ROYAL COMMISSION INTO DOMESTIC, FAMILY AND SEXUAL VIOLENCE

THE ROYAL COMMISSION INTO DOMESTIC, FAMILY AND SEXUAL VIOLENCE RECORDED PROCEEDINGS: THURSDAY, 21 NOVEMBER 2024

Natasha Stott Despoja AO:
Good morning everyone and welcome to Day 2 of the Royal Commission into Domestic, Family and Sexual Violence. I begin by acknowledging the traditional owners of the land on which we meet, the Kaurna people, and I pay my respects to the Elders past, present and emerging, and to any Elders from any communities who may be present or listening today. I ask Counsel Assisting to begin with an opening statement. Today's topic is sexual violence. Over to you.
Katie-Jane Orr:
Thank you, Commissioner. Today's public hearing is centred around sexual violence. Before we commence, I would like to reiterate the Commissioner's comments from yesterday and acknowledge anyone with lived experience of, or anyone who has been impacted by, sexual violence. Also, for anyone following on the live stream or watching the recording of this hearing later, please be aware that people may find the content of today's hearing graphic or distressing. If anyone wishes to seek support or advice, a list of support services can be found on the Royal Commission's website www.royalcommissiondfsv.sa.gov.au
Sexual violence is an important area of focus for the Royal Commission. It is included in the Commission's Terms of Reference and is not limited to sexual violence which occurs within domestic and family relationships. That means the Commission's focus extends to sexual violence occurring outside of an established intimate partner relationship. This could mean sexual violence between people who have only just met, or between people who do not know each other at all. This is consistent with the National Plan to End Violence Against Women and Children 2022-2032. The first action plan includes to improve action to prevent and address sexual violence and harassment in all settings. Sexual violence is an issue that has been receiving greater attention in recent years. The most recent statistics from the Australian Bureau of Statistics show that there has been an increase in reported sexual assault in almost all states and territories. In South Australia, the number of victim survivors of sexual assault increased from 1,816 victim survivors in 2022 to 2,014 victim survivors in 2023. This is an increase of 11 per cent in one year. This is a victimisation rate of 100 victim survivors per 100,000 persons in 2022, increased to 109 victim survivors per 100,000 persons in 2023. This data also shows that in South Australia most victims of sexual assault were female 86%, most knew the person who committed the assault against them 81 % and around a third, 32 % were aged between 10 and 17 years at the time of the incident. For the purposes of these statistics that I've just referred to, sexual assault is defined by the Australia and New Zealand Standard Offence Classification. It includes offences of incest, rape, unlawful sexual intercourse, assault with the intent to commit a sexual act, indecent assault, and threat of sexual assault. We know that sexual violence goes beyond these particular offences. It includes any sexual activity where a person is forced, coerced, or manipulated into undertaking that activity. It is generally categorised by a lack of free and voluntary consent. It does not have to be physical. It can include sexual harassment and intimidation. It also includes the many incidents of sexual violence that are never reported to police or to anyone. What this means is while

these statistics paint a picture of the prevalence of this type of violence in South Australia, they underestimate how often this violence is occurring. Given this, and given what the Commission has heard so far about the experiences of victim survivors of sexual violence, which I will come to in a moment, we have made the deliberate choice to devote a day of public hearings to this issue. There are, of course, many aspects to sexual violence and South Australia's response to it. But today we are focusing on aspects of the health response and the criminal justice response, what happens when sexual violence is reported and proceeds to police investigation and the justice system. We acknowledge that only a small proportion of sexual violence ever reaches the point of enlivening a health, police or justice response. We want to make it clear that the fact that today's focus is on the violence that reaches these systems does not mean that the victim survivors of sexual violence who do not report these crimes are being overlooked by this Royal Commission. We've been hearing their stories and receiving submissions about their experiences which are all being given careful consideration. Before I go on to outline the topics we will be hearing about today, I want to explain some language that we intend to use. The criminal justice system uses different titles when referring to a person who has experienced sexual violence. It uses complainant or alleged victim, terms which convey that a person has reported an experience of sexual violence, but that allegation may not, yet or ever, have been proved in the criminal justice system. Sometimes they are referred to as a witness, which conveys that the person is a witness to the crime that the state is trying to prosecute. Similarly, when a person is charged with criminal offending, the criminal justice system uses the term accused unless and until they are convicted of a crime. Defendant may also be used. But for today's purposes, and consistent with what we have used so far in our publications and during consultations, we will use the term victim-survivor and the term person who uses violence. We've chosen these terms because for today's purposes, the focus is not on whether or not someone was convicted of a crime. The focus is on the experiences of people after they report sexual violence. Language is important and we have been hearing that these terms, while we acknowledge are not preferred by all people, are appropriate and preferred by many. Turning to the topics we will hear about today. For today's hearings we are focusing on two discrete topics within the health and criminal justice responses to sexual violence. Both relate to a victim-survivor's experience of these systems. This morning's evidence will relate to the health response to sexual violence victims, victim survivors, and in particular forensic medical examinations in regional areas. The Royal Commission has heard that the health response to sexual violence varies significantly based on geographic location, and that in some instances, victim survivors in regional or remote locations cannot receive a forensic medical examination locally. We have heard that in many cases they have had to travel long distances to a metropolitan and location to undergo an examination. For anyone not familiar with what these examinations involve, today's witnesses will explain what they are, in very simple terms, the collection of evidence from a person who has experienced sexual violence. Our first witness is Ms Katrina Dee. Ms Dee is the current director of the Health and Recovery Trauma Safety Services, known as HaRTSS of the Women's and Children's Health Network in South Australia. As Director of HaRTSS, she oversees, among other things, Yarrow Place, which supports people who have experienced rape or sexual assault. Ms Dee

will explain what a health response to a victim survivor of sexual violence should look like. She will explain that part of the health response is this forensic medical examination that I have been speaking about, and she will explain what that examination involves. We will hear from her about how the system currently operates in the metropolitan area and we will hear from her about what is happening in regional areas. After Ms Dee, Detective Chief Superintendent Cath Hilliard will give evidence. She is a senior member of the South Australia Police and she will give us a policing perspective on this issue. She will tell us about the process undertaken by police when sexual violence is reported. She will explain that part of that is securing a health response, including a forensic medical examination. She will tell us about the impacts on policing in regional areas when a local health response is not available. The Royal Commission has also been told about a project which was commissioned in 2023 to address the health and forensic response for sexual violence victim survivors in regional areas. That project is being managed by SA Health's Rural Support Service. So to finish this morning's session we will hear from Ms Debbie Martin, Executive Director of the Rural Support Service who will tell us about this project. Then this afternoon we will turn to the prosecution of sexual violence offences and the experiences that victim survivors are having when a matter reaches the Court system. We know that criminal charges involving sexual violence can be extremely difficult to prosecute. Many matters never come to the attention of police. Even if a matter is reported to police, only a small percentage of cases proceed to trial with an even smaller percentage of those cases resulting in a conviction. This can be due to a number of factors, including the unwillingness of victim-survivors to give evidence due to fear, shame or distress, or a lack of corroborating evidence, because generally these types of offences do not have other witnesses to the acts of sexual violence. The detrimental impact that the criminal justice system can and has had on victim-survivors of sexual violence has been the subject of multiple inquiries and reviews across Australia, and the importance of a trauma-informed justice system response has been generally accepted. It is also reflected in the National Plan to End Violence Against Women. A number of legislative amendments have been made in South Australia over the last 10 years, all directed at improving victim-survivor experiences in the courtroom. system. But despite these provisions, reports to the Royal Commission about victim-survivors' experiences in the lead-up to and during a criminal trial have been almost universally negative. We have heard references to victim blaming, shame, the victim-survivor feeling like they are on trial, a lack of empathy from various different professionals working in the criminal justice system and the process being re-traumatising. It is important to pause and acknowledge that in Australia we have an adversarial system of law where two parties present a case, one for, one against. The judge or jury who decides the issues is impartial and makes their findings based on the evidence presented to them. Also, in Australia, it is a fundamental principle of the criminal law that for a person to be convicted of a criminal offence, the prosecution must prove the offence beyond reasonable doubt. Another fundamental principle, directly linked to this burden of proof, is that a person accused of committing a criminal offence has a right to silence, and it is for the prosecution to prove the case against them. These principles underpin our entire criminal justice system and find their roots in the laws of the United Kingdom. They are important. They afford fundamental rights to

individuals who are accused of a criminal offence and they are designed to protect those individuals from miscarriages of justice against them. It is not the intent of this afternoon's public hearing to review the merits of this adversarial system of law. What we intend to do is to examine how, working within and respecting the existing structures of the adversarial system, this system could better meet the needs of a person who has experienced violence. The first witness we will hear from this afternoon is Ms Sarah Quick, who is the Victims of Crime Commissioner in South Australia. She will explain what she is hearing from victim survivors of sexual offences in relation to their experiences of the criminal justice system. Ms Quick will also explain to us about what sexual assault myths are and the negative impacts that they can have on victim survivors and on society more broadly. We will then hear from Ms Siobhan Blake who is a Chief Crown Prosecutor from the Crown Prosecution Service of England and Wales. We will have a long lunch break today and the afternoon session will commence at 3.15pm SA time to allow for time differences for this final witness who is in England. In recent times, together with the police forces across England and Wales, the Crown Prosecution Service have significantly changed the way in which sexual violence matters are investigated and prosecuted within an adversarial system. We will hear about what the Crown Prosecution Service has done in partnership with police and the impact that it seems to have had on these investigations, prosecutions and on victim-survivors' experiences of the system. Thank you, Commissioner. I call Katrina Dee.

Witness:
Katrina Dee, Director, Health and Recovery Trauma Safety Services

Kerryn Hawkes:
Do you truly and solemnly affirm that the evidence you shall give will be the truth, the whole truth, and nothing but the truth? I do truly and solemnly affirm.
Katrina Dee:
I do solemnly declare.
Kerryn Hawkes:
Thank you.
Katrina Dee:
Thank you.
Katie-Jane Orr:
Thank you, Ms Dee, you are the current Director of Health and Recovery Trauma Safety Services for the Women's and Children's Health Network in South Australia, is that correct? And that's abbreviated to HaRTSS. How long have you been in that role?
Katrina Dee:
I've been the Director of HaRTSS, it was formerly Youth and Women's Safety and Well-Being Division, so it's had a name change, so that time in total is probably around 2016 to current.
Katie-Jane Orr:
And as the Director of HaRTSS, what do you oversee?
Katrina Dee:
So I oversee Yarrow Place Rape and Sexual Assault Service, Metropolitan Youth

Health and Cedar Domestic and Family Violence Health Services. All of those services provide direct service delivery to people who have experienced interpersonal violence, sexual violence, domestic and family violence. And I also oversee some of the work that we do in relation to enhancing the health care response to those issues.

Katrina Dee:
All right.

Katie-Jane Orr:
I'm going to ask you a bit more about Yarrow Place in particular. How long have you been involved with Yarrow Place?

Katrina Dee:
So I started with Yarrow Place in 1995 and was in different roles, including the manager from 2010 to 2016. And then I was in the director role.

Katie-Jane Orr:
So can you tell us a bit more about Yarrow Place, please?

Katrina Dee:
So Yarrow Place is a metropolitan-based health service for people 16 years and over who've experienced a sexual assault. We do have some youth programmes for 12 to 24 year olds, however they are for young people referred in from the child protection system. Predominantly we are providing responses to people experiencing assault post 16 years of age, and that would include counselling services, healthcare responses including medical examinations and the provision of forensic medicals as well. We do group work and we also do training and community education.

Katie-Jane Orr:
I want to ask you today about the health response when someone presents and says that they have been sexually assaulted, but I'll get you to explain some background first. Generally speaking, how do sexual assault victim survivors get to Yarrow Place?

Katrina Dee:
So Yarrow Place has a 1-800 number that's answered 24-7 and it's answered by Yarrow Place staff. So anyone can contact that number. We also have a website as well. People can directly call or we may get referrals from police, GPs, school counsellors, a range of other service providers may contact to refer somebody in.

Katie-Jane Orr:
Do you get walk-ins?

Katrina Dee:
We do get walk-ins. So we have a service in North Adelaide so people can come in and we would then triage that person and we triage any calls and that would be by a professional social worker.

Katie-Jane Orr:
So that was my next question. Once someone contacts, either they present by walking in or they contact that phone line, so what happens next?

Katrina Dee:
So they would be speaking to a social worker who would do an assessment around how recent the assault was. That will influence what services are provided. They will also do, as part of that discussion with the person, a safety assessment. So that's about physical safety as well as psychological safety. So we don't make any

assumptions that the person's calling from a safe space. So we do that assessment. We then look at how recent the assault was. A recent assault, we would be talking to people about their legal rights and options, their medical rights and options and counselling rights and options and depending on what they want to have happen would influence what service may happen next.

Katie-Jane Orr:
And so you mentioned their medical options. What do they include?

Katrina Dee:
So, sexual assault is a health issue and it has significant health consequences so we want to start by addressing those in the first instance and part of a health examination for things like injury, STIs, risk of pregnancy or risk of self-harm or suicide, we can also offer people during that examination to collect evidence which becomes part of the forensic examination.

Katie-Jane Orr:
And what happens if that forensic examination is going to take place?

Katrina Dee:
So we have forensic consultants available and that may be doctors or nurses, we would organise for one of them to be available usually within a few hours of that request and the social worker would also be present whilst that examination was undertaken.

Katie-Jane Orr:
and I am going to ask you more about those examinations, but do you arrange any follow-up with the people that present to Yarrow Place?

Katrina Dee:
Absolutely, so in terms of the medical care, once we do that examination, we will take swabs for testing around health issues, such as STIs or pregnancy or assessment of injury. So we may ask them to come back for results and to have a discussion about that, just as you would with a GP. We would also, if they have a GP, offer them the option to write to the GP or contact the GP and do a warm connection around, we've seen this person, these are the health issues, these are the likely health issues that may come up, just so they've got a soft transition to their ongoing health care with GPs etc.

Katie-Jane Orr:
and I think you mentioned counselling options as well.

Katrina Dee:
Yes, so people will be given that option and allocated to a social worker who will make an appointment to see them.

Katie-Jane Orr:
Thank you. I want to ask you now about forensic medical examinations. So can you tell us what a forensic medical examination is?

Katrina Dee:
Okay, so it is part of the health check, so as I've said, we prioritise health first, and we want to see people as soon as possible after a sexual assault, because we want to address those health concerns as soon as we can. We also, the collection of forensic evidence needs to be done within a certain time frame, otherwise we could lose some of that potential evidence. So as delicately as we can, we are attending to the body as a crime scene, in effect. So we, in a very trauma responsive way, are

taking swabs from the body such as body samples, could be urine, could be saliva, semen, hair samples, that can be tested to help support what has happened. We also might be documenting injury, bruising or strangulation in relation to supporting, again, what the victim has told us or is telling the police in relation to what's happened.

Katie-Jane Orr:
And does it sometimes include taking swabs of a person's body?

Katrina Dee:
Yes, it does, yes.

Katie-Jane Orr:
And sometimes collecting clothing that they might be wearing?

Katrina Dee:
Yes, it does.

Katie-Jane Orr:
Thank you and then that evidence is potentially used later in criminal proceedings if someone is charged.

Katrina Dee:
That's right.

Katie-Jane Orr:
Who can conduct a forensic medical examination?

Katrina Dee:
So a registered nurse or a doctor can conduct a forensic examination. In Yarrow Place, we have, what we'd say, forensic consultants, so they are doctors and nurses with additional training. That additional training enables them more expertise, I guess is the best way to explain it, into the criminal justice process. So you can have a doctor or nurse who's not trained conduct a forensic examination but when it comes to court they may not be able to interpret what they have collected. The forensic consultants have the capacity to interpret a bruise for example and so that's the difference.

Katie-Jane Orr:
So I understand that you're saying there's a distinction between the person who may collect the evidence and then the person who may give an opinion about what that evidence means.

Katrina Dee:
That's right.

Katie-Jane Orr:
And it may be the same person.

Katrina Dee:
That's exactly right. But it doesn't have to be. That's right.

Katie-Jane Orr:
So that first category of people that are collecting the evidence, you said a registered nurse or doctor can conduct that examination. Is any training required to conduct that procedure?

Katrina Dee:
It's not required but it is certainly preferred. Sexual assault is a very traumatic experience for the victim survivor and we would prefer that any nurse or doctor has had some training in both how to respond to that trauma experience as well as the

collection of the forensic evidence.

Katie-Jane Orr:

So you told us about the time frame for examinations and how ideally it should be done as soon as possible and that's from a therapeutic health reason but also from a forensic evidence perspective. Is there a cut off after which a forensic medical examination will not be conducted?

Katrina Dee:

I think they tend to say 10 days is a point at which you may not be able to find some evidence. However, we would still say a health check is really required, that has no cut-off point. And there are still some injuries, for example bruising, that may still be present, as strangulation may still need an assessment even 10 days later, so there may still be some forensic components that are required. So it's a loose cut-off point, I wouldn't have it as a hard and fast and I think every situation needs to be assessed on what the victim survivor is telling us what happened.

Katie-Jane Orr:

Is a report to police always needed for a forensic medical examination to be conducted?

Katrina Dee:

Not in metropolitan Adelaide, so we will, when we talk to people about their medical rights and options, we talk about the forensic rights and options. They have the right to a forensic that is then given to the police if they're consenting to have that happen. They also have the right to have a forensic, which is what we call a just in case, so we collect the samples and we store them for up to 12 months and nothing is ever released to police without consent of the victim. That's in metropolitan area.

Katie-Jane Orr:

And it's the idea that a person can think about what they want to do in that time.

Katrina Dee:

That's right.

Katie-Jane Orr:

Do you have any statistics around how many of the forensic procedures conducted by Yarrow Place are these just-in-case examinations?

Katrina Dee:

I think it's around 40%, so it's a significant amount where people may even come to our service initially having reported, they're thinking yes they'll go ahead and when we talk to them about the forensic examination itself and what it may mean, they then may want more time to think about what they want to do. But they'll still have the forensic, they just want a bit more time to think about the process around police investigation and legal things.

Katie-Jane Orr:

Is it the case that some victim survivors do choose to report to police afterwards?

Katrina Dee:

Yes.

Katie-Jane Orr:

I just want to ask you a bit more about the sort of procedure, like the practise of what happens when someone presents to Yarrow Place or rings the phone line after a sexual assault and I'm talking about the metro, metropolitan area. So in practise, in the metropolitan area, who is called when a forensic medical examination is needed?

And then you mentioned this before, but I wonder if you could just explain a bit more about those doctors that you have available.

Katrina Dee:

Yeah, so Yarrow Place, in its, what I'd say, so, business hours, I guess Monday to Friday 9 to 5, we have forensic consultants, so they are doctors with additional forensic training, and we have forensic nurses, nurses with additional forensic training. It's quite extensive training, who are available to provide a service during those business hours. Because we're a 24-hour service, we then have an on-call system as well. Now, the doctors and nurses in the business hours service also are available after hours, but because it's a lot of time to cover and a small number of staff, we also have casual on-call doctors and nurses. And some of those have had additional training, they would have had training from Yarrow Place and some may have gone on to do even further additional training through the university, however it's not a requirement for them to do that. Often, the doctors who are in the business hours daytime service have been doctors who came in as casuals after hours. So over years they're developing up their skill, doing additional training and then they work in the daytime service. So it's also succession plans for the service around having that availability.

Katie-Jane Orr:

And you mentioned before a call is triaged. You spoke about the things that are considered in that phone call. And then the forensic medical examination will be booked through that service once Yarrow Place takes that call and triages the response.

Katrina Dee:

That's correct and usually within a couple of hours of that request coming through if it's in daytime hours, it'll be Pennington Terrace, and if it's after hours it's in the forensic suite at the Royal Adelaide in the ED department. We also use that forensic suite in the ED department if there are injuries that need to be attended to because the ED section is right next to us there.

Katie-Jane Orr:

Thank you. And we talked earlier about the distinction between practitioners, medical practitioners who are taking samples versus the experts, if I can call them that, who you've described with the extra training. This pool of GPs or nurses that are on call, are they the ones that are taking the samples as opposed to giving the opinion?

Katrina Dee:

for Yarrow Place?

Katie-Jane Orr:

Yeah.

Katrina Dee:

It would vary on their level of expertise and whether the Court was accepting their level of experience in relation to their experience.

Katie-Jane Orr:

So the training and the expertise of those on-call doctors varies.

Katrina Dee:

It's the length of time that they have been doing the work as well.

Katie-Jane Orr:

I want to ask you about what's happening in regional and remote areas. I just want to

ask about the current situation and then we can talk about some background and some history to that. So currently is there the same access to the sexual assault health response and to forensic medical examinations in regional or remote areas?

Katrina Dee:

There isn't the same access to the forensic response and also maybe even to the medical examinations. There are counselling positions that are employed by Yarrow Place in regional areas, so there's access to counselling, however access to forensics isn't as consistent in regional.

Katie-Jane Orr:

And so what's happening on the ground?

Katrina Dee:

So, if people are presenting to regional hospitals for a sexual assault examination or a forensic or police are making a referral for a forensic, a number of those, in fact probably most of those at the moment are coming down to Yarrow Place to have a forensic medical examination conducted.

Katie-Jane Orr:

So that can involve travel from a regional location to the city?

Katrina Dee:

It does.

Katie-Jane Orr:

And based on what you said earlier, it should be done as soon as possible? So are these victim-survivors being transported to Adelaide very soon after they report sexual violence against them?

