Statement of Stephen Ayre

RFS-TAS-070

Name	**Stephen Ayre**
Address	C/-Royal Hobart Hospital
Position	Executive Director Medical Services

1. This statement is made by me in response to RFS-TAS-070 ('RFS'), issued on 7 June 2022 by the President of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (the Commission), the Honourable Marcia Neave AO.

2. My name is Stephen Ayre and I am the Executive Director Medical Services at the Royal Hobart Hospital (RHH).

Q1. When did you start working at the Department and/or Tasmanian Health Service?

3. I commenced working with the Tasmanian Health Service in May 2004.

Q2. Outline the role(s) you have held at Department and/or Tasmanian Health Service? In respect of each role a brief description of:

(a) ***the duties and responsibilities of the role***

(b) ***the period in which you held this role***

(c) ***whether the role still exists***

(d) ***which area/department of Launceston General Hospital the role operated or operates in***

(e) ***who reported to you and to whom you reported***

(f) ***whether you had any personal performance measures, key performance indicators or financial outcomes in relation to how you or your team responded to child sexual abuse, safeguarded children or kept children safe, and***

(g) ***whether you held or were required as part of those roles to hold any qualifications or credentials (including any registration to work with vulnerable people).***

4. The first role I held with the Tasmanian Health Service was as Chief Executive at the Launceston General Hospital reporting to the Executive Management. I held that role between 2004 and 2008. The role still exists.

5. The Executive team reported to me and I reported to the Director Hospital and Ambulance Services.

6. I do not recall any performance measures in relation to child sexual abuse, safeguarding of children or keeping children safe.

7. In this role, I was not required to be a registered medical practitioner.

8. In my role as the Chief Executive, my Office had an Executive Support Officer. The Director of Medical Services, Director of Nursing and Director of Corporate Services reported directly to me. The Clinical stream leads (Medical x 3 And Nursing x 3) reported to their professional lead (Director of Nursing, Director of Medical Services). The overall performance of each of the streams reported through the Hospital Executive to me (e.g. meeting DoH targets, KPIs etc.).
9.

10. My current role with the Tasmanian Health Service is as Executive Director of Medical Services with the Tasmanian Health Service South. I have held this role since 2019. This role is still current and I am the incumbent.

11. I do not have any performance measures in relation to child sexual abuse, safeguarding of children or keeping children safe.

12. In this role, I am not required to be a registered medical practitioner.

Q3. Outline any other qualifications and credentials (including any registration to work with vulnerable people) you held that were relevant to your role(s) at the Department and/or Tasmanian Health Service.

13. MBBS(Qld) MHA (NSW) FRACMA.

Structure of the Launceston General Hospital executive management team

Q4. For the time you were employed at the Department and/or the Tasmanian Health Service, please outline how the Launceston General Hospital executive management team was structured, including:

(a) the official name of the team

(b) the position title of the team members

(c) the purpose, roles and responsibilities of the team (including by reference to any relevant terms of reference)

(d) your role (if any) with that team

(e) who the team reported to

(f) how the team operated with other executive teams within the Department and/or the Tasmanian Health Service, and

(g) whether the team held meetings, and if so , please give a high-level description of the topics that were discussed, the frequency of meetings and whether minutes were taken.

14. I have no recollection – It would be in the Terms of Reference and minutes of the meetings of the group at that time.

15. After commencing at the LGH, I reformed the previous Executive Meeting which had around 20 members. This included the key members of the Director of Nursing, Director of Medical Services, Director of Corporate Services and the 2 leads from each of the three Clinical streams of Medicine, Surgery and Women's and Children's (3 medical and 3 nursing directors). The Hospital Executive was the key decision making body of the organisation managing overall hospital performance in the key performance areas and supporting strategy and planning. The Team reported to me and I reported to the Secretary of the Department.

Q5. Was there a Launceston General Hospital Board? If so, what is the relationship between the Launceston General Hospital executive management and the Launceston General Hospital Board?

16. There was no board.

Q6. Identify any committee within the Launceston General Hospital that was responsible for child safety and what roles and responsibilities this Committee (or Committees) has. If no such Committee existed, please explain why.

