

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

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

Tuesday, 6 August 2024 at 10am

(Day 045)

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 Richard Cheney SC with Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning.

2

3 MR MUSTON: The next witness, Commissioner, is
4 Dr Anderson.

5

6 <TERESA MAREE ANDERSON, sworn: [10.01am]

7

8 <EXAMINATION BY MR MUSTON:

9

10 MR MUSTON: Q. Dr Anderson, could you state your full
11 name for the record again?

12 A. Teresa Maree Anderson.

13

14 Q. And you are, currently, the chief executive of the
15 Single Digital Patient Record Implementation Authority?

16 A. Yes, a mouthful.

17

18 Q. It is. A role that you took up on 27 May of this
19 year?

20 A. Yes.

21

22 Q. Prior to that, between 1 January 2011 and 26 May of
23 this year, you were the chief executive of the Sydney Local
24 Health District?

25 A. That's correct.

26

27 Q. You've prepared a number of statements to assist the
28 Inquiry with its work, but the one I wish to take you to
29 for present purposes is that dated 30 July 2024?

30 A. Yes.

31

32 Q. Do you have a copy of that statement with you?

33 A. I do.

34

35 Q. Have you had an opportunity to read that statement
36 before giving your evidence today?

37 A. I have.

38

39 Q. I understand there are a couple of corrections that
40 you wish to make to it?

41 A. Yes, please.

42

43 Q. If you could take us through them, perhaps starting by
44 reference to the paragraph number and then telling us what
45 you would wish to correct?

46 A. Thank you. So paragraph 3. I actually provided the
47 statement on 31 January, not on 29 January.

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Q. Thank you. There's a further correction, I think?

A. Yes.

Q. Paragraph 128?

A. Paragraph 128. So annexure N is the correct version at the time of my 24 April 2023 letter. The version I was referring to was from May 2022.

Q. So that's a paragraph that deals with the terms of reference. There's an annexure N to Dr Cheung's affidavit --

A. Yes, that's correct.

Q. -- which is the version that was a current version at the time you sent the letter to him?

A. Correct.

Q. The version that you've included as an annexure to your statement was an earlier iteration?

A. Was the earlier version, yes.

Q. Thank you. In the first sort of 56-odd paragraphs of your statement you set out for us in some detail the technical avenues available to staff members within the Sydney Local Health District for the airing of workplace grievances.

A. Yes.

Q. We've received some evidence that suggests that there is a strong culture within medicine not to speak up about concerns that one might have for fear of reprisal or being seen as being a difficult person. Do you agree that that's one of the challenges that exists within the health system when one is dealing with the medical workforce?

A. In part.

Q. When you say "in part", what do you mean by that?

A. We do have many clinicians who appear to feel free to speak up, and there are some who have indicated that they don't.

Q. But would it be right to say that of those who are disinclined to speak up, for the reasons which I've just identified, it's very difficult to reach any meaningful view about what proportion of the workforce they make up because they don't speak up?

1 A. It's very challenging.

2

3 Q. During your period as chief executive of the Sydney
4 Local Health District, you were involved in the
5 introduction of a role of the chief wellness officer?

6 A. Correct.

7

8 Q. Could you explain what that officer's role was and
9 what it was anticipated that they would bring to the
10 district?

11 A. Thank you. It came on the back of our basic physician
12 trainees putting a proposal to me in a program that we call
13 "The Pitch", where staff can pitch ideas, and it came out
14 of concern around the suicide of a number of JMOs across
15 NSW Health, not in Sydney Local Health District, but they
16 were colleagues of our basic physician trainees. And so
17 they put a proposal about a staff wellbeing and support
18 program for junior medical staff, and that included looking
19 at their psychological wellbeing, their physical wellbeing
20 but also mentoring and supporting them through challenging
21 environments - health is really challenging.

22

23 So after that, the idea of a chief wellness officer, a
24 medical clinician who came from the organisation, was put
25 to me and I thought it was a great idea, supported that --

26

27 Q. Just pausing there, roughly when did that happen, do
28 you recall?

29 A. That was around 2018/19, those discussions occurred,
30 and there was a program, an evidence-based program in
31 Stanford in the US, so I supported Bethan Richards to go
32 and study that program, so that what we were doing was
33 based on evidence rather than based on, you know, a good
34 idea.

35

36 That program was initially at Royal Prince Alfred
37 Hospital. It was very successful, great feedback from the
38 junior medical staff indicating that they felt very
39 supported by it, and that was reflected in some of the
40 results of the national junior medical officer survey - the
41 title probably is wrong, but that's a regular survey that
42 occurs across the whole of Australia.

43

44 So then we determined, and with the support of the
45 ministry, extended that program to my - MDOK, which was not
46 just about junior medical staff but also senior medical
47 staff, recognising the challenges that they experience, and

1 then we've expanded that across Concord and Canterbury
2 hospitals as well.
3
4 Q. So that expansion of the My District OK program
5 serendipitously perhaps occurred before the pressures of
6 COVID were brought to bear upon the health system?
7 A. Yes. And they did a lot of work during COVID to
8 support staff on the ground. It was a really difficult
9 time for everyone.
10
11 Q. And that support that was being provided, was that
12 occurring across all three facilities --
13 A. Correct.
14
15 Q. -- within the health district?
16 A. Yes.
17
18 Q. Another aspect, we were told by Dr Richards of the
19 program, was the creation of the Sydney Local Health
20 District wellbeing database?
21 A. Correct.
22
23 Q. You're familiar with that as a project that the group
24 was undertaking?
25 A. Yes.
26
27 Q. Did you consider it to be a valuable resource?
28 A. I did.
29
30 Q. There was some evidence given about concerns around
31 the weaponisation of data that was potentially being
32 collected through that process. Did you have a view in
33 relation to that or was that something that was raised with
34 you at any time?
35 A. It was never raised with me.
36
37 Q. In terms of the value that the wellbeing database
38 brings to the system, we're told that it addresses what are
39 gaps in the "People Matter" survey. Did you understand it
40 to --
41 A. It complements that.
42
43 Q. -- have that benefit? It complements it to the extent
44 that there are gaps in the "People Matter" survey because
45 it lacks the granularity that might be needed to get
46 a proper read on how things are happening in a particular
47 facility or a particular department?

1 A. It is more at the department level, and there are
2 questions in the wellbeing survey, which is evidence based,
3 based on the Stanford study, and the questions are
4 different to those in the "People Matter" survey. I think
5 both are really valuable, but certainly it gives more
6 granular data.

7
8 I should state that as the chief executive, I didn't
9 have access to that database. Bethan would talk to me
10 about areas that required focus, but I personally did not
11 see the data because I didn't think it was appropriate.

12
13 Q. You couldn't log into it, for example?

14 A. Oh, definitely not.

15
16 Q. But the chief wellness officer reported directly to
17 you --

18 A. Correct.

19
20 Q. -- in the structure at the health district?

21 A. Yes.

22
23 Q. And it was open to you to ask her, from time to time,
24 if you had particular questions that you felt that valuable
25 data might have assisted you with --

26 A. Yes.

27
28 Q. -- to provide that information?

29 A. Mmm.

30
31 MR MUSTON: Could I ask the operator to bring up to the
32 screen the statement of Bethan `Richards, which is
33 [MOH.9999.2147.0001], and if we could scroll to page 9.

34
35 Q. Could I ask you, Dr Anderson, just to read
36 paragraph 34 of that statement to yourself, in which
37 Dr Richards tells us her view about the morale and her
38 observations of what led to a decline in morale at Concord.
39 A. Yes, thank you.

40
41 Q. Were you aware, say, from the time at which this chief
42 wellness officer and the gathering of information that has
43 been alluded to in paragraph 34 commenced, of those
44 concerns being held by at least a proportion of the medical
45 staff at Concord?

46 A. Yes, I was aware.

47

1 Q. Did you have any reason to think that the concerns
2 that were held by at least a proportion of the medical
3 staff at Concord were not, at least in the minds of those
4 people, genuine concerns?

5 A. I agree they were genuine concerns.
6

7 Q. You have told us in your statement at paragraph 113,
8 referring in particular to subparagraph (a), about
9 a document which was provided or disseminated by Associate
10 Professor Cheung on 2 May, which was, you described as his
11 nomination document. That's a document that he was putting
12 forward to seek election to the position of chair of the
13 medical staff council at Concord?

14 A. Yes.
15

16 Q. Would it be right that the concerns which we've just
17 looked at in paragraph 34 of Dr Richards' statement were
18 broadly consistent with those which were being put forward
19 by Dr Cheung in his nomination document?

20 A. Broadly, yes.
21

22 Q. That is to say, the concerns that he was raising in
23 that document were consistent with the concerns you've told
24 us that a proportion of the staff - you understood
25 a proportion of the staff at Concord to genuinely hold?

26 A. Yes.
27

28 Q. You presumably saw Dr Cheung's nomination
29 correspondence at the time it was circulated?

30 A. I did.
31

32 Q. Did it cause you any concerns?

33 A. It did.
34

35 Q. What were those concerns?

36 A. It was really the language. Although I actually
37 agreed with the sentiment, because at the time there were
38 ongoing challenges in terms of the physical facilities and
39 we were working closely with the clinicians on the planning
40 for the redevelopment of Concord hospital, the staff were
41 understandably frustrated that it took some time to get the
42 redevelopment of Concord on to the capital program, and
43 that was because there's so many competing interests across
44 the whole of NSW Health, it was hard to get Concord on to
45 the capital program, and the clinicians were understandably
46 frustrated by that.
47

1 Part of the problem with expanding services at Concord
2 is that you needed the facilities to be able to expand
3 them. So there was a real desire to increase the
4 complexity of many of the services at Concord, but you
5 couldn't do that without having adequate facilities.
6

7 So we did put a lot of energy into the clinical
8 services planning and then into getting Concord onto the
9 capital program, and initially we were successful in
10 getting 250 million, which was challenging to be able to
11 make a real difference for Concord, so we continued to work
12 with the ministry and managed to get another 100 million,
13 for the 341 million for the redevelopment.
14

15 Because aged care and rehabilitation services were in
16 1941 army ramp wards, which were not fit for purpose, in
17 the clinical services planning with the clinicians, it was
18 determined that that would be the most appropriate focus
19 for the redevelopment in addition to cancer services, which
20 would enable that increase in complexity of services for
21 cancer, including a PET scanner.
22

23 Q. We've heard about, in some of the material, a stage 1
24 and a stage 2 of the Concord redevelopment. Are you able
25 to explain, perhaps by reference to what you've just told
26 us, what that staging involved?

27 A. Thank you. So when we did the initial plans for
28 Concord, it was for the whole, and when you're putting in
29 your capital asset plan, you put in what you want for the
30 whole. But unfortunately, for those competing reasons that
31 I mentioned, we were only successful in getting
32 341 million, which meant that we had to prioritise what
33 would go into stage 1, and we continued the planning for
34 stage 2, which would have included the emergency
35 department, radiology, an expansion of ICU and theatres.
36

37 We did that in consultation with senior clinicians and
38 junior clinicians across Concord hospital. But I think it
39 actually contributed to a divide, because there were those
40 who went into the beautiful new shiny building and those
41 who did not, and, you know, I regret that that feeling was
42 there.
43

44 Q. One of the concerns that was raised, that has been
45 identified by Dr Richards and has been raised by Dr Cheung,
46 is a perception that there was under-resourcing within
47 particular departments at Concord - you understood that to

1 be one of the concerns?

2 A. Yes.

3

4 Q. Just to try and understand the answer you gave
5 a moment ago, it's your view that the separation of the
6 stage 1 and the stage 2, which had the effect that certain
7 departments were going to continue, at least in terms of
8 the physical infrastructure that they had, as they were
9 whilst others were being improved, might have exacerbated
10 that sense, within some departments, of under-resourcing
11 being a problem?

12 A. Yes, and we tried to address that. So when the
13 stage 1 was completed and moved in, in February 2022, we
14 undertook planning and refurbishment of areas that were
15 decanted as part of the redevelopment. So haematology, for
16 example, moved into the new building, so we've refurbished
17 that area, and that will be used for the osteoarthritis
18 program and vascular medicine on level 5 east. We
19 refurbished that ward, which was a cancer ward, and that
20 was changed to a surgical short-stay, and the priorities
21 for that were developed by Concord hospital.

22

23 Q. So you mentioned --

24

25 THE COMMISSIONER: I don't think Dr Richards raised this
26 issue. I think it was Associate Professor Ridley who might
27 have expressly mentioned the tension created by some people
28 going into the new building and some people staying in the
29 old.

30

31 MR MUSTON: Dr Condon?

32

33 THE COMMISSIONER: No - oh, maybe it was. It probably
34 doesn't matter at the moment. I thought it was Associate
35 Professor Ridley. It could have been one of a dozen, but -
36 yes.

37

38 MR MUSTON: I think Dr Condon did touch on it.

39

40 Q. Well, I'll ask you a question that I think I asked him
41 and he answered. Haematology, just as one of the examples
42 that you gave, as a department that was moved into the new
43 facility, was a department which may not have, at least
44 insofar as it was expressing itself, appeared quite as
45 distressed as others. Would that be fair?

46 A. Yes, that would be fair.

47

1 Q. Now, that deals with the under-resourcing side of the
2 concerns that were held by the medical workforce at
3 Concord, but aligned with that is a sense that there was
4 a separation or isolation from the administration and
5 a perception that there was less autonomy, less access to
6 administration, not being listened to. What do you say was
7 the cause of or contributed to that concern on the part of
8 at least some of the medical workforce at Concord?

9 A. Prior to COVID, I wasn't aware that there was a sense
10 of separation. We spent a lot of time at Concord. During
11 the COVID pandemic, I think in part - I've reflected on it
12 a lot. I think in part, we were not able to go on site in
13 the hospitals as much as we did previously, because of the
14 restrictions and the fear of people meeting and
15 contributing to a transmission of COVID. They were very
16 difficult times. In addition to that, the district was
17 very involved in the state COVID response and I personally
18 was very involved with that, and I do think that that took
19 me away from the front line.

20
21 Q. Take your time. If you need a break at any moment,
22 I'm sure the Commissioner will happily accommodate that.

23
24 THE COMMISSIONER: Can we go back to something that you
25 touched on but I think I need to understand a little bit
26 more.

27
28 MR MUSTON: Sure.

29
30 THE COMMISSIONER: Q. Mr Muston asked you about - for
31 want of a better expression - Dr Cheung's election
32 material. You know what I'm talking about, the document he
33 put out, and you were asked whether you had some concerns
34 about it.

35 A. Mmm-hmm.

36
37 Q. You said you agreed with the sentiment but you did
38 have some concerns of the language?

39 A. Yes.

40
41 Q. Do you remember that exchange?

42 A. Yes.

43
44 Q. Can you just tell me what - it's actually an annexure
45 to your statement, at least in my copy it's H32.4. The
46 document number is [MOH.0010.0393.0001]. Yes, that's it.
47 Do you have a hard copy of this?

1 A. In front of me? No.

2

3 Q. Yes.

4 A. No.

5

6 THE COMMISSIONER: It might be easier if the witness had
7 a hard copy.

8

9 MR MUSTON: I'm sure that can be arranged.

10

11 THE COMMISSIONER: Thank you.

12

13 Q. Please take your time to look through this, but can
14 you tell me which bits - I mean, there are some references
15 to Crown Casino and Dreamworld that might be out there
16 a bit, but in terms of the document itself, can you tell me
17 what it was that gave you that concern in terms of its
18 language? Let's start, page 1. Is there anything on that
19 page that troubled you in terms of what?

20 A. Not really. I mean --

21

22 Q. All right. Next, we've got "Public Service", times
23 are tough for public service. I think that's the unanimous
24 view of every witness that's given evidence so far, but
25 just have a look at that column and tell me if there was
26 anything that concerned you in what Dr Cheung said about
27 public service.

28 A. In terms of staff wellbeing and the --

29

30 Q. Sorry, which paragraph am I looking at there, sorry?

31 A. Oh, sorry, my apologies.

32

33 Q. What does it start with?

34 A. It's the second column, "Staff Wellbeing", talking
35 about MDOK.

36

37 Q. Sorry, okay. Nothing in "Public Service". So "Staff
38 Wellbeing". Which part concerns you there?

39 A. In relation to discouraging tackling industrial
40 issues.

41

42 Q. Just tell me what the paragraph starts with, what are
43 the words?

44 A.

45

46 *What the MDOK job description didn't*
47 *mention is that MDOK was actively*

1 *"discouraged" to tackle industrial issues.*

2

3 Q. That's something you disagree with, I take it?

4 A. I do. And the last sentence --

5

6 Q. Did you ever have a discussion with Associate
7 Professor Cheung about that paragraph, saying, "Winston",
8 you know, "I don't agree with you there, Dr Cheung", or --

9 A. I did.

10

11 Q. You did?

12 A. Yes. That was in - I can't remember exactly the date,
13 but around March/April 2022. I said, you know, that - we
14 met and we talked about, you know, how we could work
15 together. I indicated that I wanted to work with him, had
16 always --

17

18 Q. This is just after he has been elected as the chair of
19 the council?

20 A. Yes, yes. Had always had a good relationship with the
21 medical staff council, and I reassured him that the
22 wellbeing particularly of our junior medical staff was
23 always front and centre.

