Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Friday, 2 August 2024 at 10.08am

(Day 043)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting)**
Mr Daniel Fuller	**(Counsel Assisting)**

Also present:

Mr R Cheney SC with Mr Hilbert Chiu for NSW Health

THE COMMISSIONER: Good morning. My apologies for being a little bit late this morning, to all of you.

MR MUSTON: Shall I continue?

THE COMMISSIONER: Please do, yes.

<ANDREW ROBERT HALLAHAN, on former affirmation: [10.08am]

<EXAMINATION BY MR MUSTON CONTINUING:

MR MUSTON: Q. Dr Hallahan, I think we were in the middle of looking at the minutes of the meeting of 12 October 2023, which you will find in the second of those two volumes at H7.12.59. For the operator, it's [SCI.0012.0036.0001].

THE COMMISSIONER: Could you repeat that reference, please?

MR MUSTON: Sure. So it's H7.12.59 and it's up on the screen there.

Q. We were looking, I think, at page 37. Do you see there's a discussion towards the top of the page about the bandaid solutions, and then you see attributed to Dr Cheung, he seems to say, "What they want, Andrew, what they want"; do you see that?
A. Mmm-hmm.

Q. It would appear from what immediately follows that you felt he had interrupted you again at that point?
A. It would appear so.

Q. And you see your response there:

> *It's incredibly disrespectful for you to interrupt me while I'm trying to make a point.*
>
> *[That's] what you have just done. It's not okay. I'm trying to actually make a reasonable point to you. And to the group. Do you understand that?*

Did you really have any doubt about whether or not Dr Cheung understood that point that you were making to him

about interrupting?
A. I needed him to acknowledge that, yes.

Q. Did you really have any doubt about his understanding that interrupting was, to use your word, "disrespectful"?
A. Yes, I did have doubt.

Q. What was the reason that you had a doubt about that?
A. He was heightened, he was angry, and it seemed to me that he had poor control of his emotions at that point in time, so I had reasonable doubt that he understood.

Q. Did you think that that situation would be improved by asking him whether he understood that it's disrespectful to interrupt people?
A. I felt it was necessary to make that point. Yes.

Q. You felt it was necessary. My question to you was: did you think that it would have assisted the situation for you to ask him that question?
A. In the context of the situation that was playing out, yes, I did.

Q. Did you think that was likely to reduce the tension in the volatile situation that you were presented with at that meeting?
A. Remember, this was a fluid and dynamic meeting and, yes, I was hoping to achieve that.

THE COMMISSIONER: Q. As we discussed yesterday, I accept that this was a heightened meeting. I mean, I wasn't there and we can't hear it, at the moment. Doctor, is there any chance, though, and perhaps we'd have to listen to the audio, the part of the transcript that Mr Muston just took you to, where you have complained to Dr Cheung about him interrupting you on this page - I fully accept that you felt he was interrupting you. Is there any chance, though, if we look at what you've said above where Dr Cheung has said, "What they want, Andrew, what they want" - you've said:

I'm sorry, the capital works ...

et cetera. Then you said:

They said real and substantive actions. I hear what you're saying. I hear the

distress and I'm really sorry for the thing.

Is there any chance that after you've said, "I hear the distress and I'm really sorry for the thing", that he might have interpreted that you had finished that point and wanted to go on to make his own point?
A. Without the benefit of a full recording and given the passage of time that has passed, I find it very difficult to answer your question, I'm sorry.

THE COMMISSIONER: No, that's fair enough. All right. Thank you.

MR MUSTON: Q. Is it possible - just coming back to the passage we were looking at a moment ago which concluded with the, "Do you understand that?" - that this was you venting your own frustration at a meeting in which you felt you were not being respected and listened to in a way that you wanted to be?
A. That was not my intent.

Q. Again, that wasn't quite my question. Whilst it may not have been your intention, is it possible that - well, let me take it in two steps. It's possible, is it not, that you had become by that stage quite frustrated by the way in which you were engaging with Dr Cheung at that meeting?
A. I think my words would indicate that I did say to him that I found it incredibly disrespectful for him to interrupt me while I was trying to make a point.

Q. You felt that he had not been respectful to you?
A. I felt he had been "incredibly disrespectful" were my words, yes.

Q. It is likely, is it not, to have caused you to feel some frustration?
A. I would be less than human if I did not feel some frustration, that is correct.

Q. Both the tone and delivery of your question at the end of that, "Do you understand" - my question to you is do you accept that that is potentially going to have been influenced by that frustration?
A. I can't make comment on tone.

Q. Is it possible, do you think, that that response could have been, as it were, you vocalising your frustration with the situation?
A. Again, this is an imperfect transcript. It does not capture the full context of what was happening. My memory is that I was not seeking to do that, but I agree, it is possible you could interpret this imperfect transcript in that manner.

Q. Then, as you see going down the page, Dr Cheung, said:

I'm listening, Andrew, I'm listening.

And you then, to the foot of the page, continued to explain the point that you were seeking to make. If we then go over to page 38, do you see at the top of that page you say:

I think at this point in time I'm actually going to, I've got to be somewhere else.

Do you see that?
A. Mmm-hmm.

Q. Do you see you indicated to the meeting that you are, with appropriate apologies, going to leave. But then you add:

I would ask you to reflect a little bit on how these meetings are run.

Again, who was that directed at, do you recall?
A. That was directed at the chair, but it was also for consideration of all of the members.

Q. So in relation to all of the members, the great majority of them had sat silently throughout this meeting, had they not?
A. As they typically do.

Q. You see you then go on, if we get down to 18.23.09 - sorry, 18.22.57, and:

And I would ask you to consider the conduct of these meetings and the conduct of yourselves as a medical staff council.

That was presumably directed at the whole of the meeting or the attendees?
A. Yes.

Q. Did you not think that it might have been somewhat disrespectful to have been suggesting to a large group of your colleagues who had, to that point, sat quietly, that they needed to, as it were, reflect on their own conduct?
A. I felt it was appropriate to ask them that, given that they had, on multiple occasions, in my view, tolerated disrespectful behaviour by their chair towards many members of management.

Q. Tolerated disrespectful behaviour in what way? By not leaving the meeting?
A. They had sat silent without raising any concerns.

Q. But that wasn't quite the question I asked you. Did you think that it was not possibly, at least as viewed by those, that overwhelming majority that sat silent throughout that meeting, somewhat disrespectful for you to be suggesting that their conduct was, in some way, less than ideal?
A. With respect, I was of the view that that needed to be called out. My view was that the conduct of these meetings was characterised by bullying, intimidation and harassment of the general manager, of myself and of other members of the executive. My view was that members of the Concord medical staff council had, on multiple occasions, witnessed this and tolerated this, without calling it out.

My view is that under NSW Health core values, which I deeply value and hold to, we actually have a responsibility to call out inappropriate behaviour. So in this context, I felt it was appropriate to give what I still think was a gentle piece of feedback that my view was that the conduct of these meetings needed to be further considered.

Q. I'm going to ask you the question again. Perhaps we'll remind ourselves that it is - the context in which this meeting arose was, as I think you've already accepted, the staff council believed that they were not being listened to by the executive. That was a belief that they genuinely held, albeit one which you did not share?
A. Yes. That is correct, that approximately 60 per cent of the staff council had that belief. Yes.

THE COMMISSIONER: Q. Well, I don't - 60 per cent of the staff council voted for the no confidence motion?
A. True. True.

Q. Of the other 40 per cent, I'm not sure that we know what was in their mind as to why they didn't vote. They may have not had confidence but still not thought that was extreme; they might have had all sorts of views. So I think we'll just leave it at 60 per cent --
A. Fair point.

Q. -- voted no confidence.
A. Yes, I agree. My apologies.

MR MUSTON: Q. The third of those core concerns that we touched on yesterday was they felt that for those who spoke out there would be reprisals, again a view genuinely held but one which you did not share?
A. Yes, you have stated that a number of times, yes.

Q. Against that background, did you not think that suggesting to the entire medical staff council that they should consider the way in which they were conducting themselves was not [sic] something which had the capacity to exacerbate those concerns on their part?
A. With respect, I disagree. I felt it was appropriate to call out poor conduct, or at least ask people to consider their conduct. I was not threatening any reprisal. I was simply asking them to consider their conduct, as I state in that sentence. I feel that was a reasonable thing to do and something which is actually consistent with my role and my duty as the medical professional lead for the district.

Q. Reflecting on it now, could you see how that had the capacity to further aggravate a group of people who genuinely held those views, those concerns?
A. I find your question interesting. Reflecting on it now, I can understand that some could choose to take offence at that and I remain of the view that where conduct is inappropriate, particularly in a large meeting, that it is important to call it out, which I did, and in as gentle and reasonable a way as possible, in my view.

Q. I want to suggest at the highest, Dr Cheung's conduct during that meeting, at least insofar as it is reflected in

the transcript, was disrespectful?
A. Can you repeat your question, please?

Q. Taken at its highest, I want to suggest the conduct of Dr Cheung might have been regarded - at that meeting, might have been regarded as disrespectful?
A. Yes.

MR CHENEY: I'm not sure what "at its highest" can mean in that circumstance. Do we mean in its most egregious form or --

THE COMMISSIONER: That's how I take it. I take Mr Muston to be putting the point - the question to involve Mr Muston to be putting the proposition that the strongest view you could take of Dr Cheung's conduct was that it was disrespectful.

Is that the way you intend the question?

MR MUSTON: Let me break it down into some component parts.

THE COMMISSIONER: Yes.

MR MUSTON: Q. At the meeting, Dr Cheung interrupted you on one or perhaps more than one occasion?
A. On more than one occasion, yes.

Q. And he raised his voice in an angry way at a point during the meeting?
A. And he became - he appeared to become very heightened, flushed in the face, spoke rapidly with a raised voice - all the signals that he was enraged is the way I interpreted it.

THE COMMISSIONER: Q. He might speak rapidly when he's not in an angry state, but I understand the impression you are trying to convey.
A. It is the combination of behaviours which I am just trying to put to you. It is difficult to capture what happened in this meeting in a transcript. It really does not do it justice.

MR MUSTON: Q. But your experience of that meeting was, or of his conduct during that meeting was, what you were able to observe of him as, no doubt, one of the number of

faces on your screen at your computer as you sat at your desk?
A. He was the main face.

Q. But let's accept he was the main face. Your observations and experience of him during that meeting were an experience of him as a face on a screen in a Zoom or Teams meeting?
A. Yes.

Q. We'll come back to the core proposition: having regard to the content of what was said, interrupting you and speaking with a raised voice in an angry way, using the words that are attributed to him in this transcript, could, at its highest, be described as disrespectful?
A. Mmm-hmm. Yes.

Q. I want to suggest that, perhaps viewed from the perspective of Dr Cheung, your own conduct during that meeting might not have been regarded as entirely respectful. Would you agree with that?
A. With the deepest respect, no.

Q. You don't accept that someone in Dr Cheung's position, listening to what you have said to him, as recorded in this transcript, might have regarded that as somewhat disrespectful?
A. No, I do not accept that. My view was that I was seeking to remain calm and appropriate and clear.
I continue to hold that view.

Q. You went on to make a disciplinary complaint against Dr Cheung in respect of that meeting, didn't you?
A. Yes.

Q. It's a fairly serious step to take against the background of the situation which you were confronted with, particularly having regard to what you understood to be one of the principal concerns of the medical staff council - namely, the risk of reprisal for those who spoke out?
A. I'm sorry, I can't make out your words.

Q. You understood that the medical council were concerned about the risk of reprisal for those who spoke out?
I think you've agreed with that a number of times?
A. They had said that a number of times.

Q. What I'm suggesting is, making a disciplinary complaint against Dr Cheung, the spokesman of that group, in those circumstances, was a not insignificant step to take against that background; do you agree?
A. I made a complaint --

Q. Just stick with my question first, if you wouldn't mind.
A. Well, can I just --

Q. Did you think it was a significant step to take against that background - yes or no?
A. Yes, it was a significant step.

Q. Did you speak to anyone about it before you took that step?
A. Yes, I considered it and I spoke to several people.

Q. Who?
A. I - the passage of time means I can't recall the entire group of people I spoke to.

Q. Could you recall any of the people you spoke to about the possibility of making a disciplinary complaint against Dr Cheung arising out of the way he behaved during that meeting?
A. Not with absolute certainty at this point in time.

Q. Do you recall speaking to the chief executive about it before you took that step?
A. No, I don't.

Q. Why did you take the step of making a disciplinary complaint against Dr Cheung arising out of the way he conducted himself during that meeting?

MR CHIU: I'm sorry, I didn't hear that.

MR MUSTON: Q. Why did you take the step of making a disciplinary complaint against Dr Cheung arising out of the way in which he conducted himself at that meeting?
A. It was not - it was a complaint. So you say "disciplinary complaint"; it was a complaint about behaviour which we would describe as a workplace grievance. It had the potential to lead to disciplinary action, but not necessarily. It was simply to put that forward for an initial assessment.

The reason that I did that was because, in my view, it is important that we treat each other with respect at all times. That is actually a core value of our organisation and, in my view, it is important to call it out where that occurred - where that does not occur.

Other members of that medical staff council had made the observation previously that they had felt bullied by Dr Cheung in the way that the meetings were run and --

THE COMMISSIONER: Q. Sorry, just so I understand something, when Mr Muston asked, "Did you speak to anyone before making this workplace grievance complaint", you said you did but - and I understand, it's a while ago, but did you mean to convey you definitely did not speak to the chief executive or you can't remember whether you did or you didn't?
A. I can't remember, to be fully honest.

Q. Right. And is there anyone, sitting here now, that you definitely do recall you spoke to?
A. There are a number of colleagues at work who I did speak to in reflecting on what happened in that meeting, as I would normally do. That's part of our normal process and part of what would normally happen in the workplace, particularly when you have a significant conversation.

Q. By that, do you mean it's pretty normal for you to speak to your colleagues to say something like, "There was a meeting last night and it wasn't a particularly pleasant one. This is what happened" --
A. Yeah.

Q. -- that sort of thing?
A. Yeah, that sort of thing.

MR MUSTON: Q. You said a moment ago that - you tried to draw the distinction between a workplace grievance and a disciplinary matter. I think the point, correct me if I've not understood you correctly, that you were making was that the workplace grievance wouldn't necessarily become a disciplinary matter if it failed to pass through the initial assessment phase; is that right?
A. Correct. A workplace grievance can go in different directions. To be honest, what I was hoping for was that we could arrange a facilitated discussion, a mediation

between myself and Dr Cheung, so we could have a more civil and respectful dialogue than we'd previously been able to have. It is an ongoing regret that that has yet to occur.

Q. Who did you make that complaint to?
A. The complaint was made in the way - in the form of a letter to Ms Gina Finocchiaro, who is our director of workforce and corporate operations.

Q. You didn't consider at the time that you made that complaint, did you, that it was not going to pass through initial assessment?
A. I was open to an objective assessment of the complaint. I wasn't trying to pre-guess it, to be honest. I simply wanted to have a fair process that I was hopeful, consistent with the policy, would result in a pathway to resolution and improvement of the relationship between myself and Dr Cheung.

Q. But what I'm asking you is, at the time you made the complaint, you believed it was of sufficient substance, did you, to pass through the initial assessment phase?
A. I believed it was of sufficient substance to deserve an initial assessment. I did not prejudge the outcome of that assessment.

Q. So let me understand this: in complaining about his conduct, you weren't sure whether it was sufficiently serious to pass through initial assessment but you thought it was worth making in order to check whether it was?
A. The point of making it was to commence a process which would allow Dr Cheung and myself to come to a better working relationship.

THE COMMISSIONER: Q. Could you have, rather than commencing this process, gone and seen him the next day and knocked on his door or just contacted him and said, "Can we have a coffee or a discussion because I wasn't particularly happy about the way the meeting was run", and then just had a discussion with him? Was that open to you?
A. Theoretically. Sadly - and it is sad - the relationship between myself and Dr Cheung had never been good. We had had multiple interactions since his election and, to be completely frank, I do not believe that a one-on-one conversation without any structure or process would have done anything other than exacerbate an already very difficult situation. I felt that it was important to

have a structure and a process to support us. I agree with you completely, that normally I would just - if something like this happened, I'd just pick up the phone say, "Hey, look, can we talk it out?" You know,, that would be normal. Unfortunately, our relationship was not one where that was - felt to me to be a reasonable option.

MR MUSTON: Q. Did it occur to you that that structure or process could have been facilitated by some other means than by lodging a workplace grievance through the disciplinary process against Dr Cheung?
A. Again, it's an interesting question. I did consider this carefully. This is a well-defined process and pathway which has - activates the appropriate mechanisms and skills, and there is not a readily available alternative process that I felt was appropriate and fit for purpose.

