

**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

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

3
4 MR MUSTON: Shall I continue?

5
6 THE COMMISSIONER: Please do, yes.

7
8 <ANDREW ROBERT HALLAHAN, on former affirmation: [10.08am]

9
10 <EXAMINATION BY MR MUSTON CONTINUING:

11
12 MR MUSTON: Q. Dr Hallahan, I think we were in the
13 middle of looking at the minutes of the meeting of
14 12 October 2023, which you will find in the second of those
15 two volumes at H7.12.59. For the operator, it's
16 [SCI.0012.0036.0001].

17
18 THE COMMISSIONER: Could you repeat that reference,
19 please?

20
21 MR MUSTON: Sure. So it's H7.12.59 and it's up on the
22 screen there.

23
24 Q. We were looking, I think, at page 37. Do you see
25 there's a discussion towards the top of the page about the
26 bandaid solutions, and then you see attributed to
27 Dr Cheung, he seems to say, "What they want, Andrew, what
28 they want"; do you see that?

29 A. Mmm-hmm.

30
31 Q. It would appear from what immediately follows that you
32 felt he had interrupted you again at that point?

33 A. It would appear so.

34
35 Q. And you see your response there:

36
37 *It's incredibly disrespectful for you to*
38 *interrupt me while I'm trying to make*
39 *a point.*

40
41 *[That's] what you have just done. It's not*
42 *okay. I'm trying to actually make*
43 *a reasonable point to you. And to the*
44 *group. Do you understand that?*

45
46 Did you really have any doubt about whether or not
47 Dr Cheung understood that point that you were making to him

1 about interrupting?

2 A. I needed him to acknowledge that, yes.

3

4 Q. Did you really have any doubt about his understanding
5 that interrupting was, to use your word, "disrespectful"?

6 A. Yes, I did have doubt.

7

8 Q. What was the reason that you had a doubt about that?

9 A. He was heightened, he was angry, and it seemed to me
10 that he had poor control of his emotions at that point in
11 time, so I had reasonable doubt that he understood.

12

13 Q. Did you think that that situation would be improved by
14 asking him whether he understood that it's disrespectful to
15 interrupt people?

16 A. I felt it was necessary to make that point. Yes.

17

18 Q. You felt it was necessary. My question to you was:
19 did you think that it would have assisted the situation for
20 you to ask him that question?

21 A. In the context of the situation that was playing out,
22 yes, I did.

23

24 Q. Did you think that was likely to reduce the tension in
25 the volatile situation that you were presented with at that
26 meeting?

27 A. Remember, this was a fluid and dynamic meeting and,
28 yes, I was hoping to achieve that.

29

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

41

42 *I'm sorry, the capital works ...*

43

44 et cetera. Then you said:

45

46 *They said real and substantive actions.*

47 *I hear what you're saying. I hear the*

1 *distress and I'm really sorry for the*
2 *thing.*

3

4 Is there any chance that after you've said, "I hear the
5 distress and I'm really sorry for the thing", that he might
6 have interpreted that you had finished that point and
7 wanted to go on to make his own point?

8 A. Without the benefit of a full recording and given the
9 passage of time that has passed, I find it very difficult
10 to answer your question, I'm sorry.

11

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

14

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

21 A. That was not my intent.

22

23 Q. Again, that wasn't quite my question. Whilst it may
24 not have been your intention, is it possible that - well,
25 let me take it in two steps. It's possible, is it not,
26 that you had become by that stage quite frustrated by the
27 way in which you were engaging with Dr Cheung at that
28 meeting?

29 A. I think my words would indicate that I did say to him
30 that I found it incredibly disrespectful for him to
31 interrupt me while I was trying to make a point.

32

33 Q. You felt that he had not been respectful to you?

34 A. I felt he had been "incredibly disrespectful" were my
35 words, yes.

36

37 Q. It is likely, is it not, to have caused you to feel
38 some frustration?

39 A. I would be less than human if I did not feel some
40 frustration, that is correct.

41

42 Q. Both the tone and delivery of your question at the end
43 of that, "Do you understand" - my question to you is do you
44 accept that that is potentially going to have been
45 influenced by that frustration?

46 A. I can't make comment on tone.

47

1 Q. Is it possible, do you think, that that response could
2 have been, as it were, you vocalising your frustration with
3 the situation?

4 A. Again, this is an imperfect transcript. It does not
5 capture the full context of what was happening. My memory
6 is that I was not seeking to do that, but I agree, it is
7 possible you could interpret this imperfect transcript in
8 that manner.

9

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

11

12 *I'm listening, Andrew, I'm listening.*

13

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

18

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

21

22 Do you see that?

23

24

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

28

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

31

32 Again, who was that directed at, do you recall?

33

34

35

36 Q. So in relation to all of the members, the great
37 majority of them had sat silently throughout this meeting,
38 had they not?

39

40

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

43

44

45

46

47

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

1 That was presumably directed at the whole of the meeting or
2 the attendees?

3 A. Yes.

4

5 Q. Did you not think that it might have been somewhat
6 disrespectful to have been suggesting to a large group of
7 your colleagues who had, to that point, sat quietly, that
8 they needed to, as it were, reflect on their own conduct?

9 A. I felt it was appropriate to ask them that, given that
10 they had, on multiple occasions, in my view, tolerated
11 disrespectful behaviour by their chair towards many members
12 of management.

13

14 Q. Tolerated disrespectful behaviour in what way? By not
15 leaving the meeting?

16 A. They had sat silent without raising any concerns.

17

18 Q. But that wasn't quite the question I asked you. Did
19 you think that it was not possibly, at least as viewed by
20 those, that overwhelming majority that sat silent
21 throughout that meeting, somewhat disrespectful for you to
22 be suggesting that their conduct was, in some way, less
23 than ideal?

24 A. With respect, I was of the view that that needed to be
25 called out. My view was that the conduct of these meetings
26 was characterised by bullying, intimidation and harassment
27 of the general manager, of myself and of other members of
28 the executive. My view was that members of the Concord
29 medical staff council had, on multiple occasions, witnessed
30 this and tolerated this, without calling it out.

31

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

39

40 Q. I'm going to ask you the question again. Perhaps
41 we'll remind ourselves that it is - the context in which
42 this meeting arose was, as I think you've already accepted,
43 the staff council believed that they were not being
44 listened to by the executive. That was a belief that they
45 genuinely held, albeit one which you did not share?

46 A. Yes. That is correct, that approximately 60 per cent
47 of the staff council had that belief. Yes.

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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

1 the transcript, was disrespectful?

2 A. Can you repeat your question, please?

3

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

7 A. Yes.

8

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

12

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

18

19 Is that the way you intend the question?

20

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

23

24 THE COMMISSIONER: Yes.

25

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

28 A. On more than one occasion, yes.

29

30 Q. And he raised his voice in an angry way at a point
31 during the meeting?

32 A. And he became - he appeared to become very heightened,
33 flushed in the face, spoke rapidly with a raised voice -
34 all the signals that he was enraged is the way
35 I interpreted it.

36

37 THE COMMISSIONER: Q. He might speak rapidly when he's
38 not in an angry state, but I understand the impression you
39 are trying to convey.

40 A. It is the combination of behaviours which I am just
41 trying to put to you. It is difficult to capture what
42 happened in this meeting in a transcript. It really does
43 not do it justice.

44

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

1 faces on your screen at your computer as you sat at your
2 desk?

3 A. He was the main face.

4

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

9 A. Yes.

10

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

16 A. Mmm-hmm. Yes.

17

18 Q. I want to suggest that, perhaps viewed from the
19 perspective of Dr Cheung, your own conduct during that
20 meeting might not have been regarded as entirely
21 respectful. Would you agree with that?

22 A. With the deepest respect, no.

23

24 Q. You don't accept that someone in Dr Cheung's position,
25 listening to what you have said to him, as recorded in this
26 transcript, might have regarded that as somewhat
27 disrespectful?

28 A. No, I do not accept that. My view was that I was
29 seeking to remain calm and appropriate and clear.
30 I continue to hold that view.

31

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

34 A. Yes.

35

36 Q. It's a fairly serious step to take against the
37 background of the situation which you were confronted with,
38 particularly having regard to what you understood to be one
39 of the principal concerns of the medical staff council -
40 namely, the risk of reprisal for those who spoke out?

41 A. I'm sorry, I can't make out your words.

42

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

46 A. They had said that a number of times.

47

1 Q. What I'm suggesting is, making a disciplinary
2 complaint against Dr Cheung, the spokesman of that group,
3 in those circumstances, was a not insignificant step to
4 take against that background; do you agree?
5 A. I made a complaint --
6
7 Q. Just stick with my question first, if you wouldn't
8 mind.
9 A. Well, can I just --
10
11 Q. Did you think it was a significant step to take
12 against that background - yes or no?
13 A. Yes, it was a significant step.
14
15 Q. Did you speak to anyone about it before you took that
16 step?
17 A. Yes, I considered it and I spoke to several people.
18
19 Q. Who?
20 A. I - the passage of time means I can't recall the
21 entire group of people I spoke to.
22
23 Q. Could you recall any of the people you spoke to about
24 the possibility of making a disciplinary complaint against
25 Dr Cheung arising out of the way he behaved during that
26 meeting?
27 A. Not with absolute certainty at this point in time.
28
29 Q. Do you recall speaking to the chief executive about it
30 before you took that step?
31 A. No, I don't.
32
33 Q. Why did you take the step of making a disciplinary
34 complaint against Dr Cheung arising out of the way he
35 conducted himself during that meeting?
36
37 MR CHIU: I'm sorry, I didn't hear that.
38
39 MR MUSTON: Q. Why did you take the step of making
40 a disciplinary complaint against Dr Cheung arising out of
41 the way in which he conducted himself at that meeting?
42 A. It was not - it was a complaint. So you say
43 "disciplinary complaint"; it was a complaint about
44 behaviour which we would describe as a workplace grievance.
45 It had the potential to lead to disciplinary action, but
46 not necessarily. It was simply to put that forward for an
47 initial assessment.

1
2 The reason that I did that was because, in my view, it
3 is important that we treat each other with respect at all
4 times. That is actually a core value of our organisation
5 and, in my view, it is important to call it out where that
6 occurred - where that does not occur.

7
8 Other members of that medical staff council had made
9 the observation previously that they had felt bullied by
10 Dr Cheung in the way that the meetings were run and --

11
12 THE COMMISSIONER: Q. Sorry, just so I understand
13 something, when Mr Muston asked, "Did you speak to anyone
14 before making this workplace grievance complaint", you said
15 you did but - and I understand, it's a while ago, but did
16 you mean to convey you definitely did not speak to the
17 chief executive or you can't remember whether you did or
18 you didn't?

19 A. I can't remember, to be fully honest.

20
21 Q. Right. And is there anyone, sitting here now, that
22 you definitely do recall you spoke to?

23 A. There are a number of colleagues at work who I did
24 speak to in reflecting on what happened in that meeting, as
25 I would normally do. That's part of our normal process and
26 part of what would normally happen in the workplace,
27 particularly when you have a significant conversation.

28
29 Q. By that, do you mean it's pretty normal for you to
30 speak to your colleagues to say something like, "There was
31 a meeting last night and it wasn't a particularly pleasant
32 one. This is what happened" --

33 A. Yeah.

34
35 Q. -- that sort of thing?

36 A. Yeah, that sort of thing.

37
38 MR MUSTON: Q. You said a moment ago that - you tried to
39 draw the distinction between a workplace grievance and
40 a disciplinary matter. I think the point, correct me if
41 I've not understood you correctly, that you were making was
42 that the workplace grievance wouldn't necessarily become
43 a disciplinary matter if it failed to pass through the
44 initial assessment phase; is that right?

45 A. Correct. A workplace grievance can go in different
46 directions. To be honest, what I was hoping for was that
47 we could arrange a facilitated discussion, a mediation

1 between myself and Dr Cheung, so we could have a more civil
2 and respectful dialogue than we'd previously been able to
3 have. It is an ongoing regret that that has yet to occur.
4

5 Q. Who did you make that complaint to?

6 A. The complaint was made in the way - in the form of
7 a letter to Ms Gina Finocchiaro, who is our director of
8 workforce and corporate operations.
9

10 Q. You didn't consider at the time that you made that
11 complaint, did you, that it was not going to pass through
12 initial assessment?

13 A. I was open to an objective assessment of the
14 complaint. I wasn't trying to pre-guess it, to be honest.
15 I simply wanted to have a fair process that I was hopeful,
16 consistent with the policy, would result in a pathway to
17 resolution and improvement of the relationship between
18 myself and Dr Cheung.
19

20 Q. But what I'm asking you is, at the time you made the
21 complaint, you believed it was of sufficient substance, did
22 you, to pass through the initial assessment phase?

23 A. I believed it was of sufficient substance to deserve
24 an initial assessment. I did not prejudge the outcome of
25 that assessment.
26

27 Q. So let me understand this: in complaining about his
28 conduct, you weren't sure whether it was sufficiently
29 serious to pass through initial assessment but you thought
30 it was worth making in order to check whether it was?

31 A. The point of making it was to commence a process which
32 would allow Dr Cheung and myself to come to a better
33 working relationship.
34

35 THE COMMISSIONER: Q. Could you have, rather than
36 commencing this process, gone and seen him the next day and
37 knocked on his door or just contacted him and said, "Can we
38 have a coffee or a discussion because I wasn't particularly
39 happy about the way the meeting was run", and then just had
40 a discussion with him? Was that open to you?

41 A. Theoretically. Sadly - and it is sad - the
42 relationship between myself and Dr Cheung had never been
43 good. We had had multiple interactions since his election
44 and, to be completely frank, I do not believe that
45 a one-on-one conversation without any structure or process
46 would have done anything other than exacerbate an already
47 very difficult situation. I felt that it was important to

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

7
8 MR MUSTON: Q. Did it occur to you that that structure
9 or process could have been facilitated by some other means
10 than by lodging a workplace grievance through the
11 disciplinary process against Dr Cheung?

12 A. Again, it's an interesting question. I did consider
13 this carefully. This is a well-defined process and pathway
14 which has - activates the appropriate mechanisms and
15 skills, and there is not a readily available alternative
16 process that I felt was appropriate and fit for purpose.

17
18 I would also note the genesis of this is that, in my
19 view, there was potentially a breach of the value of
20 respect and civility in front of a large audience --

21
22 Q. Which --

23 A. -- and that was important to address.

24
25 Q. Are you talking about Dr Cheung or --

26
27 MR CHENEY: Can he be allowed to finish that answer,
28 Commissioner? There has been a searching examination of
29 this witness's motivations. He should be allowed to finish
30 his answer.

31
32 MR MUSTON: Q. Please continue.

33
34 THE COMMISSIONER: Q. Well, there was a natural end to
35 the sentence, but I'll just ask, had you finished your
36 answer?

37 A. I'm happy that I have said enough with that answer.

38
39 MR MUSTON: Q. Would it not have been possible to have
40 arranged for some sort of facilitated discussion with
41 Dr Cheung of the type you felt would be useful by merely
42 speaking to the chief executive or someone within the
43 workplace group and asking whether assistance could be
44 provided for you to facilitate such a discussion, without
45 the need to lodge a workplace grievance against Dr Cheung?

46 A. Anything is possible. My judgment was this was the
47 appropriate pathway to take under the values and policies

1 of NSW Health which I align with.