Katrina Dee:

There are delays in the transportation. Police have been transporting victim-survivors down, and that poses some risks for police around not having their police officers locally based and going over shift and things like that. In terms of, however, it's not a pleasant experience for the victim-survivor to be transported. And even though police are very kind and supportive, It's also, you know, being transported by police, which is also sometimes uncomfortable. There are... for some of the victim-survivors, these delays are many hours because they're coming from quite long distances. And I'm aware of circumstances, even in the last 12 months, where people have either transported themselves... One victim-survivor came by bus for a very long trip. A father brought his daughter down. and the trips are quite long that they need to stay overnight in order to then be safely travelling back the next day.

Katie-Jane Orr:

I understand that because of the preservation of evidence, victim-survivors are often asked not to change, not to wash, is that correct?

Katrina Dee:

Well we hope they're given the option to not wash or to preserve evidence and for many victim survivors if they want to report to the police they are going to want to preserve their evidence so they don't necessarily change clothing or wash. Sometimes if there has been an assault where there may be mouth swabs required that might even delay for some people eating or drinking until a mouth rinse can be done. So the impact on the victim-survivor is really significant around leaving that traumatic content on their bodies.

Katie-Jane Orr:
What are some of the other, it's probably obvious, but what are some of the other effects on victim survivors of having to travel to the city?
Katrina Dee:
We're taking them out of their community, their support system. And so sometimes I think police have offered to drive but a victim will say I'd rather go with a friend or family member and that's because they need that support. It's a really traumatic experience so I think it's about where people feel safe is where they need to have a service and if they feel safe in their community around the people that know them and support them, that's where we would want them to have a response.
Katie-Jane Orr:
If these victim survivors, I'm talking about this situation that you've explained, if they don't travel to Adelaide, is it the case that a forensic medical examination is not conducted?
Katrina Dee:
That is the case, that's my understanding.They need to come to Adelaide to have it done.
Katie-Jane Orr:
And obviously we're talking about a situation where it's not available and so the person has to make the decision whether they travel or whether they don't have it. So you've explained to us that the forensic medical response is part of the medical response. Are victim survivors getting that medical response locally?
Katrina Dee:
I don't have data on how many medical responses regional have provided, but I do know Yarrow Place has provided just medical responses to regional people in the last couple of weeks. So there are circumstances where they are coming to travel for that health response.
Katie-Jane Orr:
If police for whatever reason are not transporting the victim survivor, you mentioned a bus, you also mentioned staying in hotels, who's absorbing the cost of that?
Katrina Dee:
Sometimes a victim survivor and we have on occasion had the Commissioner for Victims' Rights, so Sarah Quick, has supported with some costs associated with hotels or where there's other incidentals associated with that.
Katie-Jane Orr:
and you explained the just-in-case examinations that are being conducted by Yarrow Place, what's happening with those in regional or remote areas?
Katrina Dee:
I don't believe they're occurring at all in regional areas.
Katie-Jane Orr:
Do you know why?
Katrina Dee:
I think in regional areas the referral comes from SAPOL for a forensic, so it may be that the expectation is that the kit is then handed over to police. Apart from that, I'm not sure why it couldn't be looked into as an option.
Katie-Jane Orr:
Other than the general there is no service available, that is the primary issue.

Katrina Dee:
That's true.
Katie-Jane Orr:
I want to ask you about some data and I can give you the statistics rather than you having to recall them if you would like.
Katrina Dee:
Yes.
Katie-Jane Orr:
And these numbers, just to be clear, came from information that you and SA Health has provided to the Royal Commission. I understand that you don't have, if I asked you about how many procedures are being conducted in regional or remote areas, I understand we don't have that data.
Katrina Dee:
No, the data I have would only be Yarrow Place data because they report to me, but regionally that would come from the local health networks.
Katie-Jane Orr:
But in terms of the procedures that Yarrow Place is conducting... Is it correct that between January 2023 and July 2024, so this year, inclusive, Yarrow Place conducted 350 forensic procedures and of those 75 were from regional areas? That's correct. And you've also mentioned that there were health checks being conducted in some occasions? That's right. and recorded there were eight health checks were completed when the regional local health network was not able to provide the service. Has the situation always been like this?
Katrina Dee:
No.
Katie-Jane Orr:
Can you give us some background to this?
Katrina Dee:
Okay. So my understanding in around 2007, a victim survivor presented at one of the regional hospitals for a health check and forensic, they were unable to have a forensic. That resulted in their matter not being prosecuted. That formal complaint was made to the Health and Community Services Complaints Commissioner. That occurred in 2007, I think the following year the complaint was made, and the Commissioner investigated the complaint, and that led to a more in-depth investigation of sexual assault, health care and forensics across Country Health at the time. The Commissioner, through that investigation, then made some directives. One of those directives was that the health response and forensic manual that Yarrow Place has was to be placed in all of the country health hospitals, which was around 60 or more, and that the Chief Medical Officer was to ensure that any paid medical staff or any contracted medical staff were aware of that manual, that they were aware that there was a responsibility to provide a healthcare response in forensic and that any new medical officers coming on board, that was to be in their induction. There was also to be a procedure written and that the Health Complaints Commissioner was going to be monitoring all of that. In 2010 there was a high-level meeting between Country Health, the CE of Health, the CEO of Women's and Children's Health Network, Police Commissioner and the Victims' Rights Commissioner and I attended that meeting as Manager of Yarrow Place and that

was to discuss, I guess, these recommendations and to look at how do we make this workable. And one of the issues was that all of those hospitals, all having the manual, was going to be challenging for police in terms of taking a victim-survivor and working out which hospital am I going to in this particular region and would that hospital actually have a doctor available because some of them are really small. So the decision was to have four general hospitals, the largest hospitals, become the hub. So that was Berri, Mount Gambier, Port Lincoln and Whyalla. So those hospitals would become the hub. And the smaller hospitals are like the spokes, so now they call it the hub and spoke model. Where I was relevant to that meeting was that Yarrow Place was asked to provide some training and support to doctors to provide the healthcare response and the forensics. So we had already been doing a that in the regions even back as far as 2003 and so this was just building on some work that we were already doing and we started to provide that training.

Katie-Jane Orr:

So those hubs, those big hospitals, was the idea that they would have medical practitioners trained and available to conduct the forensic medical examinations? That's right. And I'm sorry if you said it, but was there an agreement to proceed with this model in around 2010, 2011?

Katrina Dee:

That is my understanding, that it had gone to portfolio exec meeting and an agreement had come out of that. However, at that time I was the manager, so I wasn't at those type of meetings and I didn't get minutes of those meetings.

Katie-Jane Orr:

and Yarrow Place was to provide training to the regional practitioners?

Katrina Dee:

That's right.

Katie-Jane Orr:

Are you able to give us an idea of what that training involved?

Katrina Dee:

I'll also just add, a little bit after that, 2012, we were given some funding from Attorney General's Department to assist with some of the training in the regional areas, but also to put counsellors in those hubs. So in effect, we were trying to replicate the model in Adelaide, not exactly the same, but at least you could have forensic and access counselling. The training itself varied, varied depending on the experience of obviously the medical officers, so sometimes there might be a medical officer who has already done the training, say they come from New South Wales and they've already done training etc. So they might need different levels of support. The training may vary from a couple of days of coming to Adelaide or even us going out to regions to train and then where there was the additional need for support was around and having the opportunity to practise doing a forensic medical examination. So that might be sometimes people being trained come to Adelaide, to Yarrow Place to get some practise with our victim survivors and we also have, I can't think of the name of the role, but people who will I guess role play a victim to enable the doctors to do the training. At some point along that journey we also had permission from Chief Justice and Chief Judge to train nurses because we didn't want to train nurses and then have the Court say we're not accepting that they collected the forensic evidence. So we had that permission and then we started training nurses as well.

Katie-Jane Orr:
And did that training involve how to conduct the forensic examination, but also some more general training about trauma-informed responses to sexual assault?
Katrina Dee:
Yes, so we always do a responding to a disclosure of sexual assault, which is around the psychological support for victim-survivors, and then we do the training on doing the examination itself. We also do training around vicarious trauma, around the impact that work has on the healthcare professional.
Katie-Jane Orr:
And am I right in saying that, so there's no set training that's required in order to conduct these procedures, but it's a matter of the practitioner feeling and being equipped to be able to do it.
Katrina Dee:
That's right, it's not a requirement to be trained and we have over the years had experiences where private GPs who have had no training in regional areas have been willing to conduct a forensic. Yarrow Place might be on the phone giving them some support and some have done it without any support at all. However the preference is to be trained. That also helps support the healthcare worker I think as well.
Katie-Jane Orr:
You just mentioned then the telephone support, so under this hub and spoke model, was it anticipated that telephone support would be provided by Yarrow Place if necessary?
Katrina Dee:
Yes and we have done that on occasion and even with the further development of technology where it was like telehealth so you could screen in to help, we've done that as well.
Katie-Jane Orr:
And so this model was developed and did it start happening? Was that what was happening in regional areas?
Katrina Dee:
Yes, I think not all regions implemented it or implemented it to its full capacity, so some regions didn't train any nurses and might have relied on just one trained doctor, however others trained several nurses over several years, and Yarrow Place was occasionally responding to regional requests, but that started to increase significantly.
Katie-Jane Orr:
Right, so my next question was what's happened since, so was there a time around which the referrals to Yarrow Place started to increase or has it been a gradual?
Katrina Dee:
I think it has been gradual but then 2019 to 2020 we saw a you know that really was getting more significant and we also know COVID hit in 2020 and so Health was pivoting its focus to manage that pandemic. Understandably we all were all were doing that. I guess my concern was that we knew domestic and family violence and sexual violence was at risk of increasing during that time, and certainly the research has demonstrated that to be the case. I did note that some of the other relevant policy directives within SA Health, such as the Family Safety Framework policy

directive, which required us to screen people for domestic violence and then refer them into Family Safety Framework meetings with police, that data was going down, and attendance by health staff at Family Safety Framework meetings was going down because the meetings were no longer able to be face to face, they had to be online and health care professionals were concerned about privacy and confidentiality. So as a result of that I did escalate that to the CE of Health who then sent out a minute requesting that every local health network including metro and regional provide an executive lead that I could have as a contact point around all things sexual, domestic and family violence, and we call that the Sexual Domestic and Family Violence Executive Network, and I would then communicate with them about what we are required to continue to be vigilant about domestic and family violence and sexual violence. This is not the time to be taking our foot off the accelerator. So in that capacity I went out to meet with executives at all of the local health networks including the regional. I'm doing a road trip out and visit it. It's in the course of those conversations with some of the executives and staff there that I started to become aware of the concerns that were being raised about the model of care to the point that I was concerned that we had moved a little bit backwards towards this not being recognised as a health issue or not being recognised as something that was the responsibility of the Local Health Network.

Katie-Jane Orr:

I want to ask you more about that, but first if we can just continue the chronology. So it sounds to me that you're saying you made some attempts to reinvigorate the existing model?

Katrina Dee:

Absolutely.

Katie-Jane Orr:

And is it correct that that sort of culminated in January 2023 or perhaps later 2022 and into 2023? What happened around that time?

Katrina Dee:

The police were certainly feeling a level of frustration of needing to transport victim survivors down to Adelaide and the Attorney General had also written to the Health Minister to say they had concern around the transportation down. The Attorney General, Yarrow Place still had an agreement with the Attorney General's Department that we would be providing training into the region and obviously we have accountability and reporting to the Attorney-General's Department about what we're doing and so we were saying we are doing our best to train in regional areas but the uptake is of a concern and so that was raised with the Health Minister and that was towards the end of 2022. So January 2023 I then wrote a briefing paper for the Health Executives Council. I presented that paper and really that paper was calling on that meeting to identify, are we still on the same page that this is a health issue, that it needs to be attended to locally, as close to home as possible, and that we have a model of care that needs reinvigorating. And the outcome of that meeting was an agreement to reinvigorate the model and for Rural Support Service, the local health networks and Yarrow Place to look at the development of a procedure.

Katie-Jane Orr:

So that's an updated procedure to implement the model while it's being re-invigorated or in an attempt to re-invigorate it.

Katrina Dee:
That's right.
Katie-Jane Orr:
I understand, or the Royal Commission has heard, that since then the Rural Support Service, who you've just mentioned, has been undertaking a review of the current approach.
Katrina Dee:
Yes, I understand there's a committee set up that is having a look at the model. They are consulting with the regional health networks in relation to it.
Katie-Jane Orr:
But did this reinvigoration that you're talking about of the model occur?
Katrina Dee:
So to measure that, what we're looking at is, did Yarrow Place offer training? What was the uptake of the training? Did we have more doctors and nurses trained and accessible to provide a health check and a forensic examination? And did we reduce the number of people travelling down for a forensic? What I can confidently say is, Yarrow Place did offer training. I would say the uptake wasn't what we would have hoped it to be, the number of victim survivors travelling down to Adelaide has not decreased. I would say one region, and I will give a little shout out to them, Whyalla, has actually trained additional nurses, and what I really appreciate about that is that they've also trained some senior nurses, so what they've done is said, this is really important and we're role modelling that this is important work. So I can't say none of the regions but I would say that we still have quite a bit to do if we were really trying to reinvigorate the model. We have done that in one area but in others there still needs some work to be done.
Katie-Jane Orr:
We have received information about the total number of nurses and GPs in regional areas trained by Yarrow Place since 2019 and it was a total of 13 only.
Katrina Dee:
Uh-huh.
Katie-Jane Orr:
and that included two who have completed partial training according to the data, does that sound right?
Katrina Dee:
Yes, it has been a challenge.
Katie-Jane Orr:
So we are going to hear later this morning from Rural Support Service about their project that we've just mentioned and what their review of the current approach, where it's at really. But I do want to ask, in your view, what are the definite needs or the priorities for the approach to forensic medical examinations in regional areas?
Katrina Dee:
Look, I think whether it's reinvigorating the current model or whether it's the development of a new model of care, we need to come from a place of being very clear that this is a health issue, and it needs to be held locally by the local health networks. I don't think people will necessarily disagree with that, but I don't think what we've experienced, sorry, victim survivors would align with what people are saying and we need to have their experience aligning with the value set that we are

saying we have. So that would be fundamentally where I think we need to come from and I guess that was what the Health Complaints Commissioner's Directive way back in 2009 were attempting to do.

Katie-Jane Orr:

So that's kind of a cultural or fundamental, was the word you used, approach. Do you have any comment in a more practical sense as to what is required of a service regionally?

Katrina Dee:

There needs to be obviously nurses and doctors who have had some training and feel confident to provide a health care response and as part of that health care response be able to collect some forensic evidence. They need governance and supervision structures that enable them to feel confident. So when we hear that staff aren't feeling confident, training is part of it and leadership is the other component. It's about how they feel supported in their workplace in relation to doing that work.

Katie-Jane Orr:

24/7 access?

Katrina Dee:

Yes, ideally, 24-7 access. I think what has worked previously in the past where you might have people go on leave at Christmas and New Year, so I would say, look, let's be really careful about when we let people go on leave around those times. I mean, we all want to have that leave, but we need to cover off. It's also quite a busy time around domestic and family violence and sexual violence over those periods of time. But what we've had historically, for example, was Port Lincoln may have a victim survivor that would be transported to Whyalla and Whyalla would provide the forensics. So even the local health networks can, between themselves, work through how we're going to cover. And sometimes there are some GPs, even in smaller regional areas, that may also be willing to help. But that requires that coordination of that kind of response to ensure that there's coverage.

Katie-Jane Orr:

How can Yarrow Place assist with the regional response?

Katrina Dee:

So obviously we can continue with the training support and consultation, we still have the counselling roles in those regional areas. Into the future, if there was a model where there were doctors and nurses available in those hubs, we could look to triage calls. I would just, my only caution on the triaging of calls is that assumes that everyone wants a forensic. when in actual fact somebody could still just walk into an emergency department at a hospital and say I've been sexually assaulted, I just want a health check. What we want to make sure is they get their response and no other layers of complexity are added in to their healthcare response. So I think Yarrow Place has always been very supportive of the regional areas. Obviously we are happy to have feedback on a training and we do, we do do evaluations of the training. We will adapt training to meet the needs of the regional communities which we have done before. So making things online versus face-to-face, going out to the region rather than having people come to North Adelaide. So there's a range of things I'm sure Yarrow Place could do into the future to support.

Katie-Jane Orr:
And the triage that you mentioned, would that be like the Yarrow Place phone service that is accessible in metro areas now?
Katrina Dee:
That's right.
Katie-Jane Orr:
And then earlier in your evidence you talked about previously telephone support has been offered if needed when practitioners are conducting these examinations. Is that something Yarrow Place could continue to do if needed?
Katrina Dee:
Possibly. My only hesitation in relation to that is the volume of forensics for Yarrow Place has continued to go up as have reports of sexual violence and so availability of forensic consultants to support a regional forensic may not always be available, particularly if they're responding to an Adelaide based assault at the same time. We also experience Metro delays for some of our own victim survivors because we may be doing a forensic on one and we've got another person waiting to have theirs done. So I'm cautious about saying yes, in an ideal world with appropriate resourcing, triaging and backup telephone support would be something we would like to consider.
Katie-Jane Orr:
It's clear from your evidence that there are some barriers in regional areas and there has not been this reinvigoration.
Katrina Dee:
Mm-hmm.
Katie-Jane Orr:
And what are some of the reasons for that, as you understand it today?
Katrina Dee:
It varied on region and it also varied on who I was talking to, so if you ask some of the staff it may be some staff have said I'm willing to do it, I just don't have the structures in place around my workplace doesn't have the procedures around it to do it, they don't necessarily feel confident to do it, they're worried about going to court, they're worried that it would take up more of their time, it might be somebody they know, either the victim or perpetrator, that it may be traumatic, et cetera. So there was a range of, from staff, a range of reasons that were put forward. And a lot of those are, again, a bit myth-based. Like, we could unpack that with people, and we have done for years. Like, it's unlikely you'll go to court, and if you do go to court, it'll be on what you did, but not interpreting the evidence. And as health workers, I guess we all have that risk who have been called to court for different reasons at different times in our career. So we try to address those concerns for the staff who would actually be doing the forensics or health checks. When I was talking to executives, that's where I was probably more concerned, is what I was hearing is this model isn't sustainable and hasn't been sustainable for years. Staff don't want to do it, we can't make staff do it. And that for me was more concerning in that what I was concerned about is are the regional health networks still holding it as a local health issue and then having strategy in relation to how to resolve that issue. My sense was that wasn't occurring and hence we're still trying to work through what was raised again many, many years ago, and we sort of kicked off something that was working with

the hope that we could reinvigorate that whilst consideration is given to do we need a different model of care. I don't think there's anything problematic about reviewing or developing another model of care. It's how do we manage the experience for victim survivors in the interim.

Katie-Jane Orr:
And is what you're saying that the barriers that we're hearing about in your view are not really being, the fundamental barriers are not really being addressed?

Katrina Dee:
they need to be considered and discussed and unpacked, yes.

Katie-Jane Orr:
I just, lastly, want to ask you about self-collection kits. What are they? Can you explain?

Katrina Dee:
So they are what we call an early evidence kit, so across Australia this is a challenge. Earlier this week I was at the National Board meeting for two days of sexual assault services and we were all talking about some of the challenges around access to forensic, particularly in very remote areas. And so early evidence kits enables the victim survivor to take some swabs effectively from their own body, they're stored and enables the victim survivor to then have a shower and eat or do the things that they need to do.

Katie-Jane Orr:
Are they used in South Australia currently?

Katrina Dee:
They're not used in South Australia currently. There is a, my understanding there is a working group looking at that. I guess the things that we need to look at is, sitting on the board, the national board, I can see, you know, we have lots of discussions and we hear where they have been implemented and some of the challenges around that. So what we'd want to do in South Australia is go, okay, we don't want to replicate any of the things that don't work well. One of the things that's really important is that the health check still needs to occur. So that is the priority, is the person's health and well-being, and the forensic evidence is a part of that, but it's not the only most important thing that we do is get the forensic evidence. So what we need to make sure is the pathway for the health check still exists. We're also asking a victim survivor to take swabs from their own body when we're saying as a health system that we're not confident to do that for them. And I think that's problematic. I think it's a message we need to be careful about. And the psychological harm for victim survivors, their own pressure around, did I get my swab right? Did I contaminate it? You know, we put all those fears onto them in asking them to collect their own evidence. I'm not saying we shouldn't do it, I'm not saying we shouldn't look into it, but I think we need to look at the impact of that.

Katie-Jane Orr:
And I promised that was my last topic, but I've remembered one. You mentioned practitioners have expressed concerns about potentially going to court, and you talked about the difference between potentially giving evidence about the taking of a sample as opposed to the opinion about what that means. In your experience the former, that is the taking of the sample are those practitioners often called to court to give evidence?

Katrina Dee:
I don't know of any instances. There may be some, but certainly it would not be very frequent at all.
Katie-Jane Orr:
Thank you. I would just, Commissioner, I'll obviously ask if you have any questions but I did want to finish. Ms Dee, you asked when we spoke in advance of this hearing, you said that you were, you sort of wanted to convey a message to anyone who's listening at home after hearing the evidence today. Is that something you'd like to address?
Katrina Dee:
Absolutely. Whenever we talk about the barriers to access, what we can do is silence victim survivors from seeking help. When they hear that the system isn't working effectively, they may not seek the support they need. So my message is to any victim survivors and or potential victim survivors or anyone else listening and remembers this, that if you have experienced a sexual assault, you have the right to a healthcare response and we want you to come forward. And whether you're in a regional area or a metro, we will try and do our very best to support you. And although right now we're working out some pathways to be more effective, we still want people to come forward and we don't want them silenced because we haven't quite got it right yet.
Katie-Jane Orr:
Thank you. Commissioner, I have no further questions.
Natasha Stott Despoja AO:
I have a few but you've done a wonderful job of anticipating most of them. Thank you for your evidence today. Can I just ask you to explain in a little more detail what constitutes a trauma-informed or trauma-responsive approach? I know you've given insight through your evidence but I just wondered if you could give us an idea of what that means, what it really is?
Katrina Dee:
Absolutely. I think it's about being kind and compassionate, which is obviously part of what health care is all about. It is about believing the person. We're not there to make a decision about whether what they're saying is true or not, and when we're collecting forensic evidence, it's for potentially a criminal justice process. It's not for us to make any judgement about what's occurred. And it's about enabling time for the victim survivor to make some decisions so it's about giving them information and allowing them time to make decisions about what is right for them rather than making decisions on their behalf which is why sometimes we get people move from I'm having a forensic to I'm having a just-in-case because I've had some time to think about what and I've had you know this opportunity to understand what it is and to think things through. I don't actually think a trauma responsive response is complex, but in a busy world sometimes we aren't always as kind and compassionate as we could be. We don't always allow as much time. We don't always give the victim-survivor a sense of they are believed. Primarily, they also need to feel safe. So the space in which they're in needs to be a safe space. And that may mean asking them whether they want a support person with them, whether they're comfortable with the gender of the healthcare professional that is going to be examining them, those kind of things.