17. The overall safety of the patients and staff of the Hospital rested with the Executive team and every staff member.

Q7. During your term of employment, did Launceston General Hospital have any strategic plans, performance measures or key performance indicators that related directly or indirectly with child safety?

(a) If yes, please explain what they were.

(b) If not, why not?

18. I do not recall. I would need to review the strategic plan developed at the time and clinical services plan. Safety and Quality would have been in the plan.

Incident Management Systems

Q8. Outline your understanding of the incident management systems that were in place at Launceston General Hospital during your employment, with particular reference to how incidents were reported, recorded and investigated. In your answer, please explain?

(a) the time period for which each system applied

(b) the relevant reporting lines and processes

(c) internal notification processes (for example, which Officials would be notified of an incident and when and how they would be notified)

(d) the relevant decision-making processes, including by whom and by what means it was determined that an incident should be:

i. dealt with by an Official of a certain level (for example, at ward level, executive level or Head of Agency level) or by a minister

and/or

ii. referred or reported to an external body (for example, Tasmania Police, Child Safety Services, the Registrar under the Registration to Work with Vulnerable People Act 2013 (Tas) or relevant professional bodies

(e) the supports (if any that were provided to a complainant once an incident was reported, and/or

(f) the extent to which a complainant was keep informed of steps taken in response to, and the outcome of, a report.

19. I have no recollection other than there was a Manager of Safety and Quality – incidents were recorded in a system that was managed by him and escalated as appropriate to the appropriate Executive manager. I believe the Safety and Quality Manager reported to the Director Medical Services. Patient Complaints would also have been handled by them. If an event was reportable, that would be reported to the Director Hospitals and Ambulance Service via the Office of the CEO. Reporting outside the Hospital would be undertaken by the most appropriate person e.g. a complaint to the Medical Board by the Director Medical Services.

Risk management at Launceston General Hospital

Q9. Outline the risk management framework or structure at Launceston General Hospital during your employment and the roles you have held within it. Include in your answer any significant changes that occurred during your employment and the role of the Launceston General Hospital executive management and/or its committees.

20. I have no recollection.

Q10. Was this risk management framework the same as what was in place at the Royal Hobart Hospital? If not why not?

21. I am not aware - I presume it would have been as we were part of the one agency.

Q11. Explain how the framework described in your answer to paragraph 9 was implemented in relation to the following matters:

(a) professional boundary breaches

(b) professional misconduct, and

(c) child safety.

Include in your response:

i. your expectations as to when concerns in relation to the above matters would be escalated to you as CEO of Northern Area Health?

ii. how these expectations were communicated to appropriate staff, and

iii. the circumstances in which you would report concerns to a member of the Launceston General Hospital executive management, any board or governance group, the Head of Agency and/or any regulator or third party.

22. I would expect that any notifiable matters would be reported to me as Chief Executive.

23. Any issues which would have had significant ramifications both for the individual or the organisation would have been escalated to the Director HAS.

Q12. During your employment did you hold any concern that matters in relation to paragraph 11(a) to (c) were not being escalated to you in circumstances where they should have been? If yes, explain the timing and nature of your concerns and any action you took in response, including whether you raised your concerns with anyone else and, if so, what the response was.

24. I have no recollection.

Q13. During the Relevant Period, where you received a referral of any matters in relation to paragraphs 11(a) to (c) please identify your response to the referral, including what steps if any, you took to in response, what the outcome was and what measures were put in place to ensure the concern did not occur again.

25. I have no recollection.

Q14. During the Relevant Period, where you referred matters in relation to paragraph 11(a) to (c) to anyone, (including the Head of Agency or executive of Launceston General Hospital and/or or any regulator or third party), did you have any concerns about the response you received? If yes, explain the timing and nature of your concerns and any action you took in relation to them, including whether you raised your concerns with anyone else and, if so, what the response was.

26. I have no recollection.

Mandatory reporting

Q15. What is your understanding of when and how to report a concern of child sexual abuse or other child abuse to Child Safety Services? Who do you understand is responsible for making that report?

27. Any health professional has a requirement to make a mandatory notification to Child Safety. The professional being aware of the concern should make the report.

Q16. What is your understanding of when and how to report a concern about a practitioner's* conduct *to a professional or regulatory body (including the Australian Health Practitioners Regulation Agency? Who do you understand is responsible for making that report?