2

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

9 A. I do.

10

11 Q. You didn't include any particulars of those aspects of
12 your concerns in the complaint that you lodged against
13 Dr Cheung, did you?

14 A. No.

15

16 Q. Did you ever raise particulars of those concerns that
17 you held with Dr Cheung?

18 A. No. I would note that in a previous meeting, a member
19 of the medical staff council had openly said that she felt
20 she was being bullied, and I would note that there had been
21 no response to her in that meeting.

22

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

26 A. It was.

27

28 Q. She chose not to?

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

41

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

1 facility is not necessarily a fair indication of the
2 culture of that facility?

3 A. So if we switch to the broad subject of workplace
4 culture and how that correlates with a number of
5 complaints, is that - do I understand your question
6 clearly?

7
8 Q. Yes. So to the extent that one might think
9 objectively the number of complaints made might be some
10 indication of a culture within a workplace, within this
11 particular and unique environment of health, where the
12 making of complaints is something which people have
13 concerns about, the statistics that you might have about
14 the complaints might not be such a reliable measure of the
15 workplace culture. Would that be fair?

16 A. I don't know the answer to your question, Mr Muston.
17 I have never seen statistics correlating complaints with
18 workplace culture and other validated measures of culture.
19 I truly don't know. I think it is a very interesting
20 question and probably worthy of further study.

21
22 Q. I think at the very beginning of your evidence
23 yesterday when we were exploring the three core concerns
24 that people had at Concord, the third of which being the
25 reluctance to speak out for fear of reprisals, you answered
26 by indicating that you were genuinely puzzled by that
27 concern because you were not aware of any evidence of that.

28 A. And my view remains that Concord clinicians -
29 amongst - most of our clinicians are actually quite happy
30 to speak up.

31
32 Q. My point being, to the extent that there was a concern
33 about that, the absence of any complaints or of any
34 expressed concerns might not actually be indicative of the
35 true mood of that group in circumstances where they are, as
36 you've told us, disinclined to speak out for fear of the
37 consequences?

38 A. I think we do need to distinguish between speaking up
39 about, say, a service concern and making a workplace
40 grievance against an individual colleague. I would say in
41 health, as a very human and relationship-based area, we are
42 very generally quite reluctant to raise grievances against
43 individuals. I would also say that, in my experience,
44 clinicians across Sydney Local Health District, not
45 necessarily just Concord, and across NSW Health generally,
46 are quite happy to speak up, to raise concerns about
47 service delivery, and that is something which we, as

1 executive, welcome and encourage.

2
3 Q. Do you think that the lodging of the workplace
4 grievance had the capacity to reinforce at least
5 Dr Cheung's view, and those of the medical staff council
6 who became aware of it, that those who speak up would
7 suffer reprisals?

8 A. I did consider this very seriously. I did not make
9 this formal notification lightly, because there were
10 potential consequences that could be negative. However,
11 while I do acknowledge that could have been the case, it
12 also, to me, remained important that the values,
13 particularly the value of respect and civility, which
14 I hold very dear, were honoured.

15
16 Q. So amongst those potentially serious consequences, did
17 you consider that one of them was the risk that the
18 concerns held by a large group of the medical staff at
19 Concord hospital that there would be reprisals for those
20 who spoke out would be reinforced?

21
22 MR CHENEY: Commissioner, may I, respectfully, inquire the
23 utility of this line of examination. Is the suggestion
24 going to be that one who is considering what one regards as
25 inappropriate workplace conduct should refrain from making
26 a complaint about it through fear that that will engender
27 a concern about reprisals in others?

28
29 THE COMMISSIONER: No, that's not what I understand
30 Mr Muston is exploring. Perhaps I'll do it.

31
32 Q. I understand entirely what you have said to me about
33 the difficult relationship you told me you have had with
34 Dr Cheung and I also understand what you have told me, and
35 fully accept, the value you have told me you place on
36 respect and civility.

37
38 I think what Mr Muston, though, is putting to you is,
39 sitting here now, do you accept that one of the risks of
40 making the complaint against Dr Cheung that you did,
41 a formal-type grievance complaint, is, regardless of what
42 Dr Cheung thought about it, it risked - to those people at
43 the hospital that did have the genuine view that they are
44 not listened to or that if you speak out you can get in
45 trouble, as we've discussed, that it risked - and there's
46 a balance here, but one of the risks of it was that it
47 risked reinforcing to them the notion, whether it's right

1 or wrong, that if you speak out about what you feel is
2 a genuine problem or complaint with the hospital, that you
3 can get in trouble?
4

5 MR CHENEY: Commissioner, that was not the question that
6 was - the way it was put by Mr Muston.
7

8 THE COMMISSIONER: Well, it's the question I'm asking.
9 I'd like an answer to it, thank you.
10

11 THE WITNESS: Yes, I agree with you.
12

13 THE COMMISSIONER: Q. Okay, thanks.
14 A. And, if you permit me --
15

16 Q. Yes, go ahead.
17

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

25 THE COMMISSIONER: All right.
26

27 MR MUSTON: Q. Since you made the complaint, there has
28 been a lengthy restorative action process undertaken at
29 Concord hospital, facilitated by a group called ProActive
30 ReSolutions; is that correct?
31

32 A. Yes. I believe it was actually in progress well prior
33 to me making this complaint.
34

35 Q. That being the case, did you consider the possibility
36 of using that process to try and bridge the void that had
37 opened up in the relationship between you and Dr Cheung?
38

39 A. I did not, as my understanding of their work was that
40 it was around broad workplace culture and was not intended
41 to mediate concerns between individuals, for which there is
42 a fit for purpose pathway through skilled workforce.
43

44 Q. You were involved in that process, though?
45

46 A. Not deeply, Mr Muston, to tell the truth. I had one
47 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

1 speak to the details of that process.

2

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

7 A. I would have --

8

9 Q. I don't say it critically, but it did not involve you?

10 A. I was not invited by ProActive ReSolutions to be
11 a part of that. So there was no - nothing I said "no" to,
12 however, the focus, as I perceived it - and I felt it was
13 appropriate at the time - was they were focused on Concord
14 hospital and how it was working, and there was less
15 involvement of my position in that.

16

17 Q. Did anyone at any point share with you the conclusions
18 which had been reached by Mr McDonald about the root causes
19 of the problems at Concord hospital?

20 A. I'm aware of the restorative action plan. I have not
21 seen other reports.

22

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

25

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

27

28 MR CHENEY: No, Commissioner.

29

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

32

33 THE WITNESS: Thank you, I appreciate it.

34

35 THE COMMISSIONER: You are excused.

36

37 **<THE WITNESS WITHDREW**

38

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

41

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

45

46 **SHORT ADJOURNMENT**

47

1 THE COMMISSIONER: Yes, we're back.
2
3 <JOSEPH JOHN JEWITT, affirmed: [10.54am]
4
5 <EXAMINATION BY MR MUSTON:
6
7 MR MUSTON: Q. Mr Jewitt, could you state your full name
8 for the record, first?
9 A. Thank you. Joseph John Jewitt.
10
11 Q. And you are the acting general manager of Concord
12 Repatriation General Hospital, within the Sydney Local
13 Health District?
14 A. I was.
15
16 Q. What's your current role?
17 A. I've recently changed. Chief of staff of the office
18 of the chief executive.
19
20 Q. When did you move into that role?
21 A. Monday.
22
23 Q. Very recent.
24
25 THE COMMISSIONER: Q. Chief executive of the Sydney LHD?
26 A. Yes, Sydney Local Health District.
27
28 MR MUSTON: Q. That would be Mr Loy?
29 A. Yes, that's correct.
30
31 Q. You held the role, though, as acting general manager
32 of Concord Repatriation General Hospital from 5 September
33 2022?
34 A. That's correct.
35
36 Q. And you prepared a statement to assist the Inquiry
37 with its work dated 4 July 2024?
38 A. That's correct.
39
40 Q. Do you have a copy of that statement with you?
41 A. Yes, I do.
42
43 Q. And have you had a chance, before coming to give your
44 evidence today, to refresh your memory and read through it?
45 A. Yes.
46
47 Q. Are you satisfied that the contents of it are, to the

1 best of your recollection, true and correct?
2 A. There are just two changes.
3
4 Q. Yes, please, what are they?
5 A. The first is obviously my occupation has changed.
6
7 Q. Yes.
8 A. The second relates to paragraph 18. Let me just
9 double-check that. I make reference to the draft strategic
10 plan being discussed at an MSC meeting on 27 April.
11
12 Q. Yes.
13 A. It's on the agenda for that meeting but I haven't been
14 able to locate the minutes of that meeting to confirm, but
15 it was discussed at the MSC on 13 April. So just in terms
16 of clarity, it's my understanding it was the 27th but
17 I don't have minutes to prove that.
18
19 Q. Your best recollection is at a meeting at or around
20 that time, it was discussed with the medical staff council?
21 A. Yes, that's correct.
22
23 Q. Thank you. In your capacity, or in your former role,
24 you attended I think you tell us in paragraph 21, meetings
25 of the Concord medical staff council?
26 A. Yes, that's correct.
27
28 Q. In attending those meetings, did you get a sense that
29 at least some members of the medical staff council had some
30 concerns?
31 A. Yes, that's correct.
32
33 Q. Was the morale, to your observation, of at least
34 a portion of the medical workforce at Concord, reasonably
35 low?
36 A. In a - for some individuals, and in maybe some
37 departments, yes, that's correct.
38
39 Q. Amongst those concerns, did you have an awareness
40 through your attending these medical staff council meetings
41 that there was at least a group of people within the
42 medical staff who felt isolated from one another and from
43 the administration?
44 A. I'm not sure what you mean by "one another"?
45
46 Q. Well, let's take it in two steps. Did you get that
47 sense, or get a sense that there was a group of people

1 within the medical workforce at Concord who felt isolated
2 from the administration?

3 A. I think there was a group of people who were
4 unsatisfied with responses they had received from
5 administration. I'm not aware of them feeling isolated.
6 That wouldn't be the word I would use. But there certainly
7 were members of the medical staff council who were - who
8 remained dissatisfied with decisions or - made by the
9 executive, yes.

10
11 Q. There was a group who felt their workload and job
12 demands had increased?

13 A. Yes.

14
15 Q. There was a group who felt that administrative tasks
16 had escalated without relative increase in administrative
17 support?

18 A. Yes.

19
20 Q. Perhaps picking up on something you said a moment ago,
21 would it be more accurate to say that there was a group
22 within the medical staff who felt that they were not
23 valued, seen or heard?

24 A. I think they - yes, I think for some, that is correct.

25
26 Q. They felt that they had less access to administration
27 to raise issues than other people within the local health
28 district?

29 A. That's what they - yes - put forward, yes.

30
31 Q. And that when they did raise issues or seek to raise
32 issues, it was their belief that those issues were not
33 being adequately addressed?

34 A. Yes, that's correct.

35
36 Q. Would it also be right to say that there was a group
37 who felt that there was an unfairness in resource
38 allocation at Concord when compared with other hospitals?

39 A. Yes.

40
41 Q. And that there was a lack of transparency about how
42 decisions relating to Concord were being made?

43 A. Yes.

44
45 Q. And that there was a lack of consultancy and shared
46 decision-making in relation to decisions relevant to
47 Concord?

- 1 A. I don't - yes, I think for some, yes.
2
3 Q. That is to say, it was their belief?
4 A. Yes.
5
6 Q. Just putting to one side for present purposes whether
7 you felt that their belief was justified, did you have any
8 reason to doubt that that was their genuine belief - that
9 is to say, they genuinely felt that way?
10 A. I think for most of them, yes, that was their genuine
11 belief and understanding.
12
13 Q. In your experience working within the medical sector,
14 do you have a sense that, or have you developed a sense
15 that there is a culture within medicine not to speak up or
16 make waves for fear of reprisals or being seen as difficult
17 or as a troublemaker?
18 A. No.
19
20 Q. Could I take you to paragraph 22 of your statement,
21 please.
22 A. Yes.
23
24 Q. Do you have that there?
25 A. Yes, I do.
26
27 Q. You tell us there about a letter that was received by
28 Dr Genevieve Wallace dated August 2022?
29 A. Yes.
30
31 Q. So we can understand the timeline, did you replace
32 Genevieve Wallace in the acting role that you stepped into?
33 A. Yes, that's correct.
34
35 Q. So the letter of 24 August 2022 had been sent to
36 Dr Wallace?
37 A. That's correct.
38
39 Q. She then moved into a different position. You moved
40 into her position and picked up the letter to act on it as
41 the then person acting in that position?
42 A. Well, I was - yes, I was aware that that the letter
43 had been provided and during handover Dr Wallace had
44 discussed the letter with me, yes.
45
46 MR MUSTON: Perhaps we could get that letter up on the
47 screen. Within the folders, it is H1.22.

1
2 Q. I think, Mr Jewitt, we will get it on you screen
3 instead of burdening you with a folder if that's okay.
4 A. Yes, thank you.
5
6 Q. We'll get it put up on the screen instead of burdening
7 you with a folder, if that's okay, but if you would like
8 a hard copy, let me know, we can arrange it.
9 A. Okay.
10
11 MR MUSTON: For the operator, it is [MOH.0010.0002.0001].
12
13 Q. It will come up in a minute. It's that screen to your
14 right or there's a larger screen immediately in front of
15 you, whichever one works best for your eyes.
16 A. Okay, thank you.
17
18 Q. As I say, if you need a hard copy, let me know, we can
19 arrange that for you.
20 A. Thank you.
21
22 Q. You see there, that's an email, at the foot of that
23 page, from Dr Cheung to Dr Wallace?
24 A. Yes.
25
26 Q. Dr Wallace seems to have forwarded it to Lorna Arkell.
27 Who was Lorna Arkell in the ecosystem?
28 A. I'm not sure at that time, to be honest, no, I don't
29 know.
30
31 THE COMMISSIONER: Given we're on the topic of or we have
32 been on the topic of respect and not, I've been saying
33 "Cheung", is it "Jeung"?
34
35 MR CHIU: "Jeurn".
36
37 THE COMMISSIONER: My apologies, thank you.
38
39 MR MUSTON: In my attempt to pronounce his name
40 correctly, I've been pronouncing it incorrectly as well,
41 for which I genuinely apologise.
42
43 THE COMMISSIONER: If we were allowed to use Winston, it
44 would be so much easier for me, but anyway, I apologise for
45 mispronouncing his last name.
46
47 MR MUSTON: That has caused me to lose my train of thought

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

3
4 Q. I will just give you an opportunity to read through
5 that letter and refresh your memory as to what was being
6 suggested in it. When you need it to be scrolled down,
7 please just let us know.

8 A. Scroll down. Yes.

9
10 Q. In paragraph 22 of your statement you tell us that
11 you'd become aware of a proposal that the medical services
12 council wanted to undertake a performance review of the
13 executive and the local health district's executive. Is
14 that last paragraph of the letter under the heading
15 "Feedback on the Performance of the Concord and SLHD
16 Executives" what you had in mind when you wrote that?

17 A. Yes, that's correct.

18
19 Q. They weren't, in that paragraph, suggesting that they
20 would be taking any formal role in terms of the performance
21 reviewing of either the hospital's executive or the LHD's
22 executive, were they?