I would also note the genesis of this is that, in my view, there was potentially a breach of the value of respect and civility in front of a large audience --

Q. Which --
A. -- and that was important to address.

Q. Are you talking about Dr Cheung or --

MR CHENEY: Can he be allowed to finish that answer, Commissioner? There has been a searching examination of this witness's motivations. He should be allowed to finish his answer.

MR MUSTON: Q. Please continue.

THE COMMISSIONER: Q. Well, there was a natural end to the sentence, but I'll just ask, had you finished your answer?
A. I'm happy that I have said enough with that answer.

MR MUSTON: Q. Would it not have been possible to have arranged for some sort of facilitated discussion with Dr Cheung of the type you felt would be useful by merely speaking to the chief executive or someone within the workplace group and asking whether assistance could be provided for you to facilitate such a discussion, without the need to lodge a workplace grievance against Dr Cheung?
A. Anything is possible. My judgment was this was the appropriate pathway to take under the values and policies

of NSW Health which I align with.

Q. You made an observation a little while ago that in deciding to make the complaint against Dr Cheung, you were in part motivated by the fact that other members of the medical staff council had made the observation previously that they felt bullied by him in the way that the meetings were run. Do you recall saying that?
A. I do.

Q. You didn't include any particulars of those aspects of your concerns in the complaint that you lodged against Dr Cheung, did you?
A. No.

Q. Did you ever raise particulars of those concerns that you held with Dr Cheung?
A. No. I would note that in a previous meeting, a member of the medical staff council had openly said that she felt she was being bullied, and I would note that there had been no response to her in that meeting.

Q. It was open to that member, if she felt it was appropriate, to do so, to have made a workplace grievance complaint, was it not?
A. It was.

Q. She chose not to?
A. I would also note that it is rare for staff to do this, because they are concerned about the consequences of making such a grievance with respect to their ongoing relationship. So if, for instance - I will pick a random specialty - say an oncologist made a workplace grievance against an intensive care specialist, as Dr Cheung is, and - you know, they would be concerned about the potential flow-ons given that they have to sometimes work quite closely in the same environment. That is one of the challenges that we do have in health. However, when it is said and done that's not germane to this. I made a considered decision to take this pathway.

Q. Just picking up on something you said a moment ago about the challenge presented by people's disinclination to make complaints in circumstances where they feel they might be justified that it will have consequences for them, does that mean that such statistics as you might have about the number of complaints which have been made at a particular

facility is not necessarily a fair indication of the culture of that facility?
A. So if we switch to the broad subject of workplace culture and how that correlates with a number of complaints, is that - do I understand your question clearly?

Q. Yes. So to the extent that one might think objectively the number of complaints made might be some indication of a culture within a workplace, within this particular and unique environment of health, where the making of complaints is something which people have concerns about, the statistics that you might have about the complaints might not be such a reliable measure of the workplace culture. Would that be fair?
A. I don't know the answer to your question, Mr Muston. I have never seen statistics correlating complaints with workplace culture and other validated measures of culture. I truly don't know. I think it is a very interesting question and probably worthy of further study.

Q. I think at the very beginning of your evidence yesterday when we were exploring the three core concerns that people had at Concord, the third of which being the reluctance to speak out for fear of reprisals, you answered by indicating that you were genuinely puzzled by that concern because you were not aware of any evidence of that.
A. And my view remains that Concord clinicians - amongst - most of our clinicians are actually quite happy to speak up.

Q. My point being, to the extent that there was a concern about that, the absence of any complaints or of any expressed concerns might not actually be indicative of the true mood of that group in circumstances where they are, as you've told us, disinclined to speak out for fear of the consequences?
A. I think we do need to distinguish between speaking up about, say, a service concern and making a workplace grievance against an individual colleague. I would say in health, as a very human and relationship-based area, we are very generally quite reluctant to raise grievances against individuals. I would also say that, in my experience, clinicians across Sydney Local Health District, not necessarily just Concord, and across NSW Health generally, are quite happy to speak up, to raise concerns about service delivery, and that is something which we, as

executive, welcome and encourage.

Q. Do you think that the lodging of the workplace grievance had the capacity to reinforce at least Dr Cheung's view, and those of the medical staff council who became aware of it, that those who speak up would suffer reprisals?
A. I did consider this very seriously. I did not make this formal notification lightly, because there were potential consequences that could be negative. However, while I do acknowledge that could have been the case, it also, to me, remained important that the values, particularly the value of respect and civility, which I hold very dear, were honoured.

Q. So amongst those potentially serious consequences, did you consider that one of them was the risk that the concerns held by a large group of the medical staff at Concord hospital that there would be reprisals for those who spoke out would be reinforced?

MR CHENEY: Commissioner, may I, respectfully, inquire the utility of this line of examination. Is the suggestion going to be that one who is considering what one regards as inappropriate workplace conduct should refrain from making a complaint about it through fear that that will engender a concern about reprisals in others?

THE COMMISSIONER: No, that's not what I understand Mr Muston is exploring. Perhaps I'll do it.

Q. I understand entirely what you have said to me about the difficult relationship you told me you have had with Dr Cheung and I also understand what you have told me, and fully accept, the value you have told me you place on respect and civility.

I think what Mr Muston, though, is putting to you is, sitting here now, do you accept that one of the risks of making the complaint against Dr Cheung that you did, a formal-type grievance complaint, is, regardless of what Dr Cheung thought about it, it risked - to those people at the hospital that did have the genuine view that they are not listened to or that if you speak out you can get in trouble, as we've discussed, that it risked - and there's a balance here, but one of the risks of it was that it risked reinforcing to them the notion, whether it's right

or wrong, that if you speak out about what you feel is a genuine problem or complaint with the hospital, that you can get in trouble?

MR CHENEY: Commissioner, that was not the question that was - the way it was put by Mr Muston.

THE COMMISSIONER: Well, it's the question I'm asking. I'd like an answer to it, thank you.

THE WITNESS: Yes, I agree with you.

THE COMMISSIONER: Q. Okay, thanks.
A. And, if you permit me --

Q. Yes, go ahead.
A. The alternative risk is where there has been obvious disrespect of colleague and that is not called out, then people say, "Well, that's okay", so it comes down to the, I guess, adage of "What you permit you promote." So that was the balance, that I was - and that's what I considered, actually quite carefully. I did not make this complaint lightly in any way.

THE COMMISSIONER: All right.

MR MUSTON: Q. Since you made the complaint, there has been a lengthy restorative action process undertaken at Concord hospital, facilitated by a group called ProActive ReSolutions; is that correct?
A. Yes. I believe it was actually in progress well prior to me making this complaint.

Q. That being the case, did you consider the possibility of using that process to try and bridge the void that had opened up in the relationship between you and Dr Cheung?
A. I did not, as my understanding of their work was that it was around broad workplace culture and was not intended to mediate concerns between individuals, for which there is a fit for purpose pathway through skilled workforce.

Q. You were involved in that process, though?
A. Not deeply, Mr Muston, to tell the truth. I had one interview with Mr McDonald, the lead for ProActive ReSolutions, and the vast majority, the rest of the process, whilst I was aware of, it was conducted very much locally at Concord hospital and I am not well placed to

speak to the details of that process.

Q. So in terms of that process, which, at least insofar as ProActive ReSolutions was involved in it, rolled through, do I understand you to say that you, other than one interview, were not particularly engaged in it?
A. I would have --

Q. I don't say it critically, but it did not involve you?
A. I was not invited by ProActive ReSolutions to be a part of that. So there was no - nothing I said "no" to, however, the focus, as I perceived it - and I felt it was appropriate at the time - was they were focused on Concord hospital and how it was working, and there was less involvement of my position in that.

Q. Did anyone at any point share with you the conclusions which had been reached by Mr McDonald about the root causes of the problems at Concord hospital?
A. I'm aware of the restorative action plan. I have not seen other reports.

MR MUSTON: I've got no further questions for this witness, thank you, Commissioner.

THE COMMISSIONER: Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Doctor, thank you very much for your time. We're very grateful for it.

THE WITNESS: Thank you, I appreciate it.

THE COMMISSIONER: You are excused.

<THE WITNESS WITHDREW

MR MUSTON: I think the next witness we have today, Commissioner, is Mr Joseph Jewitt, J-E-W-I-T-T.

THE COMMISSIONER: I might just adjourn for two minutes because I can't find the statement. We'll adjourn for a short period of time.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, we're back.

<JOSEPH JOHN JEWITT, affirmed: [10.54am]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Mr Jewitt, could you state your full name for the record, first?
A. Thank you. Joseph John Jewitt.

Q. And you are the acting general manager of Concord Repatriation General Hospital, within the Sydney Local Health District?
A. I was.

Q. What's your current role?
A. I've recently changed. Chief of staff of the office of the chief executive.

Q. When did you move into that role?
A. Monday.

Q. Very recent.

THE COMMISSIONER: Q. Chief executive of the Sydney LHD?
A. Yes, Sydney Local Health District.

MR MUSTON: Q. That would be Mr Loy?
A. Yes, that's correct.

Q. You held the role, though, as acting general manager of Concord Repatriation General Hospital from 5 September 2022?
A. That's correct.

Q. And you prepared a statement to assist the Inquiry with its work dated 4 July 2024?
A. That's correct.

Q. Do you have a copy of that statement with you?
A. Yes, I do.

Q. And have you had a chance, before coming to give your evidence today, to refresh your memory and read through it?
A. Yes.

Q. Are you satisfied that the contents of it are, to the

best of your recollection, true and correct?
A. There are just two changes.

Q. Yes, please, what are they?
A. The first is obviously my occupation has changed.

Q. Yes.
A. The second relates to paragraph 18. Let me just double-check that. I make reference to the draft strategic plan being discussed at an MSC meeting on 27 April.

Q. Yes.
A. It's on the agenda for that meeting but I haven't been able to locate the minutes of that meeting to confirm, but it was discussed at the MSC on 13 April. So just in terms of clarity, it's my understanding it was the 27th but I don't have minutes to prove that.

Q. Your best recollection is at a meeting at or around that time, it was discussed with the medical staff council?
A. Yes, that's correct.

Q. Thank you. In your capacity, or in your former role, you attended I think you tell us in paragraph 21, meetings of the Concord medical staff council?
A. Yes, that's correct.

Q. In attending those meetings, did you get a sense that at least some members of the medical staff council had some concerns?
A. Yes, that's correct.

Q. Was the morale, to your observation, of at least a portion of the medical workforce at Concord, reasonably low?
A. In a - for some individuals, and in maybe some departments, yes, that's correct.

Q. Amongst those concerns, did you have an awareness through your attending these medical staff council meetings that there was at least a group of people within the medical staff who felt isolated from one another and from the administration?
A. I'm not sure what you mean by "one another"?

Q. Well, let's take it in two steps. Did you get that sense, or get a sense that there was a group of people

within the medical workforce at Concord who felt isolated from the administration?
A. I think there was a group of people who were unsatisfied with responses they had received from administration. I'm not aware of them feeling isolated. That wouldn't be the word I would use. But there certainly were members of the medical staff council who were - who remained dissatisfied with decisions or - made by the executive, yes.

Q. There was a group who felt their workload and job demands had increased?
A. Yes.

Q. There was a group who felt that administrative tasks had escalated without relative increase in administrative support?
A. Yes.

Q. Perhaps picking up on something you said a moment ago, would it be more accurate to say that there was a group within the medical staff who felt that they were not valued, seen or heard?
A. I think they - yes, I think for some, that is correct.

Q. They felt that they had less access to administration to raise issues than other people within the local health district?
A. That's what they - yes - put forward, yes.

Q. And that when they did raise issues or seek to raise issues, it was their belief that those issues were not being adequately addressed?
A. Yes, that's correct.

Q. Would it also be right to say that there was a group who felt that there was an unfairness in resource allocation at Concord when compared with other hospitals?
A. Yes.

Q. And that there was a lack of transparency about how decisions relating to Concord were being made?
A. Yes.

Q. And that there was a lack of consultancy and shared decision-making in relation to decisions relevant to Concord?

A. I don't - yes, I think for some, yes.

Q. That is to say, it was their belief?
A. Yes.

Q. Just putting to one side for present purposes whether you felt that their belief was justified, did you have any reason to doubt that that was their genuine belief - that is to say, they genuinely felt that way?
A. I think for most of them, yes, that was their genuine belief and understanding.

Q. In your experience working within the medical sector, do you have a sense that, or have you developed a sense that there is a culture within medicine not to speak up or make waves for fear of reprisals or being seen as difficult or as a troublemaker?
A. No.

Q. Could I take you to paragraph 22 of your statement, please.
A. Yes.

Q. Do you have that there?
A. Yes, I do.

Q. You tell us there about a letter that was received by Dr Genevieve Wallace dated August 2022?
A. Yes.

Q. So we can understand the timeline, did you replace Genevieve Wallace in the acting role that you stepped into?
A. Yes, that's correct.

Q. So the letter of 24 August 2022 had been sent to Dr Wallace?
A. That's correct.

Q. She then moved into a different position. You moved into her position and picked up the letter to act on it as the then person acting in that position?
A. Well, I was - yes, I was aware that that the letter had been provided and during handover Dr Wallace had discussed the letter with me, yes.

MR MUSTON: Perhaps we could get that letter up on the screen. Within the folders, it is H1.22.

Q. I think, Mr Jewitt, we will get it on you screen instead of burdening you with a folder if that's okay.
A. Yes, thank you.

Q. We'll get it put up on the screen instead of burdening you with a folder, if that's okay, but if you would like a hard copy, let me know, we can arrange it.
A. Okay.

MR MUSTON: For the operator, it is [MOH.0010.0002.0001].

Q. It will come up in a minute. It's that screen to your right or there's a larger screen immediately in front of you, whichever one works best for your eyes.
A. Okay, thank you.

Q. As I say, if you need a hard copy, let me know, we can arrange that for you.
A. Thank you.

Q. You see there, that's an email, at the foot of that page, from Dr Cheung to Dr Wallace?
A. Yes.

Q. Dr Wallace seems to have forwarded it to Lorna Arkell. Who was Lorna Arkell in the ecosystem?
A. I'm not sure at that time, to be honest, no, I don't know.

THE COMMISSIONER: Given we're on the topic of or we have been on the topic of respect and not, I've been saying "Cheung", is it "Jeung"?

MR CHIU: "Jeurn".

THE COMMISSIONER: My apologies, thank you.

MR MUSTON: In my attempt to pronounce his name correctly, I've been pronouncing it incorrectly as well, for which I genuinely apologise.

THE COMMISSIONER: If we were allowed to use Winston, it would be so much easier for me, but anyway, I apologise for mispronouncing his last name.

MR MUSTON: That has caused me to lose my train of thought

momentarily. If we could scroll down, operator, to the letter itself.

Q. I will just give you an opportunity to read through that letter and refresh your memory as to what was being suggested in it. When you need it to be scrolled down, please just let us know.
A. Scroll down. Yes.

Q. In paragraph 22 of your statement you tell us that you'd become aware of a proposal that the medical services council wanted to undertake a performance review of the executive and the local health district's executive. Is that last paragraph of the letter under the heading "Feedback on the Performance of the Concord and SLHD Executives" what you had in mind when you wrote that?
A. Yes, that's correct.

Q. They weren't, in that paragraph, suggesting that they would be taking any formal role in terms of the performance reviewing of either the hospital's executive or the LHD's executive, were they?
A. Well, it's unclear to me what that proposal was. But an anonymous survey that is then publicly capturing and then presumably reporting on the performance of individuals in the executive has a level of formality about it, I would say.

Q. All they were asking to do, though, wasn't it, was to use their language, "provide the Concord and SLHD executives with constructive feedback on their performance"?
A. I mean, that's what's proposed there, but I - a broad anonymous survey then providing feedback publicly to members doesn't necessarily afford people the ability to understand where that feedback is coming from and procedural fairness in responding to that.

Q. But the use of an anonymous survey that had privacy protections built in might have been a more efficient way of gathering the entire medical staff council's collective thoughts about performance of the executives at both the hospital and within the local health district than, say, a large meeting where everyone got their turn to air their grievances, as it were, would it not?
A. It might be efficient in capturing the information. I'm not sure that it would be as helpful to me and my team

in then understanding how to respond to that information. But NSW Health does have the "People Matter", employee survey, which does provide a significant amount of information that we then do rely on, both in terms of feedback on things we need to do to improve conditions for employees but also it provides feedback for us on things that we then need to do as well.