24

25 MR MUSTON: Can I just interpose with a question around
26 that?

27

28 THE COMMISSIONER: Of course you can.

29

30 MR MUSTON: It might be a convenient time to do it.

31

32 Q. The evidence we've received from Dr Richards was to
33 the effect that a decision was made that the wellness team
34 should not intervene in what were described as "operational
35 matters", or take any role in disputes between staff and
36 the executive beyond supporting everyone involved?

37 A. Mmm.

38

39 Q. Was that a decision that you were involved in?

40 A. No.

41

42 Q. Were you aware that that approach had been taken by
43 the wellness team and the chief wellness officer in respect
44 to what might be regarded as disputes between staff and the
45 executive?

46 A. I don't know if it was - I'm not aware of the exact
47 context, but I don't necessarily think that means between -

1 industrial matters aren't necessarily between management
2 and the clinicians; it could be an issue to do with the
3 award.
4

5 Q. Other than generally supporting all of the staff of
6 the district who might be involved in a dispute, it wasn't
7 your understanding, was it, that the chief wellness officer
8 or the My District OK team were going to be actively
9 involved in dealing with industrial issues, was it?

10 A. No, that wasn't the purpose, but they did provide
11 support to junior medical staff and, in fact, I met one
12 time with the AMA to talk about their survey, had the chief
13 wellness officer with us, talking about how we support
14 junior medical staff and particularly in relation to hours
15 worked. So it's not consistent with - that is an
16 industrial matter, hours worked, but I suppose it just
17 depends on how it's framed. Does that make sense?

18
19 MR MUSTON: Yes. Sorry, Commissioner, I interrupted you.
20

21 THE COMMISSIONER: No, no, that's fine.
22

23 Q. Was there anything else in relation to staff
24 wellbeing - was that the main point that concerned you?

25 A. And that action only happened because a problem ended
26 up in a newspaper.
27

28 Q. I don't know any background to that, obviously
29 something ended up in --

30 A. I'm not sure of the context, but we took a lot of
31 action because the issues were raised with us, not because
32 of things being in the paper.
33

34 Q. I see. Then Dr Cheung is drawing analogies between
35 the Crown Casino Royal Commission, the Dreamworld coroner's
36 inquiry and the "Commonwealth Parliamentary Workplaces".
37 Did you have any concerns relating to the analogy of those
38 matters with --

39 A. I thought it was unusual.
40

41 Q. All right. By "unusual", should I take from that that
42 whilst there might be some similar principles involved, in
43 terms of at least Dreamworld and maybe the Commonwealth
44 parliament as well, and even Crown, it's dealing with
45 corruption, that it might have been a stretch in terms of
46 what's ultimately being looked at at those three
47 inquiries - was that what was concerning you?

- 1 A. Yes.
2
- 3 Q. Next page, "The Problems". Any concerns in relation
4 to what Dr Cheung said regarding underreporting?
5 A. Not really.
6
- 7 Q. "Public Interest Disclosure"?
8 A. No.
9
- 10 Q. The "Quality Improvement Systems"?
11 A. I think the issue with the commentary is that it is
12 very black and white, that there is no reporting, and, in
13 fact, Concord does have a high rate of reporting. Having
14 said that, you don't know what you don't know. But if you
15 look at Concord's reports compared to both other parts of
16 the districts and elsewhere, it didn't stand out as having
17 low reporting rates.
18
- 19 Q. Can we just pause there. I think Associate Professor
20 Cheung told us - my memory is, without going back to the
21 transcript - that this might have been the first time there
22 was actually a contest for who should be the chair of the
23 staff medical council; is that your recollection as well?
24 A. I wasn't present for the meeting but I understand that
25 was the case.
26
- 27 Q. When there had been prior times for, to your
28 knowledge, the election of a chair to the council, was
29 this - was Associate Professor Cheung's approach a new
30 approach in terms of --
31 A. Very.
32
- 33 Q. -- putting out a document?
34 A. Yes.
35
- 36 Q. Okay. All right. Focus on minimum standards?
37 A. I think, just in the second page of "Quality
38 Improvement Systems", in his language, he talks about
39 reporting used for purposes other than quality improvement,
40 used for reprisal, for cover-up, used to intimidate, bully
41 and harass.
42
- 43 Q. Sorry, which paragraph are you on?
44 A. Sorry.
45
- 46 Q. Can you just give me the first words of it?
47 A. It's the sixth paragraph, saying "At Concord,

- 1 reporting may be used."
2
3 Q. "Reporting may be used". I see. Okay. Your concern
4 about that specifically was?
5 A. The impression given that we were covering up
6 incidents.
7
8 Q. You didn't think that was fair or accurate?
9 A. Correct.
10
11 Q. Anything else on that page and in relation to problems
12 with training?
13 A. The comment on "Focus on minimum standards", that we
14 don't have a high performance unit.
15
16 Q. Again, I'm sorry, which paragraph?
17 A. Sorry.
18
19 Q. What does that start with?
20 A. The second column, commencing with, "At Concord we
21 don't have a High Performance Unit."
22
23 Q. Yes, I see that.
24 A. So we do have structures in place to support
25 performance and to report activity data but also
26 performance data.
27
28 Q. This is structures in place even if it's not labelled
29 a high performance unit; is that what you mean?
30 A. Correct, yes.
31
32 Q. "Problems with training"?
33 A. The commentary about mandatory training generally --
34
35 Q. "Contrast this", that paragraph?
36 A. Yes:
37
38 *Contrast this with Mandatory Training at*
39 *Concord. ... established to address*
40 *minimum standards. ... no high performance*
41 *intention to achieve excellence.*
42
43 I disagree with that. We --
44
45 Q. Is that for the same reason as the previous
46 discussion?
47 A. Yes. But also the next paragraph in:

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Instead, mandatory training at Concord was set up with the wrong intentions. ... as a tick-a-box.

It's not. Mandatory training is something that happens across all of NSW Health. It is reviewed on a regular basis, what is mandatory, and it's linked to particular policies, models of care, et cetera, and with 170,000 staff, it is important to say, you know, some training you really need to do - for example, advanced life support, you know, particular clinicians have to do that if they're going to be able and they've got to continue to update their knowledge. So it is about setting standards for excellence, not a minimum standard.

Q. All right. And over the page?

A. "Underinvestment".

Q. Yes.

A. Because it gives an impression that the hospital and the district have not looked to increase the investment at Concord, but our funding model is such that, you know, the funding that we get for the district is allocated as per a formula that is used by the Ministry of Health. So there was no intention - this gives an impression, was my belief, how I read this and --

Q. You don't like the language, "Concord has allowed underinvestment", I take it?

A. Correct.

Q. In the sense that, at least to a significant degree, even if you're, for want of a better word, lobbying for more money for your district or for this particular facility within your district, in the end, you get what you're given?

A. That's correct, and I would say that I and the district lobbied hard for resources for Sydney Local Health District and for Concord hospital. But at the end of the day, we have to manage with what we have.

Q. "Intimidation, Bullying and Harassment"?

A. I agree with the sentiment that people are concerned about that, but again, I think it gives an impression that we walk away from concerns of bullying and harassment. We take them very seriously.

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Q. And you don't agree with that --

A. I don't.

Q. You don't agree with that sentiment, at least?

A. I don't agree with that sentiment, no.

Q. Then I think Dr Cheung has referred to some other inquiries, a WorkCover inquiry, a "Public Service Commission Action Plan" and "Emergency Services Agencies Inquiry", that don't directly relate, I don't think, to Concord. Did you have any issues with any of that?

A. No.

Q. Then there's "COVID-19". Were there any concerns you had in what --

A. I think again the language used gives a sense that - I actually agree, it was a really traumatic time. I think we all have post traumatic stress from COVID, and it did take a toll. He uses a war-like analogy in relation to that, and the way that this was read by myself and by others is that the needs of staff were not considered in the response, when my belief - and I think we have strong evidence to support that - is the wellbeing of staff was foremost in our thoughts and in our actions.

Q. Anything else in relation to that page, page 8 at the top?

A. I think it's just the language, and no-one was told "We have to obey the ministry". We were - sorry, that's the third paragraph on page 8. That starts:

"It was too risky to allow visitors," we were told. "It was too hard." "We have to obey the ministry."

It was never said in that way, I can absolutely say that. But we were in a very difficult time and it was very difficult for families.

MR MUSTON: Could I just ask a question in relation to that?

THE COMMISSIONER: Of course you can, yes.

MR MUSTON: Q. When you say you are certain that it was never said in that way - that is, "We have to obey the

1 ministry" - are you making the point that it was never said
2 by you in that way?

3 A. It was definitely never said by me and I can't
4 imagine - I've never been in a meeting, I've never
5 witnessed anyone saying that.

6
7 Q. But the position is, isn't it, that insofar as
8 executive at the hospital might have been engaging with the
9 medical workforce during that COVID period, it's possible
10 that they might have expressed themselves in that way?

11 A. It's possible but I had never heard that statement
12 prior to reading this nomination document. It had never
13 been raised with me.

14
15 Q. Having read it, did you follow up with executive at
16 the hospital as to whether or not anyone might have used
17 that phrase at any point in time?

18 A. I actually did.

19

20 Q. Yes, with who?

21 A. With Genevieve Wallace, who was the general manager of
22 Concord at the time.

23

24 Q. What did she tell you?

25 A. She said that they talked about the rationale for the
26 restrictions, but it wasn't about the ministry, it was
27 around what we needed to do to keep families safe and our
28 staff safe. We were trying to avoid transmission amongst -
29 from the community into the hospital. Hospitals have very
30 vulnerable patients and what we do know is that, during
31 that period, some of the outbreaks that we had in hospitals
32 across New South Wales were actually through visitors
33 coming in to the hospital.

34

35 Q. Was there, at that time, any ministry policy around --

36 A. There was.

37

38 Q. -- visitors?

39 A. Yes, there was ministry policy.

40

41 Q. And that policy provided that certain things could and
42 couldn't happen?

43 A. Yes, yes, and it had the rationale for that.

44

45 Q. And there was an obligation, at least as you and no
46 doubt the executive at the hospital perceived it, to comply
47 with that policy directive?

1 A. Yes.

2

3 Q. From the ministry?

4 A. Yes.

5

6 THE COMMISSIONER: Q. It probably doesn't need to be
7 said, but those procedures, protocols, rules, whatever we
8 call them, weren't for Concord hospital only; they were for
9 hospitals across the board, right?

10 A. The whole of the state.

11

12 Q. Anything else on that page, page 8, that concerned
13 you?

14 A. No.

15

16 Q. Then I think on page 9 we commence with "The Change",
17 and there's a column and a bit on "Living with COVID". Was
18 there anything that troubled you?

19 A. Yes. Would you mind if we go back to page 8?

20

21 Q. Yes, of course.

22 A. The last three paragraphs on that page:

23

24 *The consequence of chronic*
25 *underinvestment [is] laid bare for all who*
26 *came to ICU to see. But not the public.*
27 *The public could not see.*

28

29 *The staff prevented from speaking publicly.*
30 *Prevented from sharing their stories.*
31 *Prevented from sharing their concerns,*
32 *prevented from sharing their pain.*

33

34 *They cannot be silenced anymore.*

35

36 I have nothing that has been shared with me that indicates
37 that staff were prevented from expressing their concerns.

38

39 MR MUSTON: In relation to that, if I could just ask
40 a question --

41

42 THE COMMISSIONER: Yes, you can. You don't need to keep
43 asking permission. You know that.

44

45 MR MUSTON: I don't want to interrupt you.

46

47 THE COMMISSIONER: There is no hierarchy here, not much of

1 one.

2

3 MR MUSTON: You have the high ground, literally.

4

5 THE COMMISSIONER: I do. But not if we were standing on
6 the same floor, I wouldn't.

7

8 MR MUSTON: Q. Did you make any inquiries of Dr Cheung
9 as to what lay behind those concerns or the sentiments that
10 are reflected in those paragraphs?

11 A. I did.

12

13 Q. At the time?

14 A. Yes.

15

16 Q. What did he tell you?

17 A. He said he couldn't speak to me about it because of
18 confidentiality.

19

20 Q. That is to say, because the concerns that had been
21 raised with him --

22 A. Yes.

23

24 Q. -- as a prospective chair of the medical staff
25 council, had been raised with him in confidence?

26 A. Yes.

27

28 Q. Is it your experience that that's not an uncommon
29 feature of the medical workforce and perhaps the health
30 workforce generally, that there is reporting that happens
31 in that confidential way with people who are seen as safe
32 and trusted recipients of the information, and then there's
33 the reporting that occurs through more formal channels?

34 A. That's correct, and it makes it very difficult for us
35 to then address it. So the ministry have set up a range of
36 different mechanisms outside of the district - not just our
37 district but across the districts - to enable staff who
38 have concerns to be able to escalate them to the ministry.

39

40 There's a JMO - we call it a hotline, but that is not
41 the name, where the JMOs can ring specifically. People can
42 write directly to the ministry. For these things to be
43 investigated, it is really hard without any particulars,
44 particularly in a hospital like Concord that has, you know,
45 if you add the VMOs, around 3,000 staff, knowing where you
46 can start without looking like it's a witch-hunt. There
47 are over 90 departments at Concord, so it's really hard to

1 investigate something if you don't know what the detail is.

2

3 Q. In this case, though, it could be narrowed down at
4 least to the intensive care department --

5 A. Yes.

6

7 Q. -- that is to say, the concerns that had been, it is
8 said by Dr Cheung, expressed?

9 A. Mmm-hmm.

10

11 Q. And the fact that those concerns had not been
12 particularised or made the subject of any formal complaints
13 or grievance process did not lead you to conclude, did it,
14 that the concerns were not genuinely felt by those who
15 might have shared them with Dr Cheung?

16 A. Yes, and I spoke to the head of intensive care around
17 that time - I can't remember what date - Mark Kol - to ask
18 what was happening, are there any concerns, is there
19 anything that I need to do?

20

21 There were concerns about the pressures on ICU across
22 every ICU in New South Wales, and we did a lot of work to
23 try and protect the ICU and make it fit for purpose. So
24 our engineering staff put up, what do you call it, little
25 walls between the beds to try and isolate patients. It was
26 hard to develop a new ICU at that time. But we did make
27 a lot of efforts to do that. There were also --

28

29 THE COMMISSIONER: Q. This is driven by COVID, I assume?

30 A. Correct, yes.

31

32 Q. Thank you. Sorry, I interrupted.

33 A. And we looked at the staffing, because a lot of staff
34 were being furloughed at this time, and we developed
35 a model with the ministry about making sure that when there
36 were shortages of staff in the ICU - and this was at a time
37 even with recruitment activities that everyone was trying
38 to get staff - that we had a model that staff on the wards,
39 who had had experience in ICU previously but were now
40 working in specialty areas or who had advanced life support
41 skills, were moved into the ICU to assist to support them.

42

43 MR MUSTON: Q. In relation to those staff with the
44 advanced life support skills, amongst them were nurses who,
45 whilst they had those skills, had little to no experience
46 in ICU --

47 A. Some of them; that's correct, yes.

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Q. And that was - as needs must during the pandemic, that was what --

A. That's right, and I understand the concerns, but the alternative would have been not to accept patients from the emergency department or wards into intensive care, because we recognised we needed staffing, but we tried to put in models that would assist. We also - at that time, there was a reduction in elective surgery so we moved anaesthetic nurses and others from operating theatres into ICU and emergency department, because they had critical care experience.

Q. You haven't raised it, so I assume this is the case, but it would not have been inaccurate for Dr Cheung to have suggested that nurses in ICU who had been seconded from other departments often had had little time in ICU prior to that?

A. Some. Not all. Some had had extensive experience in ICU but had chosen to go into particular sub-specialties.

Q. And some, although having the advanced lifesaving training, had not nursed in a complex ICU unit before?

A. Correct.

Q. But all of them, as Dr Cheung says, were willing to do their best and work their hardest in a difficult situation?

A. People were amazing during that time. There was huge goodwill and people were provided with a lot of support. So my issue is a lack of context. It gives an impression, to me, and it might be a wrong impression, that he was saying that what we had done was the wrong thing.

Q. Just coming back to page 8, when we were talking about the paragraph, the penultimate paragraph in that second column, where there's a reference to staff being prevented from speaking publicly and sharing their views, that's not something that you did, but --

A. No.

Q. -- it having been raised, I think you told us, with Dr Cheung confidentially, you couldn't be satisfied, could you, that it didn't actually happen?

A. No.

MR MUSTON: I'm sorry, Commissioner, did you have any further questions about this document?

1
2 THE COMMISSIONER: Q. So page 9 of the document sets
3 out, I think, some expectations and hopes about what will
4 happen in relation to living with COVID, about opening up,
5 what the community wants, expectations regarding elective
6 surgery, operational levels, comments made that living with
7 COVID can't be achieved at current levels of resourcing and
8 a comment about political leaders, and then, on the
9 right-hand side, about the new building, et cetera. Is
10 there anything in that section that caused you concern?

