A. That's correct.

Q. Workplace Edge was an external agency, wasn't it?
A. Yes.

Q. So can you explain to us how it is that you formed the view that the strategy proposed by them or the solution proposed by them was to get rid of --
A. Well, my understanding is that they were engaged to reintegrate Amanda Reeves into the workplace. That certainly did not happen. And the restructure is notable that someone at that classification level was - their role was disappearing. They were becoming redundant, effectively.

Q. Was there anything beyond that? Did anyone ever tell you that that was the intention behind it?
A. No.

Q. But you were asked multiple times by Ms Allen about when that restructure was going to happen; correct?
A. That was correct, yes.

Q. As far as you know, she got a copy of the Workplace Edge report that proposed that restructure?
A. I believe she was actively involved in consulting with Workplace Edge and developing the business case for - oh, well, the change, org change.

Q. You told her that that restructure was not going to happen?
A. That's correct.

Q. How did she take that?
A. I normally receive silence. I wouldn't have been the only person at the time that Workplace Edge consulted - presented the proposed restructure to the employees. I believe Michel Lok and Andria Wyman-Clarke were far more involved than I was, and I'm making an assumption they

would have spoken to Cathie at that point in time. I may be wrong. I know Cathie periodically asked me when could she commence implementing the restructure.

Q. And when you told her "no", her response was silence?
A. Silence, yes.

Q. Could I ask you about the confidential bin issue?
A. Yes.

Q. That became known as "Bin Gate"; did you hear that?
A. I probably did, yes - it brings - yes.

Q. We've heard evidence that when at least one of those involved was summoned for an interview, that that was done by way of email.
A. Mmm-hmm.

Q. And the email summoning the person for the interview contained what was described as a lawful direction.
A. I believe so.

Q. The lawful direction was that the person wasn't to discuss the fact that the interview was to take place with anybody else.
A. I would have to review the email to be able to --

Q. I'm just asking you to assume that that was the effect of it. My question to you is, from an HR perspective, what is the source of the authority of someone like Ms Allen to give a lawful direction like that to a person that she intends to interview for a discipline matter?
A. Okay, it would be under section 26 of the Public Service Act, I believe it's subclause (c). Managers have a responsibility to proactively manage any performance or conduct issues that they become aware of. Now, what "proactively manage" means depends on the circumstances, but it would be reasonable for a manager to ask the people involved not to collude with each other, ie, keep the matter confidential and what was discussed during the interview confidential as well.

Q. You said 26(c) - 26(c) of the Public Service Act?
A. Section 26(3) or 26(3)(c).

Q. It's (3)(a)?
A. Yes, that clause - whilst the Public Service Act has

changed, that clause has been in it for at least a decade.

Q. So 26(3)(a) requires the public service manager to:

... pro-actively manage the work performance and personal conduct of public service employees under the manager's management; and

(b) if a case of unacceptable work performance or personal conduct arises, take prompt and appropriate action to address the matter.

A. That's correct.

Q. A direction such as the one I have described you think would be captured by --
A. I think asking an employee to keep something confidential in the information-gathering process or when you're in an investigation or a disciplinary process is reasonable.

Q. Whether that was a proportionate response to what we've called "Bin Gate" is a whole other question, isn't it?
A. I can't comment on that. I'm not the decision-maker.

MR HUNTER: Thank you.

MS COOPER: No questions, thank you.

THE COMMISSIONER: Mr Rice?

MR RICE: No, thank you.

THE COMMISSIONER: Mr Hickey?

MR HICKEY: Just a few questions, Commissioner.

<EXAMINATION BY MR HICKEY:

MR HICKEY: Q. Ms O'Connor, that question that my learned friend Mr Hunter has just asked you about - the suspected destruction of documents which ought not be destroyed is something that a person in Cathie Allen's position should not ignore?

A. Absolutely. If proven, it would be a breach of potentially legislation, definitely policy.

Q. You say "if proven". One of the steps along the way to proving that, or disproving it, indeed, is that a person in Cathie Allen's position is obliged to investigate it if suspicion of that is drawn to her attention?
A. Because the term "investigation" has some ramifications, I do not use the term "investigation" unless it's a specific terms of reference investigation. We prefer to use the term "gather information".

Q. All right. You're quite right to be careful about that. So "investigation", for you, is a term of art. Somebody in Cathie Allen's position is obliged to gather information --
A. That's correct.

Q. -- in circumstances where that suspicion has arisen?
A. That's correct, because Cathie's HR delegation is that she can manage complaints and performance conduct issues at the local level. She does not have the delegation to actually commence a disciplinary process. That delegation lies with Paul Csoban. So what would normally occur is the manager, Cathie, would gather the information required, and then if it needed escalation, then it would go up to the appropriate delegate to make a determination of how the matter should be managed.

Q. So Ms Allen herself was not delegated to impose disciplinary action if satisfied about those matters?
A. She was not the delegate to - she didn't have the delegation to commence disciplinary action. However, she could actually request that the higher delegate - propose to the higher delegate that a process be undertaken.

Q. I understand. Indeed, Ms Allen might herself be the subject of criticism if it came to pass that she had known about potential document destruction which she had not gathered information about, mightn't she?
A. Potentially.

Q. And so acting with reasonable prudence in her position, that information, that suspicion, having been reported to her, she was really obliged to at least commence to gather information?
A. That is correct.

Q. One reasonable approach that a person in Cathie Allen's position might take, in terms of gathering information, would be to conduct interviews with people who were said to have been involved in the document destruction?
A. We encourage managers to actually have conversations with people rather than doing an investigation, because - just simply time frames. A conversation with an individual is far less stressful. We can obtain the information faster, so the matter can be resolved faster.

Q. Where do you draw the distinction between an interview on the one hand and a conversation on the other, just so I can understand that answer?
A. So for a conversation - in any information-gathering process, you've got to advise the employee that you need to talk to them. You normally give them at least 48 hours' notice, so that they can actually bring a support person along with them if they so desire. Depending on what the issue is, they will get a general overview of what the issue is about, so that they can actually come prepared.

Once they meet with the manager, obviously there is certain information that we're trying to clarify. For an interview, there's a terms of reference, they're actually provided correspondence signed by the investigator inviting them or directing them to attend an interview; there is a specific requirement for the interview. Normally, depending on what the investigation is about, there are powers of investigation under the Hospital and Health Board Act, and we do do some investigations like that; otherwise, they are just - we might have Ethical Standards actually do investigations or engage an external company to conduct the investigation. So it is a far more formal process and generally they are about far more serious - more serious matters than the confidentiality bin.

Q. When you use the term "conversation", that might happen, for instance, in a meeting room?
A. Yes.

Q. You don't necessarily mean an incidental conversation at someone's desk?
A. No, no.

Q. The mere fact that it happens in a meeting room

doesn't mean it's not a conversation?
A. A conversation - for those sorts of meetings - for those sorts of conversations, they should be private, so a meeting room would be recommended.

Q. If I can ask you to assume that Ms Allen took some advice both from Mr Csoban about this particular issue and received some advice from HR about this particular issue - that is, the suspected destruction of confidential documents, so I'm asking you to assume that that's so. I'm not asking you whether you know that to be so or not, but I'm asking you to assume that that's what happened. If, in fact, she received some advice from those people, do you agree that a person in her position ought to follow whatever advice she was given?
A. Sorry --

THE COMMISSIONER: It depends on the advice.

MR HICKEY: You're quite right, Commissioner.

Q. Let's assume that Ms Allen was given advice by her superior, Mr Csoban, and by somebody that she consulted in HR to conduct conversations in meeting rooms with certain individuals about the suspected document destruction. She should follow that advice, don't you agree?
A. I would suggest that she would be sensible in following those - any advice and guidance that she has actually received.

THE COMMISSIONER: The question really is whether she would be acting reasonably in accepting that advice, isn't it, Mr Hickey?

MR HICKEY: That's the gist of it.

THE COMMISSIONER: And the answer must be "yes".

MR HICKEY: Well, one hopes it's "yes".

THE WITNESS: Yes.

THE COMMISSIONER: Q. Is that right?
A. Yes.

MR HICKEY: Q. Now, could I ask you finally some questions - you have given some evidence - you were asked

by my learned friend counsel assisting about the culture within the lab?
A. Yes.

Q. You gave some evidence to the effect that it was a toxic workplace and the indicia of that, you said, were things like it was unhappy, dysfunctional, management of issues was never timely, things of that nature?
A. That's correct.

Q. Then my learned friend asked you about the underlying issues. Can I just understand that evidence, please. Is that an opinion that you have come to more recently, or is that an opinion that you held at the time that you were working as a business partner of the FSS?
A. The specific relationship between Cathie and Amanda?

Q. Well, I'm particularly asking you about your - you used the words "toxic workplace", which is my note.
A. Yes.

Q. What I'm interested to understand is, is that a view that you held when you were working as a business partner to the FSS, or is that a view that you have come to more recently?
A. No, it would have been a view that I would have held when I was a HR business partner.

Q. Because it is important in the course of the Commission for Ms Allen to have the opportunity to respond to things that are said about her, is your evidence that you brought to her attention that you held that view that the lab was a toxic workplace?
A. I believe that it had been brought to her attention by - to her by others, such as Andria Wyman-Clarke. At one point, I remember that we engaged a psychologist, I believe there was eight to 12 sessions, to attempt to address some of the leadership issues and the relationship issues, to get the leadership team working on track. I believe that involved individual meetings with the individuals of the leadership team meeting with the psychologist, as well as actually group sessions, to try and improve that collegiality and that positive working environment. My understanding - my recollection is that it did improve for a month or two and then it fell back into old ways.

Q. In that answer, you have drawn a distinction between

your recollection and then by contrast you have used the words "I believe" in respect of a number of points. What is the substance of those beliefs that you have just mentioned? What's the source of them?
A. The belief of the psychologist being engaged? Well, I know - I know a psychologist was engaged.

Q. And as to the conversations with Ms Wyman-Clarke?
A. Yes, I - we are going back four to five years and my exact recollection on certain facts is not perfect. So it was my understanding that when the psychologist was brought in, she had a program of working with individuals as well as group.

Q. You mentioned that that's going back quite a number of years. It's not the case, is it, that the department would permit a manager to remain in a position such as Ms Allen's over such a prolonged period of time if they were solely responsible for a toxic workplace culture?
A. If there was evidence that that was the case, then I believe that management - more senior management would have acted, yes.

Q. And so it's a reasonable inference, isn't it, that management, or more senior management, the way you describe it, must have been content with Ms Allen's performance, given that she remained in that role for a number of years thereafter?
A. I actually disagree with that assertion.

Q. Can you explain why?
A. In my confidential meetings with the executive directors, they didn't necessarily believe that Cathie was doing an ideal job; that there were issues of - where she could improve.

Q. When were those confidential meetings to which you have referred?
A. I had monthly - with whom, sorry?

Q. You have just mentioned confidential meetings that you have had with EDs, I think you said?
A. That's correct.

Q. In which some complaint was made about Ms Allen's performance?
A. No, not complaints.

Q. Well, some adverse comment made about Ms Allen's performance; is that a better way to put it?
A. That's correct.

Q. When were those meetings, is what I'm trying to come to understand?
A. I used to have monthly meetings with the executive director of FSS.

Q. You say "used to". Do you mean when you were a business partner to FSS?
A. Yes.

Q. So that's going back many years, isn't it?
A. That's correct.

Q. What I'm putting to you is that given Ms Allen remains in that position, it must be the case that her performance was, after that, deemed to be satisfactory, mustn't it?
A. You would have to ask the executive director, because it's up to them to manage that person's performance.

Q. Yes, but I'm asking you, given you are a person with vast experience in this particular sphere. It would be most unlikely, would it not, that a person would be left in a position like Ms Allen's if their performance was fundamentally problematic?
A. My understanding - I understand that the - definitely John Doherty was working with Cathie Allen to support and improve her performance.

Q. But Mr Doherty ultimately left the organisation, didn't he?
A. That's correct.

Q. And so the fact that Ms Allen remained in the position must either mean that no action was taken in respect of her ongoing performance or those who managed her were satisfied about her performance; do you --
A. No, I would say that there was local management action.

THE COMMISSIONER: Excuse me, Ms O'Connor. That is so unjustified, Mr Hickey. You can glean something from the fact that she wasn't removed, but you are putting to Ms O'Connor that the fact that, what, she wasn't removed

means that everybody was happy with her work?

MR HICKEY: No, with respect, Commissioner, that's not what I said.

THE COMMISSIONER: What are you saying?

MR HICKEY: I put two propositions. One was either they were satisfied with her performance, or the first proposition I put was that nobody had turned their mind to her performance, and I did that deliberately in order that I would put it as a fair proposition, because it seems to me there can only be two propositions.

THE COMMISSIONER: No, there are an infinite number of outcomes. One outcome might be, as Ms O'Connor has been saying, that there was some degree of dissatisfaction with Ms Allen's performance, and Mr Doherty was managing that and then he left.

MR HICKEY: Yes.

THE COMMISSIONER: So it doesn't follow that she wasn't removed and we haven't seen any sign of reprimand or anything of that kind, that there was general satisfaction with her work, which is what you're driving at.

MR HICKEY: No, but, with respect, Commissioner, the steps I took were these: Mr Doherty finished up and moved on.

THE COMMISSIONER: Yes.

MR HICKEY: Presumably somebody took Mr Doherty's position.

THE COMMISSIONER: Mmm.

MR HICKEY: It follows from that that somebody either took up the management that Mr Doherty was doing of Ms Allen's performance or didn't. That's the first point that I arrive at.

THE COMMISSIONER: Yes.

MR HICKEY: That's really the proposition that I'm putting to Ms O'Connor.

THE COMMISSIONER: Well, they either did or didn't. You don't have to ask Ms O'Connor. That's tautological. They either did or didn't. But if they didn't, what follows from that?

MR HICKEY: With respect, Commissioner, I don't have the benefit of knowing the insides of this organisation.

THE COMMISSIONER: No, but - examine all you like, right, but if you are asking the witness to draw inferences, then they have to be logical inferences that don't leave huge gaps. Otherwise, it's useless to me. It's just that if Ms O'Connor says something about an inference that might be drawn from apparent inactivity on the part of an executive director, what use is that to me? It's almost weightless, because we don't - she has already said that Mr Doherty was dealing with her in some way, I suppose counselling and advising her or something - maybe reprimanding her, for all I know. So we know that much, which isn't very much. You then say, "Well, we know from the fact that she is still there and that Doherty moved on, leaving her there, therefore she must be doing a satisfactory job." It just doesn't follow.

MR HICKEY: With respect, I didn't put that; I didn't intend to.

THE COMMISSIONER: All right, you continue. I may have misunderstood. You continue, then. See how we go.

MR HICKEY: If it is not a helpful line of inquiry --

THE COMMISSIONER: The inferences aren't very helpful, Mr Hickey.

MR HICKEY: I understand. Those are the questions, Commissioner.

THE COMMISSIONER: All right, thank you, Mr Hickey. Just before you start, Ms Reece.

Q. If a workplace issue arises and the person who is in the supervisory position writes to a person who is involved in the issue in some way, or might be involved, and says to that person, "I would like to give you an opportunity to respond", what does that signify to you in human resources contexts?

A. It signifies that they have received information and that the person's - we're trying to find out that person's perceptions of those events and what occurred - from what occurred with those events from their perspective, before actually making a determination in relation to whether the matter is substantiated or not. And in also doing that, they would be looking at whether the matter can be managed at a local level, whether training, coaching, performance management - what sort of restorative practice can be undertaken to resolve the matter. In some cases, that does lead to the matter being escalated into a disciplinary process.