Q. The "People Matter" survey is cast at a level where it probably couldn't really be described as constructive feedback on the performance of the executive of the hospital and of the local health district, could it?
A. Sorry, can you --

Q. The "People Matter" survey is cast at such a level - at a high level, such that it couldn't really provide the kind of constructive feedback on the performance of the hospital and LHD executives as was contemplated by this proposal, could it?
A. Well, there's not a lot of detail in the proposal put forward by the MSC, so it would be unclear what the questions would be and what would be the detail of the information. The value of the "People Matter" survey is that it allows to you benchmark against each of those items, both within the district, other districts and the health sector and also the public service. So that gives you a much clearer sense of how you might be performing relative to other parts of the public sector, which I think is useful.

Q. Coming from a group of people, a portion of which, at least, held the concerns that we've identified already about not being heard and being, perhaps, isolated from the executive, is another way of interpreting this as merely an attempt to try and provide information and feedback in relation to those concerns which they felt they were not - had not been listened to in relation to --
A. I think my concern in relation to that proposal was it potentially set up an adversarial relationship with the executive of the MSC, which is not what I wanted to do. I wanted to be able to have the ability to have open, honest conversations with the MSC and to be able to build a more collaborative relationship, and I think, you know, withstanding the fact that there is a significant lack of detail on what the proposal is, that proposal to me didn't seem to be moving in that kind of direction.

Q. But on one view, all the proposal was seeking to do was to advise - provide a mechanism for advising the executive about the particular concerns that people within the medical staff council had in relation to their performance and the way in which they had been engaging with the staff at Concord?
A. It may. The issue would be the nature of the questions and the methodology to really understand that.

Q. Did you ever explore with Dr Cheung what the nature of the questions might have been and the way in which the answers to those questions might have been used to provide constructive feedback?
A. It's my understanding that this matter was resolved before I officially came on board in the role of acting GM.

Q. But you tell us in paragraph 22 that you considered the proposal fell outside of the proper role for the medical staff council under the by-laws?
A. Yes, that's correct.

Q. Is it the case that that's a view you reached about a matter which had already been dealt with by Dr Wallace?
A. Yes.

Q. So you had no role in the decision-making process which led to this proposal not proceeding?
A. That's correct.

Q. Okay. Just moving down to paragraph 23, at a conceptual level, is there a problem, as you see it, with members of the medical staff council wanting to hold the hospital and district executives accountable, to the very limited extent that an advisory and consultative body can?
A. I think if it - certainly in providing feedback, absolutely. I think the dynamic did not feel as if it was being advisory and providing feedback at times.

Q. In what sense?
A. I think sometimes the manner and the tone of interactions, it - I think what was important is the MSC, in terms of having an advisory role, is there to work with, in a collaborative way, the executive and support the executive in its governance of the hospital. I think if you set up a relationship that has the executive being accountable and reporting to the MSC, it creates, then, some misunderstandings as to who is ultimately accountable

for the hospital and who is ultimately accountable for the decisions being made.

Q. Is it not also a two-way street: the executive, both at the district level and at the hospital level, are there to support members of the medical staff council to deliver care to patients --
A. Yeah, absolutely.

Q. -- who use the hospital?
A. Yes. And it certainly, in the use of "accountable" doesn't mean that, you know, at the MSC, they can't ask me questions and then I have to respond to those questions and provide that feedback. That's not what I meant by that. It's more about who you answer to, and there was a tone sometimes at the MSC where the view was we were subject to the MSC, and that's obviously not the case in terms of our governance structures. That's what I meant.

Q. Did that perception, do you think, influence the way the executive was dealing with the concerns that the MSC were expressing - that is to say, the perception that what the MSC was seeking to do was to exercise a different role to that which it ought to have had, namely, as an advisory and consultative body?
A. At times, yes.

Q. In what way do you think it influenced the way in which the executive was dealing with the MSC?
A. Speaking for myself, what that had flagged for me was the need to build a rapport and a relationship with people in the MSC to avoid a situation where the dynamic was adversarial, and working with the departments and key staff who were expressing concerns through the MSC, to make sure that we were addressing those concerns and working with them as best we could to respond to their concerns and issues being raised as a way of avoiding an ongoing kind of adversarial relationship.

Q. So, to put it very simply, doing your very best to take steps to ensure that the concerns that they had in relation to not being listened to, not being consulted with about decisions, were actually being addressed --
A. Yes.

Q. -- by consulting with them --
A. Yes.

Q. -- and sharing decision-making processes and the like?
A. Yes.

Q. Do you feel that that approach was also being taken by the executive from the local health district?
A. Yes, I do.

Q. Could I ask you to jump forward to paragraph 27 of your statement. Do you see you refer there to a situation in which you felt the need to request that the chair not approach or invite other non-medical staff to the medical staff council without first speaking to you?
A. Yes.

Q. Can I just ask, could you explain in a little bit more detail the circumstances which led to you making that request of him?
A. Sure. I had representation to me from staff in the hospital that they felt uncomfortable with approaches being made by members of the MSC for them to participate and attend MSC meetings and to participate in processes, including to consumer reps who did not think it was appropriate that they were being approached by the MSC and encouraged to come along to meetings, and I was concerned that, in taking those actions, MSC may be creating a greater level of discontent and putting people in uncomfortable positions, firstly; secondly, I did not think it was within scope of the MSC to do that. The MSC is a forum for medical staff, it's not a broader forum for other forms of staff; and, thirdly, I was also concerned that these things were happening and there had not been discussion at the MSC with the members of the MSC in relation to whatever strategy or idea was being enacted in taking those actions in trying to encourage other people who are not members of the medical staff to participate in the MSC. And that's why, rather than just shutting it down, I was keen that if there was a desire to do that, that that would be a discussion with me first.

Q. Was that invitation to discuss it with you - discuss with you the possibility of other people being invited to MSC meetings - ever taken up?
A. No.

Q. Could I ask you to go to paragraph 28, it's the next one down. Could I ask you to explain, first of all, the

proposal, as you understood it, which was being put to the MSC?
A. My understanding was that the chair was very keen to see the issues that were being experienced at Concord as being much broader and, therefore, there needed to be broader system change achieved and, therefore, wanted advocacy for a broader sort of system review.

Q. What was your concern about that?
A. There were members of the MSC who were concerned that that was going beyond the remit of what the Concord MSC should do and should be focused on, so I was concerned about, you know, the MSC itself not being able to kind of function properly.

I was also concerned that there was no basis for doing that; like, there was no - nothing put forward in any discussion I was present for that illustrated there was a need to - for such a broad thing and why Concord should be the one to be pushing for that.

Q. If there was a group of members of the medical staff council who were of a different view, though, was there any real problem with them discussing it during the course of those meetings?
A. I was unaware of who else had that view. I was aware the chair had the view, because the chair was the one expressing that view, but I wasn't aware of necessarily others sharing that view.

Q. Would there have been a problem with the chair raising those issues during the meeting and seeking to ascertain whether or not there were others of a like mind within the medical staff council?
A. Yes, and that's what happened.

Q. And at the conclusion of that, what was the decision that was made, if any?
A. My recollection of the decision is that most of the members of the MSC did not see it as the role of the MSC at Concord to do that.

Q. If you go to paragraph 29, you tell us that the MSC chair also advocated for three separate parliamentary inquiries into NSW Health, and then you identify the three areas of inquiry. Did you see that as a problem - that is to say, that he was suggesting to the medical staff council

that this might be a good idea, at least in his view?
A. I saw it as going beyond the scope of the Concord MSC, and concerned that it was something that was being advocated very strongly by the chair and not necessarily supported by others within the MSC, or significant numbers of others in the MSC.

My concern was working with the MSC to ensure the MSC was fulfilling its role in providing advice to the Concord executive and the district executive, and I just felt that these sorts of things were being driven by potentially other interests or agendas, rather than actually working with us locally to address the issues locally.

Q. What other interests or agendas did you have in mind?
A. I'm not sure, but there certainly seemed to be a view of wanting to have a much broader - a broader inquiry into the - broader parts of the health system and there seemed to be no evidence or reason put forward at those meetings that would warrant the concern or the need to do that.

Q. What sort of evidence do you imagine would have been put forward in those meetings to warrant a wider inquiry of the type that you've referred to in that paragraph?
A. Well, I would imagine it would have to be evidence that would show that there was a system-wide approach and that other parts of the system were interested in supporting such an inquiry.

Q. But for that to happen, there would need to be discussion, wouldn't there, about the way the wider system has perceived the world relative to the way that Concord was perceiving the world?
A. Yes, there would have to be some way of being able to kind of assess that, yes.

Q. Is there a problem? If members of the medical staff council at Concord were of that view and wanted to test that, is there a problem with them doing so, in the context of the medical staff council meeting?
A. I think that - certainly to have discussions at the MSC, if there were concerns more broadly held, then - you know, systems and processes at Concord, I think that would be appropriate. To initiate such action, I think there are other bodies that are most appropriate to do that than the Concord MSC.

Q. Could I just take you forward. You see commencing at paragraph 31, you tell us about a particular situation in the radiology department at Concord and, if I invite you to then go forward to paragraph 34, a significant investment in medical imaging infrastructure has occurred at Concord?
A. Yes.

Q. The investment in medical imaging infrastructure that you're referring to there, is that investment which has occurred or which occurred during the period in which you were acting in the role?
A. Yes, it occurred during the period I was acting in the role.

Q. Did that occur predominantly after the vote of no confidence in the chief executive in June of 2023 occurred?
A. There were processes under way prior to that, particularly in terms of replacement of the CT scanner, and the third CT scanner, as well as planning and discussions around the MRI. The replacement of the second CT scanner, I think occurred after the vote of no confidence, and the third CT scanner, the capital works, were completed and the installation of that third scanner occurred afterwards, yes.

Q. We've heard some evidence from a radiologist within Concord who has expressed the view that equipment in the radiology department was consistently being replaced after its end of life as determined by the Medicare capital sensitivity rules. Do you have a familiarity with those rules?
A. A general familiarity, yes.

Q. And at least up until the point at which you took over in your acting role, would it be - was that observation, made by Dr Ridley, accurate?
A. No, I don't think so. Dr Ridley didn't provide any specifics, as I recall, in relation to what particular items had reached their capital sensitivity. In relation to the CT scanners, I don't believe they had reached the end of their capital sensitivity before they were replaced.

Q. When you say you don't think so, do you actually know either way whether, at least in the period prior to you taking up your role, equipment was not replaced until it had reached a point after its end of life as determined by those Medicare rules?

A. I don't know. I'd have to check that.

Q. In paragraph 35 you tell us about the business case for the procurement of the second MRI scanner having been approved and architectural plans for its installation having been approved. When did that happen?
A. I don't have the dates on me.

Q. Do you have a ballpark for, at least, to the extent you refer in paragraph 35 to the approval of the business case, when that occurred?
A. I would have to check those dates.

Q. Were you aware that --

THE COMMISSIONER: Q. What's involved with the architectural plans?
A. There needed to be plans drawn up to be able to - for the capital works, for the installation of the second scanner. So there wasn't a current sort of empty shell that that scanner could go into, so there needed to be work done to determine how we could, within the emergency department, be able to create sufficient space, so it involved moving, relocating other services in order to make room for the scanner.

Q. It doesn't involve building a new room or building a new building; it involves some building-type works to enable it to fit in the space you already have; is that how I should understand it?
A. Yes, that's correct, yes.

MR MUSTON: Q. Just so we're not at cross-purposes, was that capital works in relation to the CT scanner in the emergency department that you were talking about?
A. Yes, and it applies also to the MRI.

MR MUSTON: Perhaps, operator, could we bring up [MOH.0010.0404.0003].

THE COMMISSIONER: What document is that?

MR MUSTON: That is a document behind tab 1 of Dr Anderson's most recent offering.

THE COMMISSIONER: Is that, at the top, an email of 30 June 2023?

MR MUSTON: If we go forward to page 0003.

THE COMMISSIONER: I see, that's the 2016.

MR MUSTON: Yes. I note the time, Commissioner. It is a little bit early, but by the time the document comes up - I have several questions in relation to --

THE COMMISSIONER: It's only about 45 seconds early. You want to take the break now; is that convenient?

MR MUSTON: It would reduce the pressure on the operator who hasn't been given any fair warning of this document.

THE COMMISSIONER: All right. Why don't we take the morning adjournment now and resume at 11.50. We will adjourn until then.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes?

MR MUSTON: Q. I think I was about to ask some questions about [MOH.0010.040.0003] [sic] which is the "Health In Brief for Major Procurement Committee SLHD" document, dated 16 November 2016, or variously dated 15, 16 and 18 November 2016.

THE COMMISSIONER: That's not it.

MR MUSTON: No, it's [MOH.0010.0404.0003].

THE COMMISSIONER: That's it.

MR MUSTON: If we can scroll forward to the third page, if we could, operator. Thank you.

Q. Just have a look at that document, in the context of the questions and answers immediately before the break about the MRI. I just want to ask whether this is a document that you're familiar with.
A. No, that's not a document I'm familiar with.

Q. Before the break, in answering some questions from the Commissioner, you referred to the need to get some plans prepared for the upgrade of the facility to enable it to

accommodate the physical beast that is an MRI machine?
A. Yes.

Q. Who within the LHD is responsible for preparing plans of that type? When I say "who", let's start with the group?
A. Well, capital works processes are led by a capital infrastructure and engineering team. So they will lead a process of working with key stakeholders to be able to identify what are the needs of the capital works, what needs to be accommodated. There's obviously reference to facility guidelines and there are designers and planners who have that expertise who provide that assistance. But they oversee the process of the development of those guidelines - those plans.

Q. The designers and planners involved in that process that you referred to, they're not designers and planners who are members of the workforce at Concord hospital - no?
A. No. No. They're part of a district service, yes.

Q. Could you just scroll down to paragraph 37 in your statement.
A. Yes.

Q. Do you see you tell us there, in the second half of that paragraph, about some improvements in the working conditions within the radiology department?
A. Yes.

Q. Could you, just for we laypeople, explain what the changes in the working conditions were that you refer to in that paragraph?
A. So feedback from the radiologists highlighted the need for us to have different working arrangements to make Concord a more attractive place for staff to - as a retention as well as to attract new staff to the department. They included things such as rostered clinical support time, the ability to work from home, and to be able to kind of work from home, as well as 10-hour days. So prior to the change, there were eight-hour days.

Q. So the change from eight-hour days to 10-hour days, obviously it's two more hours' worth of work, is the change that they were being remunerated for those additional two hours' worth of work?
A. Yes.

Q. Were those sort of concerns or the concerns that those changes were seeking to address some of the concerns that you heard being expressed within the medical staff council when you first commenced in your acting role, by members of the radiology department?
A. I don't recall whether they were specifically mentioned in the MSC, but they were - when I then had subsequent meetings with staff in the department, they were issues that were raised by those staff of things that we needed to do to improve the working conditions.

Q. When you had those discussions with the staff in radiology that you've referred to, did you get the sense that those are concerns that they'd been raising for some time?
A. No, I'm not sure about that, no.

Q. You don't know? You don't know either way; is that --
A. What I can say is that they were concerned about the working conditions at Concord relative to other hospitals and other facilities, and that had been an issue for some - for a while. But I don't know whether those specific initiatives were things that were raised prior to me coming on board. I don't know that.

Q. Maybe I haven't been as clear as I could have been. Whilst the initiatives may or may not have been raised at an earlier time, the problems that those initiatives were seeking to address, did you get the view that those problems were matters that members of the radiology staff had been raising for some time prior to your arrival?
A. I think there are some who would probably say that, yes, they had been raising those, yes.

Q. Could I ask you to go over to paragraph 43 of your statement. Do you see there you refer to the ProActive ReSolutions process which was - which commenced at Concord, after the troubles seemed to reach their peak in around June 2023?
A. (Witness nods).

Q. Do you see in the last sentence there you say:

In my observation the workshop did not identify a culture of bullying and harassment within the [emergency]

department.

What was the observation or what were the observations you made that informed that conclusion?
A. During that workshop, issues specific to bullying and harassment were not raised as issues that needed to be addressed.

Q. Did you have an awareness that issues of bullying and harassment had been something which, at least at some point, had been a problem within the emergency department at Concord?
A. Yes.

Q. And do I take it from that answer that it was your view, based on the observations you made and refer to in that paragraph, that, to the extent they had been an issue, they had been - that issue had been resolved?
A. Yes.

Q. That is to say, the bullying and harassment was not being identified as something which was a continuing problem within the department?
A. Yes.

Q. Did you get the sense that the bullying and harassment that had at least allegedly been a problem in the past was still having some lingering effects on the morale of the workforce within the emergency department at Concord?
A. No.