28. There are mandatory notification requirements for a practitioner to report certain behaviours to AHPRA. Any practitioner who has concerns related to behaviour which may trigger mandatory notification is responsible for making that report. I do not recall what the requirements were in 2004-2008.

Q17. What is your understanding of when and how to make a complaint under the Health Practitioner Regulation National Law (Tasmania) Act 2010 (Tas) and the Health Complaints Act 1995 (Tas)?

29. A complaint can be made to the Medical Board of Tasmania or the Health Complaints Commission if a practitioner has practised in such a way as to pose a threat to the safety of the community.

Q18. What is your understanding of when and how to report a concern about inappropriate conduct to Tasmania Police? Who do you understand is responsible for making that report?

30. If a person believes an offence has been committed then that should be reported by the person who has the knowledge of the circumstances of the potential offence. If this involved a staff member then discussion would occur as to who made the report on behalf of the Organisation.

Q19. What is your understanding of when and how to report reportable conduct to the Registrar under the Registration to Work With Vulnerable People Act 2013 (Tas)? Who do you understand is responsible for making that report?

31. Generally my understanding is that individuals can make reports directly to the Registrar. If there is a situation of a staff member whose behaviour potentially breached the Act - this would be discussed with Human Resources and a decision made as to who should undertake the reporting on behalf of the organisation.

Q20. Are there other notifications you are aware of that are relevant and required to be made in your role, including when and to whom voluntary notifications can be made?

32. The practitioner themselves can make a voluntary notification to the appropriate body e.g. AHPRA etc.

33. In my current role as the chief medical professional at RHH I would make a notification where there was a concern about an employed medical practitioner. This would occur after appropriate internal discussion with the appropriate clinical area.

George

Q21. Did you ever become aware of any allegations of child sexual abuse in relation to George ***while he was working at the Launceston General Hospital from in or around 1989 to the date of this Notice?***

If yes, describe:

(a) what the allegation was

(b) when the allegation occurred

(c) how you became aware of the allegation

(d) whether you were concerned by the allegation (giving reasons why/why not)

(e) what role (if any) you had in dealing with the allegation

(f) what investigations if any were undertaken to investigate the allegation and your role in any investigation

(g) any steps taken against George whilst any investigation was undertaken, and

(h) the outcome of any investigation.

34. I have no recollection.

Q23. In relation to any allegation in relation to George that you became aware of did you or someone else from the Launceston General Hospital report the concern to:

(a) the Department and/or the Secretary of the Department

(b) a Minister or Ministerial Office

(c) a professional or regulatory body (including the Australian Health Practitioner Regulation Agency)

(d) Child Safety Services

(e) the Department of Justice and/or the Registrar under the Registration to Work With Vulnerable People Act 2013 (Tas), and/or the Consumer, Building and Occupational Services business unit within the Department of Justice

(f) Tasmania Police

(g) Director of Public Prosecutions

(h) any other office, agency or organisation, authority or regulator, and/or any union or representative body for nursing and medical staff.

35. I have no recollection.

Q24. If reports were made to any organisation listed in paragraph 23, describe:

(a) who made the report

(b) how the report was made

(c) when the report was made

(d) any responses received to the report (including when those responses were received), and/or

(e) the outcome of the report

36. No response.

Q25. Was the process that followed the raising of the allegation consistent with your understanding of the relevant policies, procedures, codes and guidelines in place at the relevant time, including any chaperone policy? In your answer, identify the relevant policy, procedure, code or guideline and explain the way(s) in which the process did or did not comply with it.

37. I cannot comment as I do not recall the policies or procedures relevant at the time.

Q26. In the event that a person raised allegations of child sexual abuse by a Launceston General Hospital employee would these concerns automatically be escalated to you in your role as CEO of Northern Area Health? If no, who was responsible for determining whether concerns would/would not be referred to you? Please identify such persons in your response.

38. I would have expected that allegations of a serious nature would be raised with the CEO. Issues would normally have been managed by the appropriate professional head (Director of Nursing etc.) and I would expect that they would make the CEO aware.

Q27. At the time did you have any other concerns or complaints about how the allegation against George was responded to by staff and or management and/or the Launceston General Hospital executive management from 1989 to the date of this Notice?