Natasha Stott Despoja AO:
How do you manage at Yarrow with need for interpretation, people from different backgrounds, people with disabilities, how do you manage some of those issues?
Katrina Dee:
So all of the services, Metro Youth Health, Cedar Health and Yarrow Place, all have very good rapport with interpreting services. And we have offered training also to interpreters around being trauma responsive. Some victim survivors have a preference for a family member or friend to do some, you know, of the interpretation for them, which we are respectful and supportive of. If we have concerns that, particularly in domestic violence, so that interpreter may actually be the very person who's committed the offence, then we would look for ways to ensure we aren't compromised but can provide the care safely. So we do, you know, it's having that good rapport, it's offering training to that sector that enables us to have good response there. In terms of disability, we have good relationship with Purple Orange, which is an organisation that does a lot of work around disability. We have trained their workers, they have trained ours. And we also work with whoever the consumer is, the victim-survivor, their carers or people they feel, their support people, whoever they feel comfortable with as well. And so we will try and learn around their communication style so that we're interpreting what they're saying is correct. And again, it's that taking that time assists as well.
Natasha Stott Despoja AO:
The training to which you referred earlier around medical professionals, who pays for that? Is it the hospitals or is that?
Katrina Dee:
No, that's part of the funding base, funding from the Attorney General's. That is more for regional, however. Any training that we do with Metro is really just out of Yarrow Place's budget.
Natasha Stott Despoja AO:
I'm wondering the cases that you deal with, I mean we've been talking around the time frames in which it's ideal or better to collect evidence, I'm wondering about historic cases or older cases, do you deal with those as well?
Katrina Dee:
Yes, so we provide services of anyone 16 years and over who's had an assault at 16 years or older, and it doesn't matter if it's a historical matter, and they can also still have a health cheque. If they've got a health concern from an assault that occurred two years ago, and it would reassure them to see a doctor at Yarrow Place, we can organise for that to occur. In counselling, certainly we will work with that past trauma. If that victim survivor also has a history of child sexual abuse, which so many of our survivors have, we will also provide a therapeutic response in terms of counselling around their experience of child sexual abuse as well. All of it is so relevant to their adult experience and their experiences potentially of domestic and family violence. So very aware of the intersectionality of all of that
Natasha Stott Despoja AO:
I think you mentioned that 40 % the just-in-case that constitutes 40 % of the medical collection and evidence. Do you have, and I know this is a difficult question, but how many or what percentage of those just-in-case are actually invigorated, if you like, or taken to SAPOL eventually.

Katrina Dee:
Yes, I do have some data that is relevant to the data that was collected around the regional which was around 12 to 13 per cent. However, that's in a time frame of not necessarily the total 12 months and so I would anticipate it's a higher rate when you look to we keep the kit up to 12 months. So if you look at how many did we test after 3 months, 6 months or 12 months, those figures will obviously vary over that time frame.
Natasha Stott Despoja AO:
Thank you. The regional visits that I've been on, this issue of forensic medical examination has come up every time. And I've heard first hand some of those myths to which you refer or sort of cultural issues as they may be. And I found it really concerning the stories of victims not being able to shower, you know, not being able to change, you know, spending hours on a bus or in a car. It worries me that there is, as you mentioned, there's no sort of interim response to that. If you could wave a magic wand tomorrow, what would you initiate or ensure was happening as an interim arrangement?
Katrina Dee:
Very strong leadership around this as an issue. I would ask that the relevant Executive Directors for Nursing, Medical, Chief Operating Officer, CEO, CE, Minister are saying this is a health issue, it's not an option it's not a we don't want to do it or we can't do it, we have to find a way to do it. That's a fundamental difference in how you speak to this, so that I think is really really critical. And then, in real practical terms, do what Whyalla did. Give us some nurses to train. Or doctors. We've got staff willing to train and be very flexible and support in as many ways as we possibly can. Because there's two reasons. One, it's terrible for the victim-survivor. It's just unacceptable. But it's also not fair to the staff in Yarrow Place to be picking up this additional workload.
Natasha Stott Despoja AO:
Indeed. Thank you for your evidence.
Katie-Jane Orr:
Thank you Commissioner, I'll ask the witness to be excused.
Natasha Stott Despoja AO:
You are free to go.
Katie-Jane Orr:
Thank you. Thank you. And then, Commissioner, we have a break until 11 o'clock for the next witness.
Natasha Stott Despoja AO
Okay, so thank you. We will break now until the next witness. Thank you.

Witness:
Detective Chief Superintendent Cath Hilliard, South Australia Police

Good morning everyone and we are back on day two of the Royal Commission into Domestic, Family and Sexual Violence. I call on the Counsel Assisting.

Katie-Jane Orr:
Thank you, Commissioner. I call Detective Chief Superintendent Cath Hilliard.

Kerryn Hawkes:
Do you swear that the evidence you shall give will be the truth, the whole truth, and nothing but the truth, say I swear.
Cath Hilliard:
I swear.
Katie-Jane Orr:
Thank you. You are a Detective Chief Superintendent with the South Australia Police. How long have you been a police officer?
Cath Hilliard:
37 years.
Katie-Jane Orr:
And can you tell us what your current role is?
Cath Hilliard:
I'm currently the officer in charge of the Serious Crime Coordination Branch. What that role does is provide integrative support for specialist crime branches, which includes Major Crime Investigation Branch, Public Protection Branch, Serious and Organised Crime Branch, Investigation Support Branch and Financial and Cybercrime Investigation Branch.
Katie-Jane Orr:
And within the Public Protection Branch, what does that cover?
Cath Hilliard:
The Public Protection Branch has three portfolios which consist of Family and Domestic Violence section, Sexual Crimes Investigation section and also the Offender Management section. And then there are different portfolios under each of those sections.
Katie-Jane Orr:
Do you have, we all know why we're here for this Royal Commission, do you also have operational experience working in domestic family and sexual violence?
Cath Hilliard:
Yes, so I spent more than 20 years as a detective investigator in various investigation areas which included Elizabeth CIB, Anti-Corruption Branch, Serious and Organised Crime Branch, Major Crime Investigation Branch and since 2014 I've been a manager of various areas including investigation areas which include Northern District Criminal Investigation Branch, Branch, Special Crimes Investigation Branch which then transitioned into Public Protection Branch, Family and Domestic Violence Section and also State Security Branch.
Katie-Jane Orr:
And the special crimes investigation unit, what kind of crimes does that look at?
Cath Hilliard:
At that time it consisted of what is now Sexual Crimes Investigation Section and parts of the Offender Management Section including Police Corrections Team, ANCOR Section which is the response to child sex offenders, the Joint Anti-Child Exploitation Team, a joint initiative between South Australia Police and the Australian Federal Police, the Victim management team and so ultimately there was a policy area in that which also had oversight of the multi-agency protection service and the multi-agency hub.
Katie-Jane Orr:

So today I'm going to ask you about procedures and practises relating to when reports of sexual violence are made to police. As you're aware, this morning we have heard and are hearing evidence about forensic medical examinations and the health response or the medical response to an allegation of sexual violence. And we heard evidence this morning from Ms Dee, Ms Katrina Dee, about the Yarrow Place or health response. Sorry, we want to hear from you about the policing side of this response. But with a bit of background first, if we can. When a report of sexual violence is made to South Australia Police, are there policies or guidelines to be followed?

Cath Hilliard:

Yes so we do have policies in respect to investigating criminal investigations, sexual offences investigations and then we also do have local policies respective to teams or groups which provide greater clarity. So there are additional local policies in respect to forensic medical examinations for people 16 years and under and people over the ages of 16 years.

Katie-Jane Orr:

So for today's purposes we will focus on 16 years and over. Is it correct that, excuse me, for people under 16 they're dealt with in conjunction with Child Protection, with the Department of Child Protection?

Cath Hilliard:

So it's Department of Child Protection but it's also SA Health with Child Protection Services and obviously they have facilities predominantly at the local health networks which is North Adelaide, South Adelaide and Central.

Katie-Jane Orr:

So, as I said, for today we'll focus on people over 16. Where might reports to police of sexual violence come from? How does SAPOL get notified?

Cath Hilliard:

And they actually may be communicated a number of ways. They might well be an emergency response through 000. They might be through the non-emergency response call centre, which is 131 444. They might be from people presenting at the local police station. They might be through referrals from the Department of Child Protection, aged care providers, and also from disability care providers.

Katie-Jane Orr:

Is it correct that the response will depend on the circumstances of the report?

Cath Hilliard:

Indeed it may well depend as to who initiates that initial response, so for example a triple zero response, a request for emergency, the first ones likely to be at that location in response will be frontline, whereas equally the same would be said for a person attending a local police station, however there are within each of the metropolitan and regional areas there are family violence officers, they're either attached in the metropolitan an area to the Child and Family Investigation Sections or they're attached to their Family Violence Investigation Officers in the regional areas. So they may well be involved in the response and a response may be escalated to investigators of those local areas and a response may also be escalated to Sexual Crimes Investigation Branch or a section within Public Protection branch. And of course there are other respondents who would also attend being crime scene examiners and depending on the nature of the circumstances and the

complaint.

Katie-Jane Orr:
In terms of the police response to a report of sexual violence, are there some things that always happen? Are there some things that the circumstances have in common? The response has in common, I should say?

Cath Hilliard:
So, the welfare of the victim is paramount, so that's the first priority, is to manage the welfare of the victim and identify whether there are any injuries or illnesses that need that immediate attention. There are also other priorities, identification of the perpetrator is a priority, identification of the scene or scenes, and when we talk about scene management, we're also talking about physical environment but now also the digital environment and we also have a priority to identify witnesses and how they can assist police in their investigation.

Katie-Jane Orr:
When you're talking about scene management, is that in relation to the collection of evidence?

Cath Hilliard:
Correct, a collection of evidence, whether that be physical, digital, or circumstantial.

Katie-Jane Orr:
And is it right to say that a report will always be assessed and triaged and the approach will be determined based on the circumstances?

Cath Hilliard:
Correct. On most occasions there's that immediate engagement with investigators from frontline. If it's frontline that are the first responders there will be that engagement at the local level with investigators to determine obviously the escalation and the necessary responses that should be involved in a complaint of sexual violence.

Katie-Jane Orr:
And I think you've mentioned some of the factors that will be taken into account when working out what to do next. The urgency of a response, is that a factor?

Cath Hilliard:
Absolutely, so as I said the welfare of the victim is of paramount importance, the suspect identification is also a priority, evidence collection is also a priority.

Katie-Jane Orr:
You've mentioned victim management, so I want to ask a bit more about that. And particularly in the context of sexual violence. What are some of the considerations that police officers keep in mind when they're dealing with victim survivors of sexual violence and how you're going to respond? I know you said that the welfare is of paramount concern, but can you just give us a bit more details and examples of some of the considerations.

Cath Hilliard:
A victim who experiences sexual violence, it is a traumatic experience. Victims behave differently. They may be highly emotional, they may be anxious, fearful. If they are affected by drugs or alcohol or other injuries or illnesses that may have an impact for them and equally if they've had an exposure to a previous traumatic experience that may well exacerbate the trauma. Police investigators have a victim-centric trauma-informed approach where they must deal with the victim with

sensitivity and ensure that they are informed about what their options are, what they may wish to do in respect to an investigation for sexual violence.

Katie-Jane Orr:
Is building rapport important?

Cath Hilliard:
Absolutely, so it's about that early engagement, building rapport, communication, reassurance and being in a very calm manner, explaining the processes or what it is that police are seeking from them and what actions they wish to take and enlivening that trauma informed approach to understand the trauma that they are exposed to and how we cannot exacerbate further trauma to them.

Katie-Jane Orr:
So they do have a say in what happens next?

Cath Hilliard:
Absolutely.

Katie-Jane Orr:
Is that in relation to whether the person might be charged, whether they undergo a forensic procedure, other things like that?

Cath Hilliard:
Certainly with their choices around forensic procedure, yes that is their decision to make. We know that victims of sexual violence, some people are reluctant to report to police and so therefore it is about explaining the processes to them so that they can make choices. There might be times where the suspect has already been apprehended and a victim will have an opportunity to determine whether they want to continue with the prosecution and certainly police will provide advice in respect to allow them to make an informed decision.

Katie-Jane Orr:
You mentioned before that welfare of the victim includes assessment of injuries and that's prioritised?

Cath Hilliard:
Definitely, so a victim who has sustained injuries or perhaps an illness that requires that immediate medical attention will be prioritised ahead of a forensic medical examination.

Katie-Jane Orr:
Are aspects of strangulation dealt with in a particular way?

Cath Hilliard:
Yes, so strangulation, what we do know is there are a range of other health implications for a person who has been a victim of strangulation and so therefore it's about having a medical practitioner assess any injuries to the victim so that they can provide the therapeutic or medical treatments necessary for that victim.

Katie-Jane Orr:
We've heard this morning about the Yarrow Place triage phone line, do South Australia police use that phone line?

Cath Hilliard:
Yes.

Katie-Jane Orr:
How does that work from a policing perspective?

Cath Hilliard:
And so perhaps if I talk you through the process, that would be the best. Perhaps I might break it down to metropolitan and then country because there are some differences. So, where a matter is reported to police in the metropolitan area, investigators will contact the victim management team, where they identify that there's a need for a forensic medical examination. The victim management team, which is in the public protection branch, when they are on shift they will liaise directly with the Yarrow Place triage. they provide a 24-7 capability. A crisis response worker takes the details from police investigators or from victim management team investigators of the circumstances and the crisis response worker will then communicate directly with the doctors in respect to the forensic medical and the crisis response worker will then also communicate back directly to the investigators and also to the victim regarding the arrangements of the medicals. When the victim management team are not on shift, then investigators will contact the on-call officer for the Public Protection Branch, seek advice from them and if a forensic medical is required then they'll contact the Investigation Support Desk at Communications Branch who will then reach into Yarrow Place Triage Service in a similar manner regarding the arrangements for the forensic medical.
Katie-Jane Orr:
And so that triage service you've just said makes arrangements for a, sorry I'll start again, they give advice or deal with the forensic medical examination which we'll come to in a moment. Does that triage service provide assistance to SOPOL in any other way?
Cath Hilliard:
There's certainly an avenue for advice in respect to victims who might need additional counselling, support, so they're not simply a medical triage service, they're much more in respect to provision of support for victims, families and also training of health practitioners to undertake forensic medicals.
Katie-Jane Orr:
Sorry, we've been talking about this forensic medical examination and we heard from Ms D an explanation of what that is, but I'd like to ask you, from a policing perspective, what a forensic medical examination is.
Cath Hilliard:
So where a person makes a complaint of sexual violence which incorporates penetration or ejaculation into a person's vagina, anus or mouth, then we will seek a forensic medical examination and the purpose of that, there are multiple purposes, the first is to maintain the welfare of the victim and to identify and confirm that a sexual assault has occurred and to also enable the collection of forensic evidence which may have been transferred in the commission of the sexual violence and that transfer obviously may extend to biological material but it also may extend to other foreign material.
Katie-Jane Orr:
Urine and blood samples sometimes taken?
Cath Hilliard:
Urine and blood, swabs, fibre analysis or fibres, hair. Again, it depends on the circumstances of the nature of the complaint made by the victim as to what samples may be prudent to take.

Katie-Jane Orr:
Documentation of injuries?
Cath Hilliard:
So yes, the forensic medicals record injuries and contusions, lacerations and any other matter that's of relevance to the examination.
Natasha Stott Despoja AO:
We might just pause, I was going to say, forgive me interrupting, but I think we'll just take a short break for a few minutes.
Welcome back, we can recommence proceedings. Counsel Assisting.
Katie-Jane Orr:
Thank you. We might just go back a step. You were explaining that urine and blood samples are often taken as part of that procedure.
Cath Hilliard:
Yes, again it assists investigators, especially in circumstances where a victim-survivor might make a complaint of being affected, unaware that they are affected in terms of drink spiking or any other concerns that they might have. So but also, I'm sure health practitioners can also talk about other visibility that they have with regards to urine and blood analysis.
Katie-Jane Orr:
documentation of injuries sometimes?
Cath Hilliard:
So the Yarrow Place practitioners complete a PD184 which is a form which has been devised in conjunction between South Australia Police and Yarrow Place and it records all of the information which includes injuries, advice that a victim will tell a health practitioner and the extent of the examination that they conduct, it asks for the victim to consent, so it's an all-encompassing document which is aligned to Section 7 of the Criminal Law Forensic Procedures Act.
Katie-Jane Orr:
And again, the documentation of such injuries or this evidence is to support the allegations?
Cath Hilliard:
So yes, it will help identify whether a sexual assault has occurred. It validates a complaint made by a victim survivor and provides evidence for police which may lead to the identity of a perpetrator. And equally, where a perpetrator is not known, it might still provide us with evidence such as DNA, which is then stored on the DNA database and should that perpetrator have their DNA taken at some other time through engagement with police and offending, then there is that potential for that match to occur, which then allows obviously reinvigoration of that investigation.
Katie-Jane Orr:
So you've mentioned DNA, how is that, how is the DNA found in the samples that are taken in the forensic examination?
Cath Hilliard:
So DNA is transferred through skin, through contact DNA, through semen, through saliva and sometimes through hair so we can make those determinations with regard to DNA.
Katie-Jane Orr:
the samples analysed at Forensic Science South Australia?

Cath Hilliard:
So, when a forensic medical examination is undertaken the victim management team will collect all of the samples from Yarrow Place, they will convey them to police investigation areas, those samples will be booked onto police property system and they will then be taken to Forensic Science South Australia where they will be analysed.
Katie-Jane Orr:
And you mentioned the victim survivor's consent, so is these forensic examinations only take place if the person consents for that to happen?
Cath Hilliard:
Yes, correct.
Katie-Jane Orr:
So before we move on I just want to go back, you were talking about the process and the use of the Yarrow Place triage line in metro areas, but I forgot to ask you about regional areas. Could you tell us how that works?
Cath Hilliard:
So in regional areas, investigators will largely try and locate a local, legally qualified practitioner who has been forensically trained, whether that be a doctor or a registered nurse, to undertake the forensic medical. If they can't locate such a person, then they may contact Yarrow Place. Yarrow Place triage again will try and identify suitable local responses and if again such a qualified practitioner is not located then Yarrow Place may recommend that the victim is taken to Yarrow Place or brought to Adelaide for the examination. Yarrow Place also offer to provide real-time mentoring via phone to practitioners who perhaps are not forensically trained in this space in order to support them through such a medical examination.
Katie-Jane Orr:
Thank you, we'll come back to what's happening in the regional areas in a moment. So it's medical practitioners you said, doctors or registered nurses who are performing these procedures?
Cath Hilliard:
Correct.
Katie-Jane Orr:
As to the timing of that examination, we've heard that basically as soon as possible after the incident is best. Can you talk to us about the importance of that and if there's any flexibility in that?
Cath Hilliard:
Again, it depends on the circumstances. Within 72 hours is ideally what we're trying to achieve a forensic medical. It also depends on whether there's been any delays in reporting to police. It also depends on the nature of the sexual violence that the victim has sustained. And while 72 hours is the optimal for, obviously, the seizure of evidence, there are some circumstances where there is a longer delay for some evidence and so that's determined by obviously the doctors at Yarrow Place.
Katie-Jane Orr:
So that timing window will depend on the evidence that may potentially be obtained.
Cath Hilliard:
Yep.

Katie-Jane Orr:
So we've talked about the police response, are you able to explain what you see as the police focus in this response as compared with the health focus?
Cath Hilliard:
The police focus is, again, managing the welfare of the victim, the collection of evidence and the prevention of further harm to that victim or the community, and also then, obviously, collecting all available evidence, whether that's through witnesses, physical, electronic, identification of the perpetrator and bringing that person before the courts of justice. Health intervention is focused on, again, victim welfare, management of injuries, illnesses and also those therapeutic interventions post-event which include counselling, perhaps referrals to other allied health practitioners to provide that victim with ongoing support for this matter.
Katie-Jane Orr:
Thank you, and so back to procedural, practical, operational matters. In metro areas, metropolitan areas, once you've explained to us how police officers will use the triage line, what happens next from a police point of view? How do they make that procedure happen, the forensic medical examination happen?
Cath Hilliard:
So, obviously the investigators are engaging with the victim. They'll use the arrangements as I described through Victim Management Team to arrange the forensic medical. Best practise is for police to convey or transport the victim to that medical and sometimes there are some issues around that. For example, a victim may choose for police not to convey them. They might seek other friends or family to support them in that process. Sometimes there might be some delays with the undertaking of the forensic medical due to medicals already being undertaken at that point of time. And so on those circumstances, police will make an assessment, potentially seize the exhibits, which is the clothing and underwear from the victim, they may give advice to and request that they don't shower or perhaps they might ask a victim whether they would be open to wiping out their mouth or their vagina or their anus and then using the wipe and seizing that wipe as well. So if there is a delay, police will make those arrangements with the victim. So police or either, as a victim is determined, will attend either Yarrow Place or in an emergency circumstances Royal Adelaide Hospital for the forensic medical. That provision of police is again to support and maintain the victim welfare for prior to and up to the forensic medical examination.
Katie-Jane Orr:
They're not involved in the examination itself?
Cath Hilliard:
Correct, they're not involved.
Katie-Jane Orr:
But is it correct that they collect any samples or evidence that are obtained as a result of that examination?
Cath Hilliard:
So a victim management team will collect the evidence from that forensic medical examination, not the investigators who might be attending with the victim prior to the forensic medical examination.