Q. Finally, could I ask you to go to paragraph --

THE COMMISSIONER: Q. Do I understand - where you've said in 43 that ProActive were engaged by the ministry, I take from that that they certainly weren't engaged by either Concord or the Sydney LHD; they would have been independent of the hospital and the LHD?
A. That is correct.

MR MUSTON: Q. I should probably ask in relation to that, what was your involvement in that process, the ProActive ReSolutions process which was under way at Concord hospital, in a day-to-day sense?
A. My role was to - the process was led by ProActive. My role was to support the process, to - you know, myself and members of the executive to encourage their participation

in processes as identified through ProActive, and making sure that from, you know, at a facility level, that any support that that process needed was able to be provided.

Q. Could I take you forward to paragraph 46. Do you see at the beginning of that paragraph you tell us that the respectful workforce communications workshops conducted by ProActive ReSolutions were conducted with teams including, amongst others, the Concord executive team?
A. Yes.

Q. Who within the Concord executive was involved in those workshops?
A. It was myself, the director of medical services, the director of nursing, my operations and performance manager. I believe - I would have to check the attendance, actually, my memory is not great. But it was the key members of my executive team were attending.

Q. At Concord?
A. At Concord.

Q. In broad terms, what did those workshops involve?
A. They were a facilitated workshop led by staff from a ProActive team, and it's a process really of - it's a mixture of sort of facilitated discussion as well as presentation on information in relation to respectful communication, what it is, the impact both respectful and disrespectful communication can have on individuals and the functioning of teams, my recollection, and opportunities for interaction and kind of role-playing is my recollection of the workshop.

Q. Do you have a recollection whether any of the executive from the LHD attended those workshops that were conducted by ProActive ReSolutions, at least to the extent you were at them?
A. No, no.

MR MUSTON: I have no further questions for this witness, thank you, Commissioner.

THE COMMISSIONER: Q. How many staff from ProActive were involved, do you remember?
A. There were three key staff that were involved day-to-day and one support officer who was mostly providing support from the office.

THE COMMISSIONER: Okay, thank you.

Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you very much, sir, for your time. We're very grateful. You are excused.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

MR MUSTON: The next witness is Dr Stewart Condon. His statement, at least in my folders, is H5.1.

THE COMMISSIONER: Yes, got it, thanks.

<STEWART MARTIN CONDON, affirmed: [12.05pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Dr Condon, could you state your full name for the record, please?
A. Stewart Martin Condon.

Q. You are the director of medical services at Concord hospital?
A. That's correct.

Q. I think you have been permanently in that role since November 2023?
A. Correct.

Q. And prior to that, you were acting in the role, I think since 22 March 2023?
A. Also correct.

Q. You prepared a statement dated 6 June 2024 to assist the Inquiry with its work?
A. Yes, I did.

Q. Do you have a copy of that statement with you?
A. Yes, I do.

Q. You've had an opportunity to read it before giving

your evidence?
A. I have.

Q. Are you satisfied that the contents of it are, to the best of your recollection, true and correct?
A. Yes.

MR MUSTON: That will be tendered in due course, Commissioner.

THE COMMISSIONER: Yes.

MR MUSTON: Q. Several years prior to commencing in your current role, you were involved in medical administration roles at RPA?
A. Correct, as the deputy director of medical services.

Q. As a result of the roles that you held at RPA, did you have an awareness when you accepted the acting role in March 2023, that you would be stepping into a challenging gig at Concord?
A. I think the challenge I expected was the step, going from a deputy role to a director role. Certainly most of the context at Concord wasn't available to me at the time. We had enough challenges at Prince Alfred.

Q. So at the time that you made that step across, did you have any awareness of what was the morale of the medical staff at Concord hospital?
A. No.

Q. Having arrived in the role, did you make any assessment of the morale of the medical workforce at Concord hospital?
A. I had a handover from the outgoing director of medical services and --

Q. Who was that?
A. That was Dr Jonathan Gibson.

Q. Sorry, I interrupted you.
A. No, that's fine. And certainly in my initial meetings, I gathered information as best I could, as quickly as I could. The information I had was a sense of engagement that was required. Morale was part of that bigger story for Concord and also service delivery.

Q. In terms of the morale, did you have a view what it was, or at least based on what you were told at that time, what it was that had led to the challenges with the morale within the medical workforce at Concord?
A. I think at that time my perspective was it was multifactorial. Certainly Concord, as part of a complex district, had services that were struggling to deliver service to the community. We also had medical workforce demands and challenges, and I think even outside of medical workforce, we had demands and challenges with other workforces. But at that time, I was open to understanding each of the specialties in their own way.

Q. I think you mention a need for engagement. Did you develop a sense that there were people within the medical workforce at Concord who felt like they were isolated from the administration?
A. For some specialties, yes.

Q. Which ones in particular do you think had that concern? Which specialties?
A. In terms of the engagement?

Q. Yes.
A. I think the engagement I was trying to deliver was a form of listening first, to understand what the problem might be within particular specialties. So for some of the specialties, radiology is an example, one of the things that I heard the most was about their medical workforce difficulties and challenges of actually staffing radiologists in the department. At the time I arrived, the interventional radiology service was under a lot of pressure, it wasn't fully staffed, so that was one of the priorities.

Each of the specialties, I would say, had their own unique demands and challenges and knowing that there were 36 specialties across the hospital, I think, it's hard to detail across each one of them, but there were some hot spots that we were identifying and radiology was one of those.

Q. Probably not unique within the medical workforce more broadly, at Concord, was it your sense that people were concerned that the workload and job demands placed upon them had increased?
A. I didn't judge that early. I was really interested to

actually develop relationships and understand more of the data behind that. So for the workload question, we hadn't really formulated a conclusion at that point.

Q. To the extent that you did have discussions with, for example, radiology, that raised some of those workforce challenges that were presented there, did you have a view that they were manifesting themselves as an increase in the workload and job demands upon those radiologists who were still there?
A. There was, yes, there was a sense.

Q. Did you get a sense in your dealings with specialists across the various areas, that at least some of them felt like they had less access to the administration to raise issues when they wished to or felt they needed to?
A. On occasion, yes. But I probably didn't adapt my style according to whether they had that access or had that perception. Our management style in medical services, after I had arrived, really was opening the door to everyone, and across the board, interested to hear what the issues were from our heads of department, how we could assist, particularly with medical workforce demands and turnover, as well as the service delivery. So I think we had the challenge across the board and we approached it very systematically across the board.

Q. I'm particularly interested at the moment just to try to get a read on what your sense of some of the challenges were as you arrived, fully appreciating that you sought to deal with those challenges having arrived. But when you arrived and had discussions with the workforce, did you get the sense that, at least amongst them, there was a cohort who felt that, when issues were being raised, they were not being adequately addressed?
A. There were some, yes.

Q. And did you get the sense that there was a view amongst at least a proportion of the workforce at Concord that there was some unfairness in resource allocation when compared with other hospitals?
A. I'm sorry, did you say unfairness?

Q. Unfairness?
A. So some sense of unfairness and?

Q. Unfairness in resource allocation when Concord was

compared with other hospitals within the district?
A. Some of the senior medical workforce expressed that, yeah.

Q. Did you get a sense that there was a concern within the workforce, the medical workforce, that there was a lack of transparency about how decisions relevant to Concord were being made?
A. I think my sense was a communication challenge that had occurred. There were some specialties and some specialists who hadn't had communication loops closed and didn't have that full transparency, I think, in decision-making processes.

Q. In relation to that, did you have a view, or do you have a view now, about what might have led to some specialties within the hospital having that perception, while others didn't?
A. Yes.

Q. What is it, at least as best as you can ascertain?
A. Of course. I think some of the specialties are incredibly motivated to give the best First World care they can at Concord hospital, and for some of the specialties, that does require a full suite of services - technology which is cutting edge, nursing, medical models of care which apply in the best possible way, and I think for some of the specialties, when they don't have that, they express a concern that they're not giving the best they can to their patients.

So again, by specialty, this is a different story. Some specialties are very happy with the services they have, the resources that they've been delivered, and the smaller specialties, the ones who are resourced, are happy with their models, are happy with their patient outcomes as well. So it really is a range.

Some of the resourcing questions are important for us to revisit on a regular basis, and we do so, and particularly for medical workforce, ensuring that the consultant specialists are in place to do the teaching, training and service delivery.

Q. As part of your role, did you attend routinely meetings of the medical staff council?
A. Yes, when I could.

Q. We've heard a lot of evidence about some of the disputation which occurred at those meetings.
A. (Witness nods).

Q. One thing we've heard is that there was, amongst the medical staff council, a division of views about the best way for the council to proceed in relation to issues, culminating in the vote of no confidence in the chief executive. Were you present at those meetings?
A. Yes, for most of those, yes.

Q. To the extent that you have indicated that there are some - there were some groups of specialists within the hospital who felt they were adequately resourced and generally satisfied with their lot, the division amongst the medical staff council, as best as you could ascertain through attending, about what should or shouldn't be done, did that divide along those lines - that is to say, between those specialists who were generally satisfied with their lot because they were well resourced, and those who weren't?
A. It's difficult to answer that question because in the time leading up to - just on two months ago, medical staff council, in my experience, has been 100 per cent online. We've had a lot of people dial in to meetings and not voice any opinion at all, and that would actually be the majority; 80 to 90 per cent of attendees would not say anything during a meeting. So it's difficult to understand what thoughts or feelings they had about their particular services, as opposed to the people who expressed opinion and were present at those meetings.

There was - but, at the same time, I think the people who did express opinion were the ones with concerns around resources and their particular services.

Q. That was the cohort who were expressing a view, say, that a particular perhaps more adversarial approach should be taken to the issues that they felt they were facing?
A. I believe so. In the terms of the adversarial approach, I don't think that was ever articulated as a stance for the medical staff council. I think it's an important forum for advice to the chief executive. It's interesting for me in my role, which I don't really appear in the by-laws in relation to the medical staff council in that way, and certainly the way I've adapted my operational

work plan is to connect much more directly with the heads of department rather than the medical staff council itself.

Q. There were, when one reads the minutes of the medical staff council, people, a smallish group of people, who were speaking against the proposals being put by the chair, particularly in relation to, say, the vote of no confidence in the chief executive. Do you recall that --
A. I do, yes.

Q. -- as a feature of the meetings?
A. I do, yes.

Q. Of that small group - and we can go to some of the particular names if it would assist you - is it your general recollection that that small group who were suggesting that that ought not happen, that they came from departments which broadly considered themselves to be fairly well resourced for the services that they were required to deliver at Concord?
A. As a generalisation, yes.

Q. I think one particular department which might have - or person who might have featured regularly on that side of the ledger was within the haematology department?
A. I believe so.

Q. Was the haematology department one of those departments that, generally speaking, considered itself to be reasonably well resourced at Concord?
A. I believe so, yes.

Q. You're familiar, obviously, with the clinical stream structure that was operated at the district level. Could you explain what that structure is and how it works in the context of the delivery of medical services across the district?
A. The two aspects I see to how the clinical streams have worked across the district?

Q. Yes.
A. So I've got a limited experience of Prince Alfred before I joined Concord and then at Concord as well. Clinical streams are a good way to group particular specialties together, and certainly manage workloads, service demands and conversations with executive.

Q. Just for the laypeople amongst us, let's start with the building blocks. What is a clinical stream --
A. Sure, absolutely

Q. -- in the context of the Sydney Local Health District?
A. Maybe take a step back, in fact.

Q. Yes.
A. So simple hierarchical linear reporting lines allow for a specialist or a group of specialists to report to a head of department, if we're talking in the medical workforce space. That head of department will then report to me as the director of medical services, and then I report through to the general manager.

Similarly, nursing structures are linear in that way. Department structures, or nurse unit structures, sorry, ward unit structures, work in that way so that we can offer workforce supervision and performance review and development.

So they are those linear relationships. The matrix structure applies a different approach, and a matrix approach, effectively, to group particular specialties together to have shared conversations, both at a hospital and at a district level. So it's a way of not necessarily having operational reporting lines but much more matrix level strategic level conversations.

Q. So in terms of the way that was implemented at Sydney Local Health District, how did it work? How was each of those streams within the matrix actually physically comprised?
A. It may be best to use an example.

Q. Yes, please.
A. If I think of one of the smaller streams, so renal medicine, nephrology and urology, they're grouped together as the renal urology stream. They will come together as the medical heads of department but also the stream operational staff who work at the district level to have a meeting on a regular basis with the general manager and the executive.

That stream structure actually includes the stream co-director or director at a district level, which oftentimes won't be someone from Concord. So we'll have

someone from Prince Alfred or, more recently, from Canterbury Hospital as well. So those meetings are to create that strategic level discussion and they're particularly designed to give advice, additionally to the chief executive, so that they can inform service delivery and particular needs.

Q. So decisions about resourcing of particular departments, in particular hospitals within a stream, are something that might be discussed at that level, that stream leader level, with the executive of the LHD?
A. Yes, but not only there. And so that's part of what we've been providing in medical services over the last year or so, really having a much more direct operational conversation on a hospital level, to have that similar resource conversation, knowing that I would need to take any resource demands to the general manager of the hospital. That's the key first step, in fact. The stream discussions add to that.

Q. We'll come to the way in which you're running your current role in a moment, but when you arrived, did you get the sense that those discussions that you've just told us about happening at the local level were happening or happening effectively?
A. I don't think I formed an opinion when I arrived.

Q. Do you think the clinical stream structure of Sydney LHD had the capacity, perhaps, to compound some of the communication issues, at least perceived communication issues, that were troubling a proportion of the staff at Concord, medical staff at Concord?
A. I think it could have.

Q. In what way?
A. It's much easier to understand linear hierarchical structures, and certainly when you are communicating with a particular clinician or a head of department that decision-making process relies on these people, and then you need to add other people who are not in reporting lines or approval chains, it becomes potentially confused.

Q. Could I ask you to have a look at paragraph 22 of your statement. You tell us about the speak-up culture that you're seeking to promote at Concord?
A. Mmm.

Q. Could I ask you to explain how it is that you are seeking to promote that culture, what steps you're taking to achieve that?
A. Mmm. Speaking up for safety and other concepts around patient safety and clinical governance are really important for us to drive. There is sometimes a reticence for staff members to not log incidents or not report particular things that happen in the hospital, which could have an impact or have had an impact to patient care. So I'm thinking about the incidents and the near-misses.

In my conversations on a daily basis, I'm encouraging our heads of department, our clinicians themselves - and that includes our junior medical staff particularly - that patient safety is everyone's business, and it sounds a little bit of a cliche, but it is actually true. It's just as much the business of that enrolled nurse on the ward taking care of a patient, just as much as the senior professor in a particular unit, to look at patient safety as a system issue and it's not a personal issue.

Our safety systems allow for incidents to be logged at any time of the day. They can be logged anonymously and certainly patient safety is something where I encourage, and my team encourages, a no-blame attitude to incidents occurring, and that's the approach that we encourage through our meetings with our heads of department, just as much as any of the other clinicians.

Q. You mentioned a moment ago that there's - you perceive there to be a reticence to lodge incidents and raise issues. What leads to that reticence, or what lies behind that, do you think?
A. I think many of the clinicians I speak with see it as an extra time demand in their day. That's the main concern, that they don't have time to do it, knowing that everyone is time poor, but that's the main feedback I get from clinicians.

Q. Do you get the sense that that same reticence applies in relation to speaking out about resourcing problems?
A. I don't think so, no.

Q. Or what are perceived to be resourcing problems?
A. What are perceived to be? I don't think so, no. The conversations I've had since being at Concord, people have been very open to talk about resourcing issues - medical

resources in terms of human resources, as well as the physical. So I haven't seen that reticence, no.

Q. Could I ask you to go to paragraph 27, where you tell us about the efficacy of Concord's complaints handling process. The first question about that: what sort of complaints are you talking about in that paragraph - disciplinary complaints or more broadly?
A. I think I was referring to something more broadly. It includes workforce-related complaints, so behavioural elements, but other wider complaints around clinical governance, complaints about the care.

Q. You make the observation that the process that exists at Concord is - I'm hopefully not putting words into your mouth - no worse than that which you've observed at any other hospital. Accepting that that's maybe right, could it be better, do you think?
A. Oh, these systems can always improve.

Q. Do you have any views about ways in which the system at Concord and perhaps the equivalent system that you've worked with in other hospitals might be improved to improve their efficacy but also improve the way in which they fit with broader concerns about workplace morale and the like?
A. Yes, of course. I think our clinicians need to be empowered to actually be part of the system improvements. Sometimes they feel disempowered due to time. They don't log incidents, for example, as I mentioned before.

