SUBMISSION TO THE TASKFORCE ON WOMEN'S SAFETY AND JUSTICE FROM THE CAIRNS SEXUAL ASSAULT FORENSIC-INTEGRATED RESPONSE NETWORK (SAFIR)

SAFIR is a diverse group of Cairns residents, including doctors, nurses, midwives, social workers, counsellors, Indigenous health professionals, and people with lived experience, formed following a meeting held in Cairns on 19th June 2021. The members of SAFIR are people interested in the provision of safe and accessible care for victims-survivors of sexual assault in both Cairns and regional Queensland; many of them have worked in this field, both in Far North Queensland (FNQ) and elsewhere in Australia. Since the first meeting, smaller group and individual meetings have been held to try to progress some of the actions suggested on 19th June.

SAFIR members have read through the terms of reference of the Taskforce and the information on the Taskforce website including the two discussion papers. One of SAFIR's members attended the stakeholder consultation in Cairns on 15thJuly and SAFIR members are familiar with the division of the Taskforce's work into two Parts. We believe that Part 2, Women's and girls' experience across the criminal justice system, is most relevant to SAFIR's aims, and particularly so the three themes in the (sub) part 1 of Part 2 i.e.

- Theme 1- Community understanding of sexual offending and barriers to reporting
- Theme 2- Police response, investigation and charging of sexual offences
- Theme 3-Legal and court process for sexual offences

We provide more detailed information about our concerns for Cairns and regional Queensland generally below, but at this stage wish to state:

We are concerned that there is no mention in the Terms of Reference of the Taskforce of the role of health services in the provision of care, both acute and ongoing, for victims-survivors of sexual assault (or indeed of any form of assault in the context of domestic violence). This is particularly concerning when the Emergency Departments (ED) of public hospitals across Queensland are very frequently the first port-of-call for people presenting with allegations of sexual assault; how people experience their first interaction with personnel in ED (medical and nursing staff, counsellors, Aboriginal and Torres Strait Islander healthworkers and others) will greatly affect whether and how they proceed with their case, and ultimately their physical and mental health and wellbeing.

Information about current sexual assault response services in the Cairns region and how they are expected to function:

- Acute care – people are either brought by police, may be referred by GPs or self-present to the ED of Cairns Hospital (CH).
- Triage nurses in ED should, with the permission of the person alleging the assault, contact Cairns Sexual Assault Service who can provide a support worker 24/7 within about 30 minutes. Support workers provide information regarding the advantages and disadvantages of forensic examination, and options for ongoing care/support, which can, if the victim consents, be provided through Cairns Sexual Assault Service at their premises in Grafton St, Cairns, or elsewhere in Cairns.
- A roster of CH staff (trained nurses & medical officers) should be available 24/7 to conduct a forensic examination if required and agreed to by the victim. A number of CH nurses have undergone the training to become sexual assault nurse examiners (SANEs); medical officers may have varying degrees of training – some but not all may be emergency physicians with further training in forensic medicine, junior doctors may have less training but have access to written guidelines on the protocols to be followed.
- Children under 14 go directly to the paediatrics ward where all care is managed by paediatricians.
- Forensic examinations are performed using a special collection kit and a recorded chain of evidence is ensured. ED has an area set aside for general obstetric and gynaecological examinations of women presenting to ED and this is where the forensic examination takes place. Women should also be offered Emergency Contraception (if indicated) at this stage.
- Ongoing care – referral to social workers, Indigenous health and support workers, and mental health services as needed, information about results of tests for sexually-transmitted infections, pregnancy testing and counselling – is done through the TRUE Relationships and Sexual Health Clinic that is in the same building as the Cairns Sexual Assault Service, at the TRUE premises in Grafton St, Cairns or elsewhere as desired by the victim-survivor, for example their GP, Cairns Sexual Health Service, WuChopperen or other Aboriginal and/or Torres Strait Islander Services.

The actual day-to-day functioning of the services is of concern to SAFIR members for the following main reasons:

- Presentations to Cairns ED with allegations of sexual assault are relatively uncommon- around 50 annually. Triage staff may be unaware of the need to contact Cairns Sexual Assault Service and people may wait unnecessarily long for care. However it is well recognised both in Australia and overseas (with both academic studies and media reports of movements such as that initiated by Sydney student Chanel Contos- *The Guardian* 21/2/21) that a majority of victims do not report the alleged offence to any authorities, and 50 reports probably represents well below 50% of such incidents occurring each year in Cairns.