11 A. My interpretation, which could be wrong, was that --

12
13 Q. Well, it's just your opinion, so yes.

14 A. He is giving an impression that we weren't doing
15 anything to support that COVID recovery. In fact, in terms
16 of recovery from surgery, there were, you know, plans about
17 what we would do to recover after we ceased elective
18 surgery during that time.

19
20 Q. Is there anything specific about - when you say "you",
21 I'm assuming the LHD. To me, I get the impression - and
22 I could be wrong, too - that the complaint is more about
23 resourcing, which is more from treasury or politicians,
24 than anything else?

25 A. We actually did get additional funds, Concord got
26 additional funds during that time, I can't remember exactly
27 what it was, but it was substantial. Our district, in
28 fact, because of the multitude of responses around COVID,
29 was given substantial additional funding. Our staffing
30 increased from a base of around 12,500 to 16,000 staff
31 during that time, and that included both in the hospitals
32 but also in the various COVID responses. So additional
33 resource was given, but there were challenges.

34
35 Q. Leaving that aside, the commentary, "Our political
36 leaders", and "Health care spending", et cetera, do you
37 agree that seems more directed at - well, that doesn't seem
38 directed at management of the LHD; do you agree with that?

39 A. Oh, yes.

40
41 Q. It seems more directed at Macquarie Street --

42 A. Yes.

43
44 Q. -- or maybe Canberra, and maybe both. "Medical Staff
45 Council Reform", there are some comments about some
46 aspirations for the council in those, what is it, five
47 bullet points. Is there anything there that caused you

1 concern? Put to side for a moment, while you consider that
2 or answer it, the various draft terms of reference that
3 came later on, but in terms of this document, those bullet
4 points about best interests of the public, protect health,
5 et cetera, was anything that caused you concern there?
6 A. I have no problem with those, but I do have a problem
7 with the medical staff council "must be independent,
8 incorruptible and free from external influence."
9
10 Q. What's the concern there?
11 A. One is it's very hard for the medical staff council to
12 be independent when it's a structure within the district
13 under the by-laws. It gives a false sense that it can just
14 operate over to the side when its purpose is to provide
15 advice and --
16
17 Q. Advice, yes.
18 A. So - yes.
19
20 Q. I mean, I suppose you could read that as if the
21 essential function of a medical staff council is to give
22 advice to people or management, such as yourself, it would
23 do so at least independently itself and uninfluenced by
24 others.
25 A. Mmm.
26
27 Q. To that extent, "independent" is all right, isn't it?
28 A. Yes, if you put it that way. I think the wording
29 is --
30
31 Q. Your concern is that it's not independent from the
32 hospital?
33 A. No.
34
35 Q. Is that --
36 A. Yes. And I think the statement about "it must be
37 incorruptible" - and again, it appears to me, and maybe
38 wrongly, that that is - it gives a sense that other people
39 are corruptible, which I think is unfortunate.
40
41 Q. I suppose, though, you could read it, if we're just
42 looking at the text, which is all I've got at the moment,
43 that it's just a statement that a staff council should be
44 incorruptible, without drawing aspersions on anyone else or
45 any other body?
46 A. Yes, I think if you take it separately in that
47 context. If you take it as a whole you might have

1 a different feeling.

2

3 Q. The same about external influence. Just of itself
4 there's nothing wrong --

5 A. Of itself, no.

6

7 Q. -- with saying, "We should be free from external
8 influence"?

9 A. Mmm. I mean --

10

11 MR MUSTON: Q. Another way for it might be simply to
12 interpret it as a desire that the medical staff council be
13 free and comfortable in giving frank and fearless advice to
14 the executive even when that advice differs from or
15 suggests a departure from a decision that has been made by
16 the executive?

17 A. I would have been very happy with that wording. Could
18 I go to the top of that column --

19

20 THE COMMISSIONER: Q. Yes.

21 A. -- where it says:

22

23 *At Concord we will soon be operationalising*
24 *a new hospital building. There was no*
25 *agreement with the community or staff to*
26 *spend hundreds of millions of taxpayer*
27 *dollars on a new hospital, but not maintain*
28 *hospital operations, and not improve on*
29 *them.*

30

31 Q. Yes.

32 A. I disagree with that.

33

34 Q. Which part do you disagree with?

35 A. That - in terms of "no agreement with the community or
36 staff", you know, the community as a whole and the staff as
37 a whole were very keen to have a redevelopment and the
38 ministry did provide additional funding for staff for the
39 wards that were being moved into the redevelopment. So
40 there were funds to go with that.

41

42 Q. I read that paragraph as not being - suggesting that
43 there wasn't community or staff agreement relating to a new
44 hospital, but there was no agreement that if we had this
45 new hospital, it must be maintained - the hospital
46 operations must be maintained, and we need staff and
47 departments provided with the additional health care

1 resourcing?

2 A. Yes, and it gives an impression that that wasn't
3 happening, when it was.

4
5 Q. And you disagree with that?

6 A. I disagree with that, yes.

7
8 Q. Anything in relation to the topic of "Priorities",
9 which starts at page 9 and then goes down on page 10?

10 A. On page 10, the first sentence:

11
12 *We are in the best position to decide the*
13 *priorities.*

14
15 *The people who manage the hospital finances*
16 *do not look after patients. We cannot*
17 *expect them to know what the community*
18 *expects ... Their role is to facilitate the*
19 *resourcing of the community's healthcare*
20 *priorities, not to determine them.*

21
22 Under the health care Act, the role of the district and the
23 facilities is, in fact, to make sure that we're not only
24 looking at the finances but we're making sure that we
25 provide high-quality clinical care to the community, and
26 the medical staff council alone can't determine the
27 priorities, it has to be in discussion. It would be like
28 having 170,000 staff in NSW Health determining the
29 priorities. We have to balance them.

30
31 Q. You tell me if you disagree. I tend to read that
32 paragraph as more, perhaps not a particularly precise way
33 and not looking at the Act, of saying it's the doctors and
34 nurses that look after patients and we need a say; is that
35 what --

36 A. I totally agree they need a say, and if it was that
37 wording, I would have been happy with that wording.

38
39 MR MUSTON: Q. Is it possible, though, that the wording
40 that's included there is reflective of the sentiment, at
41 least amongst some of the medical staff at Concord at that
42 time, that they weren't getting a say, they didn't feel
43 like they were being listened to?

44 A. Yes, I think that's correct.

45
46 MR MUSTON: Sorry, Commissioner, please continue.

47

1 THE COMMISSIONER: Q. Anything else in that section or
2 in - then we've got the heading "Culture of Denial and
3 Silence"?

4 A. Just above that one, if you don't mind --

5
6 Q. Yes, please.

7 A. -- where it says:

8
9 *There may be hundreds of priorities.*
10 *They all must be addressed.*

11
12 Q. Yes.

13 A. To me, it's really unrealistic. It's not possible to
14 address everyone's priorities. I'd love to. That would
15 make me very happy. But the fact is we do have to have
16 that balance and unfortunately, that means some people will
17 be unhappy, and I think without more resources it's
18 difficult, and even with more resources, it's never going
19 to meet everyone's priorities.

20
21 MR MUSTON: Q. Doesn't that have to be read, though, in
22 the context of the paragraph immediately above it, which
23 points to what was at least being proposed was the medical
24 staff council identifying all the priorities and not just
25 a chosen few and presenting them at the management at
26 Concord to resolve? Is it not possible that the phrase
27 that "all of them must be addressed" is really a reference
28 to all of them must be considered and balanced against one
29 another in that exercise which, as managers, the executive
30 must perform in deciding how to distribute resources across
31 the system?

32 A. Yes.

33
34 THE COMMISSIONER: Q. That's another way of reading it,
35 I'm sure. "Culture of Denial and Silence"?

36 A. I think it reflects how Winston felt.

37
38 Q. "Intimidation, Bullying and Harassment"?

39 A. So in here, Winston's calling for a parliamentary
40 inquiry into bullying. I'm not sure how to comment on
41 that. It's not something that we could address.

42
43 MR MUSTON: Q. But bullying and harassment had been an
44 issue at Concord, though, hadn't it, within some - or at
45 least within one department?

46 A. Yes, and between staff within departments.

47

1 Q. So it was an issue which, at least as was being
2 expressed in this document, Dr Cheung did not feel had been
3 adequately dealt with?

4 A. Yes, and when I met with him, I asked what we could
5 do. He wanted a parliamentary inquiry. I said, "It's not
6 within my gift to give." I asked for other suggestions on
7 what we could do, and he said that was my job.

8

9 THE COMMISSIONER: Q. Anything else in the balance of
10 this document relating to the topics of quality, education,
11 research, et cetera - was there anything else that
12 concerned you, or on the last page where there's a history
13 given of Concord?

14 A. In terms of research, the quagmire of bureaucracy,
15 there has been a huge amount done to support research
16 across the district and in particular at Concord. So
17 calling it a "quagmire", without, again, being clear what
18 that refers to, made it difficult for me to act.

19

20 Q. When you discussed this document with Associate
21 Professor Cheung, did he say to you that some of its
22 content was informed by discussions he'd had with
23 colleagues?

24 A. Yes.

25

26 Q. Anything else in the document that concerned you?

27 A. Not really. I mean, Concord does have a very proud
28 history and the district has continued to support that.

29

30 THE COMMISSIONER: Thank you.

31

32 Sorry, I interrupted you a long time ago and you
33 probably can't remember where you were up to.

34

35 MR MUSTON: No, I can.

36

37 Q. In relation to the concerns that were being expressed
38 by Dr Cheung in that document, you had no reason to think,
39 did you, that they were - well, put it the other way, did
40 you have any reason to think that they weren't genuine
41 concerns that he held?

42 A. No, which is why I met with him to see what we could
43 do together.

44

45 Q. The medical staff at Concord are an intelligent and
46 independent bunch, I assume?

47 A. Yes, they're great.

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Q. And in making decisions about whether or not to elect a chair of their medical staff council, you would have been confident that they all would have exercised their own independent judgment, based on their own --

A. Yes.

Q. -- personal experiences at the hospital in the lead-up to that election?

A. Yes.

Q. And to the extent that you've identified some aspects of Dr Cheung's nomination document that you think you don't agree with, or you don't agree with the way that they're expressed, you don't suggest, do you, that in making a decision to elect Dr Cheung as their medical staff council chair, that any of the medical staff at Concord were in any way duped or lured into it by anything that had been said in that document that wasn't expressed in the way that you think it ought to have been expressed?

A. No.

Q. When Dr Cheung was elected by a comfortable majority of his colleagues as the chair of the medical staff council, did you consider that that gave some indication that the concerns which were being expressed in his nomination document were more widely held, not necessarily uniformly, but more widely held?

A. Yes.

Q. Did you think that that was an issue that required serious attention?

A. Yes.

Q. What steps did you take to try and address with the medical staff council, and the medical staff at Concord more generally, the concerns which, rightly or wrongly, they genuinely held about the way Concord was being run and the way in which they were interacting with the executive?

A. Yes, so quite a number of different ways. One was to try and form a relationship with Winston, with Dr Cheung, but that was difficult, and particularly in the context of COVID and time. We attended - I attended - as many medical staff council meetings as I could during that time. Most of them were online because of the COVID restrictions, which I do feel gave a sense of distance. There were also meetings with the facility, with heads of department, with

1 clinical directors, both by myself but also various members
2 of the executive, to try to get to the bottom of the issues
3 and address them.
4

5 The management team, including the director of medical
6 services, the general manager, the director of medical
7 services for the district, and at times myself, would go to
8 the medical staff council to report back on what we were
9 doing to address the concerns. But it was difficult to get
10 a handle on what else we needed to do.
11

12 During that whole period of time there were sort of
13 issues in relation to the management of COVID which we
14 worked through with the clinicians. An example would be
15 that there were real concerns around resourcing and
16 residential aged care facilities, so we set up with the
17 head of aged care rehabilitation a task force to deal with
18 residential aged care, because that was raised as a concern
19 and the resources required. We put in additional
20 resources.
21

22 At one point we were meeting weekly to address that
23 particular concern. So we tried to address each set of
24 concerns that we were able to tangibly address as they
25 arose. It was difficult with those things that are less
26 tangible.
27

28 Q. In relation to the concerns, one of the concerns that
29 was being expressed was a fear that those who spoke out
30 about their concerns would face reprisals?

31 A. Mmm-hmm.
32

33 Q. What was done to try and address that concern,
34 accepting it's a difficult one if you don't think it's the
35 fact, but it's nevertheless a genuine concern that the
36 workforce held?

37 A. It wasn't necessarily about not thinking it's a fact
38 but knowing how to address it if you don't know - it's,
39 like, you don't know what you don't know. We gave, at the
40 medical staff council meetings, at department head
41 meetings, at the clinical council within the facility,
42 a range of avenues that people could go to, that bypassed
43 the people that they might fear would, you know, make
44 reprisals.
45

46 Q. Are you aware that at one of the medical staff council
47 meetings, Dr Cheung asked Dr Wallace if she or the district

1 would confirm in writing that there would be no reprisals
2 for people who spoke out in relation to the concerns that
3 they had?

4 A. Yes, I am aware.

5

6 Q. And were you present at that meeting?

7 A. No, I was not.

8

9 Q. You've read the minutes of that meeting?

10 A. I have, yes.

11

12 Q. Did you read the minutes of that meeting at the time?

13 A. No, I didn't. I was unfortunately preoccupied with
14 other matters.

15

16 Q. You would be aware, having read the minutes, that
17 Dr Wallace did not embrace the idea that a written
18 confirmation of the fact that there would be no reprisals
19 for those who spoke out would be useful - that is to say,
20 she said, "Why would we give you that. If you don't trust
21 us, what's a written piece of paper going to change, to
22 change that"?

23 A. Mmm.

24

25 Q. Do you think, reflecting on it, that in circumstances
26 where, as chair of the medical staff council representing
27 a group of people who held that concern, that refusing to
28 provide a written confirmation that there would be no
29 repercussions for those who spoke out with their concerns
30 might have inflamed the situation?

31 A. I think in hindsight, it might have been good to do
32 that.

33

34 Q. I gather from the answer you gave a moment ago that
35 the possibility of a written confirmation of the fact that
36 there would be no reprisals for those who spoke out was not
37 something that Dr Wallace raised with you?

38 A. No - not that I recall.

39

40 Q. You tell us in paragraph 116 of your concern that from
41 an early stage of Dr Cheung's tenure as chair the medical
42 staff council conducted itself as though an oversight body.
43 Could you just explain to us what you mean by "oversight
44 body" in that paragraph?

45 A. The impression that was formed by myself and also by
46 other members of the executive --

47

1 Q. Just pausing there, who were the other members of the
2 executive who --

3 A. So Dr Hallahan, Genevieve Wallace, when she was the
4 general manager of Concord, and then, later, Joseph Jewitt
5 who was then the acting general manager. They felt that
6 the conversations - and I was not present for all of the
7 conversations - were becoming more and more adversarial and
8 more directive.

9

10 I think it's very important that medical staff
11 councils are able to ask questions, to seek information,
12 but the way in which that was being done made the - I was
13 informed, when I wasn't there, but in some of the
14 conversation with myself, it was very directive in its
15 approach. So it wasn't just about providing feedback; it
16 was saying, "You must do this", and "If you haven't done
17 that, then you have basically failed."

18

19 Q. So just in terms of the process, were there meetings
20 happening at an executive level between yourself,
21 Dr Hallahan and - is it Dr Wallace or Ms Wallace?

22 A. Dr Wallace.

23

24 Q. -- Dr Wallace, in which they conveyed to you what had
25 happened during medical staff council meetings?

26 A. Yes, there are many meetings that happen within local
27 health districts, operational meetings, meetings about
28 Concord hospital. There is a monthly executive meeting
29 with the executive of the district and the executive of
30 Concord hospital, as well as more informal meetings on
31 a more regular basis.

32

33 Q. And through those various avenues, would it be fair to
34 characterise the situation as one in which Dr Hallahan,
35 Dr Wallace, with the assistance of yourself, were looking
36 at ways to deal with the Concord medical staff council
37 situation?

38 A. And looking at actions that needed to be taken to
39 address the concerns.

40

41 Q. Did you explore with Dr Hallahan and Dr Wallace the
42 possibility that the way that they were engaging with the
43 medical staff council might have been adding to the
44 adversarial nature of the relationship which was
45 developing?

46 A. No, I didn't.

47

1 Q. Coming back to the concept of an oversight body, other
2 than to the extent that Dr Hallahan and Dr Wallace were
3 conveying to you that, at least as they understood it, the
4 medical staff council were making demands which needed to
5 be met, did you have any reason to believe that the medical
6 staff council at Concord was doing anything other than
7 seeking to express its views about the sorts of matters
8 that the medical staff council might usefully express views
9 about, namely, concerns that it had in relation to
10 operations of the hospital, ways in which it thought things
11 could be improved, et cetera?