23 A. Well, it's unclear to me what that proposal was. But
24 an anonymous survey that is then publicly capturing and
25 then presumably reporting on the performance of individuals
26 in the executive has a level of formality about it, I would
27 say.

28
29 Q. All they were asking to do, though, wasn't it, was to
30 use their language, "provide the Concord and SLHD
31 executives with constructive feedback on their
32 performance"?

33 A. I mean, that's what's proposed there, but I - a broad
34 anonymous survey then providing feedback publicly to
35 members doesn't necessarily afford people the ability to
36 understand where that feedback is coming from and
37 procedural fairness in responding to that.

38
39 Q. But the use of an anonymous survey that had privacy
40 protections built in might have been a more efficient way
41 of gathering the entire medical staff council's collective
42 thoughts about performance of the executives at both the
43 hospital and within the local health district than, say,
44 a large meeting where everyone got their turn to air their
45 grievances, as it were, would it not?

46 A. It might be efficient in capturing the information.
47 I'm not sure that it would be as helpful to me and my team

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

8
9 Q. The "People Matter" survey is cast at a level where it
10 probably couldn't really be described as constructive
11 feedback on the performance of the executive of the
12 hospital and of the local health district, could it?

13 A. Sorry, can you --

14
15 Q. The "People Matter" survey is cast at such a level -
16 at a high level, such that it couldn't really provide the
17 kind of constructive feedback on the performance of the
18 hospital and LHD executives as was contemplated by this
19 proposal, could it?

20 A. Well, there's not a lot of detail in the proposal put
21 forward by the MSC, so it would be unclear what the
22 questions would be and what would be the detail of the
23 information. The value of the "People Matter" survey is
24 that it allows to you benchmark against each of those
25 items, both within the district, other districts and the
26 health sector and also the public service. So that gives
27 you a much clearer sense of how you might be performing
28 relative to other parts of the public sector, which I think
29 is useful.

30
31 Q. Coming from a group of people, a portion of which, at
32 least, held the concerns that we've identified already
33 about not being heard and being, perhaps, isolated from the
34 executive, is another way of interpreting this as merely an
35 attempt to try and provide information and feedback in
36 relation to those concerns which they felt they were not -
37 had not been listened to in relation to --

38 A. I think my concern in relation to that proposal was it
39 potentially set up an adversarial relationship with the
40 executive of the MSC, which is not what I wanted to do.
41 I wanted to be able to have the ability to have open,
42 honest conversations with the MSC and to be able to build
43 a more collaborative relationship, and I think, you know,
44 withstanding the fact that there is a significant lack of
45 detail on what the proposal is, that proposal to me didn't
46 seem to be moving in that kind of direction.

1 Q. But on one view, all the proposal was seeking to do
2 was to advise - provide a mechanism for advising the
3 executive about the particular concerns that people within
4 the medical staff council had in relation to their
5 performance and the way in which they had been engaging
6 with the staff at Concord?

7 A. It may. The issue would be the nature of the
8 questions and the methodology to really understand that.

9
10 Q. Did you ever explore with Dr Cheung what the nature of
11 the questions might have been and the way in which the
12 answers to those questions might have been used to provide
13 constructive feedback?

14 A. It's my understanding that this matter was resolved
15 before I officially came on board in the role of acting GM.

16
17 Q. But you tell us in paragraph 22 that you considered
18 the proposal fell outside of the proper role for the
19 medical staff council under the by-laws?

20 A. Yes, that's correct.

21
22 Q. Is it the case that that's a view you reached about
23 a matter which had already been dealt with by Dr Wallace?

24 A. Yes.

25
26 Q. So you had no role in the decision-making process
27 which led to this proposal not proceeding?

28 A. That's correct.

29
30 Q. Okay. Just moving down to paragraph 23, at a
31 conceptual level, is there a problem, as you see it, with
32 members of the medical staff council wanting to hold the
33 hospital and district executives accountable, to the very
34 limited extent that an advisory and consultative body can?

35 A. I think if it - certainly in providing feedback,
36 absolutely. I think the dynamic did not feel as if it was
37 being advisory and providing feedback at times.

38
39 Q. In what sense?

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

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

3
4 Q. Is it not also a two-way street: the executive, both
5 at the district level and at the hospital level, are there
6 to support members of the medical staff council to deliver
7 care to patients --

8 A. Yeah, absolutely.

9
10 Q. -- who use the hospital?

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

19
20 Q. Did that perception, do you think, influence the way
21 the executive was dealing with the concerns that the MSC
22 were expressing - that is to say, the perception that what
23 the MSC was seeking to do was to exercise a different role
24 to that which it ought to have had, namely, as an advisory
25 and consultative body?

26 A. At times, yes.

27
28 Q. In what way do you think it influenced the way in
29 which the executive was dealing with the MSC?

30 A. Speaking for myself, what that had flagged for me was
31 the need to build a rapport and a relationship with people
32 in the MSC to avoid a situation where the dynamic was
33 adversarial, and working with the departments and key staff
34 who were expressing concerns through the MSC, to make sure
35 that we were addressing those concerns and working with
36 them as best we could to respond to their concerns and
37 issues being raised as a way of avoiding an ongoing kind of
38 adversarial relationship.

39
40 Q. So, to put it very simply, doing your very best to
41 take steps to ensure that the concerns that they had in
42 relation to not being listened to, not being consulted with
43 about decisions, were actually being addressed --

44 A. Yes.

45
46 Q. -- by consulting with them --

47 A. Yes.

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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

1 proposal, as you understood it, which was being put to the
2 MSC?

3 A. My understanding was that the chair was very keen to
4 see the issues that were being experienced at Concord as
5 being much broader and, therefore, there needed to be
6 broader system change achieved and, therefore, wanted
7 advocacy for a broader sort of system review.

8

9 Q. What was your concern about that?

10 A. There were members of the MSC who were concerned that
11 that was going beyond the remit of what the Concord MSC
12 should do and should be focused on, so I was concerned
13 about, you know, the MSC itself not being able to kind of
14 function properly.

15

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

21

22 Q. If there was a group of members of the medical staff
23 council who were of a different view, though, was there any
24 real problem with them discussing it during the course of
25 those meetings?

26 A. I was unaware of who else had that view. I was aware
27 the chair had the view, because the chair was the one
28 expressing that view, but I wasn't aware of necessarily
29 others sharing that view.

30

31 Q. Would there have been a problem with the chair raising
32 those issues during the meeting and seeking to ascertain
33 whether or not there were others of a like mind within the
34 medical staff council?

35 A. Yes, and that's what happened.

36

37 Q. And at the conclusion of that, what was the decision
38 that was made, if any?

39 A. My recollection of the decision is that most of the
40 members of the MSC did not see it as the role of the MSC at
41 Concord to do that.

42

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

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

7
8 My concern was working with the MSC to ensure the MSC
9 was fulfilling its role in providing advice to the Concord
10 executive and the district executive, and I just felt that
11 these sorts of things were being driven by potentially
12 other interests or agendas, rather than actually working
13 with us locally to address the issues locally.

14
15 Q. What other interests or agendas did you have in mind?

16 A. I'm not sure, but there certainly seemed to be a view
17 of wanting to have a much broader - a broader inquiry into
18 the - broader parts of the health system and there seemed
19 to be no evidence or reason put forward at those meetings
20 that would warrant the concern or the need to do that.

21
22 Q. What sort of evidence do you imagine would have been
23 put forward in those meetings to warrant a wider inquiry of
24 the type that you've referred to in that paragraph?

25 A. Well, I would imagine it would have to be evidence
26 that would show that there was a system-wide approach and
27 that other parts of the system were interested in
28 supporting such an inquiry.

29
30 Q. But for that to happen, there would need to be
31 discussion, wouldn't there, about the way the wider system
32 has perceived the world relative to the way that Concord
33 was perceiving the world?

34 A. Yes, there would have to be some way of being able to
35 kind of assess that, yes.

36
37 Q. Is there a problem? If members of the medical staff
38 council at Concord were of that view and wanted to test
39 that, is there a problem with them doing so, in the context
40 of the medical staff council meeting?

41 A. I think that - certainly to have discussions at the
42 MSC, if there were concerns more broadly held, then - you
43 know, systems and processes at Concord, I think that would
44 be appropriate. To initiate such action, I think there are
45 other bodies that are most appropriate to do that than the
46 Concord MSC.

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

6 A. Yes.

7
8 Q. The investment in medical imaging infrastructure that
9 you're referring to there, is that investment which has
10 occurred or which occurred during the period in which you
11 were acting in the role?

12 A. Yes, it occurred during the period I was acting in the
13 role.

14
15 Q. Did that occur predominantly after the vote of no
16 confidence in the chief executive in June of 2023 occurred?

17 A. There were processes under way prior to that,
18 particularly in terms of replacement of the CT scanner, and
19 the third CT scanner, as well as planning and discussions
20 around the MRI. The replacement of the second CT scanner,
21 I think occurred after the vote of no confidence, and the
22 third CT scanner, the capital works, were completed and the
23 installation of that third scanner occurred afterwards,
24 yes.

25
26 Q. We've heard some evidence from a radiologist within
27 Concord who has expressed the view that equipment in the
28 radiology department was consistently being replaced after
29 its end of life as determined by the Medicare capital
30 sensitivity rules. Do you have a familiarity with those
31 rules?

32 A. A general familiarity, yes.

33
34 Q. And at least up until the point at which you took over
35 in your acting role, would it be - was that observation,
36 made by Dr Ridley, accurate?

37 A. No, I don't think so. Dr Ridley didn't provide any
38 specifics, as I recall, in relation to what particular
39 items had reached their capital sensitivity. In relation
40 to the CT scanners, I don't believe they had reached the
41 end of their capital sensitivity before they were replaced.

42
43 Q. When you say you don't think so, do you actually know
44 either way whether, at least in the period prior to you
45 taking up your role, equipment was not replaced until it
46 had reached a point after its end of life as determined by
47 those Medicare rules?

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

2

3 Q. In paragraph 35 you tell us about the business case
4 for the procurement of the second MRI scanner having been
5 approved and architectural plans for its installation
6 having been approved. When did that happen?

7 A. I don't have the dates on me.

8

9 Q. Do you have a ballpark for, at least, to the extent
10 you refer in paragraph 35 to the approval of the business
11 case, when that occurred?

12 A. I would have to check those dates.

13

14 Q. Were you aware that --

15

16 THE COMMISSIONER: Q. What's involved with the
17 architectural plans?

18 A. There needed to be plans drawn up to be able to - for
19 the capital works, for the installation of the second
20 scanner. So there wasn't a current sort of empty shell
21 that that scanner could go into, so there needed to be work
22 done to determine how we could, within the emergency
23 department, be able to create sufficient space, so it
24 involved moving, relocating other services in order to make
25 room for the scanner.

26

27 Q. It doesn't involve building a new room or building
28 a new building; it involves some building-type works to
29 enable it to fit in the space you already have; is that how
30 I should understand it?

31 A. Yes, that's correct, yes.

32

33 MR MUSTON: Q. Just so we're not at cross-purposes, was
34 that capital works in relation to the CT scanner in the
35 emergency department that you were talking about?

36 A. Yes, and it applies also to the MRI.

37

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

40

41 THE COMMISSIONER: What document is that?

42

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

45

46 THE COMMISSIONER: Is that, at the top, an email of
47 30 June 2023?

1
2 MR MUSTON: If we go forward to page 0003.
3
4 THE COMMISSIONER: I see, that's the 2016.
5
6 MR MUSTON: Yes. I note the time, Commissioner. It is a
7 little bit early, but by the time the document comes up -
8 I have several questions in relation to --
9
10 THE COMMISSIONER: It's only about 45 seconds early. You
11 want to take the break now; is that convenient?
12
13 MR MUSTON: It would reduce the pressure on the operator
14 who hasn't been given any fair warning of this document.
15
16 THE COMMISSIONER: All right. Why don't we take the
17 morning adjournment now and resume at 11.50. We will
18 adjourn until then.
19
20 **SHORT ADJOURNMENT**
21
22 THE COMMISSIONER: Yes?
23
24 MR MUSTON: Q. I think I was about to ask some questions
25 about [MOH.0010.040.0003] [sic] which is the "Health In
26 Brief for Major Procurement Committee SLHD" document, dated
27 16 November 2016, or variously dated 15, 16 and 18 November
28 2016.
29
30 THE COMMISSIONER: That's not it.
31
32 MR MUSTON: No, it's [MOH.0010.0404.0003].
33
34 THE COMMISSIONER: That's it.
35
36 MR MUSTON: If we can scroll forward to the third page, if
37 we could, operator. Thank you.
38
39 Q. Just have a look at that document, in the context of
40 the questions and answers immediately before the break
41 about the MRI. I just want to ask whether this is
42 a document that you're familiar with.
43 A. No, that's not a document I'm familiar with.
44
45 Q. Before the break, in answering some questions from the
46 Commissioner, you referred to the need to get some plans
47 prepared for the upgrade of the facility to enable it to

1 accommodate the physical beast that is an MRI machine?

2 A. Yes.

3

4 Q. Who within the LHD is responsible for preparing plans
5 of that type? When I say "who", let's start with the
6 group?

7 A. Well, capital works processes are led by a capital
8 infrastructure and engineering team. So they will lead
9 a process of working with key stakeholders to be able to
10 identify what are the needs of the capital works, what
11 needs to be accommodated. There's obviously reference to
12 facility guidelines and there are designers and planners
13 who have that expertise who provide that assistance. But
14 they oversee the process of the development of those
15 guidelines - those plans.

16

17 Q. The designers and planners involved in that process
18 that you referred to, they're not designers and planners
19 who are members of the workforce at Concord hospital - no?

20 A. No. No. They're part of a district service, yes.

21

22 Q. Could you just scroll down to paragraph 37 in your
23 statement.

24 A. Yes.

25

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

29 A. Yes.

30

31 Q. Could you, just for we laypeople, explain what the
32 changes in the working conditions were that you refer to in
33 that paragraph?

34 A. So feedback from the radiologists highlighted the need
35 for us to have different working arrangements to make
36 Concord a more attractive place for staff to - as
37 a retention as well as to attract new staff to the
38 department. They included things such as rostered clinical
39 support time, the ability to work from home, and to be able
40 to kind of work from home, as well as 10-hour days. So
41 prior to the change, there were eight-hour days.

42

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

47 A. Yes.

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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]

1 *department.*

2

3 What was the observation or what were the observations you
4 made that informed that conclusion?

5 A. During that workshop, issues specific to bullying and
6 harassment were not raised as issues that needed to be
7 addressed.

8

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

13 A. Yes.

14

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

19 A. Yes.

20

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

24 A. Yes.

25

26 Q. Did you get the sense that the bullying and harassment
27 that had at least allegedly been a problem in the past was
28 still having some lingering effects on the morale of the
29 workforce within the emergency department at Concord?

30 A. No.

31

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

33

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

39 A. That is correct.

40

41 MR MUSTON: Q. I should probably ask in relation to
42 that, what was your involvement in that process, the
43 ProActive ReSolutions process which was under way at
44 Concord hospital, in a day-to-day sense?

45 A. My role was to - the process was led by ProActive. My
46 role was to support the process, to - you know, myself and
47 members of the executive to encourage their participation

1 in processes as identified through ProActive, and making
2 sure that from, you know, at a facility level, that any
3 support that that process needed was able to be provided.
4

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

10 A. Yes.

11
12 Q. Who within the Concord executive was involved in those
13 workshops?