- The roster for MOs and SANE nurses is a voluntary one – these health professionals are working mostly in other areas of the hospital or in general practice in the community, and may be called away from those duties to attend in order to carry out the necessary forensic examination in ED. In practice there have been many gaps in the roster and victims-survivors have been advised they must wait for very long periods (up to 36 hours) before a forensic examination can be made; they are requested not to shower or change their clothes until the examination is completed.

  The variable availability of forensic examiners has meant that many victims-survivors attending ED have eventually walked out, deciding not to continue with their case and relinquishing the opportunity for care which is rightfully theirs. The busy ED, with many people attending with acute physical ailments, is also not the most appropriate environment for the care of victims-survivors of sexual assault. The forensic examination takes place in the same room as examinations of women with gynaecological presentations; frequently victims-survivors need to wait for this room to be free before their case can be proceeded with. Uniformed police are generally present with them in ED, which can be intimidating when so many other people are also present and witnessing their situation.

- Cairns Sexual Assault Service is situated at a considerable distance from ED; other services are also scattered around Cairns, requiring victims-survivors to move from one to another. The need for victims-survivors to move like this is less than ideal for both the correct conduct of forensic examinations and the compassionate provision of counselling and other care. Additionally, a significant burden may be placed on victims-survivors to retell their story multiple times when there is disconnected care.

This in itself is traumatising and exhausting. While the Director of ED has expressed his understanding that the present forensic cover is not perfect, he also has numerous other services to provide and the funding for sexual assault response is minimal.

- Victims-survivors reporting sexual assault in rural and remote regions outside Cairns will rarely encounter a nurse or doctor with sufficient training or experience to conduct the appropriate forensic examination. They will need to be transferred to Cairns for the examination, and often the person themselves has been made responsible for the travel, when either police or health services should be providing/paying for it. This lack of expertise in rural and remote regions means that victims-survivors may wait a very long time until they receive needed care; the knowledge that this is the case may result in people in these regions not proceeding with or dropping their allegations of sexual assault.

It is the considered opinion of SAFIR that the above problems can exacerbate the psychological harm done to a victim-survivor, and that the difficulties of negotiating the process is an active impediment to formalising complaints and encouraging victims to come forward, or seeking resolution through alternative remedial pathways. The impact both on the welfare of victims-survivors and on their ability to achieve positive criminal justice outcomes may prevent the needed sense of closure for the victim. It is important that we build a sense of overall trust in the system for both victims-survivors and those working with them; this will ultimately lead to more people stepping forward to report sexual assault.

Suggested solutions to the above problems

It has been identified that an integrated model of service delivery is best practice in providing effective and efficient responses to complex social and criminal justice issues. Indeed, in Queensland's Not Now, Not Ever: Report into the Prevention of Domestic and Family Violence 2015, a new approach to state-wide integrated service delivery responses was identified as necessary.

Similarly, Queensland Professor Kerry Carrington has recently advocated for a 'one-stop shop' for domestic violence and sexual violence based on her three-year study into Argentina's women and family police stations. These police stations include multi-disciplinary teams, childcare, and welcoming physical spaces etc.

Integration can operate in many forms, from simply improving collaboration and coordination between key agencies that are responding to sexual violence to true cross-sector integration. However, experience in Queensland and in other countries that provide women-centered service hubs suggests that co-locating service providers under the same roof provides a significantly improved quality of service delivery and experience for the woman who has experienced trauma.

Benefits that flow from a truly integrated service include:

- Cross agency trust and cooperation increases information exchange and breaks down barriers to professional relationships and processes.
- A common language is used and complementary practices remove silos of response.
- This promotes a 'No wrong door' approach. It does not matter who is the first point of contact for a victim-survivor, the service response is consistent and coordinated.
- This model drives shared understanding across agencies and cross agency accountability where officers from different professional frameworks learn from each other, share information, build trust and hold each other accountable.
- There are also potential cost savings in pooling resources.