I think the improvements maybe don't relate to the incident management system itself but much more around the engagement with that system, and certainly I refer in my statement about how policies and procedures can articulate certain expectations of our staff members, regards to patient safety, but that needs a follow through with our staff members, that needs a follow through with our senior doctors, our interns, our nurses and allied staff members, just as much as our clinical support staff as well.

MR MUSTON: Operator, I'm sorry to do this without notice. Could you bring up document [SCI.0012.0160.0001]?

Q. Do you see the document there, it's headed "Workforce Factsheet CORE Values Behaviours"?
A. Yes.

Q. Is that a document that you're familiar with?
A. I've heard about this document. It's not something that I've used in my practice in medical management at Concord.

Q. If we scroll down to the second page, do you see under the heading "Empowerment", there, there's a highlighted section which identifies as below the line behaviour:

> *Complain about resource limitations and constraints rather than striving to work creatively within available resources and looking for innovative solutions.*

That, I gather, is not a below-the-line item that you are specifically familiar with, having regard to what you've just told us about your familiarity with the document?
A. No. I encourage that kind of feedback on a regular basis. I think the system needs to improve by hearing as much as possible, and that statement hasn't been framed by myself or anyone in my team, but it's interesting to read.

Q. Is it your view that describing that sort of behaviour that you would encourage as a valuable and important part of workplace improvement as "below the line", is unhelpful?
A. I'm sorry, I didn't catch the end.

Q. Is it your view that describing that sort of behaviour, namely, complaining about resource limitations and constraints, to the extent it is appropriate to do so, as "below the line behaviour", is somewhat unhelpful?
A. I think there's a danger in making binary classifications around something like that. Certainly - as I've said, I encourage that, and our team encourages that with our heads of department. We are very keen to hear as much as possible about what's going on.

Q. You encourage it because you are of the view that it's important that those sorts of discussions are had?
A. Important and urgent. This is exactly how the system needs to get that feedback, that data, and improve the system itself.

Q. And it would be unhelpful if members of the workforce, at least in the context of what you're trying to achieve, were led to think that it was below the line behaviour from a core values point of view for them to have those

conversations?
A. I don't know the history of how that ended up below the line. I expect there may have been less than constructive conversations, which may have led to it.

Q. I will move on to paragraph 28. Could I ask you to go forward to that paragraph in your statement - sorry, paragraph 29. I'll just give you a moment to read that. I just want to explore - you draw the distinction between what you're able to do, I think, in your acting role, and what you've been able to do since becoming permanently employed in that role.
A. (Witness nods).

Q. What is the difference that you've felt between the acting role and the permanent role which has led to you approaching it differently - that is, the performance of the role differently?
A. Mmm. It's perhaps a reflection of how I saw the hospital and how I saw my role myself. I saw the hospital as having, as I described, an engagement gap that I could definitely assist with. I also saw my role as the acting director of medical services as someone who, like many in recent years, had been acting at the hospital and not been permanently appointed. So I was very keen to establish myself and develop trust, particularly with our medical heads of department, and also reassure them, once I had the role substantively appointed, that I could take a different, more active interventional role with their departments to assist.

Q. Do you think it's possible that a succession of people acting in roles like yours might actually have the capacity to contribute to some of these communication problems which seem to underpin a great deal of the unhappiness which has - which bubbled over at Concord?
A. I would say yes, and I'd also add that sometimes we build communications around or actions and tasks around particular people and not around processes, so sometimes we have had individual approaches of recent years that have differed as people have moved through the roles when, in fact, we should have had process-dependent tasks and work, which would have given a better continuity all the way through.

Q. In paragraph 32 you tell us about experience you have of departments being good at advocating for their own

services during consultancy, but some heads of department struggling to see the whole of hospital view. Could I ask you to expand on what you had in mind when you make that observation that some heads of department struggle to see the whole of hospital view?
A. Yes, of course. Having so many medical departments and so much work to do at Concord hospital, each of our specialists and our heads of department are very focused on their own specialty and how they can assist the patients that they serve in the best possible way. So knowing most of our clinicians are time poor, knowing that they don't have a chance to compare their departments to others, I think I have seen some departments very focused on their own individual needs without perhaps having a sense of the bigger story or the bigger picture.

I do see that as part of my role, as director of medical services, to relate to particular departments. "We understand you have needs. We're trying to get our particular consultants back up to a full complement for you, appreciate our medical workforce unit is also working on six other interview processes at the moment." So we will get there, but understanding the timing, understanding that we're doing the best we can for their department, I think needs that bigger conversation to understand we're doing the best we can for the whole hospital.

Q. Not wanting to attribute anything to the answer that you've just given, but is part of that more than just telling them, "We're doing the best we can, trust us", but actually bringing them in to the tent a little bit more and sharing with them broader information about exactly what it is that you're doing, what those wider pressures are and why those decisions are being made in the way that they're being made?
A. Yes, I agree with that statement. It is certainly the openness that we try to bring in our approach to medical services at Concord and it is part of the NSW Health core values.

Q. Can I get you to go over to paragraph 36 of your statement. You tell us in that first sentence that not many staff members at Concord hospital have seen the director of medical services work in the way that you are working before.

Let's start with what your understanding or perception

what of their experience might have been prior to you commencing in the role and adapting it in the way that you have?
A. So I don't have a full picture of how every director of medical services has operated at Concord, so I've got a limited view on more recent years and how the approach has been taken. In the executive at the hospital, it's often described as firefighting on a daily basis, that we're trying to do the best we can for particular problems which are both urgent and important.

The approach we've taken since I arrived just over a year ago is really trying to get ahead of that and be a bit more predictive of some of the issues before they become a fire itself.

So we see ourselves as a service department for the other medical services of the hospital. We see them as the customer, knowing that they are taking care of the patients, so we need to ensure a best understanding of their resourcing needs, how we could or may not be able to meet those needs, and also the demands that they have by specialty.

So we frame that conversation as a service conversation. We encourage all of our specialties to have that conversation with us. Availability can be challenging at times, people are busy and we know that we've certainly had good conversation over the last year with almost all of the specialties, sometimes less frequently than what we want. But, yes, we do see that as an approach which is maybe a newer approach to how medical services at Concord's been managing.

Q. Would it be fair to say that, in essence, you're approaching that role from the perspective of the executive needing to support the medical workforce to deliver the care that is required to be delivered through the hospital, rather than the other way around?
A. Yes.

MR MUSTON: I've got no further questions for this witness, thank you, Commissioner.

THE COMMISSIONER: Thank you.

Mr Cheney, do you have any questions for the witness?

MR CHENEY: No questions, Commissioner.

THE COMMISSIONER: Thank you very much for your time, Doctor. We're very grateful. You are excused.

<THE WITNESS WITHDREW

MR MUSTON: The next witness, I think, is Dr Richards, who I think we have told to be available at 2 o'clock.

THE COMMISSIONER: Shall I adjourn until 2 o'clock?

MR MUSTON: I'm content to adjourn until 2.

THE COMMISSIONER: Unless there are any other takers, I'll adjourn until 2 o'clock. Adjourn until 2?

MR MUSTON: Adjourn until 2, sorry.

THE COMMISSIONER: We'll do that, thank you.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Good afternoon, yes.

MR MUSTON: The next witness for today, Commissioner, is Dr Bethan Richards.

<BETHAN LEIGH RICHARDS, affirmed: [2.01pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please, Dr Richards?
A. Bethan Leigh Richards.

Q. You are the chief medical wellness officer within the Sydney Local Health District?
A. Correct.

Q. You are also a senior staff specialist in the department of rheumatology at RPA Hospital?
A. Correct.

Q. In relation to that former role, you've held that since I think 2019?

A. The chief medical wellness officer, yes, since 2019.

Q. That takes up about 0.5 FTE worth of your working life?
A. That's what it is on paper.

Q. We might come back to that. And in relation to your work as a rheumatologist within the hospital, you've worked within the local health district since 2011?
A. Correct.

Q. And as the chief wellness officer you report directly to the chief executive?
A. Correct.

Q. You prepared a statement to assist the Inquiry with its work dated 7 June 2024?
A. Yes.

Q. Do you have a copy of it with you?
A. I do.

Q. Have you had a chance to look through it before coming to give your evidence today?
A. I have.

Q. Are you satisfied that, to the best of your recollection, its contents are true and correct?
A. Yes.

MR MUSTON: That statement, Commissioner, will be tendered in due course.

Q. Can I ask you to turn to paragraph 6 of - sorry, paragraph 5, first of all, of that statement, in which you describe the My District OK program?
A. Yes.

Q. Could you just give us a little bit more detail about how that program works?
A. So My District OK program is our organisational staff wellbeing program. It's an evidence-based data-driven program where basically we collect information about levels of wellbeing, the impacts of low levels of wellbeing, the drivers of distress. We harness solutions as part of that process and then we use that data to drive or develop a framework and we, within that framework, have wellbeing

interventions that try and achieve our ultimate outcome, which is about optimising staff wellbeing.

Q. As the chief wellness officer, do you understand yourself to have a role in relation to resolving industrial disputes that crop up from time to time within the local health district?
A. So my team and I provide support to people that are involved in those and we may be involved in conversations around systems and processes that contribute to staff distress during those processes that help us then design interventions to try and, you know, improve their experience of that.

Q. How many people are there in the wellness team or your wellness team within the local health district?
A. That's a good question. So we have an FTE count of - I think we're about 6.7 at the moment, and that has a head count of about 10/11 people.

Q. Is the team comprised of medical professionals who split their role in the way that you've split your role or is it a bit of a mix?
A. It's a real diverse team. We certainly have medical professionals and we try and have representation from each of the sites where possible. A lot of what we do in delivering the programs requires administrative support and so we have - we're set up like a department. We have an operations manager, we have program managers for each of the sites, and then we have leads of the different pillars that we call them. So I have a director of psychological wellbeing that will oversee that program of work, a director of physical wellbeing, a director of culture and safety and a director of leadership.

Q. In terms of your role as the chief wellness officer, do you see value in it being a split role between a practising clinician as to part of your FTE count and the chief wellness officer as to the other part?
A. Very much so, and we've modelled off an international model where they have, you know, tried and made errors about how to make this work with about 10 to 15 years experience ahead of Australia, so we've looked at the Stanford and Mayo Clinic models that have now been rolled out across the country in the US and now in the NHS as well.

One of the key factors that was important with the chief wellness officer role was to have a practising clinician that was seen to be one of the frontline staff and have ongoing, lived experience that could speak the language of the frontline staff, but also bridge the gap to administration. So by having the 0.5, it allowed you - well, ideally a minimum 0.5 is what the recommendations are. It allows you to just have a foot in both camps and to try and, you know, help connect that divide.

Q. In terms of bridging the gap between the frontline clinicians and the executive or administration, what is the nature of that gap and what does it actually look like in the context of a front line clinician?
A. Yes, so, look, our training backgrounds and experience are completely different and fair to say, you know, I went through my entire medical training - and this would be for other health care disciplines as well - with absolutely no training in what it is to operationalise or, you know, run the business of the health care system. So I had no appreciation of the language for that, coming out.

Similarly I think people, particularly training programs these days, rarely have significant frontline clinical experience that are going into administration roles, the senior ones. And so what you have is, I guess, very different backgrounds, perspectives, lenses on things. I think we have very different levers and priorities and as a frontline clinician, I've got the patient in front of me, and that, you know, is my vocation, to give the best care to that individual patient, whereas, you know, administration may obviously have the more difficult task of trying to have a limited amount of resources and, you know, trying to give the best patient care to as many patients as possible.

They have different levers on them to what the clinicians have at those times, and I think that can sometimes - that difference in language, difference in perspective - create a difference of opinion and a gap that, you know, requires really skilled connectors and communication to try and improve the system.

Q. So what are some of those levers that might get pulled, say, by those at the executive level in an attempt to close up that gap?
A. I mean, the classic one at the moment, obviously,

we're in a resource-constrained system, we're trying to pull budgets in and we're - you know, you might have a mission to cut FTE, cut staff numbers, and on the front line, you know, you've got increasing workloads, you already think you're working over capacity and then you get word that outside what feels like your autonomy sometimes you're going to have further staff cuts, so you're trying to think "I'm trying to do the best patient care that I can", and staff cuts might come in.

It might also be around, you know, activity. So there's - the system tends to weight activity rather than outcome, fair to say, at the moment. So it's rewarded for doing more as opposed to whether that's best care for patients and whether that activity actually leads to benefits for patients. So there are different levers sometimes leading to a values disconnect. I think if I'm really about quality and safety of care and that's what is driving me and I have a perception, at least, that things are about performances and finances and activity, that creates a divide in the system.

Q. In your role and the role being played by your team, how are you aiming or what steps are you taking to try and close up that gap, aligning an understanding of the values with perhaps an appreciation of some of the pragmatic realities of operating a large health system?
A. So appreciating it's a very complex problem, I think that was the importance at the beginning of trying to get data to really understand what the issues were. I thought - you know, I had some ideas of what I thought they might be, but very different when you go out and actually collect that data to have a look at it. So I think as a first step, that data was really, really useful at starting conversations.

It was also really useful at raising the awareness around what the problem was and, you know, when we're talking about the implications of this divide, which is often staff wellbeing, in a way, we had to put fuel on the fire and the data was a way to go, "Hey, this is why this matters." There was really, you know, a sense of wellbeing, a bit of a fluffy word, you put it in, you think it's yoga and day spas and things but actually when you look at the business case for this, the financial model, the impacts that it has not only on our staff but on, patient care, on efficiency of practice, like, there are

really sort of major implications. So using the data was the first step to that.

The second step was putting a wellness governance structure in place, and that, to answer your question around the divide, I think, was one of the most helpful things that we did. We were able to do it because we had both a ground-up and a top-down approach. So I think, you know, addressing some of the drivers of distress around not feeling like you've got a voice, not feeling like you're being heard, not feeling like you're having any input in decision-making, if you set up a governance structure where you have, you know, an aligned goal and you have both frontline staff and administration working together to try and achieve that, that was a really productive and continues to be a really productive exercise.

That worked because we had backing from the chief exec from the very first moments and, you know, timing is everything. There were a lot of levers in our favour at that moment to get some funding. We had horrific staff suicides and things that helped us start that conversation very quickly.

But by having chief executive support, senior clinicians leading that process, and then putting a governance framework where this needed to be an iterative conversation - what we were talking about in 2019 or before that, in terms of wellbeing, is completely different to what we're talking about now. And so you need a structure that can allow that dynamic process to keep unfolding over time.

Q. At the start of that answer you referred to the collection of data and you described it as pouring fuel on to the fire. What is it about the collection of that data that you regard as potentially being slightly inflammatory but, nevertheless, as you explained, important?
A. It's about raising awareness. So when we started, there was a - we'd had four basic physician trainees in a four-month period take their own life and people were angry and grieving and no-one was doing anything and there was this sense that our staff were breaking and we couldn't understand why it was happening, and no-one was listening. So data gave you a way of illustrating, in different ways and tacking it to different outcomes that mattered to different people, to make this, you know, an important

issue. So we could tack it to financial outcomes when we wanted to talk to the chief financial officer and show how addressing wellbeing would, you know, save money for the health care system.

We could tack it to patient quality and safety outcomes, which, at the end of the day is a great one, because that's what we're all in the game to do.

We could tack it to improving, if I'm talking to my junior staff, exam pass rates, because that's what they cared about, you know, at the time.

It might be about performance. So if you have that data, it allows you to have conversations and the language and find the why for people that matters, and that wasn't there at the beginning and that's what we've been working really hard to find what that dataset is to be able to do that.

Having said that, once you raise awareness, and we can show that the burnout rates are really high, keeping measuring burnout and not doing anything about it puts more flame on the fire and doesn't achieve; it just makes people anxious and, you know, you get a contagion. So I think, you know, what we're measuring over time needs to reflect the program of work and what we're doing, and we also then need to look at how we, you know, reduce that sense of overwhelm about how to act on that data and that learned anxiety in a way of, you know, we know there's burnout, what can we do about it.

That, in many places, I think, is the situation at the moment. We know there's a problem. We don't know what to do. We're afraid it's going to break the bank. So we don't know where to start and there's this paralysis. We're trying to show a model that works, that won't break the bank, where, you know, with baby steps - and we've five years in, probably seven years in, actually, with the pilot work - this is where you can get to, but it's going take time.

Q. The data collection that you've referred to, is that the data or the database that you speak of in paragraph 6 of your statement - that is, the wellbeing database?
A. Yes.