14 A. It was myself, the director of medical services, the
15 director of nursing, my operations and performance manager.
16 I believe - I would have to check the attendance, actually,
17 my memory is not great. But it was the key members of my
18 executive team were attending.
19

20 Q. At Concord?

21 A. At Concord.
22

23 Q. In broad terms, what did those workshops involve?

24 A. They were a facilitated workshop led by staff from a
25 ProActive team, and it's a process really of - it's
26 a mixture of sort of facilitated discussion as well as
27 presentation on information in relation to respectful
28 communication, what it is, the impact both respectful and
29 disrespectful communication can have on individuals and the
30 functioning of teams, my recollection, and opportunities
31 for interaction and kind of role-playing is my recollection
32 of the workshop.
33

34 Q. Do you have a recollection whether any of the
35 executive from the LHD attended those workshops that were
36 conducted by ProActive ReSolutions, at least to the extent
37 you were at them?

38 A. No, no.
39

40 MR MUSTON: I have no further questions for this witness,
41 thank you, Commissioner.
42

43 THE COMMISSIONER: Q. How many staff from ProActive were
44 involved, do you remember?

45 A. There were three key staff that were involved
46 day-to-day and one support officer who was mostly providing
47 support from the office.

1
2 THE COMMISSIONER: Okay, thank you.
3
4 Mr Cheney, do you have any questions?
5
6 MR CHENEY: No, Commissioner.
7
8 THE COMMISSIONER: Thank you very much, sir, for your
9 time. We're very grateful. You are excused.
10
11 THE WITNESS: Thank you.
12
13 <THE WITNESS WITHDREW
14
15 MR MUSTON: The next witness is Dr Stewart Condon. His
16 statement, at least in my folders, is H5.1.
17
18 THE COMMISSIONER: Yes, got it, thanks.
19
20 <STEWART MARTIN CONDON, affirmed: [12.05pm]
21
22 <EXAMINATION BY MR MUSTON:
23
24 MR MUSTON: Q. Dr Condon, could you state your full name
25 for the record, please?
26 A. Stewart Martin Condon.
27
28 Q. You are the director of medical services at Concord
29 hospital?
30 A. That's correct.
31
32 Q. I think you have been permanently in that role
33 since November 2023?
34 A. Correct.
35
36 Q. And prior to that, you were acting in the role,
37 I think since 22 March 2023?
38 A. Also correct.
39
40 Q. You prepared a statement dated 6 June 2024 to assist
41 the Inquiry with its work?
42 A. Yes, I did.
43
44 Q. Do you have a copy of that statement with you?
45 A. Yes, I do.
46
47 Q. You've had an opportunity to read it before giving

1 your evidence?

2 A. I have.

3

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

6 A. Yes.

7

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

10

11 THE COMMISSIONER: Yes.

12

13 MR MUSTON: Q. Several years prior to commencing in your
14 current role, you were involved in medical administration
15 roles at RPA?

16 A. Correct, as the deputy director of medical services.

17

18 Q. As a result of the roles that you held at RPA, did you
19 have an awareness when you accepted the acting role
20 in March 2023, that you would be stepping into
21 a challenging gig at Concord?

22 A. I think the challenge I expected was the step, going
23 from a deputy role to a director role. Certainly most of
24 the context at Concord wasn't available to me at the time.
25 We had enough challenges at Prince Alfred.

26

27 Q. So at the time that you made that step across, did you
28 have any awareness of what was the morale of the medical
29 staff at Concord hospital?

30 A. No.

31

32 Q. Having arrived in the role, did you make any
33 assessment of the morale of the medical workforce at
34 Concord hospital?

35 A. I had a handover from the outgoing director of medical
36 services and --

37

38 Q. Who was that?

39 A. That was Dr Jonathan Gibson.

40

41 Q. Sorry, I interrupted you.

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

47

1 Q. In terms of the morale, did you have a view what it
2 was, or at least based on what you were told at that time,
3 what it was that had led to the challenges with the morale
4 within the medical workforce at Concord?

5 A. I think at that time my perspective was it was
6 multifactorial. Certainly Concord, as part of a complex
7 district, had services that were struggling to deliver
8 service to the community. We also had medical workforce
9 demands and challenges, and I think even outside of medical
10 workforce, we had demands and challenges with other
11 workforces. But at that time, I was open to understanding
12 each of the specialties in their own way.

13

14 Q. I think you mention a need for engagement. Did you
15 develop a sense that there were people within the medical
16 workforce at Concord who felt like they were isolated from
17 the administration?

18 A. For some specialties, yes.

19

20 Q. Which ones in particular do you think had that
21 concern? Which specialties?

22 A. In terms of the engagement?

23

24 Q. Yes.

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

35

36 Each of the specialties, I would say, had their own
37 unique demands and challenges and knowing that there were
38 36 specialties across the hospital, I think, it's hard to
39 detail across each one of them, but there were some hot
40 spots that we were identifying and radiology was one of
41 those.

42

43 Q. Probably not unique within the medical workforce more
44 broadly, at Concord, was it your sense that people were
45 concerned that the workload and job demands placed upon
46 them had increased?

47 A. I didn't judge that early. I was really interested to

1 actually develop relationships and understand more of the
2 data behind that. So for the workload question, we hadn't
3 really formulated a conclusion at that point.
4

5 Q. To the extent that you did have discussions with, for
6 example, radiology, that raised some of those workforce
7 challenges that were presented there, did you have a view
8 that they were manifesting themselves as an increase in the
9 workload and job demands upon those radiologists who were
10 still there?

11 A. There was, yes, there was a sense.
12

13 Q. Did you get a sense in your dealings with specialists
14 across the various areas, that at least some of them felt
15 like they had less access to the administration to raise
16 issues when they wished to or felt they needed to?

17 A. On occasion, yes. But I probably didn't adapt my
18 style according to whether they had that access or had that
19 perception. Our management style in medical services,
20 after I had arrived, really was opening the door to
21 everyone, and across the board, interested to hear what the
22 issues were from our heads of department, how we could
23 assist, particularly with medical workforce demands and
24 turnover, as well as the service delivery. So I think we
25 had the challenge across the board and we approached it
26 very systematically across the board.
27

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

36 A. There were some, yes.
37

38 Q. And did you get the sense that there was a view
39 amongst at least a proportion of the workforce at Concord
40 that there was some unfairness in resource allocation when
41 compared with other hospitals?

42 A. I'm sorry, did you say unfairness?
43

44 Q. Unfairness?

45 A. So some sense of unfairness and?
46

47 Q. Unfairness in resource allocation when Concord was

1 compared with other hospitals within the district?

2 A. Some of the senior medical workforce expressed that,
3 yeah.

4
5 Q. Did you get a sense that there was a concern within
6 the workforce, the medical workforce, that there was a lack
7 of transparency about how decisions relevant to Concord
8 were being made?

9 A. I think my sense was a communication challenge that
10 had occurred. There were some specialties and some
11 specialists who hadn't had communication loops closed and
12 didn't have that full transparency, I think, in
13 decision-making processes.

14
15 Q. In relation to that, did you have a view, or do you
16 have a view now, about what might have led to some
17 specialties within the hospital having that perception,
18 while others didn't?

19 A. Yes.

20
21 Q. What is it, at least as best as you can ascertain?

22 A. Of course. I think some of the specialties are
23 incredibly motivated to give the best First World care they
24 can at Concord hospital, and for some of the specialties,
25 that does require a full suite of services - technology
26 which is cutting edge, nursing, medical models of care
27 which apply in the best possible way, and I think for some
28 of the specialties, when they don't have that, they express
29 a concern that they're not giving the best they can to
30 their patients.

31
32 So again, by specialty, this is a different story.
33 Some specialties are very happy with the services they
34 have, the resources that they've been delivered, and the
35 smaller specialties, the ones who are resourced, are happy
36 with their models, are happy with their patient outcomes as
37 well. So it really is a range.

38
39 Some of the resourcing questions are important for us
40 to revisit on a regular basis, and we do so, and
41 particularly for medical workforce, ensuring that the
42 consultant specialists are in place to do the teaching,
43 training and service delivery.

44
45 Q. As part of your role, did you attend routinely
46 meetings of the medical staff council?

47 A. Yes, when I could.

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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

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

3

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

9 A. I do, yes.

10

11 Q. -- as a feature of the meetings?

12 A. I do, yes.

13

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

21 A. As a generalisation, yes.

22

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

26 A. I believe so.

27

28 Q. Was the haematology department one of those
29 departments that, generally speaking, considered itself to
30 be reasonably well resourced at Concord?

31 A. I believe so, yes.

32

33 Q. You're familiar, obviously, with the clinical stream
34 structure that was operated at the district level. Could
35 you explain what that structure is and how it works in the
36 context of the delivery of medical services across the
37 district?

38 A. The two aspects I see to how the clinical streams have
39 worked across the district?

40

41 Q. Yes.

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

47

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

3 A. Sure, absolutely

4

5 Q. -- in the context of the Sydney Local Health District?

6 A. Maybe take a step back, in fact.

7

8 Q. Yes.

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

15

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

21

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

29

30 Q. So in terms of the way that was implemented at Sydney
31 Local Health District, how did it work? How was each of
32 those streams within the matrix actually physically
33 comprised?

34 A. It may be best to use an example.

35

36 Q. Yes, please.

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

44

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

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

7
8 Q. So decisions about resourcing of particular
9 departments, in particular hospitals within a stream, are
10 something that might be discussed at that level, that
11 stream leader level, with the executive of the LHD?

12 A. Yes, but not only there. And so that's part of what
13 we've been providing in medical services over the last year
14 or so, really having a much more direct operational
15 conversation on a hospital level, to have that similar
16 resource conversation, knowing that I would need to take
17 any resource demands to the general manager of the
18 hospital. That's the key first step, in fact. The stream
19 discussions add to that.

20
21 Q. We'll come to the way in which you're running your
22 current role in a moment, but when you arrived, did you get
23 the sense that those discussions that you've just told us
24 about happening at the local level were happening or
25 happening effectively?

26 A. I don't think I formed an opinion when I arrived.

27
28 Q. Do you think the clinical stream structure of Sydney
29 LHD had the capacity, perhaps, to compound some of the
30 communication issues, at least perceived communication
31 issues, that were troubling a proportion of the staff at
32 Concord, medical staff at Concord?

33 A. I think it could have.

34
35 Q. In what way?

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

42
43 Q. Could I ask you to have a look at paragraph 22 of your
44 statement. You tell us about the speak-up culture that
45 you're seeking to promote at Concord?

46 A. Mmm.

47

1 Q. Could I ask you to explain how it is that you are
2 seeking to promote that culture, what steps you're taking
3 to achieve that?

4 A. Mmm. Speaking up for safety and other concepts around
5 patient safety and clinical governance are really important
6 for us to drive. There is sometimes a reticence for staff
7 members to not log incidents or not report particular
8 things that happen in the hospital, which could have an
9 impact or have had an impact to patient care. So I'm
10 thinking about the incidents and the near-misses.

11

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

21

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

29

30 Q. You mentioned a moment ago that there's - you perceive
31 there to be a reticence to lodge incidents and raise
32 issues. What leads to that reticence, or what lies behind
33 that, do you think?

34 A. I think many of the clinicians I speak with see it as
35 an extra time demand in their day. That's the main
36 concern, that they don't have time to do it, knowing that
37 everyone is time poor, but that's the main feedback I get
38 from clinicians.

39

40 Q. Do you get the sense that that same reticence applies
41 in relation to speaking out about resourcing problems?

42 A. I don't think so, no.

43

44 Q. Or what are perceived to be resourcing problems?

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

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

3
4 Q. Could I ask you to go to paragraph 27, where you tell
5 us about the efficacy of Concord's complaints handling
6 process. The first question about that: what sort of
7 complaints are you talking about in that paragraph -
8 disciplinary complaints or more broadly?

9 A. I think I was referring to something more broadly. It
10 includes workforce-related complaints, so behavioural
11 elements, but other wider complaints around clinical
12 governance, complaints about the care.

13
14 Q. You make the observation that the process that exists
15 at Concord is - I'm hopefully not putting words into your
16 mouth - no worse than that which you've observed at any
17 other hospital. Accepting that that's maybe right, could
18 it be better, do you think?

19 A. Oh, these systems can always improve.

20
21 Q. Do you have any views about ways in which the system
22 at Concord and perhaps the equivalent system that you've
23 worked with in other hospitals might be improved to improve
24 their efficacy but also improve the way in which they fit
25 with broader concerns about workplace morale and the like?

26 A. Yes, of course. I think our clinicians need to be
27 empowered to actually be part of the system improvements.
28 Sometimes they feel disempowered due to time. They don't
29 log incidents, for example, as I mentioned before.

30
31 I think the improvements maybe don't relate to the
32 incident management system itself but much more around the
33 engagement with that system, and certainly I refer in my
34 statement about how policies and procedures can articulate
35 certain expectations of our staff members, regards to
36 patient safety, but that needs a follow through with our
37 staff members, that needs a follow through with our senior
38 doctors, our interns, our nurses and allied staff members,
39 just as much as our clinical support staff as well.

40
41 MR MUSTON: Operator, I'm sorry to do this without notice.
42 Could you bring up document [SCI.0012.0160.0001]?

43
44 Q. Do you see the document there, it's headed "Workforce
45 Factsheet CORE Values Behaviours"?

46 A. Yes.

47

1 Q. Is that a document that you're familiar with?

2 A. I've heard about this document. It's not something
3 that I've used in my practice in medical management at
4 Concord.

5

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

9

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

14

15 That, I gather, is not a below-the-line item that you are
16 specifically familiar with, having regard to what you've
17 just told us about your familiarity with the document?

18 A. No. I encourage that kind of feedback on a regular
19 basis. I think the system needs to improve by hearing as
20 much as possible, and that statement hasn't been framed by
21 myself or anyone in my team, but it's interesting to read.

22

23 Q. Is it your view that describing that sort of behaviour
24 that you would encourage as a valuable and important part
25 of workplace improvement as "below the line", is unhelpful?

26 A. I'm sorry, I didn't catch the end.

27

28 Q. Is it your view that describing that sort of
29 behaviour, namely, complaining about resource limitations
30 and constraints, to the extent it is appropriate to do so,
31 as "below the line behaviour", is somewhat unhelpful?

32 A. I think there's a danger in making binary
33 classifications around something like that. Certainly - as
34 I've said, I encourage that, and our team encourages that
35 with our heads of department. We are very keen to hear as
36 much as possible about what's going on.

37

38 Q. You encourage it because you are of the view that it's
39 important that those sorts of discussions are had?

40 A. Important and urgent. This is exactly how the system
41 needs to get that feedback, that data, and improve the
42 system itself.

43

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

1 conversations?

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

5

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

13 A. (Witness nods).

14

15 Q. What is the difference that you've felt between the
16 acting role and the permanent role which has led to you
17 approaching it differently - that is, the performance of
18 the role differently?

19 A. Mmm. It's perhaps a reflection of how I saw the
20 hospital and how I saw my role myself. I saw the hospital
21 as having, as I described, an engagement gap that I could
22 definitely assist with. I also saw my role as the acting
23 director of medical services as someone who, like many in
24 recent years, had been acting at the hospital and not been
25 permanently appointed. So I was very keen to establish
26 myself and develop trust, particularly with our medical
27 heads of department, and also reassure them, once I had the
28 role substantively appointed, that I could take
29 a different, more active interventional role with their
30 departments to assist.