Q. So you're speaking about information gathering by means of conversations?
A. Yes.

Q. A lot of people might have information that is relevant to an affair, a matter, and in writing to people who are uninvolved, who are regarded as uninvolved in a culpable sense, do you use the language of, "I'd like to give you an opportunity to respond", or is that used in a different context?
A. It would be slightly different, because the terminology is, "We believe that you witnessed this event", or "you have information in relation to that". The first premise that you used implied that the person has done - there's an allegation against that person or a complaint against that person, alleging some wrongdoing, and they are being asked or invited to provide information so the delegate can actually make a decision on the balance of probabilities.

Q. Yes, it's language that implies, as you said, that an allegation of some kind of wrongdoing has been made and requires a response?
A. That's correct.

THE COMMISSIONER: Thanks. Anything arising out of that, Mr Hickey or anyone? No. Ms Reece?

<EXAMINATION BY MS REECE:

MS REECE: Q. Just briefly, Ms O'Connor. You were asked about your impression that the Workplace Edge presentation - I'm sorry, restructure had the aim of getting rid of Amanda Reeves' position.

A. Yes.

Q. You had also been made aware, hadn't you, that there had been a presentation - I think Mr Hunter asked you about it in cross-examination - by Workplace Edge in the workplace?
A. That's correct.

Q. And you were aware that there was a lot of unhappiness about that presentation?
A. Certain parties, certain people present, were extremely upset and stressed.

Q. Do you recall what they were upset about and how that was conveyed to you?
A. It was the impression that they were restructuring Amanda - restructuring to get rid of Amanda, and it was also looking at that - that a lot of - Workplace Edge had interviewed a lot of people. However, they had only taken the opinion of certain people to develop the restructure, as opposed to a balanced view.

Q. Some of the people who spoke to HR about that said that they felt targeted by that presentation?
A. That's correct, yes.

Q. Two of those people were Amanda Reeves and Kylie Rika?
A. That would be correct.

Q. In fact, a complaint was made as a result of that presentation?
A. That's correct.

Q. Moving to the disciplinary process --

THE COMMISSIONER: Just before you move on with that.

Q. You gave evidence that Ms Allen was asking you when the restructure would be implemented.
A. Mmm-hmm.

Q. And you said words to the effect that it wasn't going to happen.
A. That's correct.

Q. Why did you say that?
A. That's because - my understanding is that Michel Lok

is the delegate, and any restructure of the organisation has to have approval. Michel Lok refused to approve the restructure, so it wasn't going to happen. And because of the manner in which - we weren't confident - or I understand - the confidence in the conclusions that had been reached by Workplace Edge, there wasn't particular confidence in the conclusions that they had reached.

Q. You understood that that was Mr Lok's view?
A. And Ms Wyman-Clarke's, yes.

THE COMMISSIONER: Thank you. Sorry, Ms Reece.

MS REECE: Q. Was that conveyed to you directly by those two people?
A. It would have been Andria that advised me.

Q. With the disciplinary process, or the potential disciplinary process, around the confidential bin, your evidence is that Cathie Allen said to you that she wanted to start a disciplinary process at the outset?
A. Yes.

Q. And, in fact, it was you who then said, "You need an evidence base"?
A. Yes.

Q. "You need to take steps before you instigate such a process"?
A. Yes.

Q. Just finally, Ms O'Connor - and this might be a short question but perhaps a lengthy answer. You have been asked about performance management.
A. Yes.

Q. Cathie Allen at the time was, and still is, an HP7, a managing scientist, in that work unit. What would have been the process to either performance manage or sack someone in her position? How complicated is that process?
A. The performance management process for any employee - we are required to actually meet and support. We try to do it in a positive way. We invest a lot of money, time and effort. And these people - regardless of who our employee is, they have a lot of expertise in what they do. So it's to understand why there is a performance issue - sometimes it's because they are unwell, things are happening in their

personal life, so understand the causes of the performance issues, it may be training, and ensure that those issues are addressed and they are supported to improve their performance up to the necessary expectations.

Now, how long that takes and how complicated that is depends on the role that they do. Given that Cathie Allen is an HP7, that would be a complicated path. Obviously working at that local level, it would be a confidential matter between her supervisor, whichever supervisor, whichever ED it was, and Cathie. So it's between the supervisor and the individual.

After a reasonable time period and reasonable support was provided and there's evidence of that actually occurring, then if there is no improvement or minimal improvement, then we would look at instigating a performance improvement plan, which is a formal document that both parties sign. We also have a reviewer. They are given specific expectations that they have got to meet. There is specific support that is actually drafted in to those documents as well, so the employee is supported during those processes.

If they then fail to improve completely, we would abandon the process and potentially instigate a disciplinary process or suggest to the delegate to commence a disciplinary process.

If they are improving but they need more time for that improvement or the reason for the performance issue has changed, we would look at extending. So we've invested a lot of time and money into our employees within Queensland Health, and we like to support them to improve their performance, because it's easier than recruiting somebody else and training them up. We need to keep our people.

Q. The other side of that, isn't it, Ms O'Connor, is that a poorly managed performance management process can lead to industrial action?
A. Oh, absolutely.

Q. You have said that you were aware that Mr Doherty was involved in working with Cathie?
A. That's correct.

Q. And you were aware of that through these confidential meetings that you had with him?
A. That's correct.

Q. I won't ask you about that, because he's going to be a witness called in these proceedings, but what understanding did you have of the relationship between Paul Csoban and Cathie Allen?
A. My personal impression is that Paul Csoban would listen and do whatever Cathie asked him to do; that she was extremely influential over his decision-making.

MS REECE: Thank you, Commissioner.

THE COMMISSIONER: I'm sorry, I forgot to ask you something.

Q. When you send a letter to an employee to set up a conversation in a meeting room, I guess sometimes you would tell the employee the subject matter that you want to talk about, and there may be occasions when you don't do that. Are there occasions when you don't tell them what it's about?
A. Generally, what we would do is if we want to - we may not give them all the particulars of the issues against them; we might give them a broad overview. And I'm not suggesting that this has ever occurred at FSS or in this matter, but say you may want to have a conversation with an employee in relation to sexual harassment occurring on a certain date, you probably only give them that topic. You wouldn't provide them details of --

Q. The allegations that are being made and how they are supported?
A. That's right, yes.

Q. But you want them to turn up with the information, as much information as they have?
A. That's correct.

Q. So I take it that that's a reason to say, "I want to talk to you about such and such"?
A. Yes.

Q. "And I understand you were a participant or a witness", or whatever it might be?
A. Yes, or time frames. That's important, because

sometimes it's important, you know, they may have been on a day off, and if they've got a diary, evidence that, "I was in a meeting when that occurred", that's all valuable evidence.

Q. So can you think of a reason why you wouldn't tell an employee what it is you wanted to talk about?
A. It depends on the seriousness of the issue.

Q. Can you explain that?
A. So if we're going to talk to an employee about rape allegations, we're not going to disclose the sort of - all the details of that, but we would potentially state that we needed to speak to them about a sexual harassment matter that occurred on such and such a date.

Q. But even then, you are giving an indication of the subject matter?
A. That's correct.

Q. Can you think of a reason why you would write to an employee saying, "I want to speak to you about a matter in the workplace. You are not to tell anybody about this, and I'm giving you an opportunity to respond"?
A. I would never recommend that that --

Q. Why?
A. Because the employee has - it's reasonable for the employee to know what they are going to be discussing, so that they can prepare themselves. It depends - it also gives an idea of what - how serious the matter is. The more serious, the more formal we get.

Q. So it's a matter of fairness?
A. Yes, that's right.

THE COMMISSIONER: Thank you. Anything arising out of that for anyone? No? Thank you, Ms O'Connor. You've been most helpful. You are free to go and you are free to stay, of course, if you wish to.

<THE WITNESS WITHDREW

THE COMMISSIONER: Mr Hickey?

MR HICKEY: Commissioner, before you move on to the next topic, could I just raise a matter which is of some concern

to those for whom I appear?

THE COMMISSIONER: Yes.

MR HICKEY: Through the course of that evidence that we have just heard, there has been a fair degree of discussion about the processes that Workplace Edge were involved in.

THE COMMISSIONER: Yes.

MR HICKEY: And the insinuation from that evidence seems to be that there was some undue influence brought upon Workplace Edge in coming to its particular conclusions.

THE COMMISSIONER: Influence, anyway, yes.

MR HICKEY: Some influence.

THE COMMISSIONER: I think that was Ms O'Connor's evidence, was that --

MR HICKEY: Others had the impression.

THE COMMISSIONER: Yes.

MR HICKEY: Certainly the Commission has heard evidence from others where they apprehended that they had not properly been heard, and what my concern is, even if that's not Ms O'Connor's evidence, is that the suggestion from the totality of that evidence is that there was some wrongdoing on the part of, if not Cathie Allen and Justin Howes, at least Cathie Allen.

THE COMMISSIONER: Mmm-hmm.

MR HICKEY: We wrote to the Commission last Monday raising our concern that there didn't, as we yet understood it, intend to be any evidence from those people. We've had communication two days later, last Wednesday, to say, "We're looking into that", and I just wanted to raise again our concern that if that is going to be something that is a matter of inquiry for the Commission, it is evidence that we think ought to be gathered and we should have an opportunity to understand it.

THE COMMISSIONER: What you are saying is if we're going to go down the track of investigating whether Ms Allen was

involved, in some way that's adverse to her reputation and character, in relation to workplace examinations by external agencies, then it's one thing to ask people within the laboratory and the workplace, but we ought to be speaking to those external agencies to see what they say about the matter --

MR HICKEY: Yes.

THE COMMISSIONER: -- and show you, assuming there is no reason not to show you, which I can't imagine - we should show you the fruits of our labours.

MR HICKEY: That's the concern.

THE COMMISSIONER: I think that's taking place, but whether it is of any use is another matter.

MR HICKEY: I'm content with that. Out of an abundance of caution, I'm instructed to raise it.

THE COMMISSIONER: No, no, you are right to do so.

MS REECE: Commissioner, I can confirm that that is taking place.

THE COMMISSIONER: So we're looking at it and I think people have been spoken to, but what has come of it I'm not sure yet.

MR HICKEY: Perhaps I'm boxing at shadows.

THE COMMISSIONER: No, no. You are quite right to raise it.

MR HICKEY: It arises - and I don't mean any criticism by saying this - in circumstances where, for instance, Ms O'Connor's evidence arises today without any forewarning of what she was going to say. We've had no statement. So the Commissioner I hope can understand that I am not being unintentionally difficult --

THE COMMISSIONER: No. I invite you, any of you, to raise matters like this without any hesitation, because you are - the word "parties" isn't strictly correct, as you know, in a legal sense, but your clients are very interested and you have a say in all of this.

MR HICKEY: Thank you, Commissioner.

THE COMMISSIONER: Now, Mr Jones, what is happening?

MR JONES: There is an opening that will probably take about 30 minutes, and then there will be some evidence from Dr Kramer straight after that.

THE COMMISSIONER: From?

MR JONES: Dr Kramer.

THE COMMISSIONER: And anyone else?

MR JONES: No.

THE COMMISSIONER: That's it for you?

MR JONES: That's right.

THE COMMISSIONER: Is anybody else being called this afternoon?

MR JONES: I don't believe so.

THE COMMISSIONER: So we can adjourn until - what is the general consensus, 2.15 or 2.30? Because you are going to have an early afternoon, it sounds like. 2.15, Mr Hickey?

MR HICKEY: Thank you, Commissioner.

THE COMMISSIONER: Everybody happy with that - Mr Hunter?

MR HUNTER: Thank you.

THE COMMISSIONER: Mr Rice, 2.15?

MR RICE: Thank you.

THE COMMISSIONER: That suits you, Mr Jones?

MR JONES: It does, thank you, Commissioner.

THE COMMISSIONER: Very well. We will adjourn until 2.15.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Mr Jones?

MR JONES: Thank you, Commissioner. Part of your appointment includes making full and careful inquiry into whether the methods, systems and processes used by the Queensland Police Service and the Forensic and Scientific Services for forensic DNA collection are conducted in accordance with best international practice.

This topic includes the consideration of the qualifications and training of those who collect the samples; the policies, protocols and guidelines associated with the collection of samples; the quality assurance measures in place, such as competency and proficiency testing of those that collect the samples; and, in some instances, the equipment used to collect samples.

To fully and carefully investigate the collection of biological material for forensic DNA testing, you obtained a vast number of statements from: police officers, including frontline police officers, forensic managers and coordinators, and those that are in charge of the training and quality management units that impart the education and training to the police officers that collect the samples; there was also a statement obtained from a civilian police employee who works within the DNA management unit, and, Commissioner, you would have heard about her, Olivia McIntyre, in module 1; statements from medical doctors who collect the samples and are in charge of the relevant units that have staff underneath them that collect the samples; and a nurse who is in charge of training nurses that collect samples; a statement was obtained from Ms Allen, or two statements from Ms Allen, the general manager of FSS, regarding the collection and any issues that the lab has experienced with police collection; a vast number of documents, including policies, protocols and guidelines, were also obtained; a statement from Mr Ainsworth, a former senior detective, who interviewed 36 police officers and prosecutors about their experience with collection and results and understanding results; and three expert reports.

Collection of biological material for forensic DNA testing is done by two agencies. The first is the Queensland Police Service, who are responsible for the collection of biological samples from a crime scene and

reference samples from those accused people charged with indictable offences. The second agency is Queensland Health. It is responsible for the collection of certain biological samples from victims of sexual assault and people accused of committing those offences.

The relevant people in charge in Queensland Health report to Lara Keller.

The Forensic Services Group of the Queensland Police Service oversees much of the training and policies related to sample collection. The Forensic Services Group contains Brisbane-based specialist units and sections, including the biometrics unit, which contains the DNA management section, and that is headed up by Inspector Neville, who, Commissioner, you heard from in module 1; the quality management section, which is headed up by Inspector Keating, which is in charge of imparting the education and training to the officers; and the scientific section, which is headed up by Inspector Pobar, who is in charge of the locally based scientific officers. The Forensic Services Group oversees geographical units of forensic officers, which is a term used to refer to both scenes of crime officers and scientific officers, both of which are responsible for the collecting of samples from crime scenes.

The key Queensland Police Service policies and protocols that relate to sample collection and quality management are CSE100, which is a crime scene examination protocol; CSE101, which is a biological evidence protocol; PFS100, which is the quality manual; and the operational procedure manual.

Within each region, there are multiple units of scenes of crimes officers, each of which report to a forensic coordinator and a forensic manager.

There are scenes of crimes officers in every police district. A scenes of crimes officer completes a year-long training program facilitated by the Forensic Services Group quality management section, which renders them eligible to receive a Diploma of Forensic Investigation, is trained in all aspects of standard crime scene examination, including fingerprinting, photography and collection of samples for forensic DNA testing, and will attend volume crime scenes and major crime scenes, although at some major crime

scenes, there will also be a scientific officer in attendance.

Scientific officers sit within the scientific units and are only located in major centres, being the Gold Coast, Brisbane, Rockhampton, Townsville and Cairns. Scientific officers in Brisbane and Gold Coast report to the Brisbane-based scientific section of the Forensic Services Group headed up by Inspector Keating. The remaining scientific officers report to a local forensic manager.

Scientific officers are recruited generally from scenes of crime officers and must already hold a Bachelor of Science or an equivalent or similar degree. They will then undertake a training program that takes up to four years and renders them eligible to receive a Graduate Certificate in Crime Scene Investigation, have higher-level forensic skills than a scenes of crime officer but are not further trained in fingerprinting or complex photography, which is left to the scenes of crime officers, and will attend more complex major crime scenes, particularly if blood spatter analysis is required. Scenes of crime officers will assist scientific officers at most of those major crime scenes.

