

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

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

2
3 THE COMMISSIONER: Q. Mr McNevin, I was asking you
4 yesterday about the change to the cleaning system.

5 A. Yes.

6
7 Q. What interested me was the adoption of TriGene as
8 a method of cleaning, and bleach, and I wonder if you could
9 assist me with how you came to that conclusion?

10 A. Yes. Can I make a correction to my evidence from
11 yesterday?

12
13 Q. Of course you can.

14 A. Yesterday I referred to the end plugs or the bungs in
15 the bone crushing box, that they were rubber, but they're
16 actually metal.

17
18 Q. Yes, they are stainless steel, I think?

19 A. Yes. That was my mistake.

20
21 Q. Yes, that's all right. So what about the TriGene used
22 for cleaning, and the bleach?

23 A. We've been using TriGene in the laboratory for some
24 time, and we had been using a product called TriGene II and
25 that was superseded by another product called TriGene
26 Advance. I can't remember the exact details of why they
27 changed their product, but they did. So we conducted
28 Project #153 to look at TriGene Advance a bunch of other
29 cleaning products. Project #153 showed that TriGene had
30 worked quite effectively, along with Virkon and a couple of
31 other cleaning products - bleach mainly, as well. So that
32 was something that we had already had in use in the
33 laboratory as a fairly routine thing.

34
35 Q. For what, what were you using it for?

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

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

7
8 Q. I see.

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

11
12 Q. I understand that Ms Angelina Keller has a lot of
13 experience in working with bones?

14 A. Yes, she does some of the sampling, yes.

15
16 Q. At this time, at the time that this new cleaning
17 method was being considered by you, was she the one who had
18 the most experience at FSS in working with bones?

19 A. I've not counted the number of bones that she's
20 sampled versus the number other people have sampled, so --

21
22 Q. Well, what about compared with you? I think you
23 hadn't done much work in that area --

24 A. For sure. I hadn't actually gone on the tools, as it
25 were, to do the sampling myself.

26
27 Q. You were put into a position where I think you gave
28 evidence that you studied some literature and some
29 textbooks --

30 A. Yes.

31
32 Q. -- and other things. What was the position to which
33 you were appointed that required you to do that study?

34 A. Well, I was the evidence recovery supervisor. So
35 I supervise the evidence recovery team, and the evidence
36 recovery staff, along with some staff outside of the
37 evidence recovery team, did the bone sampling, amongst
38 a whole bunch of other evidence recovery tasks.

39
40 Q. I see, and previously who was doing that?

41 A. Prior to me, being the evidence recovery supervisor,
42 that was Luke Ryan. So we swapped roles.

43
44 Q. What about evidence recovery from bones - who was
45 mostly doing that? Was that done by Luke Ryan's team?

46 A. Well, it was done by staff both within the evidence
47 recovery team, so when Luke managed the team, that was the

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

5
6 Q. Who was that?

7 A. Angelina Keller was one of them, and another one was
8 Allison Lloyd.

9
10 Q. As I understand it, with bones, it's necessary to
11 handle the bone in a particular way to extract pieces of
12 bone with a view to crushing them into powder, those pieces
13 into powder, and then it is those powdered bones that
14 become the sample that parts of which are then used for
15 quantitation and amplification and so on; is that your
16 understanding?

17 A. Yes, the bone powder goes on to a DNA extraction
18 method in the analytical team, yes.

19
20 Q. When you were appointed, who was the person who was
21 regularly doing the extraction of samples from bones that
22 were received in the lab?

23 A. The DNA extraction or the sampling part?

24
25 Q. The sample extraction - the taking of the bone
26 particles.

27 A. Yes, the chopping up and crushing?

28
29 Q. Yes.

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

39
40 Q. I see that you sent your proposal to the management
41 team. You didn't send it to, for example, Mr Gardam,
42 Ms Lloyd or Ms Keller?

43 A. Ms Lloyd was part of the management team, I believe.

44
45 Q. I see. What about Ms Keller and Mr Gardam - you
46 didn't think it would be advisable to seek their views
47 about changing the cleaning system used in connection with

1 bone extraction?

2 A. Well, I think at that time, Tim had actually left
3 forensic DNA analysis.
4

5 Q. What about Ms Keller, had she left?

6 A. No, but I did talk to my own staff within evidence
7 recovery who did the bone sampling.
8

9 THE COMMISSIONER: Ms Hedge isn't here, of course.
10 Mr Hodge, can I see a copy of Project #153?
11

12 MR HODGE: Yes. It is [FSS.0205.0001.0001].
13 Commissioner, do you want a paper copy?
14

15 THE COMMISSIONER: I would, thank you. It might make
16 things more efficient for this purpose.
17

18 Q. Could I just ask you about this sperm microscopy
19 issue?

20 A. Mmm-hmm.
21

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

25 A. Yes.
26

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

30 A. Yes.
31

32 Q. When did you have that experience - at that time,
33 I mean. We're talking about 2016, 2017.

34 A. Look, I can't remember exactly. I had gone through
35 a process, when I was part of the analytical team as the
36 analytical supervisor, to be trained in DNA reporting and
37 reporting, case management of samples, you know, profile
38 analysis, profile review and then on to the reporting
39 aspects. And because I was a manager and, you know, I had
40 to fit that training in around all sorts of comings and
41 goings in the laboratory, the training was quite
42 protracted, so I can't really think of a specific date, but
43 I had undergone a certain level of reporting training prior
44 to taking on the evidence recovery role, and, look, I can't
45 recall off the top of my head exactly when I was signed off
46 to report on sexual assault cases.
47

1 Q. But you were?
 2 A. From memory, I think I was at the time that the sperm
 3 microscopy issue arose, but if I wasn't, it must have been
 4 around that time. I was certainly very familiar with all
 5 of the issues.
 6
 7 Q. We have seen evidence that the potential problem with
 8 the microscope slides used in the first instance arose in
 9 late 2015 and then arose again in early 2016, when
 10 Ms Wilson and Ms Reeves brought the matter to Mr Howes'
 11 attention, I think, and you must have become aware of it at
 12 about that time?
 13 A. I'm not sure exactly, because --
 14
 15 Q. Well, you must have, because you were head of evidence
 16 recovery, weren't you?
 17 A. Yes, but I don't know exactly what time they brought
 18 it to me.
 19
 20 Q. No, no.
 21 A. Yes, so --
 22
 23 Q. Mr Howes or somebody must have brought it to your
 24 attention early in 2016?
 25 A. Certainly prior to the - where it was mentioned first
 26 in the management team meeting, which I think - was that
 27 May or something we discussed yesterday?
 28
 29 Q. Yes.
 30 A. So it must have been prior to that date, but exactly
 31 when and how it was presented to me I can't really recall.
 32 My - at that time, the general practice was, and I had
 33 a very good working relationship with my supervisor, Paula
 34 Brisotto, and also with my other colleagues that worked
 35 under Paula Brisotto, Luke Ryan and Kirsten Scott, so when
 36 they were acting for Paula, generally we tended to raise
 37 things to each other in person first, so that's why there
 38 probably isn't some sort of record.
 39
 40 Q. Yes, I understand.
 41 A. It may have been raised in a way that was just kind of
 42 like, "Oh, some people have observed some things." "Oh,
 43 okay." You know, it may not have been a very well-formed
 44 idea and I might have said, "Well, I need more
 45 information." I think I talked about that yesterday, how
 46 one of my go-to things is --
 47

1 Q. Now, I don't want to get into the rights and wrongs
2 and rehash old history about that awful meeting. All
3 right? So don't misunderstand me.
4 A. Mmm-hmm.
5
6 Q. I get the impression that, on the one hand, Ms Reeves
7 was extremely concerned about it, but you were less
8 concerned about it; would I be right?
9 A. Yes.
10
11 Q. Can you tell me why the lack of concern? I'm not
12 criticising you for it. What I want to know is, it seems
13 to me now that when some scientists come forward and say,
14 "We may be missing samples here", that is a matter that
15 would give rise to a sense of urgency in trying to find out
16 whether that's happening and stopping it and, in due
17 course, finding out why it has happened. But there doesn't
18 seem to be a sense of urgency here, because nothing was
19 done, really, until August, when you put forward the
20 proposal for the project, and then it was worked on after
21 that. So I'm interested in why, from your point of view,
22 it didn't seem as urgent to you as it did to, for example,
23 Ms Reeves, and I think Ms Rika, to be fair?
24 A. So if you just said to me, "We see more DNA in the
25 differential slide than what's seen - or more spermatozoa
26 on the differential slide than what we saw on the evidence
27 recovery slide" --
28
29 Q. Well, we saw spermatozoa on the differential slide,
30 when there were none on the --
31 A. I'm sorry, I'm just - how was it - how, from memory,
32 it was presented to me --
33
34 Q. Oh, I see, how you understood it.
35 A. -- was that they were detecting more DNA on the
36 differential lysis slide than the evidence recovery slide.
37 And I wasn't - to me, that wasn't an unexpected finding,
38 because when you did your initial immersion of the
39 substrate, whether that was a piece of scraping from fabric
40 or a swab or whatever, in some liquid in evidence recovery,
41 that was in a larger volume than when you passed it through
42 the initial stages of the DNA extraction process, where you
43 then separate out the cellular epithelial fraction from the
44 spermatozoa fraction. That spermatozoa fraction --
45
46 Q. I'm sorry to interrupt you. Can I summarise it this
47 way: you understood the matter being raised was that there

1 were more sperm seen in the lysis stage than in the
2 original microscope slide?

3 A. Yes.

4
5 Q. But that doesn't surprise you, because that's what you
6 would expect, given the nature of the process in each case?

7 A. Yes, and that's what the very first stage of
8 Project #181 kind of shows. And I should say that we
9 didn't do nothing prior to the start of Project #181,
10 because we did that data mining first to see if we could
11 find some concrete examples.

12
13 Q. Yes.

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

19
20 Q. So am I correct if I concluded that as it was
21 presented to you, until August, the problem wasn't that
22 samples might be being missed but that there was
23 a suggestion that there was an inconsistency between the
24 two steps, the original microscope and the lysis microscope
25 examination in terms of quantity, and that from your point
26 of view, that's not unexpected, so there wasn't any sense
27 of urgency attached to it?

28 A. To be clear, I don't specifically remember how it was
29 raised to me and exactly what context and the detail that
30 I was provided in that, of it being raised to me, so that
31 makes it a little bit difficult to be very specific about
32 that. You have to also remember that we'd been using that
33 procedure for quite some time, so you would think that if
34 there had been some sort of systemic problem with that
35 procedure, it would have arisen years previous, not, you
36 know, some recent kind of development. So it didn't - we
37 hadn't changed anything.

38
39 Q. Would that not have struck you as making it more
40 serious, that if they're not seeing sperm under the
41 microscope and maybe disposing of samples without further
42 processing, but seeing sperm under the microscope after the
43 D-lysis process has been undertaken and the process has
44 been implemented a long, long time ago, there might be many
45 samples that have been missed?

46 A. No, because it seemed to me that it was being raised
47 as a recent issue, that it was only something that they had

1 observed of recent note, rather than something that they
2 had been observing for some period of time, and so it
3 seemed odd that you would suddenly notice something
4 different in a procedure that had remained unchanged for
5 quite some period of time.
6
7 Q. So --
8 A. So that's why - sorry, can I just --
9
10 Q. I'm sorry, you go ahead.
11 A. That's why my initial step was, well, let's get some
12 more information before we go jumping at shadows. It turns
13 out, yes, there were some examples we were able to find
14 when we did that data mining, and that's what led to the
15 project.
16
17 Q. So you recall that at that meeting there was
18 a difference of opinion about the level of risk, or at
19 least Ms Reeves was very anxious about matters and you were
20 not as anxious, for the reasons you have just explained.
21 Is it that you didn't appreciate or you didn't apprehend at
22 the time or think at the time that there was much risk of
23 losing valuable samples - that is, valuable for
24 a particular case or investigation?
25 A. I don't - I don't really know. I think what maybe my
26 response was, like, okay, we've identified it, we're moving
27 forward, to just keep saying that there is a problem, when
28 we were already starting down the process of moving
29 forward, seemed a little bit redundant, I think.
30
31 Q. Yes, I understand.
32 A. Yes.
33
34 THE COMMISSIONER: Is there anything arising out of that,
35 Mr Hunter?
36
37 MR HUNTER: No, thank you.
38
39 THE COMMISSIONER: Or anybody?
40
41 MS FREEMAN: Commissioner, I might have a few questions
42 for Mr McNevin.
43
44 THE COMMISSIONER: Yes, you want to examine? Just excuse
45 me a moment. There is nobody else? No. Yes, go ahead,
46 Ms Freeman.
47

1 <EXAMINATION BY MS FREEMAN:
2

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

5 A. Yes.
6

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

10 A. Yes.
11

12 Q. Your evidence earlier was that you understood the
13 outcome of that particular project was that TriGene was
14 working efficiently and effectively in terms of cleaning
15 instruments in the lab generally; is that right?

16 A. Yes, yes.
17

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

22 A. Yes.
23

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

30 A. In summary, yes.
31

32 Q. So the point of this project was to look at moving
33 from TriGene II to TriGene Advance; is that right?

34 A. Yes, I think that was the --
35

36 Q. And as part of that process, you also tested - or the
37 project looked at other possible alternatives; is that
38 right?

39 A. Yes, we had a range of other chemicals that were
40 there.
41

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

45 A. Yes.
46

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

1 remove any cleaning reagent residue" - can you just tell
2 us, what is the role in this ethanol wiping part of this
3 process?

4 A. Yes, so it's quite common in cleaning protocols, and
5 we use it when we use bleach as well, so it's used to not
6 just remove the residue of the cleaning agent, which may
7 remain, but also a way of removing those breakdown products
8 that the cleaning agent has resulted in, so it's broken
9 down the DNA in the cells or bacteria, or whatever is
10 present, and most of these things - sorry, the cleaning
11 agents - I'll just use that word, sorry, the other word
12 slipped my mind - also clean away those remnants as well in
13 a mechanical action by wiping away, wiping clean. So you
14 don't just leave the chemicals sitting on top; you wipe it
15 away.

16
17 Q. So the person doing the cleaning would apply the
18 TriGene or the bleach or the chemical agent that is being
19 used to initially clean the instrument, and then they would
20 physically wipe down the instrument with a solution of
21 ethanol; is that right?

22 A. Yes, so you actually wipe with a wetted - quite wetted
23 wipe with the cleaning agent, and then you use a wetted
24 wipe with the 70 per cent ethanol after that. So it's
25 a two-step process.

26
27 Q. Am I right in understanding that the chemical that is
28 the bleach or TriGene or Tergazyme, whatever you are using,
29 that destroys DNA but leaves fragments of it on the
30 instruments; is that right?

31 A. Yes, that's kind of the difference between making
32 something sort of sterile or disinfected versus what we
33 need to do in our laboratory, in that a cleaning agent in
34 a sort of a regular setting might be just sufficient to
35 kill the virus, inactivate the virus, inactivate the
36 bacteria, whatever, but because we also look for fragments
37 of DNA, we need to go that little extra step of wiping away
38 the remnants from that cleaning action.

39
40 Q. So the step of wiping the instrument or the equipment
41 down with the 70 per cent ethanol is an important part of
42 the cleaning process?

43 A. Yes, I believe so.

44
45 Q. Now, Project #153 was a project designed around
46 experiments looking at blood on Petri dishes; is that
47 right?

1 A. Yes, that's right.
2
3 Q. So blood on plastic?
4 A. Yes.
5
6 Q. The other project that you looked at when you were
7 considering this cleaning process was Project #148?
8 A. Yes.
9
10 Q. That was different again, wasn't it --
11 A. Yes, it was --
12
13 Q. -- in that it was saliva and buccal cells on metal
14 plugs being cleaned and seeing how the different products
15 worked?
16 A. Yes.
17
18 Q. What was the significance for you in the sense that
19 Project #148 involved saliva and buccal cells, if anything?
20 A. I guess implicit in both projects are that you have
21 only really tested one biological source, and you have to
22 then kind of extrapolate out to other biological sources -
23 bone may be one, or semen or something else. So you
24 don't - you don't have a - it's not a direct comparison.
25 It's an indirect comparison.
26
27 Q. Is there anything about saliva or the properties of
28 saliva that can make it difficult to clean compared to
29 other biological material?
30 A. Well, it's posited in Project #148 that there are some
31 proteins and things there that may make it sort of sticky
32 or something like that. But, yes, each biological material
33 is different, and much of the literature, when it -
34 sometimes they test just free DNA, so they will get some
35 extracted DNA in the form of a positive control material or
36 something, and that gets cleaned away quite easily because
37 it's not contained within a cellular biological fluid
38 matrix. And so it's not always - all the different studies
39 are not exactly necessarily the exact thing you're doing,
40 and that may be because it's not necessarily practical to
41 test the exact thing you're doing.
42
43 Q. And so in this case, neither of these projects tested
44 the cleaning of bone fragments off equipment or metal or
45 plastic?
46 A. Correct, yes.
47

1 Q. Is that because it's difficult to get enough bone
2 samples to do the required testing to be able to understand
3 the cleaning --

4 A. I think so, yes, that would be one element, predicting
5 the amount of DNA in the bone as well, so trying to have
6 some sort of control for your replicates of your test.
7 There has already been some evidence about the need to
8 control your variables, and also that the amount of DNA can
9 vary along the length or in different areas of a piece of
10 bone, and so if you are doing multiple sampling events, you
11 may not necessarily have the same amount of DNA going into
12 each test material, so it could be difficult to tease apart
13 the differences between some cleaning agents and others if
14 you are not necessarily controlling the amount of DNA you
15 are depositing in the first place. That's why a lot of
16 studies will use things like blood, because it's a readily
17 available source, you can put a precise amount on a bunch
18 of different things and carry out your cleaning then.

19
20 Q. Am I right in understanding that the process you
21 undertook was to synthesise the results of Projects #148
22 and #153 and come up with a solution for the bone cleaning
23 protocol that you needed to come up with?

24 A. Yes, we had this one project that, you know, showed
25 that there was an effective method for cleaning these
26 particular parts of the tools that we use, and then we had
27 this other method that said, "Well, the method that you're
28 using everywhere else in the laboratory is effective, so
29 let's go with that."

30
31 Q. The first part of your answer there, you were talking
32 about using the industrial dishwasher to clean --

33 A. Yes, just for the vials themselves, so that's the
34 cylinder and the bungs and the impactor.

35
36 Q. And then the second aspect of it was using the TriGene
37 to clean the other instruments?

38 A. Or bleach and ethanol as well. That was an option as
39 well. So it was a combination of bleach and ethanol, and
40 TriGene and ethanol.

41
42 Q. Plus the important step of wiping them down?

43 A. Yes, in another step.

44
45 Q. Finally, Mr McNevin, just in relation to Project #181
46 and the sperm microscopy issue, as I understand it, you
47 were on leave from March to May 2016; is that right?

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

2

3 Q. You can't recall. Okay, all right.

4 A. -- unfortunately, if there's evidence to show I was on
5 holidays, I was.

6

7 Q. Do you recall taking leave in the first part of 2016?

8 A. How many years ago was that - six?

9

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

13

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

15

16 Q. In any event, the issue was raised on 12 May 2016 in
17 a management team meeting; is that right?

18 A. If that's what we have already discussed, yes.

19

20 Q. And it was at that point that you were tasked with the
21 job of investigating the issue; is that correct?

22 A. I think that's - that's when we decided to do that
23 retrospective data analysis first or looking at - well,
24 I think it was both slightly retrospective and also
25 slightly prospective, in that we went and got a bunch of
26 unread differential lysis slides and read them.

27

28 Q. On 2 June 2016, you then actioned the initial request
29 for an investigation into the issue; is that right?

30 A. The project, yes.

31

32 Q. That was what became Project #181?

33 A. Yes.

34

35 Q. We've heard the workaround was implemented from
36 8 August 2016; is that right?

37 A. Yes.

38

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

41 A. Yes.

42

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

44 A. Yes.

45

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

1 A. Yes.

2

3 Q. And then the workaround was implemented on 8 August
4 2016?

5 A. Sounds right.

6

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

9 A. Yes.

10

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

12 A. Yes.

13

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

17 A. Correct.

18

19 Q. You are not just working usually on one project at
20 a time, are you?

21 A. Depends, but, yes, there are plenty of instances where
22 you're working on multiple things, or certainly as
23 a supervisor there might be various projects that you might
24 have some involvement in across the laboratory, yes.

25

26 Q. That might be by virtue of your role as being the
27 manager or the supervisor, which means you are on the
28 management team?

29 A. Generally speaking, yes. The members of the
30 management team are often involved in various projects, and
31 then you might have a sort of a project team underneath you
32 that would actually be doing the sort of on-the-tools work,
33 and sometimes some of those might also be on another
34 project, but more often than not, those people might be
35 just dedicated to one project, but not always.

36

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

40 A. Yes.

41

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

44

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

1 useless in cleaning them, was something that you discounted
2 because the substance that was applied containing DNA was
3 saliva?

4 A. No, not solely on that information.

5
6 Q. On what other information?

7 A. TriGene's used elsewhere and it was a common cleaning
8 agent that had been used in other laboratories, so --

9
10 Q. For what?

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

20
21 Q. How did it do that? Let's see --

22 A. I think it says - towards the end of the project,
23 where it says - it acknowledges that the finding in the
24 project is inconsistent with other findings in this
25 laboratory, under the discussion under the Ballantyne
26 paper, I believe, towards the end.

27
28 Q. Yes. Could this document be put up, please,
29 [WIT.0003.0456.0001 at 0019]. That's the beginning of the
30 "Summary & discussion". If you would read that, we will go
31 over the page when you are ready.

32 A. I believe it's on that page there. It refers to the
33 results as being "surprising" in the second sentence. So
34 the authors are already acknowledging that they weren't
35 expecting that TriGene would not work. And then
36 approximately halfway down the paragraph, it's a little
37 hard to count, but it says:

38
39 *This result also conflicts with other*
40 *testing at this laboratory using whole*
41 *blood dried onto petri dishes, where it was*
42 *found that TriGene Advance and Virkon are*
43 *the most effective cleaning agents.*

44
45 About halfway down that paragraph.

46
47 Q. Yes, I see that.

1 A. So the project's - so the way I read it - yes.
2
3 Q. So you have a report that says TriGene is almost
4 useless, and you have a report that says TriGene is quite
5 useful?
6 A. Yes.
7
8 Q. So you chose to go ahead using TriGene?
9 A. Well, really, this report is the only report that I'd
10 come across that said that --
11
12 Q. But what's its status as a report? I don't
13 understand. I'm not blaming you. I just want to
14 understand the status of reports in the lab, because for an
15 outsider, you understand --
16 A. Yes, yes.
17
18 Q. -- you've got two conflicting reports. You appear to
19 favour one report, the one with which you were involved,
20 number 153, over the other. Why?
21 A. I don't think it was really about necessarily
22 favouring one report over the other, because I took what
23 this report found and I --
24
25 Q. 148?
26 A. Yes, and said, okay, well, in this instance, cleaning
27 of these particular components of the bone cleaning
28 process - let's use the findings that this report
29 recommended.
30
31 Q. I see. So you decided to use the recommended method
32 in accordance with Project #148, the washing machine - the
33 dishwasher?
34 A. For the tools that 148 tested.
35
36 Q. But for other bone analysis equipment, bone extraction
37 equipment, you decided to use TriGene because it had worked
38 well, as you found, in Project #153?
39 A. It's not just TriGene but also bleach and ethanol that
40 are appropriate as well, and bleach and ethanol is the more
41 default cleaning agent that we would use in the laboratory.
42
43 Q. Could Project #153 be put up on the screen, please,
44 [FSS.0205.0001.0001_R at 0005_R]. If you look through the
45 paragraphs under "Sample preparation", maybe you can help
46 me with it.
47 A. Yes.

1
2 Q. So do I understand the experiment to be this: you get
3 a clean Petri dish, which is a circular dish about
4 one centimetre deep made of glass; is that right?
5 A. Made of plastic.
6
7 Q. Sorry?
8 A. Made of plastic.
9
10 Q. All right. And that has been cleaned, so it has
11 nothing in it; is that right?
12 A. It's purchased clean, yes.
13
14 Q. Yes, it's clean. The dish is then contaminated by
15 putting some blood on it?
16 A. Yes.
17
18 Q. Then you clean the blood off using each of the
19 substances you were testing - in this case, TriGene; right?
20 A. And the others, yes.
21
22 Q. And then you wipe the surface again with ethanol?
23 A. Yes.
24
25 Q. And then you see if it's clean, and you find that it's
26 clean?
27 A. Yes, you sample that to detect any residual --
28
29 Q. You take a swab off it to see if you can get any DNA,
30 and you find you have no DNA?
31 A. Yes.
32
33 Q. So how do you know it was the TriGene that removed the
34 DNA, and not the ethanol?
35 A. I guess we didn't test the ethanol just by itself, but
36 it's not really --
37
38 Q. So how do you know?
39 A. It's not really an accepted cleaning protocol.
40
41 Q. But you have a report that says TriGene is useless -
42 that's 148 - and then you use two cleaning agents on
43 a Petri dish and you say the first one you used is
44 effective. How do you reach that conclusion?
45 A. Okay, so when I say we used "TriGene is effective",
46 that is shorthand for "TriGene followed by 70 per cent
47 ethanol" in the protocol as described within that project.

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

3
4 Q. Would use what?

5 A. Just 70 per cent ethanol as an effective cleaning
6 agent.

7
8 Q. Yes, so --

9 A. So I don't think it's thought of as a cleaning agent.
10 It's more of a clean-up after you have done the cleaning
11 agent.

12
13 Q. I see. But you tested it as a cleaning agent in this
14 experiment, didn't you?

15 A. Well, as an adjunct to using - you use the cleaning
16 agent, and then you clean the cleaning agent, as it were,
17 and that's the protocol I then proposed.

18
19 Q. Wouldn't you use the same experiment to test TriGene
20 and also ethanol, so that you get results for it, or am
21 I wrong about that?

22 A. Sorry? I have misunderstood your question.

23
24 THE COMMISSIONER: No, it doesn't matter. It doesn't
25 matter.

26
27 Anything arising out of that, Ms Freeman?

28
29 MS FREEMAN: No, thank you.

30
31 THE COMMISSIONER: Anybody else? Mr Hodge, do you have
32 any re-examination?

33
34 MR HODGE: I do have some questions.

35
36 THE COMMISSIONER: I will tender Project #153 as
37 exhibit 93. I will mark it as exhibit 93.

38
39 **EXHIBIT #93 PROJECT #153 REPORT**

40
41 MR HODGE: I should say, I am told the live stream has
42 been up and down this morning; the video hasn't been
43 working; the audio was working; the audio is cutting in and
44 out; but I am assuming we'll just continue because there
45 will be a recording of it available.

46
47 THE COMMISSIONER: As long as we're getting a transcript,

1 that's the important thing.