31

32 Q. Do you think it's possible that a succession of people
33 acting in roles like yours might actually have the capacity
34 to contribute to some of these communication problems which
35 seem to underpin a great deal of the unhappiness which
36 has - which bubbled over at Concord?

37 A. I would say yes, and I'd also add that sometimes we
38 build communications around or actions and tasks around
39 particular people and not around processes, so sometimes we
40 have had individual approaches of recent years that have
41 differed as people have moved through the roles when, in
42 fact, we should have had process-dependent tasks and work,
43 which would have given a better continuity all the way
44 through.

45

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

1 services during consultancy, but some heads of department
2 struggling to see the whole of hospital view. Could I ask
3 you to expand on what you had in mind when you make that
4 observation that some heads of department struggle to see
5 the whole of hospital view?

6 A. Yes, of course. Having so many medical departments
7 and so much work to do at Concord hospital, each of our
8 specialists and our heads of department are very focused on
9 their own specialty and how they can assist the patients
10 that they serve in the best possible way. So knowing most
11 of our clinicians are time poor, knowing that they don't
12 have a chance to compare their departments to others,
13 I think I have seen some departments very focused on their
14 own individual needs without perhaps having a sense of the
15 bigger story or the bigger picture.

16
17 I do see that as part of my role, as director of
18 medical services, to relate to particular departments. "We
19 understand you have needs. We're trying to get our
20 particular consultants back up to a full complement for
21 you, appreciate our medical workforce unit is also working
22 on six other interview processes at the moment." So we
23 will get there, but understanding the timing, understanding
24 that we're doing the best we can for their department,
25 I think needs that bigger conversation to understand we're
26 doing the best we can for the whole hospital.

27
28 Q. Not wanting to attribute anything to the answer that
29 you've just given, but is part of that more than just
30 telling them, "We're doing the best we can, trust us", but
31 actually bringing them in to the tent a little bit more and
32 sharing with them broader information about exactly what it
33 is that you're doing, what those wider pressures are and
34 why those decisions are being made in the way that they're
35 being made?

36 A. Yes, I agree with that statement. It is certainly the
37 openness that we try to bring in our approach to medical
38 services at Concord and it is part of the NSW Health core
39 values.

40
41 Q. Can I get you to go over to paragraph 36 of your
42 statement. You tell us in that first sentence that not
43 many staff members at Concord hospital have seen the
44 director of medical services work in the way that you are
45 working before.

46
47 Let's start with what your understanding or perception

1 what of their experience might have been prior to you
2 commencing in the role and adapting it in the way that you
3 have?

4 A. So I don't have a full picture of how every director
5 of medical services has operated at Concord, so I've got
6 a limited view on more recent years and how the approach
7 has been taken. In the executive at the hospital, it's
8 often described as firefighting on a daily basis, that
9 we're trying to do the best we can for particular problems
10 which are both urgent and important.

11
12 The approach we've taken since I arrived just over
13 a year ago is really trying to get ahead of that and be
14 a bit more predictive of some of the issues before they
15 become a fire itself.

16
17 So we see ourselves as a service department for the
18 other medical services of the hospital. We see them as the
19 customer, knowing that they are taking care of the
20 patients, so we need to ensure a best understanding of
21 their resourcing needs, how we could or may not be able to
22 meet those needs, and also the demands that they have by
23 specialty.

24
25 So we frame that conversation as a service
26 conversation. We encourage all of our specialties to have
27 that conversation with us. Availability can be challenging
28 at times, people are busy and we know that we've certainly
29 had good conversation over the last year with almost all of
30 the specialties, sometimes less frequently than what we
31 want. But, yes, we do see that as an approach which is
32 maybe a newer approach to how medical services at Concord's
33 been managing.

34
35 Q. Would it be fair to say that, in essence, you're
36 approaching that role from the perspective of the executive
37 needing to support the medical workforce to deliver the
38 care that is required to be delivered through the hospital,
39 rather than the other way around?

40 A. Yes.

41
42 MR MUSTON: I've got no further questions for this
43 witness, thank you, Commissioner.

44
45 THE COMMISSIONER: Thank you.

46
47 Mr Cheney, do you have any questions for the witness?

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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?

- 1 A. The chief medical wellness officer, yes, since 2019.
2
- 3 Q. That takes up about 0.5 FTE worth of your working
4 life?
5 A. That's what it is on paper.
6
- 7 Q. We might come back to that. And in relation to your
8 work as a rheumatologist within the hospital, you've worked
9 within the local health district since 2011?
10 A. Correct.
11
- 12 Q. And as the chief wellness officer you report directly
13 to the chief executive?
14 A. Correct.
15
- 16 Q. You prepared a statement to assist the Inquiry with
17 its work dated 7 June 2024?
18 A. Yes.
19
- 20 Q. Do you have a copy of it with you?
21 A. I do.
22
- 23 Q. Have you had a chance to look through it before coming
24 to give your evidence today?
25 A. I have.
26
- 27 Q. Are you satisfied that, to the best of your
28 recollection, its contents are true and correct?
29 A. Yes.
30
- 31 MR MUSTON: That statement, Commissioner, will be tendered
32 in due course.
33
- 34 Q. Can I ask you to turn to paragraph 6 of - sorry,
35 paragraph 5, first of all, of that statement, in which you
36 describe the My District OK program?
37 A. Yes.
38
- 39 Q. Could you just give us a little bit more detail about
40 how that program works?
41 A. So My District OK program is our organisational staff
42 wellbeing program. It's an evidence-based data-driven
43 program where basically we collect information about levels
44 of wellbeing, the impacts of low levels of wellbeing, the
45 drivers of distress. We harness solutions as part of that
46 process and then we use that data to drive or develop
47 a framework and we, within that framework, have wellbeing

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

3
4 Q. As the chief wellness officer, do you understand
5 yourself to have a role in relation to resolving industrial
6 disputes that crop up from time to time within the local
7 health district?

8 A. So my team and I provide support to people that are
9 involved in those and we may be involved in conversations
10 around systems and processes that contribute to staff
11 distress during those processes that help us then design
12 interventions to try and, you know, improve their
13 experience of that.

14
15 Q. How many people are there in the wellness team or your
16 wellness team within the local health district?

17 A. That's a good question. So we have an FTE count of -
18 I think we're about 6.7 at the moment, and that has a head
19 count of about 10/11 people.

20
21 Q. Is the team comprised of medical professionals who
22 split their role in the way that you've split your role or
23 is it a bit of a mix?

24 A. It's a real diverse team. We certainly have medical
25 professionals and we try and have representation from each
26 of the sites where possible. A lot of what we do in
27 delivering the programs requires administrative support and
28 so we have - we're set up like a department. We have an
29 operations manager, we have program managers for each of
30 the sites, and then we have leads of the different pillars
31 that we call them. So I have a director of psychological
32 wellbeing that will oversee that program of work,
33 a director of physical wellbeing, a director of culture and
34 safety and a director of leadership.

35
36 Q. In terms of your role as the chief wellness officer,
37 do you see value in it being a split role between a
38 practising clinician as to part of your FTE count and the
39 chief wellness officer as to the other part?

40 A. Very much so, and we've modelled off an international
41 model where they have, you know, tried and made errors
42 about how to make this work with about 10 to 15 years
43 experience ahead of Australia, so we've looked at the
44 Stanford and Mayo Clinic models that have now been rolled
45 out across the country in the US and now in the NHS as
46 well.

47

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

10
11 Q. In terms of bridging the gap between the frontline
12 clinicians and the executive or administration, what is the
13 nature of that gap and what does it actually look like in
14 the context of a front line clinician?

15 A. Yes, so, look, our training backgrounds and experience
16 are completely different and fair to say, you know, I went
17 through my entire medical training - and this would be for
18 other health care disciplines as well - with absolutely no
19 training in what it is to operationalise or, you know, run
20 the business of the health care system. So I had no
21 appreciation of the language for that, coming out.

22
23 Similarly I think people, particularly training
24 programs these days, rarely have significant frontline
25 clinical experience that are going into administration
26 roles, the senior ones. And so what you have is, I guess,
27 very different backgrounds, perspectives, lenses on things.
28 I think we have very different levers and priorities and as
29 a frontline clinician, I've got the patient in front of me,
30 and that, you know, is my vocation, to give the best care
31 to that individual patient, whereas, you know,
32 administration may obviously have the more difficult task
33 of trying to have a limited amount of resources and, you
34 know, trying to give the best patient care to as many
35 patients as possible.

36
37 They have different levers on them to what the
38 clinicians have at those times, and I think that can
39 sometimes - that difference in language, difference in
40 perspective - create a difference of opinion and a gap
41 that, you know, requires really skilled connectors and
42 communication to try and improve the system.

43
44 Q. So what are some of those levers that might get
45 pulled, say, by those at the executive level in an attempt
46 to close up that gap?

47 A. I mean, the classic one at the moment, obviously,

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

10
11 It might also be around, you know, activity. So
12 there's - the system tends to weight activity rather than
13 outcome, fair to say, at the moment. So it's rewarded for
14 doing more as opposed to whether that's best care for
15 patients and whether that activity actually leads to
16 benefits for patients. So there are different levers
17 sometimes leading to a values disconnect. I think if I'm
18 really about quality and safety of care and that's what is
19 driving me and I have a perception, at least, that things
20 are about performances and finances and activity, that
21 creates a divide in the system.

22
23 Q. In your role and the role being played by your team,
24 how are you aiming or what steps are you taking to try and
25 close up that gap, aligning an understanding of the values
26 with perhaps an appreciation of some of the pragmatic
27 realities of operating a large health system?

28 A. So appreciating it's a very complex problem, I think
29 that was the importance at the beginning of trying to
30 get data to really understand what the issues were.
31 I thought - you know, I had some ideas of what I thought
32 they might be, but very different when you go out and
33 actually collect that data to have a look at it. So
34 I think as a first step, that data was really, really
35 useful at starting conversations.

36
37 It was also really useful at raising the awareness
38 around what the problem was and, you know, when we're
39 talking about the implications of this divide, which is
40 often staff wellbeing, in a way, we had to put fuel on the
41 fire and the data was a way to go, "Hey, this is why this
42 matters." There was really, you know, a sense of
43 wellbeing, a bit of a fluffy word, you put it in, you think
44 it's yoga and day spas and things but actually when you
45 look at the business case for this, the financial model,
46 the impacts that it has not only on our staff but on,
47 patient care, on efficiency of practice, like, there are

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

3
4 The second step was putting a wellness governance
5 structure in place, and that, to answer your question
6 around the divide, I think, was one of the most helpful
7 things that we did. We were able to do it because we had
8 both a ground-up and a top-down approach. So I think, you
9 know, addressing some of the drivers of distress around not
10 feeling like you've got a voice, not feeling like you're
11 being heard, not feeling like you're having any input in
12 decision-making, if you set up a governance structure where
13 you have, you know, an aligned goal and you have both
14 frontline staff and administration working together to try
15 and achieve that, that was a really productive and
16 continues to be a really productive exercise.

17
18 That worked because we had backing from the chief exec
19 from the very first moments and, you know, timing is
20 everything. There were a lot of levers in our favour at
21 that moment to get some funding. We had horrific staff
22 suicides and things that helped us start that conversation
23 very quickly.

24
25 But by having chief executive support, senior
26 clinicians leading that process, and then putting
27 a governance framework where this needed to be an iterative
28 conversation - what we were talking about in 2019 or before
29 that, in terms of wellbeing, is completely different to
30 what we're talking about now. And so you need a structure
31 that can allow that dynamic process to keep unfolding over
32 time.

33
34 Q. At the start of that answer you referred to the
35 collection of data and you described it as pouring fuel on
36 to the fire. What is it about the collection of that data
37 that you regard as potentially being slightly inflammatory
38 but, nevertheless, as you explained, important?

39 A. It's about raising awareness. So when we started,
40 there was a - we'd had four basic physician trainees in a
41 four-month period take their own life and people were angry
42 and grieving and no-one was doing anything and there was
43 this sense that our staff were breaking and we couldn't
44 understand why it was happening, and no-one was listening.
45 So data gave you a way of illustrating, in different ways
46 and tacking it to different outcomes that mattered to
47 different people, to make this, you know, an important

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

5
6 We could tack it to patient quality and safety
7 outcomes, which, at the end of the day is a great one,
8 because that's what we're all in the game to do.

9
10 We could tack it to improving, if I'm talking to my
11 junior staff, exam pass rates, because that's what they
12 cared about, you know, at the time.

13
14 It might be about performance. So if you have that
15 data, it allows you to have conversations and the language
16 and find the why for people that matters, and that wasn't
17 there at the beginning and that's what we've been working
18 really hard to find what that dataset is to be able to do
19 that.

20
21 Having said that, once you raise awareness, and we can
22 show that the burnout rates are really high, keeping
23 measuring burnout and not doing anything about it puts more
24 flame on the fire and doesn't achieve; it just makes people
25 anxious and, you know, you get a contagion. So I think,
26 you know, what we're measuring over time needs to reflect
27 the program of work and what we're doing, and we also then
28 need to look at how we, you know, reduce that sense of
29 overwhelm about how to act on that data and that learned
30 anxiety in a way of, you know, we know there's burnout,
31 what can we do about it.

32
33 That, in many places, I think, is the situation at the
34 moment. We know there's a problem. We don't know what to
35 do. We're afraid it's going to break the bank. So we
36 don't know where to start and there's this paralysis.
37 We're trying to show a model that works, that won't break
38 the bank, where, you know, with baby steps - and we've five
39 years in, probably seven years in, actually, with the pilot
40 work - this is where you can get to, but it's going take
41 time.

42
43 Q. The data collection that you've referred to, is that
44 the data or the database that you speak of in paragraph 6
45 of your statement - that is, the wellbeing database?

46 A. Yes.

47

1 Q. When in that sort of five-year period that this group
2 has been in operation did you start to collect that data?

3 A. So we did a pilot in 2018 where we just focused on
4 basic physician trainees - the medical registrars. That
5 was part of a small pocket of funding that we had to do
6 a research project to try and understand, again, what was
7 the prevalence of burnout, what were the drivers of it and
8 what were some of the potential solutions for it.
9

10 So we started that. That went very well and we got
11 ministerial funding the following year in collaboration
12 with the district to expand that to all medical staff, and
13 when we did that, we put it through the ethics longitudinal
14 sort of - we set up an ethics approved longitudinal
15 database. So that now exists and once a year we can put
16 out the same survey that gives you very granular
17 information, depending on the response rates, but very
18 granular information to help you strategically plan where
19 to put your resources and what to focus on in the next
20 12 months.
21

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

25 A. Correct.
26

27 Q. What do you mean, when you say - first of all, what
28 are the gaps and how are they being filled?

29 A. I think you can take the context of the "People
30 Matter" survey around what its intention is and what it's
31 trying to do. It's obviously a survey that has to go all
32 cross sector. So the same questions are being asked to the
33 people in education as to the people in health, as to
34 transport and other areas. So you are a little bit limited
35 in what you can ask.
36

37 It's also a very high, bird's-eye view of trying to be
38 able to compare sectors on some high-level metrics, and
39 there are some really good ones and, you know, it's a great
40 dataset to have to report up.
41

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

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

5
6 I think the second problem at the moment is that it
7 doesn't use, in the wellbeing space - it's not a wellbeing
8 survey. It asks some wellbeing questions, which is
9 fantastic and I'm really glad they're doing that and
10 working with them to look at how can we improve the way
11 they're doing that, but traditionally haven't used
12 validated measures. So you can't benchmark with best
13 practice around the world around how to measure wellbeing
14 or burnout. So we, you know, can't see how we're going
15 compared to other hospitals.