When a crime occurs and a crime scene is established, the first responding officer or investigating officer may request the scenes of crime officers to attend the scene to take, among other things, samples for forensic DNA testing. They may also request a scientific officer to attend if it is a significant matter, such as a homicide, that requires more complex scientific skills.

While there is no strict policy, if the crime scene is a major incident, such as homicide, unusual death or a serious, violent offence, the local forensic coordinator and/or forensic manager will also be contacted and will be involved in planning and coordinating the forensic response to the crime and may attend the crime scene. Sometimes, visual feeds are used to assist a forensic manager or coordinator with their decisions, that is, photographs and videos are uploaded to the forensic-register and viewed by the forensic manager or coordinator when considering what response is required.

For obvious reasons, every attempt is made to limit

the number of people that enter a crime scene. Accordingly, the forensic coordinator will be the conduit of information flow between the forensic officer or officers and the investigators. That is, the forensic officers will be inside the crime scenes; the investigators will be outside the crime scene. Investigators will be outside, speaking to witnesses and gathering evidence and feeding information back to the forensic officers, which will inform what may be sampled and taken. That way, testing and sampling can be targeted to the facts as they become known.

The decision about where and what to sample, however, is made by the forensic officers and often in collaboration with the forensic coordinator.

The location from which a sample is taken is photographed, as is the sample itself. The sample is barcoded and entered on to the forensic-register at the time by the forensic officer. The photos are loaded on to the forensic-register. Scenes of crime officers and scientific officers have access to the forensic-register, but investigators do not.

The sample is then logged and stored at the forensic property point. Police officers will then triage and determine what to send to the lab for testing in accordance with the priority 1, priority 2 and priority 3 system, Commissioner, that you heard about in module 1.

Samples are either hand delivered by the police officers or sent via registered post.

As the DNA lab also uses the forensic-register, it scans the barcode on arrival and the exhibit is recognised by the forensic-register on the lab side. Results are then returned via the forensic-register to the DNA management unit and published to the investigators via the Queensland Police Records and Information Management Exchange, otherwise known as QPRIME, and on occasion by email.

During module 1, you heard about a change in process in 2008 whereby police commenced sub-sampling items collected for DNA testing. This process is done in the DNA labs run by the police. This process involves the police taking smaller samples from larger items, such as bedding, and placing it in a robot-ready or test-tube-ready form.

These sub-samples then go to the lab and are examined for DNA. Since 2008, the only whole items that make their way to the lab are things like condoms, cigarette butts, syringes, sanitary products and chewing gum.

Proficiency testing and quality assurance measures relating to scenes of crimes officers include the following. Once every two years, a scenes of crime officer must complete a scene assessment whereby another scenes of crime officer of at least equal seniority accompanies them and completes an assessment of their evidence collection skills at a scene. At times, a scenes of crime officer will complete an online proficiency test called "After the Fact", which is a virtual scene examination. There will be court testimony monitoring and a technical review which is conducted on all major crime sampling completed by scenes of crimes officers, any crime type in which a scenes of crimes officer produces a statement, and a further random selection of reports, to ensure such scenes of crime officers have had five matters technically reviewed each year. It checks the methods used for collection and the conclusions drawn. It is conducted by a forensic officer of at least the same level of seniority.

The Queensland Police Service also provides a train the trainer program, given the size of Queensland, where certain forensic officers are given refresher training from forensic scientific group quality management section, and then they return to their locality and deliver it locally.

A review is also conducted of the examination summary of each case file. This is done to ensure that various administrative requirements have been met and is called an administrative review.

The Forensic Services Group quality management section undertakes annual internal audits of every QPS forensic laboratory used by the forensic officers. The laboratories are also accredited to international or national standards, which are audited by NATA every 18 months.

As part of your investigation, the laboratory was asked questions via Ms Allen. One of those was whether the lab had identified or raised any systemic issues, problems or errors with the methods, systems or processes used by the Queensland Police Service for forensic DNA collection.

In answering that question, in Ms Allen's statement of 16 September 2022, five matters were identified. There was an issue in 2008/9 with the swabs that were being used. There was an issue in around 2008 with post-it flags that were being used. There was ongoing work with the Queensland Police Service to ensure sufficient detail was uploaded to assist with appropriate sampling and testing on the forensic-register. There was an issue with access to the forensic-register in around January 2020, which, Commissioner, you heard about in module 1, where police officers had access to degradation values and quant values, and there was an issue with exposure to graphic imagery without warning in the forensic-register in late 2018.

Later in this module, Ms Allen will be called to give evidence, and it will be confirmed that those issues were resolved at the times that they were raised. There was no suggestion that they are systemic problems that exist currently.

Anna Davey is a scientist with expertise in methods, systems and processes relating to collection of samples for forensic DNA testing. Her experience includes quality management and auditing. She has held management roles within what is now known as the Victoria Police Forensic Services Department. One of those roles included developing and maintaining the facility's internal audit program, which included being the audit leader for several audits. She also has held a position as deputy director of the National Institute of Forensic Science.

Ms Davey was engaged by you, Commissioner, to consider the policies and practices of the Queensland Police Service with respect to collecting and transporting samples for forensic DNA testing. This included a review of the quality management review processes and qualifications and training of the relevant police officers.

It is not intended to call Ms Davey. The parties have been provided with Ms Davey's report and have indicated that they do not require her for cross-examination. The Queensland Police Service will provide a further short statement dealing with one issue that Ms Davey has identified, which will put that into its proper context. Once that is to hand, it will be distributed to the parties and made part of the tender bundle.

In her report, Ms Davey concludes that the Queensland Police Service's methods, systems and processes for collecting samples for forensic DNA testing as documented are in accordance with best international practice.

She identified some anomalies in actual practice. They were an issue with the labs that were used where the sub-sampling is done, and I understand that is what the subsequent statement will address; issues with the review of results such that it would then guide what further sub-sampling ought to be done; and issues with meeting proficiency testing requirements, the structure of the internal audit program and the system of technical reviews and administration reviews. They are anomalies, in Ms Davey's opinion, that would be found in any organisation of that size and that complexity.

Ms Davey also looked at the methods, systems and processes for transporting the sexual assault investigation kits after collection to the lab for testing. She found that those methods, systems and processes accorded with best international practice.

However, Ms Davey found that the method of assembly of the kit is not in accordance with best international practice, as the assembly process is not compliant with International Standard 18385. The assembly process does not minimise the risk of human contamination, because there are no processes in place to assess the presence of detectable human DNA in the assembled kits or to treat them with an agent which denatures any human DNA present. That appears to be consistent with the opinion of Dr Kramer, who you will hear from shortly.

Mr Ainsworth, a former detective, interviewed a number of police officers, and some issues surrounding access to results and doctors to do SAIKs were issues that police had experienced. One statement was obtained from a police officer that identified a sexual assault investigation kit being transported from Emerald and sitting at Rockhampton for four months before being transported to the lab, but that appears to have been an isolated incident.

That brings me to the collection of samples by Queensland Health. In a case of sexual assault, biological material is typically collected from the complainant and/or the accused by way of a forensic medical examination.

While the Queensland Police officers will usually arrange such an examination, physicians or nurses are engaged by Queensland Health to conduct those examinations. Usually the physician or nurse uses a sexual assault investigation kit to collect samples during the examination. Persons who are not yet sure if they want to make a police complaint can request a "just in case" kit, which does not involve the Queensland Police Service. A "just in case" kit is the same as a sexual assault investigation kit, save for the involvement of the Queensland Police Service, and it doesn't have a separate component which is a toxicology kit.

In Queensland, sexual assault investigation kits and "just in case" kits are produced and compiled by the staff at the DNA laboratory.

It should be noted that the Women's Safety and Justice Taskforce considered the quality, accessibility and use of forensic evidence gathered in legal proceedings in its report dated 1 July 2022. The Commission of Inquiry is not investigating the experiences of victim survivors in accessing sexual assault examinations, noting that such experiences were well explored by the Women's Safety and Justice Taskforce.

The Commission is instead focusing on issues that have been raised by physicians and stakeholders and which relate closely to forensic DNA testing. They complement, however, many of the findings of the Women's Safety and Justice Taskforce. They are: whether the current sexual assault investigation kits and "just in case" kits are adequate, in that they do not contain enough swabs, are not DNA free, have wooden stems and do not contain a DNA decontamination kit; whether the "just in case" kits are substandard in comparison to the regular sexual assault investigation kits; the sufficiency of the qualifications and training of those who conduct the sexual assault examinations; and the practice of Queensland Health not taking reference samples, DNA samples, from the complainant as part of the forensic examination.

Just to explain that, Commissioner, what happens currently is that a victim undergoes the procedure, the sexual assault investigation kit, and then some time later is either visited by police or has to attend the police

station to provide a reference sample.

You have engaged three experts to review the sexual assault investigation kits. They are: Associate Professor Kathy Kramer, who is an experienced clinician and forensic medical examiner and is currently the senior clinical advisor in the New South Wales Ministry of Health's prevention and response to violence, abuse and neglect. She will provide a clinical perspective and will consider the qualifications and training of those who conduct sexual assault investigation kits and the equipment and procedures used in relation to them.

You also engaged Professor Rebecca Kogios and Heidi Baker, who are molecular biologists with backgrounds in forensic science. They will advise whether the current kits and "just in case" kits enable the acquisition of high-quality DNA samples. Their report is still outstanding and will be produced to the parties upon receipt, and they are being called at a later time.

Queensland has 16 separate hospital and health services. Each of these covers a distinct geographical area, except for the Children's Health Queensland Hospital and Health Service. Each hospital and health service is partially independent but is part of Queensland Health and may be instructed by the director-general of Queensland Health via a health service directive.

The current health service directive stipulates that each hospital and health service must provide 24-hour access to forensic examinations for victims of sexual assault, including a suitable model of care for sexual assault patients under 14 years of age. Queensland Health also has a Clinical Forensic Medicine Unit based in Brisbane. The functions of the Clinical Forensic Medicine Unit are set out in the statement of Dr Griffin, who is the director of the unit.

Broadly and relevantly, the Clinical Forensic Medicine Unit provides forensic medical examinations in Brisbane and provides guidance and advice by way of a 24-hour, seven-day-a-week telephone service for the conduct of forensic examinations on complainants and accused persons across Queensland. Ultimately, the provision and conduct of sexual assault examinations is the responsibility and matter for each individual hospital and health service.

Once the sexual assault investigation kits are assembled by the lab, they are provided to the police and distributed throughout the police. Police officers generally provide the kit to the Queensland Health physician or nurse who will then conduct the forensic examination. Relevant extracts from the Queensland Police Service Operational Procedures Manual set out the role of the police officers in relation to sexual assault investigation kits.

"Just in case" kits, once produced, are provided to Pathology Queensland and it seems that it is up to each hospital and health service to ensure their physicians and nurses have access to the "just in case" kits when required.

Once the forensic examination is complete, Queensland Police Service officers take possession of the sexual assault investigation kit and are responsible for having a forensic officer barcode the exhibit and enter it into the forensic-register. The investigating officer is then responsible for transporting the kit to the laboratory.

The current interagency guidelines on responding to sexual assaults provide that a reference DNA sample from the complainant is to be taken by the practitioner conducting the examination. However, in practice, reference samples from a complainant or an accused have also been taken by the police, usually on a later occasion.

From about August 2021, Queensland Police Service have raised concerns that Queensland Health physicians and nurses are not taking reference DNA samples and, instead, leaving it to the police officers to do, contrary to the interagency guidelines.

Queensland Police Service suggests, or officers from the police service suggest, that having to ask a complainant to return a couple of days later to a police station or attending at their house so a police officer can take their reference sample unnecessarily re-traumatises the complainant. Of course, if the process is more intrusive, traumatic and repetitive than it needs to be, victims will not subject themselves to it, and matches with perpetrators will be lost. It also does not accord with a victim-focused approach, which Dr Kramer will tell you is

most important and should inform any guideline or policy or protocol.

Sexual assault examinations of a person under the age of 14 years are generally conducted by a paediatrician because of anatomical differences. The same sexual assault investigation kit is used. It may be that in more remote areas, local medical officers need to medically assess a child under 14 and conduct the examination themselves.

The Child Protection and Forensic Medical Service provides a 24-hour-a-day, seven-day-a-week call support for clinicians in Queensland, peer review of examinations and interpretation of findings on request, and workshops to provide professional development and upskilling.

The Child Protection and Forensic Medical Service is responsible for the provision of these services in the Children's Health Queensland Hospital and Health Service, but each of the remaining 15 hospital and health services are ultimately responsible for the conduct of examinations on children under 14 years in their district. Dr Jan Connors is the head of the Child Protection and Forensic Medical Service and has provided a statement to the Commission.

As is mentioned, it is up to each hospital and health service to determine how forensic medical services are delivered. Within the Gold Coast Hospital and Health Service, Dr Cathy Lincoln is the director of the forensic medicine department. Dr Lincoln has implemented further qualification and training requirements for her physicians who perform forensic medical examinations in that hospital and health service. Dr Lincoln also, on occasion, uses more equipment, such as further swabs, than what is provided in the standard SAIK and then sends all the used swabs for testing via the police.

Dr Griffin, the director of the Clinical Forensic Medicine Unit in Brisbane, says that he has received negative feedback from the lab about such a practice.

We have asked our expert - that is, Dr Kramer - to consider whether Dr Lincoln's practices of conducting further training on her staff and in using more swabs in her examinations are closer to best practice than standard Queensland-wide practices or are problematic, as suggested

by the lab via Dr Griffin.

Queensland Health has for some time employed forensic nurse examiners to conduct sexual assault examinations. Most recently, and since about 2019, Queensland Health have been training sexual assault nurse examiners through a 40-hour course to conduct sexual assault examinations.

The Women's Safety and Justice Taskforce made several recommendations relating to what the Commission is investigating, which include, relevantly, Queensland Health in partnership with the Department of Justice and Attorney-General develop and implement ongoing competency-based training and professional development for doctors and nurses who may be required to prepare reports and give evidence in criminal proceedings for sexual offences; Queensland Health develop and implement a community and education campaign to inform doctors who may be required to perform forensic medical examinations about the critical importance of this work, their role and the support available to them to perform this role well; Queensland Health and the Queensland Police Service review and revise the model for "just in case" forensic medical examinations in Queensland and implement a new approach that ensures a full medical examination is undertaken with the same number and quality of samples taken in a forensic medical examination; the sexual assault investigation kit used in Queensland be reviewed and updated to ensure it is, at the very least, of consistent quality as those used in New South Wales and Victoria; as a minimum requirement, kits must be DNA free and contain DNA decontamination kits and an adequate number of swabs and testing apparatus.

It should therefore be borne in mind that Queensland Health may already be implementing some of these recommendations. The Commission is currently investigating if and how and what progress has been made to implement those recommendations.

As referred to earlier in this opening, Commissioner, you engaged the assistance of Associate Professor Kathleen Kramer to consider the methods, systems and processes for the collection of biological material for forensic DNA testing from sexual assault victims and those accused of committing sexual assault offences.

Professor Kramer was briefed with the policies and

protocols from Queensland Health. She was also provided with statements from Dr Griffin, Dr Lincoln and Dr Connors. After careful review of the brief material, Professor Kramer concluded that the training and proficiency testing of the physicians and nurses that conduct the forensic medical examinations Queensland-wide is not best practice and does not enable the collection of high-quality samples for forensic DNA testing.

The training and proficiency testing for the Gold Coast Hospital and Health Service, however, is an exception. This is because Dr Lincoln, who oversees the Gold Coast, has implemented training and testing above that rolled out elsewhere in the state.