Katie-Jane Orr:
And you said it's ideally police officers will convey the victim-survivor to the procedure unless the victim-survivor wishes otherwise?
Cath Hilliard:
Yes.
Katie-Jane Orr:
Why is that?
Cath Hilliard:
Again, it's to maintain that welfare and to provide that provision of support. They've been through a traumatic experience and in the absence of perhaps whether a victim chooses another alternative, that's best practise.
Katie-Jane Orr:
I now want to turn to what's happening in regional areas. So we've heard that generally speaking there is a lack of forensic medical examinations being provided in regional areas. Would you agree with that?
Cath Hilliard:
Yes.
Katie-Jane Orr:
Do you have any information about the number of procedures that are being conducted regionally?
Cath Hilliard:
I'd have to take that on notice to confirm that and I guess asking for what period you would be looking at.
Katie-Jane Orr:
I understand from information the Royal Commission has received previously that it is difficult to track the number of procedures that are being conducted.
Cath Hilliard:
I'm it's not something we routinely record in our data collection as to forensic medicals. Certainly Yarrow Place would have clarity on that and bearing in mind we're reporting on a forensic medical examination and sometimes a victim will elect to have a just in case examination or potentially a welfare examination and there are some slight nuances in respect to those. So it's not something that we track and record and certainly the first point of call is for the areas to look at local resources first before they would actually make any approach to Yarrow Place.
Katie-Jane Orr:
In relation to those local resources, are you able to say, or can you give any comment about the availability of local resources?
Cath Hilliard:
And there seems to be some collaboration in certain regional areas. For example, Port Augusta, Whyalla, and Port Lincoln, they do try and collaborate in respect to supporting or provisioning of support to forensic medical examinations. But it's not without its gaps, whether, obviously, practitioners are on leave, not available. I'm aware that South Australia Police at times has also utilised Royal Flying Doctor Service and also health to assist in transporting of victims and the more remote and regional then obviously it creates difficulties for health and also for police resources.

Katie-Jane Orr:
And so, I understand from what you're saying, it just depends on the capabilities or the availability in the area, correct. We've also heard that in those cases where there's not an available service, sorry, not a service available locally, that victim survivors are often being conveyed to Adelaide for those procedures, is that correct?
Cath Hilliard:
A number of victims are conveyed to Adelaide from all the regional areas. There are times, like I said Port Augusta, Whyalla, Port Lincoln, they can utilise locally but it's not exclusive, that occurs every single occasion and so from every area victims are transported to Adelaide and from the far north perspective there are occasions where they're transported to Alice Springs.
Katie-Jane Orr:
So in practise, what does a police officer in a regional area do if it's determined that the victim should have a forensic medical examination? You've spoken about the first part of that process. Can you tell us a bit more about what that looks like?
Cath Hilliard:
So in practise police make the arrangements to transport the victim to Adelaide if that's the only alternative. If there's a local alternative then they'll convey to that local area but if there's no alternative and Yarrow Place will perform the forensic medical then police will convey or transport to Adelaide.
Katie-Jane Orr:
So it's the police officer who's trying locally first.
Cath Hilliard:
yes
Katie-Jane Orr:
and then making arrangements if something is not available locally yes you've spoken about police transporting people in metro areas
Cath Hilliard:
yes
Katie-Jane Orr:
is that is that what happens in regional areas as well
Cath Hilliard:
It's best practise, but again it is dependent on other factors in those remote and regional areas
Katie-Jane Orr:
Like what?
Cath Hilliard:
Resource implications and equally the further north you go from Port Augusta. Obviously when you look at a map of South Australia, sometimes the resources even for police mean that we might have to look at alternative solutions, such as I suggested Royal Flying Doctor Service.
Katie-Jane Orr:
And so either a police officer is travelling long distances and is then taken off duties or, no sorry I'll go back a step, you've talked about friends and family sometimes doing that transport. Is that happening in regional areas as well?

Cath Hilliard:
Yes, on some occasions, if that's the choice of the victim, then that will occur. Otherwise, police will transport, and when we talk about police, it's always to police to transport for a number of different reasons, which, depending on where they are travelling from, will be to manage fatigue, manage the victim's welfare, and, of course, some of the victims are badly affected that it needs a number of people in support.
Katie-Jane Orr:
Probably an obvious question but does that create an additional burden on the police who are doing this?
Cath Hilliard:
Yes, it does, because when they're transporting a victim to Adelaide, then they're not able to respond to any other matter that might be occurring in that particular area. And it's from the regional areas generally, it extends over, at least overnight and into the next day, so therefore police are looking at accommodation solutions for the victim survivor and the police officers until they can return to that area. Transporting a victim back to Adelaide, again, the traumatic experience, police are doing their utmost in order to minimise that trauma impact.
Katie-Jane Orr:
Ms Dee gave evidence this morning that there has been an occasion where, she spoke about police transporting victim survivors to Adelaide, she talked about friends and family transporting victim survivors to Adelaide and then she mentioned that there has been an occasion where someone arrived on a bus, are you able to comment on that?
Cath Hilliard:
I don't have the specific knowledge about that, but it's not inconceivable, depending on the nature of the complaint, the available resources of health and police, and there would be potentially a number of factors that may have been a result of that decision to use public transport.
Katie-Jane Orr:
Last resort?
Cath Hilliard:
Last resort, absolutely.
Katie-Jane Orr:
Absolutely. Are there cases where this travel might be enough to deter a victim survivor from undertaking the procedure?
Cath Hilliard:
Yes
Katie-Jane Orr:
Has that happened?
Cath Hilliard:
Yes.
Katie-Jane Orr:
Are you able to say whether the lack of access to these procedures, whether it has always been like this?

Cath Hilliard:
I understand it's been an issue for at least five years and that is through personal experience in postings and an awareness of engagement with Yarrow Place as to how we can identify alternative solutions to support victims in regional areas.
Katie-Jane Orr:
Thank you, just one final topic, we've heard this morning about just in case procedures and I think you mentioned it in your evidence, so by definition South Australia Police is not really involved in that because it's a process that's happening with health, is that correct?
Cath Hilliard:
So yes, it can be. It can also, there's probably two components to it. So a just-in-case procedure is still a forensic medical examination. It's where a victim has not reported to police and goes directly to Yarrow Place to the exclusion of police and because they haven't decided whether they want to report the matter to police or alternatively, they've reported the matter to police but they're not sure as to whether they want to take action regarding a prosecution. So a just-in-case procedure is in fact a forensic medical examination that allows the victim a greater period of time to make an informed decision as to their choice with regards to prosecution or
Katie-Jane Orr:
You and in your experience, have South Australia Police then received reports or have samples been transferred to you down the track?
Cath Hilliard:
Yes, so Yarrow Place will hold the samples up to about a year and then engage directly with the victim as to what their preference are if they haven't heard from the victims. Where a victim indicates at any time during that process that they now wish police to be advised. We have a process where the victim consent for that transmission of the evidence from Yarrow Place to South Australia Police occurs and we create obviously or reinvigorate the investigation or commence an investigation if it's not known and follow those similar processes with victim management team collecting the samples and booking them on to police property systems and then for analysis at Forensic Science SA.
Katie-Jane Orr:
And is it correct that these just-in-case procedures are not happening in regional areas?
Cath Hilliard:
My understanding is health practitioners do not have the facilities to maintain the exhibits for just-in-case procedures and so a victim who seeks a just-in-case procedure either travels to Adelaide or doesn't undertake such.
Katie-Jane Orr:
Thank you, I have no further questions.
Natasha Stott Despoja AO:
If I may, I have a few questions. I suspect we're a bit tight for time due to our earlier break, but I hope that's okay. I thank you for your evidence today. Can I just go back to your description of the trauma-informed approach? And you talked us through the sensitivity required, the rapport, some of those issues. How do you ensure that your frontline police officers have this trauma-informed and psychologically safe approach? Is that through training or other measures?

Cath Hilliard:
So training in responding to sexual violence or complaints of sexual violence occurs right from the recruit phase and it's tiered through other training courses following recruitment in respect to building on that trauma-informed approach. So the recruits would get the baseline in that respect as to what their response is. Certainly there are a number of areas that will provide support to recruits in that training in domestic family sexual violence. So they have that understanding about the impact to a victim from a victim's lens and then naturally how we need to engage with victims in order to support them through this process and any investigation that occurs.
Natasha Stott Despoja AO:
And that training is regularly updated, maintained and is it evaluated or are police monitored to see how they do cope in those situations where it requires that trauma-informed approach?
Cath Hilliard:
So from the recruit phase, the next provision of courses would be those which have a focus on family and domestic violence or detective training courses, so it's almost like a step block model where we continue to build on that. That training is reviewed, obviously there are regular courses facilitated throughout the organisation every year and for peer review in certain sectors that does occur.
Natasha Stott Despoja AO:
As part of this trauma-informed approach, you mentioned that, in terms of victim management, that it's important that people have informed consent, that they feel that they're making informed choices about what happens to them. If you have a frontline police officer responding in that frontline way to an incident that's happened, these may seem like simple questions, but I just want to clarify, how much time does that victim have to make a decision say around making a statement if you know allowing for the trauma, the impact, the shock or the uncertainty. Are they aware of their choices when that happens?
Cath Hilliard:
So frontline in those circumstances would engage the Child and Family Investigation section or the local investigators fairly rapidly to provide that support and equally that matter would then triage to that group for investigation. Again it depends on the welfare of the victim at the time, if the victim is in a position to start to make a statement then police will seek to obtain that evidence at the first available opportunity. But of course a victim has a choice all the way through even if such a statement is obtained they have a choice as to whether they wish to prosecute or not and police will attempt to inform them as to what that looks like should they proceed or should they choose not to proceed and there are certain processes that accompany where a victim might make such a decision not to proceed.
Natasha Stott Despoja AO:
What reasons would a victim choose not to proceed with a complaint or allegation?
Cath Hilliard:
The research in this space identifies that there are so many factors which are omnipresent which include fear, shame, re-traumatisation, re-victimisation from family, friends, communities. So to turn around and identify any one or two factors would be difficult. It's an individual choice for each victim. And some victims don't want to tell their story.

Natasha Stott Despoja AO:
Thank you. And I don't mean to underestimate the complexity of this, but I'm curious as to do many people withdraw their statements? many victims?.
Cath Hilliard:
They might not sign their statements if they've given a statement. Again, I would have to take that on notice to identify what that looks like. Certainly in my experience, victims of sexual abuse, victims of child sexual abuse, the numbers that wish to proceed with the prosecution do diminish.
Natasha Stott Despoja AO
And finally, we've talked about the issue of transportation, particularly and specifically in relation to forensic medical examination. And yes, we've heard stories about certainly police officers going above and beyond, doubling shifts, missing shifts, in order to provide that support and transportation. When someone chooses to use a family member or a friend to get to the city. We've heard from this morning's evidence that those costs are incurred by the victim if they're not being transported by police. Is that correct?
Cath Hilliard:
My understanding is none of this should be at cost to a victim. But the mechanism as to how a family or friend of that member would be afforded reimbursement, I would have to take that on notice as to what our process is do that if SAPOL actually undertakes that process. Certainly combined with Yarrow Place and SAPOL we do make provisions to the medical forensic medical examination and from the medical examination but as to how that extends to family and friends who might provide that service I'd have to take get greater information from the Commissioner.
Natasha Stott Despoja AO
I've done a number of regional visits during this Royal Commission and at every one the issue of access to forensic medical examination has come up, including reports of the evidence to which you referred, counsel assisting, and that was of someone on a bus for a considerable period of time. And also when I was in Kangaroo Island, people were suggesting that the idea of someone having to go to the city via the ferry was not unrealistic. So I appreciate that this is a very difficult subject and I thank you for your evidence today. Thank you.
Katie-Jane Orr:
I'll ask the witness to be excused.
Natasha Stott Despoja AO:
You are free to go. Thank you.
Katie-Jane Orr:
Thank you. We might just need to have a short break, Commissioner, for some technical arrangements.
Natasha Stott-Despoja
I suggest we adjourn for five minutes. Thank you.

Witness:
Debbie Martin, Rural Support Service, SA Health

Katie-Jane Orr:
Welcome back. I call Debbie Martin.

Kerryn Hawkes:
Do you truly and solemnly affirm that the evidence you shall give will be the truth, the whole truth, and nothing but the truth? Say, I do
Debbie Martin:
I truly and solemnly affirm.
Kerryn Hawkes:
Can you please state your full name?
Debbie Martin:
Debbie Jane Martin.
Katie-Jane Orr:
Thank you, Ms Martin. You are the Executive Director of the Rural Support Service? Yes, that's correct. Can you tell us about what the Rural Support Service is?
Debbie Martin:
Yes, so the Rural Support Service has been set up to support the six regional LHNs in country South Australia and we deliver local health networks.
Katie-Jane Orr:
Thank you.
Debbie Martin:
Sorry, local health networks and so there are six local health networks that provide health services across the country and there are a number of functions that are more efficient and effectively done once for all six and so we house those services. We provide about 90 different services and we support them often with development of models of care and so that's probably in this context. yeah. And when you say models of care is that a procedure? So a model of care is like we might look at how does something flow from when a patient comes in or even before then how a patient comes in what happens all the way through to the whatever happens at the end and so it kind of looks at the whole patient journey but it's more than that it also looks at behind the scenes education, it looks at the evaluation, it really looks at the whole model for that particular type of service. So in this context we have been asked to help develop up a model of care for regional response to sexual assault.
Katie-Jane Orr:
So I want to ask you about that, obviously. I understand it's called the Regional Responses to Sexual Assault Project. Can you describe first of all what's your role in that?
Debbie Martin:
So I chair the steering committee for that project and I'm the executive sponsor for the project, which means my job is to support the project from beginning to end, make sure it achieves its outcomes and to have oversight and to support them, you know, reduce any barriers or obstacles that may be in the way that mean they can't get their role done, the project officer's role. So that's my role.
Katie-Jane Orr:
And I want to ask you now about that project. First of all, how did it come about?
Debbie Martin:
So, in regional South Australia we have a hub and spoke model for the delivery of sexual assault services and that has been in place for many, many years and there's a whole range of reasons, which I'm sure you will ask me questions about, but why that model has been thought that it really needs to be re-looked at and there was an

idea, a thought in 2023 three that we really needed to reinvigorate the model and to try and bring on more people who are trained to deliver the service and to expand the service. So previously the Hub and Spoke covered what is four of the six regional LHNs and two didn't have any, they, people who lived in York and Northern and BH and Barossa Hills Fleurieu would have to go to Adelaide but the other areas had a service in place where they had to go into one of the major centres and it was felt that that model needed reinvigorating to get more staff participating and providing that service and also expanding.

Katie-Jane Orr:
So can I, just to pause there for a moment, I understand we've had evidence this morning that this decision to reinvigorate and expand happened in around January 2023?

Debbie Martin:
That's right.

Katie-Jane Orr:
And it happened as a result of more people travelling for forensic medical examinations as time had gone on?

Debbie Martin:
Yeah.

Katie-Jane Orr:
So, sorry I interrupted you, but that was the decision to reinvigorate and expand and did the Rural Support Service get involved at that stage?

Debbie Martin:
So the role, Yarrow Place, Women's and Children's Hospital role was to consult and work with the six regions to do that. Our role, what we had been asked to do at that point was to update the procedures, because we, that's one of the roles the RSS does is procedures for everything. So we were asked to update the procedures, so we were involved in that sense. But Women's and Children's ran the consultation to say what do we need to do to reinvigorate and as a result of that it became evident that there is considerable work. It wasn't as simple as just reinvigorating the model. There were a lot of barriers and reasons why it wasn't working as it had been intended and it was felt that we needed to take a step back. So then this is where we became involved as a rural support service because we have one of our workers which put forward a briefing to the CEO saying look, you know, we think there needs to be a whole look at the model of care from beginning to end and we put forward a proposal that there be a project officer funded to actually do that, which the six regional CEOs then did fund and then once that position was on board in December 2023, we began that project.

Katie-Jane Orr:
You just said December 2023, is that when the project commenced?

Debbie Martin:
That's when the project commenced.

Katie-Jane Orr:
I will ask you more about that in just a moment. What was the scope of this project?

Debbie Martin:
So the scope is really to look at just the initial crisis response was what we were originally, to actually be able to provide a model that would manage the initial crisis

response for victims-survivors, who are up to the age from 16 and above. And so they didn't need to travel to Adelaide, and that they could receive a timely service, and that that service would be within 24 hours. Within the 24 hour time frame available.

Katie-Jane Orr:
And so, is it correct that that project was to look at all the options, assess them and recommend a model to move forward with?

Debbie Martin:
That's right. And it could include the model that we currently have in place, if that was deemed that it could just have some things done to it that would make it work.

Katie-Jane Orr:
So you said just before it commenced in December 2023 and then before that we heard you say that it was January 2023 that a decision was made to reinvigorate the model, so is it correct that what happened in that year until the project commenced?

Debbie Martin:
Women's and Childrens undertook consultation with the LHNs about reinvigorating the model and how that might happen. So that's what happened during that year, and then look, I think it was, I can come back to you about this, but I think it was around September where we put a proposal to the CEOs to say, look, we think that it actually needs resourcing, and I think there was also a thought that from the Rural Support Service perspective, I suppose, we're quite used to working across the six LHNs and developing models, and often models that might work in metropolitan area don't work in the country area. And so we said, look, we're happy to take oversight of doing that, but working very closely with Women's and Children's and SAPOL and the Attorney-General, so we brought together a whole group of people we wanted to work together with, but I suppose that's what we proposed to the CEOs in September and then once they approved that it just took the time to get an approach project officer on board. because it is a specialised skillset.

Katie-Jane Orr:
And so the hub and spoke model that you've referred to and we've heard evidence this morning that the idea of the model is that the large four regional general hospitals would have staffed, staff, excuse me, trained to perform the forensic medical examinations and Yarrow Place would provide training, telephone support, advice to regional health practitioners. Is that correct? So you've referenced in your evidence that a decision was made or it became apparent that that hub-and-spoke model wasn't working and there were some barriers to that working. I am going to ask you to explain what they are, but can I just clarify before I do that this is information that doctors, practitioners, executives in the local health networks are reporting back to the Rural Support Service. So can you describe some of those barriers for us?

Debbie Martin:
Yeah, and just to clarity as well that we, because we've done all the project that started last year in December is fairly much complete, and so as part of that though, we did retest all of that, so we did a diagnostic phase of the project to say, so we could really understand what was happening, and so that solutions would not, would build on the things that were working and not, and address the barriers. So that was what we did at the beginning. So this, what I'm saying now, is what's come directly

here from clinicians. And we also spoke to victim survivors. And what we heard really kind of clearly is that, and it's not uncommon, that we have a generalist workforce in country. So, mostly our services in the hospital A&Es, emergency departments are provided by GPs and with a nurse. And in some hospitals, there might only be two nurses on and then the doctor's not there, they get called in. So, that's kind of how it works. And so, it's a generalist skill set. And so, it's not... So, that is one of the barriers, I suppose, is that when you've got a workforce that's generalist then they need to upskill to be able to provide services that are more specialised. And that's something we commonly do with lots of things. So one of the barriers is basically that, is actually finding people that want to specialise in particular areas, because they're employed as a generalist. So one of the barriers was that. One of the barriers is about actually having the time to do the education and the training when you've actually got a full-time role doing something else. One of the other barriers that people raised is the support that they would get. They might be the only person in that local health network that is delivering that kind of service. So peer support and being able to have that closely around you, being able to work in a team that's dealing with similar issues to you, so that was one of the barriers. some of the barriers that people, I'm just trying to think, it's the overarching governance of you know, of it because different people will be, the line management even of who reports to who and then who's on the roster actually is, so it becomes quite complex. Payment was an issue in terms of traditionally people are paid if they get called back in but that that means it's quite disruptive for people's lives in that they're on call all the time. They can't go very far. They might get called back in and then they get paid if they get called back in. Just trying to think, there was something else that came to my mind. Oh, the clinical capability at the site. So one of the issues is that generally if we don't do a lot of a particular service, then what happens is that, you know, we might say that small service won't deliver that, which is part of the reason why it was designed to be at hubs to begin with. But even so, the volume of people requiring the service isn't high. So people are concerned about currency of practise, whether they're doing the right thing, they don't want to let anyone down, you know, maintaining their skill set when they don't deliver very many services of that type. So there's some of the barriers that clinicians raised. And another barrier is vicarious traumatisation, in that obviously it's a very traumatic experience for the person who's receiving the service, but also clinicians over time can experience trauma from continually providing those types of service, so that was identified as well about being able to get enough support to debrief and after.

Katie-Jane Orr:

Thank you. We understand that some are saying that they are nervous about having to go to court.

Debbie Martin:

Yes, there's another and I'm, so essentially what the clinician has to do is they do a report after they've provided the forensic examination and they have to do an affidavit and they can potentially be called to court. Now that's what they're saying and you know people feel that it's possible that they might have to be called into court. We have checked to see over the last 10 years how many people have been called into court and apparently it's four to five people, that’s the estimation that we’ve received, that we’ve tried to find out. We got that information from Yarrow

Place so they might be able to verify that. That's from their memory as well, how many we're aware of.