16
17 In terms of, you know, why, that would add a lot more
18 questions to the survey, and at the moment, when you look
19 at it, the response rate for the survey is already, you
20 know, on the lowish end.

21
22 One of the things, I think, in terms of the gaps of
23 the survey, what doesn't it measure? Like, it doesn't
24 measure burnout or professional fulfilment in a validated
25 way; it doesn't measure the impacts of that. So in terms
26 of, you know, on an individual, what do we look at? We
27 look at anxiety rates, depression rates, recruitment,
28 retention, loss to the workforce, the organisational sort
29 of issues. We look at patient quality, safety of care. We
30 look at motor vehicle accidents on the way to work and back
31 that are related to fatigue. So there's a whole series of
32 impacts that we can look at that are really useful, again,
33 with trying to target, well, where do we put the
34 interventions.

35
36 It importantly also doesn't look at what the drivers
37 of that distress are. And so when you're trying to design
38 interventions - and wellbeing and burnout is an incredibly
39 complex area, and from what we're measuring, at the moment
40 we've got it down to about 50 different drivers of
41 distress. That's a lot of information, and we're asking
42 people to do a, you know, 10 to 12-minute survey. But
43 they are doing it because they're seeing action taken on
44 the results, and I think, you know, for the "People Matter"
45 survey, one of the great questions they have in there is
46 "Do you think this data will be acted on? And when you
47 look at the response rate to that is often around

1 10 per cent or something, it explains why people aren't
2 filling it out.

3
4 So surveys and data collection is fantastic, but we
5 need to be really careful (a) that there are too many
6 across the system - "People Matter" is doing one now, I'm
7 doing a local one, the AMA will do one, the colleges will
8 do one and suddenly there's all this data flowing down and
9 people are surveyed out and they're not seeing action based
10 on that. So I think if we can look at some connection
11 around data measurement using validated tools, not
12 re-asking questions that have been asked in other surveys,
13 that would be one really significant way forward.

14
15 I think the second thing around, you know, frontline
16 solutions - that's one of the best questions I love in our
17 survey, I think "People Matter" does do that. How that is
18 fed back to organisations at a granular level again to be
19 able to act on is probably one of the other ways that that
20 could be improved.

21
22 I've forgotten where I've started but that's probably
23 enough on that.

24
25 Q. To the extent that issues are being raised by members
26 of the workforce, concerns are being raised by members of
27 the workforce, about issues including, say, the extent to
28 which they feel that they're engaged with the executive in
29 a constructive way, is it the case that the "People Matter"
30 survey is lacking in granularity to an extent that you
31 couldn't, in the face of those sort of concerns, look to
32 the data in the "People Matter" survey and say, "Actually,
33 there's no problem here"?

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

44
45 Q. I might come back to that in relation to some specific
46 examples. Could I ask you to move forward to paragraph 8
47 of your statement, where you tell us that part of your role

1 you have focused on prevention and early detection of
2 issues rather than the treatment of them once they have
3 arisen.

4 A. Mmm.

5
6 Q. What is your group doing in its attempt to detect
7 these sorts of issues and what steps are being taken to
8 prevent them as and when they are detected?

9 A. So I think it's really important when we're talking
10 about wellbeing, is that we are trying to look at the, you
11 know, preventative lens. We're trying to take people who
12 are well or not at that best and help them get back to be
13 at their best. We're not replacing EAPs, you know, the
14 employee assistance programs; we're not providing therapy;
15 we're not the interventions for those in distress. We try
16 to connect people with those in distress.

17
18 So in terms of, you know, trying to get out in front,
19 we're trying to get out early into training programs at all
20 levels for the prevention - the intervention part. If I go
21 to the detection part first, that's where the governance
22 structure's really important. So having again the
23 ground-up, where you've got representatives from all the
24 different sectors of the organisation, you've got a monthly
25 meeting where you've got an agenda that allows people to
26 raise those issues, that's, I think, one useful way to look
27 at early detection, as well as what we found, you know,
28 with wellbeing programs, is the best solutions usually are
29 coming from the front line. They just don't have the time,
30 now, or know how to navigate the system, to implement them.

31
32 So we're very much playing that sort of connector
33 support role help, navigate the system, try and help
34 implement. So I think if you've got that structure in
35 place that allows those regular conversations, the
36 committee is great and the agenda is there, but a lot of
37 the conversations that will come up in that committee are
38 usually happening on the ground and in pre-conversations in
39 preparation for that, too.

40
41 So I think you can put the structure in place and
42 then, if you've got really good leadership and good
43 representatives around that, that's how you find out, you
44 know, what is happening early. You've got ears on the
45 ground. You've got good relationships across the network.
46 People will come and talk to you because you are
47 considered, you know, a safe surveys, and I guess having

1 a team across, having the training directors there involved
2 gives you that sort of reach out into the organisation to
3 try and, you know, do what an email can't do in terms of,
4 you know, really connecting with human beings.
5

6 Q. As part of that detection/connection, do the medical
7 staff councils at the facilities have a role to play?

8 A. So it's a good question. Only recently. So fair
9 to say in my experience of being in RPA medical staff
10 council - so slightly different but I imagine reflected at
11 Concord - is that we didn't have an integrated,
12 well-attended, well, high-functioning medical staff
13 council, and you could argue, for whatever reason, we
14 didn't need one. Things were operating well, so people
15 weren't turning up to meetings and there was this gradual
16 dissipation, I think, in attendance and things over time.
17

18 Certainly with COVID and things more recently, we have
19 reinvigorated/restructured, and attendances, last meeting,
20 was averaging sort of 130 plus people. It used to be 4.
21 So right now, the chair of the medical staff council will
22 sit on our executive MDOK committees, and that is another
23 important voice. So trying to have all those voices there
24 allows that sort of cross-communication. But it wasn't,
25 you know, in recent years.
26

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

37 A. Can you repeat that question for me?
38

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

43 A. Yes.
44

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

1 A. Yes.

2

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

8 A. Oh, yes, absolutely.

9

10 Q. So to the extent, for example, that a medical staff
11 council expressed a desire to provide, by way of advice,
12 constructive feedback on things they thought the executive
13 was doing well or not well, it would be counterproductive,
14 at least insofar as your objectives or your group's
15 objectives are concerned, to say to them, "That's beyond
16 your remit. You must not do that"?

17 A. Yes, I think the whole purpose of medical staff
18 councils is to be a barometer on the ground and a body to
19 provide recommendations and advice. These are people on
20 the front line with lived experience who see what's
21 happening every day. It's a really valuable source of
22 information.

23

24 Q. Any step which would operate to prevent the medical
25 staff council from sharing in an advisory role with the
26 executive things that are concerning the membership would
27 significantly diminish the meaningful - diminish the
28 benefit that might be achieved from having such a council?

29 A. Yes. Hospital systems work best when you've got great
30 working relationships between, you know, medical staff
31 councils, but all people in leadership positions, both
32 clinical and non-clinical.

33

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

36 A. Yes.

37

38 Q. You tell us there about the role that you and your
39 group have in providing support to staff with grievances.
40 Can I just ask you to expand a little bit on what that role
41 is and how it works in a practical sense?

42 A. So we probably play a few different roles. In terms
43 of our primary role, I think it's usually providing a level
44 of support to those people and that's either through direct
45 reach-out or indirectly through the programs, like the
46 colleague care program that we've set up, which has
47 specifically been set up to support people involved in

1 either adverse events or grievance processes, and that came
2 from, you know, data feedback from those staff that had
3 been through them to talk about, you know, the impacts and
4 the secondary victimisation often that happened with that.
5 So I think we play that role.
6

7 We play often a connector/advice role. People often
8 don't know how to navigate the system and so a lot of those
9 conversations, if they've got a grievance, it's a chat and
10 they're not aware of what their avenues are to lodge that
11 complaint. And more importantly, I think, there's a lot of
12 conversation around what the potential implications of
13 using different avenues might be for them, and so a lot of
14 fear-based discussion of who would see this and what would
15 happen and, you know, what are the repercussions and
16 things.
17

18 So I think there's a lack of awareness not just
19 grossly around, "Yes, we have an ims+ system that's an
20 electronic system we can put in", but around the, "How does
21 that actually work? Where does that information go? How
22 will it be acted on? What does that mean for me? What
23 will that mean for the other person, if it is an
24 interpersonal dispute?" So I feel like we're doing that
25 quite a lot. What's the system level intervention for
26 that? Almost, like, we need a guide for these processes,
27 and so we've started to talk about that locally now around,
28 you know, what's one of the missing parts of the equation
29 to try and help people feel like they can speak up, do they
30 have the right information. So that would be a body of
31 work that, you know, one of our team groups, working
32 groups, would then put into place.
33

34 So there's the direct support, there's the measures
35 around helping connect people with systems, helping them
36 navigate, and then there's the "What can we do at a system
37 level" intervention to try to not need to do this so often.
38

39 Q. You referred to secondary victimisation. What was it
40 you had in mind when you were referring to that as
41 a concept?

42 A. Oh, so, you know, like, anyone going through
43 a grievance or adverse event process, if they've, you know,
44 made a mistake, if they've been accused of bullying or
45 harassment, the actual process that they go through is
46 often a very traumatic one for that person on many levels,
47 and that trauma is what can lead to the concept of

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

5
6 Q. Could I get you to go forward to paragraph 20 of your
7 statement where you set out a little bit of feedback that
8 you've received about some of the formal complaint channels
9 and why they're not used. You identify there some
10 obstacles that have been drawn to your attention. Could
11 I just step through them and ask you to explain them in a
12 little bit more detail. The first is what you have
13 described as the "non-user-friendly reporting systems".
14 What's the issue there?

15 A. So often these are quite cumbersome to (a) log in to;
16 (b) the level of detail that the system either asks you to
17 do or to categorise into, and then the category that you
18 want to put it into doesn't quite exist, is a very lengthy,
19 time-consuming, often, process, and - like, in terms of
20 time on the frontline staff at the moment, like anything
21 that draws out, makes it a lengthy process, that, you know,
22 staff are somewhat reticent to do anyway. If you are
23 putting another little barrier in front of them, the high
24 chances are them not putting that, you know, entry into the
25 system are certainly there.

26
27 Q. Does that combine to mean that an assessment of the
28 number of reports that might be lodged through a system of
29 that type is not necessarily the best measure of the extent
30 to which incidents which perhaps justify reporting have
31 occurred?

32 A. Very much so. I think I outline later, but, like,
33 it's not just non-friendly systems as to why reporting's
34 not occurring.

35
36 Q. Let's go to the next one, the lack of confidentiality
37 and effectiveness in addressing grievances in a timely
38 manner. From a human perspective, what's the real
39 challenge there?

40 A. So if you're a junior doctor and you put in a report
41 against a senior doctor in your department or - let alone
42 your head of department, the first thing that system will
43 do is fire that report off to the head of department. And
44 so there is a lack of, you know, confidentiality, I guess,
45 in that process.

46
47 The areas that we work in, you know, the teams are

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

10
11 Q. In relation just to that issue, to the extent that,
12 say, a colleague were to indicate that a number of their
13 colleagues had provided information to them or concerns
14 that they had on a confidential basis, would it be
15 a reasonable, in your view, answer to that, in terms of
16 dealing with the problem, to say, "Unless you give me
17 particulars of those confidentially shared problems,
18 I can't do anything about it"?

19 A. Yes, look, I've certainly - yes - found myself in that
20 situation many times, where people want to share
21 a grievance with you but they fear the implications and
22 they want some way of reporting it but not being
23 identifiable because of those implications, and, you know,
24 it puts you in a - they ask you not to take it any further.
25 And if it's not meeting mandatory reporting requirements
26 and things, it's a really tricky position to get put in.

27
28 Q. To the extent that you're put in that position and you
29 pass the information on, albeit in perhaps an
30 unparticularised way and without disclosing the confidence,
31 would it be appropriate for someone within the executive,
32 who has had that information shared with them, to act on it
33 as though it's at least - that there's at least a real
34 possibility that a problem does, in fact, exist?

35 A. Yes, so I mean, if the information - it's
36 hypothetical, but if information has been shared with
37 executive, they would find it hard not to act on that
38 information. If it didn't have any particulars, it might
39 be very hard to act on.

40
41 Q. So in saying if it didn't have any particulars, you
42 might not be able to then turn around and, say, commence
43 a formal grievance process in respect of that confidential
44 information?

45 A. Correct.

46
47 Q. Without the particulars?

1 A. Correct.

2

3 Q. But my point is, if the existence of that confidential
4 information was shared with, say, you in your capacity as
5 an executive, you would not jump immediately to the
6 conclusion that, absent particulars, there's probably no
7 problem there?

8 A. Oh, absolutely, and you know, trying to see, you know,
9 both sides, how do you investigate further?

10

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

13 A. Mmm.

14

15 Q. What's the particular issue there?

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

30

31 Q. So sort of metrics and processes - coming back to the
32 concept of secondary victimisation that you've alluded to,
33 perhaps metrics that, say, build KPIs around how quickly
34 a grievance against a staff member needs to be dealt with
35 in order for it to be above the line from a KPI
36 perspective?

37 A. Absolutely. Do they have a support person built into
38 the process? Have they been connected with X, Y and Z
39 channels? I think there are many really constructive
40 metrics we could put around them.

41

42 Q. The next one you identify there is a lack of skill and
43 training in conflict management within the workplace.

44 A. Mmm-hmm.

45

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

1 A. Everywhere.

2

3 Q. And what is it?

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

11

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

21

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

27

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

38

39 Q. Without intending to be critical of any existing
40 staff, do you perceive there to be a risk that placing
41 people in executive and management positions who don't
42 necessarily have that training or possess that skill set
43 runs the risk that, in dealing with what are sometimes
44 volatile situations, they might respond to them in a way
45 which, quite unintentionally, makes them worse?

46 A. Yes, absolutely. I think if this is a skill that we
47 want all our managers to have, yes, we should be selecting

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

3
4 Q. I think you've already told us about the next issue,
5 which is the lack of awareness of local grievance processes
6 available to staff, but the next one, a lack of
7 independence and therefore psychological safety in the
8 complaints process, both perceived and real - what are you
9 angling at there?

10 A. So I mean, often grievance processes, again, are often
11 not straightforward. By the time something's got to
12 a grievance process, you know, the basic things have
13 usually failed and things have escalated to a certain
14 point, and, you know, there can be implications, either for
15 service delivery, for, you know, risk to reputation, to
16 risk to appearing in the media, like, a whole lot of levers
17 and drivers that can make true independence of any
18 investigation really challenging.

19
20 You build that then into the, you know, the unique
21 nature and the way we're set up, particularly in medicine,
22 of that hierarchical culture, where your job security is
23 often linked to people sponsoring your applications for
24 things, then it sets up - you know, even if you're the most
25 skilled person, trying to deal with these, you're always
26 going to have, you know, some biases that are built in to
27 that process. You may or may not be aware of them. So
28 without a truly independent process, there's often
29 a perception, you know, of an unfairness with whatever the
30 process or outcome turns out to be.