12 A. As I indicated, some of the meetings that I went to
13 myself, the impression that I formed was that, despite
14 members of the executive, the general manager of the
15 hospital providing feedback in relation to concerns that
16 had been raised, was that those actions were not adequate,
17 and it was hard to work out what else needed to happen
18 other than being told they were not adequate. And we did
19 try, when concerns were raised about finances,
20 presentations were provided to help understand the detail
21 of the financial reports of the district, and that was both
22 by the director of finance at Concord hospital, I myself
23 also gave a presentation to explain how funding is
24 allocated, how we negotiate for the service agreements, and
25 also later the director of finance for the district also
26 provided a presentation and clarification. So we did try
27 to address the concerns. It's clear that we did not do
28 that to the extent that we should have.

29
30 Q. A number of the concerns that were being expressed
31 during the meetings were concerns that were longstanding on
32 the part of the staff at Concord - that is to say, that
33 they had been asking for changes or suggesting that changes
34 could or should be made for quite a long time, in some
35 cases, without those suggestions being taken up. I'm not
36 saying that's an improper thing, but that's just as a fact;
37 is that correct?

38 A. That's right, and where that was raised with us, if
39 there was a valid reason we would give that reason, and
40 I think that that presented in a defensive way, because we
41 were trying to explain, and I think the attempt to explain
42 was seen in a negative light.

43
44 Q. You have raised, in your statement, the various
45 iterations, and the correction you gave this morning, the
46 various iterations of the terms of reference of the medical
47 staff council that were being proffered by Dr Cheung.

1 I think you tell us in paragraph 113(b) that the draft
2 terms of reference that he put forward was something that
3 stood out to you as reflecting a change in approach by the
4 medical staff council - that is, an increasingly
5 adversarial approach by the medical staff council at
6 Concord?

7 A. Yes.

8
9 Q. Could I just go to those documents. If we could go to
10 them chronologically, the first one is, chronologically, at
11 least, an attachment to your statement at tab 6, which is
12 [MOH.0010.0403.0001]. You tell us in paragraph 113(b) of
13 your statement that, as you apprehended it, what these
14 revised terms of reference contemplated was an alternate
15 governance structure for the LHD?

16 A. Correct.

17
18 Q. Could you explain what you mean, by reference, if
19 possible, to the draft terms of reference, being the 25 May
20 2022 version of them - the one up on the screen and
21 hopefully in front of you - what it was about them that you
22 understood to be proposing an alternate governance
23 structure?

24 A. Sorry, I'm just trying to find it. My apologies.
25 I can't find it. Found it. Sorry. Thank you. Apologies.

26
27 Q. No, no, take your time.

28 A. So the concerns about the terms of reference related
29 in particular around the establishment of a range of
30 subcommittees that included redevelopment, workforce
31 culture, industrial relations, consumer engagement, quality
32 and safety, education and research.

33
34 That is a duplication of structures within the
35 district. I did go to a medical staff council meeting to
36 try to explain how that duplicated existing structures
37 within the district and invited any members of the medical
38 staff council to join any of those existing committees,
39 because it would cause confusion having a second set of
40 committees that replicated the operational functions of the
41 district.

42
43 Q. It had the scope to cause confusion, but it wasn't
44 being proposed, was it, that the subcommittees of the -
45 proposed subcommittees of the medical staff council do
46 anything other than consider the particular issues with
47 a view to informing the chair and the medical staff council

1 generally of their thinking in relation to those matters
2 for the purpose of providing advice to the executive in the
3 manner broadly contemplated by the by-laws?

4 A. That's unclear to me.

5
6 Q. It wasn't clear to you that they did contemplate
7 anything more than that, though, was it?

8 A. In the functions of the medical staff council and the
9 way in which the medical staff council was running the
10 meetings, it gave an impression that this was more than
11 that.

12
13 Q. The medical staff council had, by that stage, reached
14 a point where they had a range of concerns of the type that
15 we've already gone through?

16 A. Yes.

17
18 Q. And is it not possible that the subcommittees that
19 were proposed were merely a way of enabling the medical
20 staff council to delegate to particular members or groups
21 of its membership responsibility for coming up with the
22 medical staff council's position or thinking in relation to
23 each of those individual issues?

24 A. That wasn't the impression that I formed, and it
25 would - from where I sat, would have been better for them
26 to join the existing - if they wanted to change process,
27 being part of the decision-making in those existing
28 committees would have been of more assistance.

29
30 Q. Accepting that that's probably right in terms of the
31 governance structure of the district, did you perceive or
32 consider that preventing the medical staff council from
33 delegating to its membership responsibility for thinking
34 around the concerns that they held might have been seen as
35 an attempt to stop them from thinking about those concerns
36 and expressing their views in relation to the concerns that
37 they had at that time?

38 A. I didn't at the time. In hindsight, I can see that
39 that might be the case.

40
41 Q. The meeting that you attended where the issue of the
42 subcommittees was raised resulted in the subcommittees
43 being dropped from the proposed terms of reference by
44 Dr Cheung?

45 A. Yes, and I thanked Dr Cheung for doing that.

46
47 MR MUSTON: I'm about to move to another document.

1 I might - it's 11:28:40, instead of moving to that document
2 and then having everyone walk outside --

3
4 THE COMMISSIONER: We will take the adjournment now and
5 we'll adjourn until 11.50.

6
7 **SHORT ADJOURNMENT**

8
9 THE COMMISSIONER: Yes, go ahead, Mr Muston.

10
11 MR MUSTON: I was going to take the witness next to the
12 version of the terms of reference which are attached to
13 Dr Cheung's statement.

14
15 THE COMMISSIONER: Are these the March ones?

16
17 MR MUSTON: Yes. I'll just find them. They are at
18 tab H7.12.14 of Dr Cheung's statement. They're
19 [SCI.0012.0041.0001]. I'll just see if we've got a hard
20 copy for the witness. Volume 1 of Dr Cheung's exhibits.

21
22 Q. If I could just ask you to have a look at them, is
23 there any particular aspect of that document which you
24 regard as proposing an alternate governance structure for
25 the LHD?

26 A. The section under "Function", on page 4 of 9, when it
27 has "Issues for which advice might be provided may include
28 but are not limited to", those particular things in and of
29 themselves are fine, however, they're taken from the
30 by-laws and relate to the function of the board, and so the
31 interpretation that I had at the time was that the medical
32 staff council, through Dr Cheung, was aiming to replicate
33 the functions of the board.

34
35 Q. But you accept, reading it now, do you, that all they
36 were - all, at least in terms of the words on the
37 page suggest is that the medical staff council were wishing
38 to provide advice to the executive on those matters which
39 included the matters which actual decisions were going to
40 be made about by the board?

41 A. Yes, if you take the words on the page in that way,
42 yes.

43
44 Q. But there's certainly nothing in the terms of
45 reference which suggests that the medical staff council,
46 through this draft document, was seeking to take on
47 a decision-making role, is there?

1 A. Not in the words themselves.

2

3 Q. Is there anything else about the document which gave
4 that impression?

5 A. The context that sat around it.

6

7 Q. The context being what the - what is that context?

8 A. Was the way in which the medical staff council and
9 Dr Cheung were functioning at that time.

10

11 THE COMMISSIONER: I think I would need some further
12 explanation to understand that.

13

14 Were you going to ask some questions about that?

15

16 MR MUSTON: I was going to.

17

18 THE COMMISSIONER: I will leave it with you.

19

20 MR MUSTON: Q. Could we go to tab 5 of your bundle.
21 Just keep the Dr Cheung bundle there, I'll come to another
22 document in a moment. That's a letter dated 7 May 2022
23 from Dr Cheung, in his capacity as the chair of the medical
24 staff council, to Dr Wallace, in her capacity as the
25 general manager of Concord hospital. Just going through
26 that, is there anything about that letter which you regard
27 as informing the context that you've just told us about?

28 A. No, not in itself.

29

30 Q. In essence, it was doing nothing more than raising
31 issues which were appropriately the subject of
32 consideration by the medical staff council and requesting
33 some further information from, in that case, Dr Wallace?

34 A. And normally the issues around knowing how many shifts
35 are currently not staffed, et cetera, is usually a matter
36 for the sort of nursing structures within the organisation,
37 and that includes the nurses and midwives association, the
38 NSW Nurses and Midwives' Association, so there were
39 concerns that the medical staff council, although, you
40 know, appropriately raising concerns about nursing, were
41 actually going into an area that is covered by other parts
42 of the structure.

43

44 Q. Whilst covered by other parts, to the extent that the
45 medical staff council might feel that issues around nursing
46 impact on their ability to deliver good care, it's a matter
47 that they're entitled and should appropriately raise

1 through the medical staff council?

2 A. Yes. But I think getting down to, you know, what are
3 the number of shifts, et cetera, is probably a level of
4 detail that is unusual for a medical staff council.

5

6 Q. Whilst unusual, in the context of a medical staff
7 council which had, through its election of Dr Cheung,
8 embraced collectively the concern that they weren't being
9 sufficiently engaged with by the executive, responding to
10 those sorts of questions could only have improved that
11 situation, couldn't it?

12 A. Yes, and my understanding is that at the next medical
13 staff council meeting, there were discussions in relation
14 to the questions raised by Dr Cheung.

15

16 MR MUSTON: So just for the benefit of the transcript -
17 operator, we don't need that document brought up right
18 now - that was [MOH.0010.0394.0001].

19

20 Q. Could I ask you then to go to tab 7 in your bundle,
21 which is [MOH.0010.0395.0001]. That's a letter of 16 June
22 2022 from Dr Cheung, in his capacity as chair of the
23 medical staff council, to Dr Wallace, as general manager of
24 the hospital. Is there anything about that letter which
25 you consider informs the context that you referred to
26 a moment ago and casts the terms of reference being put
27 forward in any particular light or a different light to
28 that which the words might suggest?

29 A. So on page 2 of 4, under "Mandatory Training", despite
30 the conversation that we'd had about not setting up
31 additional subcommittees, an agreement not to do that, this
32 again contemplates an education subcommittee, when the
33 preference would have been for that to be incorporated into
34 the existing education committees of the facility.

35

36 Q. But the concern that was being expressed there was
37 that the medical staff council, and from that are we to
38 infer the medical workforce at Concord, did not feel that
39 it had not been involved in the process of approving
40 mandatory training and it felt that it wanted to be?

41 A. It's not the role of the medical staff council to
42 approve mandatory training, certainly to give advice in
43 relation to concerns about training that may or may not be
44 appropriate, and there is a process for being able to sort
45 of escalate those concerns. The majority of the mandatory
46 training is set at a state level for particular groups of
47 staff.

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Q. But nothing in those paragraphs there under the heading "Mandatory Training", though, suggests that the medical staff council wanted the right to approve or any right of veto in respect of the mandatory training; is that --

A. So the last sentence says:

The major concern is that the [medical staff council] has not been involved in the process of developing or approving --

medical staff training.

Q. So the concern was not wanting a right of veto, but they wanted to be involved in the process?

A. I was happy for them to be involved but not - it's not the place of the medical staff council to approve mandatory training.

Q. So the approval of - what you perceived there to be a desire to be involved in the approval of mandatory training was one piece of context that informed your understanding of the terms of reference. Reading on, is there anything else in this letter which is an important part of that context?

A. I thought it was good that he fed back the reassurances that there would be no reprisals taken against staff.

Q. He informs Dr Wallace in that letter, though, while we're on that topic, that were still many staff who continued to fear reprisals and were still unwilling to report safety issues. Was that a concern that was dealt with or responded to in any particular way by Dr Wallace or anyone else within the executive, to your knowledge?

A. My recollection - again, it could be wrong - was that it was discussed, again at the medical staff council, and a commitment given that there would be no reprisals, but discussed a way in which those concerns could be escalated in the appropriate manner, is my understanding.

Q. I see there in the next paragraph immediately beneath that, "We think a reasonable step" picks up again this issue about providing an open letter encouraging staff to report things and confirming that reprisals will not be taken. Was this letter - as in, the one that we're looking

1 at now behind tab 7 - brought to your attention at the time
2 that it was received by Dr Wallace?

3 A. I'm not sure. I was actually on leave at this time.
4 I had COVID myself, so I - my recollection is a little
5 vague, so my apologies.
6

7 Q. If the letter wasn't received by you, which I gather
8 is a possibility, it stands to reason, doesn't it, that it
9 would not have informed any part of the context against
10 which you came to construe the terms of reference when they
11 were received by you?

12 A. Mmm.
13

14 THE COMMISSIONER: I'm just wondering if you go to the next
15 tab, I don't know whether - there's an email, the first
16 email is Dr Hallahan to Dr Anderson of 23 June, where --
17

18 MR MUSTON: You're quite right.
19

20 THE COMMISSIONER: -- there's a reference to "last letter
21 attached". I'm just wondering if that's the letter you are
22 talking about.
23

24 THE WITNESS: Yes, that makes sense.
25

26 THE COMMISSIONER: Q. There is a chance it is, anyway.
27 A. I think it is, yes.
28

29 Q. That email is a week after Associate Professor Cheung
30 has sent the 16 June letter to Dr Wallace. There is a fair
31 inference you could draw that it is this letter?
32

33 A. Yes.
34

35 MR MUSTON: I was about to come to that document, so
36 perhaps, operator, if we could bring up
37 [MOH.0010.0397.0001].
38

39 Q. As the Commissioner has pointed out, the email at the
40 foot of it from Dr Hallahan to you of 23 June 2022, is that
41 an email that you recall receiving?
42

43 A. I do now, yes.
44

45 Q. It suggests that the letter that we've just been
46 through probably was forwarded to you at that time?
47

48 A. Yes.
49

50 Q. Do you see Dr Hallahan, in that letter, characterises
51

1 the letter as containing a series of demands - just in the
2 first or second line of his email?

3 A. Yes. Mmm-hmm.

4

5 Q. If we look back at the letter - having read it, do you
6 recall whether you shared his view that it reflected
7 a series of demands from the medical staff council?

8 A. Not a series of demands, but certainly I think the
9 intention in relation to the approval function of the
10 medical staff council. But also, you know, on reading
11 this, the issue about having a summit with the emergency
12 department, that was something that was put, and there were
13 concerns by the emergency department and by Dr Philip
14 Visser, who was the head of the emergency department, that
15 that would exacerbate issues rather than solving them.

16

17 Q. I think at that time, though, those concerns, if we
18 look at it chronologically, might not have been expressed
19 at the time that this letter was sent. We can work through
20 that if you want to, but just looking at that emergency
21 department summit, it was the case that there were serious
22 cultural problems within the emergency department at
23 Concord at that time --

24 A. Yes.

25

26 Q. -- is that correct? And what was being proposed was
27 a constructive and collegial meeting to identify the
28 problems and allow those present to think about potential
29 solutions?

30 A. Yes, except the head of the department felt that the
31 timing was problematic.

32

33 THE COMMISSIONER: Q. I can see also in Dr Hallahan's
34 email to you, he's set out his opinion about the proposed
35 terms of reference as having "overlapping clinical council
36 and board roles and responsibilities". That was obviously
37 his view at the time?

38 A. Yes.

39

40 Q. I think when he gave evidence he accepted that at
41 least the text of the terms of reference probably didn't
42 support that there was an attempt at usurping the role of
43 the board, and I think that's probably something you agree,
44 at least in the text of the terms of reference?

45 A. Yes, and I think - you know, the value of hindsight,
46 looking back, I think there was a lot happening at this
47 time.

1
2 Q. Should I take from this email and perhaps other
3 discussions that - could it have been Dr - this isn't
4 a criticism, just an expression of their opinion. Could it
5 have been Dr Hallahan and Dr Wallace that put it in your
6 mind that Associate Professor Cheung and the staff council
7 were attempting to usurp board roles when, in fact, at
8 least the document being produced, wasn't supportive of
9 that? Is that a possibility?
10 A. I think that context might be fair enough, but I think
11 it's really difficult to say what was in the minds of
12 everyone, including myself, unfortunately, at that time,
13 and I have to admit I had a --
14
15 Q. Well, save for this email gives an indication of what
16 was in Dr Hallahan's mind about the terms of reference,
17 yes.
18 A. Yes.
19
20 MR MUSTON: Maybe to clear up one issue, if we could jump
21 forward to tab 9, which is [MOH.0010.0398.0001].
22
23 THE COMMISSIONER: These were the minutes that I think you
24 were referring to before the break.
25
26 MR MUSTON: Yes.
27
28 Q. So we get the chronology right, these would appear to
29 be minutes of a meeting which occurred after the letter of
30 16 June 2022?
31 A. Yes.
32
33 Q. The letter we've just been looking at at tab 7, which
34 contains a reference to the mandatory training and the
35 emergency department summit --
36 A. Yes.
37
38 Q. -- and, sorry, 5, the reporting of safety issues for
39 fear of reprisal - that letter seems to have preceded the
40 meeting, the minutes of which occur behind tab 9?
41 A. Yes.
42
43 Q. Would you agree with that chronology?
44 A. (Witness nods).
45
46 Q. If we just go to those minutes, commencing on page 5,
47 do you see the first of the issues in the letter is

1 addressed, namely, the pathways that clinicians should
2 follow if they want resources or changes to services to be
3 considered by the executive?