(a) If yes, please explain your concerns and what you think should have been done differently.

(b) If no, please explain why you have no concerns.

39. I have no recollection.

Q28. Reflecting on the matter now do you believe the investigation was appropriate and complete? If yes please explain why, if no, what was wrong with the investigation and what could have been done better?

40. I have no recollection.

Q29. Reflecting on the matter now do you agree with the outcome of the investigation? Explain the reasons for your answer.

41. I have no comment.

James Griffin

Q30 Have you ever worked with Mr Griffin and if so, for how long (including date ranges) and in what capacity?

42. No, I have not worked with James Griffin. He was an employee of the Hospital whilst I was CEO.

Q31. How would you describe your relationship with Mr Griffin?

43. I had no relationship with James Griffin.

Q32. Did anyone report to you or did you have any concerns about Mr Griffin's behaviour including allegations that he:

(a) engaged in any misconduct (including child sexual abuse)

(b) overstepped professional boundaries (hugging and non-care related touching) with paediatric patients

(c) called paediatric patients "baby", "babe", "princess" or similar

(d) had inappropriate conversations with paediatric patients, their families or visitors

(e) did not follow best practice or expected standards or procedures involving intimate engagement with paediatric patients

(f) used his mobile phone while on shift

(g) gave his mobile phone number to paediatric patients

(h) told paediatric patients they could contact him after hours or when off-duty

(i) had contact with paediatric patients after hours or when off-duty, and

(j) had ongoing contact with paediatric patients after they were discharged from hospital

44. I have no recollection of being made aware of allegations relating to James Griffin.

Q33. If your response to paragraph 32 is yes, detail:

(a) whether the concern was your own or was reported to you

(b) the nature of the behaviours

(c) when the behaviours occurred

(d) how you became aware of the behaviours

(e) when you became aware of the behaviours

(f) whether you were concerned by any of the behaviours (giving reasons why/why not)

(g) what role (if any) you had dealing with the behaviours, and

(h) how the behaviours were addressed.

45. Not applicable.

Q34. Do you have knowledge of, or did you observe anything else about Mr Griffin that concerned you, including in relation to his interactions with paediatric patients and/or children and young people generally? Please explain your answer.

46. I have no knowledge.

Q35. In relation to any concern about Mr Griffin that you became aware of, or personally held, did you or someone else from Launceston General Hospital report the concern to:

(a) the Department and/or the Secretary of the Department

(b) a Minister or Ministerial Office

(c) a professional or regulatory body (including the Australian Health Practitioner Regulation Agency)

(d) Child Safety Services

(e) the Department of Justice and/or the Registrar under the Registration to Work With Vulnerable People Act 2013 (Tas), and/or the Consumer, Building and Occupational Services business unit within the Department of Justice

(f) Tasmania Police

(g) Director of Public Prosecutions

(h) any other office, agency or organisation, authority or regulator, and/or any union or representative body for nursing and medical staff.

47. I have no knowledge.

Q36. If reports were made to any organisation listed in paragraph 32, detail:

(a) who made the report

(b) how the report was made

(c) when the report was made

(d) any responses received to the report (including when those responses were received) and/or

(e) the outcome of the report.

48. Not applicable.

Q37. Was the process that followed the raising of the concern consistent with. your understanding of the relevant policies, procedures, codes and guidelines in place at the relevant time? In your answer, identify the relevant policy, procedure, code or guideline and explain the way(s) in which the process did or did not comply with it.

49. I have no knowledge.

Q38. Did the fact that Mr Griffin was a Ward 4K Australian Nursing & Midwifery Federation Delegate impact your response to concerns raised in relation to him? If yes, explain how and why this was the case.

50. I had no knowledge.

Q39. In the event that a person raised concerns on Ward 4K about Mr Griffin in relation to the behaviours outlined in paragraph 32 would these concerns automatically be escalated to you? If no, who was responsible for determining whether concerns would/would not be referred to you? Please identify your response.

51. No, such concerns would not be automatically brought to me – The lines of accountability for a nursing staff member was through the nurse in charge of the area, to the Nursing Director for Women's and Children's and then to the Director of Nursing.