31
32 Q. High levels of burnout, I think we understand, but
33 existing professional and local workplace cultures -
34 I think you might have just touched on one of them, but are
35 there any other aspects of existing professional and local
36 workplace cultures that you have in mind as perhaps
37 a barrier to the making of complaints through existing
38 grievance channels?

39 A. Well, you know, culture is like the way we do things
40 round here, and in many medical cultures - and I think this
41 can apply probably more broadly to other disciplines as
42 well - the way things have been done for a very long time
43 has, you know, been not - a culture of not reporting, of
44 not speaking up, of not creating waves. You know, we've
45 been working very hard to try and change that culture and
46 behaviour, but fair to say that that would still be present
47 in many areas, and so I think, you know, real or perceived,

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

2

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

7 A. Much more.

8

9 Q. What does it mean?

10 A. So when you look at the domains of burnout, it's got
11 three domains. The first one's emotional exhaustion; the
12 second one is depersonalisation or cynicism; and the third
13 one is around professional efficiency or your efficiency of
14 practice.

15

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

23

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

29

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

39

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

46

47 Q. Thank you. Give me some understanding, obviously

1 based on your opinion and experience how - I assume you
2 would be talking about your own LHD, but tell me if it's
3 broader than that, but how should I understand the size of
4 this problem in the workforce you're talking about?

5 A. So it's huge. Pre-COVID, if you look at both
6 Australia, our local health district and international
7 rates, on average, we were already at about 45 per cent.
8 So it's almost half the workforce. So this problem has
9 actually been around for a very long time. Hasn't been
10 recognised.

11
12 COVID has amplified, and those rates that we're seeing
13 have gone up to, on average, about 70 per cent. What we
14 also saw in the data, and it's replicated around the world,
15 is that it affects our most vulnerable in the system. So
16 our junior doctor rates were up around 80 per cent and the
17 senior doctor maybe went up to 50 per cent. So you're
18 seeing the impacts and the brunt are - you know, it's
19 highly prevalent but it's affecting our most vulnerable and
20 then it's got these terrible consequences.

21
22 Q. A couple of things can I follow up with you on that.
23 You mentioned the junior doctors as being the most
24 vulnerable. I can think of some means by which you'd
25 describe them as the most vulnerable. Why do you say they
26 are the most vulnerable?

27 A. So they have the least power in the system, so when
28 you look at drivers of distress, that lack of control and
29 flexibility is a key driver. They have lack of job
30 security. So not only can they find that, for example, you
31 know, "There is a problem, hard to speak up, but if I do
32 speak up, that might threaten, you know, my future career."
33 So there's all these compounding factors that contribute to
34 that.

35
36 Junior doctor training is also incredibly stressful.
37 Long hours. But the actual type of work you're doing, when
38 you have a skill set that's in its infancy, also, you know,
39 puts you under high levels of stress anyway. I think we
40 really saw that in COVID, because we took all the
41 protective mechanisms away, those ward rounds where you've
42 got people next to you, the human contact, the debriefing
43 with, you know, consultants nearby, all of that was taken
44 away from them. So I think that's why it was exposed
45 during COVID as to why they suffered so much more than the
46 senior medical staff.

1 Q. You described the problem to me as "huge". I assume
2 I should take it - tell me if I'm wrong, though - that the
3 problem of burnout is not just related to junior medical
4 officers but across the range of employees in the health
5 system; would that be right?

6 A. Correct. So the average rates across the system for
7 all medical staff at the moment are just under 70 per cent.
8 That mirrors international data. So if you stop and think
9 about that for a moment, if you had a problem affecting -
10 a quality and safety problem affecting 70 per cent of
11 patients that came into hospital, you would be jumping up
12 and down and throwing resources to try and understand that
13 problem, particularly when you see the severity of the
14 consequences about it.

15

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

24

25 Q. Can I then ask you this: I would assume that, in the
26 best circumstances in the world, in a public hospital, it's
27 stressful being either a doctor or a nurse because you are
28 looking after people that are unwell, and you're trying to
29 either cure the disease or fix the injury or stop them
30 potentially dying, and I get that of itself comes with
31 a high level of stress. To the extent that this burnout
32 problem is huge, though, beyond that, what I just said,
33 there may be multifaceted causes for this, but what are, in
34 your opinion, the key causes for this burnout?

35 A. So I can show you what our data, and again, the
36 international data, tells us.

37

38 Q. Yes.

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

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

7
8 I think frustration and disempowerment. So
9 particularly in the medical cultures, but I'd say also, you
10 know, with other non-medical disciplines as well, that
11 sense of loss of autonomy, not being heard, not being seen,
12 not having a voice in the system is coming out loud and
13 clear as a driver of burnout.

14
15 The lack of social connectedness at work. So it's
16 really interesting, in our data, 33 per cent of the
17 workforce reported a sense of isolation at work being one
18 of their major drivers of distress, and that's a really
19 easy thing to do.

20
21 Q. What causes that. What do you think causes that?

22 A. Well, if you look at a variety of things, from
23 a building workplaces point of view, we have systematically
24 taken all staff lounges out, so any areas or infrastructure
25 to connect, we've taken them out of the hospital systems.

26
27 Q. Why?

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

31
32 Q. Why were they taken out, though, do you know?

33 A. That would be prior to my time, but it's something
34 that's talked about by all the senior clinicians of - that
35 was always there.

36
37 Q. I'm only asking why because it doesn't make any sense
38 to me at the moment.

39 A. Cost saving is what I imagine.

40
41 Q. Right. Okay.

42 A. I think the other - what were we talking about --

43
44 Q. Causes of burnout.

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

1 well. So the workplace obviously cannot be responsible for
2 all those factors, but the way we create a culture where
3 people can be human beings in coming to work - so we will
4 show that there is carer distress and, you know, parental
5 distress and financial security and all those things are
6 individual drivers of distress that will contribute to
7 someone's burnout, and you can't just tease it all out;
8 when you're measuring burnout, the individual will put it
9 all in there. So we can look at what the workplace drivers
10 are, and that's where our interventions are trying to help.
11

12 The biggest effect, if you look at the literature, and
13 again locally, on an individual's burnout is the leadership
14 skill of their direct manager. That manager has more of an
15 effect on your wellbeing than that person's GP, and as much
16 of an effect as their spouse.
17

18 So leadership and skilled leadership in management is
19 a really, really critical thing to look at when we're
20 trying to address this at a systems level, because of the
21 profound impact it has on staff wellbeing, staff culture
22 and a myriad of other things that will influence someone's
23 sense of feeling valued at work. The lens that they look
24 at administration through is all coloured by the guardians
25 of that culture.
26

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

36 A. Great question.
37

38 Q. I appreciate that's a really difficult question and
39 it's difficult on the fly. Have a go.

40 A. So many things.
41

42 Q. Have a go.

43 A. So many things.
44

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

1 A. So I think we need a national approach to this. It
2 would be a priority area for the federal government and
3 we'd have a task force put on to this straightaway.
4

5 Q. By that, I take it you immediately mean that burnout
6 in the public medical system is not limited to New South
7 Wales?

8 A. Absolutely. This is a worldwide problem. We want to
9 be at the leading edge of the solution to it in New South
10 Wales, and I guess that's what we're trying to do.
11

12 Q. Yes.

13 A. But I think in terms of filtering down, because it
14 does - you said "money", but that would influence money,
15 but it also influences policy at all levels, and there's so
16 much in terms of policy and awards and KPIs that if we
17 don't have that, at the highest level, made a priority area
18 and, you know, brain, think tanks around it, task force on
19 to it - that would be my starting point.
20

21 I think we then need a really clear set of accurate
22 data measurements to understand and measure the prevalence
23 of the problem, its impacts and its drivers in different
24 areas, and my, you know, wish would be we had real-time
25 access to that data and that it was fed back to heads of
26 department so that they, at their fingertips, had
27 information that they could act on.
28

29 I think the policies --
30

31 Q. Because then their decision-making would be based on
32 the best data; right?

33 A. Exactly. I think we see - staff wellbeing would be
34 seen as a quality and safety issue. I mean, it's a quality
35 and safety issue, it's a work health safety issue, it's
36 a training and accreditation issue, but as a --
37

38 Q. And not just safety for the employees but safety for
39 the patients --

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

1 example. Staff wellbeing is not a KPI. So you sort of
2 need to filter it down at all levels.
3

4 You then need oversight of it, and I hope, and I am
5 living proof, and I have three other colleagues across the
6 country that show that you need high-level clinical leader
7 and these CWO roles to be rolled out and for every
8 organisation to have someone that is empowered within the
9 organisation, with the time, budget and resources, to
10 oversee this process and to make sure that there's strategy
11 and direction, because, you know, the issues at RPA, for
12 example, might be - well, they are - completely different
13 to Concord and Canterbury. So you need to have that
14 high-level systems approach but that ability to have
15 a local sort of approach to it.
16

17 I think staffing and workload is a massive issue and
18 no doubt you've heard that from many of the statements that
19 have already been given. How do we get around - how do we
20 afford better ratios? How do we change the way we're doing
21 care so that it's not all hospital based and we could
22 offload the systems? I think hopefully there are some
23 really good ideas around that. So workload I think, you
24 know, is a big driver and we could do that.
25

26 Leadership, I think is also the absolute key, as I've
27 alluded to, and influencing the curriculum at all levels.
28 We would all be teaching the same thing, at a, you know,
29 spectrum, and we'd all be measuring the same outcomes that
30 mattered to look to this. That would then feed into
31 selection processes for people in leadership positions that
32 would have that skill set and, you know, moving forward, we
33 would have a sense of community at work, we would have
34 staff lounges to go to.
35

36 One of the most simple interventions that we did post
37 COVID, I think it cost \$1,500 a year, it was what the
38 anaesthetists/ICU surgeons wanted, which was the bread and
39 cheese to be put back into the theatre so that when they
40 couldn't get out, they could have a cheese toastie. Like,
41 it's not rocket science, a lot of this stuff. So how do we
42 do really simple-level, you know, interventions like that,
43 but without the oversight and the data and asking the front
44 line for the solutions and then having teams - I think
45 there's a lot of pebbles in the shoe that can be fixed --
46

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

1 burnout, I assume, is cumulative?

2 A. Absolutely.

3

4 Q. And the things that you can do that, for want of
5 a better expression, create a happier workplace, it's one
6 less layer in that building that might create burnout;
7 correct?

8 A. Absolutely. Absolutely. And you might eat that
9 cheese toastie with a junior and have a mentoring
10 conversation. There are all these other social connected
11 things that can happen.

12

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

21

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

27

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

37 A. (Witness nods).

38

39 THE COMMISSIONER: That's me for now.

40

41 MR MUSTON: Q. Can I take you back to paragraph 27 of
42 your statement, where you effectively I think summarise
43 a lot of the issues that you raised insofar as the
44 non-reporting culture within the medical profession are
45 concerned. Do you see that paragraph?

46 A. Yes, I'm there. Sorry.

47

1 Q. No, that's okay. Just a couple of questions about
2 that. The first is: is, at least to your observation, the
3 existence of that culture as a feature of the medical
4 profession reasonably well recognised?
5 A. Sorry?
6
7 Q. Is that culture or practice, as a feature of medicine,
8 reasonably well recognised?
9 A. Yes.
10
11 Q. Does that mean that if confronted with a situation in
12 which there might be a significant number of people within
13 a department or a facility who are expressing grave
14 concerns about something, but perhaps not the entirety of
15 the people working within that unit or facility, that one
16 can't safely assume that there's no problem?
17 A. Correct.
18
19 Q. In fact, the existence of that culture would tend to
20 mean that if you get a reasonable number of people who are
21 expressing a concern within this otherwise somewhat
22 constrained group of medical practitioners, that maybe
23 there really is a problem there that needs to be at least
24 investigated?
25 A. That would seem fair.
26
27 MR MUSTON: Just as an aside, could I ask, operator, if we
28 could go to [SCI.0012.0160.0001].
29
30 Q. Is that a document you are familiar with?
31 A. Only from watching you. Not one I've seen before.
32
33 Q. You know what's coming next?
34 A. I do, and I was shocked when I saw it the first time.
35
36 THE COMMISSIONER: It's even highlighted in advance.
37
38 MR MUSTON: Q. You might have answered my next question,
39 but if the operator could scroll down to the second page.
40 You see the highlighted section there? That, I presume, is
41 what you were shocked by?
42 A. Yes, well, I'd like to think maybe there's been
43 a transcribing error or something.
44
45 Q. You'd like to think so.
46
47 THE COMMISSIONER: I'm going to assume --

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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

1 were the observations that you have made across that period
2 that led you to - or led you to conclude that there was
3 a decline in the morale at Concord? Obviously not on an
4 observation by observation basis, but what are the sorts of
5 things that have led you over that period to reach that
6 conclusion?

7 A. A few different things. I've been in the district
8 since my student training, so for over 23/4 years, and so
9 I have a lot of close colleagues that work at Concord
10 hospital and I guess in my position as the chief wellness
11 officer, you know, one of the first things I did when we
12 started looking at rolling out the program there in the
13 pre-work in 2019/2020 was I went and sat down with all the
14 heads of department and just listened to see, you know,
15 what the key wellbeing issues were.
16

17 And I guess the - it was interesting how themes arise
18 with that sort of qualitative feedback quite quickly. It
19 was very clear to me, and you know had been, I guess, that
20 Concord really prided themselves on that sense of community
21 and there was a sense that that had eroded over time and
22 that people, you know, felt very isolated from one another,
23 that increasing gap, I would guess I was referring to, with
24 administration, and that sense of, you know, being really
25 proud to work there had dissipated and they were all
26 telling me, you know, the stories, I guess, related to
27 that.
28

29 One of the - you know, as an aside - key things at
30 Concord hospital they really love and pride themselves on
31 is market day. They all get their lunches, they all
32 connect. With COVID and everything, that got taken away,
33 and so lots of stories around the loss of sense of
34 community, and that would be an example of how, you know,
35 it had been lost.
36

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

39 A. Correct.
40

41 Q. -- that you refer to in the second sentence there, but
42 am I right to gather from what you've said that the steady
43 decline in morale at Concord was something which preceded
44 COVID?

45 A. Absolutely. I - from the feedback, certainly from my
46 colleagues, you know, that - it was probably, you know,
47 years and years over that, and as we're talking about, in a

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

3

4 Q. In terms of the isolation from administration that
5 you've referred to there, there's a number of other issues
6 which I'm going to ask you whether they are, in effect,
7 symptoms of the same thing. The lack of access to
8 administration to raise issues, I assume is part of that
9 isolation from administration that you refer to?

10 A. Yes, I think so. I think, you know, rhetoric around
11 lack of visibility, lack of being able to, you know, get
12 a meeting, perhaps delayed or lack of responses to emails -
13 those sorts of things just sort of - as an isolated one-off
14 thing, you wouldn't think too much but it felt like
15 a cumulative.

16

17 Q. What about the lack of transparency about
18 decision-making and the lack of consultancy and shared
19 decision-making?

20 A. That certainly was voiced on several occasions.

21

22 Q. Does that, in essence, carry with it a sense of a lack
23 of power of the type you spoke to as one of the key drivers
24 of distress?