2

3 MR HODGE: Thank you.

4

5 <EXAMINATION BY MR HODGE:

6

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

9

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

12

13 Sorry, go ahead.

14

15 MR HODGE: Thank you, Commissioner.

16

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

20

21 A. Mmm.

22

23 Q. When you made the recommendation to change the
24 cleaning method in relation to bone, did you go back and
25 read the reports for Project #148 and 153?

26

27 A. I don't think I went back and read 153, because I was
28 kind of more familiar with that project, because - it
29 doesn't matter why, but I was just more familiar with that
30 project.

31

32 148 - I'm not sure if I initially did. I do remember
33 my first response was to task one of my staff members to go
34 and dig out that project and have a read and then talk to
35 me about it. I think - I more than likely did. Whether
36 I read it in depth or I just looked at the recommendations
37 I can't quite recall exactly. I'm not sure. I might have
38 just gone back and read the recommendations. I might have
39 read the whole project. I can't remember, I'm sorry.

40

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

48

49 A. Mmm-hmm.

50

1 Q. This seems to be the email or the chain of emails that
2 has led to the issue being raised; is that right?

3 A. Yes. So Michael had raised it to me, said, "How come
4 we're still using Tergazyme? That's not good." He had
5 come and spoken to me in person, from what I can sort of
6 piece together from the emails, and so I'd said to him,
7 "Look, can you" --

8

9 Q. Sorry, please keep going.

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

21

22 Q. The issue that he was raising with you in the first
23 place as to the existing cleaning method - what did you
24 understand that to be?

25 A. It was more an issue with the chemical we were using,
26 the Tergazyme, that it wasn't really suitable for storage
27 where we were storing it, and the way we were just kind of
28 flushing it down the drain wasn't the right thing to be
29 done, and then we had issues with what to do with the empty
30 packaging. It looks like those are the three main points
31 that he raised with me.

32

33 Q. Did you find out whether there was any scientific
34 reason why you were using Tergazyme in the first place?

35 A. It was unclear as to why we were - I did sort of
36 recall having some conversations with a couple of my staff
37 members who did the bone processing, and I said, like, "So
38 how do we use it? Why do we use that, anyway?", and it was
39 unclear exactly why. It might have been that that was
40 a method that was imported from external to our laboratory.
41 I don't believe that we had carried out any specific
42 testing, like, way back in the day to say that this was the
43 best method. It was just a method that we had imported
44 along with some other methods, as far as I understand.

45

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

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

8
9 Q. Did you come to understand, though, at some point that
10 it might have been the method that was used in the
11 mortuary?

12 A. I think it was posited that that may have been
13 a reason, yes. But of course the mortuary is a little bit
14 different to the DNA lab.

15
16 Q. Tell me if I'm right about this: the way, then, in
17 which this proceeds under the course of a week, as I have
18 understood the various evidence you have given, is you have
19 a conversation with one of your subordinates about
20 potential problems with the use of the current chemical?

21 A. Michael's not my direct report, no.

22
23 Q. I'm sorry, you have a conversation with somebody else
24 in the lab?

25 A. With another staff member.

26
27 Q. And that conversation is not about the effectiveness
28 of the chemical in cleaning things, but it's about other
29 consequences, disposal and things like that?

30 A. Yes, yes.

31
32 Q. And so you then raise a question with Ms Brisotto, who
33 is your superior, about making a change; is that right?

34 A. Can we scroll up to the next part of the email? I'm
35 assuming that's what that next bit says.

36
37 Q. Yes, if we go to the next page, if we go up, you can
38 see at the bottom of the email chain, you say to
39 Ms Brisotto:

40
41 *Given some issues with using/disposing of*
42 *Tergazyme as outlined ... should we*
43 *implement the alternative protocol using*
44 *the dishwasher as outlined in*
45 *Proposal#148 ...*

46
47 A. Yes, so I had obviously recalled that at a time

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

5
6 Q. Then she responds - and you see this email at the top
7 of the page - and says:

8
9 *Anything that removes a [workplace health*
10 *and safety] risk is worthwhile ...*

11
12 A. Yes.

13
14 Q. Just tell me if I'm right, but there wasn't
15 a conversation in between this, where she said to you,
16 "What sort of validation have you done about the
17 effectiveness of this for cleaning all of the equipment in
18 relation to bone"?

19 A. No, no, because I had said to her, you know, "We're
20 using Tergazyme. Should we get rid of it?"

21
22 Q. Yes, for reasons unrelated to the effectiveness of the
23 cleaning?

24 A. Yes, pretty much exactly as that email trail says,
25 yes.

26
27 Q. Then if we go to the first page of that email, .8817,
28 you then send an email saying:

29
30 *Alrighty,*

31
32 *I'll do all the right comms as soon as*
33 *practical.*

34
35 A. Yes.

36
37 Q. If we then go to the document which is
38 [FSS.0001.0056.8823], this is another chain of emails
39 between you and Ms Brisotto. If we just start with the
40 earliest email in time, so, operator, if you can bring up
41 the bottom of page .8824 and then effectively the top
42 two-thirds of page .8825. So you were sending an email to
43 her --

44 A. Yes.

45
46 Q. -- on 18 June, which is basically that afternoon,
47 after you have said you will do the comms --

1 A. Yes.
2
3 Q. -- which is the wording that you're proposing to send
4 around?
5 A. Yes.
6
7 Q. And that's going to go to the management team to
8 approve?
9 A. Yes.
10
11 Q. You say in that email:
12
13 *For some time Tergazyme has been used as*
14 *a cleaning agent in the preparation of bone*
15 *& teeth samples ...*
16
17 Then you say it has been brought to your attention that
18 there are issues storing it, and then you have your draft
19 recommendations, which are:
20
21 *Implement the cleaning of the bone crushing*
22 *equipment using the dishwasher as per --*
23
24 and that's just a typo, it should be "Proposal #148", and
25 then --
26
27 *Use bleach and/or TriGene followed by 70%*
28 *ethanol to clean the remaining equipment in*
29 *line with other Evidence Recovery*
30 *laboratory equipment.*
31
32 A. Mmm.
33
34 Q. Just tell me if I'm right: what then happens is you
35 get an email back from Ms Brisotto later that afternoon, so
36 we see that beginning at the bottom of page .8823, and she
37 just tracks some changes in red?
38 A. Yes.
39
40 Q. She fixes some typos in your email?
41 A. Yes.
42
43 Q. If we then go up to the top of that first page, we see
44 you email her back on the Friday and say:
45
46 *Not sure who decided Tergazyme was the best*
47 *cleaning agent, it's just been part of the*

1 *process for such a long time.*

2

3 And then there is a reference to some conversations where
4 you have been told it's been used in the mortuary?

5 A. Yes, so that must have been where I said earlier
6 I sort of recall having a conversation with some staff.

7

8 Q. And presumably - you tell me if I'm right -
9 I understand you say there are differences in terms of
10 human tissue between your lab and the mortuary --

11 A. No, I was just meaning that there's more a different
12 sort of purpose.

13

14 Q. Difference in purpose?

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

21

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

26 A. Yes.

27

28 Q. And, again, I just want to confirm, from when you
29 raised this issue with Ms Brisotto to when you send this
30 email to your team, neither of you discuss the idea that
31 perhaps you should either investigate why you were using
32 that chemical to clean bone differently from other places
33 in the lab; is that right?

34 A. Other than the conversation that was included in the
35 email trail.

36

37 Q. Where you say you don't know?

38 A. Yes.

39

40 Q. And neither of you discuss the idea that perhaps you
41 should validate, test, do any kind of experiment to check
42 whether it was a good idea to make this change; that's
43 right?

44 A. Correct, based on those reasons that we've outlined in
45 that email.

46

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

1 hindsight, think that was an error in process?

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

16
17 THE COMMISSIONER: Q. What sort of things do you use
18 bleach to clean in the lab?

19 A. The lab. So the walls, the bench, sampling equipment,
20 keyboards, mice - all sorts of things.

21
22 Q. And here you have at the top of the first paragraph on
23 the document on the screen:

24
25 *... Tergazyme has been used ... to clean*
26 *the parts of the bone crusher that come*
27 *into contact with the exhibit, and all of*
28 *the manual handling tools such as chisels*
29 *and the like.*

30
31 A. Mmm.

32
33 Q. So then at the end, what you recommend is using the
34 dishwasher to clean the vials in accordance with
35 Project #148 and otherwise to use TriGene, bleach and
36 ethanol to clean other parts of the bone crusher that come
37 into contact with the exhibit and all of the manual
38 handling tools such as chisels and the like; is that right?

39 A. Yes.

40
41 Q. And so how is TriGene used and how is bleach used and
42 how is ethanol used to clean those tools?

43 A. Okay, so the ethanol is just used after you use either
44 the bleach or the TriGene - oh, you mean those specific
45 tools?

46
47 Q. Mmm.

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

8
9 Q. And the people who clean the instruments, are they
10 scientists or are they staff who are --

11 A. Yes, scientists, my scientists.

12
13 Q. -- scientists?
14 A. Yes.

15
16 Q. It's just that in the email that you sent - or,
17 rather, the change procedure that you instituted, if I can
18 find it.

19 A. Is this around the dishwasher, Commissioner?

20
21 Q. Yes, where you say, "Here is the change that we're
22 making now."

23 A. So one thing I wasn't actually super clear on was
24 whether the scientists would give the bone vial bits to the
25 operational officers to run the dishwasher and they would
26 give them back, or whether the scientists would go and fire
27 up the dishwasher themselves. That was something I hadn't
28 actually nussed out and left it to the scientists to
29 discuss that with the operational officers themselves, the
30 exact sort of fine process of that.

31
32 MR HODGE: Operator, can you do this for me: I want to
33 eventually bring three documents up on the screen, so can
34 we start by moving that email from Mr McNevin to one side
35 of the screen.

36
37 Q. You definitely read Project #148; is that right?

38 A. Well, at the time that I signed off on the project,
39 yes, so back when it was initially done. With respect to
40 sort of proceeding to this implementing it, I may have only
41 just gone and quickly read the recommendations. I can't
42 remember whether I went back and reread the whole project
43 from start to finish.

44
45 Q. Can we bring up 148, which is [WIT.0003.0456.0001].
46 For the moment, let's bring that up slightly bigger, so
47 it's possible for that to be read, so maybe make that half

1 of the screen, thank you. Then can we go to page - in the
2 PDF version, it should be page 8 of the document - page 7
3 of the document, page 9 of the document. Maybe just go to
4 the one that has page 1 at the bottom. Thank you. There
5 are multiple page 1s, I think. Go to the one that has the
6 heading "Abstract" at the top. Perfect. I just want to
7 understand, would you have read the abstract?

8 A. Subsequent to the email or are you talking about back
9 when the project was done? I mean, look, I've read it,
10 yes.

11
12 Q. At some time, you read it?

13 A. Yes, yes.

14
15 Q. If we just zoom in on the second-last paragraph on
16 that page, you see it says:

17
18 *Any suitable cleaning protocol must not*
19 *damage the stainless steel components of*
20 *the crushing vials by causing rusting or*
21 *pitting.*

22
23 A. Mmm-hmm.

24
25 Q. You understood that any damage to stainless steel
26 components was going to be significant?

27 A. Mmm-hmm.

28
29 Q. I'm sorry, you're saying "mmm-hmm". You need to
30 answer out loud.

31 A. I'm sorry, yes. My apologies, yes. Yes, yes,
32 I understood.

33
34 Q. And you understood that at the time when you were
35 making this recommendation?

36 A. Yes.

37
38 Q. So did you turn your mind at the time to the question
39 of whether any of the cleaning products you were saying
40 were going to be used might damage steel components?

41 A. That's why I was looking at TriGene, because that's
42 why we use TriGene elsewhere in the laboratory to - because
43 we have other instruments that are more sensitive to
44 corrosion, so you use something alternative to bleach.
45 I think I've already covered that in evidence.

46
47 Q. I just want to try to understand this, though. This

1 is your recommendation that you would use bleach and/or
2 TriGene followed by 70 per cent ethanol?

3 A. As appropriate.
4

5 Q. What does that mean?

6 A. Well, the assumption is that all of the people
7 receiving that email, including my staff, understand why we
8 use TriGene in some circumstances and bleach in others, so
9 there is an implicit understanding amongst the laboratory
10 staff about which would be the more appropriate chemical to
11 use for whatever thing you're cleaning.
12

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

15 A. The metal components.
16

17 Q. But why not just say that in your email?

18 A. Sorry, but it seemed pretty obvious to me when I was
19 writing the email, I guess. My apologies if it's not
20 obvious to anyone else, but - and I also assume that for
21 any of the laboratory staff, that would be fairly obvious
22 as well, because, like I said, that's the way we do things
23 across multiple areas of the laboratory. So it's not an
24 unusual or foreign concept to them. So for the staff that
25 work in the laboratory day in, day out, that would be -
26 I believe it would be pretty obvious, anyway.
27

28 THE COMMISSIONER: Q. Isn't that the kind of thing you
29 would put into a document?

30 A. That would go into an SOP.
31

32 Q. "Do not use bleach on metal instruments"?

33 A. That would probably go into a standard operating
34 procedure, yes.
35

36 Q. But when you issue your change management, "Use bleach
37 and/or TriGene followed by 70 per cent ethanol as
38 appropriate to clean the remaining equipment", isn't the
39 notion that you do not use bleach for metal instruments
40 something that is fundamental to the new process that you
41 are introducing?

42 A. I think, Commissioner, because it's that fundamental
43 to laboratory processes, it's a given, would be my thinking
44 in my mind.
45

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

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

10
11 Q. Yes.

12 A. Are you referring to the spreadsheet?

13
14 Q. No, I'm referring to --

15 A. To the email?

16
17 Q. Yes, I guess it's the spreadsheet. It is the change
18 management register.

19 A. Yes, so that spreadsheet doesn't really contain a lot
20 of detail. It's not meant to provide any kind of fine
21 detail. It's meant to just provide us with a reference of,
22 like, a timeline as we have gone through and changed
23 things.

24
25 Q. So it is a note. I understand.

26 A. It's more like a notation in that respect.

27
28 THE COMMISSIONER: You go ahead, Mr Hodge.

29
30 MR HODGE: Q. I just then want to try to understand the
31 process of reasoning in your head. You say, at the time,
32 you turned your mind to the fact that there were metal
33 instruments that were going to be used, and therefore you
34 would say bleach and/or TriGene --

35 A. Mmm.

36
37 Q. -- thinking everyone would understand you were to use
38 TriGene on the metal instruments?

39 A. Certainly all the staff in my team, I thought, yes.

40
41 Q. But you say this is a positive thought you had at the
42 time?

43 A. That was the thought I had at the - I believe that -
44 well, I can't remember exactly what I was thinking, you
45 know, three years ago. But from - as I sit now, thinking
46 about what I probably was thinking, then yes.

47

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

5 A. Yes.

6
7 Q. And therefore you would recommend that for the bone
8 crusher vials?

9 A. Yes.

10
11 Q. And you wouldn't recommend that for the other
12 equipment?

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

28
29 Q. Yes, which is the first part of your dash?

30 A. Yes.

31
32 Q. But my question is, when it then came to the second
33 part of your dash, which is all of the other equipment, why
34 is it that you decided to recommend bleach and/or TriGene,
35 given that (a) you knew bleach wasn't appropriate to use on
36 metal equipment, and (b) you had read Project #148 and you
37 knew that TriGene, when it had been used, had not been
38 effective at cleaning away bone fragments?

39 A. No, because we didn't test bone fragments in
40 Project #148; we tested saliva. Bone cleaning vials.

41
42 THE COMMISSIONER: Q. Do you regard Project #148 as
43 determining that the dishwasher is good for getting rid of
44 DNA in saliva but that it didn't test - you couldn't infer
45 anything else from that project?

46 A. Oh, no. You know, that cleaning protocol might
47 actually work for lots of things. I don't actually know.

1
2 Q. Wasn't the purpose of the test, if it had any purpose,
3 to determine what cleaning agent would be best for getting
4 rid of DNA in the vials?
5 A. I think it was just looking more just for an
6 alternative protocol because they had previously been using
7 an autoclave, and so they wanted to come up with a new
8 protocol.
9
10 Q. Yes, an alternative protocol in order to determine
11 what would get rid of DNA on the vials?
12 A. Yes.
13
14 Q. Not DNA in saliva but DNA from whatever source?
15 A. Yes, saliva was the biological --
16
17 Q. Yes, it was the medium, it happened to be the medium
18 they used?
19 A. Yes, yes.
20
21 Q. So it was an experiment to determine what alternative
22 protocol might be good at getting rid of DNA on the vials
23 to ensure they are not contaminated?
24 A. Yes.
25
26 Q. So Mr Hodge's question is: why not use the dishwasher
27 to clean all bone-crushing equipment that can fit into the
28 machine?
29 A. I don't see why you couldn't.
30
31 Q. Why didn't you? Yes, I can't see any reason you
32 couldn't, either, but I'm asking you why you didn't
33 recommend it?
34 A. Because we had these other cleaning protocols that
35 were used for all these other things, it seemed pretty
36 straightforward that we would just implement those.
37
38 MR HODGE: Q. Tell me, though, if my understanding is
39 right: 148 was a project that studied the effectiveness of
40 a cleaning method on the equipment that you were making
41 a recommendation about?
42 A. On the specific equipment that I made the
43 recommendation about, and then I said, "Let's follow that
44 cleaning protocol for that specific bit of equipment."
45
46 Q. And 153 was not a project about the cleaning of the
47 equipment that you were making a recommendation about?

1 A. It was a more generic project to --

2

3 Q. Sorry, it was not a project about the cleaning of the
4 equipment that you were making a recommendation about?

5 A. Well, there was no project to cover the equipment
6 other than the bone crushing vials. There had been no
7 project that covered anything other than the bone crushing
8 vials.

9

10 Q. Is the answer to my question, "Yes, that's right",
11 that Project #153 was not a project testing the cleaning of
12 the equipment that you were making a recommendation about?

13 A. Well, can I be a little bit more specific? Because
14 when you talk about equipment, there's two sets of
15 equipment that I'm referring to in the email. There's one
16 set of equipment, which is the bone crushing vials, which
17 Project #148 covers, and then there's the remaining
18 equipment, which no project covers. So 153, yes, doesn't
19 cover either of those sets of equipment.

20

21 THE COMMISSIONER: Q. So the answer to Mr Hodge's
22 question is, yes, 153 does not relate to any of the
23 equipment with which you were concerned?

24 A. Yes, so we only have a project that covers a small
25 portion of the equipment.

26

27 Q. No, we're just talking about 153.

28 A. Sorry, yes.

29

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

33 A. Yes.

34

35 MR HODGE: Q. 153 is about cleaning blood from a plastic
36 Petri dish?

37 A. That's the experiment method under test, yes.

38

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

42

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

45

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

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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,

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

7 A. Mmm.

8
9 Q. -- and this result conflicts with other testing using
10 whole blood dried on to Petri dishes, where it was found
11 that TriGene was very effective, and it cites Project #148.

12
13 So the writers of this report, in considering the use
14 of TriGene to clean bone crushing equipment, bone
15 extraction equipment, have identified that their conclusion
16 that TriGene is very ineffective is in conflict with an
17 earlier experiment relating to plastic Petri dishes, and
18 then they conclude that it may be that no one cleaning
19 agent will be suitable for all cleaning tasks. So that
20 reads to me like a warning that you have to do these things
21 piece by piece; what's good for a plastic Petri dish may
22 not be good for other instruments.

23
24 As I understood your evidence earlier, you were very
25 conscious of the content of Project #153 because you were
26 involved in it, but was I right in understanding that you
27 had asked one of your colleagues to have a look at 148 and
28 come back to you with a summary of it, or did you read it?

29 A. Look, I can remember that was the first step
30 I definitely - the first step I said was, "Can you go and
31 dig out that project and have a bit of a read", and then
32 I'm sure I probably would have at least read the
33 recommendations. Whether I went back and read the whole
34 project or not I can't really recall.

35
36 THE COMMISSIONER: All right, thank you.

37
38 MR HODGE: Q. To your knowledge, has anyone since you
39 made the recommendation raised with you the question of
40 whether this should be tested or evaluated?

41 A. No.

42
43 Q. Have you had any further discussions about it with
44 Ms Brisotto?

45 A. No.

46
47 MR HODGE: Then I wanted to move to a different topic,

1 Commissioner --

2

3 THE COMMISSIONER: Yes.

4

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

7

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

12 A. Yes, yes, yes.

13

14 Q. I can take you to the email, but you remember, that
15 was the email where you had the emoji smiley face and the
16 emoji sad face.

17 A. Yes, yes.

18

19 Q. Do you remember whether you were aware at the end of
20 2017 or the beginning of 2018 about what feedback had been
21 given by other members of the management team?

22 A. Probably not. I probably wasn't aware.

23

24 Q. Do you recall whether you were aware of any
25 controversy over Project #184 or resistance from members of
26 the management team?

27 A. I might have been vaguely aware. I can't really
28 remember. I mean, sorry, that was quite a while ago.

29

30 Q. Do you recall Amanda Reeves or Kylie Rika raising
31 issues with the conclusions in the draft Project #184
32 paper?

33 A. I don't really have a memory of that, no. It seems -
34 I mean, it's a little bit hard, because I've already heard
35 some evidence and things, so I don't know what's now --

36

37 THE COMMISSIONER: Q. You don't know what you know now
38 and what you knew then?

39 A. Yes, exactly.

40

41 Q. Just do your best, Mr McNevin.

42 A. Yes, I don't really - I don't really remember clearly,
43 no.

44

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

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

9
10 Q. I now want to ask you about another topic. You gave
11 some evidence this morning, I think in answer to a question
12 the Commissioner asked you, about the issue in relation to
13 sperm microscopy.

14 A. Mmm.

15
16 Q. I might have misunderstood, but I thought that the
17 evidence you gave the Commissioner was to the effect that
18 you hadn't realised that the issue was sperm not being
19 detected; you thought the issue was just a difference
20 between the number of sperm heads being seen using diff
21 lysis and the number of sperm heads seen using the ordinary
22 microscopy evidence recovery method?

23 A. So I actually don't really remember exactly how it was
24 raised to me. My sort of vague recollection is that there
25 was a difference between the two. And maybe if you
26 consider that if you had an evidence recovery slide where
27 you had no sperm detected and you only had one or two
28 detected on a differential lysis slide, that would fit
29 within the paradigm of, you know, a small difference
30 between the two. So maybe if I wasn't provided with a lot
31 of information, maybe that's why my recollection is a
32 little bit more vague. Look, I actually don't really
33 remember how it was raised to me, so I can't really make
34 a clear comment on what was said to me, so therefore what
35 my level of alert was.

36
37 Q. I thought - and I might have misunderstood - that the
38 evidence that you were giving to some questions your
39 counsel Ms Freeman was asking was to the effect that in
40 about May 2016 you had undertaken a data analysis and
41 determined the difference between the number of sperm being
42 able to be seen using the evidence recovery slide versus
43 the diff lysis slide?

44 A. I can't remember exactly the timeline, but there was -
45 it was probably between those two management team meetings
46 when I went away and did that extra work. Oh, look,
47 I can't even remember whether it - how long it took to do

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

11
12 Q. If we're just thinking it through, how likely is it
13 that somebody came and said to you, "There's an issue that
14 needs to be studied because we're getting a difference
15 between the number of sperm that we're finding on evidence
16 recovery slides and the number of sperm that we're finding
17 on diff lysis slides"?

18 A. Well, things - over the course of my time as a manager
19 looking after both the analytical team and then the
20 evidence recovery team, people would sometimes raise things
21 and you would look into them and then you would go back to
22 them and they would realise that it actually wasn't the
23 issue that they thought it was. So it wasn't necessarily
24 given that someone brought something up, that it was going
25 to be something that needed further investigation. And
26 like I said, I don't - because I don't recall exactly how
27 it was mentioned to me and what evidence I was given,
28 I can't really comment on whether the information given to
29 me should have caused me to do a certain set of actions
30 straight away, because I can't remember what information
31 was given to me.

32
33 Q. Assume for the moment that it was Mr Howes who raised
34 the issue with you. Does that seem likely, that it would
35 have been Mr Howes?

36 A. Not necessarily, no. He could have gone to whoever -
37 because I want to say Paula, but I think at that time Paula
38 was on maternity leave and some other people were acting in
39 her role. So it would not be unexpected that Justin could
40 have gone to the other team leader and said, "Look, can you
41 have a conversation with Allan about this." So that
42 wouldn't be an unusual scenario, either.

43
44 Q. I take it from what you're saying you accept that the
45 information, or one step in the chain of the information
46 coming to you, must have been Mr Howes?

47 A. Well, there seems to be some emails around that, so

1 I think that's pretty incontrovertible.

2

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

11 A. Yes.

12

13 Q. And you say you don't think it was the second issue
14 that was raised with you; you think it was the first issue?

15 A. I don't know how it was phrased or what information
16 was given to me, so I can't make a statement --

17

18 Q. But it has a substantial effect, doesn't it? You must
19 see that it has a substantial effect that if, within your
20 lab, for semen, samples are not being tested because an
21 evidence recovery slide is showing no sperm heads, that
22 that is a potentially significant issue in relation to
23 sexual assault cases in Queensland; you can see that,
24 surely?

25 A. And that's why we went and carried out all the work we
26 did.

27

28 Q. But I just want to understand: do you say that was
29 the issue that was presented to you, or do you say that the
30 issue, as you recall it, that was presented to you was
31 simply that there seemed to be different numbers of sperm
32 heads being detected on evidence recovery slides as
33 compared to diff lysis slides?

34 A. I don't really remember exactly how it was put to me,
35 so I can't really make any statements either way. It was
36 how many years ago - six years ago?

37

38 THE COMMISSIONER: Q. I guess the point that is being --

39 A. I can't quite remember.

40

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

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

9
10 So what is being put to you is, having regard to the
11 effect upon you that this must have had if you had been
12 told, "We are likely throwing away valuable evidence", that
13 being the implication, and that you didn't have that sense
14 of urgency - does that assist you in recalling what you
15 were told? Alternatively, maybe you were told that, "We're
16 losing evidence", or words to that effect, "because we're
17 misreading microscopy slides or they're being badly
18 prepared", and that didn't strike you as urgent. What do
19 you say? Can you help me?

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

30
31 Q. No, that's all right. You can't remember, you say?

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

33
34 MR HODGE: Q. The reason I need to clarify this is
35 because this morning, in answer to some questions that the
36 Commissioner asked you, as I understood it, your evidence
37 was that your appreciation or your understanding of the
38 urgency and how urgent it was was due to your understanding
39 that there were fewer sperm heads being detected on ER
40 slides as distinct from no sperm heads? So I just want to
41 understand, and you should take a moment to think about
42 this: do you think that that statement, if I've understood
43 your evidence from this morning, was correct, or do you
44 just not know what you were told?