Professor Kramer made the following recommendations in relation to the training and proficiency testing of those conducting forensic medical examinations: move to a competency-based training across Queensland; create a process for re-credentialling physicians and nurses; and training be tailored to local sampling guidelines and local sexual assault investigation kits and in DNA contamination minimisation kits.

Dr Kramer also observed that the equipment and procedures used in conducting forensic medical examinations in sexual assault matters does not reflect best practice and does not enable the collection of high-quality samples for forensic DNA testing. Professor Kramer made the following recommendations in relation to the equipment and procedures. Commissioner, to your front, on the right there are some plastic bags.

THE COMMISSIONER: Yes.

MR JONES: This one with the pink slip is the "just in case" kit. The other kit is identified as a "tamper-evident, highlight unauthorised access" bag. That is the SAIK kit. In that, Commissioner, you will find six swabs. And I should pause to note, this is how the kit comes via the police. It's open. It consists of six swabs. Commissioner, you will see there that the swabs are made of wood, the handles or the stick part of it is made of wood, and the tip is made of cotton. The evidence bag is not sealed, and it comes with a Queensland Health Forensic and Scientific Services sexual assault investigation kit document, which is for the recording of

details, and that is that document there (indicating).

THE COMMISSIONER: Yes.

MR JONES: It does not provide a guideline. It has a toxicology form in it. And the other document is in fact a drop sheet which is placed under the person the subject of the kit to collect any evidence that may come from them as they undress.

Now, in making the conclusion that Professor Kramer makes about the equipment and the practices, she makes the following recommendations in relation to the equipment and procedures: the stems of the swabs contained in the SAIK be made from plastic or aluminium instead of wood; similarly, the swabs should have a rayon tip as opposed to cotton; the interagency working group be created and regularly review sampling guidelines and alter procedures to adhere to the guidelines and the equipment; the SAIK contain DNA-free equipment; the buccal sampling equipment be added, along with a glass slide specimen jar and biohazard bag. I just pause there to say this about the glass slide. Up until about 2013, the clinician would take the swab and smear it on to the glass slide. That was stopped in around 2013, and it seems that Professor Kramer says it should be reinstated, and that, as I understand it --

THE COMMISSIONER: Do we know why it was stopped?

MR JONES: Not immediately, to my knowledge.

THE COMMISSIONER: It might be interesting to find out.

MR JONES: Dr Griffin may mention it in his statement, and I understand that - I believe perhaps Kogios and Baker may suggest its reinstatement as well.

THE COMMISSIONER: We should find out why it was removed, because that might bear upon that recommendation.

MR JONES: Yes. I have read it, and we will see if we can get you an answer.

The swabs should be pre-labelled, to avoid illegible handwriting but also to act as a guide to prompt testing for those conducting the examination.

THE COMMISSIONER: To act as a what?

MR JONES: A prompt. That would be particularly important in Queensland, where all but one of the physicians from the CFMU are located in Brisbane and they provide a telephone service to doctors that may rarely do these types of examinations.

THE COMMISSIONER: So, so far, I understand that there are six swabs in the kit. There are no instructions on how to proceed in taking samples; is that right?

MR JONES: That's right. There is the completion form there, which would act as somewhat of a guide, but --

THE COMMISSIONER: Well, let's see.

MR JONES: For example, "Type of assault - digital, penile" and, over the page, there are the types of swabs, areas to swab.

THE COMMISSIONER: Let's see. I see.

MR JONES: Dr Kramer will tell you, though, that there are things missing from that.

THE COMMISSIONER: There are omissions, yes.

MR JONES: There are omissions. One caveat that Dr Kramer puts on this is that for various reasons, kits need to be locally put together in the sense not physically, but a group needs to come together that includes the physicians and the people from the lab, because there might be lab capabilities that need to inform what things need to be made from, et cetera.

THE COMMISSIONER: Yes.

MR JONES: And there will be physician experience about what is something regularly seen in their local jurisdiction.

THE COMMISSIONER: Yes. I would think that one of the things that would be done as a matter of course from time to time would be that those with knowledge of how the samples are taken would speak to those who use the samples

by way of testing them - that is, FSS - with a view to understanding what is working and what isn't working.

MR JONES: Yes.

THE COMMISSIONER: And I see from the form which you drew to my attention, which would be filled in by the person who takes the samples, that it was approved, one of them at least, by FSS. I'm talking about the Forensic and Scientific Services form, which contains all the checklists for samples. So have we seen any material relating to the design and ongoing monitoring of the use of these systems?

MR JONES: Not in relation to the ongoing monitoring, but the design. Ms Allen in her second statement provides some evidence that, in consultation with Dr Griffin, the kit was designed.

THE COMMISSIONER: And when was that, do you know?

MR JONES: That was in 2012 I believe. Yes, July 2012, at paragraph 150 of Ms Allen's statement of 11 October 2022.

THE COMMISSIONER: And it's stayed the same since then, as far as you know?

MR JONES: We are making some inquiries - or they will be made, I should say.

THE COMMISSIONER: All right. You go on with what Professor Kramer says.

MR JONES: Commissioner, though, you identify some important points, and it goes beyond just the Brisbane-based physician; it must be feedback given from the lab to the physicians, but then the physicians elsewhere operating, as to what is important and what is being seen by them and the use.

Dr Lincoln is critical of the kits currently as they are, from experience, the difficulty to use them, scant detail in the guide, in the sheets, and space to record information. But Dr Kramer even suggests that consultation with the Director of Public Prosecutions about the type of evidence that is useful to be gathered is important as well. For example, nail clippings, if they were useful, ought to be gathered. Dr Griffin speaks in his statement

about the kits formerly having a nail clipping collection container, but it was rarely used, is my understanding of what Dr Griffin says, so it was --

THE COMMISSIONER: Is there a nail clipping container?

MR JONES: Not now, there is not. But Dr Griffin says that it was rarely used, so it was gotten rid of.

The kits contain better documentation regarding how the examination ought to be conducted; the DNA contamination minimised kits should be included with guidelines and training to be considered; and health staff be provided with support from a local medical director, and that is particularly important because currently it seems as though anyone outside of Brisbane does not have that local support.

As I said before, some of those recommendations come with the caveat that not enough information is known locally by Dr Kramer to proffer the opinion that they would not be best practice or they would be best practice in Queensland.

What should occur, though, is a review of the kits with contribution from the lab, doctors, nurses, police and other stakeholders, such as prosecutorial services, and that seems to tie in with the recommendations of the taskforce.

Reference samples should be taken at the time of administering the sexual assault investigation kit. Dr Kramer will tell you, Commissioner, that that is informed by a patient-centred dictum-informed, culturally safe approach.

THE COMMISSIONER: Do we know why a reference sample isn't taken as part of the SAIK process?

MR JONES: The guidelines in place have it that Queensland Health should take it. Dr Griffin was involved in drafting those guidelines and says it's a typographical error, and there has - information that hasn't formed part of the brief, but there was a lot of to and fro, but Superintendent Frieberg's statement addresses it and exhibits to her statement address the issues that they had with Dr Griffin and the issue with the reference sample.

His view seemed to be that he wanted it to be evidence based if there was to be a change, he was concerned about contamination, and then costs and training that would follow on from police officers having to take samples.

Dr Lincoln says it should be no problem for us to take reference samples. We would just need to know about how they were going to be used so that we could inform the patient and obtain proper, informed consent.

Of course, Dr Kramer will tell you --

THE COMMISSIONER: But this is a patient who is already giving samples according to the process in the SAIK kit?

MR JONES: That's right.

THE COMMISSIONER: So why would such a person need to give further consent to give a reference sample?

MR JONES: A doctor will always, before taking samples or doing a procedure, ask for full and informed consent. They would need to know how a reference sample is going to be stored, how long it's going to be kept.

THE COMMISSIONER: I see. Yes, I understand.

MR JONES: Of course, Dr Kramer will tell you that all other states, if not all, most other states, take the reference samples at the time of doing the procedure, and if there was a contamination issue, that person could be the rare one --

THE COMMISSIONER: Give another one.

MR JONES: -- to come back on another occasion, rather than everybody.

Superintendent Frieberg, I believe, attaches a transcript of a conversation with Dr Griffin that had to be terminated because it became somewhat heated about the reference samples.

Dr Kramer says that the sexual assault investigation kits do not accord with Australian Standard, and I noted earlier that this seems to be consistent with what Davey finds, that the failure calls into question the integrity

of the results or can call into question the integrity of the results, because there is a failure to seal the sexual assault investigation kits, and the failure to produce DNA-free sexual assault investigation kits, and Dr Lincoln has attached a photo to her statement of SAIKs arriving with other people's hair under the labels that are stuck to the side of them, and Dr Kramer comments in her report that that is deeply concerning.

Medical directors and clinician leads should receive scientific feedback to guide and improve local practices. It seems at the moment that there is no feedback from the lab.

"Just in case" kits should contain a mechanism to collect clothing for sampling for forensic DNA testing and toxicology. Toxicology is obviously not relevant to the DNA collection, but the clothing certainly is. At the moment, because the police are not involved, there is no process or storage facility to collect a complainant's clothing. Dr Kramer will tell you that that is below optimal, because things like underwear can contain very significant DNA evidence.

A terminal clean of an examination room which is a hospital grade clean to decontaminate a room after a potentially infectious patient has been in the room is not sufficient for the cleaning of a room where a person will have their DNA sampled. That is the process at the moment that Dr Lincoln has at the Gold Coast. Dr Kramer commends her for attempting to have a better process in place, but that is the wrong type of process. Any sampling room should be cleaned using a method informed by the Royal College of Pathologists of Australia's national guidelines and should remove DNA. Otherwise, the policies Queensland-wide for cleaning are appropriate.

Evidence gathering should include early evidence kits. The taskforce heard about victims travelling long distances without being able to shower or go to the toilet, sometimes then arriving and a doctor refusing to do the examination because they were not experienced in the examination, in remote locations. Early evidence kits, as I understand them, to enable someone to gather some of their own evidence, so that they can go to the toilet or have other treatments if they are injured, are preferred over the sexual examination kit. It collects urine, for example,

clothing, and those sorts of things.

As part of the investigation, Ms Allen was asked some questions about the sexual assault investigation kits. It seems that only Dr Griffin was consulted about the contents of the sexual assault kits, and that's found at paragraph 150 of that statement of 11 October 2022.

Ms Allen, in that same statement, states that improvements to SAIK could be made to ensure the components permit the best-quality biological samples to be taken.

Commissioner, that concludes the opening. I call Associate Professor Kathleen Kramer. She will give evidence via videolink and will take an affirmation.

<KATHLEEN KRAMER, affirmed: [3.09pm]

<EXAMINATION BY MR JONES:

MR JONES: Q. You are Kathleen Kramer?
A. Yes.

Q. I will just get you to speak up, Professor. You are an associate professor in the University of New South Wales School of Medicine?
A. Yes, I am.

Q. You have been admitted to a Bachelor of Arts, Bachelor of Medicine, Bachelor of Surgery and a Bachelor of Science with honours?
A. Yes, at the University of Sydney.

Q. You have been admitted to a Graduate Diploma of Forensic Medicine?
A. Yes.

Q. And to a Graduate Certificate of Medical and Forensic Management of Adult Sexual Assault?
A. Yes.

Q. You are a Fellow of the Faculty of Clinical Forensic Medicine?
A. Yes, I am.

Q. You are a Member of the Australian College of Rural and Remote Medicine?

A. Yes, that's correct.

Q. You are a registered medical doctor in New South Wales?
A. Yes.

Q. And you specialise in forensic medicine?
A. That's correct.

Q. You have research interests in issues affecting the forensic and medical management of adult and child sexual assault victims?
A. Yes, I do. Yes, and I'm a published researcher.

Q. And you are the senior clinical adviser in the New South Wales Ministry of Health's Prevention and Response to Violence, Abuse and Neglect?
A. Yes, I am a senior clinical adviser to the Ministry of Health, but I would like to go on record as saying I'm not representing the ministry here today but myself as a private person.

Q. Thank you. This month, you prepared a report for the Commission of Inquiry?
A. Yes, I did, Mr Jones.

Q. Do you have a copy of that report with you?
A. I do. May I be allowed to refer to it?

THE COMMISSIONER: Yes, feel free to refer to it at any time you wish, Professor.

THE WITNESS: Thank you.

MR JONES: Q. That report considers the systems, processes and methods used in Queensland to collect samples for forensic DNA testing from victims of sexual assault and people accused of perpetrating sexual assaults?
A. Yes, it does.

Q. Your report also considered 10 issues that were raised by Dr Lincoln in her statement?
A. I believe that's correct.

Q. Shortly I will ask you to tell the Commissioner about your review of those methods and systems and processes for collecting the samples, but I would like to set the

background regarding the lack of international and national guidelines. You say there are two essential features of best practice in this area of sample collection from victims and perpetrators: one, practices that are informed by evidence?
A. Yes.

Q. Two, practices that are patient-centred, trauma-informed and culturally safe?
A. Yes.

Q. I will get you to explain those in a moment, but would you tell the Commissioner why there are no national or international guidelines addressing best practice for collection and storage and analysis of those samples, please?
A. Well, I'll touch briefly on analysis and then leave that to a DNA scientist. Analysis in countries like the UK is done by private laboratories. What they do is commercial in confidence; it's very hard to get information or get them to share information about what they do. In a big country like the US, the DNA labs are going to be in individual counties. County by county will have different resources and different ways of doing things. America has attracted a good deal of criticism about the way it handles forensic samples. So it's very difficult to get best practice about the analysis of samples internationally.

But coming more to my field, which is really around how we collect and store samples, there are no international guidelines. That might sound surprising, but there are two very, very good reasons why that is the way it is. The first is that how you are going to collect samples and what you are going to do with them is part of a justice process and it's got to fit the needs of the justice system. That means it's going to be informed by whatever laws are pertinent in that jurisdiction around what is a sex crime and what is evidence of a sex crime, and that is going to be different in Alabama compared to England and Tasmania compared to Queensland. So what you need are processes that are fit for that legal jurisdiction.

The other thing that comes into play is what that lab that you are sending your samples to is capable of. There is no point, for example, sending them an oral rinse, which is a sampling technique to get sperm cells from the mouth,

but if that lab can't process an oral rinse, if it can only process an oral swab, there is no point sending them an oral rinse.

Local labs will develop their own sort of skills and strengths. Their own data might show, for example, when it comes to skin swabs, that they get much better results with, say, a two-swab technique, a wet and a dry, or they get much better results with a single-swab technique. So international guidelines can't take those kinds of subtle local nuances about what this lab can do and what these courts require into account. So there's nothing, you know, internationally.

To some extent, within countries, there may be some guidelines, but they are usually very generically worded and they come with a rider saying, "This has to be adapted locally. You have to develop your own processes, your own SAIK kit, your own sampling guidelines, your own training that is tailored to your particular kit."

But as you alluded to earlier, I still think there are some broad principles about what is best practice when you are wanting to collect these samples. I think you can draw some broad overarching guidelines that then determine what a process for developing local best practice would look like. Does that answer your question?

Q. Thank you. I will take you to those in a moment. Just on something you have said there about the data and about what may be collected and produce better-quality results or greater results, I take it, then, from that that it is important that that data be collected and that feedback be given to those that are designing the kit?
A. Absolutely. You need robust quality assurance processes that say what works and what doesn't work and a way of sharing that information from all of the actors in the field. You have patients, you have doctors, you have labs, you have police, you have the courts as the triers of fact, and all of them have unique bits of information about how well a system is working or not working. So if a lab is finding that the doctors' handwriting is illegible, for example, that has to be fed back to doctors. If doctors are finding that they are forever opening a second kit because there aren't enough swabs in a single kit, then that has to be fed back to the lab who makes the kit and the police, who are of course paying for those kits.