25 A. Absolutely. I think lack of control, lack of
26 autonomy, lack of feeling heard; it's like all the key
27 things that drive burnout, which are all profoundly human
28 being factors, I think contributed significantly to the
29 distress and the amplification of that distress.

30

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

35 A. Correct.

36

37 Q. You then refer to a survey or some survey and focus
38 group discussions. In relation to the survey, when was
39 that, the survey, undertaken and what was it?

40 A. So we do the Sydney Local Health District annual
41 medical officer survey, and the first one was 2020; the
42 second one was 2021; and then we do it yearly.

43

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

1 A. Yes, and fair to say they weren't isolated to Concord.
2 They were general frustrations within the medical
3 fraternity across the district.
4

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

8 A. Yes.
9

10 Q. And when was that?

11 A. The results were presented at a variety of different
12 forums, both through our governance structure with the MDOK
13 committees and then at extra meetings that we held as we
14 were planning to shift to an all-staff model, and from MDOK
15 to My District OK, and they were presented at grand rounds,
16 at conferences. So they've been presented in a variety of
17 different forums.
18

19 The focus of the presentations I guess may have
20 shifted a little bit but the data is certainly available
21 and in the hands of above.
22

23 Q. So the data and the findings about the particular
24 troubles or challenges which existed at Concord hospital -
25 were they shared with the chief executive of the district?

26 A. We created heat maps around what the drivers of
27 distress were for each of the hospitals and broke it down
28 by departments, and so I guess the - there was, you know,
29 a cut of the results. It wouldn't have had verbatim
30 qualitative statements in it. We did a thematic analysis
31 and put the themes together about what some of the common
32 issues were, so the language may have been around things
33 like frustration with bureaucratic processes, or sort of
34 broad language around that, rather than specifics.
35

36 Q. Within the executive as a result of the various
37 presentations that you've just described, do you think
38 there is likely to have been an awareness of the existence
39 of this sort of data in relation to Concord hospital, say,
40 from 2021, 2022?

41 A. We tended to look with a district lens. We were very
42 early on, I guess, in the process with the way we were
43 presenting the data. Fair to say, when we started, and
44 particularly the first year, there was a lot of fear around
45 that the data would be weaponised.
46

47 Q. Fear by whom?

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

7
8 We started to look at areas and present the data where
9 we thought we'd focus energies and be able to put
10 interventions, and so we did not start with
11 bullying/harassment, for example. We could sort of
12 highlight the rates of bullying/harassment and point out
13 the differences in rates between, perhaps, our more
14 granular data and some other data that the district had,
15 and that was very useful.

16
17 We were able to, you know, glean insights from that
18 around where the bullying was happening and, you know, that
19 it wasn't necessarily just happening between senior and
20 junior staff, that actually, some of it was coming from
21 patients and carers and other areas. So we focused,
22 I guess, on that level of detail and that was different at
23 different meetings.

24
25 Q. You referred to the weaponisation of the data?

26 A. Mmm.

27
28 Q. In what way did you perceive that administration was
29 fearful that the data could be weaponised?

30 A. Oh, look, I was aware when we were, you know,
31 designing the survey and things that there were class
32 action lawsuits out, that the - you know, we were recording
33 some data around whether lunch breaks were being taken and
34 what the barriers and things to that were so that we could,
35 you know, design interventions and things in that way.

36
37 I think there was a fear at that time that, you know,
38 particular parts of data could be taken and used by
39 different factions for other purposes that weren't what
40 this was intended to be, which was a constructive exercise
41 locally about how do we improve things for staff. And
42 I think any time you collect granular data, there's always
43 the risk that things will end up in the media, and that -
44 like, and we've seen it happen. So I understand the fears
45 and I think, hence, why we tried to really do it in as
46 robustly ethical, de-identified, high-level reporting, to
47 begin with, way as we could.

1
2 Fair to say that I think those fears have dissipated
3 a lot over the years but it's been a journey of getting
4 comfortable with what that data is and how to discuss it.
5

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

12 A. That was a potential risk.
13

14 Q. Those fears you saw as an impediment that needed to be
15 overcome in order to gather the information required for
16 your purposes to try and identify those problems and solve
17 them?

18 A. Yes, it was the language around how do we have
19 constructive conversations. We saw it when we put out, you
20 know, length-of-stay reports and they suddenly became, you
21 know, hostile negotiations about, "You're not doing your
22 job correctly. You've got to get patients out quicker",
23 and things like that. Actually, when we changed the
24 rhetoric around let's understand the data, what's it
25 telling us and how do we intervene - so it was the same
26 sort of process that we needed to go through, and I think
27 at the same time, clinicians needed to feel safe that they
28 weren't going to be identified when data was being
29 presented. So there were sort of two sides to this coin
30 that we needed to appreciate when we were doing a very new
31 novel process that, you know, potentially shone lights on
32 difficult areas for people.
33

34 Q. Did you become acutely aware that, by at least early
35 2023, if not before that, in a fairly significant way,
36 wellness did not abound at Concord?

37 A. Yes.
38

39 Q. Were you asked by the executive or anyone within the
40 executive to stage or assist with any sort of intervention
41 into how that might be dealt with, or your group?

42 A. No. It was felt - and we've tried to sort of respect
43 this process the entire way - that the wellness team needed
44 to be really careful about intervening in "operational
45 matters", I think was the language being used, and so when
46 there were disputes that involved people both sides and
47 we're trying to look after both sides, how do you position

1 yourself in sort of neutral territory to do that? So hence
2 we positioned ourselves with just trying to provide support
3 for those involved, but never requested from above to be
4 involved in any other process than doing what we were
5 already doing.
6

7 Q. Does that, though, proceed on the assumption that what
8 might have been happening at Concord was a dispute between
9 both sides rather than a gap between both sides that might
10 constructively have been bridged?

11 A. I think things start as a gap and seem to amplify very
12 quickly, certainly at the end, seem to amplify very
13 quickly.
14

15 Q. Could I get you to jump over to paragraph 37 of your
16 statement where you point to a situation at Concord as
17 highlighting what can occur when staff feel that they've
18 exhausted local mechanisms but feel that their complaints
19 have not been heard or addressed. What do you think, at
20 least based on the information that you've been able to
21 gather in your current role, are some of the reasons why
22 those feelings developed at Concord in the way that they
23 did, seemingly to a greater extent than they might have
24 developed or had developed at RPA and at Canterbury? That
25 was a very long-winded way, of saying based on what you
26 know as the chief wellness officer, why do you think it
27 happened?

28 A. In terms of the "why" being why did it - why did it
29 escalate to a vote of no confidence?
30

31 Q. What was it about the culture or about the engagement
32 between the frontline workforce and the executive at
33 Concord which, to your view, led to it spiralling in the
34 way that it did?

35 A. I think everything's got a breaking point, and what
36 was a slow-burning discontent, amplified by COVID,
37 sky-rocketing rates of burnout, leads to people not
38 necessarily being their best selves, physiologically you're
39 not - higher centres are off, you're in your lizard brain,
40 and then combining that with a sense that you have
41 exhausted every mechanism that you know how and are still
42 not going anywhere, I think people hit a point where they
43 felt they had no other option than to, you know, take quite
44 drastic action, is I guess my interpretation of it, and
45 that was the action that they felt was the only thing they
46 had available to them.
47

1 Q. Could I ask you to go down to the next paragraph,
2 paragraph 38, where you talk about the value of a strong
3 relationship between clinicians and administration and the
4 role that medical staff councils can play in that. In the
5 last sentence you tell us that the structure was in place
6 at Concord - that is, the medical staff council structure -
7 but it wasn't working effectively. Do you have a view as
8 to why that might have been the case?

9 A. I didn't attend the meetings. So it would be my
10 assumptions and probably biases from what I had witnessed
11 at the RPA medical staff council, and that was what I was
12 alluding to before. I think it didn't have - well, it had
13 had the same leadership for a very long time, it didn't
14 have a strong agenda, no-one was attending, it wasn't
15 identifying the key issues that needed to be escalated, but
16 certainly the experience of my first, you know, five, six
17 years within it is that there weren't these sorts of things
18 happening.

19
20 So, you know, talking to colleagues, you see this
21 pattern a little bit where everything, when it's running
22 really well, there's not a lot for the medical staff
23 council to be discussing at those meetings and they become
24 really important when, you know, key issues arise. That,
25 I think, seems to certainly have happened.

26
27 Q. Is there potentially an issue that where those key
28 issues start to arise and the medical staff council becomes
29 more engaged and perhaps more adversarial than might
30 traditionally have been the case, that responding to that
31 as though it is a dispute between the medical staff
32 council, the frontline workers on the one hand, and
33 hospital administration on the other, serves only to widen
34 the gap which might, in fact, be the cause of the problem
35 in the first place?

36 A. Yes, and I think that's why you need the strong
37 working relationships in place, because if they're there,
38 you know, good times, great, but when the challenges come,
39 you've got that lens of, you know, a constructive, "How do
40 we work this out together?" So, yes, I think, you know,
41 both sides - we on the medical side have the onus on
42 ourselves to make sure we keep strong medical staff
43 councils, keep those relationships going, so that we can,
44 you know, raise those issues and keep that structure in
45 place for future generations.

46
47 Q. If you do, undesirable though it is, reach a point

1 where the sorts of issues that you have identified in
2 paragraph 34 as existing at Concord build to a level where
3 there is that real discontent within the medical staff
4 council, is it, in your view, incumbent upon executive or
5 the administration to try and find solutions to that, to
6 bridge that gap, in circumstances where a frayed medical
7 workforce has reached a point where it might not be able to
8 do so itself?

9 A. Yes, I think it's a bit unfair to just put it on one
10 side. It has to be a two-way street. So, yes, if that -
11 if difficulties arrive and they're escalating, this is
12 where having, you know, good strong leaders on both sides
13 to try and (a) nip it in the bud early but if it does
14 circulate have, you know, those skill sets to be able to
15 deescalate it and bring it back to a constructive way
16 forward.

17
18 Q. On both sides, both within the medical staff council
19 and within the executive, to the extent that things might
20 have started to become problematic through burnout and
21 other causes, it really comes down to strong and
22 appropriate leadership on both sides aimed at finding -
23 collaborating to find solutions to the problems rather than
24 entering into a situation of conflict with one another?

25 A. Absolutely.

26
27 Q. Could I take you to paragraph 39, finally. You tell
28 us a little bit there about what you perceive to be one of
29 the structural issues that you think might have contributed
30 to the communication problems being the clinical stream
31 structure.

32 A. (Witness nods).

33
34 Q. From your perspective, could you just explain to us
35 what you understand - or how the clinical streams structure
36 worked within Sydney Local Health District, or didn't work,
37 as the case may be?

38 A. Yes. So it's an interesting structure. Again,
39 I share my experiences of both being within, obviously,
40 a very messy clinical stream, I was in neurosciences, bone
41 and joint health, ENT, immunology, like with eight to 10
42 other departments with very different issues, to mine as
43 a rheumatologist, and as head of department. It was
44 a parallel structure that felt like, you know, its roles
45 were to look at a district lens on things. So obviously
46 we, you know, have rheumatology services, for example, at
47 all - RPA, Concord and Canterbury, so when you're planning

1 strategic allocation of those resources and things having
2 a district lens on some of that strategic planning can be
3 very useful.
4

5 What it doesn't do and what I found very challenging
6 is, as the operational lead for your site, it doesn't
7 connect in to that, and the way it was set up for us, you
8 know, at least, when you've got one person who is trying to
9 represent, you know, eight different departments, three
10 different sites, so 20-plus different people often, who
11 have completely different needs, aspirations, goals, you
12 have set a process up to fail.
13

14 So I think it was seen very much as a reporting up,
15 and what the clinical stream directors had was a direct
16 line to the chief executive that the heads of department,
17 who are running day-to-day business, did not have. So it
18 disempowered heads of department, and that led to some
19 conflict, I think, on the ground and some challenges around
20 communication and identifying issues and having issues
21 escalated up quickly through those levels.
22

23 I understand, you know, in a way if you're a chief
24 executive, you cannot have 172 reports coming in to you and
25 you need to look at how do you plan your resources with
26 a district lens. So I think from my perspective, the
27 clinical stream director, as someone on the ground trying
28 to run a service, didn't help me very much, and I think
29 what COVID taught us is we devolved back to division
30 lines - division of medicine, division of surgery - and
31 within that structure, those chairs don't actually sit up
32 and have authority, even though that's where a lot of the
33 feedback mechanisms are going.
34

35 So one of the things, yes, to try and prevent the next
36 Concord-type situation and improve the rest of the district
37 is to re-look at our medical structures and how they can
38 better align and work together.
39

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

1 bit more detail the problem that you identified there in
2 paragraph 40 about the lack of diversity, in particular, in
3 the people who hold those roles or have held those roles?

4 A. Yes, I think (a) you've got the structural problem,
5 that then makes it very difficult for the people taking on
6 those clinical leadership roles in truly representing the
7 diverse interests of, you know, the subgroups that they are
8 representing. I think historically what we saw was the
9 same people in those roles for very long periods of time
10 and so we didn't necessarily have a time period for
11 re-looking at re-election of those roles, like we do with
12 many other, I guess, leadership roles, and that would be
13 another suggestion, I guess, moving forward.

14
15 I think the position description of those needs to
16 match, you know, the time that those people can spend. If
17 you truly want someone to represent properly 10 different
18 departments across three different hospitals, you need to
19 have the right FTE attached to that to be able to do it.

20
21 So I think we either need to change the structure, we
22 need to look at selection processes and how, you know, we
23 create succession planning, skill development, turn those
24 roles over so that we improve leadership I think across the
25 district and then, you know, also look at - my final point,
26 which has gone. I probably need some sugar. Apologies.
27 I've forgotten my train of thought.

28
29 Q. You may not know this, but is the clinical stream
30 structure where you have this smaller group of clinical
31 stream directors who are reporting to the chief executive,
32 a unique feature of the Sydney Local Health District or is
33 it something which has been rolled out in other districts?

34 A. We have a new acting at the moment and he has
35 certainly said that's not the way he runs things and he
36 found it unique.

37
38 MR MUSTON: Thank you, Dr Richards. I have no further
39 questions of you.

40
41 THE WITNESS: Thank you.

42
43 THE COMMISSIONER: Mr Cheney, do you have any questions?

44
45 MR CHENEY: No, Commissioner.

46
47 THE COMMISSIONER: Dr Richards, thank you very much for

1 your time. We're very grateful.
2
3 THE WITNESS: Pleasure.
4
5 THE COMMISSIONER: You are excused.
6
7 MR MUSTON: I think the only thing that flows out of that
8 is that you have set the Inquiry team, and indirectly
9 Dr Richards, some homework in relation some of that --
10
11 THE WITNESS: I'll send you some studies.
12
13 MR MUSTON: I will cause someone to reach out to you in
14 relation to that.
15
16 THE WITNESS: No problem.
17
18 **<THE WITNESS WITHDREW**
19
20 THE COMMISSIONER: All right. So we adjourn until
21 10 o'clock on Monday?
22
23 MR MUSTON: 10 o'clock on Monday.
24
25 THE COMMISSIONER: Thank you all. We'll adjourn until
26 10 o'clock on Monday.
27
28 **AT 3.39PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
29 **TO MONDAY, 5 AUGUST 2024 AT 10AM**
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