Consequently, it is our stance that a freestanding, multi-agency service centre is needed. One where victims-survivors could be seen immediately, in surroundings that are less medicalised, where there are dedicated spaces for history taking, consultations with counsellors and other support people, and where medical examination and follow-up could all take place. This should be staffed by health professionals fully trained in the care of victims-survivors of sexual assault, who can be both nurses or midwives with specific training, and doctors with specific forensic training, sexual assault counsellors and case managers, and police officers. SAFIR recommends that an appropriate setting in Cairns would be the Sexual Health Clinic in Cairns North, although obviously existing infrastructure would need to be added to.

While there would be additional set up costs required it is expected that there would not be a significant increase in operational costs as re-structuring current staffing in agencies through re-allocating roles to staff who already undertake this work. In fact, there would be scope for efficiencies of service delivery to be achieved.

In addition we advocate for:

- More encouragement and incentives for medical officers currently trained as sexual health or emergency physicians to undertake the necessary forensic training to become expert examiners and expert witnesses on SA in court proceedings. In particular we recommend establishment or re-establishment of university courses in forensic medical examination for medical practitioners and registered nurses and/or midwives, , and a mentoring system to ensure initial contacts are safe and effective for victims, and supported for practitioners for sustainability of service.

  It is important to note that while SANEs and junior doctors have sufficient training to take histories, conduct some general physical examinations and collect samples, they do not have the forensic knowledge and experience to act as expert witnesses in court. Sexual assault services require the oversight of senior doctors with appropriate training and qualifications, who may supervise others either directly or by phone or video (the latter two are particularly appropriate to rural and remote regions of Queensland) and take ultimate responsibility for court reports. Such doctors need to have professional autonomy within the proposed integrated services.

- ***Larger regional towns acting as hubs and providing centres of excellence for the surrounding regions****;* this is what happens with the provision of healthcare in all other areas, with outreach services in medicine, paediatrics, antenatal care etc and transfer of patients as needed to the larger centre. Increasingly (and especially during the pandemic) good use has been made of telemedicine and this is likely to continue.

- *A sexual assault response hub in Cairns that could provide telephone/videolink consultation with smaller centres* when a victim-survivor presents. Such a system is in place in Mt Isa and we recommend that the Taskforce examine the system there. This model could, we believe, be applicable elsewhere in regional Queensland. It would depend on more doctors and nurses becoming expert and qualified in forensic examination for victims-survivors of sexual assault, and on these health professionals being appropriately paid for their work, and not simply volunteers from other healthcare roles.

- ***Involvement of First Nations' health services in all planning and advocacy, which we believe is essential*****, and a close working relationship with domestic violence services is also recommended.**

Adjunct Professor Caroline de Costa

The Cairns Institute JCU Cairns

Attached below is the submission of Detective Senior Sergeant Edward Kinbacher, which should be read in conjunction with and complementary to the submission of SAFIR.

This submission is an annexure to the professional and community representative's submission by the group SAFIR under the hand of and led by Professor Caroline de Costa.

My name is Edward Kinbacher and I am a Detective Senior Sergeant with the Queensland Police Service, I am the Officer in Charge of the Cairns Criminal Investigation Branch and have been an Detective in North Queensland for the past 34 years. My submission is however made as a private individual and nothing in my submission should be considered to be made on the authority of the Police Service, nor should it be taken as necessarily reflecting the Service's viewpoint. Of course, my submission is based on my observations and experiences while performing my functions as an investigator and as an Officer in Charge, with some knowledge of the history that brought us to the present situation and efforts by the Police Service to improve services for victims of sexual assault. I have taken a long-term interest in this issue and believe that, in keeping with my location and rank level within the Service, that I can comment on the situation with some authority – at least from the perspective of a practitioner's experiences in regional Queensland.

My responsibilities include the management of investigations of sexual offences concerning adult victims in the Far North Region, particularly in the Cairns metropolitan area and liaison with other government agencies involved in service provision to such persons.