Q40. Are you now aware of any concerns, reports or allegations (whether formal or informal) raised by others in relation to Mr Griffin's conduct, including in relation to

the behaviours outlined in paragraph 32, that were not escalated to you at the time but should have been? If yes, explain the nature of the concern or report and the action you would have taken, had the concern or report been escalated to you.

52. I am not aware of concerns in relation to James Griffin.

Q41. Do you have any other concerns or complaints about how concerns in relation to Mr Griffin's conduct toward paediatric patients (including the behaviours listed in paragraph 32 above) were responded to by staff and or management and/or Launceston General Hospital executive management team during the Relevant Period?

(a) If yes, please explain your concerns and what you think should have been done differently

(b) If no, please explain why you have no concerns.

53. From what I now know about the circumstances of Mr Griffin's behaviour, it does appear that over familiarity and potential boundary issues were not more robustly dealt with by his supervisors.

Q42. Where concerns or reports in relation to Mr Griffin's behaviour were referred to you, were you directed (formally or informally) to take particular actions that you did not agree with? If so, please detail.

54. No. I don't recall having concerns or reports raised with me.

Q43. Prior to 31 July 2019, were you aware of any allegation that Mr Griffin had engaged in child sexual abuse of, or had had an inappropriate relationship with, a child or young person (whether or not a paediatric patient of Launceston General Hospital)? If yes, state the nature of each such allegation and when and how you became aware of it.

55. I was not aware.

Other people of concern

Q44. Did you have any concerns about conduct similar to that described in paragraph 32 in relation to other staff members at Launceston General Hospital or the Royal Hobart Hospital? If so, please answer paragraphs 30 to 42 in relation to each of those concerns.

56. In 2021, I was made aware of a [redacted] a non-clinical worker in the Children/Adolescent ward at RHH by way of a second hand complaint of incidents that occurred prior to 2016. This was in my role as acting CE for a short period in the absence of the CE. The enquiries that were made at the time of my acting role were incomplete in that key staff were not available. I sought HR advice with regard to these matters. I was not aware of the outcome as [redacted], Chief Executive, returned from leave and I handed this back to her in her role.

Q45. During the Relevant Period, were you aware of past allegations of child sexual abuse at Launceston General Hospital and/or the Royal Hobart Hospital and how such allegations have been managed? If yes, did such awareness influence the action

you took in response to concerns in relation to Mr Griffin or any person identified in answer to paragraph 44 above.

57. .I am aware of previous allegations made around a patient in 1989 following a request for information. I don't believe I had knowledge of the Griffin matter so it hasn't influenced my decision making with regard to that matter. The recent issue at RHH ([redacted]) I believe was dealt with following advice. I was not the decision maker in the progression of the [redacted] matter as the matter was still under review when I ceased the acting role.

Q46. With the benefit of hindsight, do you consider that you acted appropriately in relation to the matters outlined in your statement? If so, why? If not, what would you change or do differently?

58. I have always acted to ensure the safety of patients at all times and acted within the legal framework of my appointment. I don't have any comment to make as I do not recall the issues being raised with me.

Q47. Given your experiences at Launceston General Hospital, what do you think needs to change to make children safer from child sexual abuse whilst patients at Launceston General Hospital?

59. I have no comment to make, only that the incidents that have occurred would have focussed staff on ensuring the safety of paediatric patients

Q48. How do you think the health system's response to allegations of child sexual abuse can be improved?

60. The early engagement of investigative authorities external to the local setting.

Q49. What steps is the Department of Health taking to rebuild community confidence in Launceston General Hospital or otherwise improve child safety in hospital and health settings in Tasmania?

61. Improvements in child safety are occurring with increased knowledge of Child Safety issues and a focus on education of employees. Community confidence will be gained through consistent application of requirements to maximise safety within the Hospital.

Right to Information

Q50. What role if any did you have as the Chief Executive Officer of Northern Area Health Services in accepting, considering and approving requests for information made under the Right to Information Act 2009 (Tas) or other request for medical records?

62. I do not believe that as CEO, I had a specific role in relation to information requests. Information requests would normally be handled by a dedicated officer. I do recall having some involvement with information requests during the period I was CEO.