Q. When in that sort of five-year period that this group has been in operation did you start to collect that data?
A. So we did a pilot in 2018 where we just focused on basic physician trainees - the medical registrars. That was part of a small pocket of funding that we had to do a research project to try and understand, again, what was the prevalence of burnout, what were the drivers of it and what were some of the potential solutions for it.

So we started that. That went very well and we got ministerial funding the following year in collaboration with the district to expand that to all medical staff, and when we did that, we put it through the ethics longitudinal sort of - we set up an ethics approved longitudinal database. So that now exists and once a year we can put out the same survey that gives you very granular information, depending on the response rates, but very granular information to help you strategically plan where to put your resources and what to focus on in the next 12 months.

Q. Just in relation to the granular nature of that data, you make the observation in paragraph 6 that it effectively fills gaps in the "People Matter" surveys?
A. Correct.

Q. What do you mean, when you say - first of all, what are the gaps and how are they being filled?
A. I think you can take the context of the "People Matter" survey around what it's intention is and what it's trying to do. It's obviously a survey that has to go all cross sector. So the same questions are being asked to the people in education as to the people in health, as to transport and other areas. So you are a little bit limited in what you can ask.

It's also a very high, bird's-eye view of trying to be able to compare sectors on some high-level metrics, and there are some really good ones and, you know, it's a great dataset to have to report up.

What I found coming into the position, and trying to get the results of that and then operationalise it, was without doing extensive further research and audit, I couldn't act on anything. So, for example, you know when we might say, "The district's got bullying rates of X per cent", it's like, "Well, where is the bullying, what

facility, what department, who is doing it, why is that happening?" None of that was there. So the datasets were useful but not to operationalise on the frontline level. So that's one of the problems.

I think the second problem at the moment is that it doesn't use, in the wellbeing space - it's not a wellbeing survey. It asks some wellbeing questions, which is fantastic and I'm really glad they're doing that and working with them to look at how can we improve the way they're doing that, but traditionally haven't used validated measures. So you can't benchmark with best practice around the world around how to measure wellbeing or burnout. So we, you know, can't see how we're going compared to other hospitals.

In terms of, you know, why, that would add a lot more questions to the survey, and at the moment, when you look at it, the response rate for the survey is already, you know, on the lowish end.

One of the things, I think, in terms of the gaps of the survey, what doesn't it measure? Like, it doesn't measure burnout or professional fulfilment in a validated way; it doesn't measure the impacts of that. So in terms of, you know, on an individual, what do we look at? We look at anxiety rates, depression rates, recruitment, retention, loss to the workforce, the organisational sort of issues. We look at patient quality, safety of care. We look at motor vehicle accidents on the way to work and back that are related to fatigue. So there's a whole series of impacts that we can look at that are really useful, again, with trying to target, well, where do we put the interventions.

It importantly also doesn't look at what the drivers of that distress are. And so when you're trying to design interventions - and wellbeing and burnout is an incredibly complex area, and from what we're measuring, at the moment we've got it down to about 50 different drivers of distress. That's a lot of information, and we're asking people to do a, you know, 10 to 12-minute survey. But they are doing it because they're seeing action taken on the results, and I think, you know, for the "People Matter" survey, one of the great questions they have in there is "Do you think this data will be acted on ? And when you look at the response rate to that is often around

10 per cent or something, it explains why people aren't filling it out.

So surveys and data collection is fantastic, but we need to be really careful (a) that there are too many across the system - "People Matter" is doing one now, I'm doing a local one, the AMA will do one, the colleges will do one and suddenly there's all this data flowing down and people are surveyed out and they're not seeing action based on that. So I think if we can look at some connection around data measurement using validated tools, not re-asking questions that have been asked in other surveys, that would be one really significant way forward.

I think the second thing around, you know, frontline solutions - that's one of the best questions I love in our survey, I think "People Matter" does do that. How that is fed back to organisations at a granular level again to be able to act on is probably one of the other ways that that could be improved.

I've forgotten where I've started but that's probably enough on that.

Q. To the extent that issues are being raised by members of the workforce, concerns are being raised by members of the workforce, about issues including, say, the extent to which they feel that they're engaged with the executive in a constructive way, is it the case that the "People Matter" survey is lacking in granularity to an extent that you couldn't, in the face of those sort of concerns, look to the data in the "People Matter" survey and say, "Actually, there's no problem here"?

A. So that would be one risk. I think there's two parts to that. Are we asking the right questions? Are people feeling de-identified enough to fill that out and actually put authentic true answers in there? Is that information fed back to local health districts? And, if it is and it makes it to executive, is that filtered any lower down? And so I think that process can work, but it can also fall down at many different levels, and certainly that was - you know, my experience early on that wasn't information that was coming through.

Q. I might come back to that in relation to some specific examples. Could I ask you to move forward to paragraph 8 of your statement, where you tell us that part of your role

you have focused on prevention and early detection of issues rather than the treatment of them once they have arisen.
A. Mmm.

Q. What is your group doing in its attempt to detect these sorts of issues and what steps are being taken to prevent them as and when they are detected?
A. So I think it's really important when we're talking about wellbeing, is that we are trying to look at the, you know, preventative lens. We're trying to take people who are well or not at that best and help them get back to be at their best. We're not replacing EAPs, you know, the employee assistance programs; we're not providing therapy; we're not the interventions for those in distress. We try to connect people with those in distress.

So in terms of, you know, trying to get out in front, we're trying to get out early into training programs at all levels for the prevention - the intervention part. If I go to the detection part first, that's where the governance structure's really important. So having again the ground-up, where you've got representatives from all the different sectors of the organisation, you've got a monthly meeting where you've got an agenda that allows people to raise those issues, that's, I think, one useful way to look at early detection, as well as what we found, you know, with wellbeing programs, is the best solutions usually are coming from the front line. They just don't have the time, now, or know how to navigate the system, to implement them.

So we're very much playing that sort of connector support role help, navigate the system, try and help implement. So I think if you've got that structure in place that allows those regular conversations, the committee is great and the agenda is there, but a lot of the conversations that will come up in that committee are usually happening on the ground and in pre-conversations in preparation for that, too.

So I think you can put the structure in place and then, if you've got really good leadership and good representatives around that, that's how you find out, you know, what is happening early. You've got ears on the ground. You've got good relationships across the network. People will come and talk to you because you are considered, you know, a safe surveys, and I guess having

a team across, having the training directors there involved gives you that sort of reach out into the organisation to try and, you know, do what an email can't do in terms of, you know, really connecting with human beings.

Q. As part of that detection/connection, do the medical staff councils at the facilities have a role to play?
A. So it's a good question. Only recently. So fair to say in my experience of being in RPA medical staff council - so slightly different but I imagine reflected at Concord - is that we didn't have an integrated, well-attended, well, high-functioning medical staff council, and you could argue, for whatever reason, we didn't need one. Things were operating well, so people weren't turning up to meetings and there was this gradual dissipation, I think, in attendance and things over time.

Certainly with COVID and things more recently, we have reinvigorated/restructured, and attendances, last meeting, was averaging sort of 130 plus people. It used to be 4. So right now, the chair of the medical staff council will sit on our executive MDOK committees, and that is another important voice. So trying to have all those voices there allows that sort of cross-communication. But it wasn't, you know, in recent years.

Q. To the extent that the medical staff councils, if operating well, potentially provide a useful source of information about the way staff are seeing things - medical staff, I should say - seeing things on the ground, would it be contrary to the sort of objectives that you and your group have in mind to be taking any steps which would operate to prevent the medical staff councils from speaking about issues or engaging with one another about particular issues that they see as relevant to the operation of the hospital?
A. Can you repeat that question for me?

Q. To the extent that - start with this proposition. The medical staff councils are potentially an important conduit of information from the frontline workers, medical workers, through to the executive, including your team.
A. Yes.

Q. By gathering that information, you use it as part of the important prevention and early detection measures that - well, functions that you hold?

A. Yes.

Q. Would you see it as counterproductive in terms of your efforts to achieve prevention and early detection for any step to be taken which operates to prevent or attempt to prevent a medical staff council from discussing or engaging on issues that they feel are important?
A. Oh, yes, absolutely.

Q. So to the extent, for example, that a medical staff council expressed a desire to provide, by way of advice, constructive feedback on things they thought the executive was doing well or not well, it would be counterproductive, at least insofar as your objectives or your group's objectives are concerned, to say to them, "That's beyond your remit. You must not do that"?
A. Yes, I think the whole purpose of medical staff councils is to be a barometer on the ground and a body to provide recommendations and advice. These are people on the front line with lived experience who see what's happening every day. It's a really valuable source of information.

Q. Any step which would operate to prevent the medical staff council from sharing in an advisory role with the executive things that are concerning the membership would significantly diminish the meaningful - diminish the benefit that might be achieved from having such a council?
A. Yes. Hospital systems work best when you've got great working relationships between, you know, medical staff councils, but all people in leadership positions, both clinical and non-clinical.

Q. Can I ask you to jump forward to paragraph 11 of your statement, on page 3, right at the very bottom?
A. Yes.

Q. You tell us there about the role that you and your group have in providing support to staff with grievances. Can I just ask you to expand a little bit on what that role is and how it works in a practical sense?
A. So we probably play a few different roles. In terms of our primary role, I think it's usually providing a level of support to those people and that's either through direct reach-out or indirectly through the programs, like the colleague care program that we've set up, which has specifically been set up to support people involved in

either adverse events or grievance processes, and that came from, you know, data feedback from those staff that had been through them to talk about, you know, the impacts and the secondary victimisation often that happened with that. So I think we play that role.

We play often a connector/advice role. People often don't know how to navigate the system and so a lot of those conversations, if they've got a grievance, it's a chat and they're not aware of what their avenues are to lodge that complaint. And more importantly, I think, there's a lot of conversation around what the potential implications of using different avenues might be for them, and so a lot of fear-based discussion of who would see this and what would happen and, you know, what are the repercussions and things.

So I think there's a lack of awareness not just grossly around, "Yes, we have an ims+ system that's an electronic system we can put in", but around the, "How does that actually work? Where does that information go? How will it be acted on? What does that mean for me? What will that mean for the other person, if it is an interpersonal dispute?" So I feel like we're doing that quite a lot. What's the system level intervention for that? Almost, like, we need a guide for these processes, and so we've started to talk about that locally now around, you know, what's one of the missing parts of the equation to try and help people feel like they can speak up, do they have the right information. So that would be a body of work that, you know, one of our team groups, working groups, would then put into place.

So there's the direct support, there's the measures around helping connect people with systems, helping them navigate, and then there's the "What can we do at a system level" intervention to try to not need to do this so often.

Q. You referred to secondary victimisation. What was it you had in mind when you were referring to that as a concept?
A. Oh, so, you know, like, anyone going through a grievance or adverse event process, if they've, you know, made a mistake, if they've been accused of bullying or harassment, the actual process that they go through is often a very traumatic one for that person on many levels, and that trauma is what can lead to the concept of

secondary victimisation. So they become a victim of the processes, the system, you know, their own thoughts and things around what are the impacts on staff wellbeing and how do our systems and processes contribute to that.

Q. Could I get you to go forward to paragraph 20 of your statement where you set out a little bit of feedback that you've received about some of the formal complaint channels and why they're not used. You identify there some obstacles that have been drawn to your attention. Could I just step through them and ask you to explain them in a little bit more detail. The first is what you have described as the "non-user-friendly reporting systems". What's the issue there?
A. So often these are quite cumbersome to (a) log in to; (b) the level of detail that the system either asks you to do or to categorise into, and then the category that you want to put it into doesn't quite exist, is a very lengthy, time-consuming, often, process, and - like, in terms of time on the frontline staff at the moment, like anything that draws out, makes it a lengthy process, that, you know, staff are somewhat reticent to do anyway. If you are putting another little barrier in front of them, the high chances are them not putting that, you know, entry into the system are certainly there.

Q. Does that combine to mean that an assessment of the number of reports that might be lodged through a system of that type is not necessarily the best measure of the extent to which incidents which perhaps justify reporting have occurred?
A. Very much so. I think I outline later, but, like, it's not just non-friendly systems as to why reporting's not occurring.

Q. Let's go to the next one, the lack of confidentiality and effectiveness in addressing grievances in a timely manner. From a human perspective, what's the real challenge there?
A. So if you're a junior doctor and you put in a report against a senior doctor in your department or - let alone your head of department, the first thing that system will do is fire that report off to the head of department. And so there is a lack of, you know, confidentiality, I guess, in that process.

The areas that we work in, you know, the teams are

small, it's often very identifiable who has put in complaints. Obviously if it's a grievance and there's been a thing, but I think that sense of applying confidentiality to these system-level processes in areas where, you know, people know who put that in is - you know, it's an issue everywhere. I think because the implications, particularly for medical, junior medical staff, are so profound, there's a big barrier to wanting to use that system, especially when you feel identifiable.

Q. In relation just to that issue, to the extent that, say, a colleague were to indicate that a number of their colleagues had provided information to them or concerns that they had on a confidential basis, would it be a reasonable, in your view, answer to that, in terms of dealing with the problem, to say, "Unless you give me particulars of those confidentially shared problems, I can't do anything about it"?
A. Yes, look, I've certainly - yes - found myself in that situation many times, where people want to share a grievance with you but they fear the implications and they want some way of reporting it but not being identifiable because of those implications, and, you know, it puts you in a - they ask you not to take it any further. And if it's not meeting mandatory reporting requirements and things, it's a really tricky position to get put in.

Q. To the extent that you're put in that position and you pass the information on, albeit in perhaps an unparticularised way and without disclosing the confidence, would it be appropriate for someone within the executive, who has had that information shared with them, to act on it as though it's at least - that there's at least a real possibility that a problem does, in fact, exist?
A. Yes, so I mean, if the information - it's hypothetical, but if information has been shared with executive, they would find it hard not to act on that information. If it didn't have any particulars, it might be very hard to act on.

Q. So in saying if it didn't have any particulars, you might not be able to then turn around and, say, commence a formal grievance process in respect of that confidential information?
A. Correct.

Q. Without the particulars?

A. Correct.

Q. But my point is, if the existence of that confidential information was shared with, say, you in your capacity as an executive, you would not jump immediately to the conclusion that, absent particulars, there's probably no problem there?
A. Oh, absolutely, and you know, trying to see, you know, both sides, how do you investigate further?

Q. Just moving to the next issue, it is the effectiveness of processes in addressing grievances in a timely manner.
A. Mmm.

Q. What's the particular issue there?
A. Oh, look, certainly, you know, when you compare what I think are really robust grievance processes that are put in place for patients, and having been a head of department for seven years and sort of living that and seeing first-hand how well and timely they are managed, the loops are closed, the patients are kept up to date, you know, at every step of the process, and then witnessed or been support person for colleagues going through the same process, which tends to be drawn out, not a lot of communication about where things are up to, not knowing what the next steps are - I think we can really learn from what we're doing really well with the patient complaint system and look at how do we put the same metrics and processes for the staff complaints system.

Q. So sort of metrics and processes - coming back to the concept of secondary victimisation that you've alluded to, perhaps metrics that, say, build KPIs around how quickly a grievance against a staff member needs to be dealt with in order for it to be above the line from a KPI perspective?
A. Absolutely. Do they have a support person built into the process? Have they been connected with X, Y and Z channels? I think there are many really constructive metrics we could put around them.

Q. The next one you identify there is a lack of skill and training in conflict management within the workplace.
A. Mmm-hmm.

Q. The first question around that is where is that lack of skill and training in terms of the hierarchy?

A. Everywhere.

Q. And what is it?
A. So I think respecting that managing these really often difficult, emotionally charged, complex problems requires a high level of skill and often, you know, knowledge and self-regulation so you can regulate the other person. We don't teach that skill set at any point of training, from university through to intern, residency, vocational training or to senior level staff.

So if we want to be good at this, you know, surely we would value this skill set and build it at a basic level into university training programs, perhaps at a slightly more advanced level by HETI to intern/resident programs, and the same could be for nursing staff and allied health staff, the colleges would then build it into their curriculum for vocational staff, and consultants or people going to senior leadership positions would also receive ongoing very advanced level support for that.

So you take that sense of, you know, there's the leading self, there's the, you know, leading your teams, leading departments, leading organisations, and you can break that down into a skill set that needs to be taught at all levels.

It's very hard now, you know, criticising senior staff who have never had any of that training, who've got to go back to the basic level of training. So I think moving forward, we need to build this in right at the beginning of our structures and then look at what's the workplace role in delivering this training, and how can all those other bodies that contribute to education and training sort of unify so that we're teaching the same thing to the same craft groups speaking the same language. Then we would get good at it.