It is a fundamental contention upon which I base my submissions, that the question of how best to manage the forensic examination and support mechanisms for a sexual assault complainant; properly falls within the Taskforce's Terms of Reference and Scope as part of the experience of women in the criminal justice system. Particularly in the following areas that the Taskforce may consider:

- *actual or perceived barriers which contribute to the low reporting of sexual offences and the high attrition rate throughout the formal legal process of those who do report;*
- *the need for attitudinal and cultural change across Government, as well as at a community, institution and professional level…*
- *the unique barriers faced by girls, Aboriginal and Torres Strait Islander women, culturally and linguistically diverse women, incarcerated women, elderly women, women in rural, remote and regional areas and LGBTIQA+ women, when accessing justice as both victims and offenders;*
- *policing and investigative approaches, including the collection of evidence and specialist training and trauma-informed responses to victims and survivors.*

I submit that the present inter-departmental arrangements for the three involved Queensland Government Departments, the Queensland Police Service, Justice and Attorney General and Health, fail frequently to adequately meet the psychological, medical/forensic and generally humanitarian needs of complainants and victims of sexual assault. I further submit that not only do the arrangements present a barrier to complaint, they at times are a psychological risk to victim complainants.

It is important to state that although I would categorise the State's arrangements as to be generally poor and not fit for purpose, the degree of dysfunction around the State is best described as patchy, with the South East corner, and Townsville's and Toowoomba's services likely being adequate, while the services in regional Queensland could be said to range from satisfactory to very poor. Toowoomba's model has often been mentioned as providing a high level of care and is effective. The Gold Coast and Logan forensic medical model is considered by informed persons as a best practice response to 'acute care' events. Local responses are much dependent on circumstances, and the goodwill of quite specific individuals working in the various localities. It must be recognised that the quality of service is entirely dependent on the various individuals' goodwill; and appropriate levels of service is only maintained while they perform their role.

I believe that the following issues contribute to poor outcomes for victim complainants:

- That service delivery is process-based as opposed to victim-centric.
- That the three departments' service delivery are effectively separate functions as opposed to commonly integrated. Organisational silos is perhaps an effective way to describe the nature of the issue's causal factor, although some level of role distinction and organisation independence must exist – and will be discussed as a key challenge in finding possible solutions to the concerns.
- That the departmental services delivered are provided at various locations as opposed to a single service point.
- Service delivery is I believe compromised to persons of Aboriginal and Torres Strait background and persons from other ethnic groups. Sexual assault within the Asian community I believe to be particularly underreported.
- That the provision of the forensic examination process within the Accident and Emergency (A & E) sections of hospitals is arguably inappropriate from the victim and Queensland Health's perspective. Qualified by acknowledging that acute presentations may require a victim being treated within A & E.
- That Health's delivery is mediated through 16 Hospital Boards around Queensland which have varying levels of commitment to their service delivery obligations to sexual assault victims, with no common ethos concerning the manner or standard of delivery to those victims.
- That Health has a vast number of priorities greater than the medically non-urgent nature of the forensic examination of sexual assault victims, and tend to triage the timing of the forensic examination response more on a scientific basis, as to opposed to one sympathetic to the psychological and like needs of a victim patient.

- That Health's approach – outside south-east Queensland - of reliance on a volunteer workforce to provide around the clock forensic examination capacity is a flawed approach.
- The lack of a dedicated, collegial and long-term common interdepartmental management group that works to a common clear purpose.
- I submit the tripartite interagency agreements that exist fail when mediated through the differing priorities and bureaucracies of Qld Health and through the various hospital boards.

The above is but a brief precis to highlight the scope of the issues and is not intended to be a comprehensive analysis.

I submit the following as recent examples of what I say is evidence of the nature of the problem and negative outcomes for victims.

- A child rape victim upon presentation at Cairns Base Hospital Accident and Emergency (A & E) was initially advised that no forensic examination was possible for 36 hours due to no on-call staff availability. After high level complaints at Cairns Base Hospital, the examination was conducted in a shorter timeframe. This is presented as an example of the disconnect between QHeath and the psychological needs of a victim complainant.
- rape victim incident – after almost 24 hours waiting for a forensic examination in Cairns Base Hospital A & E – the victim simply left the hospital without an examination being conducted. This victim was later located by police and the examination conducted.
- A rape victim was advised by Cairns Base Hospital that no forensic on-call staff were available to conduct the exam. This occurred at a time when there was a four-day period of no forensic staff being available either full time or on call at the hospital. The examination was ultimately provided by a private GP.
- Just-in-Case examination incident. A sexual assault victim who chose not to immediately make a formal complaint chose the 'Just-in-Case' forensic exam pathway, however upon presentation with the counselling service at the hospital was advised that no forensic staff were available to conduct the examination. Other services had to be arranged to the significant inconvenience and distress of the victim.
- Victim who believed she was sexually assaulted and drugged discontinued process incident. A victim self-presented at A & E, she was advised that she could not be assisted. She later met with police and examined, however due to the time that had passed since the incident there was little likelihood of proving drugs were administered to her against her will. Victim complainant ultimately chose to conclude the complaint process.
- Victim of a rape at a hospital in the Cairns region who upon police attempting to arrange a forensic examination was turned away on the basis there were no staff qualified to conduct the exam. Efforts to have the examination conducted at a nearby larger centre met with the same response. The victim ultimately transported herself to Cairns where the forensic examinations was conducted.

