TRANSCRIPT OF PROCEEDINGS

COMMISSION OF INQUIRY INTO THE TASMANIAN GOVERNMENT'S RESPONSES TO CHILD SEXUAL ABUSE IN INSTITUTIONAL SETTINGS

At Clarendon Room, Country Club Tasmania,
Country Club Avenue, Prospect Vale, Launceston

BEFORE:

The Honourable M. Neave AO (President and Commissioner)
Professor L. Bromfield (Commissioner)
The Honourable R. Benjamin AM (Commissioner)

On 1 July 2022 at 10.02am

(Day 19)

MS BENNETT: Commissioners, the first witness this morning is Sue McBeath who appears remotely. Could I ask that the witness be sworn?

<SUE LEE MCBEATH, affirmed: [10.02am]

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. Ms McBeath, you have COVID at the moment, thank you very much for being present. Could you please tell the Commissioners your full name and professional address?
A. Susan Lee McBeath and I work at the Royal Hobart Hospital, Hobart.

Q. You've made a statement in response to a notice to assist the Commission; is that right?
A. That's right.

Q. And save for a matter that we'll come to in a moment around paragraph 35, are the contents of that statement true and correct?
A. That's right.

Q. You refer in paragraph 35 of your statement to a conversation you had in February 2021 with Mr Ayre, could you tell the Commissioners what you remember about that conversation?
A. I was acting as the Executive Director of Nursing and Midwifery, and so, I was located in a corridor in a part of the hospital very close to Stephen and I had become aware of the podcast, The Nurse, and having viewed the podcasts I was shocked and horrified having worked previously at the LGH in the position that now Janette Tonks holds. And at that time, during that period Stephen had been the CEO, and so, I expressed my shock and absolute horror at that, you know, what was in the podcast, and I said to him, "I knew nothing of this", and he said that he had been contacted by the police during the time that he was the CEO and, on the advice of HR, he was advised to let the police investigation take its course and that's what he disclosed to me at that time.

So, I suppose I was shocked that there had been evidence at that time because I would have then viewed my first interaction with certain behaviours differently having been a forensic nurse examiner and I would have seen

his - so, a forensic nurse examiner like Ms Whitemore has received training on concern on predatory behaviours and so I would have seen his behaviours differently had I known that there was a police investigation because, instead of it being confused professional boundaries of a newly qualified Registered Nurse, I would have seen it much more sinister, and that's really regrettable that I didn't have that information.

Because, as a health professional, duty of care is something that we hold very strongly, it's one of our core values. We sign a declaration every year and at the same period I had used duty of care to proceed with an investigation which I thought was actually in the public's interest and had gone to the Industrial Commission, and that was during the time that Stephen was also the CEO. So, you know, I was just a bit sort of shocked that duty of care wasn't used at that time with that knowledge by a health professional.

Q. Is there any chance, Ms McBeath, that - there was some misunderstanding about the time period that you were talking about; could he have been talking about, he more recently heard about something?
A. No, he - I remember - I remembered it incorrectly and it wasn't until I heard Liz Stackhouse's statement or her evidence that I realised I had it incorrect and that he was the CEO that followed Ms Stackhouse and, if she finished in 2003, then his four-year tenure was within the four years from her completing her role as the CEO; there might have been an interim locum for a month or two. In my statement from the best of my knowledge, without access to any of my documents or resources, and so, I think that's why I kind of got the dates wrong but it was during his period as the CEO.

Q. I just wanted to check that there was no scope in your conversation with him for misunderstanding --
A. No.

Q. -- that he was really meaning to say some other time he was told later, much later in time?
A. No, no.

Q. Is there anything else about that conversation that you said to him that you think the Commissioners should know?

A. No, just that - you know, like, I said that he should ring, he should listen to the podcasts, that it was shocking and that, you know, his behaviour obviously escalated and, you know, it was just unbelievable that this had happened. And, you know, I mean, I don't know whether he ever did or not but I didn't have another conversation with him about it.

Q. Did Mr Ayre talk about giving evidence to this Commission?
A. I contacted him on 10 June following a phone call that I had that I needed to give evidence, and I knew that he possibly could need to give evidence and I knew that he was also going on leave, and so, I really just rang him, I think at 3 o'clock on the 10th, just to say, "I've been required to give evidence, I'm sure that you might actually get a call, just my thought that he was going on leave, and he said that he'd already been in contact with [redacted] and that he viewed - he had told [redacted] that there was no - there was nothing further that he could add that couldn't be obtained from the HR files, so he didn't think that he was needed to be called, yep.

MS BENNETT: Thank you. Commissioners, those were the questions that I had for Ms McBeath, unless there are any other matters that the Commissioners wanted me to explore with her.

Sorry, Commissioners, before you release Ms McBeath. Please Commissioners, those are the matters. Thank you, Ms McBeath, for making yourself available.

PRESIDENT NEAVE: Thank you, Ms McBeath.

MS BENNETT: The next witness, Commissioners - perhaps I'll allow Ms McBeath to - thank you.

The next witness is Mr Stephen Ayre, the former Chief Executive of Launceston General Hospital.