Q. Without intending to be critical of any existing staff, do you perceive there to be a risk that placing people in executive and management positions who don't necessarily have that training or possess that skill set runs the risk that, in dealing with what are sometimes volatile situations, they might respond to them in a way which, quite unintentionally, makes them worse?
A. Yes, absolutely. I think if this is a skill that we want all our managers to have, yes, we should be selecting

for it, but we should also be training for it or we're not going to have a very big selection pool.

Q. I think you've already told us about the next issue, which is the lack of awareness of local grievance processes available to staff, but the next one, a lack of independence and therefore psychological safety in the complaints process, both perceived and real - what are you angling at there?
A. So I mean, often grievance processes, again, are often not straightforward. By the time something's got to a grievance process, you know, the basic things have usually failed and things have escalated to a certain point, and, you know, there can be implications, either for service delivery, for, you know, risk to reputation, to risk to appearing in the media, like, a whole lot of levers and drivers that can make true independence of any investigation really challenging.

You build that then into the, you know, the unique nature and the way we're set up, particularly in medicine, of that hierarchical culture, where your job security is often linked to people sponsoring your applications for things, then it sets up - you know, even if you're the most skilled person, trying to deal with these, you're always going to have, you know, some biases that are built in to that process. You may or may not be aware of them. So without a truly independent process, there's often a perception, you know, of an unfairness with whatever the process or outcome turns out to be.

Q. High levels of burnout, I think we understand, but existing professional and local workplace cultures - I think you might have just touched on one of them, but are there any other aspects of existing professional and local workplace cultures that you have in mind as perhaps a barrier to the making of complaints through existing grievance channels?
A. Well, you know, culture is like the way we do things round here, and in many medical cultures - and I think this can apply probably more broadly to other disciplines as well - the way things have been done for a very long time has, you know, been not - a culture of not reporting, of not speaking up, of not creating waves. You know, we've been working very hard to try and change that culture and behaviour, but fair to say that that would still be present in many areas, and so I think, you know, real or perceived,

that culture of, you know, "Don't report", is still there.

THE COMMISSIONER: Q. Can I just ask - no criticism, Mr Muston - about the assumption "we all know what burnout means", can you just tell me from your perspective, I assume it means more than just fatigue?
A. Much more.

Q. What does it mean?
A. So when you look at the domains of burnout, it's got three domains. The first one's emotional exhaustion; the second one is depersonalisation or cynicism; and the third one is around professional efficiency or your efficiency of practice.

What does it sort of translate to in a real-world environment? If your body is under extreme stress, so occupational distress, for prolonged periods of time and that is not successfully managed, you will become emotionally exhausted, your coping mechanisms in that way, because you don't have a lot to give to others, tend to be to detach.

So in medicine, that may manifest as seeing patients as the next problem walking through the door; they're a bed number, not a named human being in front of you. And so you try and conserve your own energy by, you know, reducing compassionate care.

That can also lead to, you know, negativity and cynicism and things, and obviously reduced activity or performance, and in medical staff, at least, it's interesting, that's the last thing that goes. When you see that drop off - because type A, AAA, you know, personalities, their best coping technique when they're stressed is usually to work harder. So when you see the productivity drop off, that's when you know we're at - you know, we're on that slippery end of the slope there.

In an activity-based funding environment, this is why it is such a key issue of, you know, having 60, 70 per cent burnout rates in our staff, this is the impact at the other end. So not only on the ability to deliver compassionate care to patients, but also the efficiency with which we deliver that care. That's what burnout is capturing.

Q. Thank you. Give me some understanding, obviously

based on your opinion and experience how - I assume you would be talking about your own LHD, but tell me if it's broader than that, but how should I understand the size of this problem in the workforce you're talking about?
A. So it's huge. Pre-COVID, if you look at both Australia, our local health district and international rates, on average, we were already at about 45 per cent. So it's almost half the workforce. So this problem has actually been around for a very long time. Hasn't been recognised.

COVID has amplified, and those rates that we're seeing have gone up to, on average, about 70 per cent. What we also saw in the data, and it's replicated around the world, is that it affects our most vulnerable in the system. So our junior doctor rates were up around 80 per cent and the senior doctor maybe went up to 50 per cent. So you're seeing the impacts and the brunt are - you know, it's highly prevalent but it's affecting our most vulnerable and then it's got these terrible consequences.

Q. A couple of things can I follow up with you on that. You mentioned the junior doctors as being the most vulnerable. I can think of some means by which you'd describe them as the most vulnerable. Why do you say they are the most vulnerable?
A. So they have the least power in the system, so when you look at drivers of distress, that lack of control and flexibility is a key driver. They have lack of job security. So not only can they find that, for example, you know, "There is a problem, hard to speak up, but if I do speak up, that might threaten, you know, my future career." So there's all these compounding factors that contribute to that.

Junior doctor training is also incredibly stressful. Long hours. But the actual type of work you're doing, when you have a skill set that's in its infancy, also, you know, puts you under high levels of stress anyway. I think we really saw that in COVID, because we took all the protective mechanisms away, those ward rounds where you've got people next to you, the human contact, the debriefing with, you know, consultants nearby, all of that was taken away from them. So I think that's why it was exposed during COVID as to why they suffered so much more than the senior medical staff.

Q. You described the problem to me as "huge". I assume I should take it - tell me if I'm wrong, though - that the problem of burnout is not just related to junior medical officers but across the range of employees in the health system; would that be right?
A. Correct. So the average rates across the system for all medical staff at the moment are just under 70 per cent. That mirrors international data. So if you stop and think about that for a moment, if you had a problem affecting - a quality and safety problem affecting 70 per cent of patients that came into hospital, you would be jumping up and down and throwing resources to try and understand that problem, particularly when you see the severity of the consequences about it.

The burnout rates in non-medical staff are also high, and there are certainly pockets with our nursing colleagues. Fair to say that the data collection around that has been less rigorous. There's been one large Australian study that included about 8,000 mixed healthcare workers, and that burnout rate came out at 70 per cent. So that's our largest dataset, but we haven't really got good national data around this.

Q. Can I then ask you this: I would assume that, in the best circumstances in the world, in a public hospital, it's stressful being either a doctor or a nurse because you are looking after people that are unwell, and you're trying to either cure the disease or fix the injury or stop them potentially dying, and I get that of itself comes with a high level of stress. To the extent that this burnout problem is huge, though, beyond that, what I just said, there may be multifaceted causes for this, but what are, in your opinion, the key causes for this burnout?
A. So I can show you what our data, and again, the international data, tells us.

Q. Yes.
A. So workload and hours spent - so the actual workload and the complexity, so the number of patients coming through, the complexity; the long hours that sometimes mirrors workload but it can be for other reasons; the increasing level of non-clinical tasks, so administration, you know, college will have requirements, there's teaching requirements, there's the paperwork. I've got to prescribe complex drugs in rheumatology, there's a whole lot of paperwork that goes with that. So there's a lot of

compliance-checking processes, administrative processes, that take you away from where your meaning and value in practice is. So one of the big drivers of burnout is that lack of meaning in work, particularly for, you know, people that go into health care that are often driven as a vocation not just as a job, so to speak.

I think frustration and disempowerment. So particularly in the medical cultures, but I'd say also, you know, with other non-medical disciplines as well, that sense of loss of autonomy, not being heard, not being seen, not having a voice in the system is coming out loud and clear as a driver of burnout.

The lack of social connectedness at work. So it's really interesting, in our data, 33 per cent of the workforce reported a sense of isolation at work being one of their major drivers of distress, and that's a really easy thing to do.

Q. What causes that. What do you think causes that?
A. Well, if you look at a variety of things, from a building workplaces point of view, we have systematically taken all staff lounges out, so any areas or infrastructure to connect, we've taken them out of the hospital systems.

Q. Why?
A. Very good question, and, you know, great intervention to try and reduce burnout, but to restore community at work would be to put staff lounges back in.

Q. Why were they taken out, though, do you know?
A. That would be prior to my time, but it's something that's talked about by all the senior clinicians of - that was always there.

Q. I'm only asking why because it doesn't make any sense to me at the moment.
A. Cost saving is what I imagine.

Q. Right. Okay.
A. I think the other - what were we talking about --

Q. Causes of burnout.
A. Yes, drivers of burnout, so I think it's really important with burnout, and we do measure this and it's important to show, that there are individual factors as

well. So the workplace obviously cannot be responsible for all those factors, but the way we create a culture where people can be human beings in coming to work - so we will show that there is carer distress and, you know, parental distress and financial security and all those things are individual drivers of distress that will contribute to someone's burnout, and you can't just tease it all out; when you're measuring burnout, the individual will put it all in there. So we can look at what the workplace drivers are, and that's where our interventions are trying to help.

The biggest effect, if you look at the literature, and again locally, on an individual's burnout is the leadership skill of their direct manager. That manager has more of an effect on your wellbeing than that person's GP, and as much of an effect as their spouse.

So leadership and skilled leadership in management is a really, really critical thing to look at when we're trying to address this at a systems level, because of the profound impact it has on staff wellbeing, staff culture and a myriad of other things that will influence someone's sense of feeling valued at work. The lens that they look at administration through is all coloured by the guardians of that culture.

Q. Assume that I think that a system with as many employees and as important as the health system - assume I think that it's a bad thing that burnout is a huge problem in it, because I think anyone would. Indulge me in this fantasy that money is not an issue - so let's pretend money is not an issue - what would be the key things you would do to address the problem and try and reduce burnout? You probably can't ever entirely eliminate it in a health system, but to reduce it down from the huge problem?
A. Great question.

Q. I appreciate that's a really difficult question and it's difficult on the fly. Have a go.
A. So many things.

Q. Have a go.
A. So many things.

Q. When your evidence is over, we will come back to you, as well, if you want to reflect more on it, but have a go at it now, because I'm sure you've thought about it.

A. So I think we need a national approach to this. It would be a priority area for the federal government and we'd have a task force put on to this straightaway.

Q. By that, I take it you immediately mean that burnout in the public medical system is not limited to New South Wales?
A. Absolutely. This is a worldwide problem. We want to be at the leading edge of the solution to it in New South Wales, and I guess that's what we're trying to do.

Q. Yes.
A. But I think in terms of filtering down, because it does - you said "money", but that would influence money, but it also influences policy at all levels, and there's so much in terms of policy and awards and KPIs that if we don't have that, at the highest level, made a priority area and, you know, brain, think tanks around it, task force on to it - that would be my starting point.

I think we then need a really clear set of accurate data measurements to understand and measure the prevalence of the problem, its impacts and its drivers in different areas, and my, you know, wish would be we had real-time access to that data and that it was fed back to heads of department so that they, at their fingertips, had information that they could act on.

I think the policies --

Q. Because then their decision-making would be based on the best data; right?
A. Exactly. I think we see - staff wellbeing would be seen as a quality and safety issue. I mean, it's a quality and safety issue, it's a work health safety issue, it's a training and accreditation issue, but as a --

Q. And not just safety for the employees but safety for the patients --
A. For staff, exactly. And I say that because in health we're really good at quality and safety issues, we've got a framework and process, we just haven't ever thought of staff wellbeing as a quality and safety issue. So we haven't embedded it into the national, you know, quality and safety standards. Again, when you do that, we haven't embedded it into the service agreements that the local health districts will have with the Ministry of Health, for

example. Staff wellbeing is not a KPI. So you sort of need to filter it down at all levels.

You then need oversight of it, and I hope, and I am living proof, and I have three other colleagues across the country that show that you need high-level clinical leader and these CWO roles to be rolled out and for every organisation to have someone that is empowered within the organisation, with the time, budget and resources, to oversee this process and to make sure that there's strategy and direction, because, you know, the issues at RPA, for example, might be - well, they are - completely different to Concord and Canterbury. So you need to have that high-level systems approach but that ability to have a local sort of approach to it.

I think staffing and workload is a massive issue and no doubt you've heard that from many of the statements that have already been given. How do we get around - how do we afford better ratios? How do we change the way we're doing care so that it's not all hospital based and we could offload the systems? I think hopefully there are some really good ideas around that. So workload I think, you know, is a big driver and we could do that.

Leadership, I think is also the absolute key, as I've alluded to, and influencing the curriculum at all levels. We would all be teaching the same thing, at a, you know, spectrum, and we'd all be measuring the same outcomes that mattered to look to this. That would then feed into selection processes for people in leadership positions that would have that skill set and, you know, moving forward, we would have a sense of community at work, we would have staff lounges to go to.

One of the most simple interventions that we did post COVID, I think it cost $1,500 a year, it was what the anaesthetists/ICU surgeons wanted, which was the bread and cheese to be put back into the theatre so that when they couldn't get out, they could have a cheese toastie. Like, it's not rocket science, a lot of this stuff. So how do we do really simple-level, you know, interventions like that, but without the oversight and the data and asking the front line for the solutions and then having teams - I think there's a lot of pebbles in the shoe that can be fixed --

Q. But the example you give of the cheese toastie, it's -

burnout, I assume, is cumulative?
A. Absolutely.

Q. And the things that you can do that, for want of a better expression, create a happier workplace, it's one less layer in that building that might create burnout; correct?
A. Absolutely. Absolutely. And you might eat that cheese toastie with a junior and have a mentoring conversation. There are all these other social connected things that can happen.

Right now, like, the first thing I'm seeing managers want to do, is to remove, like, these really cheap things that actually have profound impact for frontline staff. And so I think, as our, you know, awareness grows and, you know, we share ideas, there's no community of practice around staff wellbeing at the moment to share what's working at different organisations, we're looking for someone to host that both at a state and national level.

I think, yes, I could keep going on, but there is a whole lot of things that I think are inexpensive that we can do. Then there's, you know, the big - the big levers and the awards and the policies and the processes that are trickier.

Q. I'm not going to ask you to do this in the witness box because it can easily be done outside of it and doesn't need to be done during your evidence, but a couple of times you've mentioned international literature. I'll just get someone in the Inquiry team to follow that up with you to make sure we've got visibility on what it is you're talking about and perhaps also make sure we - I'd be the last person to know at the moment, we probably have all this, but where the best sources of data are about all of this.
A. (Witness nods).

THE COMMISSIONER: That's me for now.

MR MUSTON: Q. Can I take you back to paragraph 27 of your statement, where you effectively I think summarise a lot of the issues that you raised insofar as the non-reporting culture within the medical profession are concerned. Do you see that paragraph?
A. Yes, I'm there. Sorry.

Q. No, that's okay. Just a couple of questions about that. The first is: is, at least to your observation, the existence of that culture as a feature of the medical profession reasonably well recognised?
A. Sorry?

Q. Is that culture or practice, as a feature of medicine, reasonably well recognised?
A. Yes.

Q. Does that mean that if confronted with a situation in which there might be a significant number of people within a department or a facility who are expressing grave concerns about something, but perhaps not the entirety of the people working within that unit or facility, that one can't safely assume that there's no problem?
A. Correct.

Q. In fact, the existence of that culture would tend to mean that if you get a reasonable number of people who are expressing a concern within this otherwise somewhat constrained group of medical practitioners, that maybe there really is a problem there that needs to be at least investigated?
A. That would seem fair.

MR MUSTON: Just as an aside, could I ask, operator, if we could go to [SCI.0012.0160.0001].

Q. Is that a document you are familiar with?
A. Only from watching you. Not one I've seen before.

Q. You know what's coming next?
A. I do, and I was shocked when I saw it the first time.

THE COMMISSIONER: It's even highlighted in advance.

MR MUSTON: Q. You might have answered my next question, but if the operator could scroll down to the second page. You see the highlighted section there? That, I presume, is what you were shocked by?
A. Yes, well, I'd like to think maybe there's been a transcribing error or something.

Q. You'd like to think so.

THE COMMISSIONER: I'm going to assume --

THE WITNESS: Maybe like the way someone is complaining is what they are referring to, rather than just to complain at all, like that --

THE COMMISSIONER: Q. I'm going to make the assumption that the person that drafted that is not intending to be - is neither evil nor intending to be evil, and bona fide thought that that was a good way of describing something that is a "below the line" behaviour, but I assume you would tell me that, at least in your opinion, that is perhaps not world's best practice in terms of something to be in a code of conduct?
A. I think the language could be shifted to be a lot more clear about what was being meant. I think - we encourage people to speak up. We have programs to encourage people to speak up. And so I guess I'm - the word "complain", whether that's not the best word, whether they were thinking about something a bit more forceful or disrespectful with that word, but that's what's written there.

MR MUSTON: Q. Expressed in that way, it would tend to suppress what might otherwise be healthy dialogue about issues faced by a particular unit or facility?
A. Yes, what I was concerned is that that would be used against someone around, you know, if this was a formal document, but it's not one I've seen in practice.