Katie-Jane Orr:
Okay, thank you. So that's information received from Yarrow Place about practitioners conducting examinations through the Yarrow Place service.

Debbie Martin:
No that is the regional people who have had to come into court.

Katie-Jane Orr:
Oh, sorry, I understand.

Debbie Martin:
Because they support them with that, so they said that maybe four to five times in the last 10 years have regional people like the GP or the nurse to present that call.

Katie-Jane Orr:
And we had Ms Dee giving evidence this morning from Yarrow Place and she was explaining the distinction between the person who takes the samples, which in the hub and spoke model would be the GP that you're talking about, compared with the expert who would give the opinion about the evidence. And they are the Yarrow Place expert who have had more training. So that four to five people in ten years, we're talking about they are the people taking the samples, the expert evidence is it.

Debbie Martin:
Oh, it is always provided by Yarrow Place, yeah, they provide that, we don't, the clinicians locally don't.
But I think there's a concern. Yeah, the concern yeah, valid or not is that they may have to present at court and because some people have had to yes, I Think that's where that comes from.

Katie-Jane Orr:
You mentioned training, specialist training. I want to ask you a bit more about that. So we also heard this morning that the training can sort of fit in two categories. One is a more general trauma-informed, how to respond to sexual violence training. And then there's the how to conduct a forensic medical examination training. I understand that trauma-informed training is often provided anyway to medical practitioners in regional areas, is that correct?

Debbie Martin:
We provide, so RSS and some of the regions as well, provide Ask, Assess, Respond training, which is related more to domestic violence, but as part of that, it provides some trauma-informed care training. So it's not delivered specially around sexual assault, but it is delivered in regard to... as part of their Ask, Assess, Respond. So a lot of the clinicians will have had that training, but it's not, the Yarrow Place, my understanding of the Yarrow Place training is that it's a full day training that they provide, which is a trauma informed response to sexual assault training that they provide in regional areas, and my understanding is that it's difficult to get nursing staff to attend that training because it's a full day.

Katie-Jane Orr:
You so even when conducted locally, it's difficult to get them to attend the one day.

Debbie Martin:
Yeah. I think that's because of workforce issues.

Katie-Jane Orr:
And then we also heard this morning that training to conduct a forensic medical examination is not required, there's no requirement, but of course it's better if it's been undertaken. But Ms Dee explained that the level of training is really up to the individual practitioner and dependent on their experience and skills. And so, is that consistent with your understanding that there's no set amount of training that needs to be undertaken by these practitioners?
Debbie Martin:
My understand is that it's between two and five days and it depends on the skill set of the practitioner but I do also my understanding is also that you know Yarrow Place, if they had concerns about somebody being able to deliver the train the service after that training that they would make that known like yes I don't think that it's not just the clinician that gets to decide whether they're ready
Katie-Jane Orr:
Okay, thank you. Back to your project. So you said before it's, I think you said before it's nearly completed, is that correct?
Debbie Martin:
It's at the report stage, so we do have a, you know, there's a draft report which is just being, the project officer has had to attend something overseas, so, but the project report is being, it's in draft form, it's just being edited to make it easier for non-subject matter experts to understand because obviously the model needs to be agreed by people like myself and CEOs and lots of other people that are not an expert and so it needs a bit more fleshing out of some things and so that's what's happening at the moment just to get it really clear what it is that we're proposing.
Katie-Jane Orr:
And then what's the next step?
Debbie Martin:
It's due to go to the CEO meeting on the 10th of December.
Katie-Jane Orr:
And is it then for the CEOs to decide whether they adopt the recommendations in the report?
Debbie Martin:
Yes, I would imagine at that meeting that they will probably take it on notice, like they will take it away and have more conversations about it. But the purpose of that meeting is for them to provide feedback and to say, you know, strengthen this, what about that, you know, how's it going to be funded, you know, all the things that CEOs are going to ask. And anything we might have that's not clear, you know, we'll go back. So it's really their opportunity to really view it and get a sense of how comfortable they're feeling with it and whether there's anything else we need to do prior to it being fully accepted. But in saying that, I know the CEOs are really committed to implementing some change. So they have already agreed to fund the continuation of the project officer for another 12 months so that whatever is eventually agreed can be implemented. They have already put aside resources for that.
Katie-Jane Orr:
And when you say put resources aside, you mean for that project officer to continue in their role to go through the implementation stage. I am going to ask you about the

proposed model, perhaps first because you've mentioned it. Through this implementation stage, what sort of do you see happening in that 12 months?

Debbie Martin:

So, I think there are things that we potentially can do straight away within the model, but there's a number of things that will need to be worked through. How are we going to fund that to happen? How it will be funded? We'll have to be some looking at how is that going to be funded. Some things can be funded within the existing mechanisms. So I think some of those things could potentially begin. So what we're envisaging is that we will try to implement things that are quick to do while we concurrently work on looking at how do we resource some of the things that are more difficult. And then there's other things that are not just about money but also about policy, procedure or about agreements. So, for example, one of the things we're trying to build into this new model is early evidence kits. Other states have early evidence kits and we don't have early evidence kits. We believe that that would be very useful in regional South Australia. So more work will need to be done, but it's definitely within our model. We're recommending early evidence kits be available in every hospital in regional South Australia.

Katie-Jane Orr

And when you say more work needs to be done, do you mean by the Rural Support Service of others?

Debbie Martin:

At the moment I think that sits with SAPOL, whether that remains sitting with SAPOL, but at this point in time there is a project, there has been a project sitting with SAPOL in relation to the early evidence kits.

Katie-Jane Orr:

So funding, you think some of the proposed model can be absorbed within current costs?

Debbie Martin:

Yeah, some and some can be commissioned for activity, like there are activity-based funding codes that the Commonwealth provide. As part of the project, we've looked at in other states, what other states are doing and overseas as well, jurisdictions, and probably New South Wales is the model that we think is probably the more mature that we've been looking at in terms of utilising the activity-based funding codes at the Commonwealth have provided their new codes, maybe not that new, but in health it's I think they're 18 months or two years old, but they're not, like they haven't been around all this time. So New South Wales utilised activity based funding through those codes to provide their service, but their advice to us has been that that doesn't fully cover the cost of the service and that's where we will need to look at like how do we manage that. And there are other people at this point in time, SAPOL funds some of it, Attorney Generals fund some of it, Health funds some of it. So it's about, I think, what we think from a country perspective is if we can pull our resources and work in a multi-agency way and look at where some things maybe that are funded now by a particular party could be funded through activity based, maybe we shift that and then we maybe use those resources for something that can't be, that's what we will need to work through in the next stage.

Katie-Jane Orr:

Yeah, so that hasn't been costed yet?

Debbie Martin:
No. We've got, all we have is, we know how much we will be funded, so we do know... Yeah, we know how much the activity-based funding is for each episode, at each time a service is delivered. Part of the problem for us is that at this point in time in country, women only really present to the hospital, or men and victim survivors only present to the hospital generally with SAPOL. We don't provide a just-in-case or you know the storage of evidence so which in metropolitan women, men, victim survivors can attend Yarrow Place and they can have evidence collected and they don't have to make a decision about whether they want police involvement. People living in rural South Australia don't have that option at this time and we would like them to have that option as part of this.
Katie-Jane Orr:
So you're saying it's hard, correct me if I'm wrong, it's hard to estimate the cost because it may well be that demand will increase?
Debbie Martin:
We suspect it will significantly.
Katie-Jane Orr:
If the options are available?
Debbie Martin:
Yes.
Katie-Jane Orr:
And so you can estimate the activity cost, you've still got some left over that, I'm being very simplistic about this, that you're not sure how much that's going to cost and that's a work in progress.
Debbie Martin:
That's right.
Katie-Jane Orr:
and then as to approval for additional funding I understand from your evidence that that hasn't been obtained yet.
Debbie Martin:
No.
Katie-Jane Orr:
Thank you. So this proposed model, if you don't mind explaining to us what, in a general sense, is okay?
Debbie Martin:
I'll try not to get into the weeds.
Katie-Jane Orr:
But just about what it is that is being suggested.
Debbie Martin:
So I think the first thing to put the model in its context is what we've heard from clinicians on the ground is about feeling isolated. And their main role might be an A&E nurse, or it might be an inpatient nurse, or it could be someone working community health, or it could be a GP. But they're not a part of a team that actually deals with sexual assault, or even a team that deals with trauma, domestic violence or other areas. So one of the things that we're recommending as part of this model is that the services related to sexual assault be embedded in our prevention and response to violence and neglect teams. And at the moment in each LHN there is

one FTE, and that's new. the CEOs have really identified that this is an area where they need to invest and they have all put in place a person who's responsible for some of that coordination around the prevention and response to violence, abuse and neglect. So what we're recommending is we build on that and that we create teams within each LHN, one team or maybe some LHNs that are bigger, might want more than one team but we're recommending that there be a team in each regional LHN that has a responsibility for that response to prevention and response to violent abuse and neglect and we're saying that we want this whatever resources we have for this programme to be embedded in that so I think that that is really important I mean it does go a bit outside the scope of what we were asked. However, that was really clear feedback from clinicians that they felt that they were quite isolated and it would be good to be able to be embedded into a team. We don't have enough, in terms of the number of people that would use the service, funding a team just for sexual assault wouldn't be possible. To have something like Yarrow Place in every region is just not possible. But if we were to create a small team in each LHN that had that responsibility, we think that's achievable. We think, and we think not, but we don't think that team would be able to operate 24-7. So, what we're proposing is that we work and continue, as we do now, working really closely with Yarrow Place so that we're leveraging off the fact that they do have staff on call 24-7. And so the proposal is that we continue to work together really strongly with Yarrow Place for the provision of the service and that Yarrow Place would continue to provide expert advice into the regions because even though we'll have these prevention and response, yeah, even though we'll have these, I keep going, say PARVAN is what we call them, so the PARVAN teams, we'll have these teams in place. They're still only small, so they will still need that support from Yarrow Place is what we're thinking. So, if I, that's kind of the setting, and the other thing that we want to do with the model is uplift the governance in the space, and so we don't have a statewide policy about how forensic medical examination would occur and there is legislation in that space so we believe that really we need to put in place a really clear policy. We need to be able to put in place really clear education and training so that not only are people trained but they're maintained and supported. So all of that sits around kind of the outside and probably isn't seen by the person who's receiving the service, but we think that's fundamental to making the service work in the long run. What we're then proposing is, I'm trying to find my picture of my model because it will be easier for me to remember it, but what we're proposing is that everybody comes straight. if somebody is a victim of sexual assault, that they would come directly into the A&E, they could if they wish, come directly to the A&E of the hospital in the town that they live, with or without the police, right? So it's up to them, whether they want police involvement or not, right from the beginning. So we're recommending that they be able to come straight in to the hospital and that that hospital would provide just the basics at the beginning, like the initial assessment and look at any physical issues that might need to be dealt with as well, you know, in terms of strangulation or head injury or any other injuries as a result of the sexual assault, and that they would ring a 1800 number. So we're proposing there would be a statewide 1800 number that they can get initial support from, and the victim survivor can get initial support from, where they can, and when we get early evidence kits, I'll say when because I'm hopeful, you know, that's hopeful, obviously I'm under oath, I don't know if we're

going to get, but I'm hopeful we will get early evidence kits. They could also be used in that context to gather early evidence, but that could be talked through with the victim survivor, with the nurse or the doctor, whoever's there in the A&E, along with whoever's on call roster, could have that conversation with them and they can make a decision then about, you know, what they want to do, because they might just want their physical injuries dealt with and they may not want to go further, they may want to do the early evidence kit they may want to have a forensic examination which we would then arrange the next appointment which wouldn't be necessarily at that site we don't believe we would have capacity to offer that at the site so they would need to go to one of the bigger hub sites to have that forensic examination done and the proposal is that we would offer that seven days a within business like 8am to 5pm and that's the proposal.

Katie-Jane Orr:
Okay, I'm going to ask you a few questions.

Debbie Martin:
Yeah.

Katie-Jane Orr:
Okay, thank you for that overview. So a person attends, are you suggesting any local A&E or emergency department? And you said they'll get a basic response with their physical systems addressed, systems, excuse me, symptoms addressed. Perhaps if I can explain it like this to make sure I'm correct. We heard evidence this morning that there is a health medical response, which includes injuries, welfare, and then there is the forensic medical procedure.

Debbie Martin:
So they'd get the health response.

Katie-Jane Orr:
And then in terms of if... so is the suggestion that the 1800 number, and I will ask you more about that line in a minute, that they only give advice if a forensic medical examination is going to happen, or any advice?

Debbie Martin:
Any. So they would provide advice, so it could be that they don't want to have a forensic medical examination but they can still be linked up to counselling, and they may have other, like as they talk on the phone to someone who's got more skill in that area, they may divulge other information, so there have to be some backwards and forwards with regard to that conversation and it would be dependent on the person as to what needed to happen next.

Katie-Jane Orr:
Okay, and then who, so you said 8 til 5, is the idea that it will be limited to 8 til 5, or will it be a 24 hour?

Debbie Martin:
So the 24 hour phone line will be 24 hours is the intention, but the actual for staff to provide the forensic examination would be available eight to five, seven days a week is the thought, which you know means that it does mean people still have to wait, but what's happening at the moment is people having to wait or they're having to travel to Adelaide and they still have to wait. Yes. So we think that on the whole that given that 72 hour window especially if we had the early evidence kids that could provide a good service and the other thing that I didn't mention that we've built in for when the

actual forensic is being conducted is that what we're wanting is some telehealth built in with Yarrow Place so we're recommending that there be something to support because we're still going to have the same issue that clinicians maybe haven't done that, provided that service before or not very often or it might be a while since they have. So depending on the skill of the clinician and what they feel that they need, they could actually use the telehealth to provide support from Yarrow Place. So that's the proposal. Obviously that would need funding.

Katie-Jane Orr:
And who's providing the actual forensic medical examination, who's doing that in this model?

Debbie Martin:
So it would be the person at the site, so it would either be a GP or a nurse who is trained.

Katie-Jane Orr:
Who is trained?

Debbie Martin:
Who's trained. Yeah, we're recommending that they're trained.

Katie-Jane Orr:
Um, okay.

Debbie Martin:
And we have noticed in other states there's requirements for people to be trained.

Katie-Jane Orr:
And is it right that in this model, they would be part of this team, this team that you've talked about? And who's responding on the phone line?

Debbie Martin:
So during the day, the plan with the 1800 number is that it will divert to the local team. But overnight, it will divert to the women's and children's team, who already take calls.

Katie-Jane Orr:
And then that local team, are you talking about this team that you're setting up?

Debbie Martin:
Yeah, that's right.

Katie-Jane Orr:
We've heard a lot about workforce issues in regional areas. How do you think, or is there a plan for supporting this model in terms of a local workforce?

Debbie Martin:
We think where we're more successful in, because workforce issues are not uncommon, obviously, like in South Australia, but nationally and internationally, but where we've found we've had the most success in attracting and retaining staff with specialty areas is when they are together, and where they're provided really good education, where they've got really clear guidelines, and there's really good governance, they've got, you know, clarity of role, where they've got peer support. So where they've got those things in place, you know, you have more success in attracting and retaining staff. And one of the things that we've, the project officer has told me that she has calculated, so we haven't had anyone else check this, but we believe that about 85 % of people that have been trained in the last few years to provide services have stopped providing a service. So we've got a massive attrition

rate at the moment. We train people, they don't continue because of all the barriers we've talked about. So we've got to do something that wraps around our workforce and supports them and so yeah the things they're saying is you know being part of a team, not having to be on call 24-7, you might be the only person in your region that's delivering this service, you've got family, you've got other commitments, you're constantly on call. So it's not a sustainable model, we don't expect people to do that in other areas.

Katie-Jane Orr:
other areas. What do you mean other areas?

Debbie Martin:
In other areas of health, we don't expect people to do that, so I think they really do need to, but it's not sustainable to have that one or two people on call all the time, which is why then they can't provide the service at different times when people come to Adelaide.

Katie-Jane Orr:
So we've heard about some of the issues with the hub and spoke, or sorry, I'll start again. There's been this issue in regional areas, and as at January 2023, this decision was made that something had to be done. So what's been happening in the meantime while this report's being conducted?

Debbie Martin:
Yeah, so the LHNs have committed that they would endeavour to continue to have the hub and spoke model in place, and that has been varyingly successful, depending on the LHN. I think it's, and I know you're probably going to ask me why that is, but it has been varyingly successful, and I think it is about the challenges of workforce, but yeah, that is what's been happening. So in some LHNs they are still delivering quite a bit of the forensic sexual assault for their community and even for other communities, I would say, like the Flinders and Upper North, I'd say is a really good example that they are not only providing services for their communities but also for the Eyre and Far North community, a lot of people are coming to. But I don't think, you know, I suppose from where I've worked in country for a long time and I think every LHN is different and the resources they've got are different, yes, just because something might work in one place doesn't mean it can work everywhere.

Katie-Jane Orr:
And so the different LHNs are, for whatever reason, are providing different approaches.

Debbie Martin:
Yeah, well, they've got different numbers of people prepared to provide the service. Some of them have got more distances for people to travel, like, yeah, there's a lot of... And that's, I suppose, why when we come to the model that we're proposing, we've tried to consult really very thoroughly with clinicians, as well as the client, like the victim survivors as we have spent a fair bit of time talking with advocacy groups and running yarning circles with clinicians and workers, trying to really understand what are the barriers, and if we're going to get this to work, how could it work? And we're still talking through, even though this proposed model is nearly ready to go to the CEOs, still, I suppose the thing we're most grappling with is that workforce issue. You know, it is really that workforce issue and how to build it in a really sustainable way. We've got RFDS saying that they're happy to be involved as well. Maybe they

can fly people in to do the forensic examination. So there's other agencies as well that are saying, together, and that is often how things work in countries, that it's together that we can do things. So we're really looking at that multi-agency approach, like how can we all use the resources we've got in a way that's going to lead to having a better outcome.

Katie-Jane Orr:
I just want to ask you about some numbers, because I know that you've considered this as part of the project. So the Royal Commission has obtained information about how many practitioners are available or qualified to conduct these forensic medical examinations in each local health network. Do you have those figures?

Debbie Martin:
This figure we have is 8, that there are eight people in total who are trained that are providing the service at the moment. Which means some LHNS only have one person.

Katie-Jane Orr:
The region that you referred to before, including Whyalla and Port Augusta, has 1, 2 and 4? Yeah. And is it correct that there are regions that have none?

Debbie Martin:
Yes, so Barossa Hills Fleurieu was never part of the hub-and-spoke model and has always, patient, victim survivors have always gone to Adelaide. We don't, Barossa Hills Fleurieu is part of these projects that we've identified that they'd like to be able to provide that service within their LHN. I think the other, Yorke and Northern have got one, I know I've got it here somewhere, Yorke and Northern I think have got one, Riverland have got one, no two.

Katie-Jane Orr:
and Port Lincoln has one.

Debbie Martin:
and Limestone Coast don't have any.

Katie-Jane Orr:
Oh, sorry, Limestone Coast, don't have any, is that what you said?

Debbie Martin:
But they do have people trained but don’t have anyone currently providing.

Katie-Jane Orr:
Okay, thank you.

Katie-Jane Orr:
While we're on data, if I could just ask you, I asked you previously or the Royal Commission asked previously about data from regional areas about the number of forensic medical examinations being conducted and is it correct that that data has not been able to be obtained?

Debbie Martin:
Yeah, so we have, there is no one data source. So for the project to get an idea, we've got SAPOL data, Yarrow Place have pulled some data, like had to physically pull data, and then we've had to ring LHNs and get data, and that's because we don't, now that the electronic Sunrise is being rolled out across all of country, we'll be on the same system as Metro, so that will enable us to have data in the future but that is not finished being rolled out and so we haven't there's not a consistent data source.

Katie-Jane Orr:
Is Sunrise the new system?
Debbie Martin:
Yes. This is a new system it's been in Metro for some time.
Katie-Jane Orr:
Thank you I have no further questions.
Natasha Stott Despoja AO:
Thank you. I'll just have a couple of questions. I actually was going to ask about the possibility of flying in practitioners in order to perform examinations as opposed to the onus being on the victim survivor. And you mentioned the Royal Flying Doctor Service is interested in in being involved. Does that happen at all currently?
Debbie Martin:
No, but it is certainly something that we've been thinking about as well in terms of you know whether if each LHN has a team whether there's an ability to fly people as well either around or from metros and maybe from Yarrow Place or from another part of country or RFDS do have trained staff as well. So maybe there's a way to bring all of that together. So we have been thinking about whether it is possible to fly people in rather than having victim-survivors travel.
Natasha Stott Despoja AO:
You've answered quite specific questions from Counsel Assisting regarding the project and the stage that it is up and the model that is proposed. I'm just curious about the oversight policy or legislative oversight in terms of once the CEOs make a decision, is it up to them, is that where the buck stops that they're responsible for that decision or is there a layer of government or governance that we should know about?
Debbie Martin:
Yes, so if the CEOs can, if recommendations relate to things within the CEO's remit, as in they have the resources to do that, then they can approve that. But there will be recommendations that, and we are in the process of, a briefing is sitting with me at the moment, to the department to say we are going to recommend as part of this report that policy be developed. That's not something that we can do. The LHNs can't do that and neither can the RSS. That is done by the department so we are going to recommend that there be a policy developed around what happens statewide.
Natasha Stott Despoja AO:
That was, is that the legislative proposals you referred to in relation to governance and a statewide policy?
Debbie Martin:
There is already legislation in the state, so it's like normally, well quite frequently, if there's legislation, there'll be a policy that sits under that that says this is how you implement that. We don't have a policy, so we're going to recommend that there be a policy put in place that provides that overarching governance around forensic medical examinations.
Natasha Stott Despoja AO:
The last point in relation to data collection and the difficulties in having that statewide or all data about the local health networks and obviously there are steps being taken to fix that.