PRESIDENT NEAVE: And I understand that he is being represented? Yes.

MR ZEEMAN: Please the Commissioner, my name is Zeeman.

<STEPHEN JAMES AYRE, sworn: [10.10am]

<EXAMINATION BY MS BENNETT:

MS BENNETT: Q. Can you tell the Commissioners your full name and professional address?
A. I'm Stephen James Ayre and my address is the Royal Hobart Hospital, Liverpool Street, Hobart.

Q. You've made a statement in response to a notice to assist the Commission?
A. I have.

Q. Have you read that statement recently?
A. Yes.

Q. Are its contents true and correct?
A. Yes.

Q. We've just heard evidence from Ms McBeath - let me pause there. Did you hear her evidence?
A. I heard just some of it.

Q. Okay, what did you hear of her evidence?
A. I heard that she said that I disclosed to her in 2021 that I'd had previous knowledge of this event.

Q. Yes. Did you disclose to her in 2021 that you had previous knowledge of Griffin's conduct?
A. Absolutely not.

Q. Well, what did you tell her in 2021?
A. I told her that I hadn't listened to the podcast and that I was as surprised by the allegations that had come forward as other people were who worked at - in Launceston at that time.

Q. She describes being quite shocked at your disclosure and that it made an impression upon her. Well, what do you think you said to her that was shocking in that conversation?
A. I don't believe I said anything shocking to her in that conversation.

Q. So, did you suggest that you had ever heard - perhaps, Mr Ayre, you talked about things you had heard subsequently. Did you talk about what you had learned

about Griffin's conduct after his death and arrest - arrest and death?
A. Can you repeat the question, please?

Q. Did you speak with Ms McBeath about anything you had subsequently learned about Griffin's conduct after he had died?
A. No, I did not.

Q. You did not speak about Griffin's conduct at all?
A. Absolutely, I had - have had no - I have not taken any - I haven't followed any of the information that was forward-coming from his death in 2019.

Q. You've not followed with any interest at all the revelation that there was a paediatric nurse at Launceston General Hospital while you were the CEO?
A. I'd have to say that I took a very peripheral interest because I didn't have any knowledge of it.

Q. But you had knowledge of the hospital, didn't you?
A. I had knowledge of the hospital, but I didn't have any details about how long anything had been happening, so I didn't take a particular interest in the Griffin matter at that time.

Q. Did you know that Griffin had been a nurse on the ward in the hospital while you were CEO?
A. Yes, I subsequently learnt of that.

Q. When did you learn that?
A. Would probably be after 2019; I can't recall.

Q. And that still didn't pique your interest?
A. I guess it did - there was some interest in that, but as I didn't have any knowledge of that prior to 2019 I did not take particular interest; I believed that I hadn't had any knowledge of that.

Q. Leaving aside the lack of knowledge that you assert, as someone who continues in leadership positions in hospitals in Tasmania, weren't you concerned that a paedophile had worked on a children's ward while you were the CEO?
A. Absolutely.

Q. So, why did that not pique your interest to make

further enquiries about what had happened?
A. Because I didn't have any role at that time in 2019 with regard to Launceston.

Q. Is this a problem that is necessarily confined to Launceston?
A. No, it's a problem that all hospitals may have an issue with.

Q. And the systems and processes that need to operate to keep children and patients safe are common to all hospitals, are they not?
A. Absolutely.

Q. Did you think there was anything that might be learned from the fact that Griffin, a paedophile, had worked on the hospital where you were CEO for a number of years?
A. Could you repeat the question?

Q. Did you think there was anything to be learned from the fact that Griffin had operated without your knowledge while you were CEO for four years?
A. Absolutely.

Q. So, did you take any steps to inform yourself about what you might learn from that fact?
A. No, I had confidence that the system was - at Royal Hobart was being dealt with appropriately and the changes that had been implemented and the other aspects associated with child safety had changed significantly.

Q. As I understand your evidence, you didn't know anything about how Griffin operated?
A. I didn't.

Q. So, how could you know that your systems were sufficient to meet that concern?
A. I had confidence that the system had actually addressed that issue.

Q. Without yourself knowing anything about or showing any curiosity of how Griffin had operated at Launceston, you felt there was nothing for you to learn from that lesson?
A. There would always be something to learn from the information as it came forward, but it wasn't - the issue of Launceston from 2004 to 2008 was not in my current thinking with regard to the role that I had in 2019.

Q. So you drew no link between - sorry, I withdraw that. Do you consider now that the health system has something to learn from its experiences in responding to or failing to respond to Griffin?
A. Absolutely.

Q. And, when have you realised that?
A. I have realised that as I've become aware of the information that's been coming forward.

Q. What is the information that has led you to believe that this case has some relevance to you, and I mean by that in your leadership position in a hospital?
A. In my leadership position in a hospital?

Q. Yes, when did you decide that the case of Griffin might have something for you to learn?
A. As in all leadership leaders in hospitals there would be something to learn from these - the information that comes forward.

Q. When did you decide there was something to learn from the Griffin example?
A. When I became aware of the issue with Griffin.