Q. Now, absent the national and international guidelines, you touched on three considerations that were important for underpinning any policy or protocol.
A. Yes.

Q. What are they?
A. They have to be evidence based, and that evidence is coming from a multiplicity of sources. There will be published research; there will be your own internal quality assurance processes; there will be what other labs in your country are doing that you could perhaps learn from. But either way, there has to be a good, solid reason for why you do things the way you do things and the flexibility to change them as things evolve.

Separate to that, there is the more sort of patient-focused aspect of things. Although I don't want to segue into talking about rape myths, that women make things up, the research evidence clearly shows that it is uncommon for women to make up a rape allegation or a sexual assault allegation out of whole cloth. That being the case --

THE COMMISSIONER: Q. Professor Kramer, just to digress a moment, you cite a paper by Ferguson in 2016 for that proposition, that false complaints are rare.
A. Yes.

Q. I will look at the paper in due course, but could you summarise for me the substance of it, if you can remember it?
A. There has been a number, a number of papers. Ferguson's is a nice kind of overview of all of the previous research; it ties everything together. But let me give you a concrete number from Australia. In Melbourne, the Victorian Institute of Forensic Medicine did two studies 10 years apart looking at the false complaint rate in women who were having a sexual assault investigation kit, and in both of their studies it came up with the same figure of 2 per cent, so 2 per cent making them up.

That is not zero, and I'm not saying it never happens, but it's the minority of cases. If we accept that as a fact, then what that leads us to say is that at the centre of all this process, there is going to be a patient, there is going to be a person, who in all likelihood has had a very traumatic event, and their needs and their

wellbeing have got to inform this process just as much as the needs of the lab will inform this process. Does that answer your question?

Q. Yes, that's very helpful, thank you. Just going back to the needs of the lab and so on, you have explained very clearly why there can't be a universal practice that could be the subject of an international standard, because it depends upon the legal jurisdiction and the scientific capability of the lab in question, and it follows from that, I gather, that in order to create the best procedure and the best equipment for collecting samples, you would expect that the procedure and the equipment be the product of close consultation between perhaps all of these, certainly some of these - the lab, police, the Director of Prosecutions, perhaps the lawyers bodies --
A. Yes.

Q. -- and perhaps Queensland Health generally, as having to pay for all of it, but, in any event, at the centre of it would be police, as investigators who understand what actually happens at the crime scene and what they confront; the lab, who alone knows what they do and what they need to do the best that they can; and perhaps the Director of Prosecutions, who can speak to the evidentiary significance of what is done. Is that the tenor of what you are saying?
A. Yes, that is the tenor, but I would add in the doctor or nurse who is using the kit, who is in some ways the first user, because it's got to be fit for purpose. If they've got packaging that, for example, is very hard to open or very hard to seal, then you've got a SAIK that's not really fit for purpose. It's a trivial example. But it's often the people at the coalface who are using the kits who will be the first ones to say things are not working.

Q. Who would be the source of collated information of that kind?
A. Perhaps I could use New South Wales as an example?

Q. Yes.
A. Without meaning to say this is the one true way to do it; it is just a practical, worked example of something that seems to work.

We have a meeting every six months. The police attend; the lab attends; the Ministry of Health attends,

because the Ministry of Health writes policy; the ministry's training wing called ECAV, Education Centre Against Violence - ECAV trains doctors and nurses to do the job - attend; and then we ensure that there are representatives from both big metropolitan services that have a lot of turnover, because often they will identify a system issue first, but also we have a representative from rural practice because their needs can be very different, and we have a representative from a doctor who is mostly seeing adults and a doctor who is mostly seeing children.

So all of those people are in the room together. We get together every six months and we look at the sampling guidelines, which is our document that tells staff what samples to take, in what way and under what circumstances. Issues arising out of the sampling guidelines can then affect how the actual SAIK kit is designed. Although the six-monthly meeting is not specifically about the SAIK, it is a forum to share these issues, which might then lead to a change in SAIK development.

Q. Thank you very much. That's very helpful.
A. Would you like me to show you --

Q. Go ahead.
A. I have two swabs on my desk here, and if you just wanted me to show you a practical example of how these communications improve practice and things?

Q. Yes, please, yes.
A. So I have here a swap as it was when I started doing the work back in - back in 2008 I think I did my basic training. It's labelled "Vulval swab", and you have to write the patient's name, date of birth, et cetera, et cetera, on it. That takes time. If I'm doing six, seven, eight, nine, ten swabs, here I am painstakingly writing all of that information on every swab, one by one.

Here's the swab in the current kit. The current kit has pre-labelled, pre-printed labels. All I've got to do for the vulval swab is stick "Vulval swab" label on it. It has a unique number that ties it to this particular patient. So that's quick and easy, and for a patient who is sitting there, really wanting to get changed or have a shower or go home, those little changes in design, they really matter, and we wouldn't have this if we didn't all

talk to each other.

Q. Yes. Your first swab looks like the Queensland swab, except the Queensland swab doesn't say where the sample was taken, so it is that degree behind.
A. Yes.

Q. Thank you, that's very helpful. And it's an easy thing to introduce - a meeting like that. It doesn't cost anything.
A. No. And it's so helpful.

Q. Yes.
A. The one thing I guess it lacks is a direct patient voice, but we would hope that the doctors who attend that meeting would represent feedback from patients.

Q. The doctors are two self-identifying doctors who are very busy in this field; is that the idea?
A. Well, the idea is - so the regular people, so ECAV, the training wing, sends their doctor, and New South Wales Health sends its senior clinical advisers - one adult, that's me, and one child. It may well be, between those three people, you've actually got some adult and child metro and rural representatives. But if you didn't, if, for example, all of those were metro doctors and you wanted a regional voice, then the committee would invite someone from country Australia to join.

THE COMMISSIONER: Thank you very much. Yes, Mr Jones.

MR JONES: Q. Sorry, what was the stem and the tip of that current swab made of?
A. This has got a plastic flexible shaft and a cotton tip, which I believe is made of rayon.

Q. Rayon, thank you.
A. It's still called a cotton tip, even though it's not cotton.

Q. And contrast that with Queensland, which is a wooden stem and a pure cotton tip?
A. Yes. There is research to suggest that the rayon gives you a better yield, although DNA scientists could talk about that in far more detail than I can. But wearing my doctor's hat, I worry a good deal about having a wooden swab when you're inserting it into something like a rectum

or like a vagina. Although it might not be very likely that it will break, if it does break, it's going to have sharp edges. If you were to perforate the rectum, then you are leaking faecal material into the abdomen, and that's actually a life-threatening situation. I am quite bothered by the thought of using wooden swabs, and I would advise against it.

Q. Thank you. Could we just go back to the terms "patient centred", "trauma informed" and "culturally safe", and could you just unpack those for us and how they then inform the policies, procedures, methods and systems, please?
A. Doctors are health care professionals. We have an ethical obligation to our clients. It's our overriding principle, and at the core of it is this dictum, "Don't hurt people". And how not hurting people looks like in a sexual assault setting involves putting the patient at the centre of things. If the patient does not want to go to police, we're not going to pressure them to go to police, for example.

Being what we call trauma informed - we can reasonably assume that most of our patients have had a recent highly traumatic event and that that is going to be affecting them in the here and now. For example, they may be distressed, they may be tired, they may still be intoxicated, and you have got to tailor your processes around their needs. So you might need to slow things down. You might need to take frequent breaks. Even if that means a slight delay in taking your samples, that's what good trauma-informed patient care looks like. And it means respecting their decisions. If they don't want me to take anal swabs, I'm not going to take them and I'm not going to pressure them.

So it's patient centred, it's trauma informed and culturally safe, which is really referring to our Aboriginal and Torres Strait Islander patients or clients, that we are not behaving in a way that somehow denies their Aboriginality or their experience as an Aboriginal person. We know that a lot of Aboriginal people have issues with trust in health and trust in police. An example of culturally safe care is that we would respect that that is their lived reality and that I need to earn their trust and I need to respect their decision if they feel, for example, that they in this instance couldn't feel safe enough to go to police. Whatever I personally may want them to do,

culturally safe care is going to be about what is right for them.

I do think, in the long run, what is good for the patient is actually going to be good for the criminal justice system. If you have a patient who feels respected and cared for here at the beginning of their justice journey, I think they are more likely to go the distance. I think their wellbeing and their mental health is going to be better, and I think they are going to be able to give better, clearer evidence in court.

I know several New South Wales detectives have said to me over the years that complainants who are supported by a sexual assault service do better on the stand and, in particular, do better under cross-examination. So it's not - putting the patients first I don't think is going to in any way jeopardise or compromise the justice system. I actually think our needs dovetail.

Q. Tying those principles, then, to two examples, taking a reference sample, for example, at another occasion by the authorities - that is, the police - rather than at the same time as a SAIK is performed, the examination is performed, is that a patient-centred, trauma-informed, culturally safe approach?
A. I think common sense says that it's going to be easier for patients for things to be a one-stop shop. You know, you come into my sexual assault service, I take all of the samples from you that we know are going to be needed in this case, and it's done and dusted.

Now, common sense is one thing. At the end of the day, you probably have to go to patients, go to a victims advocate group, and say, "What would you like?" I mean, really, they determine what is - part of being patient centred, they determine what is trauma informed here.

But I would argue the practice that occurs in most jurisdictions, for us to do it all in one go, it's just easier, you are not having to come back for a second time, you are not having someone who is not a health care professional taking your sample. There is no delay from the lab's point of view between getting the SAIK and getting the DNA reference sample. It all arrives at the one time. There is no risk that police might think it's already done, because commonsense would say, "Why didn't

the doctor do all of that?" So I guess it is seamless, what's good for the patient is also good for the system.

I think they're quite - I think they're quite acceptable to patients, even to children. I don't think doing a buccal swab is any more traumatising to a child than doing any other sort of throat swab. Remember, a buccal swab can be collected by the patient themselves, with guidance from the doctor, so if they are willing and able, they can take their own cheek swab with me watching, and then it's done.

Again, would you like to see what a buccal swab looks like?

THE COMMISSIONER: Q. Yes, please.
A. I've got one here. It looks a little bit different to the other swabs. It's a bit like a lollipop. It's a foam padding on the end of the stick. It's literally rubbed against one cheek and the other cheek, and then the examiner presses that swab against - it's probably a little bit hard to see here - there is a card here that you press it against to transfer that material, and the buccal swab is then thrown away and this is what will go to the lab.

So, look, it's simple, it's quick, it's easy, it's done and dusted, and it's not one more thing that a victim survivor, who has a lot going on, one more thing for them to have to do. So I would strongly recommend it.

Q. Why has the issue ever arisen that a buccal swab would not be taken at the time of the main examination?
A. I don't know the answer to that question. Queensland seems to have gone its own way there, and I'm not really sure why.

THE COMMISSIONER: Okay, I'm asking the wrong person. I will find out, perhaps. Thanks.

MR JONES: Q. Is your understanding that Queensland is the only jurisdiction that does that?
A. I believe it is just Queensland, yes.

Q. What about early evidence kits, could you explain what they are and whether they would fit into a patient-centred, trauma-informed and culturally safe approach to sexual assault investigations, particularly in the context of how

large Queensland is, with so many parts that are regional and rural?
A. I have a saying, time is DNA. You know, the more time that passes, the more DNA you are losing. The reality is that a patient may present to a facility that doesn't have the capacity to do a full SAIK and they will be transferred elsewhere; or you do have a forensic examiner on site, but they are with another patient and there is a delay; or, in a lot of places, this is secondary employment for your doctors or nurses, they have a day job and then they are on call overnight to come in and do this. So you present at 10 o'clock in the morning. You may be told, "Our doctor or nurse can't come until 5 o'clock tonight."

There are lots of reasons that just perfectly naturally occur why there might be a delay in doing a full SAIK. And also there are some acts that are going to remove DNA. A patient, you know, may be desperate to go to the bathroom. We don't really want to tell those people, "Oh, no, please, hold on until you have your SAIK. You're going to lose all this evidence", or, you know, if it was an oral assault, someone may need to eat or drink and they have a very uncomfortably dry mouth, or they may need to take some medications with some water, and we don't want to be saying to them, "Oh, I would really rather you didn't do that because you are going to lose this kind of potentially important evidence."

So what is the solution to geography and to human needs to do things like go to the bathroom? Well, one solution is early evidence collection processes that are perhaps - well, are definitely best done with some kind of dedicated kit for the purpose. They are commonly called early evidence kits, but in different states in Australia each kit will have its own particular name. I think we call them early evidence kits in New South Wales. I think they are called preliminary forensic kits in WA.

What these kits do is they allow the patient to self-collect some samples. So if it was an oral assault, they would rinse and spit into a jar. If it was a vaginal or anal assault, there would be a gauze wipe, you'd wipe yourself, and there may be a urine sample which can either be used for DNA testing or toxicology testing, depending on what state you are in. So you have these little kits. The patient can self-collect the samples and then is a little bit freer to travel to another hospital or go to the

bathroom if they need to and know that, hopefully, we have not lost any evidence in the process.

I think they're just kind. It's kind to the patient to be able to offer this. It is good for them, and it is good for the justice system, because otherwise there is a real risk we're going to lose that evidence. I know in New South Wales it's not uncommon for us to get a hit from an early evidence kit, when there was no hit, DNA hit, from the full SAIK done four or six hours later. So they work.

So far, there don't seem to have been any issues with their acceptability to the courts in Australia, so I think they are worth some serious thought.

Q. Just on that, do you, at these half-yearly meetings that you have, receive data and feedback from the lab about that?
A. Yes. There are two sort of sources of feedback to doctors about what the lab are experiencing with the samples that we send them. One is our regular, six-monthly sampling guidelines meeting. And the other is, once a month, the lab sends preliminary results from all of the SAIKs from the last month to the Ministry of Health. So I receive them at the Ministry of Health.

As I said, they've got the preliminary DNA results, but what they also have is feedback. That might be feedback about, "This swab could also have been considered in this situation", or, "Your handwriting was terrible", or - well, they're usually more polite than that, but, "There was an issue with your handwriting", or, "This wasn't sealed properly", or, "This slide wasn't made properly", whatever.

We get that feedback. I collate it into the different regions in New South Wales and I send that out to the medical director of their sexual assault service, who can then action it internally. They might review their own processes, they might give a particular doctor or nurse some additional training, but I leave it to them to action it as they see best.

So regular six-monthly guidelines, we look at what has been happening in the lab in the last six months, plus monthly we're getting those month-by-month reports that I'm sending out to the field.

THE COMMISSIONER: Q. So the lab sends you a summary of results with information relevant to you every month?
A. Yes. For each SAIK kit, there will be a one-page preliminary result, you know, "We got a hit from X, Y or Z sample." That's not so much important in itself as the other feedback about potential quality issues. I might get - don't quote me, but I might get, I don't know, 70 of these sheets one month, and I will divvy them up, I will send Newcastle theirs, I will send Royal Prince Alfred Hospital theirs, and then they will look in detail at their own - let's say they've got 10 sheets, they will look at their 10 sets of results and see if there is anything that they could learn from them.

THE COMMISSIONER: Thank you very much.

MR JONES: I just note there that the results, as you probably know, Commissioner, come back via the forensic-register to the Queensland Police Service, not to Queensland Health, in Queensland.

THE COMMISSIONER: Yes. Yes, that's right.

THE WITNESS: These results are not the final results, so we're not going to be putting them into expert certificates, we're not going to be giving testimony about them. We don't give the results to the patients. They are purely a quality assurance process.

Could I come back - let me know if I'm veering off track.