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

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

9
10 Q. In any event, do you remember whether any more senior
11 manager approached you in the first half of 2016 and said,
12 "This is urgent. We have to do something about this"?

13 A. I don't really remember the timeline. That's the
14 thing. I don't remember whether someone came to me and
15 said --

16
17 Q. Let me ask you the question more generally - I will do
18 it specifically. Do you remember Justin Howes approaching
19 you at any stage and saying something to the effect of,
20 "Allan, this is urgent. What are you doing about this?"

21 A. No. I don't remember that specific type of
22 conversation, no.

23
24 Q. Do you remember him, even in a general way, raising or
25 suggesting that this was something that ought to be
26 resolved urgently?

27 A. I don't really remember. I know that we discussed it
28 in the management team and certainly there was sufficient -
29 there was sufficient impetus for us to go about, "Okay,
30 let's look into this deeper." I remember that, because we
31 did. That's what we did. We went and looked at some data
32 and said, "Okay, is there a problem to investigate? Yes,
33 there is. Let's investigate it."

34
35 Q. Do you remember Cathie Allen coming to you at any
36 stage to speak to you about urgency?

37 A. Look, I don't remember - I don't think they would have
38 come and spoken to me in a one-on-one sort of manner and,
39 you know, in the way you're sort of positing it. It was
40 probably in part of a management team meeting or something,
41 part of the conversation.

42
43 Q. But you don't remember it, though?

44 A. No, I don't really remember. It was quite a while
45 ago. Sorry, I - I don't remember.

46
47 Q. Again, looking back on it with hindsight and knowing

1 what you know now, does it surprise you that there was no
2 urgency that was raised about this?

3 A. Again, I don't know exactly what information was
4 provided to Justin, how many examples, whether those
5 examples were over, you know, a period of thousands of
6 samples or over a period of 20 samples. I really don't
7 know how it sort of came about. I mean, I've seen that
8 there's, you know, a few emails back and forth, but
9 I don't - I haven't really looked into the detail of over
10 what time period they were, what - you know, what was the
11 context of, you know, was it one sample out of many in the
12 one case, or these sorts of things. I don't really know
13 exactly what the situation was, so I can't - you know, it's
14 too long ago, I'm sorry. I don't really remember. I mean,
15 I guess looking back on it, if you ask, did we act upon it
16 fast enough, is that kind of maybe - I don't know. It's
17 hard to look at things so distant and be certain about
18 exactly the scenario that was given and the steps that you
19 took at the time.

20
21 Q. When you look back at what happened in relation to
22 Project #184 and the Options Paper and what you know now,
23 does anything about that strike you as unusual?

24 A. You know, it obviously speaks to some of the
25 interpersonal issues that were going around at the time.

26
27 Q. Project #184 speaks to interpersonal issues?

28 A. I'm talking about the --

29
30 Q. The DIFP process?

31 A. Yes.

32
33 Q. Project #184 is the Options Paper.

34 A. Looking at it now, isn't that what some other people
35 seem to have raised already?

36
37 Q. Perhaps step back. Tell me if you agree with these
38 things. You know that there was a project that was never
39 brought to completion in accordance with the ordinary
40 policies of the lab?

41 A. Yes, yes.

42
43 Q. And you know that there was a document that was
44 presented to police, and you have seen that document?

45 A. Yes, yes.

46
47 Q. And you know that there was a process that was

1 implemented, which was the DIFP process?

2 A. Yes.

3

4 Q. It meant that samples within the DIFP range were not
5 going to be - if they were priority 2 cases, they weren't
6 going to be tested?

7 A. Yes, unless we were asked for - asked --

8

9 Q. If the police asked?

10 A. Yes, if the police had given us information to then go
11 and do the work.

12

13 Q. So when you say given you information, you mean unless
14 they asked you to go and --

15 A. Yes, provide us with a task or a request, yes.
16 "Requested it" would have been a better choice of words.

17

18 Q. You know that the Commissioner put out an interim
19 report and that the government has stopped that DIFP
20 process?

21 A. Yes, yes.

22

23 Q. What I'm interested in understanding is, when you look
24 back on that now, with the benefit of the information that
25 you now know, does anything about that seem unusual to you
26 in terms of how the lab was managed?

27 A. It's a rather broad - a rather big question. I guess
28 I'd - I'd always assumed, rightly or wrongly, that there
29 was that well-developed process of investigators looking at
30 their DNA results and that they would have that information
31 in the forensic-register to say that this could give you
32 a result if you request further work on it, and that we
33 would do that.

34

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

45

46 Q. You had experience - you were in the management team?

47 A. Yes, yes.

1
2 Q. You had lengthy experience with the management of the
3 lab. My question is: looking back on it, does anything
4 about the process seem unusual to you in terms of how the
5 lab was managed?

6 A. I mean, it - I guess the idea of an Options Paper
7 wasn't something that seemed to be too common, so that
8 itself would be an unusual option, I guess.

9
10 MR HODGE: Commissioner, I don't have any further
11 questions for Mr McNevin.

12
13 THE COMMISSIONER: Thank you. Thank you, Mr McNevin, for
14 your assistance. You are free to go, and of course you are
15 free to stay as well, if you wish.

16
17 <THE WITNESS WITHDREW

18
19 MR HODGE: Commissioner, do you want to take the morning
20 adjournment now, and then I think Ms Reece is going to call
21 a witness.

22
23 THE COMMISSIONER: Who is that?

24
25 MR HODGE: It is Therese O'Connor.

26
27 THE COMMISSIONER: Very well. We will adjourn until half
28 past 11.

29
30 **SHORT ADJOURNMENT**

31
32 THE COMMISSIONER: Ms Reece?

33
34 MS REECE: Thank you, Commissioner. I call Therese
35 O'Connor, who is in the witness box.

36
37 <THERESE O'CONNOR, affirmed: [11.38am]

38
39 <EXAMINATION BY MS REECE:

40
41 MS REECE: Q. Ms O'Connor, can you tell the Commission
42 your current position?

43 A. My current position as of yesterday is principal
44 adviser, people and performance, HR branch, Department of
45 Health. Last week I was the acting principal employee
46 relations adviser for the HR branch that looked after the
47 former business units that formed Health Support

1 Queensland.

2

3 Q. In 2017, you were employed as a senior adviser within
4 Statewide People and Performance?

5 A. That's correct.

6

7 Q. Part of the role there was in providing support to
8 those various business units you have just spoken of?

9 A. That is correct.

10

11 Q. One of them was Forensic and Scientific Services?

12 A. As a business partner, yes.

13

14 Q. In April 2018, you worked as a human resources
15 business partner?

16 A. That's correct.

17

18 Q. For Forensic and Scientific Services?

19 A. For Health Support Queensland, and the business that
20 I supported was Forensic - FSS.

21

22 Q. And in the capacity both in that earlier role as
23 senior adviser, Statewide People and Performance, and in
24 your role as a business partner, you worked with the DNA
25 Analysis Unit at FSS?

26 A. That is correct.

27

28 Q. The original engagement with that business unit or
29 that DNA Analysis Unit arose out of your role providing
30 specialist HR advice to Queensland Health?

31 A. That's correct. I could elaborate?

32

33 Q. Yes.

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

40

41 Q. You started managing that matter in about mid-2017?

42 A. That's correct.

43

44 Q. And then, at a later stage, that piece of work was
45 overseen by your colleague, Shaun Mulholland?

46 A. Shaun was always involved with it, but he - the actual
47 workload and the negotiations, et cetera, and meetings were

1 attended by Shaun.

2
3 Q. You weren't involved in, for example, setting up the
4 Livingstones process?

5 A. No. That was Health Support Queensland that developed
6 the terms of reference and engaged Livingstones.

7
8 Q. Similarly with the report which was obtained from the
9 New Zealand lab?

10 A. That is correct. It was HSQ.

11
12 Q. You did then have some involvement in the engagement
13 of workplace consultants, Workplace Edge?

14 A. In reflection, I've looked back through my records.
15 I'm not sure that I actually had done quotes for Workplace
16 Edge. My understanding is Workplace Edge was part of
17 a standing arrangement offer that we have with the
18 department, because Workplace Edge was directly engaged
19 with HSQ - by HSQ, and I wasn't at HSQ at that time.

20
21 Q. So it wasn't the case that you got quotes from the
22 companies which were then put forward to HSQ?

23 A. That's correct.

24
25 Q. You think your involvement --

26 A. Was later.

27
28 Q. -- didn't extend to that?

29 A. Pardon?

30
31 Q. It didn't extend to that?

32 A. No, it didn't extend to that.

33
34 Q. You became aware, though, that they had been engaged
35 to do some work around the reintegration of Ms Amanda
36 Reeves to her previous position?

37 A. That's correct.

38
39 Q. And you weren't involved in writing the terms of
40 reference?

41 A. No, I was not.

42
43 Q. Your evidence is that you became aware that Workplace
44 Edge developed a restructure of the DNA Analysis Unit?

45 A. That's correct.

46
47 Q. If I could ask that the witness be shown

1 [FSS.0001.0083.4017], Commissioner, this document was
2 disclosed in the "Sperm Microscopy (Culture)" doc set.
3 First of all, Ms O'Connor, are you familiar with this
4 document?
5 A. Well, I have seen it, yes.
6
7 Q. If you could go to page 2, and, Mr Woolridge, if you
8 could then enlarge that flow chart there, or the team
9 chart?
10 A. Yes.
11
12 Q. This is the team chart. It reflects the people and
13 the positions that you are familiar with --
14 A. That is correct.
15
16 Q. -- from that period of time?
17 A. Yes.
18
19 Q. And you see at the yellow headings there, or the
20 yellow boxes, there are two team leaders?
21 A. That's correct.
22
23 Q. They were HP6s, weren't they?
24 A. I would have to look, but, yes, they're HP6s. The
25 next level below are HP5s.
26
27 Q. And then everyone underneath in the white boxes are
28 HP4 and below?
29 A. That's correct.
30
31 Q. You see from that chart there that perhaps in the
32 light beige boxes, are those - they're the HP5s you have
33 just referred to?
34 A. Yes, I have.
35
36 Q. And there are six of them?
37 A. Yes, that would be correct.
38
39 Q. Then if you go to page 6, Mr Woolridge, of the same
40 document, if you could then again focus on the chart there.
41 Do you recall seeing that this was a proposed
42 organisational restructure?
43 A. In all honesty, I can't actually recall seeing it, but
44 in all likelihood I would have seen it, definitely.
45
46 Q. Mr Woolridge, if you could then zoom out from that and
47 then on to the text under "Implications". Ms O'Connor, it

1 notes there that the implications would be that there would
2 be three new team leaders at the HP6 levels to lead the
3 teams?

4 A. Yes.

5

6 Q. That would have been an additional HP6, wouldn't it?

7 A. I'm assuming - yes.

8

9 Q. But then there was to be a reduction in supervisors
10 from the six HP5s that we saw in that first flow chart to
11 five on this proposal?

12 A. That would be correct.

13

14 Q. Did you form a view as to what the implications were
15 for this workplace from that proposed restructure?

16 A. Yes, I did.

17

18 Q. And what was that?

19 A. My view is that the organisational change was designed
20 so that Amanda Reeves' HP5 position would be abolished.

21

22 Q. Did this restructure go ahead?

23 A. No, it did not.

24

25 Q. You were not involved in the decision-making,
26 I understand, but you became aware that Workplace Edge -
27 that the work didn't go ahead with them?

28 A. No, it did not.

29

30 Q. And that their recommendations shouldn't be acted
31 upon?

32 A. That is correct.

33

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

36

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

39

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

43

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

46

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

1 of that email chain, there is an email from you to Kylie
2 Rika?

3 A. That's correct.
4

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

9 A. That's correct.
10

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

12 A. Yes.
13

14 Q. Did you then have some conversation with Cathie Allen
15 about that, which is suggested perhaps in the final
16 sentence?

17 A. I may or may not have had conversations with Cathie.
18 I cannot recall.
19

20 Q. You do recall, though, during the rest of the time
21 that you worked with FSS and the DNA Analysis Unit, that
22 Ms Allen asked you multiple times something along the lines
23 of, "When is the organisational restructure going to
24 occur"?

25 A. That is correct, that is correct, and I believe that
26 she was referring to the Workplace Edge proposed
27 restructure.
28

29 Q. Did she specifically tell you what it was in
30 particular that she was interested to implement?

31 A. No.
32

33 Q. And you advised her that that wasn't going to happen?

34 A. That is correct.
35

36 Q. When did you cease working at FSS?

37 A. There was - I ceased - technically I ceased working in
38 FSS on 2 February 2019, but because of resourcing, I still
39 supported them for at least four or five months after I had
40 moved into a new position.
41

42 MS REECE: Commissioner, the document that is on the
43 screen has already been provided, has already been tendered
44 as part of Ms Kylie Rika's evidence, but it has been
45 extracted and given a new number for ease of reference in
46 the proceedings.
47

1 THE COMMISSIONER: I will mark it exhibit 95.

2

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

4

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

8

9 MS REECE: The review?

10

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

13

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

17

18 THE COMMISSIONER: Thank you.

19

20 MS REECE: Thank you, Commissioner.

21

22 Q. At the time you sent that email, Ms O'Connor, that was
23 after you started working in this business partner role
24 that you have told the Commissioner about?

25 A. That is correct, yes.

26

27 Q. Your report as of April 2018, your direct report, was
28 to Andria Wyman-Clarke?

29 A. I would have reported through to Andrew Riddell and
30 then through to Andria.

31

32 Q. She was the general manager for HR?

33 A. That's correct.

34

35 Q. For HSQ?

36 A. That's correct, yes.

37

38 Q. Can you just explain briefly what your role became
39 once you actually started working with that DNA Analysis
40 Unit in that business partner role?

41 A. A HR business partner is there to provide expert or
42 specialist advice in relation to HR issues, but it's an
43 advice and supporting role, so if managers have queries,
44 employees have queries, we can provide advice about how
45 that matter should progress, we provide support to managers
46 in resolving complaints, a wide range of HR and industrial
47 issues.

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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 --

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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

1 you destroy?

2 A. That's correct.

3

4 Q. And what were these documents?

5 A. I cannot recall, and that's one of the things - that's
6 part of the information that would need to have been
7 gathered in identifying, if it was a confidential document,
8 if that document was necessary to keep, because in the
9 digital age we now keep scanned copies or the data may have
10 been entered on the forensic-register, so whether that
11 particular copy of the document - it could have been
12 archived, saved elsewhere and been fine to --

13

14 Q. Do you have any recollection whether you were aware -
15 whether Ms Allen told you what the complaint was, because
16 it couldn't simply be putting documents into the
17 confidential document destruction bin?

18 A. Throwing away confidential - disposing of confidential
19 documents in the confidential bin.

20

21 Q. But that's what it's there for.

22 A. It's there - so --

23

24 Q. What I mean is were you given to understand that the
25 documents being thrown away ought not have been thrown
26 away?

27 A. That's correct.

28

29 Q. I see.

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

33

34 THE COMMISSIONER: Thank you.

35

36 MS REECE: Q. When you say Ms Allen wanted to take
37 disciplinary action, do you recall what it was that she
38 wanted to do? How did she express that to you?

39 A. I'm pretty sure it was, "I want to discipline them."

40

41 Q. And you said "all of them". Amanda Reeves at that
42 point, I understand, had left her employment at FSS?

43 A. She had left her employment with FSS. However, she
44 still fell under - she was still an employee of Queensland
45 Health, and there are legislative - under chapter 6 -
46 part 5, chapter 6 of the Public Service Act, under the
47 disciplinary provisions, you can actually refer a matter to

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

3
4 Q. The advice that you gave Ms Allen was that you would
5 need further information to provide advice --

6 A. That's correct.

7
8 Q. -- in order for - would it have been you who started
9 a disciplinary process?

10 A. I would have - this is part of the support process.
11 HR normally provides support in drafting the disciplinary
12 notices to show cause. There's two processes. We
13 obviously provide summary options and risk assessments in
14 relation to all processes. We would develop the documents
15 in draft form, and they would be escalated through to the
16 delegate to review and sign.

17
18 Q. The process that was then followed was that a number
19 of meetings were set up?

20 A. That's my understanding, that there were a number of
21 meetings set up. I believe Andrew Riddell was meant to be
22 involved in the meetings. But if Kylie believes that I was
23 in the meeting, I assume that she was correct.

24
25 Q. Your view of this issue is that obviously there are
26 these important rules around records management?

27 A. Yes.

28
29 Q. But your recollection is that you weren't given the
30 detail of what had been disposed and why it was an issue?

31 A. There was insufficient information to be able to
32 substantiate an allegation, because we couldn't tell who
33 had thrown what confidential document in the bin.

34
35 Q. Did you become aware at any stage that Mr Csoban and
36 Ms Allen had accessed the confidential bin and retrieved
37 some documents?

38 A. I may have been aware of it. I cannot recall it,
39 though.

40
41 Q. And that they retrieved a number of documents, which
42 were then categorised and sent in an email to Andria
43 Wyman-Clarke?

44 A. Again, I may have been aware of it. I cannot recall.

45
46 Q. Do you recall whether any further disciplinary action
47 was taken against any of these individual staff members?

1 A. My understanding is that that matter did not result in
2 a disciplinary process. With the human resource
3 delegations, Paul Csoban would have had the delegation to
4 commence a disciplinary process. However, at no stage did
5 he approach me to commence a disciplinary process.
6

7 Q. Was Ms Reeves interviewed as part of that process, do
8 you know?

9 A. No, she wouldn't have been.
10

11 Q. So it was just the three other scientists who were
12 seen standing around?

13 A. I believe so.
14

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

26 A. That's correct.
27

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

30 A. Yes.
31

32 Q. But you don't actually recall bumping into her, as
33 such?

34 A. No.
35

36 Q. Mr Woolridge, could you please bring up
37 [TRA.500.010.0001 at 0110]. Ms O'Connor, can you see this
38 is some transcript that you have been shown. Down at
39 line 29, Ms Rika says:
40

41 *... I did follow up with Therese O'Connor*
42 *myself. I just said, "Look" - because*
43 *I bumped into [her] in the library, and*
44 *I just said to her ...*
45

46 Can you see that piece of text there?

47 A. Yes, I do.

1
2 Q. She asked you:

3
4 *... "What's come of that meeting that I had,*
5 *because that was a really stressful time*
6 *for me and I'd really like an outcome*
7 *or" ...*

8
9 And Ms Rika says:

10
11 *... that basically the answer to that*
12 *question might be obvious in the sense that*
13 *Paul Csoban was no longer employed as ED.*

14
15 So that, on her evidence, is the response that you gave her
16 to that question. Is that an accurate reflection of that
17 conversation, to the best of your memory?

18 A. My recollection of the conversation is extremely
19 limited, but I'm sure I would have said more. But it
20 doesn't surprise me at all that I would have said that.

21
22 Q. While you were in that position - again I'm
23 delineating the time when you were providing support around
24 the Amanda Reeves complaint --

25 A. Yes.

26
27 Q. -- and then this period from early 2018 onwards, when
28 you were the business partner - you would sit in the
29 library, in your office, and many employees would come and
30 speak to you confidentially, wouldn't they?

31 A. That's correct.

32
33 Q. They were about predominantly human resources issues?

34 A. Correct.

35
36 Q. Those people included Ms Rika, Ms Caunt, Ms Keller and
37 Ms Quartermain?

38 A. That's correct.

39
40 Q. How did those meetings come about?

41 A. My understanding is Andria Wyman-Clarke provided them
42 with my contact details. They would email me or phone me
43 and ask for a meeting when they could get away. It was -
44 they would always specifically request that the matter was
45 confidential, that I was not to take any action in relation
46 to what they were raising. It was more that they wanted HR
47 to be aware of what was happening.

1
2 Q. Did they ever tell you why they didn't want you to
3 take any further action in what they were raising with you?

4 A. They were fearful of Amanda Clark - sorry, they were
5 fearful of Cathie Allen and, if they had made a complaint,
6 they may be treated the same way as Amanda.
7

8 Q. Is that something they told you directly?

9 A. Yes.
10

11 Q. The types of issues they were raising with you also
12 sometimes concerned scientific processes?

13 A. That is correct.
14

15 Q. You're not someone who has any scientific
16 qualifications?

17 A. No, I definitely don't.
18

19 Q. Do you recall what those issues were that they were
20 raising with you?

21 A. It was about the testing processes and the fact that
22 it would have - testing processes, validity of the
23 processes. One of the ones that stands out to me is -
24 I think it's Angelique's [sic] conversation in relation to
25 them creating a new bone extraction - DNA extraction
26 process from bone. She is a recognised expert in those
27 processes, and there was no consultation with her for the
28 new process, and she had considerable concerns in relation
29 to what was happening. I would have to dig out and refer
30 to my notes about the specific details of it.
31

32 Fortunately, when John Doherty became executive
33 director - he came up from the forensic lab down in
34 Victoria Police. His background is actually a forensic
35 scientist, so he does have a very strong understanding of
36 DNA and the science all behind it. So I can remember one
37 meeting that I had Kylie and Emma in my office talking, it
38 was about the retesting of samples, and there was a view
39 that Justin and Cathie were saying, "Don't retest samples."
40 Because John - I knew John was in the building and
41 available, so I actually went out and got him to come and
42 meet with Kylie and Emma in my office to have a discussion
43 about what their concerns were, so that they could have -
44 air their views with somebody that could fully understand
45 the science in relation to it.
46

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

1 to speak to you about flexible work arrangements?

2 A. That's correct.

3

4 Q. Do you recall how many staff might have come to you
5 about that issue?

6 A. Not off the top of my head, no.

7

8 Q. Was it more than five?

9 A. Probably.

10

11 Q. Did those staff members work across the DNA Analysis
12 Unit?

13 A. They would have worked across the DNA Analysis Unit;
14 they would have also worked in the forensic chemistry unit
15 as well.

16

17 Q. What was your understanding of the difficulties that
18 they were having with flexibility in their work
19 arrangements?

20 A. My understanding is that Cathie's view was that
21 a person had to work full time and be present between 8.30
22 and 4.30; that when a court or a police officer called in
23 relation to a DNA report, the person who had been writing
24 the report and analysing the report had to be available to
25 speak to the inquiry.

26

27 Q. Your understanding was that the difficulty they were
28 having was in progressing their applications beyond
29 Ms Allen?

30 A. That's correct.

31

32 Q. Who was the person who actually had the delegation to
33 approve those arrangements at the time?

34 A. At that time, it probably would have been Ms Allen.
35 Since 2008, there has been an amendment to the Industrial
36 Relations Act where it's very, very clear, an employee's
37 ability to apply for flexible working arrangements, and the
38 delegation for that is with the executive director. So --

39

40 Q. Sorry, go on.

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

1
2 Q. What was the risk as you perceived it? What was the
3 risk you were advising about?
4 A. The right to work part-time, especially returning from
5 maternity leave, it's enshrined in legislation and
6 continues to be enshrined. People wanting part-time work,
7 it should actually be encouraged. Quite often they are
8 wanting it because they have an identifiable trait under
9 the Anti-Discrimination Act, so the risk would be that we
10 would have industrial disputes or discrimination claims
11 made against the department, of which we would have little
12 to no defence.
13
14 Q. What experience were you drawing on when you gave the
15 executive director that advice?
16 A. At that point, I would have had 20 years' experience
17 in industrial relations and HR.
18
19 Q. Does that include outside of the Department of Health?
20 A. Yes. I've had 15 years - I've worked 15 years with
21 Together Queensland as an industrial adviser, or an
22 industrial officer. I've then worked with the Department
23 of Health in Metro North as a HR business partner and then
24 in the history that you have already described. So it
25 comes down to experience. I've faced very, very similar
26 situations and it's just - it's one of those things that,
27 as a HR practitioner, you're surprised that management
28 actually ask you, that they're going to deny somebody
29 coming back from maternity leave part-time. It's
30 legislated. We have to comply with it.
31
32 Q. And this was one of the concerns that you --
33 A. I would have raised, yes.
34
35 Q. -- held about that workplace?
36 A. Absolutely, yes.
37
38 Q. Finally, Ms O'Connor, given your engagement with that
39 workplace as a human resources professional, what is your
40 view of the culture of that workplace?
41 A. It would be what we described as a toxic workplace.
42
43 Q. What do you mean when you say "toxic workplace"?
44 A. It's a very unhappy, very stressful, dysfunctional
45 working place. They may be good with the science or the
46 expertise that they do, but their actually working together
47 and the management of issues was never appropriate, timely,

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

6
7 Q. What were the underlying issues, as you saw them?

8 A. My understanding is that it had actually started when
9 the lab was first set up. We had some really good,
10 brand-new scientists, including Cathie Allen and Amanda
11 Reeves. When the managing scientist left, Cathie and
12 Amanda both applied for the managing scientist role.
13 Cathie was successful, and it's my understanding that from
14 then, the working relationship between the two of them, and
15 the personal relationship between the two of them,
16 deteriorated significantly.

17
18 Q. Just to be clear, though, that's something that you
19 must have been told by others?

20 A. That's correct.

21
22 Q. That's not something you were there for?

23 A. That's nothing that I - through the documents that
24 I have read, I can categorically say they did not have
25 a working relationship.

26
27 Q. Ms Reeves, at the time, held one of those HP5
28 supervising scientist roles?

29 A. That's correct, yes.

30
31 Q. And sat on the management team?

32 A. That's correct.

33
34 Q. Just one final question. This is going back to the
35 flexible work arrangements. What impact was that having on
36 that workplace at the time, from the point of view of
37 morale?

38 A. It was extremely stressful for the people who were
39 trying to make a work/life balance, you know, meet their
40 personal needs and their family's needs as well as their
41 working needs.

42
43 Q. And they were coming to you to express these concerns?

44 A. Yes.

45
46 MS REECE: Thank you, Commissioner. That's Ms O'Connor's
47 evidence.

1
2 <EXAMINATION BY MR HUNTER:
3

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

9 A. That's correct.
10

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

12 A. Yes.
13

14 Q. So can you explain to us how it is that you formed the
15 view that the strategy proposed by them or the solution
16 proposed by them was to get rid of --

17 A. Well, my understanding is that they were engaged to
18 reintegrate Amanda Reeves into the workplace. That
19 certainly did not happen. And the restructure is notable
20 that someone at that classification level was - their role
21 was disappearing. They were becoming redundant,
22 effectively.
23

24 Q. Was there anything beyond that? Did anyone ever tell
25 you that that was the intention behind it?

26 A. No.
27

28 Q. But you were asked multiple times by Ms Allen about
29 when that restructure was going to happen; correct?

30 A. That was correct, yes.
31

32 Q. As far as you know, she got a copy of the Workplace
33 Edge report that proposed that restructure?

34 A. I believe she was actively involved in consulting with
35 Workplace Edge and developing the business case for - oh,
36 well, the change, org change.
37

38 Q. You told her that that restructure was not going to
39 happen?

40 A. That's correct.
41

42 Q. How did she take that?

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

1 would have spoken to Cathie at that point in time. I may
2 be wrong. I know Cathie periodically asked me when could
3 she commence implementing the restructure.
4

5 Q. And when you told her "no", her response was silence?

6 A. Silence, yes.
7

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

9 A. Yes.
10

11 Q. That became known as "Bin Gate"; did you hear that?

12 A. I probably did, yes - it brings - yes.
13

14 Q. We've heard evidence that when at least one of those
15 involved was summoned for an interview, that that was done
16 by way of email.