It is my submission that these recent examples highlight the nature of the problems being experienced in Cairns, which I believe are replicated across regional Queensland. It should be noted that this situation reflects a slow, long term deterioration of services by QHealth from the old version of Government Medical fficers to today's Hospital Board's being delegated responsibility for the forensic examination function.

The above examples occurred when significant gaps existed in the on-call roster in Cairns. When very limited overnight forensic medical staff were available – with the largest gap in forensic staff availability being four continuous days. Other occasions occurred frequently where very limited staffing was available on weekends and overnight. There was no contingency plan provided by QHealth to fill the gaps. I can provide the relevant QHealth staff rosters to the Taskforce if necessary.

It should be acknowledged that since I have commenced to advocate strongly in the Cairns community about what I say are the problems in the nature of the service provision to victims of sexual assault, that Cairns Hospital has improved its response and moved to address the concerns. However, the existence of the McMurdo Taskforce itself should not be discounted as a significant factor that has added the necessary motivation for their change of stance, and I am concerned that the present arrangements may well be transitory. I also do not believe that the changes in Cairns will necessarily be reflected around the state. Finally, even the new response is unsatisfactory as is not a properly integrated response, as proposed by SAFIR, in what I submit are the best interests of the victim.

I support the SAFIR proposal of the path forward being a multi-agency integrated response that is victim-centric and -focused. That a team drawn from the three agencies operate from one premises led by the Sexual Assault Counselling Service. That QHealth staff provide a full time 24-hour response capacity, and that the Police Service has dedicated and appropriate interview rooms and a forensic examination space to address the issue particularly of DNA and photography. That such units are established and led by a forensically trained doctor and supported by nursing staff and operate as centres of excellence to support staff in smaller hospitals and medical centres particularly those situated in isolated regional locations. I submit that isolation should not necessarily imply that victims are not appropriately supported – the approach of Doctor De Boos at Mount Isa is perhaps a way forward in remote locations.

I submit that to support full time health staffing that additional functions can be added to the role; arguably the Townsville and particularly the Gold Coast models, where nurses and at the Gold Coast Doctors provide services in Police Watchhouses, is one such appropriate function. I advise that the Police Service and Griffith University are presently researching how best to provide cost-effective health services in Police Watchhouses. The knock-on health benefits to persons detained, and the potential to provide an independent presence to monitor the risk, and thereby aid in preventing deaths in custody, are I submit synergies that could found by a new approach to the thinking surrounding the integration of health services into the legal system.

I also submit that the integrated approach addresses the problems associated with departmental silos and is in keeping with Government priorities to improve the effectiveness of common services delivered across multi-agencies. A pooling of presently existing funding and alignment of departmental programs, will I suggest mean that ongoing costs will require little 'new' money from Government. Though initial start-up establishment costs may be needed, these are not thought exorbitant if presently existing buildings are repurposed. Without listing them all, I suggest such centres are needed at major regional centres, Cairns, Townsville, Mount Isa, and Rockhampton being example locations.

However, discussions held with competent practitioners highlight the need for a level of professional distance and autonomy that must be maintained by doctors, particularly in respect to expert evidence and testimony of forensic doctors treating victims in an acute incident response. It has been emphasised that significant risks exist at the time of giving evidence if such experts could be perceived to have too close a relationship with sexual assault support services or the Police Service. A real lack of bias must exist and be seen to exist.

A further issue of concern is that the Police Service's position concerning the merits of a case and offender prosecution can on occasion put them at odds with more 'activist' sexual assault support services, with consequent tensions in relationships.