THE COMMISSIONER: Q. Go ahead. What did you want to raise?
A. With that six-monthly meeting, its predominant purpose is to revise the document that we call our sampling guidelines. From what has been given to me, it appears that there is no equivalent document in Queensland, which would be --

MR JONES: Q. I was just about to ask you some questions.
A. Okay, I will stop talking, then.

Q. What is a sample guideline?
A. Right. Well, in the other states and territories, there is a state- or territory-specific document written

for the examiners to guide you about what to do. Like, I mean, what samples do I actually take and where do I take them from, under what time frames and in what manner?

For example, let's say the allegation is that some fingers went into a vagina. It was two hours ago. Do I swab for DNA if it's two hours? What if it was 16 hours ago, do I still swab? Does it matter if the person has washed or not washed? When we talk about a vulval swab, I mean, the vulva covers a lot of geography. I mean, it's everything in front of the hymen, so some bits of the vulva are external, but some bits of the vulva are internal, and that's going to have legal ramifications. So you need a document that says, "Right, okay, with a history of digital vaginal penetration, you are going to take this swab if it's within this time frame and the patient hasn't washed, and this is the area that you sample and this is how you sample it." Otherwise, I don't know how people decide what they are going to do, and I don't know how the lab or the courts know exactly where the samples came from.

Everything's interdependent. What goes into your SAIK kit, what goes into your sampling guidelines and your training, they are all informed by each other. So, you know, sampling guidelines - a SAIK kit, for example, has got to have everything in it that you need in order for you to follow the sampling guidelines, so they have to marry up, and your training protocols have to reflect both of those. Everything has got an interrelationship. It's really hard to single one out and say, "Okay, make a SAIK kit this way and you will be right", because the other two things come into play.

Q. Of the material that was briefed to you, you could not identify a sample guideline?
A. No. There was some guideline about toxicology, when to take blood or urine, but I couldn't identify anything that told you about DNA and other sort of biological evidence testing.

Q. And the medical examination information form is not something you would regard as a guideline?

THE COMMISSIONER: Q. Do you have a copy of it there, Professor?
A. I'm just opening it now.

MR JONES: Q. It's [WIT.0043.0052.0001], and it should be document 1.2 in your brief, Professor.
A. Yes, I have it in front of me. This is just a very short, three-page document. It gives you space to write down what samples you did take. It gives you space to write a very short summary of the assault details and a few other forensically relevant details, like, "Has the person showered?", or whatever.

But what it doesn't do - let's say, for instance, on page 1 you tick a box, "Have they cleaned their teeth?", "yes" or "no". But what that doesn't tell you is how that affects your choice of sample. If it was an oral assault and they have cleaned their teeth, do I still collect an oral sample or not?

Now, the lab, hopefully, will have from its own QA processes - they will have data that shows if you have washed your mouth or cleaned your teeth, the chances of a yield are nil. So I'm going to have sampling guidelines that say, hypothetically speaking in this example, "Don't take an oral sample if the patient has cleaned their teeth", and then in this form I would document, "They've cleaned their teeth", tick, and that would explain why I didn't take an oral sample. It sounds very convoluted. Sorry about that.

Q. Noting that you obviously consider sample guidelines important, if not vital --
A. Yes.

Q. -- do they take on greater importance in a place like Queensland where all of our forensic physicians, save for one, are based in Brisbane, thus the clinicians that are performing these examinations regionally and rurally are emergency doctors, it seems, by and large, without any specific training?
A. A sampling guidelines document could certainly give you guidance about, okay, "This is the story my patient has told me. This is the history that I've got to work with. What samples does this history suggest I would recommend to the patient?", who of course may decline to have some or all of them. So it gives you some information about, well, what am I going to take in the first place, and also where it's taken from. Again, what is a vulval swab will be defined in your sampling guidelines. Now, the fewer cases you do, the less training you have, the more useful that

document becomes.

But there are some important caveats here. You have to know that the document exists. You have to be able to get your hands on it easily. You have to have enough time, when you're a busy emergency department doctor, to sit down, refresh your memory or read this document for the first time. You then have to kind of interpret it to the patient who is in front of you, because this would be a generic document, it covers all possible eventualities, but in reality I've just got one person with a particular history and I'm trying to figure out, well, how do I apply that to this person?

As I said earlier, the sampling guidelines, the kit, the training, they all work together, and if you don't have any training, then your kit can be brilliant and your sampling guidelines can be brilliant, and you still might get very poor collection processes.

I do realise that in Queensland there is an advice number that you can call. New South Wales has a similar one for child cases; if you are doing a child sexual assault, you can call a 1800 24 -hour number and it goes straight through to a child protection physician, who will give you advice. But you have to know that that number exists, in the first place, to call. You have to be able to find that number. You have to be willing to call the number, and the advice that you get has to be the correct advice.

So you kind of also need these processes. How often are people calling our line, or, more to the point, how often are people not calling our line and what are the barriers, and what QA processes do we have to make sure that the advice that we are giving is the right advice? So I'm not saying - it is a useful step, but it has its limitations and I don't think you could ever replace proper training and retraining and re-credentialling. And by proper training --

THE COMMISSIONER: Q. I have seen some information that doctors who are on call at some hospital or some facility are often reluctant to make themselves available to take samples. Have you encountered that in New South Wales?
A. Yes. It's not, I think, so much that doctors are lazy and don't want to get out of bed and come and see these

clients; it's that people who haven't been trained and aren't comfortable and confident knowing what they are doing, they really worry they are going to do something wrong and they are going to cause a miscarriage of justice. They are worried they are going to screw something up and it's going to lead to a bad outcome in court, whether that's somebody going free who shouldn't have or someone being incarcerated who shouldn't have, and, you know, it's a huge weight on people's shoulders.

It was definitely an issue in New South Wales. I can remember when I started out, I got a one-day training that was very patchy and not very practical, and the next thing I knew, there I was in an emergency department with a real patient, you know, no other training, no other onboarding, and the nearest doctor to me who was also doing that work was more than 100 kilometres away.

So we did two things. One is we offered a fairly attractive remuneration. I think that - I cannot tell a lie, that has definitely made a difference for regional doctors. They all have busy practices during the day. If you get up at 3 o'clock in the morning and come and spend three hours with a patient, that has an impact on you, your family and your practice the next day, and being remunerated for that, it does help, and it sends a message of respect as well. So there's no two ways about it, money was a factor.

But I think the far bigger factor and the reason we have dramatically increased our workforce since I started back in 2008 is the training that we brought in. In 2012, we had a big review of the sexual assault training. What it went from was from this one-day face-to-face training that we had been doing to what is now a full-blown graduate certificate, so a year-long course.

The tack that we took - and I think we're unique in Australia in doing this - is our course has what we call competency-based assessment, which is terminology we take from the Australian skills quality agency. That's the body that accredits TAFE courses and universities and so on. So competency based assessment, and I think this would equate to what is called proficiency testing in the documents you have sent me.

Proficiency testing is all about demonstrating that

you can do it. So at various stages in this graduate certificate, you are asked, in as realistic a scenario as we can come up with, to do the job, and you are marked off against objective evidence that you did it properly. When you took a vulval swab, did you take it from the right place? When you took your vulval swab, did you do the right steps to minimise any risk that it was contaminated? When you took the vulval swab, were you careful with the patient and checking in with them that they were still consenting and that they were still okay?

We do exams and we will watch you do it. You will write an expert certificate and you will go into a moot court and you will present it, with two lawyers doing the examination-in-chief and cross-examination, and they will mark you about whether you were able to present your evidence and defend your evidence.

So what you get at the end of that is some confidence. If I were a candidate, I could walk away at the end of that and go, "Do you know what, I can do it. I know I can do it, because I just did it and they watched me." The people who employ you can have some confidence that you can do it, because you have been signed off as doing it. I think it particularly made a huge difference to our sexual assault nurse examiner workforce, because they could not only have some confidence in themselves, but hospitals were more willing to employ them, because they knew that they had or were working towards this qualification that would mean that you could have some assurance that they could do it properly.

Q. Yes, that's why I asked you, because it occurred to me that the problem we face in Queensland might be in large part, certainly in a significant part, due to a lack of confidence of a doctor in engaging in something that is going to entangle the doctor in the legal system, which is never a pleasant thing to do, particularly if you're unfamiliar with how it all works. So what you have said is very interesting.

A. That prompts me to say that that thought about having to spend a day in court, if you're a busy rural GP - most rural GPs are very passionate and committed to their practice - if you cancel your patients for a day to go sit around a courtroom, well, no-one's looking after your patients and nobody is going to fill in for you for the day, and there are no extra hours; you can't, like, squash

them in somewhere else. So they are going to miss out, and they are my actual patients that I have a duty of care of, care towards, that I am perhaps compromising their care in order to go in and see some patient who I don't yet have a duty of care of, because they are not my patient until I turn up and accept them.

Q. Yes, I think we in Queensland have a mandatory system for expert evidence in criminal trials, don't we, where you have to do it by telephone unless there is a good reason not to.
A. Wonderful.

Q. It's mandatory. Anyway, that's a digression. That's something we have that you don't, at last.

MR JONES: Q. Just to close off on the --
A. It's all very well - sorry.

THE COMMISSIONER: Q. Go ahead.
A. A graduate certificate is a big commitment. It costs New South Wales Health a lot of money to do, and it costs the doctors and nurses who do it a significant time commitment. If I had to pick something that really made it work, it was Health deciding to fund having a medical director in each of the sexual assault services around the state.

Actually, let me take a step back. Decades ago, Health decided that every local health district - I think that's our equivalent of your HHS - you know, every HHS is going to have a sexual assault service scattered, you know, there will be one in Bourke and one in Broken Hill and all across the state. Once you had that basic platform, it then decided --

Q. Sorry, in each health district, you will have what, a sexual assault what?
A. At least one sexual assault service. So in my mid-north coast local health district, we have three - Kempsey hospital, Port Macquarie hospital and Coffs hospital - so you are never more than hour's drive away from a sexual assault service.

The next step, though, was to give the local health districts the funds to have a medical director in those sexual assault services. Having that local person makes

a huge difference, because - you know, I live here in Coffs Harbour, I know the community, I know my doctors. I can recruit, I can support them. If they come and join my service, they won't have the experience I have of being utterly alone. They know they can call me for advice. They know I will come in and supervise them. They know I will do refresher simulation training with them as they need.

So it was that political willpower to fund that. And it's not just about my pay. It's the infrastructure around it, that Health has policies that I can enact, and it has training resources that I can send my doctors off to, like the graduate certificate, and it has a support network for me, that Health funds all of our medical directors to meet twice a year and support each other and train each other. So you wind up with this very inclusive network.

That's something that has taken decades to develop. And I'm not saying, "Queensland should do what New South Wales does", but I do think it is a model that is worth looking at. If the alternative is a doctor who has never done any sexual assault training, fussing around with a kit that may not be fit for purpose, with no clear idea about what to do - again, come back to the patient. How does the patient feel at the centre of all of that, and is that patient going to continue with their justice journey if they have a bad experience right then?

THE COMMISSIONER: Yes.

MR JONES: Q. Just before I take you to your opinions on Queensland, could you just step the Commissioner through the - at line 245 of your report, you speak of the training for clinicians and nurses in the US and the UK and nationally in Australia. Could you just distil from that the international and national training, please?
A. Yes. So, for example, the US Office of Justice has a set of national training guidelines for doctors and nurses doing sexual assault work. What you find when you drill down in those guidelines, they always wind up being very, very generic and then they will say, "Okay, this has to be adapted for your local jurisdiction." So the first thing is that whatever training you have, it's got to be local, it has to be locally specific. It can't be so generic that in fact it doesn't enable you to actually practically do the nitty-gritty of the job.

So you have to have some sampling guidelines, you have to have a kit that is processed, you have to have training that is informed by those things, and you have to have training that has some kind of proficiency testing. I've got to walk away at the end of the day and think, "Okay, I know I can do this."

And icing on the cake, perhaps, some sort of ownership of this. I mean, somebody has to drive all of this, and I think the only way you can do it in regional Queensland, as with regional New South Wales, is you have got to have someone like me - in little old Coffs Harbour, we're just a small town, but we've still got a "me" as a medical director, supporting my staff, training my staff, feeding information back to the ministry, getting information from the ministry down to me, and this kind of network. Does that answer your question?

Q. Yes, thank you. So let's move then to your opinions about Queensland. We will start at line 275. This is about Queensland's practices. Are they, in your opinion, patient centred, trauma informed and culturally safe?
A. I've got sort of two steps to answering that question. Queensland Health has produced guidelines. It contains these overarching principles for what a response is going to look like. I have read those guidelines and I think that broadly speaking they are trauma informed and they are culturally safe.

What I can't comment on is how those principles get enacted in practice, so I have no idea what it looks like at the coalface with an actual patient, whether that is actually trauma informed and culturally safe. But certainly the principles that are outlined, on the whole, are.

Some exceptions would be, one, not taking that reference buccal sample at the time. I think that's something that needs reviewing.

I think that not having an early evidence kit, particularly in a huge state like Queensland, I think that's not particularly patient informed.

A minor quibble with those health guidelines is they say patients will be "encouraged to report to police", and

I would like to see something more neutral about, for instance, that staff will explore the options. Particularly encouraging an Aboriginal person to go to police might not be culturally safe at all.

I know when it comes to a buccal swab, there is a theoretical concern with the quality of the swab. If there has been an oral assault, if you think there might be sperm cells in the mouth, those sperm cells are a rich source of DNA. There's a small possibility that you might wind up with both patient and offender on your buccal swab. This seems to happen vanishingly rarely in practice, if indeed it happens at all. In those cases, you are going to have to call the patient back, or the complainant back, and you are going to have to take a second buccal swab. But I think it makes way more sense to very, very, very occasionally do that for one person than to call everyone back for their buccal swab at a later stage.

Yes, broadly, those guidelines look right.

Thinking about early evidence collection processes would be, I think, very important for distressed patients, and thinking about taking those reference buccal swabs at the time that you are taking all your other samples, I think, is almost a no-brainer.

Q. Thank you. Mr Woolridge, would you bring up [EXP.0005.0003.0001 at 0013], please. This is your report. I'm not sure if it is on your screen, doctor.
A. Yes, I can see it.

Q. Are Queensland's practices regarding choice of samples informed by evidence? And we're starting at line 325, which is the page over, but stay on that page, Mr Woolridge, please, because we'll use the diagram.
A. There aren't any sampling guidelines. I've had to infer what samples are taken in Queensland from the contents of your SAIK. So when I look at those --

Q. You are referring there to that form we discussed earlier?
A. Yes, and I think there is a document that I think was 1.1, the configuration of SAIKs. I think that also has a list of components.

MR JONES: Yes, that's with your SAIKs, Commissioner.

It's underneath, it looks like that.

THE COMMISSIONER: What is that we're looking at?

MR JONES: It is an FSS document, which is what goes into the SAIKs.

THE COMMISSIONER: Yes.

MR JONES: Q. Sorry, Professor.
A. So I look at what goes into the SAIKs and I'm looking at what's missing that you could think about adding. So the first one is anal samples. In this picture, we've chopped some poor person in half.

Q. Just one second. Could you zoom that picture up. It's cut off on our screen, Professor, so you might just need to tell us what the top, middle and bottom arrows are, because we don't have the writing next to it?
A. Oh, you could dispense with the writing. It's not terribly important. I will explain it. So just to orient you, we have chopped a person in half. We have removed the left half of their body and we're looking at them from the side. On the right-hand side of that picture, that's a butt cheek. On the left-hand side of the picture, that's someone's tummy. Down the bottom, you have their thigh. Up the top, you have got their chest.