17 A. Mmm-hmm.
18

19 Q. And the email summoning the person for the interview
20 contained what was described as a lawful direction.

21 A. I believe so.
22

23 Q. The lawful direction was that the person wasn't to
24 discuss the fact that the interview was to take place with
25 anybody else.

26 A. I would have to review the email to be able to --
27

28 Q. I'm just asking you to assume that that was the effect
29 of it. My question to you is, from an HR perspective, what
30 is the source of the authority of someone like Ms Allen to
31 give a lawful direction like that to a person that she
32 intends to interview for a discipline matter?

33 A. Okay, it would be under section 26 of the Public
34 Service Act, I believe it's subclause (c). Managers have
35 a responsibility to proactively manage any performance or
36 conduct issues that they become aware of. Now, what
37 "proactively manage" means depends on the circumstances,
38 but it would be reasonable for a manager to ask the people
39 involved not to collude with each other, ie, keep the
40 matter confidential and what was discussed during the
41 interview confidential as well.
42

43 Q. You said 26(c) - 26(c) of the Public Service Act?

44 A. Section 26(3) or 26(3)(c).
45

46 Q. It's (3)(a)?

47 A. Yes, that clause - whilst the Public Service Act has

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

2
3 Q. So 26(3)(a) requires the public service manager to:

4
5 *... pro-actively manage the work*
6 *performance and personal conduct of public*
7 *service employees under the manager's*
8 *management; and*

9
10 *(b) if a case of unacceptable work*
11 *performance or personal conduct arises,*
12 *take prompt and appropriate action to*
13 *address the matter.*

14
15 A. That's correct.

16
17 Q. A direction such as the one I have described you think
18 would be captured by --

19 A. I think asking an employee to keep something
20 confidential in the information-gathering process or when
21 you're in an investigation or a disciplinary process is
22 reasonable.

23
24 Q. Whether that was a proportionate response to what
25 we've called "Bin Gate" is a whole other question, isn't
26 it?

27 A. I can't comment on that. I'm not the decision-maker.

28
29 MR HUNTER: Thank you.

30
31 MS COOPER: No questions, thank you.

32
33 THE COMMISSIONER: Mr Rice?

34
35 MR RICE: No, thank you.

36
37 THE COMMISSIONER: Mr Hickey?

38
39 MR HICKEY: Just a few questions, Commissioner.

40
41 <EXAMINATION BY MR HICKEY:

42
43 MR HICKEY: Q. Ms O'Connor, that question that my
44 learned friend Mr Hunter has just asked you about - the
45 suspected destruction of documents which ought not be
46 destroyed is something that a person in Cathie Allen's
47 position should not ignore?

1 A. Absolutely. If proven, it would be a breach of
2 potentially legislation, definitely policy.
3

4 Q. You say "if proven". One of the steps along the way
5 to proving that, or disproving it, indeed, is that a person
6 in Cathie Allen's position is obliged to investigate it if
7 suspicion of that is drawn to her attention?

8 A. Because the term "investigation" has some
9 ramifications, I do not use the term "investigation" unless
10 it's a specific terms of reference investigation. We
11 prefer to use the term "gather information".
12

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

17 A. That's correct.
18

19 Q. -- in circumstances where that suspicion has arisen?

20 A. That's correct, because Cathie's HR delegation is that
21 she can manage complaints and performance conduct issues at
22 the local level. She does not have the delegation to
23 actually commence a disciplinary process. That delegation
24 lies with Paul Csoban. So what would normally occur is the
25 manager, Cathie, would gather the information required, and
26 then if it needed escalation, then it would go up to the
27 appropriate delegate to make a determination of how the
28 matter should be managed.
29

30 Q. So Ms Allen herself was not delegated to impose
31 disciplinary action if satisfied about those matters?

32 A. She was not the delegate to - she didn't have the
33 delegation to commence disciplinary action. However, she
34 could actually request that the higher delegate - propose
35 to the higher delegate that a process be undertaken.
36

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

41 A. Potentially.
42

43 Q. And so acting with reasonable prudence in her
44 position, that information, that suspicion, having been
45 reported to her, she was really obliged to at least
46 commence to gather information?
47

A. That is correct.

1
2 Q. One reasonable approach that a person in Cathie
3 Allen's position might take, in terms of gathering
4 information, would be to conduct interviews with people who
5 were said to have been involved in the document
6 destruction?

7 A. We encourage managers to actually have conversations
8 with people rather than doing an investigation, because -
9 just simply time frames. A conversation with an individual
10 is far less stressful. We can obtain the information
11 faster, so the matter can be resolved faster.

12
13 Q. Where do you draw the distinction between an interview
14 on the one hand and a conversation on the other, just so
15 I can understand that answer?

16 A. So for a conversation - in any information-gathering
17 process, you've got to advise the employee that you need to
18 talk to them. You normally give them at least 48 hours'
19 notice, so that they can actually bring a support person
20 along with them if they so desire. Depending on what the
21 issue is, they will get a general overview of what the
22 issue is about, so that they can actually come prepared.

23
24 Once they meet with the manager, obviously there is
25 certain information that we're trying to clarify. For an
26 interview, there's a terms of reference, they're actually
27 provided correspondence signed by the investigator inviting
28 them or directing them to attend an interview; there is
29 a specific requirement for the interview. Normally,
30 depending on what the investigation is about, there are
31 powers of investigation under the Hospital and Health Board
32 Act, and we do do some investigations like that; otherwise,
33 they are just - we might have Ethical Standards actually do
34 investigations or engage an external company to conduct the
35 investigation. So it is a far more formal process and
36 generally they are about far more serious - more serious
37 matters than the confidentiality bin.

38
39 Q. When you use the term "conversation", that might
40 happen, for instance, in a meeting room?

41 A. Yes.

42
43 Q. You don't necessarily mean an incidental conversation
44 at someone's desk?

45 A. No, no.

46
47 Q. The mere fact that it happens in a meeting room

1 doesn't mean it's not a conversation?

2 A. A conversation - for those sorts of meetings - for
3 those sorts of conversations, they should be private, so
4 a meeting room would be recommended.

5
6 Q. If I can ask you to assume that Ms Allen took some
7 advice both from Mr Csoban about this particular issue and
8 received some advice from HR about this particular issue -
9 that is, the suspected destruction of confidential
10 documents, so I'm asking you to assume that that's so. I'm
11 not asking you whether you know that to be so or not, but
12 I'm asking you to assume that that's what happened. If, in
13 fact, she received some advice from those people, do you
14 agree that a person in her position ought to follow
15 whatever advice she was given?

16 A. Sorry --

17
18 THE COMMISSIONER: It depends on the advice.

19
20 MR HICKEY: You're quite right, Commissioner.

21
22 Q. Let's assume that Ms Allen was given advice by her
23 superior, Mr Csoban, and by somebody that she consulted in
24 HR to conduct conversations in meeting rooms with certain
25 individuals about the suspected document destruction. She
26 should follow that advice, don't you agree?

27 A. I would suggest that she would be sensible in
28 following those - any advice and guidance that she has
29 actually received.

30
31 THE COMMISSIONER: The question really is whether she
32 would be acting reasonably in accepting that advice, isn't
33 it, Mr Hickey?

34
35 MR HICKEY: That's the gist of it.

36
37 THE COMMISSIONER: And the answer must be "yes".

38
39 MR HICKEY: Well, one hopes it's "yes".

40
41 THE WITNESS: Yes.

42
43 THE COMMISSIONER: Q. Is that right?

44 A. Yes.

45
46 MR HICKEY: Q. Now, could I ask you finally some
47 questions - you have given some evidence - you were asked

1 by my learned friend counsel assisting about the culture
2 within the lab?

3 A. Yes.

4
5 Q. You gave some evidence to the effect that it was
6 a toxic workplace and the indicia of that, you said, were
7 things like it was unhappy, dysfunctional, management of
8 issues was never timely, things of that nature?

9 A. That's correct.

10
11 Q. Then my learned friend asked you about the underlying
12 issues. Can I just understand that evidence, please. Is
13 that an opinion that you have come to more recently, or is
14 that an opinion that you held at the time that you were
15 working as a business partner of the FSS?

16 A. The specific relationship between Cathie and Amanda?

17
18 Q. Well, I'm particularly asking you about your - you
19 used the words "toxic workplace", which is my note.

20 A. Yes.

21
22 Q. What I'm interested to understand is, is that a view
23 that you held when you were working as a business partner
24 to the FSS, or is that a view that you have come to more
25 recently?

26 A. No, it would have been a view that I would have held
27 when I was a HR business partner.

28
29 Q. Because it is important in the course of the
30 Commission for Ms Allen to have the opportunity to respond
31 to things that are said about her, is your evidence that
32 you brought to her attention that you held that view that
33 the lab was a toxic workplace?

34 A. I believe that it had been brought to her attention
35 by - to her by others, such as Andria Wyman-Clarke. At one
36 point, I remember that we engaged a psychologist, I believe
37 there was eight to 12 sessions, to attempt to address some
38 of the leadership issues and the relationship issues, to
39 get the leadership team working on track. I believe that
40 involved individual meetings with the individuals of the
41 leadership team meeting with the psychologist, as well as
42 actually group sessions, to try and improve that
43 collegiality and that positive working environment. My
44 understanding - my recollection is that it did improve for
45 a month or two and then it fell back into old ways.

46
47 Q. In that answer, you have drawn a distinction between

1 your recollection and then by contrast you have used the
2 words "I believe" in respect of a number of points. What
3 is the substance of those beliefs that you have just
4 mentioned? What's the source of them?

5 A. The belief of the psychologist being engaged? Well,
6 I know - I know a psychologist was engaged.

7
8 Q. And as to the conversations with Ms Wyman-Clarke?

9 A. Yes, I - we are going back four to five years and my
10 exact recollection on certain facts is not perfect. So it
11 was my understanding that when the psychologist was brought
12 in, she had a program of working with individuals as well
13 as group.

14
15 Q. You mentioned that that's going back quite a number of
16 years. It's not the case, is it, that the department would
17 permit a manager to remain in a position such as Ms Allen's
18 over such a prolonged period of time if they were solely
19 responsible for a toxic workplace culture?

20 A. If there was evidence that that was the case, then
21 I believe that management - more senior management would
22 have acted, yes.

23
24 Q. And so it's a reasonable inference, isn't it, that
25 management, or more senior management, the way you describe
26 it, must have been content with Ms Allen's performance,
27 given that she remained in that role for a number of years
28 thereafter?

29 A. I actually disagree with that assertion.

30
31 Q. Can you explain why?

32 A. In my confidential meetings with the executive
33 directors, they didn't necessarily believe that Cathie was
34 doing an ideal job; that there were issues of - where she
35 could improve.

36
37 Q. When were those confidential meetings to which you
38 have referred?

39 A. I had monthly - with whom, sorry?

40
41 Q. You have just mentioned confidential meetings that you
42 have had with EDs, I think you said?

43 A. That's correct.

44
45 Q. In which some complaint was made about Ms Allen's
46 performance?

47 A. No, not complaints.

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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

1 means that everybody was happy with her work?
2
3 MR HICKEY: No, with respect, Commissioner, that's not
4 what I said.
5
6 THE COMMISSIONER: What are you saying?
7
8 MR HICKEY: I put two propositions. One was either they
9 were satisfied with her performance, or the first
10 proposition I put was that nobody had turned their mind to
11 her performance, and I did that deliberately in order that
12 I would put it as a fair proposition, because it seems to
13 me there can only be two propositions.
14
15 THE COMMISSIONER: No, there are an infinite number of
16 outcomes. One outcome might be, as Ms O'Connor has been
17 saying, that there was some degree of dissatisfaction with
18 Ms Allen's performance, and Mr Doherty was managing that
19 and then he left.
20
21 MR HICKEY: Yes.
22
23 THE COMMISSIONER: So it doesn't follow that she wasn't
24 removed and we haven't seen any sign of reprimand or
25 anything of that kind, that there was general satisfaction
26 with her work, which is what you're driving at.
27
28 MR HICKEY: No, but, with respect, Commissioner, the steps
29 I took were these: Mr Doherty finished up and moved on.
30
31 THE COMMISSIONER: Yes.
32
33 MR HICKEY: Presumably somebody took Mr Doherty's
34 position.
35
36 THE COMMISSIONER: Mmm.
37
38 MR HICKEY: It follows from that that somebody either took
39 up the management that Mr Doherty was doing of Ms Allen's
40 performance or didn't. That's the first point that
41 I arrive at.
42
43 THE COMMISSIONER: Yes.
44
45 MR HICKEY: That's really the proposition that I'm putting
46 to Ms O'Connor.
47

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

5
6 MR HICKEY: With respect, Commissioner, I don't have the
7 benefit of knowing the insides of this organisation.

8
9 THE COMMISSIONER: No, but - examine all you like, right,
10 but if you are asking the witness to draw inferences, then
11 they have to be logical inferences that don't leave huge
12 gaps. Otherwise, it's useless to me. It's just that if
13 Ms O'Connor says something about an inference that might be
14 drawn from apparent inactivity on the part of an executive
15 director, what use is that to me? It's almost weightless,
16 because we don't - she has already said that Mr Doherty was
17 dealing with her in some way, I suppose counselling and
18 advising her or something - maybe reprimanding her, for all
19 I know. So we know that much, which isn't very much. You
20 then say, "Well, we know from the fact that she is still
21 there and that Doherty moved on, leaving her there,
22 therefore she must be doing a satisfactory job." It just
23 doesn't follow.

24
25 MR HICKEY: With respect, I didn't put that; I didn't
26 intend to.

27
28 THE COMMISSIONER: All right, you continue. I may have
29 misunderstood. You continue, then. See how we go.

30
31 MR HICKEY: If it is not a helpful line of inquiry --

32
33 THE COMMISSIONER: The inferences aren't very helpful,
34 Mr Hickey.

35
36 MR HICKEY: I understand. Those are the questions,
37 Commissioner.

38
39 THE COMMISSIONER: All right, thank you, Mr Hickey. Just
40 before you start, Ms Reece.

41
42 Q. If a workplace issue arises and the person who is in
43 the supervisory position writes to a person who is involved
44 in the issue in some way, or might be involved, and says to
45 that person, "I would like to give you an opportunity to
46 respond", what does that signify to you in human resources
47 contexts?

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

13
14 Q. So you're speaking about information gathering by
15 means of conversations?

16 A. Yes.

17
18 Q. A lot of people might have information that is
19 relevant to an affair, a matter, and in writing to people
20 who are uninvolved, who are regarded as uninvolved in
21 a culpable sense, do you use the language of, "I'd like to
22 give you an opportunity to respond", or is that used in
23 a different context?

24 A. It would be slightly different, because the
25 terminology is, "We believe that you witnessed this event",
26 or "you have information in relation to that". The first
27 premise that you used implied that the person has done -
28 there's an allegation against that person or a complaint
29 against that person, alleging some wrongdoing, and they are
30 being asked or invited to provide information so the
31 delegate can actually make a decision on the balance of
32 probabilities.

33
34 Q. Yes, it's language that implies, as you said, that an
35 allegation of some kind of wrongdoing has been made and
36 requires a response?

37 A. That's correct.

38
39 THE COMMISSIONER: Thanks. Anything arising out of that,
40 Mr Hickey or anyone? No. Ms Reece?

41
42 <EXAMINATION BY MS REECE:

43
44 MS REECE: Q. Just briefly, Ms O'Connor. You were asked
45 about your impression that the Workplace Edge
46 presentation - I'm sorry, restructure had the aim of
47 getting rid of Amanda Reeves' position.

1 A. Yes.

2

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

7 A. That's correct.

8

9 Q. And you were aware that there was a lot of unhappiness
10 about that presentation?

11 A. Certain parties, certain people present, were
12 extremely upset and stressed.

13

14 Q. Do you recall what they were upset about and how that
15 was conveyed to you?

16 A. It was the impression that they were restructuring
17 Amanda - restructuring to get rid of Amanda, and it was
18 also looking at that - that a lot of - Workplace Edge had
19 interviewed a lot of people. However, they had only taken
20 the opinion of certain people to develop the restructure,
21 as opposed to a balanced view.

22

23 Q. Some of the people who spoke to HR about that said
24 that they felt targeted by that presentation?

25 A. That's correct, yes.

26

27 Q. Two of those people were Amanda Reeves and Kylie Rika?

28 A. That would be correct.

29

30 Q. In fact, a complaint was made as a result of that
31 presentation?

32 A. That's correct.

33

34 Q. Moving to the disciplinary process --

35

36 THE COMMISSIONER: Just before you move on with that.

37

38 Q. You gave evidence that Ms Allen was asking you when
39 the restructure would be implemented.

40 A. Mmm-hmm.

41

42 Q. And you said words to the effect that it wasn't going
43 to happen.

44 A. That's correct.

45

46 Q. Why did you say that?

47 A. That's because - my understanding is that Michel Lok

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

8
9 Q. You understood that that was Mr Lok's view?
10 A. And Ms Wyman-Clarke's, yes.

11
12 THE COMMISSIONER: Thank you. Sorry, Ms Reece.

13
14 MS REECE: Q. Was that conveyed to you directly by those
15 two people?

16 A. It would have been Andria that advised me.

17
18 Q. With the disciplinary process, or the potential
19 disciplinary process, around the confidential bin, your
20 evidence is that Cathie Allen said to you that she wanted
21 to start a disciplinary process at the outset?

22 A. Yes.

23
24 Q. And, in fact, it was you who then said, "You need an
25 evidence base"?

26 A. Yes.

27
28 Q. "You need to take steps before you instigate such
29 a process"?

30 A. Yes.

31
32 Q. Just finally, Ms O'Connor - and this might be a short
33 question but perhaps a lengthy answer. You have been asked
34 about performance management.

35 A. Yes.

36
37 Q. Cathie Allen at the time was, and still is, an HP7,
38 a managing scientist, in that work unit. What would have
39 been the process to either performance manage or sack
40 someone in her position? How complicated is that process?

41 A. The performance management process for any employee -
42 we are required to actually meet and support. We try to do
43 it in a positive way. We invest a lot of money, time and
44 effort. And these people - regardless of who our employee
45 is, they have a lot of expertise in what they do. So it's
46 to understand why there is a performance issue - sometimes
47 it's because they are unwell, things are happening in their

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

5
6 Now, how long that takes and how complicated that is
7 depends on the role that they do. Given that Cathie Allen
8 is an HP7, that would be a complicated path. Obviously
9 working at that local level, it would be a confidential
10 matter between her supervisor, whichever supervisor,
11 whichever ED it was, and Cathie. So it's between the
12 supervisor and the individual.

13
14 After a reasonable time period and reasonable support
15 was provided and there's evidence of that actually
16 occurring, then if there is no improvement or minimal
17 improvement, then we would look at instigating
18 a performance improvement plan, which is a formal document
19 that both parties sign. We also have a reviewer. They are
20 given specific expectations that they have got to meet.
21 There is specific support that is actually drafted in to
22 those documents as well, so the employee is supported
23 during those processes.

24
25 If they then fail to improve completely, we would
26 abandon the process and potentially instigate
27 a disciplinary process or suggest to the delegate to
28 commence a disciplinary process.

29
30 If they are improving but they need more time for that
31 improvement or the reason for the performance issue has
32 changed, we would look at extending. So we've invested
33 a lot of time and money into our employees within
34 Queensland Health, and we like to support them to improve
35 their performance, because it's easier than recruiting
36 somebody else and training them up. We need to keep our
37 people.

38
39 Q. The other side of that, isn't it, Ms O'Connor, is that
40 a poorly managed performance management process can lead to
41 industrial action?

42 A. Oh, absolutely.

43
44 Q. You have said that you were aware that Mr Doherty was
45 involved in working with Cathie?

46 A. That's correct.

47

1 Q. And you were aware of that through these confidential
2 meetings that you had with him?

3 A. That's correct.
4

5 Q. I won't ask you about that, because he's going to be
6 a witness called in these proceedings, but what
7 understanding did you have of the relationship between
8 Paul Csoban and Cathie Allen?

9 A. My personal impression is that Paul Csoban would
10 listen and do whatever Cathie asked him to do; that she was
11 extremely influential over his decision-making.
12

13 MS REECE: Thank you, Commissioner.
14

15 THE COMMISSIONER: I'm sorry, I forgot to ask you
16 something.
17

18 Q. When you send a letter to an employee to set up
19 a conversation in a meeting room, I guess sometimes you
20 would tell the employee the subject matter that you want to
21 talk about, and there may be occasions when you don't do
22 that. Are there occasions when you don't tell them what
23 it's about?

24 A. Generally, what we would do is if we want to - we may
25 not give them all the particulars of the issues against
26 them; we might give them a broad overview. And I'm not
27 suggesting that this has ever occurred at FSS or in this
28 matter, but say you may want to have a conversation with an
29 employee in relation to sexual harassment occurring on
30 a certain date, you probably only give them that topic.
31 You wouldn't provide them details of --
32

33 Q. The allegations that are being made and how they are
34 supported?

35 A. That's right, yes.
36

37 Q. But you want them to turn up with the information, as
38 much information as they have?

39 A. That's correct.
40

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

43 A. Yes.
44

45 Q. "And I understand you were a participant or
46 a witness", or whatever it might be?

47 A. Yes, or time frames. That's important, because

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

5
6 Q. So can you think of a reason why you wouldn't tell an
7 employee what it is you wanted to talk about?

8 A. It depends on the seriousness of the issue.
9

10 Q. Can you explain that?

11 A. So if we're going to talk to an employee about rape
12 allegations, we're not going to disclose the sort of - all
13 the details of that, but we would potentially state that we
14 needed to speak to them about a sexual harassment matter
15 that occurred on such and such a date.
16

17 Q. But even then, you are giving an indication of the
18 subject matter?

19 A. That's correct.
20

21 Q. Can you think of a reason why you would write to an
22 employee saying, "I want to speak to you about a matter in
23 the workplace. You are not to tell anybody about this, and
24 I'm giving you an opportunity to respond"?

25 A. I would never recommend that that --
26

27 Q. Why?

28 A. Because the employee has - it's reasonable for the
29 employee to know what they are going to be discussing, so
30 that they can prepare themselves. It depends - it also
31 gives an idea of what - how serious the matter is. The
32 more serious, the more formal we get.
33

34 Q. So it's a matter of fairness?

35 A. Yes, that's right.
36

37 THE COMMISSIONER: Thank you. Anything arising out of
38 that for anyone? No? Thank you, Ms O'Connor. You've been
39 most helpful. You are free to go and you are free to stay,
40 of course, if you wish to.
41

42 <THE WITNESS WITHDREW
43

44 THE COMMISSIONER: Mr Hickey?
45

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

1 to those for whom I appear?

2

3 THE COMMISSIONER: Yes.

4

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

8

9 THE COMMISSIONER: Yes.

10

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

14

15 THE COMMISSIONER: Influence, anyway, yes.

16

17 MR HICKEY: Some influence.

18

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

21

22 MR HICKEY: Others had the impression.

23

24 THE COMMISSIONER: Yes.

25

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

33

34 THE COMMISSIONER: Mmm-hmm.

35

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

45

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

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

7
8 MR HICKEY: Yes.

9
10 THE COMMISSIONER: -- and show you, assuming there is no
11 reason not to show you, which I can't imagine - we should
12 show you the fruits of our labours.

13
14 MR HICKEY: That's the concern.

15
16 THE COMMISSIONER: I think that's taking place, but
17 whether it is of any use is another matter.

18
19 MR HICKEY: I'm content with that. Out of an abundance of
20 caution, I'm instructed to raise it.

21
22 THE COMMISSIONER: No, no, you are right to do so.

23
24 MS REECE: Commissioner, I can confirm that that is taking
25 place.

26
27 THE COMMISSIONER: So we're looking at it and I think
28 people have been spoken to, but what has come of it I'm not
29 sure yet.

30
31 MR HICKEY: Perhaps I'm boxing at shadows.

32
33 THE COMMISSIONER: No, no. You are quite right to raise
34 it.

35
36 MR HICKEY: It arises - and I don't mean any criticism by
37 saying this - in circumstances where, for instance,
38 Ms O'Connor's evidence arises today without any forewarning
39 of what she was going to say. We've had no statement. So
40 the Commissioner I hope can understand that I am not being
41 unintentionally difficult --

42
43 THE COMMISSIONER: No. I invite you, any of you, to raise
44 matters like this without any hesitation, because you are -
45 the word "parties" isn't strictly correct, as you know, in
46 a legal sense, but your clients are very interested and you
47 have a say in all of this.

1
2 MR HICKEY: Thank you, Commissioner.
3
4 THE COMMISSIONER: Now, Mr Jones, what is happening?
5
6 MR JONES: There is an opening that will probably take
7 about 30 minutes, and then there will be some evidence from
8 Dr Kramer straight after that.
9
10 THE COMMISSIONER: From?
11
12 MR JONES: Dr Kramer.
13
14 THE COMMISSIONER: And anyone else?
15
16 MR JONES: No.
17
18 THE COMMISSIONER: That's it for you?
19
20 MR JONES: That's right.
21
22 THE COMMISSIONER: Is anybody else being called this
23 afternoon?
24
25 MR JONES: I don't believe so.
26
27 THE COMMISSIONER: So we can adjourn until - what is the
28 general consensus, 2.15 or 2.30? Because you are going to
29 have an early afternoon, it sounds like. 2.15, Mr Hickey?
30
31 MR HICKEY: Thank you, Commissioner.
32
33 THE COMMISSIONER: Everybody happy with that - Mr Hunter?
34
35 MR HUNTER: Thank you.
36
37 THE COMMISSIONER: Mr Rice, 2.15?
38
39 MR RICE: Thank you.
40
41 THE COMMISSIONER: That suits you, Mr Jones?
42
43 MR JONES: It does, thank you, Commissioner.
44
45 THE COMMISSIONER: Very well. We will adjourn until 2.15.
46
47 **LUNCHEON ADJOURNMENT**

1
2 THE COMMISSIONER: Mr Jones?

3
4 MR JONES: Thank you, Commissioner. Part of your
5 appointment includes making full and careful inquiry into
6 whether the methods, systems and processes used by the
7 Queensland Police Service and the Forensic and Scientific
8 Services for forensic DNA collection are conducted in
9 accordance with best international practice.