You did mention earlier that you anticipate demand for the kind of forensic medical testing and examination that's expected to increase. And I know it's hard to quantify, but I'm trying to... I'm wondering if there, even anecdotally, if you have a sense of how many victims... choose not to go ahead with a complaint because of the deterrence of travel and all the associated trauma and logistics that go with it.

Debbie Martin:

I don't know. I just think about it as a person myself that lives in country and go, well, I'm surprised that, you know, that people do, like it's quite a deterrent, isn't it, what happens at the moment. So, you know, my gut tells me that there would be, there's got to be a lot more people than what are presenting at the moment. But I don't have any evidence, like I don't have anything that I can, you know, say is definitive. The other thing, just linking back to the question, first question about what else can the CEOs do, all recommendations, one of the other things that we're recommending is there's a clinical capability framework which the department provides, Department of Health and Wellbeing, which delineates hospitals and says this hospital does this, this hospital does that, and it's based on your clinical capability, that's why it's called that. So you can't birth babies in these size hospitals if you haven't got all the resources, right. And that clinical capability framework is silent in regard to this issue of forensic medical examinations, but in other states it is actually within that document, so we are going to also recommend that that to be built in because that will then clearly delineate what needs to happen at each hospital. And it helps, I think, with the resourcing flow, and then because the other thing is obviously at the moment the hospitals will be funded for whatever it is that is presenting at the hospital, now, the services they're delivering. But if there's an increase, then we need to get an activity commission. So we need to be clear about that. And then if there are additional costs, as I said before, then that's something CEOs, you know, they're not, they can't make decisions outside their budget. So there will need to be some conversations about, can that be covered maybe by things that people don't have to pay for anymore? You know, maybe, because Attorney General's already put quite a lot of money in, SAPOL already put a lot of money in, maybe there's ways to reuse that money if we could get activity based funding for some of the things they pay for now. So that's what we're thinking, but there may also, you know, interstate are telling us that the activity based funding only covers about 70 % of the service, so the rest has to be found somewhere.

Natasha Stott Despoja AO:

It's interesting to put it in that context of clinical capability because what we seem to be drawing out from the discussions is that while there are a number of perceived barriers, rightly or wrongly, there is potentially the clinical capability, or it's potentially not as difficult as we might think to provide some of these services in situ, at least looking at the figures for Yarrow Place completing 33 FMEs and 32 just-in-case FMEs between January 2023 and July 2024 inclusive, these were because the local health networks could not provide. So that's a large number, which is why I guess it begs the question how many victims didn't pursue. So, but Ms Martin, thank you for your evidence today, Counsel Assisting.

Katie-Jane Orr:

Can I ask if the witness could be excused, please, Commissioner?

Natasha Stott Despoja AO:
You're free to go. Thank you very much. Thank you.
Katie-Jane Orr:
Commissioner, that brings us to the lunch break and we will resume later than normal at 3.15pm.
Natasha Stott Despoja AO:
Right, well I suggest we close proceedings for now and we will reconvene at quarter past three. Thank you.

Witness:
Commissioner Sarah Quick, Victims of Crime Commissioner

Natasha Stott Despoja AO:
Welcome back to day two of public hearings for the Royal Commission into Domestic, Family and Sexual Violence. Counsel Assisting. Thank you.
Katie-Jane Orr:
Commissioner, I'll call Sarah Quick.
Kerryn Hawkes:
You swear that the evidence you shall give will be the truth, the whole truth, and nothing but the truth. Say, I swear.
Sarah Quick:
I swear.
Kerryn Hawkes:
Thank you and please state your name.
Sarah Quick:
Sarah Louise Quick
Kerryn Hawkes:
Thank you.
Katie-Jane Orr:
Thank you. You are the Victims of Crime Commissioner in South Australia.
Sarah Quick:
Yes.
Katie-Jane Orr:
Can you tell the Royal Commission what that role is?
Sarah Quick:
So as Commissioner, I'm an independent statutory officer appointed by the Governor under the Victims of Crime Act and I commenced working with Victims of Crime in 2008 before being appointed Commissioner in 2023.
Katie-Jane Orr:
As the Victims of Crime Commissioner, what is your role?
Sarah Quick:
I guess broadly or to summarise, my role is to protect and promote and advance victims' rights and really to assist victims to exercise their rights as well as assisting them in dealing with the impact of crime. So it's important to ensure that victims have information available to them about their rights and exercising their rights, and also the health and welfare services available to them. I can assist victims in their dealings with government agencies, so there's the role of individual advocacy on

behalf of victims as well as grievance resolution. I can assist victims to have a voice in proceedings that impact on them, so that might be assisting victims with victim impact statements or assisting them to make submissions to the Parole Board. And then I can also make community impact statements under Section 15 of the Sentencing Act, rather than focusing on the impact on an individual victim, the impact on a community. And then I have a role in educating public officials about victims' rights and victims' needs and how best to respond to victims and I also have a role in identifying any systemic issues and advocating for systemic reforms, so advising the government on those reforms and how best to use resources to benefit victims.

Katie-Jane Orr:
You've been talking about victims that you assist, are there any eligibility criteria and what type of victims can you and do you provide assistance to?

Sarah Quick:
Certainly. So I am able to assist victims of criminal offences that happen in South Australia. In some limited circumstances I might assist a South Australian resident who becomes a victim of a crime in another jurisdiction, particularly if that jurisdiction doesn't have accessible or equivalent support, so I might be able to provide some assistance to them. But I can assist victims at any stage of the criminal justice process and at times Victims actually might approach my office for information and support before they even make a report to police. Often victims of crime, and particularly victims of sexual assault, can be quite apprehensive about making a report and will contact my office for information to better understand their reporting options. A number of victims request support to have someone attend a police station with them, it's a very daunting process, but unfortunately my office doesn't have the capacity to provide that level of support and I don't think there is a service that routinely provides that, but certainly that's something that victims have talked about as needing and would be beneficial to them.

Katie-Jane Orr:
You said you were appointed under the Victims of Crime Act, is it right that your role and what you are able to do, who you are able to assist, is governed by that Act?

Sarah Quick:
Absolutely, and as such there are some limits to the service that I can provide to victims, so being guided by the Act, some assistance can only be provided if a report has been made and if a victim is cooperating with an investigation and prosecution. In terms of victims of sexual assault and domestic violence, we could consider a report or a disclosure to a medical practitioner or professional as a report.

Katie-Jane Orr:
Do you in some circumstances provide financial assistance to people?

Sarah Quick:
Yes, particularly immediately after a crime has happened we might get requests for financial assistance to deal with the immediate impact of a crime. So sometimes that might be by way of an ambulance account or medical treatment or some other essential item that is really going to assist a victim in dealing with the impact of that crime.

Katie-Jane Orr:
You've mentioned victims of sexual violence. Do I take it that in your role some of the people you help are those who are affected by sexual violence?
Sarah Quick:
Absolutely. I think it's important to understand that there is no automatic involvement from my office. So it is very much on a as-needs or as-requested basis. So we really rely on victims approaching us or being referred to us for support. But very often, the involvement that we have with victims is once a victim becomes concerned about a particular process or dissatisfied with a process, that's often when they make contact with my office.
Katie-Jane Orr:
And do you, in that context, receive feedback from them about their experiences?
Sarah Quick:
Absolutely. I mean, feedback comes in a number of ways. Sometimes we will receive feedback about a victim's experience, sort of indirectly. We might be speaking to them about another process. We might be providing them with information about compensational counselling and they speak about their overall experience. At other times, the feedback is more direct because a victim is contacting us to make or lodge a formal grievance. So it kind of happens in two ways. When they do approach us to make or lodge a grievance, if that grievance relates to a breach of victim's rights, then I am able to consult. I will obtain a victim's consent to consult with the agency responsible. And if after consultation I'm satisfied that there has been a failure to comply with victims rights and that that agency hasn't sort of dealt appropriately with the grievance, then I can recommend that a written apology be issued to the victim.
Katie-Jane Orr:
Do you still continue to receive complaints and grievances?
Sarah Quick:
Yes.
Katie-Jane Orr:
Does the volume change over time?
Sarah Quick:
Yes, so what I've noticed in the last financial year, so 2023-24 financial year, is that my office actually received fewer complaints than ever before and I certainly don't think that is indicative of increased victim satisfaction. I'm concerned that victims may not be aware of complaint mechanisms or they may be so frustrated and exhausted that they don't actually want to engage in another process, or they may be complaining directly to an agency and that that complaint is being dealt with internally by the agency. And whilst that is entirely appropriate, it's problematic from my perspective because I might not have vision of all the systemic issues confronting victims and therefore I'm not able to necessarily advocate for appropriate reforms.
Katie-Jane Orr:
Turning to victims' experiences in the criminal justice system who've experienced sexual violence, generally speaking, are you able to share some of the themes, what you've been hearing from those people?
Sarah Quick:
I think, firstly, I'd say that I'm acutely aware that victims' experiences of crime and the criminal justice system are unique, and therefore victims' views do vary. But there

are certainly some common themes that emerge, and I think the overriding theme is that victims still feel largely excluded from and traumatised by the criminal justice system. And that certainly was reflected in a recent Victorian report that described victims as feeling silenced and sidelined. So very much victims feel as though they're kept on the periphery of proceedings and that is really in stark contrast to what's been described as the centrality of the accused, that the accused is seen to be central and vital to the administration of justice and victims are somewhat on the periphery of that.

Katie-Jane Orr:
Secondary?

Sarah Quick:
Secondary, yes, and certainly in terms of victims' rights, they feel as though their rights are secondary to or subordinate to the rights of the accused. I think victims very much appreciate that we have an adversarial system and they don't want the rights of the accused to be impinged upon. What they're frustrated by is that they feel as though they have to fight for their rights to be respected and observed and given due consideration. They're also further frustrated by the fact that the onus is on victims to have their rights respected and pursued. So, for example, a victim is entitled to be kept informed if they ask. So that presumes that a victim's first going to know that they have rights, and secondly, that they know to ask to have those rights instituted. So that can be very frustrating, because often by the time a victim becomes aware of their rights, they've missed opportunities to exercise those rights along the way. And I guess following on from that, an example would be that victims often expect that they're going to be kept informed that that will be informed on the process, and instead they feel as though they're kept in the dark, and again that kind of conveys this message that they're irrelevant to the processes. The problem with that is that it lays this foundation for all subsequent interactions that that victim has in the criminal justice process, and for victims that feels like a foundation of distrust, rather than when rights are proactively observed and respected, there's a foundation of trust built.

Katie-Jane Orr:
Are you saying as well, that if that is done at an earlier stage, they haven't missed that opportunity I guess?

Sarah Quick:
Exactly.

Katie-Jane Orr:
We've heard a bit about disbelief. Is that a thing?

Sarah Quick:
Definitely, I mean, victims very much confront attitudes and behaviours that leave them feeling blamed and judged, and that is particularly evident for victims of sexual violence. Victims are also incredibly frustrated and disadvantaged by the time it takes to resolve of matters, particularly through the Court process. And that consistently features as an issue in reports for victims of crime. And the longer it takes for a matter to be resolved, the more likely it is that a victim loses confidence in the justice system. And it also runs the risk that a victim is going to suffer a secondary injury. What we need to appreciate is that when a matter is unresolved, for victims, it's very much as though they and their life is suspended. They're unable

to move forward in their healing and often just with their life in a practical sense.
Katie-Jane Orr:
When you say secondary injury, can you just explain what you mean?
Sarah Quick:
Yeah, I think trauma caused by the justice process rather than the crime itself.
Katie-Jane Orr:
Further trauma, in addition to that.
Sarah Quick:
Yeah.
Katie-Jane Orr:
I'm sorry, I may have interrupted you.
Sarah Quick:
Oh, I was just going to say, in terms of the timeframes, I mean, some victims are actually unable to endure the timeframes. One victim that I spoke to, she was talking about the protracted nature of the proceedings, and she very much described that as a kick in the guts for her, and it was her sole reason for requesting a discontinuance. And that's incredibly frustrating from her perspective, but it also means that justice isn't done.
Katie-Jane Orr:
So can I just clarify, she expressed that she didn't want the charges or the prosecution to go ahead.
Sarah Quick:
Correct.
Katie-Jane Orr:
It was withdrawn?
Sarah Quick:
Yes. She felt she couldn't endure the emotional stress any longer.
Katie-Jane Orr:
Sorry, I keep interrupting you. What about their understanding of the process?
Sarah Quick:
I think generally speaking victims find the entire criminal justice process as incredibly complex, confusing, difficult to navigate and because of that they really expect strong and consistent support to be able to navigate that system. In South Australia we have a range of services for victims and they're excellent services but unfortunately they're not necessarily well connected and most don't deal with a victim's needs holistically, they deal with aspects of victims' needs throughout the criminal justice process. And they're also, those services interact with victims at moments in time, so there isn't a service that really supports a victim of sexual violence from the time they report a crime to the time that the matter is finalised. And so for victims that's frustrating and exhausting and we often find that victims experience agency or service confusion and fatigue. So at times, a victim might contact my office. They may have been referred by another agency. But by the time they've made contact with my office, they actually don't know what my office is or why they're ringing my office. Because they've contacted so many different agencies throughout their process.

Katie-Jane Orr:
Is it correct as well that an individual victim's experience might be entirely different depending on which agency they happen to connect with or which particular professional they might be dealing with at the time?
Sarah Quick:
Absolutely.
Katie-Jane Orr:
So that's the overview. But if we can move to victim survivors who are asked to give evidence in a trial. So we know that there have been quite some many legislative changes over time, probably more so over the last 10 years designed to improve the experience of victim-survivors giving evidence. I might give some examples, and you tell me if you can think of any more, but do they include, we have vulnerable witness provisions for giving evidence, which includes being able to give evidence from outside a courtroom via CCTV, for example, or having a closed court where people can't come in. We do have a priority trial system for the victim-survivors who are children, with an attempt to shorten the timeframes that you've been speaking about. There are provisions to record someone's evidence so it can be replayed if it needs to be used again, if there was a retrial or a mistrial. And there's also provisions to use police-recorded interviews as evidence. So if a police officer interviews, in particular, a child, then that may be used as evidence instead of the person having to tell their storey again. There are rules that do not permit cross-examination in relation to sexual history without the permission of the judge. There's no access to counselling notes for sexual offence victims. There are provisions around comments not being allowed to be made in relation to lack of complaint for sexual offences, but that's being interpreted in various ways. So these are the types of provisions that we do have in our legislation already. Is that consistent with your understanding?
Sarah Quick:
Absolutely.
Katie-Jane Orr:
In your view, and based on your interactions with victim-survivors going through this process, have those provisions helped in any way?
Sarah Quick:
Look, I think they do. But I think giving evidence and being cross-examined remains the most challenging and confronting part of the criminal justice system for most victims, not all victims, but most victims. And a recent survey of victims in Victoria confirms that, in that of the respondents to that survey, of those respondents that gave evidence, only a third of those respondents would give evidence again. So whilst those provisions are important and have merit, it's clearly not enough to deal with victims' overall experience.
Katie-Jane Orr:
What are you hearing about that experience in particular?
Sarah Quick:
I think it's just confronting that they feel as though they're not believed, that very much the focus is on their behaviour, often, rather than the behaviour of the defendant. And that they very much feel as though not just in giving evidence and cross-examined, but the justice system as a whole starts from this position of disbelief. That's the way it's perceived by victims, rather than starting from a neutral

position and working towards either proving or disproving a crime. I think also victims in the Court process are somewhat shocked when they realise they're not entitled to their own lawyers. It's often difficult for them to comprehend that prosecutions are on behalf of the state and in the public interest rather than solely on their behalf and therefore it's quite difficult for them to understand the role of a prosecutor, that the role of the prosecutor is to help the Court reach a decision based on all the evidence. And the way that kind of manifests is that victims observe the defence lawyer and their passionate advocacy for their client and they expect prosecutors to display that same passion and advocacy for them. And when they don't, victims often perceive that sort of more subdued approach of prosecutors as indicative that the case doesn't matter to the prosecutor. And that's certainly not the case, but that's the way it can be perceived by victims. and again that enhances that level of distrust that victims might have of the system overall.

Katie-Jane Orr:
And what about, we've had some submissions referring to respect and dignity. Can you talk to, I'm talking about giving evidence.

Sarah Quick:
Yeah, absolutely. I mean, I think, you know, as we've said, those provisions that you outlined certainly assist with isolated aspects of a victim's experience, but they don't deal with victims' overall sense that the system doesn't treat them with the same level of respect and dignity, their overall distrust of the system that really questions their credibility, and just that sense of inequity between the defendant's rights and their rights.

Katie-Jane Orr:
And I want to move to the topic of sexual assault myths and some of the research that's been done in that area. Can you explain what we mean when we talk about sexual assault myths, or rape myths as it's sometimes called?

Sarah Quick:
Certainly. I mean, I think, firstly, I'd say that attitudes, community attitudes generally, are beginning to change, but that change is very slow with regard to sexual assault. And so problematic myths and stereotypes and misconceptions do still persist, and they do still persist in the face of evidence that easily dispels those myths. evidence around the way victims behave during and after sexual assault is really contrary to those outdated views that are perpetuated through myths and misconceptions. So for example, real or credible victims would report a crime immediately. Now, by consequence that's saying that a delayed report is indicative of a false report. But the evidence, there's lots of empirical evidence to say that most victims actually do delay reporting or may never report sexual assault. And we know there are a range of reasons why victims might delay or not report, and fear of an offender or fear of not being believed, shock, humiliation, perhaps even dependence on a perpetrator, are all reasons that contribute to delayed reporting or not
even perhaps not knowing what supports are available to them.

Katie-Jane Orr:
Can you give us another example of a myth?

Sarah Quick:
Certainly, a commonly held myth is that a victim of a sexual assault or a traumatic incident will be able to provide a clear and consistent and detailed account of their

victimisation, and that's really inconsistent with research on human memory and the impact of trauma on memory. The research demonstrates that more often than not, Victims that have experienced a one-off traumatic incident are far more likely to have fragmented and confused memories, memories that lack specific detail.

Katie-Jane Orr:
I think it's fair to say that there are many of these myths.

Sarah Quick:
Yeah.

Katie-Jane Orr:
If I could just, perhaps, list a few more.

Sarah Quick:
Yep.

Katie-Jane Orr:
A belief that rape is always violent or involves physical force. A belief that you cannot be sexually assaulted by your husband or partner. If the victim had previously consented to sexual activity, they must have consented on this occasion. And I mean I could I could go on but..

Sarah Quick:
Can I add one?

Katie-Jane Orr:
Yes.

Sarah Quick:
In terms of the myth that, you know, victims of sexual assault or people regularly make false reports around sexual assault, the evidence is also very clear that that is a very small percentage of sexual assault reports. I think it's less than 5%. And I think even in that small percentage, we also need to be very careful about making judgments because we need to understand the motivations of a person who makes a false report as well and perhaps there is a need to understand the context of that. That person might be requiring some other support as well.

Katie-Jane Orr:
And, I think you explained this before, but is it the case that these outdated, I think you said, beliefs have been researched and proven not to be true?

Sarah Quick:
Absolutely, there's extensive research.

Katie-Jane Orr:
Community attitudes are changing?

Sarah Quick:
Slowly.

Katie-Jane Orr:
Slowly, right. So my next question then is, if they are relied on, or if they feature in the criminal justice system, what are the effects of that?

Sarah Quick:
I think there are multiple effects. I mean, overall, they deeply impact a victim's experience and erode a victim's confidence in the criminal justice system, which further contributes to that reluctance to report. So if a victim's a victim of a subsequent sexual assault, then they may not even bother reporting, which means offenders are walking free, and that has implications for community safety, obviously.

Because they focus on the victim's behaviour, that the myths and misconceptions focus on the victim's behaviour rather than the behaviour of the perpetrator, then they ultimately seek to undermine a victim's credibility. If they feature during the investigation phase, it might mean that certain lines of inquiry aren't pursued. If a victim accepts the false notion that they are to blame, so if they accept one of the myths, then that might actually mean that they're going to stay in an unsafe relationship or unsafe environment. During the trial process, if they feature during a trial and they remain unchallenged during that trial process, then it might mean the judge or the jury are left with misinformation that just creates doubt and ultimately may contribute to an acquittal

Katie-Jane Orr:
because it undermines the behaviour of the...

Sarah Quick:
Correct. It plants the seed of doubt.

Katie-Jane Orr:
I expect that there are, obviously the perpetuation of these myths would have an impact in the immediate criminal justice environment, but that would extend to the broader community as well.

Sarah Quick:
Absolutely, and because they're in the broader community, the justice system is not immune.

Katie-Jane Orr:
Through your experience dealing with victim survivors who have been involved in the criminal justice system and indeed professionals who are involved in the criminal justice system, would you say these myths are still being perpetuated?

Sarah Quick:
Absolutely. I've heard from both victims and people working within the justice system that they are still evident. I think it's important to understand that it's not always the result of ill intent, that most professionals working in criminal justice are doing the best they can, and in fact some people might not even be aware that they are employing those myths and misconceptions. At other times, I think it's difficult because I think people might be aware that a myth has arisen, but not be able or know how to or have the evidence to be able to challenge that myth directly. And then I guess we also have to acknowledge that they are advantageous to defence. And so because they are advantageous to defence, it's difficult to eradicate them and that's why it's really crucial that people have available to them empirical evidence to be able to challenge those myths as soon as they arise.

Katie-Jane Orr:
So that brings me to my next question. So you made a submission as the Victims of Crime Commissioner to the Royal Commission and it recommends the development of a toolkit to address misconceptions and stereotypes relating to sexual violence. Can you explain a bit more about that?