4 A. Yes.

5

6 Q. That doesn't seem to be expressed in a way that is
7 particularly troubling or indicative of a demand,
8 reasonable or otherwise, being made by the medical staff
9 council, does it?

10 A. Oh, that's correct, yes.

11

12 Q. You see at 3(b) there we've got raised the concern
13 which again was reflected in the letter about some
14 ambiguity around the escalation process if requests were
15 rejected at a local level, and how that was to be dealt
16 with?

17 A. Mmm-hmm.

18

19 Q. It's not unreasonable for the medical staff council to
20 want to have an understanding about how requests that they
21 might make to management, if rejected, can be escalated if
22 they feel it requires further consideration?

23 A. Not at all.

24

25 Q. And Dr Hallahan indicated that the medical staff
26 council chair should write to the - sorry, to you, "TA" --

27 A. That's me.

28

29 Q. -- directly in relation to that issue. But that
30 again isn't an unreasonable thing for a medical staff
31 council to be addressing in the context of the ordinary
32 operations of such a beast, is it?

33 A. No.

34

35 Q. Turning over to the next page there, 0006, do you see
36 at point (d) "Mandatory training", there's a discussion of
37 that issue around training and what has been expressed in
38 the meeting, it would seem perhaps better than expressed in
39 the letter, was a desire that the medical staff would like
40 to have a greater voice in the development of teaching and
41 training? Do you agree with that?

42 A. Yes.

43

44 Q. You received those minutes by email, I gather, from
45 what appears on the first page behind that tab?

46 A. Mmm-hmm.

47

1 Q. Do you have a recollection of reading them at the
2 time?

3 A. I would have, yes, but do I recall when I read it?
4 Apologies, I don't.

5

6 Q. But there's nothing about what was said under that
7 heading of "Mandatory training", which would have led you
8 to feel concerned that the medical staff council was
9 seeking to impose itself on issues which were not
10 appropriate?

11 A. No, I think the wording in the minutes is consistent
12 with what I would think was the role of the medical staff
13 council.

14

15 Q. And then we have under the heading (e) "Safety issues
16 and fear of retribution", an issue that we don't need to
17 traverse, but the request for written confirmation that
18 there wouldn't be any reprisals, and that's left where we
19 see it being left at the end, namely, that the executive
20 would take it on notice.

21 A. Yes.

22

23 Q. Reflecting on it now, do you have a recollection of
24 having had any thoughts around that particular issue at the
25 time that you received and read the minutes?

26 A. I really don't recall.

27

28 Q. Let's move on to the ED summit, which appears
29 immediately beneath that. There was, it would appear, some
30 discussion of what was proposed. Dr Hallahan seems to have
31 asked who was to be involved, and Dr Cheung has explained
32 it would involve JMOs and senior medical officers. Do you
33 see there on page 7, at about point 4 on the page, there's
34 a reference to a contribution made by P Visser?

35 A. Visser, mmm-hmm.

36

37 Q. I gather from what appears in parentheses next to his
38 name that he was the head of the emergency department at
39 that time?

40 A. That's correct.

41

42 Q. So earlier when you were referring to Dr Visser's
43 concerns around this proposal, just to put it at least in
44 chronology, it doesn't appear from what appears in those
45 minutes that he was expressing concerns about it at that
46 time?

47 A. I mean, he does say that he will discuss it with

1 a group of specialists in ED to determine if they're
2 prepared to engage, and sees it as well intended at
3 rebuilding relationships, but unsure if they're prepared to
4 engage at that time, and he would take it to the
5 consultants' meeting.
6

7 My understanding is that discussions that were had
8 subsequent to this meeting, because he was privy to issues
9 within the emergency department - my understanding is he
10 didn't want those aired in a general meeting and felt
11 uncomfortable.
12

13 Q. But just to put the earlier letter into its
14 chronology, a proposal was put by Dr Cheung in his letter
15 that there be a forum to discuss some of the cultural
16 problems within the emergency department?
17

18 A. Mmm-hmm.
19

20 Q. That proposal was then raised at a meeting of the
21 medical staff council. It was discussed in the way that we
22 see here and identified by the then head of the department
23 as a well-intentioned idea to refocus and rebuild
24 relationships, but one which required consideration and
25 input from members of the staff within the emergency
26 department before a decision was made to go ahead with it.
27

28 A. Yes.
29

30 Q. That decision, as you've told us, was ultimately made
31 by Dr Visser that, at that particular point in time, it
32 would not be, he felt, a productive way of dealing with
33 some of those cultural issues?
34

35 A. Yes, and I supported that decision.
36

37 Q. And there's no suggestion, is there, that that
38 decision was not also accepted by the medical staff council
39 at the time?
40

41 A. There were subsequent conversations. Winston wanted
42 to proceed with that forum and he was asked not to.
43

44 Q. But it didn't proceed?
45

46 A. It didn't proceed.
47

48 Q. And there was no attempt to insist on it happening
49 over the objection of others, for example?
50

51 A. No.
52

53 Q. In fact, I think if we turn over to tab 10, which is
54

1 [MOH.0010.0399.0001] --

2 A. Yes.

3

4 Q. -- that seems to be another set of minutes from the
5 next meeting. Just pausing there, on the first page, the
6 email seems to have been forwarded by or sent by Genevieve
7 Wallace to a Lorna Arkell. Who is Lorna Arkell in the
8 ecosystem?

9 A. It was Genevieve's executive assistant.

10

11 Q. Turn over to page 5 of that document. Do you see
12 there's the next discussion, it would seem, by the medical
13 staff council of the emergency department summit proposal?

14 A. Mmm-hmm.

15

16 Q. It doesn't appear from that that there was any real
17 dissent by Dr Cheung or anyone else, at least at that
18 meeting, from the view being expressed by Dr Visser in
19 relation to the desirability of postponing a summit like
20 that to some later time?

21 A. That's correct. And I explained that it had been
22 a very challenging time for the ED, particularly with the
23 pressures of COVID.

24

25 Q. Just having worked through all of that and bringing it
26 back to the context of the terms of reference, none of what
27 appears in the minutes and the correspondence between
28 Dr Cheung and Dr Wallace, at least, really suggests that
29 the medical staff council was seeking to take a greater
30 role than what might ordinarily be expected of a body like
31 that within the health system, did it?

32 A. If you go from the minutes, yes.

33

34 Q. Ultimately, the minutes are what are most important,
35 aren't they, because they reflect what the medical staff
36 council as a body is doing in terms of making decisions and
37 seeking information?

38 A. Yes, and - but what they don't sometimes convey is the
39 language and tone that are used in those meetings and what
40 was conveyed to me was an increasing sense of irritation,
41 that the management of the facility and district were not
42 performing adequately.

43

44 Q. Who conveyed that to you?

45 A. That was conveyed both in meetings that I attended but
46 they were small in number, but primarily from the facility
47 and district executive who attended.

1
2 Q. So it was by Dr Hallahan and Dr Wallace?
3 A. Yes, and later Joseph Jewitt, who was the acting
4 general manager.
5
6 Q. So at least in those early stages when Dr Wallace was
7 still part of the furniture at Concord, they were conveying
8 to you that, at least as they --
9 A. Perceived it.
10
11 Q. -- perceived it, the meetings were indicative of an
12 unhappiness on the part of the workforce with the way in
13 which executive was dealing with things?
14 A. Yes.
15
16 THE COMMISSIONER: Q. I understand what you're probably
17 meaning to convey when you said that the minutes don't
18 convey the tone that's used. By that, should I take it
19 that some of the people recorded as talking in the minutes
20 are doing so with a fair amount of passion from time to
21 time?
22 A. Yes.
23
24 Q. "Language", though, what do you mean by that?
25 I assume they're not swearing or --
26 A. Oh, no, definitely not.
27
28 Q. So what's the point you wanted me to take from
29 "language", or is it really tone is what you meant?
30 A. It was tone and a sense of being directed and
31 unsatisfied.
32
33 THE COMMISSIONER: All right.
34
35 MR MUSTON: Q. Just exploring that, whilst tone might
36 convey a sense of frustration --
37 A. Mmm.
38
39 Q. -- and anger, perhaps --
40 A. Mmm.
41
42 Q. -- tone, in and of itself, is not going to convert
43 something which is not a direction into a direction, is it,
44 or a demand?
45 A. It's hard to give an example, but --
46
47 Q. Very hard, I'd suggest, because it can't?

1 A. I think the way in which you ask a question can give
2 an impression of a direction. The language that you use
3 can do that.

4
5 Q. Put another way, there's no - to the extent that the
6 minutes, accepting they don't convey tone, they do
7 represent, one is entitled to assume, an accurate
8 reflection of the mood of the meeting in what was being
9 said and what was being sought. Would that be right?

10 A. Generally, yes.

11
12 Q. And there's nothing in the minutes of the meetings
13 that conveys any sort of demands, is there?

14 A. I can't say without going through them in great detail
15 to find you particular examples.

16
17 Q. To the extent that anything might have been expressed
18 in a tone that made it sound more like a request than
19 a demand, it was really requests for information, not
20 requests for any particular step or action to be - or
21 decision to be made?

22 A. If you go to some of the later minutes where there's
23 actually recording of those minutes --

24
25 Q. Just for present purposes, I just want to try and
26 stick with the ones we've got at this point in time, if
27 that's okay.

28 A. What I've read today, because I haven't refreshed my
29 memory on it, then I would agree with your statement.

30
31 Q. So if we could go back to tab 8, and that's
32 [MOH.0010.0397.0001], if you turn over to the second
33 page of that email, do you see Dr Hallahan's
34 characterisation of it was that the meeting was principally
35 Winston - that's Dr Cheung - "trying to put Gen" - that's
36 Dr Wallace, and to a lesser extent himself, on the spot.
37 Do you see that?

38 A. Yes.

39
40 Q. Reading the minutes of that meeting, that's not really
41 an entirely fair characterisation of what transpired, is
42 it?

43 A. So my understanding is that is a different set of
44 minutes, isn't it? The 23rd. Sorry.

45
46 Q. I'm sorry, you're right.

47 A. Yes, that's a reflection of the same minutes. Yes,

1 apologies. I hadn't - so the - at the time he would have
2 written this would have been immediately following that
3 meeting. The minutes of that meeting come out
4 approximately a month later, and that's what I mean.
5 I wasn't present for that meeting, but he came away from
6 the meeting with that impression. Unfortunately I can't
7 assume to know exactly what he was referring to because
8 I wasn't present, but certainly the minutes don't reflect
9 the sentiment that he felt, and I don't know how he felt
10 other than what he said.

11
12 Q. So undoubtedly what he said in his email was
13 reflective of the way he felt about his experience of that
14 meeting?

15 A. Mmm-hmm.

16
17 Q. But is it possible that his experience of the meeting
18 and what he might have felt about it is not necessarily the
19 most objective view of actually what had transpired at the
20 meeting?

21 A. I can't speak for him.

22
23 THE COMMISSIONER: I think - I mean, personally I would
24 interpret it as - there's a whole range of issues raised at
25 this meeting. I would take what Dr Hallahan has said in
26 the email to be principally reflecting the topic of safety
27 issues and fear of retribution, and I would take, unless
28 I'm corrected, "put Gen on the spot", to relate probably to
29 the request by Associate Professor Cheung for a written
30 confirmation about no reprisals, for which the initial
31 response was, "If you don't trust the executive, then
32 a memo is unlikely to change that", but with the professor
33 then saying, "Well, it's a symbolic gesture", and then it
34 being left with "We'll take it on notice". I would suspect
35 that - so it's not a question for you, I'm just making
36 transparent my thought processes in case it's helpful to
37 anyone. I think that's probably what it relates to, and
38 that may well have been the most significant thing to
39 Dr Hallahan when he's reflected on that meeting.

40
41 MR MUSTON: Q. By that point, do you have a sense, or
42 did you get the sense from reading that email, that
43 Dr Hallahan felt that the relationship between the
44 executive and the medical staff council at Concord had
45 become a little bit combative?

46 A. Yes.

47

1 Q. Did you reflect at that time on the possibility that
2 the way in which the executive - by which I don't mean you
3 personally but the broader executive team - were engaging
4 with the medical staff council at Concord might have been
5 contributing to the combative nature of that relationship
6 to the extent it was combative?

7 A. At the time, my thinking was if we were able to
8 demonstrate what we were doing in response to the concerns,
9 that that would decrease the tensions, and I probably
10 wrongly assumed that the general fatigue that everyone had
11 at this time was contributing to that increased tension.
12

13 Q. If we move forward to 12 October 2022, Dr Cheung sent
14 his letter to Mr Ajaka, which we find in tab 1 of the
15 folder that you have in front of you, not the small one,
16 but the larger one.
17

18 MR MUSTON: For your benefit, Commissioner, it's H7.12.1,
19 and for the benefit of the operator, it's
20 [SCI.0012.0108.0001].
21

22 THE WITNESS: I'm sorry, I'm not sure which.
23

24 MR MUSTON: Q. Sorry, I think the larger folder --

25 A. This one?
26

27 Q. There should be a tab there that says H7.12.1. Whilst
28 I think the answer you gave a moment ago was that you were
29 hopeful that by conveying to the medical staff council what
30 was being done you would resolve some of their concerns --

31 A. Yes.
32

33 Q. -- was it clear to you when this letter was sent and
34 received that those efforts, at least up to that point, had
35 not resolved the concerns of the medical staff council --

36 A. Yes.
37

38 Q. -- at Concord? Did you have any reason to think that
39 the letter sent by Dr Cheung didn't reflect the concerns of
40 the broader medical staff council at Concord - that is to
41 say, as opposed to just Dr Cheung's own personal feelings
42 about the topic?

43 A. No, and he was communicated with pretty promptly about
44 arranging a meeting to discuss his concerns.
45

46 Q. Can I take you to paragraph 120 of your statement. At
47 least on the chronology, as I understand it, the first

1 communication with Dr Cheung after he had sent that letter
2 was a telephone call that you refer to of the following
3 day, in paragraph 120?

4 A. Yes.

5
6 Q. You had been informed by Mr Ajaka that Dr Cheung had
7 made attempts to obtain some contact details of him and to
8 ensure that he - that is, Mr Ajaka - had received the
9 letter?

10 A. Yes.

11
12 Q. You conveyed to Dr Cheung that his behaviour in doing
13 that was inappropriate. What was inappropriate about his
14 behaviour in seeking to obtain contact details for the
15 chair of the local health district?

16 A. It wasn't the trying to obtain the contact details; it
17 was contacting Mr Ajaka's previous employers and also to
18 them expressing concern about Concord, and they contacted
19 Mr Ajaka, who contacted me and asked me to contact Winston
20 and say, "That is not the way to communicate", and to get
21 him to go through the normal processes, and that included
22 to Nerida Bransby, who is the secretariat for the board.

23
24 THE COMMISSIONER: Q. I may have misunderstood this part
25 of your statement. The reference to "previous employers" -
26 and then it says "including Parliament House", previous
27 employers is who?

28 A. So Mr Ajaka was the president at the parliament, and
29 so Dr Cheung contacted the office of the president of the
30 parliament - sorry, I'm probably not using the right
31 terminology, but there's a unit in parliament and Mr Ajaka
32 was previously the president of the parliament and had that
33 unit, and that unit was contacted by Dr Cheung. That was
34 what he was --

35
36 Q. To seek his contact details?

37 A. To seek his contact details and also share his
38 concerns in relation to Concord.

39
40 MR MUSTON: Q. What you tell us in the statement is that
41 those attempts had been made to ensure that Mr Ajaka had
42 received the letter and obtain the contact details. Do you
43 say now that, in addition to what you have told us in the
44 statement, that Dr Cheung was sharing with the
45 administrative person who he might have contacted in a
46 department at parliament his particular concerns around
47 Concord hospital?

1 A. Yes.

2

3 Q. In your discussion with Mr Ajaka --

4

5 THE COMMISSIONER: I don't think Associate Professor
6 Cheung has had that put to him for his response, so we
7 might need to make a note for procedural fairness reasons
8 about that.

9

10 MR MUSTON: Q. In your discussion with Mr Ajaka, was
11 there any discussion between the two of you about the
12 possibility that Mr Ajaka might ring Dr Cheung and confirm
13 that the letter had been received and that something would
14 be done about it?

15 A. He asked me to do that and, in addition to saying
16 there was a better way to approach Mr Ajaka, I indicated to
17 him that he did have the letter.

18

19 Q. In the context of Dr Cheung's concerns around not
20 being listened to and fearing reprisals for speaking out,
21 did it occur - did you reflect at the time on the
22 possibility that chastening him for seeking contact details
23 of the person he was wanting to get in touch with, namely,
24 the board chair, might have exacerbated those concerns?

25 A. Not at the time, because I did say in the conversation
26 that we take his concerns seriously, that we would organise
27 a meeting as quickly as we could to discuss those concerns.