10
11 This topic includes the consideration of the
12 qualifications and training of those who collect the
13 samples; the policies, protocols and guidelines associated
14 with the collection of samples; the quality assurance
15 measures in place, such as competency and proficiency
16 testing of those that collect the samples; and, in some
17 instances, the equipment used to collect samples.

18
19 To fully and carefully investigate the collection of
20 biological material for forensic DNA testing, you obtained
21 a vast number of statements from: police officers,
22 including frontline police officers, forensic managers and
23 coordinators, and those that are in charge of the training
24 and quality management units that impart the education and
25 training to the police officers that collect the samples;
26 there was also a statement obtained from a civilian police
27 employee who works within the DNA management unit, and,
28 Commissioner, you would have heard about her, Olivia
29 McIntyre, in module 1; statements from medical doctors who
30 collect the samples and are in charge of the relevant units
31 that have staff underneath them that collect the samples;
32 and a nurse who is in charge of training nurses that
33 collect samples; a statement was obtained from Ms Allen, or
34 two statements from Ms Allen, the general manager of FSS,
35 regarding the collection and any issues that the lab has
36 experienced with police collection; a vast number of
37 documents, including policies, protocols and guidelines,
38 were also obtained; a statement from Mr Ainsworth, a former
39 senior detective, who interviewed 36 police officers and
40 prosecutors about their experience with collection and
41 results and understanding results; and three expert
42 reports.

43
44 Collection of biological material for forensic DNA
45 testing is done by two agencies. The first is the
46 Queensland Police Service, who are responsible for the
47 collection of biological samples from a crime scene and

1 reference samples from those accused people charged with
2 indictable offences. The second agency is Queensland
3 Health. It is responsible for the collection of certain
4 biological samples from victims of sexual assault and
5 people accused of committing those offences.
6

7 The relevant people in charge in Queensland Health
8 report to Lara Keller.
9

10 The Forensic Services Group of the Queensland Police
11 Service oversees much of the training and policies related
12 to sample collection. The Forensic Services Group contains
13 Brisbane-based specialist units and sections, including the
14 biometrics unit, which contains the DNA management section,
15 and that is headed up by Inspector Neville, who,
16 Commissioner, you heard from in module 1; the quality
17 management section, which is headed up by Inspector
18 Keating, which is in charge of imparting the education and
19 training to the officers; and the scientific section, which
20 is headed up by Inspector Pobar, who is in charge of the
21 locally based scientific officers. The Forensic Services
22 Group oversees geographical units of forensic officers,
23 which is a term used to refer to both scenes of crime
24 officers and scientific officers, both of which are
25 responsible for the collecting of samples from crime
26 scenes.
27

28 The key Queensland Police Service policies and
29 protocols that relate to sample collection and quality
30 management are CSE100, which is a crime scene examination
31 protocol; CSE101, which is a biological evidence protocol;
32 PFS100, which is the quality manual; and the operational
33 procedure manual.
34

35 Within each region, there are multiple units of scenes
36 of crimes officers, each of which report to a forensic
37 coordinator and a forensic manager.
38

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

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

3
4 Scientific officers sit within the scientific units
5 and are only located in major centres, being the
6 Gold Coast, Brisbane, Rockhampton, Townsville and Cairns.
7 Scientific officers in Brisbane and Gold Coast report to
8 the Brisbane-based scientific section of the Forensic
9 Services Group headed up by Inspector Keating. The
10 remaining scientific officers report to a local forensic
11 manager.

12
13 Scientific officers are recruited generally from
14 scenes of crime officers and must already hold a Bachelor
15 of Science or an equivalent or similar degree. They will
16 then undertake a training program that takes up to
17 four years and renders them eligible to receive a Graduate
18 Certificate in Crime Scene Investigation, have higher-level
19 forensic skills than a scenes of crime officer but are not
20 further trained in fingerprinting or complex photography,
21 which is left to the scenes of crime officers, and will
22 attend more complex major crime scenes, particularly if
23 blood spatter analysis is required. Scenes of crime
24 officers will assist scientific officers at most of those
25 major crime scenes.

26
27 When a crime occurs and a crime scene is established,
28 the first responding officer or investigating officer may
29 request the scenes of crime officers to attend the scene to
30 take, among other things, samples for forensic DNA testing.
31 They may also request a scientific officer to attend if it
32 is a significant matter, such as a homicide, that requires
33 more complex scientific skills.

34
35 While there is no strict policy, if the crime scene is
36 a major incident, such as homicide, unusual death or
37 a serious, violent offence, the local forensic coordinator
38 and/or forensic manager will also be contacted and will be
39 involved in planning and coordinating the forensic response
40 to the crime and may attend the crime scene. Sometimes,
41 visual feeds are used to assist a forensic manager or
42 coordinator with their decisions, that is, photographs and
43 videos are uploaded to the forensic-register and viewed by
44 the forensic manager or coordinator when considering what
45 response is required.

46
47 For obvious reasons, every attempt is made to limit

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

12
13 The decision about where and what to sample, however,
14 is made by the forensic officers and often in collaboration
15 with the forensic coordinator.

16
17 The location from which a sample is taken is
18 photographed, as is the sample itself. The sample is
19 barcoded and entered on to the forensic-register at the
20 time by the forensic officer. The photos are loaded on to
21 the forensic-register. Scenes of crime officers and
22 scientific officers have access to the forensic-register,
23 but investigators do not.

24
25 The sample is then logged and stored at the forensic
26 property point. Police officers will then triage and
27 determine what to send to the lab for testing in accordance
28 with the priority 1, priority 2 and priority 3 system,
29 Commissioner, that you heard about in module 1.

30
31 Samples are either hand delivered by the police
32 officers or sent via registered post.

33
34 As the DNA lab also uses the forensic-register, it
35 scans the barcode on arrival and the exhibit is recognised
36 by the forensic-register on the lab side. Results are then
37 returned via the forensic-register to the DNA management
38 unit and published to the investigators via the Queensland
39 Police Records and Information Management Exchange,
40 otherwise known as QPRIME, and on occasion by email.

41
42 During module 1, you heard about a change in process
43 in 2008 whereby police commenced sub-sampling items
44 collected for DNA testing. This process is done in the DNA
45 labs run by the police. This process involves the police
46 taking smaller samples from larger items, such as bedding,
47 and placing it in a robot-ready or test-tube-ready form.

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

5
6 Proficiency testing and quality assurance measures
7 relating to scenes of crimes officers include the
8 following. Once every two years, a scenes of crime officer
9 must complete a scene assessment whereby another scenes of
10 crime officer of at least equal seniority accompanies them
11 and completes an assessment of their evidence collection
12 skills at a scene. At times, a scenes of crime officer
13 will complete an online proficiency test called "After the
14 Fact", which is a virtual scene examination. There will be
15 court testimony monitoring and a technical review which is
16 conducted on all major crime sampling completed by scenes
17 of crimes officers, any crime type in which a scenes of
18 crimes officer produces a statement, and a further random
19 selection of reports, to ensure such scenes of crime
20 officers have had five matters technically reviewed each
21 year. It checks the methods used for collection and the
22 conclusions drawn. It is conducted by a forensic officer
23 of at least the same level of seniority.

24
25 The Queensland Police Service also provides a train
26 the trainer program, given the size of Queensland, where
27 certain forensic officers are given refresher training from
28 forensic scientific group quality management section, and
29 then they return to their locality and deliver it locally.

30
31 A review is also conducted of the examination summary
32 of each case file. This is done to ensure that various
33 administrative requirements have been met and is called an
34 administrative review.

35
36 The Forensic Services Group quality management section
37 undertakes annual internal audits of every QPS forensic
38 laboratory used by the forensic officers. The laboratories
39 are also accredited to international or national standards,
40 which are audited by NATA every 18 months.

41
42 As part of your investigation, the laboratory was
43 asked questions via Ms Allen. One of those was whether the
44 lab had identified or raised any systemic issues, problems
45 or errors with the methods, systems or processes used by
46 the Queensland Police Service for forensic DNA collection.

1 In answering that question, in Ms Allen's statement of
2 16 September 2022, five matters were identified. There was
3 an issue in 2008/9 with the swabs that were being used.
4 There was an issue in around 2008 with post-it flags that
5 were being used. There was ongoing work with the
6 Queensland Police Service to ensure sufficient detail was
7 uploaded to assist with appropriate sampling and testing on
8 the forensic-register. There was an issue with access to
9 the forensic-register in around January 2020, which,
10 Commissioner, you heard about in module 1, where police
11 officers had access to degradation values and quant values,
12 and there was an issue with exposure to graphic imagery
13 without warning in the forensic-register in late 2018.
14

15 Later in this module, Ms Allen will be called to give
16 evidence, and it will be confirmed that those issues were
17 resolved at the times that they were raised. There was no
18 suggestion that they are systemic problems that exist
19 currently.
20

21 Anna Davey is a scientist with expertise in methods,
22 systems and processes relating to collection of samples for
23 forensic DNA testing. Her experience includes quality
24 management and auditing. She has held management roles
25 within what is now known as the Victoria Police Forensic
26 Services Department. One of those roles included
27 developing and maintaining the facility's internal audit
28 program, which included being the audit leader for several
29 audits. She also has held a position as deputy director of
30 the National Institute of Forensic Science.
31

32 Ms Davey was engaged by you, Commissioner, to consider
33 the policies and practices of the Queensland Police Service
34 with respect to collecting and transporting samples for
35 forensic DNA testing. This included a review of the
36 quality management review processes and qualifications and
37 training of the relevant police officers.
38

39 It is not intended to call Ms Davey. The parties have
40 been provided with Ms Davey's report and have indicated
41 that they do not require her for cross-examination. The
42 Queensland Police Service will provide a further short
43 statement dealing with one issue that Ms Davey has
44 identified, which will put that into its proper context.
45 Once that is to hand, it will be distributed to the parties
46 and made part of the tender bundle.
47

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

5
6 She identified some anomalies in actual practice.
7 They were an issue with the labs that were used where the
8 sub-sampling is done, and I understand that is what the
9 subsequent statement will address; issues with the review
10 of results such that it would then guide what further
11 sub-sampling ought to be done; and issues with meeting
12 proficiency testing requirements, the structure of the
13 internal audit program and the system of technical reviews
14 and administration reviews. They are anomalies, in
15 Ms Davey's opinion, that would be found in any organisation
16 of that size and that complexity.

17
18 Ms Davey also looked at the methods, systems and
19 processes for transporting the sexual assault investigation
20 kits after collection to the lab for testing. She found
21 that those methods, systems and processes accorded with
22 best international practice.

23
24 However, Ms Davey found that the method of assembly of
25 the kit is not in accordance with best international
26 practice, as the assembly process is not compliant with
27 International Standard 18385. The assembly process does
28 not minimise the risk of human contamination, because there
29 are no processes in place to assess the presence of
30 detectable human DNA in the assembled kits or to treat them
31 with an agent which denatures any human DNA present. That
32 appears to be consistent with the opinion of Dr Kramer, who
33 you will hear from shortly.

34
35 Mr Ainsworth, a former detective, interviewed a number
36 of police officers, and some issues surrounding access to
37 results and doctors to do SAIKs were issues that police had
38 experienced. One statement was obtained from a police
39 officer that identified a sexual assault investigation kit
40 being transported from Emerald and sitting at Rockhampton
41 for four months before being transported to the lab, but
42 that appears to have been an isolated incident.

43
44 That brings me to the collection of samples by
45 Queensland Health. In a case of sexual assault, biological
46 material is typically collected from the complainant and/or
47 the accused by way of a forensic medical examination.

1
2 While the Queensland Police officers will usually
3 arrange such an examination, physicians or nurses are
4 engaged by Queensland Health to conduct those examinations.
5 Usually the physician or nurse uses a sexual assault
6 investigation kit to collect samples during the
7 examination. Persons who are not yet sure if they want to
8 make a police complaint can request a "just in case" kit,
9 which does not involve the Queensland Police Service.
10 A "just in case" kit is the same as a sexual assault
11 investigation kit, save for the involvement of the
12 Queensland Police Service, and it doesn't have a separate
13 component which is a toxicology kit.
14

15 In Queensland, sexual assault investigation kits and
16 "just in case" kits are produced and compiled by the staff
17 at the DNA laboratory.
18

19 It should be noted that the Women's Safety and Justice
20 Taskforce considered the quality, accessibility and use of
21 forensic evidence gathered in legal proceedings in its
22 report dated 1 July 2022. The Commission of Inquiry is not
23 investigating the experiences of victim survivors in
24 accessing sexual assault examinations, noting that such
25 experiences were well explored by the Women's Safety and
26 Justice Taskforce.
27

28 The Commission is instead focusing on issues that have
29 been raised by physicians and stakeholders and which relate
30 closely to forensic DNA testing. They complement, however,
31 many of the findings of the Women's Safety and Justice
32 Taskforce. They are: whether the current sexual assault
33 investigation kits and "just in case" kits are adequate, in
34 that they do not contain enough swabs, are not DNA free,
35 have wooden stems and do not contain a DNA decontamination
36 kit; whether the "just in case" kits are substandard in
37 comparison to the regular sexual assault investigation
38 kits; the sufficiency of the qualifications and training of
39 those who conduct the sexual assault examinations; and the
40 practice of Queensland Health not taking reference samples,
41 DNA samples, from the complainant as part of the forensic
42 examination.
43

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

1 station to provide a reference sample.

2
3 You have engaged three experts to review the sexual
4 assault investigation kits. They are: Associate Professor
5 Kathy Kramer, who is an experienced clinician and forensic
6 medical examiner and is currently the senior clinical
7 advisor in the New South Wales Ministry of Health's
8 prevention and response to violence, abuse and neglect.
9 She will provide a clinical perspective and will consider
10 the qualifications and training of those who conduct sexual
11 assault investigation kits and the equipment and procedures
12 used in relation to them.

13
14 You also engaged Professor Rebecca Kogios and
15 Heidi Baker, who are molecular biologists with backgrounds
16 in forensic science. They will advise whether the current
17 kits and "just in case" kits enable the acquisition of
18 high-quality DNA samples. Their report is still
19 outstanding and will be produced to the parties upon
20 receipt, and they are being called at a later time.

21
22 Queensland has 16 separate hospital and health
23 services. Each of these covers a distinct geographical
24 area, except for the Children's Health Queensland Hospital
25 and Health Service. Each hospital and health service is
26 partially independent but is part of Queensland Health and
27 may be instructed by the director-general of Queensland
28 Health via a health service directive.

29
30 The current health service directive stipulates that
31 each hospital and health service must provide 24-hour
32 access to forensic examinations for victims of sexual
33 assault, including a suitable model of care for sexual
34 assault patients under 14 years of age. Queensland Health
35 also has a Clinical Forensic Medicine Unit based in
36 Brisbane. The functions of the Clinical Forensic Medicine
37 Unit are set out in the statement of Dr Griffin, who is the
38 director of the unit.

39
40 Broadly and relevantly, the Clinical Forensic Medicine
41 Unit provides forensic medical examinations in Brisbane and
42 provides guidance and advice by way of a 24-hour,
43 seven-day-a-week telephone service for the conduct of
44 forensic examinations on complainants and accused persons
45 across Queensland. Ultimately, the provision and conduct
46 of sexual assault examinations is the responsibility and
47 matter for each individual hospital and health service.

1
2 Once the sexual assault investigation kits are
3 assembled by the lab, they are provided to the police and
4 distributed throughout the police. Police officers
5 generally provide the kit to the Queensland Health
6 physician or nurse who will then conduct the forensic
7 examination. Relevant extracts from the Queensland Police
8 Service Operational Procedures Manual set out the role of
9 the police officers in relation to sexual assault
10 investigation kits.

11
12 "Just in case" kits, once produced, are provided to
13 Pathology Queensland and it seems that it is up to each
14 hospital and health service to ensure their physicians and
15 nurses have access to the "just in case" kits when
16 required.

17
18 Once the forensic examination is complete, Queensland
19 Police Service officers take possession of the sexual
20 assault investigation kit and are responsible for having
21 a forensic officer barcode the exhibit and enter it into
22 the forensic-register. The investigating officer is then
23 responsible for transporting the kit to the laboratory.

24
25 The current interagency guidelines on responding to
26 sexual assaults provide that a reference DNA sample from
27 the complainant is to be taken by the practitioner
28 conducting the examination. However, in practice,
29 reference samples from a complainant or an accused have
30 also been taken by the police, usually on a later occasion.

31
32 From about August 2021, Queensland Police Service have
33 raised concerns that Queensland Health physicians and
34 nurses are not taking reference DNA samples and, instead,
35 leaving it to the police officers to do, contrary to the
36 interagency guidelines.

37
38 Queensland Police Service suggests, or officers from
39 the police service suggest, that having to ask
40 a complainant to return a couple of days later to a police
41 station or attending at their house so a police officer can
42 take their reference sample unnecessarily re-traumatizes
43 the complainant. Of course, if the process is more
44 intrusive, traumatic and repetitive than it needs to be,
45 victims will not subject themselves to it, and matches with
46 perpetrators will be lost. It also does not accord with
47 a victim-focused approach, which Dr Kramer will tell you is

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

3
4 Sexual assault examinations of a person under the age
5 of 14 years are generally conducted by a paediatrician
6 because of anatomical differences. The same sexual assault
7 investigation kit is used. It may be that in more remote
8 areas, local medical officers need to medically assess
9 a child under 14 and conduct the examination themselves.

10
11 The Child Protection and Forensic Medical Service
12 provides a 24-hour-a-day, seven-day-a-week call support for
13 clinicians in Queensland, peer review of examinations and
14 interpretation of findings on request, and workshops to
15 provide professional development and upskilling.

16
17 The Child Protection and Forensic Medical Service is
18 responsible for the provision of these services in the
19 Children's Health Queensland Hospital and Health Service,
20 but each of the remaining 15 hospital and health services
21 are ultimately responsible for the conduct of examinations
22 on children under 14 years in their district. Dr Jan
23 Connors is the head of the Child Protection and Forensic
24 Medical Service and has provided a statement to the
25 Commission.

26
27 As is mentioned, it is up to each hospital and health
28 service to determine how forensic medical services are
29 delivered. Within the Gold Coast Hospital and Health
30 Service, Dr Cathy Lincoln is the director of the forensic
31 medicine department. Dr Lincoln has implemented further
32 qualification and training requirements for her physicians
33 who perform forensic medical examinations in that hospital
34 and health service. Dr Lincoln also, on occasion, uses
35 more equipment, such as further swabs, than what is
36 provided in the standard SAIK and then sends all the used
37 swabs for testing via the police.

38
39 Dr Griffin, the director of the Clinical Forensic
40 Medicine Unit in Brisbane, says that he has received
41 negative feedback from the lab about such a practice.

42
43 We have asked our expert - that is, Dr Kramer - to
44 consider whether Dr Lincoln's practices of conducting
45 further training on her staff and in using more swabs in
46 her examinations are closer to best practice than standard
47 Queensland-wide practices or are problematic, as suggested

1 by the lab via Dr Griffin.

2
3 Queensland Health has for some time employed forensic
4 nurse examiners to conduct sexual assault examinations.
5 Most recently, and since about 2019, Queensland Health have
6 been training sexual assault nurse examiners through
7 a 40-hour course to conduct sexual assault examinations.

8
9 The Women's Safety and Justice Taskforce made several
10 recommendations relating to what the Commission is
11 investigating, which include, relevantly, Queensland Health
12 in partnership with the Department of Justice and
13 Attorney-General develop and implement ongoing
14 competency-based training and professional development for
15 doctors and nurses who may be required to prepare reports
16 and give evidence in criminal proceedings for sexual
17 offences; Queensland Health develop and implement
18 a community and education campaign to inform doctors who
19 may be required to perform forensic medical examinations
20 about the critical importance of this work, their role and
21 the support available to them to perform this role well;
22 Queensland Health and the Queensland Police Service review
23 and revise the model for "just in case" forensic medical
24 examinations in Queensland and implement a new approach
25 that ensures a full medical examination is undertaken with
26 the same number and quality of samples taken in a forensic
27 medical examination; the sexual assault investigation kit
28 used in Queensland be reviewed and updated to ensure it is,
29 at the very least, of consistent quality as those used in
30 New South Wales and Victoria; as a minimum requirement,
31 kits must be DNA free and contain DNA decontamination kits
32 and an adequate number of swabs and testing apparatus.

33
34 It should therefore be borne in mind that Queensland
35 Health may already be implementing some of these
36 recommendations. The Commission is currently investigating
37 if and how and what progress has been made to implement
38 those recommendations.

39
40 As referred to earlier in this opening, Commissioner,
41 you engaged the assistance of Associate Professor Kathleen
42 Kramer to consider the methods, systems and processes for
43 the collection of biological material for forensic DNA
44 testing from sexual assault victims and those accused of
45 committing sexual assault offences.

46
47 Professor Kramer was briefed with the policies and

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

9
10 The training and proficiency testing for the
11 Gold Coast Hospital and Health Service, however, is an
12 exception. This is because Dr Lincoln, who oversees the
13 Gold Coast, has implemented training and testing above that
14 rolled out elsewhere in the state.

15
16 Professor Kramer made the following recommendations in
17 relation to the training and proficiency testing of those
18 conducting forensic medical examinations: move to
19 a competency-based training across Queensland; create
20 a process for re-credentialling physicians and nurses; and
21 training be tailored to local sampling guidelines and local
22 sexual assault investigation kits and in DNA contamination
23 minimisation kits.

24
25 Dr Kramer also observed that the equipment and
26 procedures used in conducting forensic medical examinations
27 in sexual assault matters does not reflect best practice
28 and does not enable the collection of high-quality samples
29 for forensic DNA testing. Professor Kramer made the
30 following recommendations in relation to the equipment and
31 procedures. Commissioner, to your front, on the right
32 there are some plastic bags.

33
34 THE COMMISSIONER: Yes.

35
36 MR JONES: This one with the pink slip is the "just in
37 case" kit. The other kit is identified as a
38 "tamper-evident, highlight unauthorised access" bag. That
39 is the SAIK kit. In that, Commissioner, you will find six
40 swabs. And I should pause to note, this is how the kit
41 comes via the police. It's open. It consists of six
42 swabs. Commissioner, you will see there that the swabs are
43 made of wood, the handles or the stick part of it is made
44 of wood, and the tip is made of cotton. The evidence bag
45 is not sealed, and it comes with a Queensland Health
46 Forensic and Scientific Services sexual assault
47 investigation kit document, which is for the recording of

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

2

3 THE COMMISSIONER: Yes.

4

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

10

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

28

29 THE COMMISSIONER: Do we know why it was stopped?

30

31 MR JONES: Not immediately, to my knowledge.

32

33 THE COMMISSIONER: It might be interesting to find out.

34

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

38

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

41

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

44

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

1
2 THE COMMISSIONER: To act as a what?
3
4 MR JONES: A prompt. That would be particularly important
5 in Queensland, where all but one of the physicians from the
6 CFMU are located in Brisbane and they provide a telephone
7 service to doctors that may rarely do these types of
8 examinations.
9
10 THE COMMISSIONER: So, so far, I understand that there are
11 six swabs in the kit. There are no instructions on how to
12 proceed in taking samples; is that right?
13
14 MR JONES: That's right. There is the completion form
15 there, which would act as somewhat of a guide, but --
16
17 THE COMMISSIONER: Well, let's see.
18
19 MR JONES: For example, "Type of assault - digital,
20 penile" and, over the page, there are the types of swabs,
21 areas to swab.
22
23 THE COMMISSIONER: Let's see. I see.
24
25 MR JONES: Dr Kramer will tell you, though, that there are
26 things missing from that.
27
28 THE COMMISSIONER: There are omissions, yes.
29
30 MR JONES: There are omissions. One caveat that Dr Kramer
31 puts on this is that for various reasons, kits need to be
32 locally put together in the sense not physically, but
33 a group needs to come together that includes the physicians
34 and the people from the lab, because there might be lab
35 capabilities that need to inform what things need to be
36 made from, et cetera.
37
38 THE COMMISSIONER: Yes.
39
40 MR JONES: And there will be physician experience about
41 what is something regularly seen in their local
42 jurisdiction.
43
44 THE COMMISSIONER: Yes. I would think that one of the
45 things that would be done as a matter of course from time
46 to time would be that those with knowledge of how the
47 samples are taken would speak to those who use the samples

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

3
4 MR JONES: Yes.

5
6 THE COMMISSIONER: And I see from the form which you drew
7 to my attention, which would be filled in by the person who
8 takes the samples, that it was approved, one of them at
9 least, by FSS. I'm talking about the Forensic and
10 Scientific Services form, which contains all the checklists
11 for samples. So have we seen any material relating to the
12 design and ongoing monitoring of the use of these systems?

13
14 MR JONES: Not in relation to the ongoing monitoring, but
15 the design. Ms Allen in her second statement provides some
16 evidence that, in consultation with Dr Griffin, the kit was
17 designed.

18
19 THE COMMISSIONER: And when was that, do you know?

20
21 MR JONES: That was in 2012 I believe. Yes, July 2012, at
22 paragraph 150 of Ms Allen's statement of 11 October 2022.

23
24 THE COMMISSIONER: And it's stayed the same since then, as
25 far as you know?

26
27 MR JONES: We are making some inquiries - or they will be
28 made, I should say.

29
30 THE COMMISSIONER: All right. You go on with what
31 Professor Kramer says.

32
33 MR JONES: Commissioner, though, you identify some
34 important points, and it goes beyond just the
35 Brisbane-based physician; it must be feedback given from
36 the lab to the physicians, but then the physicians
37 elsewhere operating, as to what is important and what is
38 being seen by them and the use.

39
40 Dr Lincoln is critical of the kits currently as they
41 are, from experience, the difficulty to use them, scant
42 detail in the guide, in the sheets, and space to record
43 information. But Dr Kramer even suggests that consultation
44 with the Director of Public Prosecutions about the type of
45 evidence that is useful to be gathered is important as
46 well. For example, nail clippings, if they were useful,
47 ought to be gathered. Dr Griffin speaks in his statement

1 about the kits formerly having a nail clipping collection
2 container, but it was rarely used, is my understanding of
3 what Dr Griffin says, so it was --
4

5 THE COMMISSIONER: Is there a nail clipping container?
6

7 MR JONES: Not now, there is not. But Dr Griffin says
8 that it was rarely used, so it was gotten rid of.
9

10 The kits contain better documentation regarding how
11 the examination ought to be conducted; the DNA
12 contamination minimised kits should be included with
13 guidelines and training to be considered; and health staff
14 be provided with support from a local medical director, and
15 that is particularly important because currently it seems
16 as though anyone outside of Brisbane does not have that
17 local support.
18

19 As I said before, some of those recommendations come
20 with the caveat that not enough information is known
21 locally by Dr Kramer to proffer the opinion that they would
22 not be best practice or they would be best practice in
23 Queensland.
24

25 What should occur, though, is a review of the kits
26 with contribution from the lab, doctors, nurses, police and
27 other stakeholders, such as prosecutorial services, and
28 that seems to tie in with the recommendations of the
29 taskforce.
30

31 Reference samples should be taken at the time of
32 administering the sexual assault investigation kit.
33 Dr Kramer will tell you, Commissioner, that that is
34 informed by a patient-centred dictum-informed, culturally
35 safe approach.
36

37 THE COMMISSIONER: Do we know why a reference sample isn't
38 taken as part of the SAIK process?
39

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

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

5
6 Dr Lincoln says it should be no problem for us to take
7 reference samples. We would just need to know about how
8 they were going to be used so that we could inform the
9 patient and obtain proper, informed consent.