Sarah Quick:
Yeah, I mean I think having a resource that would be available to all criminal justice professionals, police, lawyers, people working to support victims, having it widely available that really distils and synthesises the evidence that's there to ensure that all legal and justice professionals have up-to-date information about the reality of sexual

assault and how victims generally behave during and after a sexual assault. I mean I think that sort of tool kit would be incredibly valuable. It would have to be accompanied by training and I'd like to see that as mandatory training for all legal and justice professionals.

Katie-Jane Orr:
There is guidance like this provided by the Crown Prosecution Service in the United Kingdom. We are going to hear from them.

Sarah Quick:
And I believe Victoria may also have a similar resource.

Katie-Jane Orr:
I want to ask you a different thing now, if I can, before we finish. You mentioned providing community impact statements to the Court for sentencing, can you explain what they are and when you might provide them.

Sarah Quick:
Sure, so it is very much like a victim impact statement, but rather than focusing on the impact on one individual victim, it can outline the impact on a neighbourhood or a community and also outline the social and economic costs of a crime.

Katie-Jane Orr
Can I just stop you there? I'm sorry, can you just explain what a victim impact statement is for anyone who doesn't understand that.

Sarah Quick:
It's a statement for the Court that outlines the impact of the crime on the victim. It doesn't go into a detailed account of the crime, it's very much focusing on the impact that might be the emotional, physical, psychological, financial impact on a victim.

Katie-Jane Orr:
And it's provided to the Court during the sentencing process?

Sarah Quick:
During sentencing submissions…to be taken into account.

Katie-Jane Orr:
Sorry, sorry. So this is a similar statement, but it's about the impact on the community.

Sarah Quick:
Correct. And I guess we've been providing them, well they were introduced in South Australia in 2010 and since that time my office has provided them in a range of matters, domestic violence, arson, murder and more recently a number of child exploitation matters. They can be particularly useful where there's not a victim easily identifiable who can talk or provide the Court with information about the impact. So that's why they're quite useful in child exploitation matters. So I work closely with the joint anti-child exploitation team to identify cases where it might be seen that a community impact statement would be valuable. And I think they've proven to be a very useful mechanism for ensuring the Court has information that can challenge some of those myths and misconceptions. So for example, in one matter, there was an offending where the offender was getting young people to produce and send images of themselves. And that sort of matter really runs the risk of victim blaming, because the victim has participated in producing that image. So the community impact statement was really useful in highlighting the fact that that offending happens within a very unequal relationship, a relationship that involves humiliation

and control and coercion and so just ensuring that the Court takes that information into account.

Katie-Jane Orr:

Thank you. And one last topic at the risk of going backwards. This morning we heard evidence about access to forensic medical examinations for sexual violence victims in regional areas. You're nodding, you're aware of these issues. Have you had some involvement in that?

Sarah Quick:

Yes, absolutely.

Katie-Jane Orr:

Can you tell us about that?

Sarah Quick:

Well, I mean, I sit on the Regional Response Committee. But more broadly, I'm often called upon to assist where there is a victim of a sexual assault in a regional area where that victim can't access a forensic medical exam in their region and where there's a requirement for the victim to travel to Adelaide. So I might be approached for funding to assist in those travel costs. Sometimes it might be flights, accommodation, food costs while the person is here. It can be incredibly traumatic for a victim to have to travel. I mean certainly there might be a small percentage of victims who want to, who want to leave their region, but on the whole I'd say that most victims want to be able to access those forensic medical examinations close to home and that really choice should be paramount that you know a victim should be able to exercise the choice to have that close to home if they can. So my goal is really to ensure that victims aren't disadvantaged because of the region that they live in.

Katie-Jane Orr:

Thank you. I have no further questions.

Natasha Stott Despoja AO:

Thank you. I have a few questions if that's okay Commissioner. Just a couple of little ones to begin with. You've talked about the diminution of complaints or a relatively lower number, to which you don't attribute necessarily victim satisfaction with the process. And you mentioned the need for greater awareness of rights. What should be happening to ensure that people have a greater consciousness of their rights and also the work?

Sarah Quick:

It's challenging because victims should be receiving information about their rights as soon as they make a report, so I produce an information booklet that's handed out by police when a victim makes a report. There are circumstances where that might not happen for various reasons, But even where victims do have that booklet available to them, the challenge is getting them to open the booklet and read the booklet. You know, they might be traumatised, they might put it to the side, and it's kind of having people check in with them during their involvement with different agencies or different stages of the process to make sure that they're referred back to that information. So access to information, in terms of information about complaint process, I mean I'm trying to increase the visibility of that complaint mechanism on my website. I don't really have all the answers to that question though.

Natasha Stott Despoja AO:
When you do secure an apology, as a result of a complaint, is there any compensation for that?
Sarah Quick:
No.
Natasha Stott Despoja AO:
So, is that a sufficient deterrent for that agency, for example, to change behaviour or treatment of victims?
Sarah Quick:
Look, I think, again, most agencies want to do the right thing by victims, but at times the speed at which things happen or the workload that confronts criminal justice professionals means that at times victims might miss the opportunity or might miss the information to exercise their rights. In terms of a sufficient deterrent, I don't know that I could speak to that.
I think it becomes very problematic to attach compensation because then the agency is going to possibly fight harder to deny any wrongdoing, so you get stuck in a legal battle. I think for victims, the validation is what they're seeking, that they were denied the right. Probably the most problematic thing is that once a victim has been denied a right and the process has progressed, then we can't go back and give the victim that opportunity again. And that's, of all the things that a victim would want, that's probably what they want the most, is to be able to, where they've been denied an opportunity to make a victim impact statement, I mean, in an ideal world, they would want that opportunity. So that is why it's so important that victims are aware of their rights early on in criminal proceedings.
Natasha Stott Despoja AO:
You talked about community attitudes changing slowly, and we're able to measure that. We've got a national community attitude survey that tells us on some of these matters, particularly pertaining to sexual violence, that things are improving. Having said that, you've just given us some extraordinary examples, or maybe common examples. I've been reading through transcripts of sexual violence cases, trials, and I've been very concerned to see some of those myths to which you refer absolutely being perpetuated. You've given us an example of, you know, toolkit, education. You've indicated that you'd prefer mandatory training. I'm wondering if there are other best practise examples, be they in different jurisdictions, and obviously we'll be referencing the UK example, but are there any states or territories that are doing this better or at all?
Sarah Quick:
Oh, look, I don't know that I can speak to best practise in terms of a particular jurisdiction. I think lots of jurisdictions have aspects of good practise and want to be able to improve responses for victims. But it is very difficult to challenge the broader community attitudes. And until the broader community attitudes do change, then they are still going to influence the criminal justice process.
Natasha Stott Despoja AO:
Does the media have a role to play in this?
Sarah Quick:
Absolutely.

Natasha Stott Despoja AO:
Particularly in relation to reporting on cases of sexual violence?
Sarah Quick:
Yes, absolutely. I think, I can't think of an example right now of poor media reporting but I think just the media generally and the way sexual assault is portrayed is can be problematic and that perhaps we need some broader guidelines around media reporting.
Natasha Stott Despoja AO:
As Counsel Assisting has eloquently demonstrated it's not only the impact of these myths on the immediate case or trial or someone's trauma, it is that flow-on effect. Do you find some of the victims with which you associate that they are put off not only to make a complaint in the first place because of some of these myths and trauma, but you mentioned the number of withdrawn or discontinued cases. Is that something that concerns you and is it something you see regularly?
Sarah Quick:
Absolutely, I mean, you know. Victims just feel as though their injury is protracted because the criminal justice process is protracted too. I've had victims who have become aware that their matter has been adjourned and it might have been relisted for 12 months down the track. I've had one victim who has been suicidal because of that time frame that they have to face another 12 months of uncertainty and anxiety around the criminal justice process.
Natasha Stott Despoja AO:
And specifically in relation to sexual violence, victims and complaints?
Sarah Quick:
Yeah, right, definitely.
Natasha Stott Despoja AO:
I know this is in the domestic family violence space as well as sexual violence, but I just have a final question in relation to safe at home. If you would explain to us what that involves.
Sarah Quick:
So, the Safe at Home programme is able to provide or is really responsible for assessing a victim's home security and looking at upgrading security on that home so that a victim can feel safe to stay in their home. The Safe at Home programme, from memory, is only for high-risk victims, high-risk female victims of domestic and family violence. So my office is often called upon also to provide some funding for security upgrades so I can do medium lower risk and not necessarily I can assist male victims for example with security. In looking at security our aim is always to ensure that it's a deterrent from anyone entering a home. So a lot of people request CCTV and that is not something that we would routinely assist with. It's problematic because one, it doesn't really stop an offender getting into a property. Domestic and family violence offenders can be quite strategic and will damage cameras or avoid cameras and then it also runs the risk that it can increase the hypervigilance of the victims so they might end up sitting watching cameras thinking that it's keeping them safe but actually making them more vulnerable.
Natasha Stott Despoja AO:
And I ask that question sort of in the context as we've recognised sexual violence can occur within that domestic family violence context. I'll sneak one more in. You

mentioned Victorian research where a third, you said a third of victims?
Sarah Quick:
A third of the respondents to that survey.
Natasha Stott Despoja AO:
A third of respondents to that survey said that they wouldn't give evidence again. Do we have any comparable research or figures in South Australia?
Sarah Quick:
Not that I'm aware of. We haven't had a comprehensive victim survey in South Australia for decades.
Natasha Stott Despoja AO:
Should we have one?
Sarah Quick:
That'd be great.
Natasha Stott Despoja AO:
On that note, I will hand back to Counsel Assisting.
Katie-Jane Orr:
Thank you Commissioner, I'll ask this witness be excused please and we then have a break until 4.30pm our time before the next witness.
Natasha Stott Despoja AO:
Thank you, Commissioner, you are free to go. Thank you.

Witness:
Siobhan Blake, Crown Prosecution Service, UK

Natasha Stott Despoja AO:
Welcome back to the last session of this second day of public hearings for the Royal Commission into Domestic, Family and Sexual Violence. I hand over to you, Counsel Assisting.
Katie-Jane Orr:
Thank you Commissioner. I call Siobhan Blake who will be appearing remotely via video link.
Kerryn Hawkes:
Do you truly and solemnly affirm that the evidence you shall give will be the truth, the whole truth, and nothing but the truth? Say, I do truly and solemnly affirm.
Siobhan Blake:
I truly and solemnly affirm.
Kerryn Hawkes:
Thank you and please state your full name.
Siobhan Blake:
Siobhan Therese Blake.
Katie-Jane Orr:
So, Ms Blake, you are appearing before the Royal Commission from the United Kingdom?
Siobhan Blake:
I am.

Katie-Jane Orr:
Thank you for appearing with us. Is it correct that you're the Chief Crown Prosecutor of the West Midlands?
Siobhan Blake
That is correct.
Katie-Jane Orr:
How long have you been in that position?
Siobhan Blake:
I've been the Chief Crown Prosecutor of the West Midlands since April 2021. I was formerly the Chief Crown Prosecutor of Mersey Cheshire, a role that I was appointed to in I think it was June 2016. I think it's fair to describe me as a career prosecutor.
Katie-Jane Orr:
And for those of us in Australia, the Crown Prosecution Service is the prosecution service for England and Wales.
Siobhan Blake:
That is correct, yes.
Katie-Jane Orr:
But is it correct that you're split into different regions with different Chief Crown Prosecutors.
Siobhan Blake:
That is correct. The Crown Prosecution Service is run by the Director of Public Prosecutions. He then has some senior lawyers who support him. And then in terms of the operational work, that's split into 14 areas and a number of specialist divisions. Each area has a Chief Grand Prosecutor and their geographical appointments in effect. So we have delegated responsibility on behalf of the Director of Public Prosecutions for our areas.
Katie-Jane Orr:
And is it correct that you specialise in rape and serious sexual offences prosecutions?
Siobhan Blake:
That is correct. When I was an operational prosecutor, I was one of the first making serious sexual offence specialists who were appointed by the Crown Prosecution Service. That goes back to about the early 2000s. I now hold a role within our national organisation as the Chief Crown Prosecutor Lead for rape and serious sexual offences.
Katie-Jane Orr:
So I understand that there was a review or an overhaul of the way in which sexual violence offences were investigated and prosecuted in England and Wales.
Siobhan Blake:
That is correct. We found in 2018 that there had been a reduction of the number of cases that were referred to us by the police and then were subsequently charged by us and entering court. We began to look at the reasons for that. At the same time, or simultaneously, the CPS inspectorate undertook an inspection on rape and serious sexual offences and made some recommendations, and the government also commissioned in 2020 a cross-criminal justice system review of rape and serious sexual offences. As a result of all this focus, both the Crown Prosecution Service and policing started a significant review and a significant piece of work around rape and

serious sexual offences, specifically focusing on adult rape.

Katie-Jane Orr:

Thank you. Before we go on, are you able to explain, you said there was a drop-off in the number of referrals from police to the prosecution service. Are you able to explain what was going on at the time that might have led to that?

Siobhan Blake:

I think it was an extremely complex landscape. There was a drop-off generally in referrals sort of across all crime types, from policing to the CPS. However, the drop in adult rape specifically seemed to be outpacing the average drop-off. Part of that was, I think, most probably as a result of the growing complexity of this crime type. It seems to have very much been linked to the explosion in digital material, so third-party disclosure and the investigation of these cases became far more complex. There were some other issues with regard to some cases where there were significant issues around the handling of disclosure, where both ourselves and policing had to undertake a review and also the focus on specialism, particularly in investigations, wasn't necessarily being driven forward at the speed that it had been. So I think it was a very complex landscape. There was no one point that you could look to and say this was the reason, but a number of issues coalesced and this was the result.

Katie-Jane Orr:

And how was the relationship between the prosecution and police investigators at that time?

Siobhan Blake:

I think it has become quite tense, there were definitely, I think, as well we have to realise that it was at a time we were going into the lockdown situation as a result of the pandemic, so the ability for us to speak to each other in person and those relationships that maybe in the past we'd had had become quite stifled just due to the circumstances we found ourselves in. And the development of the digital approach to case handling, it's also meant that we weren't maybe in the position that we had been in the past around our relationships. So there were definitely issues and both policing and the CPS acknowledged that at the time and that was one of the key areas we wanted to focus on in terms of the work that we were doing.

Katie-Jane Orr:

So, that work that you were doing, you've mentioned that both police and the CPS conducted reviews. Can you explain that to us please?

Siobhan Blake:

Well, primarily, as I say, the focus when we started this piece of work was very much on the relationships, which we acknowledge weren't in the right place, so the relationships between policing and the CPS. So in 2020, we commissioned a number of pieces of work, both independently and jointly. So we commissioned a joint national action plan between the Crown Prosecution Service and policing, and we developed a number of themes that we wanted to focus on in this area of work. And we commissioned that work to not only our policy advisors, but also frontline policing and prosecutors, to really work on developing solutions and the way forward, and also start to develop a future plan for how this work should look. We also undertook in the Crown Prosecution Service a wide-ranging piece of work on developing and understanding of myths and stereotypes, particularly in the arena of

adult rape. So that was a piece of work that was commissioned in 2018. We worked across all criminal justice agencies and also with our third sector stakeholders, so victims groups and women's groups, when collating and compiling that. And that piece of work was published in late 2020. I think it was a change of approach for us, because at the same time that that work was being perfected, we also revoked our legal guidance, so the Crown Prosecution Service has a huge library of legal guidance, the purpose of which is to support prosecutors in excellent decision making, and also it's a facility that is actually open to the public, so it's public facing, so it has the key purpose of supporting and assisting our prosecutors in making good decisions, but it also has that public facing piece. So for the first time we mapped our myths and stereotype work into our legal guidance, both to support prosecutors and embed some of that learning into their decision-making, but it also allowed us to have that public-facing approach to myths and stereotypes in this piece.

Katie-Jane Orr:

I will ask you a bit more about some of those things that you've mentioned and the focus of that review. So you've mentioned working together with police and the focus on achieving that. Can you talk us through that?

Siobhan Blake:

Yes, well, we knew that we needed to build better relationships, and when I talk about better relationships, specifically good relationships between frontline prosecutors and investigative officers, so in terms of policing those investigators, because we felt, and when I say we, that really is the royal we, in as much as policing and the Crown Prosecution Service, that if we could focus on really improving that frontline liaison and support, we could build robust prosecutions. I think the key to all this work was that our ultimate joint objective was to narrow the justice gap, so we wanted to see more perpetrators prosecuted successfully for the right offences. So with that as our almost overarching aim, we focused on a number of areas. So the Joint National Action Plan has made specific aims and objectives within it. There was a leadership piece first and foremost, so in terms of the joint action plan, once it had been formulated and a focus for that action plan had been set, and the focus just very briefly really can be articulated as improving our relationships and our communications with victims, improving our relationships and communications with the support agencies work with victims, so independent sexual advisers, advocates specifically. Then some of the procedural justice issues that impact policing and CPS, so investigative standards and also the advice that we at the CPS provide to the police, and at the stage we provide them. And also, a big piece around data analysis in terms of understanding this work at a more fundamental and strategic level. And finally, but most probably most importantly, embedding what we came to know as the suspect-centric approach. So we formulated an action plan that was supported within the Crown Prosecution Service with what was known as RASSO 2025, which was an overarching strategic approach to making serious sexual offences that was to last at that point five years. That was quite novel for the CPS to actually put in place such a long-term strategic plan for this area of work, and then we launched that jointly. We launched the Joint National Action Plan, and It was launched by the National Police Chiefs' Leagues and the Director of Public Prosecutions in a conference where we pulled together a lot of the key operational prosecutors and policing in England and Wales. We had a very large

conference where we discussed these issues, discussed these action plans. So that was to set the scene for really the next five years as to how we were going to move forward jointly. That joint national action plan then coalesced into Operation Bluestone Soteria, which was a Home Office funded project, where both policing and the Crown Prosecution Service did very specific pieces of work to improve this area of investigation and prosecution. The difference with that was it was, particularly in the case of the police, very much a collaboration between external academics and policing, and a group of external academics did a deep dive into some of the areas of policing that they felt was specifically going to impact and drive change and improvement in this area. With CPS we did something very similar.

Katie-Jane Orr:

No, no, it's hard with the delay, sorry. So that's as part of this reform, academics are being consulted by both police and the Crown Prosecution Service. And also, while I remember, you mentioned RASSO, is that...

Siobhan Blake:

That's rape and serious sexual offences.

Katie-Jane Orr:

No, not at all. Sorry, now you mentioned this suspect-centric approach. Can you explain that please?

Siobhan Blake:

Yes, one of the things that we found, one of the key pieces of learning that we found both in terms of the prosecution team, so policing and the Crown Prosecution Service, is there was a tendency to potentially focus on an investigation that looked into the actions and motivations of a complainant rather than focusing on the actions and motivations of a suspect. So we developed a set of guidance and training that really did focus the minds of both policing and prosecutors on the actions and behaviours of a suspect. So there were a number of elements to that. First and foremost, we did a great deal of training for prosecutors on trauma-informed approach, so understanding the impact on memory and on potential behaviours of complainants in these sorts of cases. So people really understood that there was no such thing as a standard operating model for complainants in these cases. We also started to focus very much on the fact that perpetrators quite often fit particular types of modus operandi, so they behave in a certain way, and there was very much a focus on looking into a suspect's behaviours, not just simply at the time of the offending, but taking a little bit more of a broader approach. So looking into previous behaviours, trying to understand if there were any patterns that could be identified, looking at any previous complaints and how we might be able to use those as bad character evidence, and really on that. So I suppose the best way of explaining that is maybe to illustrate a case where we really did adopt that suspect-centric approach. And it was a case where a complainant had been out for the night, she's had a bit to drink, she'd become intoxicated and she'd lost the group of friends she was with. She left the nightclub that she was in and the defendant had intercepted her as she left the nightclub, offered her some assistance and support in getting home. Subsequently he raped her. Rather than focusing on any of the issues around the complainant or what had happened to the complainant on that evening, in the run up to the evening, the investigative team really focused on what the defendant had been doing during the course of the evening and what came to light was he was

sitting in a nightclub for many, many hours on his own, he wasn't drinking or socialising, he was very much silently observing. He then saw this particular lady leave and he then immediately intercepted her. And so the whole focus on the investigation was really to ask the questions, well, why was he there? What was he doing? Who sits in a nightclub for hours and hours and hours drinking water and speaking to nobody? I'm really just reframing the narrative and the focus of the investigation to focus in on his behaviours and actions and lead into the question, well, who's the most credible when it comes to giving evidence in those sorts of circumstances?

Katie-Jane Orr:
So rather than a focus on the complainant and her behaviour, the focus was on the defendant.

Siobhan Blake:
Absolutely.

Katie-Jane Orr:
And is it, this is an example of how, sorry, I'll take it back a step. You said partly the suspect-centric approach is about mindset and how people are approaching it. But as I understand it, the example you're giving is about how that mindset can actually shift the investigative techniques that are used.

Siobhan Blake:
Precisely right. One of the key findings from the academics reporting in Bluestone was quite frequently when you start to really look into a defender or suspect's background and behaviours, what you find are incidents of previous offending. So we have had situations since we've been employing the suspect-centric approach where we've had cases where we have started an investigation with one complaint, one contemporaneous complaint. The police have investigated that defendant and actually found other, either complaints that haven't actually been formally made or indeed have been formally made and there's been a decision that there's insufficient evidence for them to proceed and actually being able to revive those complaints and prosecute that offender for a much more broad-ranging span of criminality. So there is just something there about the mindset shifting, the focus shifting and then quite frequently the evidence then follows.

Katie-Jane Orr:
And if we can turn to myths and stereotypes which you've talked about, can you explain that work and what has come about as a result of it?