Q. And, when was that?
A. Well, that would have been around the time of 2019 when the issues unfolded.

Q. So, in 2019 you thought there was something to learn from the example of Griffin?
A. Yes.

Q. And you took no steps to learn anything about his offending?
A. I took - I was confident that the system would actually uncover the issues that needed to be addressed and that this would unfold as further information came to hand. This information was not available prior to 2019 to me.

Q. Did you take any steps in 2019 to learn anything about the Griffin example?
A. I can't recall.

Q. I think you've just given evidence that you didn't know anything about Griffin at all in February 2021 when

you spoke to Ms McBeath; that was your evidence, wasn't it?
A. Correct, yes.

Q. Can I take it from that, that between 2019 when you decided that there was something to be learned as a hospital administrator and leader from the example of Griffin, and February 2021 when you spoke with Ms McBeath, you made no enquiries about Griffin's conduct or behaviours?
A. No, I did not make any enquiries; I had confidence that the issues were being dealt with and would be uncovered and that we would be - we'd had knowledge of the issues as they unfolded and as the information became available.

Q. Can I suggest to you that that is an astonishing lack of curiosity?
A. I don't believe that's a lack of curiosity, I believe it's a confidence that the issues will unfold and they will be - any issues can be addressed as they are identified.

PRESIDENT NEAVE: Ms Bennett, I had a question.

MS BENNETT: Please.

PRESIDENT NEAVE: Q. You've said that you were satisfied that the processes that were in place in the hospital, of which you are now the leader, to protect children in the future, did you talk to anyone in the hospital about what steps had been taken in light of the information that was becoming evident about Mr Griffin's behaviour at Launceston? How did you interrogate the people who you were so confident in or the systems that you were so confident in? How did you check that your perception of that was correct?
A. I had confidence in the leadership of the Women's and Children's Service, the Medical Director who's a paediatrician, paediatric --

Q. Did you speak to those people about what they put in place in response to Griffin?
A. I don't recall speaking to them specifically about that.

Q. So, you relied on your knowledge of their - I'm not sure, personality or processes or something, that this couldn't happen?

A. I relied on the systems that we had in place at the Royal Hobart that this could not happen; that we had minimised the risk at the Royal Hobart.

PRESIDENT NEAVE: Thank you.

COMMISSIONER BENJAMIN: Q. Dr Ayre, your academic qualifications are as a doctor; is that right?
A. That's correct.

Q. Do you have any academic qualifications in management and running a large organisation?
A. Yes, I have a Masters in Health Administration and I have got a Fellowship of the Royal Australasian College of Medical Administrators.

Q. That's from Queensland; is that right?
A. Sorry?

Q. That's from Queensland, it shows up on your statement, the Masters?
A. No, New South Wales.

Q. Thank you.
A. Excuse me, I just feel ...

Q. Are you all right?

MS BENNETT: I think Dr Ayre feels unwell. Perhaps we can adjourn.

SHORT ADJOURNMENT

PRESIDENT NEAVE: Thank you, Ms Bennett.

MS BENNETT: Thank you, Commissioners. Commissioners, your Counsel Assisting team appear to seek an adjournment of the balance of today's witnesses. We propose that their substantive evidence be called back before this Commission in the middle of August, that being the balance of the witnesses being Dr Renshaw and Ms Morgan-Wicks.

I'd now like to identify the reasons that I seek that adjournment, Commissioners, and that is that there was a medical emergency prior to this adjournment application and that event has had an impact on all present, including those due to give evidence.

It is our obligation, our duty, to ensure that the very best evidence is available to this Commission and in our view it is our recommendation that end is best served by adjourning the balance of today.

I'd like to emphasise, Commissioners, that in making this recommendation to you I have consulted with the families of Zoe Duncan and with Mr Ben Felton as two of the lived experience witnesses who are impacted by this application.

I recognise that there are many other people impacted by this application who were expecting to hear evidence today which we are now proposing to defer.

Commissioners, we understand the difficulty and the inconvenience of this application and we nonetheless put it before the Commissioners for your consideration.

Can I make one final observation before I conclude this application and that is this: there were many nurses and police officers who responded to the issue that arose and they did so with enormous professionalism and care and concern; it showcased the best of the health system in Tasmania and it is in some way fitting, Commissioners, that that is the final comment that I would like to make to you today, is that the fundamentals of the people, the women and men who operate that system are so caring and so professional and they demonstrated that in this room today.

Those are the matters that I seek to raise, Commissioners.

PRESIDENT NEAVE: Thank you for the application, Ms Bennett, and we accept that application and we will adjourn proceedings, thank you.

MS BENNETT: Commissioners, I should be clear: I seek to adjourn those witnesses until mid-August. This hearing I seek to return on Monday where there will be policy witnesses giving evidence as scheduled. The substantive evidence from today is what I seek to adjourn until mid-August. I apologise for any lack of clarity about that. Please the Commissioners.

PRESIDENT NEAVE: Thank you, Ms Bennett, I grant the

application.

AT 11.35AM THE COMMISSION WAS ADJOURNED TO MONDAY, 4 JULY 2022 AT 10.00AM