What we've got here is the rectum, so that is where the top arrow is pointing to. This is where stool is stored just prior to defecation. The middle arrow is pointing to the actual anal canal itself. There is an anal sphincter at the end of your gut that relaxes to let poo out and tightens to keep poo in, and that sphincter creates its own little tunnel, if you like, called the anal canal. Then on the outside, you have the perianal region, so these are the wrinkly bits that you wipe afterwards.

Looking at your swabs, it looks like you take a perianal swab and you take a rectal swab, but you don't take a swab from the anal canal itself. I think this is something that is worth considering, for a number of reasons.

The most important is that somebody may put something, a finger, a penis, an object that has been moistened with something that might have DNA on it, like saliva - they may

attempt to put it in. They may get it into the anal canal without getting it all the way into the rectum. So if you are just sampling the rectum, but no material ever got that far up, you are always going to get a negative sample and you are going to miss what was in the anal canal. Yes, hopefully you will have picked it up on your perianal swab, on those wrinkly outside bits, but the wrinkly outside bits are external. That is not going to be proof of penetration.

So, something you could think about would be having processes and sufficient swabs that you take all three swabs, again with the client's permission. Someone might be happy for you to take a perianal swab but not the others. Any evidence is better than none; I'll take what I can get. So that was the first thing that sort of popped out at me.

Q. I will just get Mr Woolridge to turn over the page, then.
A. The next thing that popped out at me is glass slides, which I believe used to be in the kit and now aren't. Again, may I show you a slide, so you can see what I'm referring to is?

THE COMMISSIONER: Q. Yes, please.
A. I just might hold this up against a piece of cardboard, so you can see it a little bit more easily. Perhaps my hand might be better. What we have here is literally a glass slide. I've labelled this one "Vulval slide". What you do with it, if you have a swab that you think might have sperm cells on it - it's very hard to do backwards, but anyway - you can rub a little bit of it on to the slide and then you can look at that slide under a microscope and see sperm cells.

What is the utility of that? Well, a couple of reasons. If you know you've got sperm cells on your slide, you've got a really good chance that there is going to be DNA on that swab. Sperm is a very rich source of DNA. So when the lab is deciding, well, what tests will I run on which samples first, you want to pick the sample that is most likely to give you a result first. If I had something on my low vaginal swab - sorry, a slide from my low vagina, let's say that has sperm on it, but my high vaginal slide doesn't have sperm on it. The lab is going to test my low vaginal swab first, because they know from its slide that

it is highly likely to have results. So it affects workflow in the lab.

The other thing it does is, even if you don't get DNA, you found sperm cells, so that has some evidentiary value of itself. And sperm cells degrade in a certain pattern over time, so you can look at those sperm cells under a microscope and say they were likely to have been deposited one day ago, thee days ago, whatever. So it's got its own independent value.

At the moment, what happens in Queensland is the lab gets the swab out and makes the slide in the laboratory.

In most other jurisdictions, the slide would be made by the medical and forensic examiner at the time of the consultation. The theory behind this was that it's moister, it hasn't had a chance to dry out, and it is easier to put material on. We now know from research that that is not just a theory; it's actually true in the real world. Slides made by doctors and nurses at the time have more sperm cells on them and sperm cells in better quality than swabs made back in the laboratory, which might be days, weeks, months later. It does add a slight amount of extra time, but it really is a very, very quick process.

My understanding - the reasons why Queensland stopped doing it is a training issue. If I pull my slide back, this slide is going to sit in a microscope; a little robot arm is going to pop it under a microscope; the microscope is going to take a picture; the computer is going to analyse that picture. So it's all this automated stuff before a human gets anywhere near it.

The microscope is only going to be looking at what's in view. So if I made a swab, a slide, and I just wipe stuff all over it, I'm going to have all of this material that the microscope won't see. Why is that problematic? Well, if there wasn't a whole lot of DNA on my swab to begin with and I've just wiped it everywhere, maybe I've just wiped off everything on to my slide. The slides can't be tested for DNA. So if you had poorly made slides, you may compromise the evidence from the swab. So I gather there were some issues with poorly made slides, and the decision was made to get rid of them.

I think, given that we now know that you get better

results if you do them properly at the time, I think you could think about bringing them back, and there are some solutions. One is proficiency-based testing or what we would call competency-based assessment, so when I'm training doctors and nurses, I'm watching them do this and I'm marking them off as getting it right or getting it wrong. But in the absence of that, I believe you can get slides that actually have a circle marked on them for the spot where you rub, which again would potentially alleviate that problem. So that's something to think about.

MR JONES: Q. Just at the bottom of that page, I will just quickly go through those two, because you have covered them, I think, earlier, that is, the printed labels being faster, avoiding illegible handwriting, but also prompting the physician or nurse what to test?
A. Yes. Again, I will just show you quickly. Here's one from us, and it's got a whole bunch of pre-labelled - I've also got blank ones, so you've got plenty of flexibility. But just pulling this out, it's straightaway a little prompt to me to go, okay, these are the sorts of things that I could collect, which if I were a doctor with a very low caseload where it might be months since I last did it, I think that's actually quite useful. I can't prove that, there's no research; it's just my commonsense. Sorry, do go on.

THE COMMISSIONER: Q. The label shows the location the sample was taken, and what are the other things on the label?
A. There is a number on the label that is a unique number for this sexual assault kit. Each sexual assault kit will be - this one is --

Q. Yes, I understand.
A. Yes, Y and a certain number. It means that I don't need to write the patient's name, date of birth, today's date, my name all over the swabs. I just have that --

THE COMMISSIONER: I see, yes. I understand now. Thanks.

MR JONES: Q. You have dealt with the collecting and storage of buccal swabs?
A. Yes.

Q. And that is to take them to avoid a second episode of sampling?

A. Yes.

Q. And to be sampled by a health care professional rather than a police officer. I assume chances are that it will be more successful if it is taken by a health professional, but also you don't have a police agency taking it, which may retraumatise a complainant?
A. Actually, anecdotally, the - let me take a step back. You've got your buccal swab and it has to be pressed on to a piece of paper, this special Whatman paper. If you don't press hard enough or long enough or if you don't have your swabs wet enough, you don't transfer enough material. Anecdotally, police do get more material on to these cards than doctors. But we got around that problem in New South Wales by using what are called indicator cards. So when I press into the circle here, it changes colour if there is material successfully transferred. So you get this immediate visual, "I have done it right", or, "No, I need to collect a bit more from the cheek and press again." So hopefully that problem will go away.

Q. Finally, could you just take us through your final observation in that table with, over the page, the 70ml specimen jar and the biohazard bag to store it in?
A. I apologise for writing "a pen in the kit". I wasn't meaning that a specimen jar had anything to do with a pen. I just think having a pen in the kit, rather than using a pen that has been lying around the emergency department that God knows who has touched and has God knows what DNA on it - so I think a pen in the kit should be its own line. I apologise for that.

Anyway, a specimen jar. The kits don't seem to have them in. I think they are really useful things to have. For example, if I found a hair in the vagina that isn't the patient's hair, it's nice to have something to put it into, or if the patient has a tampon in and I think that there might be semen on that tampon, it's nice to have a sealable, nice tight jar to put it in.

And I know that this Commission of Inquiry is not looking at toxicology, but it does mean that you have a sample jar that you could collect urine for toxicology without having to open up a special kit. They are inexpensive. It's easy to add. They've got a variety of uses. And the only thing to be aware of when you are thinking about cost is that if you are going to have

a specimen jar, you are going to need a biohazard bag to put it in.

I'll just show you one. Biohazard bags - I have one here - are sealable. So if you've got biological material like a wet tampon in, it's not going to leak and potentially infect anyone who picks it up. So if you are going to include a specimen jar, you probably want to include one of these, especially, you know, if you wound up with a urine sample that leaked and it wasn't in a biohazard bag, then (a) you have lost that material but (b) you have then potentially contaminated whatever else was in the kit that now has blood or whatever all over it. So these are things that have cost implications that need to be thought through.

Q. Now, in Queensland, the police officer who attends with the patient who is having a SAIK performed would provide evidence bags to collect clothing. The police are not involved in "just in case" kits. Do you have an opinion about whether clothing ought to still be collected or not with "just in case" kits?
A. Yes, I do have an opinion, and I feel quite strongly that they should, because I think there is considerable evidentiary value in this. If we think that the majority of assaults are going to be penis in vagina assaults, vaginas are self-cleaning. What goes in is going to come out. One of the places it's going to come out on is your undies or your pants. So undies that you wore around the time of the assault, the first pair that you put on after the assault - the gusset of those undies can be DNA gold.

I don't understand why patients who aren't ready to go to police yet should miss out on that. Particularly, you know, you may have a patient who is so traumatised that having swabs taken of their genitals is just a bridge too far, but they might still be willing to give you the undies. So just, again, it's patient centred, it's trauma informed. Why should somebody miss out here?

Again, resources come into it. You have to have the bags, you have to have them stored somewhere. Training comes into it. People have got to know where the bags are. People have to know how to use the bags - for instance, one item of clothing per bag. And you are going to need some spare clothes. If you are going to go around collecting people's clothes, you have to give them something, so

that's a thing to consider. And also, clothing bags can be quite bulky. Back at the lab end, where these "just in case" kits are being stored, you may need a lot more storage space if you are also going to collect clothing.

So I can see that there may have been a number of very practical resource reasons for not doing it, but if we were truly being patient centred, then we would do it.

Q. Do you do it in New South Wales, and where are they stored?
A. When you have a medical and forensic examination in New South Wales, it's the same whether you opt to release immediately to police, whether you opt for what we call temporary hospital storage and you call it just in case - it's just terminology. We will take the same samples, we will take the same clothes, we will do our toxicology. It's exactly the same. You get the same evidence collected. But with temporary hospital storage, we will store it in our sexual assault services, the same way we store our immediate release to police.

So we have evidence lockers, evidence fridges, evidence freezers, with evidence registers. We will store it. Anecdotally, we think that about 80 per cent of people who initially chose temporary hospital storage do go on to release to police. Not everyone's ready to make a big decision like that in the middle of the night, but you give them time and space to think things through. So, again, I think it's good for the patient, puts them back in control, and I think it's also good for the criminal justice system, and we don't give a lesser service to somebody who is going for temporary hospital storage.

I must say, though --

Q. How long do you keep them for?
A. Yes. I was about to say that we only store ours for three months. Queensland stores theirs for 12 months. Your system is better. And that was purely resourcing. They take up a lot of space, and if you are a busy metro service doing 250 SAIKs a year, space in your evidence freezer becomes an issue.

In an ideal world, you know what, they would all get processed. You would just process them all and release the results to the police where it was appropriate and store

the results in a safe place where the police can't get to them for everyone else, because why three months, why 12 months? Five years from now, someone might go, "Do you know what, I'm ready to go to court now." Why do they get to miss out on having that DNA evidence because after three months or 12 months we chucked it?

THE COMMISSIONER: Q. In some jurisdictions they do that. In West Virginia, I think, they process every SAIK kit and then just deal with it accordingly.
A. Absolutely. If you take somebody who is 18 or 19 years old and not ready to go to police yet, perhaps has a very kind of chaotic life at the moment, but when they are 24 or 25, a little bit older, a little bit more mature, they might be ready to go to police, and it seems to me a shame that they would miss out. And particularly these days when labs are so efficient, they are so automated, they so robotised, it requires so much less staff time than it did 10 years ago that I think it has now become financially viable to start having this conversation.

MR JONES: Q. You finally conclude about this aspect of the Queensland choice of samples informed by evidence - you say:

> *... I would suggest bringing Queensland into accord with the rest of Australia by using DNA-free SAIK components ...*

Can you explain what DNA-free SAIK components are, and is it the case that Queensland is the only state that does not have DNA-free components?
A. So "DNA-free" is exactly what it says on the tin, that there has been a process that removes DNA from whatever it is that is going through the process - your specimen jar, your gloves, your swabs, your slides, whatever.

Yes, Queensland is the only jurisdiction that doesn't have DNA-free equipment in its SAIK. Sometimes one state goes its own way and it turns out that that state is right, they are at the cutting edge, and sooner or later the other states follow suit. So I don't want to argue that purely because only Queensland does it, that by default means that it's wrong. But if you are going to deviate from what everybody else does, I think you have to have very clearly articulated and defensible reason for doing that, and I can't think what the reason would be, and nothing in the

documents that were provided to me gave a rationale for why you would be so different to everybody else.

Q. What about special facilities and rooms and decontamination kits - you are told that often accused are sampled in watch-houses. What is your opinion on the rooms that are used and procedures associated with cleaning, for example, that you observed from the policies?
A. In an ideal world, we would all follow the guidelines that the Royal College of Pathologists put out about a room. It would be a dedicated room. It would be locked. There would be a log any time anyone walked in or walked out. You might even have reference samples of the DNA of all of the people who regularly use that room. There will be a clean before the room is used by cleaners who are trained in how to do a DNA clean, which is different to how to do an ordinary hospital clean.

Ordinary hospital cleans, all we want to do is kill germs. With a DNA clean, we want to remove DNA, so it's its own process. Those staff would be trained, they would be credentialled, there would be a log of every time it is cleaned. That's your all-singing, all-dancing forensic suite, and not everybody has that. Even I don't have one of those. I share a room in the ED, and if I were to go into the police station to swab a person of interest there, I certainly wouldn't have a dedicated room there, either.

So, that being reality, what can you do to reduce the risk? There are a number of steps that can minimise the risk of DNA contamination. By "DNA contamination", I mean getting DNA somewhere where it ought not to be. For example, we really don't want me sneezing my DNA all over my swab, or we really don't want me accidentally moving semen from someone's abdomen into their vagina as I examine them. You can move DNA around. So you need to remove DNA, where you can, from the surfaces you are going to touch and have processes, when you are moving from one body region of the patient to another, to make sure that you are not moving DNA as you go.

This is where what are called DNA decontamination kits come into their own. I hate that term, because it kind of implies that it is a foolproof method to remove DNA, and it's not. There isn't a foolproof method. All it is is doing all the steps that you can do to make that risk as little as possible.

So, separate to our SAIK kit, just to use New South Wales for an example because it is the state I'm most familiar with, we have our DNA decon kit. When I open it up, it has a DNA-free sheet that I'm going to put over my trolley, so whether I was using a desk at a watch-house or whether I was using a trolley in an emergency department, I could put a DNA-free sheet over it, DNA-free sheet over the bed, DNA-free gown for me, DNA-free gown for the patient, multiple sets of DNA-free gloves. So I'm wearing two pairs of gloves throughout the collection process, and every time I move from one body region to another or any time I have reason to touch something that might be contaminated, I just take my top pair off and pop a second pair on. So you need lots of gloves if you are going to be doing this.

So DNA decon kits I think are really, really helpful, but again a kit on its own is useless without training. How do I use it? How do I open a kit? You know, do I put on my gown first, my gloves first? You know, whatever. Where is it going to be stored? How am I going to find it? What else needs to happen? I mean, I can't drape DNA-free sheets over everything, so what else needs to happen in the way of cleaning? There needs to be a protocol for cleaning. For example, the switch on my examination light, how does that get cleaned? So it's almost a DNA-minimisation process that includes some cleaning protocols and is much assisted by having a dedicated kit like this. I think if it prevents one miscarriage of justice, it's done its job.

Q. So Queensland doesn't have the decontamination kit, as far as you have been able to ascertain from the material provided to you?
A. Yes.

Q. Correct?
A. That's correct.

Q. There obviously are, though, Queensland Health cleaning policies, and your conclusion is that they are up to scratch?
A. Yes.