10
11 Of course, Dr Kramer will tell you --

12
13 THE COMMISSIONER: But this is a patient who is already
14 giving samples according to the process in the SAIK kit?

15
16 MR JONES: That's right.

17
18 THE COMMISSIONER: So why would such a person need to give
19 further consent to give a reference sample?

20
21 MR JONES: A doctor will always, before taking samples or
22 doing a procedure, ask for full and informed consent. They
23 would need to know how a reference sample is going to be
24 stored, how long it's going to be kept.

25
26 THE COMMISSIONER: I see. Yes, I understand.

27
28 MR JONES: Of course, Dr Kramer will tell you that all
29 other states, if not all, most other states, take the
30 reference samples at the time of doing the procedure, and
31 if there was a contamination issue, that person could be
32 the rare one --

33
34 THE COMMISSIONER: Give another one.

35
36 MR JONES: -- to come back on another occasion, rather
37 than everybody.

38
39 Superintendent Frieberg, I believe, attaches
40 a transcript of a conversation with Dr Griffin that had to
41 be terminated because it became somewhat heated about the
42 reference samples.

43
44 Dr Kramer says that the sexual assault investigation
45 kits do not accord with Australian Standard, and I noted
46 earlier that this seems to be consistent with what Davey
47 finds, that the failure calls into question the integrity

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

9
10 Medical directors and clinician leads should receive
11 scientific feedback to guide and improve local practices.
12 It seems at the moment that there is no feedback from the
13 lab.

14
15 "Just in case" kits should contain a mechanism to
16 collect clothing for sampling for forensic DNA testing and
17 toxicology. Toxicology is obviously not relevant to the
18 DNA collection, but the clothing certainly is. At the
19 moment, because the police are not involved, there is no
20 process or storage facility to collect a complainant's
21 clothing. Dr Kramer will tell you that that is below
22 optimal, because things like underwear can contain very
23 significant DNA evidence.

24
25 A terminal clean of an examination room which is
26 a hospital grade clean to decontaminate a room after
27 a potentially infectious patient has been in the room is
28 not sufficient for the cleaning of a room where a person
29 will have their DNA sampled. That is the process at the
30 moment that Dr Lincoln has at the Gold Coast. Dr Kramer
31 commends her for attempting to have a better process in
32 place, but that is the wrong type of process. Any sampling
33 room should be cleaned using a method informed by the Royal
34 College of Pathologists of Australia's national guidelines
35 and should remove DNA. Otherwise, the policies
36 Queensland-wide for cleaning are appropriate.

37
38 Evidence gathering should include early evidence kits.
39 The taskforce heard about victims travelling long distances
40 without being able to shower or go to the toilet, sometimes
41 then arriving and a doctor refusing to do the examination
42 because they were not experienced in the examination, in
43 remote locations. Early evidence kits, as I understand
44 them, to enable someone to gather some of their own
45 evidence, so that they can go to the toilet or have other
46 treatments if they are injured, are preferred over the
47 sexual examination kit. It collects urine, for example,

1 clothing, and those sorts of things.

2
3 As part of the investigation, Ms Allen was asked some
4 questions about the sexual assault investigation kits. It
5 seems that only Dr Griffin was consulted about the contents
6 of the sexual assault kits, and that's found at
7 paragraph 150 of that statement of 11 October 2022.

8
9 Ms Allen, in that same statement, states that
10 improvements to SAIK could be made to ensure the components
11 permit the best-quality biological samples to be taken.

12
13 Commissioner, that concludes the opening. I call
14 Associate Professor Kathleen Kramer. She will give
15 evidence via videolink and will take an affirmation.

16
17 <KATHLEEN KRAMER, affirmed: [3.09pm]

18
19 <EXAMINATION BY MR JONES:

20
21 MR JONES: Q. You are Kathleen Kramer?

22 A. Yes.

23
24 Q. I will just get you to speak up, Professor. You are
25 an associate professor in the University of New South Wales
26 School of Medicine?

27 A. Yes, I am.

28
29 Q. You have been admitted to a Bachelor of Arts, Bachelor
30 of Medicine, Bachelor of Surgery and a Bachelor of Science
31 with honours?

32 A. Yes, at the University of Sydney.

33
34 Q. You have been admitted to a Graduate Diploma of
35 Forensic Medicine?

36 A. Yes.

37
38 Q. And to a Graduate Certificate of Medical and Forensic
39 Management of Adult Sexual Assault?

40 A. Yes.

41
42 Q. You are a Fellow of the Faculty of Clinical Forensic
43 Medicine?

44 A. Yes, I am.

45
46 Q. You are a Member of the Australian College of Rural
47 and Remote Medicine?

1 A. Yes, that's correct.

2

3 Q. You are a registered medical doctor in New South
4 Wales?

5 A. Yes.

6

7 Q. And you specialise in forensic medicine?

8 A. That's correct.

9

10 Q. You have research interests in issues affecting the
11 forensic and medical management of adult and child sexual
12 assault victims?

13 A. Yes, I do. Yes, and I'm a published researcher.

14

15 Q. And you are the senior clinical adviser in the
16 New South Wales Ministry of Health's Prevention and
17 Response to Violence, Abuse and Neglect?

18 A. Yes, I am a senior clinical adviser to the Ministry of
19 Health, but I would like to go on record as saying I'm not
20 representing the ministry here today but myself as
21 a private person.

22

23 Q. Thank you. This month, you prepared a report for the
24 Commission of Inquiry?

25 A. Yes, I did, Mr Jones.

26

27 Q. Do you have a copy of that report with you?

28 A. I do. May I be allowed to refer to it?

29

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

32

33 THE WITNESS: Thank you.

34

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

39 A. Yes, it does.

40

41 Q. Your report also considered 10 issues that were raised
42 by Dr Lincoln in her statement?

43 A. I believe that's correct.

44

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

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

6 A. Yes.

7
8 Q. Two, practices that are patient-centred,
9 trauma-informed and culturally safe?

10 A. Yes.

11
12 Q. I will get you to explain those in a moment, but would
13 you tell the Commissioner why there are no national or
14 international guidelines addressing best practice for
15 collection and storage and analysis of those samples,
16 please?

17 A. Well, I'll touch briefly on analysis and then leave
18 that to a DNA scientist. Analysis in countries like the UK
19 is done by private laboratories. What they do is
20 commercial in confidence; it's very hard to get information
21 or get them to share information about what they do. In
22 a big country like the US, the DNA labs are going to be in
23 individual counties. County by county will have different
24 resources and different ways of doing things. America has
25 attracted a good deal of criticism about the way it handles
26 forensic samples. So it's very difficult to get best
27 practice about the analysis of samples internationally.

28
29 But coming more to my field, which is really around
30 how we collect and store samples, there are no
31 international guidelines. That might sound surprising, but
32 there are two very, very good reasons why that is the way
33 it is. The first is that how you are going to collect
34 samples and what you are going to do with them is part of
35 a justice process and it's got to fit the needs of the
36 justice system. That means it's going to be informed by
37 whatever laws are pertinent in that jurisdiction around
38 what is a sex crime and what is evidence of a sex crime,
39 and that is going to be different in Alabama compared to
40 England and Tasmania compared to Queensland. So what you
41 need are processes that are fit for that legal
42 jurisdiction.

43
44 The other thing that comes into play is what that lab
45 that you are sending your samples to is capable of. There
46 is no point, for example, sending them an oral rinse, which
47 is a sampling technique to get sperm cells from the mouth,

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

4
5 Local labs will develop their own sort of skills and
6 strengths. Their own data might show, for example, when it
7 comes to skin swabs, that they get much better results
8 with, say, a two-swab technique, a wet and a dry, or they
9 get much better results with a single-swab technique. So
10 international guidelines can't take those kinds of subtle
11 local nuances about what this lab can do and what these
12 courts require into account. So there's nothing, you know,
13 internationally.

14
15 To some extent, within countries, there may be some
16 guidelines, but they are usually very generically worded
17 and they come with a rider saying, "This has to be adapted
18 locally. You have to develop your own processes, your own
19 SAIK kit, your own sampling guidelines, your own training
20 that is tailored to your particular kit."

21
22 But as you alluded to earlier, I still think there are
23 some broad principles about what is best practice when you
24 are wanting to collect these samples. I think you can draw
25 some broad overarching guidelines that then determine what
26 a process for developing local best practice would look
27 like. Does that answer your question?

28
29 Q. Thank you. I will take you to those in a moment.
30 Just on something you have said there about the data and
31 about what may be collected and produce better-quality
32 results or greater results, I take it, then, from that that
33 it is important that that data be collected and that
34 feedback be given to those that are designing the kit?

35 A. Absolutely. You need robust quality assurance
36 processes that say what works and what doesn't work and
37 a way of sharing that information from all of the actors in
38 the field. You have patients, you have doctors, you have
39 labs, you have police, you have the courts as the triers of
40 fact, and all of them have unique bits of information about
41 how well a system is working or not working. So if a lab
42 is finding that the doctors' handwriting is illegible, for
43 example, that has to be fed back to doctors. If doctors
44 are finding that they are forever opening a second kit
45 because there aren't enough swabs in a single kit, then
46 that has to be fed back to the lab who makes the kit and
47 the police, who are of course paying for those kits.

1
2 Q. Now, absent the national and international guidelines,
3 you touched on three considerations that were important for
4 underpinning any policy or protocol.

5 A. Yes.
6

7 Q. What are they?

8 A. They have to be evidence based, and that evidence is
9 coming from a multiplicity of sources. There will be
10 published research; there will be your own internal quality
11 assurance processes; there will be what other labs in your
12 country are doing that you could perhaps learn from. But
13 either way, there has to be a good, solid reason for why
14 you do things the way you do things and the flexibility to
15 change them as things evolve.
16

17 Separate to that, there is the more sort of
18 patient-focused aspect of things. Although I don't want to
19 segue into talking about rape myths, that women make things
20 up, the research evidence clearly shows that it is uncommon
21 for women to make up a rape allegation or a sexual assault
22 allegation out of whole cloth. That being the case --
23

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

27 A. Yes.
28

29 Q. I will look at the paper in due course, but could you
30 summarise for me the substance of it, if you can remember
31 it?

32 A. There has been a number, a number of papers.
33 Ferguson's is a nice kind of overview of all of the
34 previous research; it ties everything together. But let me
35 give you a concrete number from Australia. In Melbourne,
36 the Victorian Institute of Forensic Medicine did two
37 studies 10 years apart looking at the false complaint rate
38 in women who were having a sexual assault investigation
39 kit, and in both of their studies it came up with the same
40 figure of 2 per cent, so 2 per cent making them up.
41

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

1 wellbeing have got to inform this process just as much as
2 the needs of the lab will inform this process. Does that
3 answer your question?
4

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

17 A. Yes.
18

19 Q. -- and perhaps Queensland Health generally, as having
20 to pay for all of it, but, in any event, at the centre of
21 it would be police, as investigators who understand what
22 actually happens at the crime scene and what they confront;
23 the lab, who alone knows what they do and what they need to
24 do the best that they can; and perhaps the Director of
25 Prosecutions, who can speak to the evidentiary significance
26 of what is done. Is that the tenor of what you are saying?

27 A. Yes, that is the tenor, but I would add in the doctor
28 or nurse who is using the kit, who is in some ways the
29 first user, because it's got to be fit for purpose. If
30 they've got packaging that, for example, is very hard to
31 open or very hard to seal, then you've got a SAIK that's
32 not really fit for purpose. It's a trivial example. But
33 it's often the people at the coalface who are using the
34 kits who will be the first ones to say things are not
35 working.
36

37 Q. Who would be the source of collated information of
38 that kind?

39 A. Perhaps I could use New South Wales as an example?
40

41 Q. Yes.

42 A. Without meaning to say this is the one true way to do
43 it; it is just a practical, worked example of something
44 that seems to work.
45

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

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

12
13 So all of those people are in the room together. We
14 get together every six months and we look at the sampling
15 guidelines, which is our document that tells staff what
16 samples to take, in what way and under what circumstances.
17 Issues arising out of the sampling guidelines can then
18 affect how the actual SAIK kit is designed. Although the
19 six-monthly meeting is not specifically about the SAIK, it
20 is a forum to share these issues, which might then lead to
21 a change in SAIK development.

22
23 Q. Thank you very much. That's very helpful.

24 A. Would you like me to show you --

25
26 Q. Go ahead.

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

30
31 Q. Yes, please, yes.

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

39
40 Here's the swab in the current kit. The current kit
41 has pre-labelled, pre-printed labels. All I've got to do
42 for the vulval swab is stick "Vulval swab" label on it. It
43 has a unique number that ties it to this particular
44 patient. So that's quick and easy, and for a patient who
45 is sitting there, really wanting to get changed or have
46 a shower or go home, those little changes in design, they
47 really matter, and we wouldn't have this if we didn't all

1 talk to each other.

2

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

6 A. Yes.

7

8 Q. Thank you, that's very helpful. And it's an easy
9 thing to introduce - a meeting like that. It doesn't cost
10 anything.

11 A. No. And it's so helpful.

12

13 Q. Yes.

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

17

18 Q. The doctors are two self-identifying doctors who are
19 very busy in this field; is that the idea?

20 A. Well, the idea is - so the regular people, so ECAV,
21 the training wing, sends their doctor, and New South Wales
22 Health sends its senior clinical advisers - one adult,
23 that's me, and one child. It may well be, between those
24 three people, you've actually got some adult and child
25 metro and rural representatives. But if you didn't, if,
26 for example, all of those were metro doctors and you wanted
27 a regional voice, then the committee would invite someone
28 from country Australia to join.

29

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

31

32 MR JONES: Q. Sorry, what was the stem and the tip of
33 that current swab made of?

34 A. This has got a plastic flexible shaft and a cotton
35 tip, which I believe is made of rayon.

36

37 Q. Rayon, thank you.

38 A. It's still called a cotton tip, even though it's not
39 cotton.

40

41 Q. And contrast that with Queensland, which is a wooden
42 stem and a pure cotton tip?

43 A. Yes. There is research to suggest that the rayon
44 gives you a better yield, although DNA scientists could
45 talk about that in far more detail than I can. But wearing
46 my doctor's hat, I worry a good deal about having a wooden
47 swab when you're inserting it into something like a rectum

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

8
9 Q. Thank you. Could we just go back to the terms
10 "patient centred", "trauma informed" and "culturally safe",
11 and could you just unpack those for us and how they then
12 inform the policies, procedures, methods and systems,
13 please?

14 A. Doctors are health care professionals. We have an
15 ethical obligation to our clients. It's our overriding
16 principle, and at the core of it is this dictum, "Don't
17 hurt people". And how not hurting people looks like in
18 a sexual assault setting involves putting the patient at
19 the centre of things. If the patient does not want to go
20 to police, we're not going to pressure them to go to
21 police, for example.

22
23 Being what we call trauma informed - we can reasonably
24 assume that most of our patients have had a recent highly
25 traumatic event and that that is going to be affecting them
26 in the here and now. For example, they may be distressed,
27 they may be tired, they may still be intoxicated, and you
28 have got to tailor your processes around their needs. So
29 you might need to slow things down. You might need to take
30 frequent breaks. Even if that means a slight delay in
31 taking your samples, that's what good trauma-informed
32 patient care looks like. And it means respecting their
33 decisions. If they don't want me to take anal swabs, I'm
34 not going to take them and I'm not going to pressure them.

35
36 So it's patient centred, it's trauma informed and
37 culturally safe, which is really referring to our
38 Aboriginal and Torres Strait Islander patients or clients,
39 that we are not behaving in a way that somehow denies their
40 Aboriginality or their experience as an Aboriginal person.
41 We know that a lot of Aboriginal people have issues with
42 trust in health and trust in police. An example of
43 culturally safe care is that we would respect that that is
44 their lived reality and that I need to earn their trust and
45 I need to respect their decision if they feel, for example,
46 that they in this instance couldn't feel safe enough to go
47 to police. Whatever I personally may want them to do,

1 culturally safe care is going to be about what is right for
2 them.

3
4 I do think, in the long run, what is good for the
5 patient is actually going to be good for the criminal
6 justice system. If you have a patient who feels respected
7 and cared for here at the beginning of their justice
8 journey, I think they are more likely to go the distance.
9 I think their wellbeing and their mental health is going to
10 be better, and I think they are going to be able to give
11 better, clearer evidence in court.

12
13 I know several New South Wales detectives have said to
14 me over the years that complainants who are supported by
15 a sexual assault service do better on the stand and, in
16 particular, do better under cross-examination. So it's
17 not - putting the patients first I don't think is going to
18 in any way jeopardise or compromise the justice system.
19 I actually think our needs dovetail.

20
21 Q. Tying those principles, then, to two examples, taking
22 a reference sample, for example, at another occasion by the
23 authorities - that is, the police - rather than at the same
24 time as a SAIK is performed, the examination is performed,
25 is that a patient-centred, trauma-informed, culturally safe
26 approach?

27 A. I think common sense says that it's going to be easier
28 for patients for things to be a one-stop shop. You know,
29 you come into my sexual assault service, I take all of the
30 samples from you that we know are going to be needed in
31 this case, and it's done and dusted.

32
33 Now, common sense is one thing. At the end of the
34 day, you probably have to go to patients, go to a victims
35 advocate group, and say, "What would you like?" I mean,
36 really, they determine what is - part of being patient
37 centred, they determine what is trauma informed here.

38
39 But I would argue the practice that occurs in most
40 jurisdictions, for us to do it all in one go, it's just
41 easier, you are not having to come back for a second time,
42 you are not having someone who is not a health care
43 professional taking your sample. There is no delay from
44 the lab's point of view between getting the SAIK and
45 getting the DNA reference sample. It all arrives at the
46 one time. There is no risk that police might think it's
47 already done, because commonsense would say, "Why didn't

1 the doctor do all of that?" So I guess it is seamless,
2 what's good for the patient is also good for the system.
3

4 I think they're quite - I think they're quite
5 acceptable to patients, even to children. I don't think
6 doing a buccal swab is any more traumatising to a child
7 than doing any other sort of throat swab. Remember,
8 a buccal swab can be collected by the patient themselves,
9 with guidance from the doctor, so if they are willing and
10 able, they can take their own cheek swab with me watching,
11 and then it's done.
12

13 Again, would you like to see what a buccal swab looks
14 like?
15

16 THE COMMISSIONER: Q. Yes, please.

17 A. I've got one here. It looks a little bit different to
18 the other swabs. It's a bit like a lollipop. It's a foam
19 padding on the end of the stick. It's literally rubbed
20 against one cheek and the other cheek, and then the
21 examiner presses that swab against - it's probably a little
22 bit hard to see here - there is a card here that you press
23 it against to transfer that material, and the buccal swab
24 is then thrown away and this is what will go to the lab.
25

26 So, look, it's simple, it's quick, it's easy, it's
27 done and dusted, and it's not one more thing that a victim
28 survivor, who has a lot going on, one more thing for them
29 to have to do. So I would strongly recommend it.
30

31 Q. Why has the issue ever arisen that a buccal swab would
32 not be taken at the time of the main examination?

33 A. I don't know the answer to that question. Queensland
34 seems to have gone its own way there, and I'm not really
35 sure why.
36

37 THE COMMISSIONER: Okay, I'm asking the wrong person.
38 I will find out, perhaps. Thanks.
39

40 MR JONES: Q. Is your understanding that Queensland is
41 the only jurisdiction that does that?

42 A. I believe it is just Queensland, yes.
43

44 Q. What about early evidence kits, could you explain what
45 they are and whether they would fit into a patient-centred,
46 trauma-informed and culturally safe approach to sexual
47 assault investigations, particularly in the context of how

1 large Queensland is, with so many parts that are regional
2 and rural?

3 A. I have a saying, time is DNA. You know, the more time
4 that passes, the more DNA you are losing. The reality is
5 that a patient may present to a facility that doesn't have
6 the capacity to do a full SAIK and they will be transferred
7 elsewhere; or you do have a forensic examiner on site, but
8 they are with another patient and there is a delay; or, in
9 a lot of places, this is secondary employment for your
10 doctors or nurses, they have a day job and then they are on
11 call overnight to come in and do this. So you present at
12 10 o'clock in the morning. You may be told, "Our doctor or
13 nurse can't come until 5 o'clock tonight."
14

15 There are lots of reasons that just perfectly
16 naturally occur why there might be a delay in doing a full
17 SAIK. And also there are some acts that are going to
18 remove DNA. A patient, you know, may be desperate to go to
19 the bathroom. We don't really want to tell those people,
20 "Oh, no, please, hold on until you have your SAIK. You're
21 going to lose all this evidence", or, you know, if it was
22 an oral assault, someone may need to eat or drink and they
23 have a very uncomfortably dry mouth, or they may need to
24 take some medications with some water, and we don't want to
25 be saying to them, "Oh, I would really rather you didn't do
26 that because you are going to lose this kind of potentially
27 important evidence."
28

29 So what is the solution to geography and to human
30 needs to do things like go to the bathroom? Well, one
31 solution is early evidence collection processes that are
32 perhaps - well, are definitely best done with some kind of
33 dedicated kit for the purpose. They are commonly called
34 early evidence kits, but in different states in Australia
35 each kit will have its own particular name. I think we
36 call them early evidence kits in New South Wales. I think
37 they are called preliminary forensic kits in WA.
38

39 What these kits do is they allow the patient to
40 self-collect some samples. So if it was an oral assault,
41 they would rinse and spit into a jar. If it was a vaginal
42 or anal assault, there would be a gauze wipe, you'd wipe
43 yourself, and there may be a urine sample which can either
44 be used for DNA testing or toxicology testing, depending on
45 what state you are in. So you have these little kits. The
46 patient can self-collect the samples and then is a little
47 bit freer to travel to another hospital or go to the

1 bathroom if they need to and know that, hopefully, we have
2 not lost any evidence in the process.

3
4 I think they're just kind. It's kind to the patient
5 to be able to offer this. It is good for them, and it is
6 good for the justice system, because otherwise there is
7 a real risk we're going to lose that evidence. I know in
8 New South Wales it's not uncommon for us to get a hit from
9 an early evidence kit, when there was no hit, DNA hit, from
10 the full SAIK done four or six hours later. So they work.

11
12 So far, there don't seem to have been any issues with
13 their acceptability to the courts in Australia, so I think
14 they are worth some serious thought.

15
16 Q. Just on that, do you, at these half-yearly meetings
17 that you have, receive data and feedback from the lab about
18 that?

19 A. Yes. There are two sort of sources of feedback to
20 doctors about what the lab are experiencing with the
21 samples that we send them. One is our regular, six-monthly
22 sampling guidelines meeting. And the other is, once
23 a month, the lab sends preliminary results from all of the
24 SAIKs from the last month to the Ministry of Health. So
25 I receive them at the Ministry of Health.

26
27 As I said, they've got the preliminary DNA results,
28 but what they also have is feedback. That might be
29 feedback about, "This swab could also have been considered
30 in this situation", or, "Your handwriting was terrible",
31 or - well, they're usually more polite than that, but,
32 "There was an issue with your handwriting", or, "This
33 wasn't sealed properly", or, "This slide wasn't made
34 properly", whatever.

35
36 We get that feedback. I collate it into the different
37 regions in New South Wales and I send that out to the
38 medical director of their sexual assault service, who can
39 then action it internally. They might review their own
40 processes, they might give a particular doctor or nurse
41 some additional training, but I leave it to them to action
42 it as they see best.

43
44 So regular six-monthly guidelines, we look at what has
45 been happening in the lab in the last six months, plus
46 monthly we're getting those month-by-month reports that I'm
47 sending out to the field.

1
2 THE COMMISSIONER: Q. So the lab sends you a summary of
3 results with information relevant to you every month?
4 A. Yes. For each SAIK kit, there will be a one-page
5 preliminary result, you know, "We got a hit from X, Y or Z
6 sample." That's not so much important in itself as the
7 other feedback about potential quality issues. I might
8 get - don't quote me, but I might get, I don't know, 70 of
9 these sheets one month, and I will divvy them up, I will
10 send Newcastle theirs, I will send Royal Prince Alfred
11 Hospital theirs, and then they will look in detail at their
12 own - let's say they've got 10 sheets, they will look at
13 their 10 sets of results and see if there is anything that
14 they could learn from them.

15
16 THE COMMISSIONER: Thank you very much.

17
18 MR JONES: I just note there that the results, as you
19 probably know, Commissioner, come back via the
20 forensic-register to the Queensland Police Service, not to
21 Queensland Health, in Queensland.

22
23 THE COMMISSIONER: Yes. Yes, that's right.

24
25 THE WITNESS: These results are not the final results, so
26 we're not going to be putting them into expert
27 certificates, we're not going to be giving testimony about
28 them. We don't give the results to the patients. They are
29 purely a quality assurance process.

30
31 Could I come back - let me know if I'm veering off
32 track.

33
34 THE COMMISSIONER: Q. Go ahead. What did you want to
35 raise?

36 A. With that six-monthly meeting, its predominant purpose
37 is to revise the document that we call our sampling
38 guidelines. From what has been given to me, it appears
39 that there is no equivalent document in Queensland, which
40 would be --

41
42 MR JONES: Q. I was just about to ask you some questions.

43 A. Okay, I will stop talking, then.

44
45 Q. What is a sample guideline?