I however submit that these difficulties are not necessarily overwhelming and may well find a solution by categorising sexual assault incident into tiers – for example a Tier 1 matter is an acute response incident requiring direct medical intervention as well as forensic examination. Such matters could be treated in the manner of the Gold Coast and Logan model. Tier 2 incidents are all other reports and formal complaints that do not require an immediate medical response. Historical sexual assault incidents are but one example of what may fit into this category – and be responded to in the suggested organisationally collegial response manner.

These are mere suggestions that the Taskforce may consider.

I also suggest that the McMurdo Taskforce review the failure of efforts over past years by the Police Service to convince Qld Health of the need to change their viewpoint and operational practice in respect to these issues. I believe that much will be learned of the nature of the problem if such an analysis is undertaken.

I submit that the failure of any university in Australia to provide a properly accredited training scheme for a Forensic Nurse Examiners' qualification results in staff resource and hiring problems that need consideration. This course was in the past provided by Monash University – I suspect budgetary reasons led to it no longer being offered. The training question for medical staff, doctors and nurses, is likely to be a question that can properly be considered by the McMurdo Taskforce.

I submit that the Taskforce should consider the role and functions of the Clinical Forensic Medicine Unit of Queensland Health from the perspective of the effectiveness of its past performance and its suitability to provide ongoing services. I believe the reportedly singular focus of the Unit to the needs -almost exclusively – of the south east corner of the State is I say problematic.

A consistent theme in my discussions with persons involved in the provision of services across the various departments and in meetings with the SAFIR group was the of the need for a degree of regional autonomy and capacity to flexibly meet the unique problems specific to locations, and the needs of victims, across the State. Hence there is a challenge in how to provide a consistent policy and service delivery ethos across the State – which presumably must be based in a centralised group drawn from the three departments - while maintaining a level of local autonomy. This may be a difficult balance to strike. I do not believe that any presently existing group can adequately undertake such a role – based on practitioner feedback of the effectiveness of the presently responsible units' past performance.

In closing this submission, I wish to recommend to the Inquiry consideration of the SAFIR submission as warranting close analysis and consideration by the McMurdo Taskforce. The treatment of a sexual assault victim upon them initially coming forward is of critical importance to their recovery and the effective prosecution of offenders if such a path is commenced. I say that unquestionably the present arrangements fail to properly support a victim and can do actual harm. I suspect an analogy that may be apt is if the present arrangements could be seen to be a dam wall which restricts the flow of complaints into the broader systems open to a victim; be they the criminal justice path or other remedial pathways. I say the dam should be removed or at least its wall lowered to allow a greater number of victims to safely and reliably seek assistance from the systems that were established to assist and support them.

Edward J. Kinbacher

Detective Senior Sergeant - Officer in Charge

Cairns Criminal Investigation Branch

* * * * *

SAFIR MEMBERS SUPPORTING SUBMISSION TO TASKFORCE ON WOMEN'S SAFETY AND JUSTICE, JULY 2021

Professor Caroline de Costa- The Cairns Institute James Cook University

Detective Senior Sergeant Edward Kinbacher – Cairns CIB

Dr Kay Haig – formerly Director Cairns Family Planning Services

Dr Mark Wenitong - Adjunct Professor QUT), Strategic Director Research Knowledge Translation Lowitja Institute

Ms Deb Malthouse - CEO Apunipima Cape York Health Council

Ms Dania Ahwang -CEO Wuchopperen Health Service

Ms Suzanne Andrews- CEO Gurriny Yealamucka Health Service

Adjunct Professor Darren Russell- Director Cairns Sexual Health Clinic

Ms Elizabeth Morter- Director Cairns Sexual Assault Services

Ms Sandra Downing -Senior Lecturer College of Public Health JCU Cairns

Ms Carla Gorton- Cairns Women's Network, Member of Public Health Association of Australia

Dr Jacqueline Mein-Tropical Public Health Services Cairns CHSSS

Dr Anusha Lazzarini – North Queensland Lady Doctors' Association

Dr Amanda Roberts- Stratford Medical Centre Cairns

Ms Bec Coutis- COO Women of the World Cairns

Mrs Yolonde Entsch - Women of the World Cairns

Ms Robyn Whyte- CEO Northern Queensland Primary Health Network

Dr Shelley Le Cong - RFDS Cairns

Dr Patricia Fagan- Womens Health Program Manager Peninsula and Torres Regional Health Authority 1992-1997

Ms Tanya Galvin –Cairns

Ms Fern Campbell - Cairns