Q. Save for the approach taken at the Gold Coast?
A. From what I have understood Dr Lincoln's report to

say, they are not doing a DNA clean; they are doing a terminal clean. A terminal clean is a clean that again is designed - it's a hospital-based clean designed to kill infectious diseases, kill microbes. So it looks like they are not doing a DNA clean; they are doing a terminal clean only. Now, I may have misunderstood the document or it may not be complete, so I'm not going to swear to that. But it looks like that's what they are doing. But the document itself - wait up, what's it called? I will make sure I get the name right. Not that one.

Q. This, as I understand it, is an extra procedure, is it not, that Dr Lincoln has implemented above and beyond the cleaning protocol, or not?
A. I couldn't work that out, whether they are just doing a terminal clean or whether they are doing a terminal clean and doing the room cleaning process described in the Queensland Health Sexual Offences Medical Protocol.

Q. Just for the record, that's [FSS.0001.0019.1201]. We don't need a copy of it brought up, thanks.
A. So, yes, that's a little unclear to me exactly what's happening with the Gold Coast. I'm assuming that the clinical forensic medical unit is doing this room cleaning protocol, in the absence of them saying that they do anything different. I think the Child Protection and Forensic Medical Service - I think they explicitly said that they don't do any DNA decon. And it's completely unclear what sort of risk mitigation strategies, if any, occur in the rest of Queensland.

Q. Thank you. Just before I leave this topic, you provided an opinion about the Queensland kits not being DNA free. Is it your opinion that they would not meet the Australian Standard 18385:2017?
A. I haven't read that standard since it first came out. My recollection is that it recommends that the components of any - that any collection equipment that is going to be used to send that sample to a lab for forensic DNA testing, that that collection equipment be DNA free, is my recollection of what those standards say.

Q. Would you expect the SAIK bag that has the equipment in it to be sealed - that is, sealed prior to use?
A. Yes. I mean, if you are going to say it is DNA free then you need to know that nobody has touched it, hasn't stuck their hand in it or done anything. So you will need

some kind of packaging that you open up and then you tip it out on to your DNA-free surface because you have bleached it or because you have a DNA-free sheet on it. You tip it out and you now know that everything on your work surface is DNA free. The packaging is going to go straight into the bin.

If you looked at that packaging and there was any kind of issue with the integrity of the seal, you wouldn't use that kit.

Q. And you have made passing observation of what Dr Lincoln has found on kits to be foreign hair?
A. Yes. So separate to the issue - I mean, if your kits aren't DNA free then they don't have to be sealed, because they are not DNA free anyway, so, you know, who cares? But if the manufacturing process is such that there is a risk that you are going to contaminate your swabs, they're contaminated before you even start because there is just no thought to DNA, then that's a concern. So the photographs that you sent me that had hair, I mean, if the hair shaft has a bulb attached to it that's got DNA in it, that's just not good enough in this day and age, and particularly in the light of the Vincent report into the wrongful conviction of Farah Jama. That was a DNA contamination issue in Victoria that led to a person going to gaol who did not commit that particular crime.

So we now know that it's a live issue. DNA testing is so sensitive. I think we're talking about being able to detect something like a billionth of a gram of DNA. You can't see it. I can't look at my swabs and go, "Oh, yep, this one's safe to use", so I need some kind of robust processes so that I know that this sample - not I personally, that the criminal justice system can have some confidence that when a DNA hit comes back from the lab, that that did not occur because of contamination in some previous step before it got to the lab.

If you are talking about a stranger assault, it's particularly important that that sample should be DNA free, and then if it's not a stranger assault, if you know who the person is, again, you need those processes in the room, the examination room, to make sure that I'm not moving DNA around from one body site to another.

Q. There are two final things you proffer an opinion on.

Firstly, Queensland practices regarding design and composition of the SAIK, and you have given evidence about it being a collaborative effort, but other than that you can't go any further because it's data informed, as well as locally informed.
A. Yes.

Q. Is that correct?
A. That's correct.

Q. And you formed the opinion that the practices regarding training are not, in Queensland, informed by evidence - that is, they ought to have proficiency testing, statewide sampling guides and competency based assessment?
A. Mmm-hmm. Yes, I think summarises things. The thought that you could have doctors doing that with no training or having watched a 90-minute webinar - I think if patients knew that's what they were getting, they would lose confidence in the system. Patients deserve better than that. We wouldn't let doctors with such little training do other procedures, so why should this be different? If anything, this should have even higher standards because it's meeting the needs not only of patient care but of the entire criminal justice system.

MR JONES: Thank you, Professor, those are my questions. That's the evidence-in-chief, Commissioner.

THE COMMISSIONER: Thank you, Mr Jones.

Q. I just have one final question for my purposes. You have your six-monthly meetings that you described, with all those people?
A. Yes.

Q. Do you have meetings of any kind with colleagues in other jurisdictions, in other states?
A. Not officially. There is an organisation - well, there is an organisation called FAMSACA, Forensic and Medical Sexual Assault Clinicians Australia, and for the purpose of transparency, I should say that I'm currently their president. We have a two-yearly conference, and at every conference we have our updates from the field and the representative from each state or territory will say what's changed in their state or territory since the last conference two years ago. That's been an invaluable source of sharing information. It has definitely led to

practices. So, for example, after I went to that conference - I wasn't president at the time - and heard that Perth were testing for condom lubricant residues, well, now we do that in New South Wales and --

Q. I see, yes.
A. So there is that. Also the Royal College of Pathologists has this Faculty of Clinical Forensic Medicine. So fellowship of that enables you to call yourself a specialist in forensic medicine. Most people working in the field are not going to go all the way up the top of the tree to become fellows, but the Royal College of Pathologists has an annual conference as well, and that's a valuable way to informally hear what your colleagues are doing.

THE COMMISSIONER: Thank you. Just excuse me a moment, Professor.

MR JONES: Sorry, I have just been reminded that I said to you I would give you a reference point. Dr Griffin at paragraph 52 of his statement says that the slides were utilised incorrectly and wasted evidence.

THE COMMISSIONER: Thanks, we'll get into that another time.

MR JONES: That was in about 2010.

THE COMMISSIONER: Mr Hunter do you have any questions?

MR HUNTER: Just one very brief subject.

<EXAMINATION BY MR HUNTER:

MR HUNTER: Q. Professor, I act for the Queensland Police Service. My question concerns the opinion expressed by Dr Griffin in his statement, and I understand you have seen Dr Griffin's statement?
A. I have.

Q. In particular, I'm talking about what he said at paragraph 72 concerning reasons why Queensland Health practitioners ought not be taking reference samples from complainants, and he says:

There can be some barriers to reference

sampling at the time of an examination. The principal barrier is the risk of collecting a "mixed sample"; that is, one that contains two persons' DNA. This risk is minimised or eliminated by waiting for a period of a day or two before collecting.

Do you have a view about that reason, expressed as a basis for not taking a sample at the time of the examination?
A. Yes, I do. And I think I alluded to this earlier. Yes, there is a possibility that if there is semen in the mouth you are going to get a mixed sample. That semen might be in the mouth from the assault or it may be from an unrelated consensual act. So in theory, you could get a mixed profile. Mixed profiles are generally bad for the lab because the sample is useless. We need to know the patient's DNA so we can subtract that from all our other samples because, of course, the patient's DNA is going to show up on everything. So if you have a mixed sample it temporarily puts a stop to what the lab can do until we get a pure sample.

But in the real world, mixed samples seem to be extremely uncommon. So why would I have everyone come back after a couple of days and get their buccal swab, when what I could do is do everyone at the time, and in those rare occasions, if ever, that you get a mixed sample, just call that one person back. So I don't think the notion of mixed samples is a show-stopper.

And if there was an oral assault - this is where training and sampling guidelines come in - take your sample for the offender's DNA first. So take your oral rinse or take your mouth swab first, hopefully you will have removed at least some of that DNA load, and then take your buccal swab, and that would be an extra little step you could take to make that buccal swab the best quality that you can.

Q. Of course, if there was no allegation of an oral component to the assault, then there is no risk of cross-contamination or getting a double profile in that case, then, is there?
A. Well, there might be if the person had consensual penile - let's say they had had sex, performed oral sex on their boyfriend the day before and then were assaulted that day, I mean, or - yes.

Q. Does it really matter, though, in terms of minimising the risk of getting two profiles, whether you test on the occasion when the forensic examination is done or whether you do it two days later?
A. Yes, that's a really good point, unless you specifically said to the patient, "Don't have oral sex between now and getting your buccal swab", you could just be getting exactly the same problem down the track, they had consensual fellatio with their boyfriend on the morning that they went into the police station to give their buccal swab, now you have a mixed profile. So you never really get rid of the risk and it just doesn't seem to happen very often, so I think it's like the cart is in front of the horse there.

MR HUNTER: Thank you.

THE COMMISSIONER: Anybody else?

MS COOPER: No questions.

THE COMMISSIONER: Mr Rice?

MR RICE: Just two things.

<EXAMINATION BY MR RICE:

MR RICE: Q. Professor Kramer, I represent Queensland Health. You have spoken at some length about the desirability of training and proficiency assessment. I'm just having some difficulty reconciling what you say about that with the summary you have given of the training provided not only in New South Wales but elsewhere in Australia. You might be able to clarify that for me. It commences at page 24 and goes over to page 25 of your report.
A. Give me two seconds, Mr Rice. Just give me a tick to find the relevant pages.

Q. Take, for example, even the final box on page 24. You see the heading there "Table 2"?
A. Yes, "Training elsewhere in Australia", yes.

Q. It commences a review of what happens around the country?
A. Yes.

Q. For instance, we see the first entry pertaining to your state, that the at least introductory training appears to be by way of live webinars, which is rather similar to what happens in Queensland, with no assessment, which is also rather similar to what happens in Queensland, but I'm having difficulty reconciling that with what you say about proficiency assessments. So perhaps you could clarify?
A. Absolutely. So let's just talk about doctors and nurses separately. Nurses have to do the full graduate certificate with the proficiency training.

Doctors could just do those four 90-minute live webinars and not do any proficiency testing. So they would need, when they go and work for their local health district, they will go to a credentialling process, they would need to satisfy their credentialling committee that they have the skills. So mostly what happens there is doctors do that basic training and then they will go locally and do some simulation-based training with their local sexual assault service.

Having said that, the majority of doctors in New South Wales have done the full graduate certificate. It's become very uncommon for there to be doctors doing this work who only did those webinars and didn't go on to do the full graduate certificate. Does that clear things up?

Q. Well, that leaves the rest of the country.
A. Yes.

Q. Which you deal with on page 25, and again, I appreciate this is a summary, but as I read it, there isn't any proficiency assessment in any of those entries?
A. No, that is --

Q. Have I got it wrong?
A. No, that's my understanding as well. In South Australia, when I did their course back in 2009, they did have an assessment afterwards, but looking at their training website this year, that seems to have gone. So I think New South Wales is the only state doing proficiency training, and I think this is one of the reasons why so many examiners from other states enrol in the New South Wales course. So we regularly have people from particularly the eastern seaboard, so Tasmania, Victoria, the ACT and Queensland, we will often have staff from those states doing our graduate certificate, and it's free.

Q. Just to summarise, then, from what you say, New South Wales has a form of proficiency testing with the graduate certificate, so called. Save for that, am I right that you have not identified any other form of proficiency testing around the country in the review that you have done?
A. That's right. The only other people doing proficiency testing that I can think of are New Zealand, has a proficiency testing which is optional, and just to take a step back, I mentioned earlier that you could become a specialist in forensic medicine. You have your fellowship through the Royal College of Pathologists, that has a lot of testing along the way in that five-year training program. It's only available to doctors. We're talking very small numbers of people who have ever gone through that, but somebody who did have their fellowship, you could be confident that they had undergone proficiency testing.

Q. There is just one other small point, and because it is a small point I hesitate to raise it, but since you have, I will, and it concerns the cleaning regime at the Gold Coast.
A. Yes.

Q. Could I just bring up for you Dr Lincoln's statement. It's [WIT.0043.0136.0001] I think.
A. Thank you, yes, I have it in front of me.

Q. Okay. The relevant page is page 48. In your evidence you refer to the terminal clean, and I suspect you may have been referring to paragraph 193. Could you just confirm that for me?
A. I'm just scrolling down, Mr Rice. Just give me two ticks. Yes, 193. So two of their facilities have dedicated rooms and they are cleaned terminally, and there is no mention of whether there is a DNA clean as well as that or whether their terminal clean has been modified. So I'm assuming that terminal cleaning is all that occurs.

Q. Could you look down to paragraph 197 and see if that is relevant.
A. Yes, 197 goes on to say:

> *... clinicians conduct a "pre-examination surface DNA clean" by wiping down all surfaces in the room with bleach ...*

So if they are doing that, then yes, that would be satisfactory.

Q. You see underneath that, the doctor has referenced an exhibit CL-94 which gives a description of the kind of activity involved. We don't need to go to it.
A. Oh, I haven't seen CL-94 so I can't --

Q. We can look at that for ourselves. But does paragraph 197 cause you to modify what your evidence is about the terminal clean?
A. Yes. So they are doing a terminal clean, which is neither here nor there because it doesn't affect your DNA, and it looks like the individual clinician is also doing their own DNA clean just prior to the examination, which would be the same process that we use here in Coffs Harbour for example. That's exactly what we do, and it accords with the advice given in the Queensland Health Sexual Offences Medical Protocol and it also accords I think with the procedures that the Royal College of Pathologists used to recommend in a document I think they have now - is now no longer available. So, yes, I do - that is a very longwinded way, as I think my way through, of saying, yes, I would like to amend my earlier answer and say that the Gold Coast does appear to be compliant with good practices in its DNA cleaning.

MR RICE: Thank you. Commissioner, I have no other questions, but since the subject of taking reference samples has cropped up, we think there may have been some relevant that has not come to light and I just want to draw attention to it.

THE COMMISSIONER: Yes. Go ahead, Mr Rice. What is it?

MR RICE: I can do that after others have finished, it need not detain Professor Kramer.

THE COMMISSIONER: You want to, in effect, inform me, is that right? Thank you very much for that. All right, anybody else?

MR HICKEY: No, thank you.

THE COMMISSIONER: Ms Mckenzie?

MS MCKENZIE: No, thank you.

THE COMMISSIONER: Anyone else? Well, thank you very much, Professor Kramer, that was extremely helpful. Thank you for taking the time to do this.

THE WITNESS: Thank you for asking me, I'm honoured.

THE COMMISSIONER: Please feel free to turn off the link as soon as you wish.

<THE WITNESS WITHDREW

THE COMMISSIONER: Yes, Mr Rice.

MR RICE: I can do that tomorrow.

THE COMMISSIONER: You can give it to Mr Jones and he will make sure I see it as soon as practicable.

Mr Jones, is there anything else we need to do today?

MR JONES: No, thank you, Commissioner.

THE COMMISSIONER: Do your colleagues know what is happening tomorrow?

MR JONES: I'm not sure. They do.

THE COMMISSIONER: You can deal with all of that after we adjourn and you can tell me what's happening tomorrow, do you know?

MR JONES: No, not yet.

THE COMMISSIONER: I will find out.

MR JONES: Oh, here we go, John Doherty, Michel Lok and Andria Wyman-Clarke.

THE COMMISSIONER: Yes.

MS COOPER: Commissioner, just further to my earlier application for leave to appear, I confirm that I now have instructions as well for Mr Doherty and also Paul Csoban.

THE COMMISSIONER: Yes, you have leave to appear for those

gentlemen as well.

MS COOPER: Thank you.

THE COMMISSIONER: 9.30, Mr Jones; is that right?

MR JONES: Yes, thank you, Commissioner.

THE COMMISSIONER: Adjourn until 9.30, please.

AT 4.57PM THE COMMISSION WAS ADJOURNED TO WEDNESDAY, 19 OCTOBER 2022 AT 9.30AM

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