46 A. Right. Well, in the other states and territories,
47 there is a state- or territory-specific document written

1 for the examiners to guide you about what to do. Like,
2 I mean, what samples do I actually take and where do I take
3 them from, under what time frames and in what manner?
4

5 For example, let's say the allegation is that some
6 fingers went into a vagina. It was two hours ago. Do
7 I swab for DNA if it's two hours? What if it was 16 hours
8 ago, do I still swab? Does it matter if the person has
9 washed or not washed? When we talk about a vulval swab,
10 I mean, the vulva covers a lot of geography. I mean, it's
11 everything in front of the hymen, so some bits of the vulva
12 are external, but some bits of the vulva are internal, and
13 that's going to have legal ramifications. So you need
14 a document that says, "Right, okay, with a history of
15 digital vaginal penetration, you are going to take this
16 swab if it's within this time frame and the patient hasn't
17 washed, and this is the area that you sample and this is
18 how you sample it." Otherwise, I don't know how people
19 decide what they are going to do, and I don't know how the
20 lab or the courts know exactly where the samples came from.
21

22 Everything's interdependent. What goes into your SAIK
23 kit, what goes into your sampling guidelines and your
24 training, they are all informed by each other. So, you
25 know, sampling guidelines - a SAIK kit, for example, has
26 got to have everything in it that you need in order for you
27 to follow the sampling guidelines, so they have to marry
28 up, and your training protocols have to reflect both of
29 those. Everything has got an interrelationship. It's
30 really hard to single one out and say, "Okay, make a SAIK
31 kit this way and you will be right", because the other two
32 things come into play.
33

34 Q. Of the material that was briefed to you, you could not
35 identify a sample guideline?

36 A. No. There was some guideline about toxicology, when
37 to take blood or urine, but I couldn't identify anything
38 that told you about DNA and other sort of biological
39 evidence testing.
40

41 Q. And the medical examination information form is not
42 something you would regard as a guideline?
43

44 THE COMMISSIONER: Q. Do you have a copy of it there,
45 Professor?

46 A. I'm just opening it now.
47

1 MR JONES: Q. It's [WIT.0043.0052.0001], and it should
2 be document 1.2 in your brief, Professor.

3 A. Yes, I have it in front of me. This is just a very
4 short, three-page document. It gives you space to write
5 down what samples you did take. It gives you space to
6 write a very short summary of the assault details and a few
7 other forensically relevant details, like, "Has the person
8 showered?", or whatever.

9
10 But what it doesn't do - let's say, for instance, on
11 page 1 you tick a box, "Have they cleaned their teeth?",
12 "yes" or "no". But what that doesn't tell you is how that
13 affects your choice of sample. If it was an oral assault
14 and they have cleaned their teeth, do I still collect an
15 oral sample or not?

16
17 Now, the lab, hopefully, will have from its own QA
18 processes - they will have data that shows if you have
19 washed your mouth or cleaned your teeth, the chances of
20 a yield are nil. So I'm going to have sampling guidelines
21 that say, hypothetically speaking in this example, "Don't
22 take an oral sample if the patient has cleaned their
23 teeth", and then in this form I would document, "They've
24 cleaned their teeth", tick, and that would explain why
25 I didn't take an oral sample. It sounds very convoluted.
26 Sorry about that.

27
28 Q. Noting that you obviously consider sample guidelines
29 important, if not vital --

30 A. Yes.

31
32 Q. -- do they take on greater importance in a place like
33 Queensland where all of our forensic physicians, save for
34 one, are based in Brisbane, thus the clinicians that are
35 performing these examinations regionally and rurally are
36 emergency doctors, it seems, by and large, without any
37 specific training?

38 A. A sampling guidelines document could certainly give
39 you guidance about, okay, "This is the story my patient has
40 told me. This is the history that I've got to work with.
41 What samples does this history suggest I would recommend to
42 the patient?", who of course may decline to have some or
43 all of them. So it gives you some information about, well,
44 what am I going to take in the first place, and also where
45 it's taken from. Again, what is a vulval swab will be
46 defined in your sampling guidelines. Now, the fewer cases
47 you do, the less training you have, the more useful that

1 document becomes.

2
3 But there are some important caveats here. You have
4 to know that the document exists. You have to be able to
5 get your hands on it easily. You have to have enough time,
6 when you're a busy emergency department doctor, to sit
7 down, refresh your memory or read this document for the
8 first time. You then have to kind of interpret it to the
9 patient who is in front of you, because this would be
10 a generic document, it covers all possible eventualities,
11 but in reality I've just got one person with a particular
12 history and I'm trying to figure out, well, how do I apply
13 that to this person?

14
15 As I said earlier, the sampling guidelines, the kit,
16 the training, they all work together, and if you don't have
17 any training, then your kit can be brilliant and your
18 sampling guidelines can be brilliant, and you still might
19 get very poor collection processes.

20
21 I do realise that in Queensland there is an advice
22 number that you can call. New South Wales has a similar
23 one for child cases; if you are doing a child sexual
24 assault, you can call a 1800 24 -hour number and it goes
25 straight through to a child protection physician, who will
26 give you advice. But you have to know that that number
27 exists, in the first place, to call. You have to be able
28 to find that number. You have to be willing to call the
29 number, and the advice that you get has to be the correct
30 advice.

31
32 So you kind of also need these processes. How often
33 are people calling our line, or, more to the point, how
34 often are people not calling our line and what are the
35 barriers, and what QA processes do we have to make sure
36 that the advice that we are giving is the right advice? So
37 I'm not saying - it is a useful step, but it has its
38 limitations and I don't think you could ever replace proper
39 training and retraining and re-credentialling. And by
40 proper training --

41
42 THE COMMISSIONER: Q. I have seen some information that
43 doctors who are on call at some hospital or some facility
44 are often reluctant to make themselves available to take
45 samples. Have you encountered that in New South Wales?

46 A. Yes. It's not, I think, so much that doctors are lazy
47 and don't want to get out of bed and come and see these

1 clients; it's that people who haven't been trained and
2 aren't comfortable and confident knowing what they are
3 doing, they really worry they are going to do something
4 wrong and they are going to cause a miscarriage of justice.
5 They are worried they are going to screw something up and
6 it's going to lead to a bad outcome in court, whether
7 that's somebody going free who shouldn't have or someone
8 being incarcerated who shouldn't have, and, you know, it's
9 a huge weight on people's shoulders.

10
11 It was definitely an issue in New South Wales. I can
12 remember when I started out, I got a one-day training that
13 was very patchy and not very practical, and the next thing
14 I knew, there I was in an emergency department with a real
15 patient, you know, no other training, no other onboarding,
16 and the nearest doctor to me who was also doing that work
17 was more than 100 kilometres away.

18
19 So we did two things. One is we offered a fairly
20 attractive remuneration. I think that - I cannot tell
21 a lie, that has definitely made a difference for regional
22 doctors. They all have busy practices during the day. If
23 you get up at 3 o'clock in the morning and come and spend
24 three hours with a patient, that has an impact on you, your
25 family and your practice the next day, and being
26 remunerated for that, it does help, and it sends a message
27 of respect as well. So there's no two ways about it, money
28 was a factor.

29
30 But I think the far bigger factor and the reason we
31 have dramatically increased our workforce since I started
32 back in 2008 is the training that we brought in. In 2012,
33 we had a big review of the sexual assault training. What
34 it went from was from this one-day face-to-face training
35 that we had been doing to what is now a full-blown graduate
36 certificate, so a year-long course.

37
38 The tack that we took - and I think we're unique in
39 Australia in doing this - is our course has what we call
40 competency-based assessment, which is terminology we take
41 from the Australian skills quality agency. That's the body
42 that accredits TAFE courses and universities and so on. So
43 competency based assessment, and I think this would equate
44 to what is called proficiency testing in the documents you
45 have sent me.

46
47 Proficiency testing is all about demonstrating that

1 you can do it. So at various stages in this graduate
2 certificate, you are asked, in as realistic a scenario as
3 we can come up with, to do the job, and you are marked off
4 against objective evidence that you did it properly. When
5 you took a vulval swab, did you take it from the right
6 place? When you took your vulval swab, did you do the
7 right steps to minimise any risk that it was contaminated?
8 When you took the vulval swab, were you careful with the
9 patient and checking in with them that they were still
10 consenting and that they were still okay?

11
12 We do exams and we will watch you do it. You will
13 write an expert certificate and you will go into a moot
14 court and you will present it, with two lawyers doing the
15 examination-in-chief and cross-examination, and they will
16 mark you about whether you were able to present your
17 evidence and defend your evidence.

18
19 So what you get at the end of that is some confidence.
20 If I were a candidate, I could walk away at the end of that
21 and go, "Do you know what, I can do it. I know I can do
22 it, because I just did it and they watched me." The people
23 who employ you can have some confidence that you can do it,
24 because you have been signed off as doing it. I think it
25 particularly made a huge difference to our sexual assault
26 nurse examiner workforce, because they could not only have
27 some confidence in themselves, but hospitals were more
28 willing to employ them, because they knew that they had or
29 were working towards this qualification that would mean
30 that you could have some assurance that they could do it
31 properly.

32
33 Q. Yes, that's why I asked you, because it occurred to me
34 that the problem we face in Queensland might be in large
35 part, certainly in a significant part, due to a lack of
36 confidence of a doctor in engaging in something that is
37 going to entangle the doctor in the legal system, which is
38 never a pleasant thing to do, particularly if you're
39 unfamiliar with how it all works. So what you have said is
40 very interesting.

41 A. That prompts me to say that that thought about having
42 to spend a day in court, if you're a busy rural GP - most
43 rural GPs are very passionate and committed to their
44 practice - if you cancel your patients for a day to go sit
45 around a courtroom, well, no-one's looking after your
46 patients and nobody is going to fill in for you for the
47 day, and there are no extra hours; you can't, like, squash

1 them in somewhere else. So they are going to miss out, and
2 they are my actual patients that I have a duty of care of,
3 care towards, that I am perhaps compromising their care in
4 order to go in and see some patient who I don't yet have
5 a duty of care of, because they are not my patient until
6 I turn up and accept them.

7
8 Q. Yes, I think we in Queensland have a mandatory system
9 for expert evidence in criminal trials, don't we, where you
10 have to do it by telephone unless there is a good reason
11 not to.

12 A. Wonderful.

13
14 Q. It's mandatory. Anyway, that's a digression. That's
15 something we have that you don't, at last.

16
17 MR JONES: Q. Just to close off on the --

18 A. It's all very well - sorry.

19
20 THE COMMISSIONER: Q. Go ahead.

21 A. A graduate certificate is a big commitment. It costs
22 New South Wales Health a lot of money to do, and it costs
23 the doctors and nurses who do it a significant time
24 commitment. If I had to pick something that really made it
25 work, it was Health deciding to fund having a medical
26 director in each of the sexual assault services around the
27 state.

28
29 Actually, let me take a step back. Decades ago,
30 Health decided that every local health district - I think
31 that's our equivalent of your HHS - you know, every HHS is
32 going to have a sexual assault service scattered, you know,
33 there will be one in Bourke and one in Broken Hill and all
34 across the state. Once you had that basic platform, it
35 then decided --

36
37 Q. Sorry, in each health district, you will have what,
38 a sexual assault what?

39 A. At least one sexual assault service. So in my
40 mid-north coast local health district, we have three -
41 Kempsey hospital, Port Macquarie hospital and Coffs
42 hospital - so you are never more than hour's drive away
43 from a sexual assault service.

44
45 The next step, though, was to give the local health
46 districts the funds to have a medical director in those
47 sexual assault services. Having that local person makes

1 a huge difference, because - you know, I live here in
2 Coffs Harbour, I know the community, I know my doctors.
3 I can recruit, I can support them. If they come and join
4 my service, they won't have the experience I have of being
5 utterly alone. They know they can call me for advice.
6 They know I will come in and supervise them. They know
7 I will do refresher simulation training with them as they
8 need.

9
10 So it was that political willpower to fund that. And
11 it's not just about my pay. It's the infrastructure around
12 it, that Health has policies that I can enact, and it has
13 training resources that I can send my doctors off to, like
14 the graduate certificate, and it has a support network for
15 me, that Health funds all of our medical directors to meet
16 twice a year and support each other and train each other.
17 So you wind up with this very inclusive network.

18
19 That's something that has taken decades to develop.
20 And I'm not saying, "Queensland should do what New South
21 Wales does", but I do think it is a model that is worth
22 looking at. If the alternative is a doctor who has never
23 done any sexual assault training, fussing around with a kit
24 that may not be fit for purpose, with no clear idea about
25 what to do - again, come back to the patient. How does the
26 patient feel at the centre of all of that, and is that
27 patient going to continue with their justice journey if
28 they have a bad experience right then?

29
30 THE COMMISSIONER: Yes.

31
32 MR JONES: Q. Just before I take you to your opinions on
33 Queensland, could you just step the Commissioner through
34 the - at line 245 of your report, you speak of the training
35 for clinicians and nurses in the US and the UK and
36 nationally in Australia. Could you just distil from that
37 the international and national training, please?

38 A. Yes. So, for example, the US Office of Justice has
39 a set of national training guidelines for doctors and
40 nurses doing sexual assault work. What you find when you
41 drill down in those guidelines, they always wind up being
42 very, very generic and then they will say, "Okay, this has
43 to be adapted for your local jurisdiction." So the first
44 thing is that whatever training you have, it's got to be
45 local, it has to be locally specific. It can't be so
46 generic that in fact it doesn't enable you to actually
47 practically do the nitty-gritty of the job.

1
2 So you have to have some sampling guidelines, you have
3 to have a kit that is processed, you have to have training
4 that is informed by those things, and you have to have
5 training that has some kind of proficiency testing. I've
6 got to walk away at the end of the day and think, "Okay,
7 I know I can do this."

8
9 And icing on the cake, perhaps, some sort of ownership
10 of this. I mean, somebody has to drive all of this, and
11 I think the only way you can do it in regional Queensland,
12 as with regional New South Wales, is you have got to have
13 someone like me - in little old Coffs Harbour, we're just
14 a small town, but we've still got a "me" as a medical
15 director, supporting my staff, training my staff, feeding
16 information back to the ministry, getting information from
17 the ministry down to me, and this kind of network. Does
18 that answer your question?

19
20 Q. Yes, thank you. So let's move then to your opinions
21 about Queensland. We will start at line 275. This is
22 about Queensland's practices. Are they, in your opinion,
23 patient centred, trauma informed and culturally safe?

24 A. I've got sort of two steps to answering that question.
25 Queensland Health has produced guidelines. It contains
26 these overarching principles for what a response is going
27 to look like. I have read those guidelines and I think
28 that broadly speaking they are trauma informed and they are
29 culturally safe.

30
31 What I can't comment on is how those principles get
32 enacted in practice, so I have no idea what it looks like
33 at the coalface with an actual patient, whether that is
34 actually trauma informed and culturally safe. But
35 certainly the principles that are outlined, on the whole,
36 are.

37
38 Some exceptions would be, one, not taking that
39 reference buccal sample at the time. I think that's
40 something that needs reviewing.

41
42 I think that not having an early evidence kit,
43 particularly in a huge state like Queensland, I think
44 that's not particularly patient informed.

45
46 A minor quibble with those health guidelines is they
47 say patients will be "encouraged to report to police", and

1 I would like to see something more neutral about, for
2 instance, that staff will explore the options.
3 Particularly encouraging an Aboriginal person to go to
4 police might not be culturally safe at all.

5
6 I know when it comes to a buccal swab, there is
7 a theoretical concern with the quality of the swab. If
8 there has been an oral assault, if you think there might be
9 sperm cells in the mouth, those sperm cells are a rich
10 source of DNA. There's a small possibility that you might
11 wind up with both patient and offender on your buccal swab.
12 This seems to happen vanishingly rarely in practice, if
13 indeed it happens at all. In those cases, you are going to
14 have to call the patient back, or the complainant back, and
15 you are going to have to take a second buccal swab. But
16 I think it makes way more sense to very, very, very
17 occasionally do that for one person than to call everyone
18 back for their buccal swab at a later stage.

19
20 Yes, broadly, those guidelines look right.

21
22 Thinking about early evidence collection processes
23 would be, I think, very important for distressed patients,
24 and thinking about taking those reference buccal swabs at
25 the time that you are taking all your other samples,
26 I think, is almost a no-brainer.

27
28 Q. Thank you. Mr Woolridge, would you bring up
29 [EXP.0005.0003.0001 at 0013], please. This is your report.
30 I'm not sure if it is on your screen, doctor.

31 A. Yes, I can see it.

32
33 Q. Are Queensland's practices regarding choice of samples
34 informed by evidence? And we're starting at line 325,
35 which is the page over, but stay on that page,
36 Mr Woolridge, please, because we'll use the diagram.

37 A. There aren't any sampling guidelines. I've had to
38 infer what samples are taken in Queensland from the
39 contents of your SAIK. So when I look at those --

40
41 Q. You are referring there to that form we discussed
42 earlier?

43 A. Yes, and I think there is a document that I think was
44 1.1, the configuration of SAIKs. I think that also has
45 a list of components.

46
47 MR JONES: Yes, that's with your SAIKs, Commissioner.

1 It's underneath, it looks like that.

2

3 THE COMMISSIONER: What is that we're looking at?

4

5 MR JONES: It is an FSS document, which is what goes into
6 the SAIKs.

7

8 THE COMMISSIONER: Yes.

9

10 MR JONES: Q. Sorry, Professor.

11 A. So I look at what goes into the SAIKs and I'm looking
12 at what's missing that you could think about adding. So
13 the first one is anal samples. In this picture, we've
14 chopped some poor person in half.

15

16 Q. Just one second. Could you zoom that picture up.
17 It's cut off on our screen, Professor, so you might just
18 need to tell us what the top, middle and bottom arrows are,
19 because we don't have the writing next to it?

20 A. Oh, you could dispense with the writing. It's not
21 terribly important. I will explain it. So just to orient
22 you, we have chopped a person in half. We have removed the
23 left half of their body and we're looking at them from the
24 side. On the right-hand side of that picture, that's
25 a butt cheek. On the left-hand side of the picture, that's
26 someone's tummy. Down the bottom, you have their thigh.
27 Up the top, you have got their chest.

28

29 What we've got here is the rectum, so that is where
30 the top arrow is pointing to. This is where stool is
31 stored just prior to defecation. The middle arrow is
32 pointing to the actual anal canal itself. There is an anal
33 sphincter at the end of your gut that relaxes to let poo
34 out and tightens to keep poo in, and that sphincter creates
35 its own little tunnel, if you like, called the anal canal.
36 Then on the outside, you have the perianal region, so these
37 are the wrinkly bits that you wipe afterwards.

38

39 Looking at your swabs, it looks like you take
40 a perianal swab and you take a rectal swab, but you don't
41 take a swab from the anal canal itself. I think this is
42 something that is worth considering, for a number of
43 reasons.

44

45 The most important is that somebody may put something,
46 a finger, a penis, an object that has been moistened with
47 something that might have DNA on it, like saliva - they may

1 attempt to put it in. They may get it into the anal canal
2 without getting it all the way into the rectum. So if you
3 are just sampling the rectum, but no material ever got that
4 far up, you are always going to get a negative sample and
5 you are going to miss what was in the anal canal. Yes,
6 hopefully you will have picked it up on your perianal swab,
7 on those wrinkly outside bits, but the wrinkly outside bits
8 are external. That is not going to be proof of
9 penetration.

10
11 So, something you could think about would be having
12 processes and sufficient swabs that you take all three
13 swabs, again with the client's permission. Someone might
14 be happy for you to take a perianal swab but not the
15 others. Any evidence is better than none; I'll take what
16 I can get. So that was the first thing that sort of popped
17 out at me.

18
19 Q. I will just get Mr Woolridge to turn over the page,
20 then.

21 A. The next thing that popped out at me is glass slides,
22 which I believe used to be in the kit and now aren't.
23 Again, may I show you a slide, so you can see what I'm
24 referring to is?

25
26 THE COMMISSIONER: Q. Yes, please.

27 A. I just might hold this up against a piece of
28 cardboard, so you can see it a little bit more easily.
29 Perhaps my hand might be better. What we have here is
30 literally a glass slide. I've labelled this one "Vulval
31 slide". What you do with it, if you have a swab that you
32 think might have sperm cells on it - it's very hard to do
33 backwards, but anyway - you can rub a little bit of it on
34 to the slide and then you can look at that slide under
35 a microscope and see sperm cells.

36
37 What is the utility of that? Well, a couple of
38 reasons. If you know you've got sperm cells on your slide,
39 you've got a really good chance that there is going to be
40 DNA on that swab. Sperm is a very rich source of DNA. So
41 when the lab is deciding, well, what tests will I run on
42 which samples first, you want to pick the sample that is
43 most likely to give you a result first. If I had something
44 on my low vaginal swab - sorry, a slide from my low vagina,
45 let's say that has sperm on it, but my high vaginal slide
46 doesn't have sperm on it. The lab is going to test my low
47 vaginal swab first, because they know from its slide that

1 it is highly likely to have results. So it affects
2 workflow in the lab.

3
4 The other thing it does is, even if you don't get DNA,
5 you found sperm cells, so that has some evidentiary value
6 of itself. And sperm cells degrade in a certain pattern
7 over time, so you can look at those sperm cells under
8 a microscope and say they were likely to have been
9 deposited one day ago, three days ago, whatever. So it's
10 got its own independent value.

11
12 At the moment, what happens in Queensland is the lab
13 gets the swab out and makes the slide in the laboratory.

14
15 In most other jurisdictions, the slide would be made
16 by the medical and forensic examiner at the time of the
17 consultation. The theory behind this was that it's
18 moister, it hasn't had a chance to dry out, and it is
19 easier to put material on. We now know from research that
20 that is not just a theory; it's actually true in the real
21 world. Slides made by doctors and nurses at the time have
22 more sperm cells on them and sperm cells in better quality
23 than swabs made back in the laboratory, which might be
24 days, weeks, months later. It does add a slight amount of
25 extra time, but it really is a very, very quick process.

26
27 My understanding - the reasons why Queensland stopped
28 doing it is a training issue. If I pull my slide back,
29 this slide is going to sit in a microscope; a little robot
30 arm is going to pop it under a microscope; the microscope
31 is going to take a picture; the computer is going to
32 analyse that picture. So it's all this automated stuff
33 before a human gets anywhere near it.

34
35 The microscope is only going to be looking at what's
36 in view. So if I made a swab, a slide, and I just wipe
37 stuff all over it, I'm going to have all of this material
38 that the microscope won't see. Why is that problematic?
39 Well, if there wasn't a whole lot of DNA on my swab to
40 begin with and I've just wiped it everywhere, maybe I've
41 just wiped off everything on to my slide. The slides can't
42 be tested for DNA. So if you had poorly made slides, you
43 may compromise the evidence from the swab. So I gather
44 there were some issues with poorly made slides, and the
45 decision was made to get rid of them.

46
47 I think, given that we now know that you get better

1 results if you do them properly at the time, I think you
2 could think about bringing them back, and there are some
3 solutions. One is proficiency-based testing or what we
4 would call competency-based assessment, so when I'm
5 training doctors and nurses, I'm watching them do this and
6 I'm marking them off as getting it right or getting it
7 wrong. But in the absence of that, I believe you can get
8 slides that actually have a circle marked on them for the
9 spot where you rub, which again would potentially alleviate
10 that problem. So that's something to think about.

11
12 MR JONES: Q. Just at the bottom of that page, I will
13 just quickly go through those two, because you have covered
14 them, I think, earlier, that is, the printed labels being
15 faster, avoiding illegible handwriting, but also prompting
16 the physician or nurse what to test?

17 A. Yes. Again, I will just show you quickly. Here's one
18 from us, and it's got a whole bunch of pre-labelled - I've
19 also got blank ones, so you've got plenty of flexibility.
20 But just pulling this out, it's straightaway a little
21 prompt to me to go, okay, these are the sorts of things
22 that I could collect, which if I were a doctor with a very
23 low caseload where it might be months since I last did it,
24 I think that's actually quite useful. I can't prove that,
25 there's no research; it's just my commonsense. Sorry, do
26 go on.

27
28 THE COMMISSIONER: Q. The label shows the location the
29 sample was taken, and what are the other things on the
30 label?

31 A. There is a number on the label that is a unique number
32 for this sexual assault kit. Each sexual assault kit will
33 be - this one is --

34
35 Q. Yes, I understand.

36 A. Yes, Y and a certain number. It means that I don't
37 need to write the patient's name, date of birth, today's
38 date, my name all over the swabs. I just have that --

39
40 THE COMMISSIONER: I see, yes. I understand now. Thanks.

41
42 MR JONES: Q. You have dealt with the collecting and
43 storage of buccal swabs?

44 A. Yes.

45
46 Q. And that is to take them to avoid a second episode of
47 sampling?

1 A. Yes.

2
3 Q. And to be sampled by a health care professional rather
4 than a police officer. I assume chances are that it will
5 be more successful if it is taken by a health professional,
6 but also you don't have a police agency taking it, which
7 may retraumatise a complainant?

8 A. Actually, anecdotally, the - let me take a step back.
9 You've got your buccal swab and it has to be pressed on to
10 a piece of paper, this special Whatman paper. If you don't
11 press hard enough or long enough or if you don't have your
12 swabs wet enough, you don't transfer enough material.
13 Anecdotally, police do get more material on to these cards
14 than doctors. But we got around that problem in New South
15 Wales by using what are called indicator cards. So when
16 I press into the circle here, it changes colour if there is
17 material successfully transferred. So you get this
18 immediate visual, "I have done it right", or, "No, I need
19 to collect a bit more from the cheek and press again." So
20 hopefully that problem will go away.

21
22 Q. Finally, could you just take us through your final
23 observation in that table with, over the page, the 70ml
24 specimen jar and the biohazard bag to store it in?

25 A. I apologise for writing "a pen in the kit". I wasn't
26 meaning that a specimen jar had anything to do with a pen.
27 I just think having a pen in the kit, rather than using
28 a pen that has been lying around the emergency department
29 that God knows who has touched and has God knows what DNA
30 on it - so I think a pen in the kit should be its own line.
31 I apologise for that.

32
33 Anyway, a specimen jar. The kits don't seem to have
34 them in. I think they are really useful things to have.
35 For example, if I found a hair in the vagina that isn't the
36 patient's hair, it's nice to have something to put it into,
37 or if the patient has a tampon in and I think that there
38 might be semen on that tampon, it's nice to have
39 a sealable, nice tight jar to put it in.

40
41 And I know that this Commission of Inquiry is not
42 looking at toxicology, but it does mean that you have
43 a sample jar that you could collect urine for toxicology
44 without having to open up a special kit. They are
45 inexpensive. It's easy to add. They've got a variety of
46 uses. And the only thing to be aware of when you are
47 thinking about cost is that if you are going to have

1 a specimen jar, you are going to need a biohazard bag to
2 put it in.

3
4 I'll just show you one. Biohazard bags - I have one
5 here - are sealable. So if you've got biological material
6 like a wet tampon in, it's not going to leak and
7 potentially infect anyone who picks it up. So if you are
8 going to include a specimen jar, you probably want to
9 include one of these, especially, you know, if you wound up
10 with a urine sample that leaked and it wasn't in
11 a biohazard bag, then (a) you have lost that material but
12 (b) you have then potentially contaminated whatever else
13 was in the kit that now has blood or whatever all over it.
14 So these are things that have cost implications that need
15 to be thought through.

16
17 Q. Now, in Queensland, the police officer who attends
18 with the patient who is having a SAIK performed would
19 provide evidence bags to collect clothing. The police are
20 not involved in "just in case" kits. Do you have an
21 opinion about whether clothing ought to still be collected
22 or not with "just in case" kits?

23 A. Yes, I do have an opinion, and I feel quite strongly
24 that they should, because I think there is considerable
25 evidentiary value in this. If we think that the majority
26 of assaults are going to be penis in vagina assaults,
27 vaginas are self-cleaning. What goes in is going to come
28 out. One of the places it's going to come out on is your
29 undies or your pants. So undies that you wore around the
30 time of the assault, the first pair that you put on after
31 the assault - the gusset of those undies can be DNA gold.