28

29 Q. The aspect of the conversation which I'm exploring,
30 though, is that in which you've conveyed to him your belief
31 that his behaviour in reaching out to Mr Ajaka or seeking
32 the contact details of Mr Ajaka was inappropriate?

33 A. Yes, because that's what I was asked to do.

34

35 Q. But did you personally think it was inappropriate at
36 the time, or is it just that Mr Ajaka felt it was
37 inappropriate and he asked you to convey that?

38 A. The normal process would be to contact Nerida, which
39 is not what he did. He went to the board chair's previous
40 employer and I would suggest that is --

41

42 THE COMMISSIONER: Q. Sorry, just on that, so Mr Ajaka
43 was the president of the legislative council.

44 A. Yes, apologies.

45

46 Q. Professor Cheung has had, what, a discussion with
47 someone within that office, has he?

1 A. Yes.
2
3 Q. And how has that come to your attention?
4 A. Through Mr Ajaka.
5
6 Q. Right. So the extent of your knowledge in relation to
7 what may or may not have been said by the associate
8 professor to someone within the office of the president of
9 the legislative council has been reported to you by
10 Mr Ajaka himself; correct?
11 A. Correct.
12
13 MR MUSTON: By that stage, it's third-hand.
14
15 THE COMMISSIONER: Yes.
16
17 THE WITNESS: Sorry.
18
19 THE COMMISSIONER: No, no, that's all right.
20
21 MR MUSTON: Q. I'll come back to the question.
22 Particularly in that context where you didn't really know
23 what had been said by Dr Cheung --
24
25 THE COMMISSIONER: Sorry to interrupt. Sorry to
26 interrupt.
27
28 Q. For all you know, I suppose, in fairness, we don't
29 know whether, whoever it was within the office of the
30 president of the legislative council may have asked
31 Associate Professor Cheung what was the reason he was
32 calling, and he may well have answered that by saying,
33 "Well, I'm calling for this reason" --
34 A. He may have.
35
36 Q. -- "related to Concord hospital"?
37 A. Yes.
38
39 MR MUSTON: Q. Did you reflect at the time on the
40 possibility that indicating to Dr Cheung that he was
41 engaging in behaviour which was inappropriate in reaching
42 out to Mr Ajaka might have exacerbated his concerns about
43 not being listened to on the one hand and a threat of
44 reprisal for speaking up?
45 A. I didn't see it at the time as a threat of reprisal.
46 I did indicate that we took Dr Cheung's concerns very
47 seriously. You know, I apologise if he felt that it was

1 a reprisal, that wasn't the intention, but I was asked to
2 indicate that calling his previous employer was not
3 appropriate.
4

5 Q. I'll come back to a question I asked you a moment ago.
6 Whilst Mr Ajaka might have been irritated by that intrusion
7 into his previous employer, was it your view at the time
8 that that was really inappropriate?

9 A. It's unusual.

10
11 Q. I'll ask the question again. Was it your view at the
12 time, whatever Mr Ajaka might have thought, that reaching
13 out to former employers of Mr Ajaka in an attempt to find
14 his contact details was really inappropriate?

15 A. I felt it was inappropriate at the time.
16

17 THE COMMISSIONER: Q. Do you know what details are
18 available for someone like the chair of the medical staff
19 council in relation to contacting the board? Do they have
20 access to emails or phone numbers?

21 A. They have access to emails. Most of the contact is
22 through Nerida, and Winston previously used those avenues,
23 so I knew he was familiar with them.
24

25 MR MUSTON: Q. I think, in fact, shortly after this
26 exchange you told him what those mechanisms were in the
27 document which is H7.12.2, and it's [SCI.0012.0069.0001].
28 That's in the Dr Cheung bundle.

29 A. Would you mind repeating the number?
30

31 Q. Sorry, I might have given you a bum steer there.

32 A. I've got that. Yes, I've got that.
33

34 THE COMMISSIONER: Q. Where it says that you were
35 contacted by Mr Ajaka, the board chair, who informed you
36 that Associate Professor Cheung had made several attempts
37 to contact him to ensure he's received a letter, and to
38 obtain his mobile number - Mr Ajaka, I take it, had made no
39 attempt to return those attempts by - he wanted you to
40 respond?

41 A. Yes.
42

43 MR MUSTON: Q. I'm sorry, I've led you astray. It is
44 tab 11 in your folder, I think, which is
45 [MOH.0010.0400.0001]. That's the letter that you sent, it
46 would seem, several days later to Dr Cheung.

47 A. On the 13th - the 18th, the day --

1
2 Q. It looks like 18 October 2022, just looking at the
3 document. Do you have that document there?
4 A. Oh, yes.
5
6 Q. It appears to have been sent on the 18th, but refers
7 back, as you can see in the first paragraph, to the
8 conversation of the 13th. Then if we turn over to page 2
9 of that document, it seems to be a screenshot which
10 includes, with the helpful red box in the bottom right-hand
11 corner --
12 A. The email address.
13
14 Q. -- what seems to be a generic email address for the
15 local health district board?
16 A. The board, yes.
17
18 Q. In response to or as a reaction to the letter that
19 Dr Cheung had sent to Mr Ajaka, a summary of Dr Cheung's
20 concerns was prepared. You tell us about that in
21 paragraph 121 of your statement.
22 A. Yes. That was a - I was on leave at the time.
23
24 Q. Who prepared that summary?
25 A. Genevieve Wallace with the assistance, I think, of
26 Joseph Jewitt, I think. I'm not sure exactly because
27 I wasn't there.
28
29 Q. So in relation to the concerns, many of the concerns
30 that were being expressed by Dr Cheung in his letter, they
31 related directly to the way in which executive at the
32 hospital was engaging with its staff, medical staff?
33 A. Mmm-hmm.
34
35 Q. And so this document that was provided to the board
36 was, as it were, Dr Wallace's side of that story?
37 A. Yes.
38
39 Q. But would you accept that that's possibly a somewhat
40 one-sided view of the situation as it was panning out at
41 the hospital?
42 A. I think we had both sides of the - we had the letter
43 from Dr Cheung and the - I'm assuming the board chair and
44 the acting chief executive asked Genevieve for a response
45 to the concerns raised, which would be a fairly normal
46 thing to do.
47

- 1 Q. In the response that was provided, there's reference
2 to the "People Matter" survey, but there doesn't appear to
3 be any reference to the information which had been gathered
4 by Dr Richards and her wellness team in relation to staff
5 morale and the issues which were causing concern at
6 Concord?
- 7 A. So that wellness survey, as I indicated, isn't
8 routinely given to the executive. So Genevieve wouldn't
9 have had access to that, is my understanding.
- 10
- 11 Q. Would it have been something that she could have asked
12 for?
- 13 A. She may have. I can't answer that.
- 14
- 15 Q. Do you think, reflecting on it, that granular
16 information about some of the concerns that were held by
17 members of the medical staff at Concord hospital might have
18 been useful to the board in assessing complaints made by
19 Dr Cheung?
- 20 A. I think in hindsight it could have been very helpful,
21 mmm.
- 22
- 23 Q. Would you agree that the summary that was prepared by
24 Dr Wallace and provided to the board really suggests
25 there's no problems at all at Concord?
- 26 A. I'm just trying to find the document.
- 27
- 28 Q. It's behind tab 12 in your bundle. Sorry, I have
29 jumped there without telling you where it is or telling the
30 operator where it is. It's [MOH.0010.0416.0001]. Do you
31 have that document?
- 32 A. Yes.
- 33
- 34 Q. Looking at the first - just, for example, the first
35 bullet point under the heading "Staff Morale", a reference
36 to there being no specifics and it's therefore very hard to
37 comment on the allegation, but the suggestion is high-level
38 workforce data does not indicate a significant issue at
39 Concord --
- 40 A. Yes.
- 41
- 42 Q. You, as the chief executive of the organisation, had
43 an appreciation of the problems at Concord --
- 44 A. Yes.
- 45
- 46 Q. -- insofar as staff morale was concerned. The chief
47 wellness officer had a comfortable appreciation of the

1 problems at Concord insofar as staff morale were concerned.
2 Was there any reason why someone in the position of
3 Dr Wallace ought not to have had at least some awareness of
4 those same problems that had obviously filtered their way
5 up to higher echelons within the executive?

6 A. I think it's fair enough to say that - I mean, what
7 she does say is it's hard to comment on the allegation.
8 The workforce data, in terms of turnover - because I think
9 it goes more than just saying there's a staff morale issue;
10 it was saying that the turnover rate at Concord was
11 significantly greater than other places. I think this is
12 one of the problems when you use just the data to - when
13 you're reviewing the data rather than the feel, the vibe.
14

15 Q. Is your point there that merely relying on the data
16 can create something of a false impression and not
17 necessarily --

18 A. Yes.
19

20 Q. That's perhaps not the best phrase to use, using just
21 the raw data, relying on that sometimes actually fails to
22 accurately or really in any way assess or measure what the
23 real position on the ground is?

24 A. I think we would agree that data plus commentary is
25 usually the best.
26

27 Q. So, for example, if we go over to the second
28 page there, where there's issues, "Concern Raised:
29 Intimidation and bullying by managers", the first bullet
30 point there refers to complaints which were made, and the
31 way in which they were dealt with, predominantly dismissed.

32 A. I don't - it depends what you mean "dismissed".
33

34 Q. Well, not substantiated?

35 A. Not substantiated.
36

37 Q. I think we have a reference to the HETI accreditation?

38 A. Yes.
39

40 Q. Just insofar as that HETI accreditation is concerned,
41 that's not something which is likely to have unearthed the
42 significant concerns which were being expressed by way of
43 intimidation and bullying, at least in a way which is
44 reflected in any sort of statistics, is it?

45 A. Not in the statistics, but the JMOs were specifically
46 asked by - independently by the HETI, who aren't part of
47 us, they're separate, and I think they did attempt to gain

1 an understanding of whether there were concerns,
2 particularly with the junior medical staff, by asking those
3 questions.

4
5 Q. You've told us elsewhere in your statement about an
6 independent review that was undertaken of the emergency
7 department in April 2018 by some people from Alfred Health?

8 A. Yes.

9
10 Q. That review concluded that there was, in fact,
11 a significant concern within the emergency department
12 arising out of a culture of intimidation and bullying by
13 a small group of staff specialists who held senior roles
14 within the emergency department and had done so for a long
15 time; do you recall that?

16 A. Yes.

17
18 Q. And it reported an obvious level of anxiety from
19 staff, including staff specialists, registrars, HMOs and
20 nurses around discussing that matter?

21 A. Yes.

22
23 Q. I accept you didn't prepare this document, but do you
24 think, insofar as it touched on the concerns raised around
25 intimidation and bullying, it might have been helpful for
26 the board to have been informed of that fact?

27 A. They were aware of the cultural review in the
28 emergency department, but no, it wasn't linked to that
29 document.

30
31 Q. This document, the summary document, that we're
32 looking at was not provided, presumably, to the staff of
33 the medical staff council at Concord; it was just a memo to
34 the board?

35 A. That's my understanding.

36
37 THE COMMISSIONER: Q. Do you think I have to be careful
38 about data like percentages of resignations or retention
39 rates in a sector as big as the New South Wales public
40 health system in the sense that it's not quite like other
41 industries where people, if there's a morale problem in a
42 small firm, might have lots of different firms they could
43 move to, I suppose doctors and nurses have - I guess they
44 could leave the public system and go and work privately,
45 but would you agree that mere percentages of retention or
46 resignation alone don't mean that there might not be
47 a morale problem in a particular hospital or a particular

1 site?

2 A. Yes, if you use the data by itself, yes.

3

4 THE COMMISSIONER: Thanks.

5

6 MR MUSTON: Q. In terms of this summary that was
7 provided to the board by Dr Wallace, to the extent that it
8 seems to convey the strong impression that there is no
9 problem at Concord, does that potentially suggest that
10 concerns held by the medical staff council that they
11 weren't being listened to might have had something in it?

12 A. If you take it by itself, yes, but I think part of it
13 is also about action and significant action was taken in
14 relation to concerns expressed by the medical staff,
15 including recruitment. So, you know, significant increase
16 in junior medical staff, senior medical staff over this
17 time is just one example.

18

19 Q. So in response to Dr Cheung's letter to the board,
20 a meeting was arranged between yourself, Dr Cheung,
21 Mr Ajaka and Dr Sammut on 15 November 2022?

22 A. Yes.

23

24 Q. Just in relation to that, why was that meeting
25 proposed instead of, say, members of the medical workforce,
26 who were expressing concerns or felt concerns, given an
27 opportunity to raise these issues in front of the board?

28 A. The - it was felt that we needed to respond quickly to
29 Professor Cheung and he asked for a meeting, so we met with
30 him, and then there was a series of meetings subsequent to
31 that.

32

33 Q. But that initial meeting with Dr Cheung didn't involve
34 Mr Ajaka, Dr Sammut or yourself extending an invitation to
35 Dr Cheung to come and speak to the board about his
36 concerns, did it?

37 A. No. The board chair felt that in the first instance,
38 Dr Sammut, who is one of the board members and himself and
39 I should meet with Winston.

40

41 Q. Did the board chair express to you any reasons for not
42 suggesting, as Dr Cheung seemed to desire, that he be given
43 an opportunity, and perhaps some of his colleagues who were
44 feeling these concerns at Concord, be given an opportunity
45 to share those concerns which they felt had not been heard,
46 with the board?

47 A. I can't recall the exact sort of wording around

1 organising that, other than - and maybe it was sort of the
2 distance as well, because Mr Ajaka was overseas and we
3 wanted to meet with Winston as soon as he and I both
4 returned from leave.

5
6 Q. So the meeting on 15 November, was it an in-person
7 meeting?

8 A. Yes.

9
10 Q. So Mr Ajaka had been overseas, as had you?

11 A. He was overseas when we received the letter. He came
12 back, and I was overseas I think until the 13th, and the
13 meeting was organised before --

14
15 Q. As soon as you were back?

16 A. Yes.

17
18 Q. You had the meeting on the 15th and at that meeting
19 you tell us there was some discussion about Dr Cheung
20 attending a meeting of the clinical quality council. Do
21 you recall that?

22 A. Yes.

23
24 Q. What was at least your understanding of what the
25 purpose behind Dr Cheung attending a meeting of the
26 clinical quality council was?

27 A. My understanding at the time of that meeting was that
28 at the meeting with Mr Ajaka, Dr Sammut and myself,
29 Dr Cheung expressed concern that there were not appropriate
30 safety and quality processes within the district. He asked
31 about them. We explained about the clinical councils that
32 sit at a facility level, the clinical quality councils that
33 sit at a district level, the nature of the reports that
34 they get, et cetera, and he was invited to be a member of
35 the clinical quality council, particularly so he could
36 understand what was discussed, how those safety data were
37 reviewed by the council, how ims+ were reviewed. So in
38 part, it was felt that that would help to inform Dr Cheung
39 and, you know, that was the primary purpose.

40
41 MR MUSTON: I note the time, Commissioner.

42
43 THE COMMISSIONER: Yes. We'll adjourn until 2 o'clock.

44
45 MR CHENEY: Commissioner, could I just raise this, I think
46 my friend's aware of this, but Mr Griffiths, the next
47 witness, is unavailable tomorrow, so I just wanted to be

1 sure that we --

2

3 MR MUSTON: We will get to Mr Griffiths, but Mr Minns can
4 probably be excused until tomorrow.

5

6 THE COMMISSIONER: Well, I think he's just heard that.
7 Our apologies for you coming along.

8

9 All right. So we'll adjourn until 2 and let's excuse
10 Mr Minns now so that he doesn't sit around, and we'll have
11 him at 10 o'clock tomorrow, I imagine, and it may be we
12 finish before 4 today, but if we do, we do. We'll just
13 leave it at that. Adjourn until 2, thanks.

14

15 LUNCHEON ADJOURNMENT

16

17 THE COMMISSIONER: Yes, Mr Muston.

18

19 MR MUSTON: Q. I think, Dr Anderson, you had just told
20 us about the purposes for which it was suggested that
21 Dr Cheung might attend the meeting of the clinical quality
22 council.

23

24

25 Q. I think if you go to the larger of the two folders in
26 front of you there, there's a tab H7.12.4, which is
27 [SCI.0012.0113.0001]?

28

29

30 Q. Do you recognise that as your letter to Dr Cheung of
31 16 December 2022?

32

33

34 Q. In which, at the end, if you turn over to the second
35 page, you suggest that, to reassure him of the strong
36 governance processes in place, he was invited to attend the
37 clinical quality council?

38

39

40 Q. Would you go over to the next - two tabs forward,
41 to H7.12.6. In fact, maybe an easier way to deal with
42 it is if you go forward to tab H7.12.7, which is
43 [SCI.0012.0071.0001]?

44

45

46 Q. That's an email - just perhaps start on the second
47 page of that email, and working backwards, in the way that

1 they sometimes are unhelpfully set out?