Siobhan Blake:
We've had myths and stereotypes work in the CPS for quite a long time, and we've… If I might explain, all the prosecutors who deal with rape and serious sexual offences in the CPS are specialists, so they receive specialist training. But we became very aware that the myths and stereotypes work had not been updated to really reflect that digital age, so part of the impetus for doing the work that was started in 2018 was really to have a look at how myths and stereotypes had shifted. What we found was some of the fundamental issues that sit behind myths and stereotypes hadn't changed. But what they have done is morphed, given the changes in sexual behaviour, the real explosion in online dating, the issues around things such as taking naked photographs as part of the beginnings of an intimate relationship. And all these sorts of behaviours have morphed into slightly new and different myths and

stereotypes than maybe the standard myths that we all think about of the clothes that somebody's wearing or whether they've had to drink. So we refreshed that myths and stereotypes training. And as I say, the key to it was really making it fit for the modern age and the modern world as far as intimate relationships are concerned. and also folding it into and linking it to our legal guidance so putting it right at the heart of our decision-making as prosecutors.

Katie-Jane Orr:

Sorry, before you go on, can I ask you to give an example of how you say a myth has morphed into the digital age?

Siobhan Blake:

Yes, well, for instance, we found that there was quite a strong pervasive myth around online communications and dating. So there was, and I suppose it's in effect the old behaviours myth of when you give consent. So there was a belief that if you were communicating in an intimate way online with somebody, then in effect you gave almost conditional consent, if you then met them, to have some form of sexual contact with them. So if you were exchanging nude photographs or having a relatively intimate conversation with somebody, that then if you met them in person, that morphed into some form of consent or whatever might be occurring in person. So that's a sort of classic myth and stereotype, which is all about judgement and shame and placing that, and the responsibility of being placed on a complainant, but it had almost morphed into a myth and stereotype that's very much linked to the digital age that we find ourselves in.

Katie-Jane Orr:

Thank you. So you were telling us about the work that was done in relation to myths and stereotypes.

Siobhan Blake:

Yes, so we did that work, put it in the centre of our decision-making. We've subsequently built on that work because we wanted to develop it and really see how it could not only just highlight those myths and stereotypes and make certain that we were consciously dealing with them in our decision-making at the stage that we were making decisions around charging cases and also ensuring that we could talk about them in terms of the investigation, but also so we could find a way of managing them and dealing with them in a trial and a courtroom scenario. So, as a result of that, we commissioned another piece of research from some independent academics and that was called Equally Ours. What that research found is, although obviously it's really good that we've identified myths and stereotypes and we were calling them out and we were talking about them, there's something quite powerful about the language and the way you frame them, which is very useful in a courtroom scenario. So, the first thing we've done as a result of that is that we've renamed our myths and stereotypes as misconceptions and assumptions. The reason for that was myths and stereotypes were seen as something that wasn't necessarily really pinpointing the fact that these were wrong, based on wrong facts or incorrect facts, and we thought that misconceptions and assumptions was a better phrase. And then it was all about how we use those, how we use our language and how we formulate and present things to juries. So for instance, rather than saying something along the lines of women quite often don't respond when they've been raped by being very necessarily outwardly distressed and crying and screaming, which can, because it's a negative,

can actually build in a certain amount of embedding of that myth and stereotype. The way to formulate that sort of point is to say something like, no rape victim is going to react in the same way as another, and there is no right and wrong way to react to an incident such as this. So there's something about the formulation of words. So we're getting quite sophisticated, in essence, about the way that we can use some of this learning and hopefully introduce that into a courtroom in a way that's easy to understand for juries but very powerful in terms of the narrative of the prosecution case.

Katie-Jane Orr:

Are you able to give an example of how an investigation might meet a myth? Sorry, I've used the language that you've just stopped using.

Siobhan Blake:

It does trip up a bit, so we're all working on that. I think one of the key areas, an investigation that I'm personally quite okay with, was an investigation, a wide-ranging investigation with subsequent prosecution that involved a number of sex workers who were raped. So one of the most deep-seated misconceptions is that if you're a sex worker, you can't be raped, so that you can't remove consent or negate consent. By focusing very much on the behaviours of the perpetrator and really keeping front and centre at all the time that the consent is a gift that is given by the complainant in a case. We built an incredibly strong case against this defendant who was a serial perpetrator, incredibly dangerous, and brought that case to court. I think that case illustrated two things. First and foremost, the fact that the complainant was a sex worker and the rape had taken place during the period that she was working didn't in any way offer a bar to the investigation, so that was very much driving through that misconception. But also, I think it informs the way we support and communicate with complainants because she was very apprehensive about giving evidence. She was very apprehensive about coming forward in the first place, and incredibly brave to do so, and was constantly saying throughout the course of that prosecution, I'm not going to be believed. So I think one of the key issues that we have to all be aware of as criminal justice professionals is sometimes our complainants, our victims, have actually absorbed some of these misconceptions and assumptions themselves, and that can be a bar to us keeping them engaged. So by recognising them, understanding them and tackling them head-on, but in a very positive way, we can actually make a difference and keep victims engaged and also give them the confidence to go forward and then present a case to a jury which can be explained and understood and in that case convicted. So that's a classic example of this more dynamic approach and this more suspect-centric approach.

Katie-Jane Orr:

And thank you. I think you said earlier that a lot of the work in this area that has been put together is publicly available, or is otherwise circulated?

Siobhan Blake:

Yes.

Katie-Jane Orr:

Can you tell us about that?

Siobhan Blake:

So could you repeat that, there was just a hiccup on the line.

Katie-Jane Orr:
Now I just asked you to explain how it's available or how it's being distributed.
Siobhan Blake:
All the work that's been undertaken on Operation Soteria and in fact the work that's gone before, but mainly Operation Soteria and now our National Operating Model, which is the roll-out of the learning that we've gained in the CPS over the last four or five years now, is available on our website, so anybody can go on to Google, put in CPS and violence against women and girls and all this work will be available to them, plus hyperlinks to some of the documentation around the work that the police have done on Bluestone. All of this work was undertaken with the support and the funding of the Home Office, so all the operations, the team, the bluestone work from policing is available on the government website and you can see if anybody is interested they can actually look at the year one review and the findings. So it's all out there and published in the public domain. I think transparency is a very important part of this work because there is a piece around public confidence, around violence against women and girls.
Katie-Jane Orr:
And thank you. As part of this new model, is there ongoing training?
Siobhan Blake:
Absolutely. I think one of the key areas that we focused on in the work that we've done jointly with the police was around early advice and really prosecutors and police officers coming together in a meaningful way at the earliest stage of these investigations to really focus the investigations and build in that suspect-centric approach. There's also sort of that critical frame check and challenge around misconceptions and assumptions, and really focus an investigation. So that work has been embedded both by the joint leadership approach, but also a significant amount of training that's been rolled out for both police officers right across the country and prosecutors over the past two or three years. All that training, as in policing terms, was developed under the Bluestone Soteria model, and all police forces, all 43 police forces, have rolled out that training nationally. We at the CPS have undertaken our own training focusing on prosecutors and something very similar. So we pulled all the learning out of the Soteria and the work that came before on the joint national action plan and have built that into training, both for people who are new specialists to the role, but also for our prosecutors who have been undertaking this work for a long period. So we've done a big piece of refresher training, and that's ongoing, it's a constant process and part of the national operating model is a constant refreshing of our training, constant development of our techniques and approach.
Katie-Jane Orr:
Was some of that training conducted together with police and prosecutors?
Siobhan Blake:
Yes, we have done some training on a joint basis. As I referred to earlier, we've had the big national conference where we really looked at these issues and started to try and think as a prosecution team about how we could have the most impact on these, both investigations and that early decision-making piece and we've developed that. And areas have taken that locally with the police forces that they work with on a day-to-day basis and developed and enhanced that.

Katie-Jane Orr:
You mentioned earlier in your evidence about when these reviews were undertaken, about advice or consultation with academics and with victims' groups and agencies. How important was consultation through that review process?
Siobhan Blake:
Absolutely critical, because a key part of this work was to improve public confidence around the criminal justice system as a whole and how the criminal justice system deals with rape and serious sexual offences. So a key element of that was having the victim's voice in the work that we developed around this piece. So there was, in the Crown Prosecution Service, we have an external engagement group, which is a group who are made up of key representatives of women's groups, survivors' groups, victims' groups, and they regularly work with us. So we have a meeting once a quarter and we will talk through the decision-making, we will talk through the initiatives that we intend to roll out, we ask them for commentary around our legal guidance and they give us feedback on that. We worked with them to develop the myths and stereotypes work and the Equally Ours work, and policing does something very similar, so there is definitely a key role for those stakeholders because it is all about transparency at the end of the day.
Katie-Jane Orr:
I'm going to ask about money. Did it require some investment to implement these things that are happening?
Siobhan Blake:
Yes, it did require some investment. As I think I've already referred to, the Soteria project was a Home Office funded initiative, and so there was additional funding and resources available to drive that piece of work through. Also, both policing and the Crown Prosecution Service have made this a priority around their resourcing. It's a key priority for policing, the government and the CPS. Part of the drive of that was the cross-government review on rape, which started in 2020 and reported in 2021, and that really was an end-to-end review of criminal justice agencies. So again that was obviously funded by the government and it has been it has been an area of focus for resource.
Katie-Jane Orr:
And so it's probably obvious to say, but the review itself needed to be funded, but then the implementation of these new approaches that you're talking about also required investment.
Siobhan Blake:
Absolutely, and one of the things that we at CPS have done over this period is we've grown the number of rape specialist prosecutors that we have in England and Wales, and we've put substantial resources into those teams. I can't speak for the police, but certainly from my observations as interested external, it's clear that there has been a focus in police forces as well around specialisation and building up some resilience in these teams.
Katie-Jane Orr:
In your view, or if there has been a formal evaluation, have these changes in approach had an impact? Have they been successful?
Siobhan Blake:
Well, in terms of raw data, they certainly have and we have had a 163 % increase in

the number of adult rape charges since January 2021. That is an impressive percentage. The volumes are still most probably not where we would want them to be in terms of the number of cases that we're taking through the courts, but in terms of quarter-on-quarter progress, what we've seen is a significant increase in the number of cases that the police are referring to us for consideration of charge, and again, a significant increase in the number of cases that we are then charging. I think the other thing that's really important to notice out of the cases that we are having referred to us by the police, we charge about 70 % of those cases, and that is a relatively stable figure. So despite the fact that the volumes are going up, the quality is remaining static and I think that is a real reflection of some of the progress we've made in these cases.

Katie-Jane Orr:

How about in relation to the experience of these victim survivors and the people going through the process?

Siobhan Blake:

I think that is something that is a work in progress. We have certainly undertaken a lot of work around communicating and supporting victims through the criminal justice system. So we started to reach out to victims by way of a letter in the Crime Prosecution Service at a very early stage in the proceedings just to tell a complainant that we were now in receipt of their case, that we were looking at it for charging, introducing the lawyer who was dealing with their case to them via that letter and giving them a single point of contact within the Crown Prosecution Service where they could really reach out to us if they required any support or information from us. Again, policing have done a huge piece around supporting and maintaining victim confidence and engagement during the course of the process. We are about to, well we have just launched in fact, we're running pilots at the moment, but it's pilots with a view to a national rollout later in the year, what we're now calling a pre-trial victim or complainant meeting. So, after a not guilty plea has been entered, there will be a meeting offered to all complainants with a CPS member of the rape and serious sexual offence team and we will talk through the trial process and the criminal justice landscape with them at that period. So we are trying to support victims and maintain their engagement throughout the process in a far more proactive way than maybe we did in the past, where the burden very much fell on the police.

Katie-Jane Orr:

And what about, you've told us about the changes to approach in relation to the misconceptions and the suspect-centric approach, do you think that approach in terms of the investigation is having a positive impact on their experience, the victim's experience?

Siobhan Blake:

I would certainly, I would hope so. I think, again, it's a mixed landscape. We have victim survivors who tell us that they had a really supportive experience. We have others where unfortunately they still feel that the criminal justice system has not offered them what they need to take them through this really traumatic experience. I think what I would say in terms of the approach of the agencies, and certainly the approach of the Crown Prosecution Service, is we are a lot more sophisticated in our understanding of trauma, and hopefully that is reflected, and the training that we give

our lawyers is reflected in the way that we interact with our victim-survivors. I think one of the key areas where we have really made universal gains is in the work that we've done to interact more effectively with the independent sexual violence advocates, who tend to be working with a victim-survivor throughout the whole of the process and indeed beyond, and what we implemented as a very early stage of Soteria was an agreement with all our intra-agencies, a memorandum of understanding about how we'd work with them. And so our interaction and support and the information that we share with ISVS is a lot more effective and then that really does hopefully assist them in supporting the victim through the process. Certainly we've had a lot of good feedback on that from those agencies and organisations.

Katie-Jane Orr:

The focus, obviously, has been on investigation and the prosecution's role. How are things going when a matter gets to court?

Siobhan Blake:

Well, obviously the focus for us was on that early stage, because we'd identified that we had some really quite tangible issues that we could address in relatively short time around that early investigation and advice and charge stage. The cross-government review took a far more holistic approach to the criminal justice system in general. Obviously, at the moment, we have quite significant backlogs within our Crown Court system as a result of the pandemic and various other issues. So it is taking, potentially, not always, but in many cases, a significant period of time for these cases to get to trial, and of course that is problematic and something that we are working both with our colleagues in Her Majesty's Courts and Tribunal Service to address, but also it's a very great focus for the judiciary. They very much want to prioritise this type of work. We also work very closely with our professional colleagues at the external bar, so our barristers who are prosecuting these cases, both in terms of offering them training around some of this work, so the misconceptions and assumptions work, and also some of the more procedural justice issues and the trauma-informed approach. That's a work in progress and we're very much in a position of continuous improvement around that piece of work.

Katie-Jane Orr:

I understand that your judicial officers, well there are specialist judicial officers that preside over RASSO matters, is that correct?

Siobhan Blake:

That is correct. All the judiciary who deal with rape and serious sexual offences have specialist training around that particular area of law, so we tend to refer them as being ticketed to do that type of work. So they have their own judicial training that specifically deals with many of the issues that we've talked about today from a policing and prosecution perspective, but obviously from that judicial perspective. They also have a substantial amount of learning in their judicial directions that are available to them, and many of those judicial directions which are available are very much focused on trying to tackle some of those myths and stereotypes, misconceptions and assumptions and how to deal with juries when you might see those sort of issues arising.

Katie-Jane Orr:
So are you talking about the directions that a judge will give to a jury at the end of a criminal trial?
Siobhan Blake:
That is correct.
Katie-Jane Orr:
And there are directions available that they can use in relation to these issues that we've been talking about today.
Siobhan Blake:
That's right, I think there are over 200 alternative directions that they can use when case appropriate.
Katie-Jane Orr:
Thank you. Just one last question. I should confirm for any lawyers listening that you have an adversarial model in your jurisdiction and none of this review or reform has fundamentally changed the structure that you're working within.
Siobhan Blake:
That is correct, we still have the adversarial model and all this work is really focused on improving the way we build the prosecution case in the first place and then the way we present that prosecution case when we ultimately get into a courtroom environment.
Katie-Jane Orr:
Thank you. Ms Blake, I have no further questions.
Natasha Stott Despoja AO:
Ms Blake, I do have a few more questions for you, but I want to thank you for being up so early and for giving us your time today and for some of these innovative insights. You mentioned the increase in referrals and obviously in charges. I'm wondering about whether or not there's been a reduction in discontinuances, so people deciding victims withdrawing their complaints. Does that mean something that's operated in parallel to some of these changes?
Siobhan Blake:
It's difficult to give you a very specific piece of data around that. And the reason I say that is we have attrition that moves right the way through the system. So we are still... We've got attrition right at the very beginning. So when a complaint is made, but very shortly after that complaint is made, the victim for whatever reason decides they don't want a criminal justice outcome. Right the way through to attrition in after charge, there are a lot of factors at the moment that are playing into that post-charge attrition. Historically, it tended to be the case that once a case had been charged, we had a very limited amount of victim attrition post-charge. At the moment, that victim attrition has actually increased a little, and the reason for that is some of the length of time that the system is taking to deal with these cases. So it's maybe not necessarily a binary comparison that we can make at the moment. We still get considerable amounts of pre-charged victim attrition. That's quite a complex landscape because we record all, or the police record, all reported rape complaints and they can include what are known as third-party complaints, so where somebody else has made the report, maybe not necessarily with the consent of the victim. So it takes a little bit of unpicking and I think there's a huge data piece to do before I could give you a definitive answer to that.

Natasha Stott Despoja AO:
I realise it's complex, but thank you for that. Speaking of data, you mentioned positive feedback in response to Counsel Assisting's questions. In terms of formal evaluations, is that something that you can comment on?
Siobhan Blake:
Yes, there has been, because we had both academics working in the Operation Bluestone criteria, so in the policing area, and also as far as Operation Soteria from the CPS point of view was concerned, we also had an academic who assessed and evaluated Operation Soteria. So we have got formal reports, formal independent reports, on both of those projects or initiatives. We're really extrapolating what worked well, what maybe didn't work so well, what we needed to maybe focus on a little bit further. We took that evaluation and we have developed what's known as a national operating model, which we've rolled out across the whole of the Crime Prosecution Service now, where we've taken the key elements of the work that has either worked on a data-based analysis or on a qualitative-based analysis. Much of this is to be, at the moment, is qualitative, but we've taken those key issues and we've rolled them out in that national operating model. But again, the reports have all been published, they're all in the public domain. Professor Vanessa Munro undertook the review of Operation Soteria on behalf of the CPS and her reports are on our website.
Natasha Stott Despoja AO:
I think our Secretariat has been combing through them. I'm interested in, when we talk about assumptions or misconceptions, you're confident that you have applied an intersectional lens to addressing some of these, I guess, myths and stereotypes.
Siobhan Blake:
That was one of the absolutely critical bits of the updated work. I think in the past we'd taken maybe a very binary view of myths and stereotypes. Part of the work that we undertook 2018 through to 2020 was that intersectionality and the way that key elements worked with different victim-survivor groups, that was why it was absolutely critical that we had our stakeholders work with us so that we could make sure that it was more reflective of modern Britain, in essence, and also the diversity of the victim-survivor groups we work with. So yes, that was actually addressed specifically, and we have in our guidance a very specific piece around different victim groups and how that can interrelate. you
Natasha Stott Despoja AO:
Just a couple more if I may. I'd like just to ask a bit more about the training that you referred to. With police and CPS, was it conditional? Was it voluntary? How did you roll that out? And if voluntary, was there a sort of a take-up rate that you can share with us or was it across the board.
Siobhan Blake:
Well, certainly with the training that was rolled out within the Crime Prosecution Service that was conditional. We asked all our specialist prosecutors to undertake that training. So we have trained everybody in essence. We developed training courses dependent on experience. So we have an initial induction course. But what we didn't want to do, and the danger is if you've got specialists who have been working in the area a very long time, sometimes they miss out on some of the developed training packages, so we also did a refresher course. That was

mandatory. We also complemented the specific training around rape and serious sexual offences and that sort of very legally focused training with complementary training around victims and how we communicate with victims and the trauma-informed approach and we're actually still continuing that piece of training as we move into having more face-to-face meetings with victims.

Natasha Stott Despoja AO:

Great, and my final question is, I think I'm emulating Counsel Assisting in a way, but I'm reminded of a comment made by our Commissioner for Victims' Rights, who appeared before you, and she was addressing that issue of misconceptions and stereotypes, et cetera, and said, the issue is that it continues to be advantageous for the defence. So we know that eradicating or changing the culture around some of these things is not only difficult, but sometimes not appealing. So I was gratified to hear you talking about the work that you're doing, barristers, judiciary, et cetera. Do you have any advice on that, any recommendations as to how best to address these issues in that broader legal context.

Siobhan Blake:

I think the prosecutor has the power to formulate the narrative, so the judiciary obviously stand very much in part and I'm very respectful of their judicial independence, but in terms of the barristers that we work with, I think the key to it is really engaging with them in a meaningful sense, and making them our partners in this journey, which sounds a little bit cliche, but fundamentally it's about offering them support, because I'll, and I'm sure it's the same in your jurisdiction, but certainly we are, the Bar is independent, they prosecute and they defend, we work with them, they'll work with the prosecution service one day on one trial and then the defence, What we can offer as a national prosecution service is that support on the training, we can offer them the access to the work that we've undertaken. A couple of months ago I went and spoke at the Criminal Bar Association, specifically to the barristers that work on what we call our Rape Advocate Panel, so all our barristers who undertake this work have been trained by the Bar Council on rape and serious sexual offences cases. We have some input into that training and the other area where we try and really make this a live and vibrant conversation is we do sit down with the Bar and we ask for their input into some of our developments. So, for instance, with some of the work that we did around our legal guidance, we actually had a – we invited a group of senior barristers to come and look at our guidance when it was in draught form and give us feedback and assist in the consultation process and we had a specific working group that we set up to do that. So it's about making them, I think, an active partner in that conversation and helping and taking their learning and their expertise in the work that we develop. And then it becomes a two-way conversation and it starts to roll into the work that they do in terms of their training and their outlook.

Natasha Stott Despoja AO:

That's very interesting, very helpful. So we may exist in adversarial systems, but there is always room for collaboration. So thank you for that. Thank you for your evidence. And I hand back to Counsel Assisting.

Katie-Jane Orr:

Thank you, Commissioner. I have no further questions, and I'd ask that the witness be excused.

Natasha Stott Despoja AO:
You are free to go, Ms Blake. Enjoy the rest of your day. Thank you very much. That brings us to a conclusion for the second day. And so I suggest we adjourn. and I thank everyone for their attention and support.

END OF TRANSCRIPT