32
33 I don't understand why patients who aren't ready to go
34 to police yet should miss out on that. Particularly, you
35 know, you may have a patient who is so traumatised that
36 having swabs taken of their genitals is just a bridge too
37 far, but they might still be willing to give you the
38 undies. So just, again, it's patient centred, it's trauma
39 informed. Why should somebody miss out here?

40
41 Again, resources come into it. You have to have the
42 bags, you have to have them stored somewhere. Training
43 comes into it. People have got to know where the bags are.
44 People have to know how to use the bags - for instance, one
45 item of clothing per bag. And you are going to need some
46 spare clothes. If you are going to go around collecting
47 people's clothes, you have to give them something, so

1 that's a thing to consider. And also, clothing bags can be
2 quite bulky. Back at the lab end, where these "just in
3 case" kits are being stored, you may need a lot more
4 storage space if you are also going to collect clothing.

5
6 So I can see that there may have been a number of very
7 practical resource reasons for not doing it, but if we were
8 truly being patient centred, then we would do it.

9
10 Q. Do you do it in New South Wales, and where are they
11 stored?

12 A. When you have a medical and forensic examination in
13 New South Wales, it's the same whether you opt to release
14 immediately to police, whether you opt for what we call
15 temporary hospital storage and you call it just in case -
16 it's just terminology. We will take the same samples, we
17 will take the same clothes, we will do our toxicology.
18 It's exactly the same. You get the same evidence
19 collected. But with temporary hospital storage, we will
20 store it in our sexual assault services, the same way we
21 store our immediate release to police.

22
23 So we have evidence lockers, evidence fridges,
24 evidence freezers, with evidence registers. We will store
25 it. Anecdotally, we think that about 80 per cent of people
26 who initially chose temporary hospital storage do go on to
27 release to police. Not everyone's ready to make a big
28 decision like that in the middle of the night, but you give
29 them time and space to think things through. So, again,
30 I think it's good for the patient, puts them back in
31 control, and I think it's also good for the criminal
32 justice system, and we don't give a lesser service to
33 somebody who is going for temporary hospital storage.

34
35 I must say, though --

36
37 Q. How long do you keep them for?

38 A. Yes. I was about to say that we only store ours for
39 three months. Queensland stores theirs for 12 months.
40 Your system is better. And that was purely resourcing.
41 They take up a lot of space, and if you are a busy metro
42 service doing 250 SAIKs a year, space in your evidence
43 freezer becomes an issue.

44
45 In an ideal world, you know what, they would all get
46 processed. You would just process them all and release the
47 results to the police where it was appropriate and store

1 the results in a safe place where the police can't get to
2 them for everyone else, because why three months, why
3 12 months? Five years from now, someone might go, "Do you
4 know what, I'm ready to go to court now." Why do they get
5 to miss out on having that DNA evidence because after three
6 months or 12 months we chucked it?

7
8 THE COMMISSIONER: Q. In some jurisdictions they do
9 that. In West Virginia, I think, they process every SAIK
10 kit and then just deal with it accordingly.

11 A. Absolutely. If you take somebody who is 18 or
12 19 years old and not ready to go to police yet, perhaps has
13 a very kind of chaotic life at the moment, but when they
14 are 24 or 25, a little bit older, a little bit more mature,
15 they might be ready to go to police, and it seems to me
16 a shame that they would miss out. And particularly these
17 days when labs are so efficient, they are so automated,
18 they so robotised, it requires so much less staff time than
19 it did 10 years ago that I think it has now become
20 financially viable to start having this conversation.

21
22 MR JONES: Q. You finally conclude about this aspect of
23 the Queensland choice of samples informed by evidence - you
24 say:

25
26 *... I would suggest bringing Queensland*
27 *into accord with the rest of Australia by*
28 *using DNA-free SAIK components ...*
29

30 Can you explain what DNA-free SAIK components are, and is
31 it the case that Queensland is the only state that does not
32 have DNA-free components?

33 A. So "DNA-free" is exactly what it says on the tin, that
34 there has been a process that removes DNA from whatever it
35 is that is going through the process - your specimen jar,
36 your gloves, your swabs, your slides, whatever.

37
38 Yes, Queensland is the only jurisdiction that doesn't
39 have DNA-free equipment in its SAIK. Sometimes one state
40 goes its own way and it turns out that that state is right,
41 they are at the cutting edge, and sooner or later the other
42 states follow suit. So I don't want to argue that purely
43 because only Queensland does it, that by default means that
44 it's wrong. But if you are going to deviate from what
45 everybody else does, I think you have to have very clearly
46 articulated and defensible reason for doing that, and
47 I can't think what the reason would be, and nothing in the

1 documents that were provided to me gave a rationale for why
2 you would be so different to everybody else.

3
4 Q. What about special facilities and rooms and
5 decontamination kits - you are told that often accused are
6 sampled in watch-houses. What is your opinion on the rooms
7 that are used and procedures associated with cleaning, for
8 example, that you observed from the policies?

9 A. In an ideal world, we would all follow the guidelines
10 that the Royal College of Pathologists put out about
11 a room. It would be a dedicated room. It would be locked.
12 There would be a log any time anyone walked in or walked
13 out. You might even have reference samples of the DNA of
14 all of the people who regularly use that room. There will
15 be a clean before the room is used by cleaners who are
16 trained in how to do a DNA clean, which is different to how
17 to do an ordinary hospital clean.

18
19 Ordinary hospital cleans, all we want to do is kill
20 germs. With a DNA clean, we want to remove DNA, so it's
21 its own process. Those staff would be trained, they would
22 be credentialled, there would be a log of every time it is
23 cleaned. That's your all-singing, all-dancing forensic
24 suite, and not everybody has that. Even I don't have one
25 of those. I share a room in the ED, and if I were to go
26 into the police station to swab a person of interest there,
27 I certainly wouldn't have a dedicated room there, either.

28
29 So, that being reality, what can you do to reduce the
30 risk? There are a number of steps that can minimise the
31 risk of DNA contamination. By "DNA contamination", I mean
32 getting DNA somewhere where it ought not to be. For
33 example, we really don't want me sneezing my DNA all over
34 my swab, or we really don't want me accidentally moving
35 semen from someone's abdomen into their vagina as I examine
36 them. You can move DNA around. So you need to remove DNA,
37 where you can, from the surfaces you are going to touch and
38 have processes, when you are moving from one body region of
39 the patient to another, to make sure that you are not
40 moving DNA as you go.

41
42 This is where what are called DNA decontamination kits
43 come into their own. I hate that term, because it kind of
44 implies that it is a foolproof method to remove DNA, and
45 it's not. There isn't a foolproof method. All it is is
46 doing all the steps that you can do to make that risk as
47 little as possible.

1
2 So, separate to our SAIK kit, just to use New South
3 Wales for an example because it is the state I'm most
4 familiar with, we have our DNA decon kit. When I open it
5 up, it has a DNA-free sheet that I'm going to put over my
6 trolley, so whether I was using a desk at a watch-house or
7 whether I was using a trolley in an emergency department,
8 I could put a DNA-free sheet over it, DNA-free sheet over
9 the bed, DNA-free gown for me, DNA-free gown for the
10 patient, multiple sets of DNA-free gloves. So I'm wearing
11 two pairs of gloves throughout the collection process, and
12 every time I move from one body region to another or any
13 time I have reason to touch something that might be
14 contaminated, I just take my top pair off and pop a second
15 pair on. So you need lots of gloves if you are going to be
16 doing this.

17
18 So DNA decon kits I think are really, really helpful,
19 but again a kit on its own is useless without training.
20 How do I use it? How do I open a kit? You know, do I put
21 on my gown first, my gloves first? You know, whatever.
22 Where is it going to be stored? How am I going to find it?
23 What else needs to happen? I mean, I can't drape DNA-free
24 sheets over everything, so what else needs to happen in the
25 way of cleaning? There needs to be a protocol for
26 cleaning. For example, the switch on my examination light,
27 how does that get cleaned? So it's almost
28 a DNA-minimisation process that includes some cleaning
29 protocols and is much assisted by having a dedicated kit
30 like this. I think if it prevents one miscarriage of
31 justice, it's done its job.

32
33 Q. So Queensland doesn't have the decontamination kit, as
34 far as you have been able to ascertain from the material
35 provided to you?

36 A. Yes.

37
38 Q. Correct?

39 A. That's correct.

40
41 Q. There obviously are, though, Queensland Health
42 cleaning policies, and your conclusion is that they are up
43 to scratch?

44 A. Yes.

45
46 Q. Save for the approach taken at the Gold Coast?

47 A. From what I have understood Dr Lincoln's report to

1 say, they are not doing a DNA clean; they are doing
2 a terminal clean. A terminal clean is a clean that again
3 is designed - it's a hospital-based clean designed to kill
4 infectious diseases, kill microbes. So it looks like they
5 are not doing a DNA clean; they are doing a terminal clean
6 only. Now, I may have misunderstood the document or it may
7 not be complete, so I'm not going to swear to that. But it
8 looks like that's what they are doing. But the document
9 itself - wait up, what's it called? I will make sure I get
10 the name right. Not that one.

11
12 Q. This, as I understand it, is an extra procedure, is it
13 not, that Dr Lincoln has implemented above and beyond the
14 cleaning protocol, or not?

15 A. I couldn't work that out, whether they are just doing
16 a terminal clean or whether they are doing a terminal clean
17 and doing the room cleaning process described in the
18 Queensland Health Sexual Offences Medical Protocol.

19
20 Q. Just for the record, that's [FSS.0001.0019.1201]. We
21 don't need a copy of it brought up, thanks.

22 A. So, yes, that's a little unclear to me exactly what's
23 happening with the Gold Coast. I'm assuming that the
24 clinical forensic medical unit is doing this room cleaning
25 protocol, in the absence of them saying that they do
26 anything different. I think the Child Protection and
27 Forensic Medical Service - I think they explicitly said
28 that they don't do any DNA decon. And it's completely
29 unclear what sort of risk mitigation strategies, if any,
30 occur in the rest of Queensland.

31
32 Q. Thank you. Just before I leave this topic, you
33 provided an opinion about the Queensland kits not being DNA
34 free. Is it your opinion that they would not meet the
35 Australian Standard 18385:2017?

36 A. I haven't read that standard since it first came out.
37 My recollection is that it recommends that the components
38 of any - that any collection equipment that is going to be
39 used to send that sample to a lab for forensic DNA testing,
40 that that collection equipment be DNA free, is my
41 recollection of what those standards say.

42
43 Q. Would you expect the SAIK bag that has the equipment
44 in it to be sealed - that is, sealed prior to use?

45 A. Yes. I mean, if you are going to say it is DNA free
46 then you need to know that nobody has touched it, hasn't
47 stuck their hand in it or done anything. So you will need

1 some kind of packaging that you open up and then you tip it
2 out on to your DNA-free surface because you have bleached
3 it or because you have a DNA-free sheet on it. You tip it
4 out and you now know that everything on your work surface
5 is DNA free. The packaging is going to go straight into
6 the bin.

7
8 If you looked at that packaging and there was any kind
9 of issue with the integrity of the seal, you wouldn't use
10 that kit.

11
12 Q. And you have made passing observation of what
13 Dr Lincoln has found on kits to be foreign hair?

14 A. Yes. So separate to the issue - I mean, if your kits
15 aren't DNA free then they don't have to be sealed, because
16 they are not DNA free anyway, so, you know, who cares? But
17 if the manufacturing process is such that there is a risk
18 that you are going to contaminate your swabs, they're
19 contaminated before you even start because there is just no
20 thought to DNA, then that's a concern. So the photographs
21 that you sent me that had hair, I mean, if the hair shaft
22 has a bulb attached to it that's got DNA in it, that's just
23 not good enough in this day and age, and particularly in
24 the light of the Vincent report into the wrongful
25 conviction of Farah Jama. That was a DNA contamination
26 issue in Victoria that led to a person going to gaol who
27 did not commit that particular crime.

28
29 So we now know that it's a live issue. DNA testing is
30 so sensitive. I think we're talking about being able to
31 detect something like a billionth of a gram of DNA. You
32 can't see it. I can't look at my swabs and go, "Oh, yep,
33 this one's safe to use", so I need some kind of robust
34 processes so that I know that this sample - not
35 I personally, that the criminal justice system can have
36 some confidence that when a DNA hit comes back from the
37 lab, that that did not occur because of contamination in
38 some previous step before it got to the lab.

39
40 If you are talking about a stranger assault, it's
41 particularly important that that sample should be DNA free,
42 and then if it's not a stranger assault, if you know who
43 the person is, again, you need those processes in the room,
44 the examination room, to make sure that I'm not moving DNA
45 around from one body site to another.

46
47 Q. There are two final things you proffer an opinion on.

1 Firstly, Queensland practices regarding design and
2 composition of the SAIK, and you have given evidence about
3 it being a collaborative effort, but other than that you
4 can't go any further because it's data informed, as well as
5 locally informed.

6 A. Yes.

7
8 Q. Is that correct?

9 A. That's correct.

10
11 Q. And you formed the opinion that the practices
12 regarding training are not, in Queensland, informed by
13 evidence - that is, they ought to have proficiency testing,
14 statewide sampling guides and competency based assessment?

15 A. Mmm-hmm. Yes, I think summarises things. The thought
16 that you could have doctors doing that with no training or
17 having watched a 90-minute webinar - I think if patients
18 knew that's what they were getting, they would lose
19 confidence in the system. Patients deserve better than
20 that. We wouldn't let doctors with such little training do
21 other procedures, so why should this be different? If
22 anything, this should have even higher standards because
23 it's meeting the needs not only of patient care but of the
24 entire criminal justice system.

25
26 MR JONES: Thank you, Professor, those are my questions.
27 That's the evidence-in-chief, Commissioner.

28
29 THE COMMISSIONER: Thank you, Mr Jones.

30
31 Q. I just have one final question for my purposes. You
32 have your six-monthly meetings that you described, with all
33 those people?

34 A. Yes.

35
36 Q. Do you have meetings of any kind with colleagues in
37 other jurisdictions, in other states?

38 A. Not officially. There is an organisation - well,
39 there is an organisation called FAMSACA, Forensic and
40 Medical Sexual Assault Clinicians Australia, and for the
41 purpose of transparency, I should say that I'm currently
42 their president. We have a two-yearly conference, and at
43 every conference we have our updates from the field and the
44 representative from each state or territory will say what's
45 changed in their state or territory since the last
46 conference two years ago. That's been an invaluable source
47 of sharing information. It has definitely led to

1 practices. So, for example, after I went to that
2 conference - I wasn't president at the time - and heard
3 that Perth were testing for condom lubricant residues,
4 well, now we do that in New South Wales and --

5
6 Q. I see, yes.

7 A. So there is that. Also the Royal College of
8 Pathologists has this Faculty of Clinical Forensic
9 Medicine. So fellowship of that enables you to call
10 yourself a specialist in forensic medicine. Most people
11 working in the field are not going to go all the way up the
12 top of the tree to become fellows, but the Royal College of
13 Pathologists has an annual conference as well, and that's
14 a valuable way to informally hear what your colleagues are
15 doing.

16
17 THE COMMISSIONER: Thank you. Just excuse me a moment,
18 Professor.

19
20 MR JONES: Sorry, I have just been reminded that I said to
21 you I would give you a reference point. Dr Griffin at
22 paragraph 52 of his statement says that the slides were
23 utilised incorrectly and wasted evidence.

24
25 THE COMMISSIONER: Thanks, we'll get into that another
26 time.

27
28 MR JONES: That was in about 2010.

29
30 THE COMMISSIONER: Mr Hunter do you have any questions?

31
32 MR HUNTER: Just one very brief subject.

33
34 <EXAMINATION BY MR HUNTER:

35
36 MR HUNTER: Q. Professor, I act for the Queensland
37 Police Service. My question concerns the opinion expressed
38 by Dr Griffin in his statement, and I understand you have
39 seen Dr Griffin's statement?

40 A. I have.

41
42 Q. In particular, I'm talking about what he said at
43 paragraph 72 concerning reasons why Queensland Health
44 practitioners ought not be taking reference samples from
45 complainants, and he says:

46
47 *There can be some barriers to reference*

1 *sampling at the time of an examination.*
2 *The principal barrier is the risk of*
3 *collecting a "mixed sample"; that is, one*
4 *that contains two persons' DNA. This risk*
5 *is minimised or eliminated by waiting for*
6 *a period of a day or two before collecting.*
7

8 Do you have a view about that reason, expressed as a basis
9 for not taking a sample at the time of the examination?

10 A. Yes, I do. And I think I alluded to this earlier.
11 Yes, there is a possibility that if there is semen in the
12 mouth you are going to get a mixed sample. That semen
13 might be in the mouth from the assault or it may be from an
14 unrelated consensual act. So in theory, you could get
15 a mixed profile. Mixed profiles are generally bad for the
16 lab because the sample is useless. We need to know the
17 patient's DNA so we can subtract that from all our other
18 samples because, of course, the patient's DNA is going to
19 show up on everything. So if you have a mixed sample it
20 temporarily puts a stop to what the lab can do until we get
21 a pure sample.
22

23 But in the real world, mixed samples seem to be
24 extremely uncommon. So why would I have everyone come back
25 after a couple of days and get their buccal swab, when what
26 I could do is do everyone at the time, and in those rare
27 occasions, if ever, that you get a mixed sample, just call
28 that one person back. So I don't think the notion of mixed
29 samples is a show-stopper.
30

31 And if there was an oral assault - this is where
32 training and sampling guidelines come in - take your sample
33 for the offender's DNA first. So take your oral rinse or
34 take your mouth swab first, hopefully you will have removed
35 at least some of that DNA load, and then take your buccal
36 swab, and that would be an extra little step you could take
37 to make that buccal swab the best quality that you can.
38

39 Q. Of course, if there was no allegation of an oral
40 component to the assault, then there is no risk of
41 cross-contamination or getting a double profile in that
42 case, then, is there?

43 A. Well, there might be if the person had consensual
44 penile - let's say they had had sex, performed oral sex on
45 their boyfriend the day before and then were assaulted that
46 day, I mean, or - yes.
47

1 Q. Does it really matter, though, in terms of minimising
2 the risk of getting two profiles, whether you test on the
3 occasion when the forensic examination is done or whether
4 you do it two days later?
5 A. Yes, that's a really good point, unless you
6 specifically said to the patient, "Don't have oral sex
7 between now and getting your buccal swab", you could just
8 be getting exactly the same problem down the track, they
9 had consensual fellatio with their boyfriend on the morning
10 that they went into the police station to give their buccal
11 swab, now you have a mixed profile. So you never really
12 get rid of the risk and it just doesn't seem to happen very
13 often, so I think it's like the cart is in front of the
14 horse there.

15
16 MR HUNTER: Thank you.

17
18 THE COMMISSIONER: Anybody else?

19
20 MS COOPER: No questions.

21
22 THE COMMISSIONER: Mr Rice?

23
24 MR RICE: Just two things.

25
26 <EXAMINATION BY MR RICE:

27
28 MR RICE: Q. Professor Kramer, I represent Queensland
29 Health. You have spoken at some length about the
30 desirability of training and proficiency assessment. I'm
31 just having some difficulty reconciling what you say about
32 that with the summary you have given of the training
33 provided not only in New South Wales but elsewhere in
34 Australia. You might be able to clarify that for me. It
35 commences at page 24 and goes over to page 25 of your
36 report.

37 A. Give me two seconds, Mr Rice. Just give me a tick to
38 find the relevant pages.

39
40 Q. Take, for example, even the final box on page 24. You
41 see the heading there "Table 2"?

42 A. Yes, "Training elsewhere in Australia", yes.

43
44 Q. It commences a review of what happens around the
45 country?

46 A. Yes.

47

1 Q. For instance, we see the first entry pertaining to
2 your state, that the at least introductory training appears
3 to be by way of live webinars, which is rather similar to
4 what happens in Queensland, with no assessment, which is
5 also rather similar to what happens in Queensland, but I'm
6 having difficulty reconciling that with what you say about
7 proficiency assessments. So perhaps you could clarify?

8 A. Absolutely. So let's just talk about doctors and
9 nurses separately. Nurses have to do the full graduate
10 certificate with the proficiency training.

11
12 Doctors could just do those four 90-minute live
13 webinars and not do any proficiency testing. So they would
14 need, when they go and work for their local health
15 district, they will go to a credentialling process, they
16 would need to satisfy their credentialling committee that
17 they have the skills. So mostly what happens there is
18 doctors do that basic training and then they will go
19 locally and do some simulation-based training with their
20 local sexual assault service.

21
22 Having said that, the majority of doctors in New South
23 Wales have done the full graduate certificate. It's become
24 very uncommon for there to be doctors doing this work who
25 only did those webinars and didn't go on to do the full
26 graduate certificate. Does that clear things up?

27
28 Q. Well, that leaves the rest of the country.

29 A. Yes.

30
31 Q. Which you deal with on page 25, and again,
32 I appreciate this is a summary, but as I read it, there
33 isn't any proficiency assessment in any of those entries?

34 A. No, that is --

35
36 Q. Have I got it wrong?

37 A. No, that's my understanding as well. In South
38 Australia, when I did their course back in 2009, they did
39 have an assessment afterwards, but looking at their
40 training website this year, that seems to have gone. So
41 I think New South Wales is the only state doing proficiency
42 training, and I think this is one of the reasons why so
43 many examiners from other states enrol in the New South
44 Wales course. So we regularly have people from
45 particularly the eastern seaboard, so Tasmania, Victoria,
46 the ACT and Queensland, we will often have staff from those
47 states doing our graduate certificate, and it's free.

1
2 Q. Just to summarise, then, from what you say, New South
3 Wales has a form of proficiency testing with the graduate
4 certificate, so called. Save for that, am I right that you
5 have not identified any other form of proficiency testing
6 around the country in the review that you have done?

7 A. That's right. The only other people doing proficiency
8 testing that I can think of are New Zealand, has
9 a proficiency testing which is optional, and just to take
10 a step back, I mentioned earlier that you could become
11 a specialist in forensic medicine. You have your
12 fellowship through the Royal College of Pathologists, that
13 has a lot of testing along the way in that five-year
14 training program. It's only available to doctors. We're
15 talking very small numbers of people who have ever gone
16 through that, but somebody who did have their fellowship,
17 you could be confident that they had undergone proficiency
18 testing.

19
20 Q. There is just one other small point, and because it is
21 a small point I hesitate to raise it, but since you have,
22 I will, and it concerns the cleaning regime at the Gold
23 Coast.

24 A. Yes.

25
26 Q. Could I just bring up for you Dr Lincoln's statement.
27 It's [WIT.0043.0136.0001] I think.

28 A. Thank you, yes, I have it in front of me.

29
30 Q. Okay. The relevant page is page 48. In your evidence
31 you refer to the terminal clean, and I suspect you may have
32 been referring to paragraph 193. Could you just confirm
33 that for me?

34 A. I'm just scrolling down, Mr Rice. Just give me two
35 ticks. Yes, 193. So two of their facilities have
36 dedicated rooms and they are cleaned terminally, and there
37 is no mention of whether there is a DNA clean as well as
38 that or whether their terminal clean has been modified. So
39 I'm assuming that terminal cleaning is all that occurs.

40
41 Q. Could you look down to paragraph 197 and see if that
42 is relevant.

43 A. Yes, 197 goes on to say:

44
45 *... clinicians conduct a "pre-examination*
46 *surface DNA clean" by wiping down all*
47 *surfaces in the room with bleach ...*

1
2 So if they are doing that, then yes, that would be
3 satisfactory.
4

5 Q. You see underneath that, the doctor has referenced an
6 exhibit CL-94 which gives a description of the kind of
7 activity involved. We don't need to go to it.

8 A. Oh, I haven't seen CL-94 so I can't --
9

10 Q. We can look at that for ourselves. But does
11 paragraph 197 cause you to modify what your evidence is
12 about the terminal clean?

13 A. Yes. So they are doing a terminal clean, which is
14 neither here nor there because it doesn't affect your DNA,
15 and it looks like the individual clinician is also doing
16 their own DNA clean just prior to the examination, which
17 would be the same process that we use here in Coffs Harbour
18 for example. That's exactly what we do, and it accords
19 with the advice given in the Queensland Health Sexual
20 Offences Medical Protocol and it also accords I think with
21 the procedures that the Royal College of Pathologists used
22 to recommend in a document I think they have now - is now
23 no longer available. So, yes, I do - that is a very
24 longwinded way, as I think my way through, of saying, yes,
25 I would like to amend my earlier answer and say that the
26 Gold Coast does appear to be compliant with good practices
27 in its DNA cleaning.
28

29 MR RICE: Thank you. Commissioner, I have no other
30 questions, but since the subject of taking reference
31 samples has cropped up, we think there may have been some
32 relevant that has not come to light and I just want to draw
33 attention to it.
34

35 THE COMMISSIONER: Yes. Go ahead, Mr Rice. What is it?
36

37 MR RICE: I can do that after others have finished, it
38 need not detain Professor Kramer.
39

40 THE COMMISSIONER: You want to, in effect, inform me, is
41 that right? Thank you very much for that. All right,
42 anybody else?
43

44 MR HICKEY: No, thank you.
45

46 THE COMMISSIONER: Ms McKenzie?
47

1 MS MCKENZIE: No, thank you.
2
3 THE COMMISSIONER: Anyone else? Well, thank you very
4 much, Professor Kramer, that was extremely helpful.
5 Thank you for taking the time to do this.
6
7 THE WITNESS: Thank you for asking me, I'm honoured.
8
9 THE COMMISSIONER: Please feel free to turn off the link
10 as soon as you wish.
11
12 <THE WITNESS WITHDREW
13
14 THE COMMISSIONER: Yes, Mr Rice.
15
16 MR RICE: I can do that tomorrow.
17
18 THE COMMISSIONER: You can give it to Mr Jones and he will
19 make sure I see it as soon as practicable.
20
21 Mr Jones, is there anything else we need to do today?
22
23 MR JONES: No, thank you, Commissioner.
24
25 THE COMMISSIONER: Do your colleagues know what is
26 happening tomorrow?
27
28 MR JONES: I'm not sure. They do.
29
30 THE COMMISSIONER: You can deal with all of that after we
31 adjourn and you can tell me what's happening tomorrow, do
32 you know?
33
34 MR JONES: No, not yet.
35
36 THE COMMISSIONER: I will find out.
37
38 MR JONES: Oh, here we go, John Doherty, Michel Lok and
39 Andria Wyman-Clarke.
40
41 THE COMMISSIONER: Yes.
42
43 MS COOPER: Commissioner, just further to my earlier
44 application for leave to appear, I confirm that I now have
45 instructions as well for Mr Doherty and also Paul Csoban.
46
47 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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