2 A. Yes.

3

4 Q. Do you see that's an email from Dr Cheung to
5 Dr Sammut?

6 A. Yes.

7

8 Q. In which he refers to the invitation to attend the
9 clinical quality council and makes a request that he and
10 a number of his colleagues at Concord be given an
11 opportunity to make brief presentations about their
12 concerns?

13 A. Yes.

14

15 Q. If you then go back to the first page of that
16 document, the 1 February 2023 email from Dr Sammut to
17 Dr Cheung, you see that Dr Cheung's request to have his
18 colleagues attend and make those presentations is refused.

19 A. Yes.

20

21 Q. Were you involved in the decision-making process
22 around whether or not Dr Cheung might be given the
23 opportunity to make a presentation to the clinical quality
24 council and have a number of his colleagues attend and make
25 brief presentations of the type suggested?

26 A. Yes.

27

28 Q. What was the reason for refusing to afford them the
29 opportunity to do that, or your reason, at least?

30 A. Yes, thank you. The agenda for the clinical quality
31 council is sort of set in advance, and it has a number of
32 functions, which is looking at quality data across the
33 district, serious ims+, et cetera, and as Dr Sammut says,
34 that when Dr Cheung was invited to be a member of that
35 meeting, it was first to provide him with a better
36 understanding of the systems that were in place within the
37 district.

38

39 He hadn't been to a clinical quality council
40 previously, and there are a number of presentations, they
41 had already been organised for the next meeting, and he was
42 invited to attend a meeting to understand the clinical
43 quality council, and that normally, in the first instance,
44 there would be a draft presentation, we would have some
45 understanding of the content. The meeting runs for about
46 an hour and a half, so what was proposed, although it was
47 an hour, I think in reality it was felt that it would take

1 up the entire meeting, and so I emailed Dr Cheung, I think
2 the next day - I can't remember exactly - inviting him and
3 those clinicians to meet with me and Dr Sammut to go
4 through their concerns.

5
6 Q. Just in terms of the email the next day, could you go
7 to tab H7.12.8, which is [SCI.0012.0074.0001]?

8 A. Yes.

9
10 Q. You'll see if we scroll down - just to that point
11 there is great - that's an email from Dr Cheung to
12 Dr Sammut of 2 February 2023, in which Dr Cheung provides
13 his response to Dr Sammut's email. You'll see again he
14 makes clear in the last - in the second paragraph, that at
15 least insofar as he is concerned, the concerns and issues
16 that he and his colleagues had had been raised locally
17 without any significant progress having been made?

18 A. Yes.

19
20 Q. Do you see again the reference to the fear of
21 reprisals for raising concerns at the local level?

22 A. Yes.

23
24 Q. Which was the reason he tells us, or you understood,
25 did you, for him having written his letter to the board?

26 A. Yes.

27
28 Q. So you understood at that point that Dr Cheung found -
29 he and his colleagues found themselves in a position where
30 they felt that they were not being heard or listened to by
31 the executive, at least at the local level?

32 A. Yes.

33
34 Q. They had reached out to the board in an attempt to
35 convey their genuine concerns to the board?

36 A. Yes.

37
38 Q. That request had been rebuffed with a suggestion that,
39 instead, Dr Cheung might attend the clinical quality
40 council?

41 A. So a meeting - he was invited and we had the meeting
42 with two of the board members, with John Ajaka and
43 Dr Sammut and myself, in the first instance, and then he
44 was invited to come to the clinical quality council, and he
45 wasn't rebuffed - well, my interpretation was that we
46 weren't rebuffing him; we were giving him an opportunity to
47 meet with John Sammut and myself and the various

1 departments, so it was a very public forum, so - to air
2 their concerns.

3

4 Q. But this is down the track. I'm just trying to step
5 us through this process. The public forum that you speak
6 of is something that came a little bit later, I think, in
7 that chronology - that is, each of the different
8 departments coming?

9 A. Yes, my understanding is that it was pretty close to
10 that time that I emailed Dr Cheung inviting him to meet
11 with us.

12

13 Q. It was clear, though, from Dr Cheung's initial email,
14 that he at least understood that his attendance at the
15 clinical quality council was to afford him an opportunity,
16 him and his colleagues an opportunity, to raise the
17 concerns that they had been wanting to raise with the
18 board?

19 A. That's not my understanding from the meeting that we
20 had, and --

21

22 Q. My question to you is: was it clear from you to
23 Dr Cheung's email of 1 February that that was at least his
24 understanding of where things sat after the meeting?

25 A. Yes.

26

27 Q. So Dr Cheung had reached out, through his letter, and
28 sought to address the board with his concerns?

29 A. Yes.

30

31 Q. And a meeting had been held between yourself,
32 Dr Sammut and Dr Cheung, where it was indicated that that
33 would not be appropriate - that is, meeting with the entire
34 board and sharing the concerns with them?

35 A. It wasn't put to him that it wasn't appropriate. It
36 was put to him that the board chair wanted to meet with
37 him, with John Sammut and myself, not that it was
38 inappropriate to meet with the board.

39

40 Q. But the meeting in which the clinical quality council
41 was raised was a meeting --

42 A. With John Sammut, John Ajaka and myself.

43

44 Q. And at that meeting, whilst people walked away from it
45 with different views, Dr Cheung at least felt that instead
46 of presenting his problems to the board, the suggestion was
47 that they all be presented to the clinical quality council.

- 1 Now, I accept you take a different view of what happened at
2 the meeting, but that was Dr Cheung's understanding?
- 3 A. That's his understanding. I'd just like to emphasise
4 that I did also write to him after the meeting with
5 John Ajaka, John Sammut, indicating what was our
6 understanding of the outcome, and that was before this
7 letter.
8
- 9 Q. Having sought to facilitate a situation in which his
10 concerns could be shared with the clinical quality council,
11 that attempt was again rebuffed?
- 12 A. An alternate opportunity was provided.
13
- 14 Q. But principal amongst the concerns that the medical
15 staff council had were a concern about the way in which the
16 executive had performed?
- 17 A. At that stage it was primarily the executive at
18 Concord, is my understanding.
19
- 20 Q. What I want to suggest is by refusing to enable
21 Dr Cheung, as he'd suggested, to present those concerns to
22 the clinical quality council, that could only have
23 reinforced his view, at least, that the medical staff
24 council at Concord were not being listened to?
- 25 A. In hindsight, I think I would agree with that. In
26 hindsight, I think it would have been good for him to
27 present to the board.
28
- 29 Q. Again, having regard to the nature of the concerns
30 that Dr Cheung was raising on behalf of his colleagues, the
31 repeated reference by Dr Sammut to the need to provide
32 verifiable evidence before steps could be taken to deal
33 with those concerns was not, I suggest, entirely helpful?
- 34 A. I think it was trying to understand some of the
35 specific concerns and evidence to support those.
36
- 37 Q. I think if we turn over now to H7.12.9, which is
38 [SCI.0012.0073.0001], we will find the email that you were
39 alluding to a moment ago, an email from you of 2 February
40 2023 to Dr Cheung, copied in to Dr Sammut and Dr Hallahan,
41 in which, at the top of page 2, we see your offer of
42 a meeting with the clinicians, with Dr Sammut, Dr Hallahan
43 and yourself?
- 44 A. Yes.
45
- 46 Q. That meeting occurred, I take it?
- 47 A. Yes.

1
2 Q. At that meeting, presentations were made by members of
3 the medical staff at Concord hospital?
4 A. Yes.
5
6 Q. Have you had an opportunity to review the documents
7 which appear behind tabs 10 and 11 of Dr Cheung's
8 statement? They don't need to be brought up but for the
9 benefit of the record, they're [SCI.0012.0164.0001] and
10 [SCI.0012.0076.0001]. Do you see one of them's styled as
11 annexure J and the other one as annexure K?
12 A. Yes.
13
14 Q. In the course of preparing your evidence, did you have
15 an opportunity to review those documents?
16 A. These particular ones, no, but they spoke to this.
17 I don't recall getting a copy.
18
19 Q. No, my question was going to be: to the best of your
20 recollection, do those two documents, as Dr Cheung has
21 suggested, reflect accurately what at least those two of
22 his colleagues shared with you, Dr Sammut and Dr Hallahan
23 during the course of the meeting?
24 A. Generally. I can't say specifically, but that was
25 generally what was raised.
26
27 Q. The tenor of their concerns that they were expressing?
28 A. Yes.
29
30 Q. Can I ask you to turn over to H7.12.15, which is
31 [SCI.0012.0079.0001], and if you go to the end of that -
32 sorry, I'll see if you have that document.
33 A. Sorry, could you repeat it again?
34
35 Q. Yes, of course. Tab H7.12.15 --
36 A. Yes.
37
38 Q. -- which is a letter addressed to Dr Cheung?
39 A. Mmm-hmm.
40
41 Q. If we turn over to the fourth page of it, you'll see
42 it would appear to be from you, dated 21 April 2023?
43 A. Yes.
44
45 Q. So is this right, at around the same time as the
46 meeting with yourself, Dr Cheung, Dr Sammut and Dr Hallahan
47 in which the concerns were being expressed, you had

1 a separate meeting with Dr Cheung and Dr Hallahan to
2 discuss the terms of reference again?
3 A. I think that was a couple of months later, but yes.
4
5 Q. The documents will tell us what the dates are,
6 A. Sorry.
7
8 Q. No, no, you could quite well be right.
9 A. Mmm.
10
11 Q. So you attended a meeting in April of 2023 with
12 Dr Cheung and Dr Hallahan to discuss the terms of
13 reference?
14 A. Yes.
15
16 Q. And I gather that the terms of reference that you were
17 talking about at that point were that later document in
18 time, being the 3 March 2023 draft --
19 A. Yes, that's correct.
20
21 Q. -- that did not include the subcommittees?
22 A. Yes.
23
24 Q. The letter goes on to express a range of reasons why
25 it was perceived that the proposed terms of reference were
26 inconsistent with the by-laws?
27 A. Yes.
28
29 Q. Can I suggest that the tone of that letter, insofar as
30 it did that, is a little bit legalistic and formal in its
31 approach?
32 A. I would agree in hindsight. At the time, I thought it
33 was appropriate given we'd been talking about the terms of
34 reference for nearly 12 months.
35
36 Q. And as part of these discussions, or certainly as part
37 of the discussions during this meeting, was there ever an
38 occasion when you said to - you or Dr Hallahan said to
39 Dr Cheung, to the best of your recollection, "Let's just
40 put the terms of reference and the by-laws to one side for
41 a moment and work out what is it exactly you're trying to
42 achieve here for the medical staff council and see if
43 there's a way we can do that for you"?
44 A. My recollection is that I indicated that I wanted to
45 work with Dr Cheung and that Andrew could work with him on
46 a terms of reference that were suitable for the by-laws and
47 met his needs.

- 1
2 Q. But your position in relation to the terms of
3 reference was that, whilst Andrew could work with him, the
4 Concord medical staff council would be using the same terms
5 of reference as every other medical staff council, wasn't
6 it?
- 7 A. That would be the normal way. I do have a broad view
8 of medical matters and if you note in the minutes of the
9 various medical staff council meetings, I - when I was
10 present, I never pulled up the medical staff council for
11 talking about issues in the broader sense, but I agree that
12 the letter, as it stands, is quite legalistic.
13
- 14 Q. But my question was, in terms of the approach that you
15 were taking to the terms of reference, it was your
16 position, was it not, that the Concord medical staff
17 council would be using the same terms of reference as every
18 other medical staff council within your district?
- 19 A. My understanding across the state, because they're
20 based on the model by-laws linked to the Act.
21
- 22 Q. And that was what you had expressed previously in an
23 email, I think, to Dr Hallahan?
- 24 A. Yes.
25
- 26 Q. That is, that that was the way it was going to be, and
27 that was the position that you adopted in your discussions
28 with Dr Cheung, I want to suggest?
- 29 A. Yes.
30
- 31 Q. At the conclusion of the meeting - or at the
32 conclusion of the letter, I should say, you refer to his
33 attempts to deviate from the usual by-laws as being simply
34 unacceptable. Do you see that on page 3?
- 35 A. Yes. Mmm-hmm.
36
- 37 Q. Do you agree that characterising his behaviour in that
38 way in a letter like this perhaps had the capacity to
39 exacerbate the combative relationship which had come to
40 exist between Dr Cheung and his medical staff council
41 colleagues and the executive?
- 42 A. I do now, yes.
43
- 44 Q. And is it the case that at the end of the meeting when
45 you handed him a copy - or at the time you handed him
46 a copy of this letter, you also handed him a copy of the
47 code of conduct?

1 A. Yes, that's correct.

2

3 Q. And at the end of the letter there's a reference to
4 the fact that as an employee of the Sydney Local Health
5 District, he is required to abide by that code of conduct
6 and failure to do so would give rise to disciplinary
7 action?

8 A. Yes.

9

10 Q. Do you see that, in the context of the relationship
11 which had developed between Dr Cheung, the medical staff
12 council and the executive at that time, that dealing with
13 him in that way - that is to say, referring to the prospect
14 of a disciplinary action and handing him a code of conduct
15 - the code of conduct might have been seen as somewhat
16 threatening to Dr Cheung?

17 A. Yes, it was unhelpful.

18

19 Q. Could I ask you to turn forward to tab H7.12.19.

20

21 THE COMMISSIONER: Q. Did you draft the letter,
22 Dr Anderson?

23 A. No, I did not.

24

25 Q. Was it a collaboration?

26 A. Yes, it was.

27

28 Q. Who drafted it with you?

29 A. Dr Hallahan came to me with a first draft, and I then
30 sought advice from the Ministry of Health legal branch,
31 hence why --

32

33 Q. That's about the stuff concerning the by-laws; is that
34 the legal advice?

35 A. Yes, because - you know, as I said, in hindsight,
36 I might have done it differently, but at the time, because
37 it's the by-laws and it's linked to the Act, I thought
38 going to legal branch was the appropriate mechanism to
39 clarify what I thought was a legal matter, because it's
40 not - you know, I'm not a lawyer, so my interpretation was
41 that we were expected to function according to the Health
42 Services Act and to the by-laws, and part of my obligation
43 as a chief executive - and in fact, we do an attestation
44 each year that says that we have made sure that the health
45 service operates in accordance with the Health Services Act
46 and the by-laws.

47

1 Q. Yes. Other than any input that may have fallen out
2 through that advice you received, was the final version of
3 this letter substantially similar to the draft that
4 Dr Hallahan had prepared?

5 A. There were similarities, but it's not exactly the
6 same.

7
8 Q. What about the paragraphs that Mr Muston took you to
9 at the end of the letter about reminding Associate
10 Professor Cheung that he's an employee and he's got
11 obligations and that could give rise to disciplinary
12 action - was that in the draft?

13 A. I can't recall, I'm sorry.

14
15 THE COMMISSIONER: Okay.

16
17 MR MUSTON: Q. Can we go forward to H7.12.19 in your
18 folder?

19 A. Nineteen?

20
21 Q. Nineteen --

22 A. Yes.

23
24 Q. -- which is [SCI.0012.0008.0001]?

25 A. Yes.

26
27 Q. Do you see that? That's an email exchange. If you
28 turn all the way through to the end of it at page 4, you
29 see there's an email from Dr Hallahan to Dr Cheung
30 enclosing a revised version or providing a revised version
31 of a terms of reference?

32 A. Is that 21 April?

33
34 Q. An email of 21 April 2023 from Dr Hallahan to
35 Dr Cheung, copied to you, on page 4 of the document, at the
36 very back.

37 A. From Andrew to Winston, with a copy to me, yes.

38
39 Q. That email set out or provided when might be described
40 as the same terms of reference, an acceptable terms of
41 reference insofar as Dr Hallahan and yourself were
42 concerned?

43 A. Consistent with the by-laws, yes.

44
45 Q. If we go forward, then, to page 3, you see, on 1 May
46 2023, Dr Cheung's sent an email to Dr Hallahan seeking some
47 information, making some inquiries about --

1 A. Yes.
2
3 Q. -- the terms of reference and wanting to make sure
4 there's no ambiguity so he can report back to his medical
5 staff council?
6 A. Yes.
7
8 Q. At the top of that page, page 3, Dr Hallahan says
9 "Thanks. I'll seek advice and come back to you"?
10 A. Yes.
11
12 Q. And then we turn back to page 1, there's an email of
13 5 May from Dr Cheung to yourself?
14 A. Yes.
15
16 Q. Which sets out, in effect, the chronology and
17 indicates that Dr Cheung is awaiting a formal response from
18 Dr Hallahan?
19 A. Yes.
20
21 Q. Are you aware of whether Dr Hallahan ever sent
22 a response to that email?
23 A. No, I'm not.
24
25 Q. Having regard to the queries that were being raised by
26 Dr Cheung in the 1 May email on page 3, it would have been
27 constructive if he had, would you not agree?
28 A. It would have been helpful.
29
30 Q. I think you tell us in paragraph 131 of your statement
31 that from that point on you didn't have any further
32 involvement in the terms of reference issue?
33 A. No.
34
35 MR MUSTON: Could I ask, just as an aside, the operator
36 to bring up [SCI.0012.0160.0001], and scroll up to the top
37 of that document.
38
39 Q. Dr Anderson, is that a document that you're familiar
40 with?
41 A. I wasn't until the other day.
42
43 Q. So you don't know what the origin of this document is
44 or who created it?
45 A. No, I don't.
46
47 Q. Could I ask that we scroll down to the second page.