Q51. Identify the policies and procedures of the Launceston General Hospital in place in 2003 to 2005 which set out the process and procedures for responding to a request for release of information to former patients of the Launceston General Hospital. Where these processes and procedures different for patients who were victims of

sexual abuse by staff at the Launceston General Hospital.

63. I have no recollection.

Q52. Outline your knowledge of the right for information request by Mr Ben Felton in 2005 as it related to records of a sexual assault complaint against George [redacted] ***in 1989, including:***

(a) how you became aware of the request

(b) the steps you took to facilitate the request

(c) what steps you took to inform the Head of Agency of the request

(d) any directions you received about the request and who gave you those directions

(e) any conversations (before, during and after this request) you had with Mr Felton and how these conversations were recorded, and

(f) any barriers to complying with Mr Felton's request.

64. I have no recollection.

Q53 Were you at any point directed not to release the requested information, if so please explain who gave the directions and why.

65. I have no recollection.

Q54. Are you aware of any legal advice available to you at the time that would have prevent you from releasing the requested information? If so please outline who provided the advice.

66. I have no recollection.

Q55. Identify whether Launceston General Hospital's response as described in answer to paragraph 52 above complied with Launceston General Hospital's policies and procedures in place at the relevant time. If Launceston General Hospital's response did not comply with the policies and procedures in place at the relevant, please explain the respects in which Launceston General Hospital's response did not comply.

67. I have nothing to comment on.

Q56. Do you have any concerns or complaints about how [redacted] ***request was handled? If yes, please detail these concerns and complaints and how you think the request should have been responded to.***

68. I have nothing to comment on.

Q57. Are you aware of whether the policies and procedures outlined in response to paragraph 51 changed after [redacted] ***request? If so how?***

69. I am not aware.

Royal Hobart Hospital

Q58. Have you observed any positive or negative cultural changes in relation to preventing, identifying, reporting and responding to child sexual abuse in the Tasmanian Health Service? In your response, please draw from your experience in both Launceston General Hospital and Royal Hobart Hospital.

70. I have the perception that sometimes long standing behaviours or quirks are tolerated by colleagues and managers and excused as "He has always been like that" or "it is harmless".

Q59. Describe the purpose and features of the Speaking Up for Safety Pilot, including how likely it is to be implemented by Royal Hobart Hospital or elsewhere.

71. The *Speaking up for Safety Project* is focussed on giving junior clinical staff strategies to respond to safety concerns they identify at the time, particularly where the person who is about to cause a safety event is more senior than them. The focus is on preventing a safety event from occurring. Over 60% of clinical staff have now received the training. The next stage allows anonymous reporting of behaviours that may prevent staff from speaking up for safety e.g. derogatory comments, bullying and breaches in safety protocols. When a breach is reported, the targeted staff member is advised of the report but not in detail and it is not formalised so that they are just made aware. Repeated reports result in a more formal approach via Performance management.

The Commission

Q60. Has anyone in a position of authority (whether or not employed by Launceston General Hospital) discouraged you from assisting this Commission? If yes, please outline in general terms the form the discouragement took.

72. No discouragement from anyone.

Sources of information for this statement

Q61. Have you refreshed your memory for the purposes of this statement by reviewing any documents or other records or by speaking to any other person (other than a lawyer assisting you with the statement)? If so:

(a) please give details of each person you spoke to and the matters you discussed; and

(b) please provide a list of, and attach to your statement a copy of, each documents you have used to assist you in making this statement, including diary notes, emails, text messages, policy documents, incidents reports and correspondence.

73. I have had no access to information from my period of employment as CEO LGH. I have been provided with correspondence to the Police Commander Northern District and the reply from the Acting Commander.

Other information

Q62. Is there further information you would like to provide to the Commission regarding the Launceston General Hospital?

74. No.

Q63. Is there further information you would like to provide to the Commission regarding the Tasmanian Health Service (including any other hospital within the Tasmanian Health Service) and/or the Department?

75. No.

B. REQUEST FOR DOCUMENTS

Q64. Produce a copy of any document referred to in response to any paragraph in this Notice (including any document which you used to refresh your memory referred to in your answer to paragraph 61 above).

76. Letter to and from Police Commander Northern District (TRFS.0070.0064.0001).