Q. If it were held out as one of the core values of the district, to pick up on something you said, it would tend to reinforce the view that those who speak out about some of the challenges that they might face will face retribution, either as a difficult person or as a troublemaker?
A. Yes.

MR MUSTON: We can put that document away, thank you, operator. I think it can be put away more permanently somewhere else.

Q. Now, could I ask you to jump forward to paragraph 34, where you start to tell us a little bit about some of the challenges, as you perceive them to exist at Concord hospital. You tell us in the first sentence there that since 2011, when you commenced within the district, you observed a decline in the morale of staff at Concord. What

were the observations that you have made across that period that led you to - or led you to conclude that there was a decline in the morale at Concord? Obviously not on an observation by observation basis, but what are the sorts of things that have led you over that period to reach that conclusion?
A. A few different things. I've been in the district since my student training, so for over 23/4 years, and so I have a lot of close colleagues that work at Concord hospital and I guess in my position as the chief wellness officer, you know, one of the first things I did when we started looking at rolling out the program there in the pre-work in 2019/2020 was I went and sat down with all the heads of department and just listened to see, you know, what the key wellbeing issues were.

And I guess the - it was interesting how themes arise with that sort of qualitative feedback quite quickly. It was very clear to me, and you know had been, I guess, that Concord really prided themselves on that sense of community and there was a sense that that had eroded over time and that people, you know, felt very isolated from one another, that increasing gap, I would guess I was referring to, with administration, and that sense of, you know, being really proud to work there had dissipated and they were all telling me, you know, the stories, I guess, related to that.

One of the - you know, as an aside - key things at Concord hospital they really love and pride themselves on is market day. They all get their lunches, they all connect. With COVID and everything, that got taken away, and so lots of stories around the loss of sense of community, and that would be an example of how, you know, it had been lost.

Q. Just in relation to that, that removal of market day might have been part of the amplification --
A. Correct.

Q. -- that you refer to in the second sentence there, but am I right to gather from what you've said that the steady decline in morale at Concord was something which preceded COVID?
A. Absolutely. I - from the feedback, certainly from my colleagues, you know, that - it was probably, you know, years and years over that, and as we're talking about, in a

slow iterative cumulative type way and then there were a few amplifying features.

Q. In terms of the isolation from administration that you've referred to there, there's a number of other issues which I'm going to ask you whether they are, in effect, symptoms of the same thing. The lack of access to administration to raise issues, I assume is part of that isolation from administration that you refer to?
A. Yes, I think so. I think, you know, rhetoric around lack of visibility, lack of being able to, you know, get a meeting, perhaps delayed or lack of responses to emails - those sorts of things just sort of - as an isolated one-off thing, you wouldn't think too much but it felt like a cumulative.

Q. What about the lack of transparency about decision-making and the lack of consultancy and shared decision-making?
A. That certainly was voiced on several occasions.

Q. Does that, in essence, carry with it a sense of a lack of power of the type you spoke to as one of the key drivers of distress?
A. Absolutely. I think lack of control, lack of autonomy, lack of feeling heard; it's like all the key things that drive burnout, which are all profoundly human being factors, I think contributed significantly to the distress and the amplification of that distress.

Q. And so those themes, did I catch your evidence correctly earlier, were themes which emerged in discussions you had with heads of department at Concord when you first commenced in your role in 2019?
A. Correct.

Q. You then refer to a survey or some survey and focus group discussions. In relation to the survey, when was that, the survey, undertaken and what was it?
A. So we do the Sydney Local Health District annual medical officer survey, and the first one was 2020; the second one was 2021; and then we do it yearly.

Q. So those surveys or the results of those surveys revealed, did they, these concerns amongst the workforce at Concord that you've outlined in the balance of paragraph 34?

A. Yes, and fair to say they weren't isolated to Concord. They were general frustrations within the medical fraternity across the district.

Q. Were you asked to share the results of those surveys or findings of those surveys and focus group discussions with the executive within the district?
A. Yes.

Q. And when was that?
A. The results were presented at a variety of different forums, both through our governance structure with the MDOK committees and then at extra meetings that we held as we were planning to shift to an all-staff model, and from MDOK to My District OK, and they were presented at grand rounds, at conferences. So they've been presented in a variety of different forums.

The focus of the presentations I guess may have shifted a little bit but the data is certainly available and in the hands of above.

Q. So the data and the findings about the particular troubles or challenges which existed at Concord hospital - were they shared with the chief executive of the district?
A. We created heat maps around what the drivers of distress were for each of the hospitals and broke it down by departments, and so I guess the - there was, you know, a cut of the results. It wouldn't have had verbatim qualitative statements in it. We did a thematic analysis and put the themes together about what some of the common issues were, so the language may have been around things like frustration with bureaucratic processes, or sort of broad language around that, rather than specifics.

Q. Within the executive as a result of the various presentations that you've just described, do you think there is likely to have been an awareness of the existence of this sort of data in relation to Concord hospital, say, from 2021, 2022?
A. We tended to look with a district lens. We were very early on, I guess, in the process with the way we were presenting the data. Fair to say, when we started, and particularly the first year, there was a lot of fear around that the data would be weaponised.

Q. Fear by whom?

A. Both frontline people filling it out and I think by administration as well. And so hence we went through that ethics process, but even through that we, you know, were very cautious with the way we put the data together and the way, you know, we started to present it so that it was done in a very constructive way.

We started to look at areas and present the data where we thought we'd focus energies and be able to put interventions, and so we did not start with bullying/harassment, for example. We could sort of highlight the rates of bullying/harassment and point out the differences in rates between, perhaps, our more granular data and some other data that the district had, and that was very useful.

We were able to, you know, glean insights from that around where the bullying was happening and, you know, that it wasn't necessarily just happening between senior and junior staff, that actually, some of it was coming from patients and carers and other areas. So we focused, I guess, on that level of detail and that was different at different meetings.

Q. You referred to the weaponisation of the data?
A. Mmm.

Q. In what way did you perceive that administration was fearful that the data could be weaponised?
A. Oh, look, I was aware when we were, you know, designing the survey and things that there were class action lawsuits out, that the - you know, we were recording some data around whether lunch breaks were being taken and what the barriers and things to that were so that we could, you know, design interventions and things in that way.

I think there was a fear at that time that, you know, particular parts of data could be taken and used by different factions for other purposes that weren't what this was intended to be, which was a constructive exercise locally about how do we improve things for staff. And I think any time you collect granular data, there's always the risk that things will end up in the media, and that - like, and we've seen it happen. So I understand the fears and I think, hence, why we tried to really do it in as robustly ethical, de-identified, high-level reporting, to begin with, way as we could.

Fair to say that I think those fears have dissipated a lot over the years but it's been a journey of getting comfortable with what that data is and how to discuss it.

Q. So those early fears, as you perceived them, at least, from the administration side, were essentially a fear that by capturing information which might reveal problems, that that information, if put into the hands of, say, class action lawyers, might be used to hold the system to account for those problems?
A. That was a potential risk.

Q. Those fears you saw as an impediment that needed to be overcome in order to gather the information required for your purposes to try and identify those problems and solve them?
A. Yes, it was the language around how do we have constructive conversations. We saw it when we put out, you know, length-of-stay reports and they suddenly became, you know, hostile negotiations about, "You're not doing your job correctly. You've got to get patients out quicker", and things like that. Actually, when we changed the rhetoric around let's understand the data, what's it telling us and how do we intervene - so it was the same sort of process that we needed to go through, and I think at the same time, clinicians needed to feel safe that they weren't going to be identified when data was being presented. So there were sort of two sides to this coin that we needed to appreciate when we were doing a very new novel process that, you know, potentially shone lights on difficult areas for people.

Q. Did you become acutely aware that, by at least early 2023, if not before that, in a fairly significant way, wellness did not abound at Concord?
A. Yes.

Q. Were you asked by the executive or anyone within the executive to stage or assist with any sort of intervention into how that might be dealt with, or your group?
A. No. It was felt - and we've tried to sort of respect this process the entire way - that the wellness team needed to be really careful about intervening in "operational matters", I think was the language being used, and so when there were disputes that involved people both sides and we're trying to look after both sides, how do you position

yourself in sort of neutral territory to do that? So hence we positioned ourselves with just trying to provide support for those involved, but never requested from above to be involved in any other process than doing what we were already doing.

Q. Does that, though, proceed on the assumption that what might have been happening at Concord was a dispute between both sides rather than a gap between both sides that might constructively have been bridged?
A. I think things start as a gap and seem to amplify very quickly, certainly at the end, seem to amplify very quickly.

Q. Could I get you to jump over to paragraph 37 of your statement where you point to a situation at Concord as highlighting what can occur when staff feel that they've exhausted local mechanisms but feel that their complaints have not been heard or addressed. What do you think, at least based on the information that you've been able to gather in your current role, are some of the reasons why those feelings developed at Concord in the way that they did, seemingly to a greater extent than they might have developed or had developed at RPA and at Canterbury? That was a very long-winded way, of saying based on what you know as the chief wellness officer, why do you think it happened?
A. In terms of the "why" being why did it - why did it escalate to a vote of no confidence?

Q. What was it about the culture or about the engagement between the frontline workforce and the executive at Concord which, to your view, led to it spiralling in the way that it did?
A. I think everything's got a breaking point, and what was a slow-burning discontent, amplified by COVID, sky-rocketing rates of burnout, leads to people not necessarily being their best selves, physiologically you're not - higher centres are off, you're in your lizard brain, and then combining that with a sense that you have exhausted every mechanism that you know how and are still not going anywhere, I think people hit a point where they felt they had no other option than to, you know, take quite drastic action, is I guess my interpretation of it, and that was the action that they felt was the only thing they had available to them.

Q. Could I ask you to go down to the next paragraph, paragraph 38, where you talk about the value of a strong relationship between clinicians and administration and the role that medical staff councils can play in that. In the last sentence you tell us that the structure was in place at Concord - that is, the medical staff council structure - but it wasn't working effectively. Do you have a view as to why that might have been the case?
A. I didn't attend the meetings. So it would be my assumptions and probably biases from what I had witnessed at the RPA medical staff council, and that was what I was alluding to before. I think it didn't have - well, it had had the same leadership for a very long time, it didn't have a strong agenda, no-one was attending, it wasn't identifying the key issues that needed to be escalated, but certainly the experience of my first, you know, five, six years within it is that there weren't these sorts of things happening.

So, you know, talking to colleagues, you see this pattern a little bit where everything, when it's running really well, there's not a lot for the medical staff council to be discussing at those meetings and they become really important when, you know, key issues arise. That, I think, seems to certainly have happened.

Q. Is there potentially an issue that where those key issues start to arise and the medical staff council becomes more engaged and perhaps more adversarial than might traditionally have been the case, that responding to that as though it is a dispute between the medical staff council, the frontline workers on the one hand, and hospital administration on the other, serves only to widen the gap which might, in fact, be the cause of the problem in the first place?
A. Yes, and I think that's why you need the strong working relationships in place, because if they're there, you know, good times, great, but when the challenges come, you've got that lens of, you know, a constructive, "How do we work this out together?" So, yes, I think, you know, both sides - we on the medical side have the onus on ourselves to make sure we keep strong medical staff councils, keep those relationships going, so that we can, you know, raise those issues and keep that structure in place for future generations.

Q. If you do, undesirable though it is, reach a point

where the sorts of issues that you have identified in paragraph 34 as existing at Concord build to a level where there is that real discontent within the medical staff council, is it, in your view, incumbent upon executive or the administration to try and find solutions to that, to bridge that gap, in circumstances where a frayed medical workforce has reached a point where it might not be able to do so itself?
A. Yes, I think it's a bit unfair to just put it on one side. It has to be a two-way street. So, yes, if that - if difficulties arrive and they're escalating, this is where having, you know, good strong leaders on both sides to try and (a) nip it in the bud early but if it does circulate have, you know, those skill sets to be able to deescalate it and bring it back to a constructive way forward.

Q. On both sides, both within the medical staff council and within the executive, to the extent that things might have started to become problematic through burnout and other causes, it really comes down to strong and appropriate leadership on both sides aimed at finding - collaborating to find solutions to the problems rather than entering into a situation of conflict with one another?
A. Absolutely.

Q. Could I take you to paragraph 39, finally. You tell us a little bit there about what you perceive to be one of the structural issues that you think might have contributed to the communication problems being the clinical stream structure.
A. (Witness nods).

Q. From your perspective, could you just explain to us what you understand - or how the clinical streams structure worked within Sydney Local Health District, or didn't work, as the case may be?
A. Yes. So it's an interesting structure. Again, I share my experiences of both being within, obviously, a very messy clinical stream, I was in neurosciences, bone and joint health, ENT, immunology, like with eight to 10 other departments with very different issues, to mine as a rheumatologist, and as head of department. It was a parallel structure that felt like, you know, its roles were to look at a district lens on things. So obviously we, you know, have rheumatology services, for example, at all - RPA, Concord and Canterbury, so when you're planning

strategic allocation of those resources and things having a district lens on some of that strategic planning can be very useful.

What it doesn't do and what I found very challenging is, as the operational lead for your site, it doesn't connect in to that, and the way it was set up for us, you know, at least, when you've got one person who is trying to represent, you know, eight different departments, three different sites, so 20-plus different people often, who have completely different needs, aspirations, goals, you have set a process up to fail.

So I think it was seen very much as a reporting up, and what the clinical stream directors had was a direct line to the chief executive that the heads of department, who are running day-to-day business, did not have. So it disempowered heads of department, and that led to some conflict, I think, on the ground and some challenges around communication and identifying issues and having issues escalated up quickly through those levels.

I understand, you know, in a way if you're a chief executive, you cannot have 172 reports coming in to you and you need to look at how do you plan your resources with a district lens. So I think from my perspective, the clinical stream director, as someone on the ground trying to run a service, didn't help me very much, and I think what COVID taught us is we devolved back to division lines - division of medicine, division of surgery - and within that structure, those chairs don't actually sit up and have authority, even though that's where a lot of the feedback mechanisms are going.

So one of the things, yes, to try and prevent the next Concord-type situation and improve the rest of the district is to re-look at our medical structures and how they can better align and work together.

Q. In paragraph 40 you tell us about something that seems to have the capacity to exacerbate some of those problems with the structure, and that is the particular qualities of the people who sometimes get appointed into those roles. Again, I'm not for one moment suggesting that everyone who held those roles within Sydney Local Health District from time to time were not well intentioned and well qualified to hold them, but could you just explain to us in a little

bit more detail the problem that you identified there in paragraph 40 about the lack of diversity, in particular, in the people who hold those roles or have held those roles?
A. Yes, I think (a) you've got the structural problem, that then makes it very difficult for the people taking on those clinical leadership roles in truly representing the diverse interests of, you know, the subgroups that they are representing. I think historically what we saw was the same people in those roles for very long periods of time and so we didn't necessarily have a time period for re-looking at re-election of those roles, like we do with many other, I guess, leadership roles, and that would be another suggestion, I guess, moving forward.

I think the position description of those needs to match, you know, the time that those people can spend. If you truly want someone to represent properly 10 different departments across three different hospitals, you need to have the right FTE attached to that to be able to do it.

So I think we either need to change the structure, we need to look at selection processes and how, you know, we create succession planning, skill development, turn those roles over so that we improve leadership I think across the district and then, you know, also look at - my final point, which has gone. I probably need some sugar. Apologies. I've forgotten my train of thought.

Q. You may not know this, but is the clinical stream structure where you have this smaller group of clinical stream directors who are reporting to the chief executive, a unique feature of the Sydney Local Health District or is it something which has been rolled out in other districts?
A. We have a new acting at the moment and he has certainly said that's not the way he runs things and he found it unique.

MR MUSTON: Thank you, Dr Richards. I have no further questions of you.

THE WITNESS: Thank you.

THE COMMISSIONER: Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Dr Richards, thank you very much for

your time. We're very grateful.

THE WITNESS: Pleasure.

THE COMMISSIONER: You are excused.

MR MUSTON: I think the only thing that flows out of that is that you have set the Inquiry team, and indirectly Dr Richards, some homework in relation some of that --

THE WITNESS: I'll send you some studies.

MR MUSTON: I will cause someone to reach out to you in relation to that.

THE WITNESS: No problem.

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THE COMMISSIONER: All right. So we adjourn until 10 o'clock on Monday?

MR MUSTON: 10 o'clock on Monday.

THE COMMISSIONER: Thank you all. We'll adjourn until 10 o'clock on Monday.

AT 3.39PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO MONDAY, 5 AUGUST 2024 AT 10AM

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