1 To the extent that the complaining "about resource
2 limitations and constraints rather than striving to work
3 creatively within available resources and looking for
4 innovative solutions" in that highlighted portion is
5 described as "below the line behaviour", would you agree
6 that that's unhelpful to be putting that forward as a core
7 value or behaviour of the health district?
8 A. I think it's unhelpful. I wouldn't have worded it in
9 that way, but I don't know the context in which it was
10 developed.

11
12 THE COMMISSIONER: Q. On the first page of the document
13 there's a contact. Who is that, do you know?

14 A. I think she was - she's a workforce manager, and
15 I think was at Concord at that particular time.

16
17 Q. But you don't know whether that person had any role in
18 drafting this?

19 A. No.

20
21 Q. As distinct from being the contact?

22 A. No, and I've never seen the document used. And as the
23 chief executive, there are many documents that I don't see,
24 but I'm not familiar with it, I'm sorry.

25
26 MR MUSTON: Q. Did Dr Hallahan tell you that during the
27 course of the medical staff council meeting, Dr Cheung
28 raised this document with him in a slightly aggravated way?

29 A. I don't know if my recollection is coloured by the
30 other day, because that was the first time that I recall
31 hearing that, but I might have heard it previously.

32
33 Q. As you would have heard the other day, Dr Hallahan
34 made a disciplinary complaint against Dr Cheung arising out
35 of the meeting at which, amongst other things, that
36 document was discussed. At the time that the disciplinary
37 complaint was made by Dr Hallahan, did you discuss that
38 with him - that is to say, before he made it?

39 A. No, and my understanding is it wasn't a disciplinary
40 complaint.

41
42 Q. A workforce grievance?

43 A. I understand he made a workplace grievance, and no,
44 I wasn't aware about it before, but I was after.

45
46 THE COMMISSIONER: Q. Can I just, sorry to interrupt,
47 otherwise I'll forget, slightly off topic, but back at the

1 document still on the screen, if we could go to the second
2 page and the bit that's highlighted that Mr Muston asked
3 you about, you've explained to me you weren't aware of this
4 document until this Inquiry. Do I take from your answer
5 that - do you think sitting in the witness box now, had
6 this document been brought to your attention, you might
7 have suggested a different wording --

8 A. I definitely would have.

9
10 Q. Yes, okay, and I take it that different wording might
11 have suggested - forgetting what the exact wording would
12 have been, but it would have clarified that complaints that
13 are bona fide and genuine are matters that, in fact,
14 management encourages to be made, without any
15 repercussions?

16 A. Absolutely.

17
18 THE COMMISSIONER: All right.

19
20 MR MUSTON: Q. On the medical staff meeting of 29 June
21 2023, a vote of no confidence in yourself as chief
22 executive was passed by the medical staff council at
23 Concord?

24 A. Yes.

25
26 Q. In paragraph 134 of your statement, you tell us that
27 you remain uncertain as to the precise allegations asserted
28 by Associate Professor Cheung --

29 A. Yes.

30
31 Q. -- which led to that? The complaints and concerns of
32 the medical staff council were expressed with reasonable
33 clarity in the letter of 12 October 2022 to the board,
34 weren't they?

35 A. In relation to Concord hospital, but I didn't feel,
36 and still don't feel, it was specific to myself, even
37 though I was the chief executive. So it's hard to respond
38 to all of those issues when we felt we were responding to
39 the concerns that were being raised.

40
41 Q. But a number of the concerns - I think we've already
42 traversed this, but a number of the concerns raised are not
43 necessarily amenable to precise allegations or the delivery
44 of specific particulars; would you agree with that?

45 A. Yes.

46
47 Q. And I guess to the extent that he and those who voted

1 in favour of that motion were acutely feeling those
2 concerns and feeling that they had not been addressed by
3 the district, did you appreciate at that time that that was
4 what underpinned their vote of no confidence?

5 A. Yes.

6
7 THE COMMISSIONER: When I unhelpfully interrupted you
8 about the document still on the screen, you were discussing
9 with Dr Anderson the grievance complaint. Did I take you
10 off track for that?

11
12 MR MUSTON: You may have.

13
14 Q. I think you told us in relation to that that you were
15 not aware of the fact that the grievance complaint had been
16 lodged before it was lodged?

17 A. Correct.

18
19 Q. But you did become aware after the event?

20 A. Yes.

21
22 Q. What did you do in relation to that grievance
23 complaint after it was brought to your attention that it
24 had been made?

25 A. It was being dealt with by workforce and it would have
26 been inappropriate for me to have done anything about it.
27 It needed to go through its process. I would not
28 normally - it is not what I should be doing, is to
29 interfere with any process like that.

30
31 Q. At the time, cognisant of Dr Cheung and his
32 colleagues' concern that those who spoke out would face
33 reprisals, did you think the lodging of a workplace
34 grievance against him was something that was helpful?
35 I know you didn't lodge it, but did you think about it?

36 A. I think it is difficult to comment. I wasn't in the
37 meeting where that occurred and whether you're management,
38 clinicians, environmental staff, everyone has a right to
39 feel how they feel, so I didn't see it was my place to give
40 a commentary on that.

41
42 Q. Did you explore with Dr Hallahan --

43 A. I didn't think it was my place to do that, because
44 then I would be getting into a pseudo investigation of the
45 matter, which I didn't think was appropriate.

46
47 THE COMMISSIONER: Q. Accepting you didn't know about

1 the grievance complaint that Dr Hallahan instigated against
2 Professor Cheung, prior to that, or at any stage, did
3 Dr Hallahan speak to you and say he had been to a meeting
4 of the council and he was unhappy about being interrupted
5 and about rudeness at that meeting?

6 A. I don't recall him mentioning it, but other people,
7 clinicians, who were present said to me that they felt very
8 uncomfortable in the way that he'd been treated.

9
10 MR MUSTON: Q. Coming back to the vote of no confidence
11 and what you understood likely underpinned it, did it occur
12 to you at that point that perhaps the executive, at least
13 at the hospital, had not been engaging with the medical
14 staff at Concord in a manner which was optimum and might
15 have assisted to alleviate the concerns that the medical
16 staff had?

17 A. Yes, I think anyone who has had a vote of no
18 confidence in them would be reflecting on what might have
19 been.

20
21 Q. As part of that process of reflection, what did you
22 and other members of the executive do?

23 A. Had discussions with the Ministry of Health, who
24 arranged for ProActive ReSolutions - they went through
25 a tender process and had ProActive ReSolutions come to
26 undertake an intervention, which I think was partially
27 successful, and that involved a listening, having an
28 independent group listen to the concerns and then attempt
29 to improve the communication.

30
31 Q. Were you involved in that process?

32 A. Some of it.

33
34 Q. What was your involvement?

35 A. The main part that I was involved in was in relation
36 to radiology. I did think that I might get invited to some
37 of the other working groups to hear their concerns once
38 they'd been aired with ProActive ReSolutions, but the
39 radiology was the only one I was invited to.

40
41 Q. Did part of that process involve, at least to your
42 understanding, ProActive ReSolutions making any sort of
43 assessment of what the root causes of the breakdown in the
44 relationship between the staff at Concord and the executive
45 of both the hospital and the district might have been?

46 A. There was no formal report as such, but an action plan
47 that was developed with - by ProActive in partnership with

1 the clinicians, that the district - that the general
2 manager in particular, he attended many of those workshops,
3 he was invited to them, and I think that the general
4 feeling was that it was a breakdown of communication,
5 primarily, and that by going through a process of listening
6 to the clinicians, working out what are the actions,
7 documenting those actions and taking them back, that that
8 would assist in the resolution of the issues.

9
10 Q. Did anyone ever share with you - when I say "anyone",
11 that is anyone from ProActive ReSolutions or anyone else
12 share with you - their views about where that breakdown had
13 occurred, the communication breakdown, or why it had
14 occurred?

15 A. At a general level in relation to communication, if
16 I look at the radiology, it was particularly about being
17 clearer about what actions are being taken and actions that
18 aren't, giving clearer rationale for those actions not
19 being taken. We had two workshops with radiology, and
20 again, an action plan was developed from that and a second
21 meeting - one was in September 2023 and another was
22 in February '24, and the feedback I had was - from
23 Mr McDonald was that he also thought that the second
24 meeting was really positive and that issues overall had
25 improved.

26
27 Q. Just in terms of being a bit clearer about what was
28 going to happen and what wasn't going to happen within
29 radiology, for example, could I ask you to go back to
30 tab H7.12.11 of the Dr Cheung folder, which is annexure K
31 of his statement, [SCI.0012.0076.0001]?

32 A. H7?

33
34 Q. H7.12.11.

35 A. Mmm-hmm.

36
37 Q. At the top of that document, hopefully, it says
38 "Annexure K"?

39 A. Yes.

40
41 Q. I just want to ask, in terms of some of the
42 complaints or concerns that had been aired by radiology,
43 accepting that this is before this ProActive ReSolutions
44 process, but could I take you down to the
45 paragraph commencing, "It's not just the cuts in
46 resources"? Do you see that paragraph about four from the
47 top?

1 A. Yes.

2

3 Q. Then there's a reference to "Teresa", which I assume
4 is a reference to you --

5 A. That must be me.

6

7 Q. -- having taken several millions dollars from
8 radiology trust funds because you were convinced that the
9 vascular surgeons would leave without decent equipment;
10 did you understand what that concern related to?

11 A. I definitely don't understand that.

12

13 Q. The next concern, "virtually every major imaging
14 equipment in the last decade has been replaced beyond its
15 end of life." Did you understand what Dr Ridley was --

16 A. I understand what he's saying. I don't agree with it.

17

18 Q. In what way do you not agree with it?

19 A. Because we have replaced significant amounts of
20 medical imaging equipment at Concord hospital. By "end of
21 life", having seen Dr Ridley's testimony, he's referring to
22 capital sensitivity, which is different to end of life.
23 Capital sensitivity is terminology that relates to Medicare
24 and for private patients, Medicare - you don't get
25 reimbursed once a piece of equipment reaches a certain age,
26 but that equipment may be still very functional. The
27 equipment is assessed by our biomedical team and it also -
28 the majority of that equipment is under maintenance
29 contracts. So it's not obsolete.

30

31 In the public health system, we do try to use
32 equipment to that point because of the limited resources
33 that we have, but, as I said, significant equipment has
34 been replaced at Concord hospital over the last, you know,
35 even the last six or seven years, and that includes
36 mammography, fluoroscopy, CT and obviously - the first
37 MRI's been replaced; we're hoping to have a second MRI.

38

39 Q. Just dealing with the proposition that if we read
40 Dr Ridley's statement there, where he refers to "end of
41 life", as a reference to the sensitivity rules that are
42 engaged by Medicare --

43 A. Yes.

44

45 Q. -- would he be correct in his assertion that at least
46 a significant portion of the major imaging equipment had
47 been replaced beyond its end of life in that sense - that

- 1 is --
- 2 A. I haven't got the figures in front of me, but it's not
3 the majority, no. The majority is around that time.
4
- 5 Q. If we go down a couple of sentences, do you see
6 there's a sentence commencing:
7
- 8 *When the imaging stream decided not to*
9 *replace the mammo unit the MSC got*
10 *involved.*
- 11
- 12 A. Yes.
- 13
- 14 Q. "Mammo unit", I take it, is the mammography unit?
15 A. Yes.
16
- 17 Q. There's a reference to you having readily agreed that
18 women's imaging was an important service at Concord?
19 A. Yes.
20
- 21 Q. Is that something you remember agreeing with?
22 A. Definitely, yes.
23
- 24 Q. He then suggests that, despite that support, it took
25 another seven years to replace the already obsolete
26 equipment?
27 A. I don't agree with that statement.
28
- 29 Q. Why not?
30 A. Because it is giving an impression that it was seven
31 years past the capital sensitivity, and that's not my
32 understanding. I will have to look at - take it on notice,
33 but that's not my understanding.
34
- 35 Q. At the time that you had this discussion with him,
36 which was that initial meeting between yourself, Dr Cheung,
37 Dr Sammut and Mr Ajaka, when the various members of the
38 Concord workforce addressed you, did you engage with those
39 propositions then and seek to get to the bottom of what
40 the --
41 A. I don't recall him - I do recall him indicating that
42 equipment was purchased past end of life. I don't recall
43 him saying mammography was seven years past its useful
44 life.
45
- 46 Q. It's possible that he said it and you can't recall?
47 A. It's possible but I - it is something that I think

1 I would recall.

2

3 Q. The next little issue he raises there relates to the
4 second MRI?

5 A. Yes.

6

7 Q. I'll come to the documents that you've given us in a
8 minute, but he makes the point it's more than seven years
9 since you had agreed to the need for a second MRI at
10 Concord. Just pausing there --

11 A. That's correct.

12

13 Q. And it's six years since the ministry endorsed the
14 procurement; is that correct?

15 A. That's not correct.

16

17 Q. Four years since Genevieve, who I assume is
18 a reference to Dr Wallace, told the medical staff council
19 that the second MRI would be operational within six to
20 12 months, do you know one way or the other whether that's
21 the case?

22 A. No, sorry. And I don't recall that being mentioned in
23 the meeting, but it could have.

24

25 Q. Still, as he points out, still no sign of the second
26 MRI, despite the extensively discussed impacts of the
27 inadequate capacity. The first point, as at that point in
28 time it's correct to say, isn't it, that there was not
29 a second MRI yet in the building at Concord?

30 A. Definitely. Definitely, yes.

31

32 Q. And would it be right to say that the radiology
33 department had been extensively advocating the need for it,
34 based on what at least they perceived to be the impacts of
35 the inadequate capacity?

36 A. Yes, I would agree.

37

38 THE COMMISSIONER: This is not a question for you,
39 Dr Anderson, but there might be some significance that this
40 document says it's four years since Genevieve told the
41 staff council the second MRI would be operational in six to
42 12 months, and I don't have anyone saying to me or this
43 Inquiry that's not right.

44

45 MR MUSTON: No.

46

47 THE COMMISSIONER: Okay. Sorry, when I say, "That's not

1 right", that wasn't said is what I mean.

2

3 MR MUSTON: Yes, that's exactly the position.

4

5 Q. Could I ask you to go back, finally, to your own
6 statement folder there, the smaller of the folders in front
7 of you hopefully, behind tab 1.

8 A. Tab 1?

9

10 Q. Yes, which is document [MOH.0010.0404.0001].

11 A. Yes.

12

13 Q. If you turn to page 3 in that little bundle, you see
14 there's a "Health In Brief For Major Procurement Committee
15 SLHD" which appears to be --

16 A. That's me, yes.

17

18 Q. -- your recommendation that the second MRI scanner be
19 procured for Concord. That was a document you signed on
20 18 November 2016?

21 A. Correct.

22

23 Q. If we go back to the emails which immediately precede
24 that in the bundle, we see an email just starting on
25 page 1, at the very foot of that page, from Pravindra Singh
26 to Tim Sinclair?

27 A. Yes.

28

29 Q. Just pausing there, who is Pravindra Singh?

30 A. He was the acting manager for the business case unit
31 in the --

32

33 Q. The business case unit did what at the LHD?

34 A. So one of the concerns previously - this was back in
35 2018 - that clinicians had is that they didn't have time to
36 prepare business cases without support, so we developed
37 a business case unit in the finance department and capital
38 assets team to assist clinicians with business cases.

39

40 Q. And who's Mr Sinclair?

41 A. He was the general manager at the time.

42

43 Q. At Concord?

44 A. At Concord. Oh, wait a minute. Yes, I think he was
45 still at that - I'll have to check, take it on notice. He
46 was the general manager of Concord hospital and through
47 a competitive recruitment process was appointed as director

1 of operations for the district around that time.

2

3 Q. Just looking at the email there, of 15 February 2018,
4 if we turn over to the second page, it contains a draft or
5 it purports to attach a draft business case and brief. Do
6 you have any explanation or are you able to provide any
7 explanation as to why it took 18 months from signing the
8 major procurement committee SLHD document to preparation of
9 the draft business case?

10 A. My understanding was that there were challenges in
11 getting the data to support the business case.

12

13 Q. What data?

14 A. It would have been a range of activity data on
15 utilisation of the existing MRI, case mix of patients
16 coming through the radiology department, et cetera.

17

18 Q. Just looking --

19

20 THE COMMISSIONER: Q. Is this different data than what
21 is in the November 2016, "Health In Brief Major
22 Procurement" document that Mr Muston was asking you about
23 regarding, if we go back to it - it's on page 3 of this
24 chain - the key issues:

25

26 *Concord hospital currently has one --*

27

28 what does "3T" mean?

29 A. 3T is the nature of the MRI:

30

31 Q.

32

33 *... one 3T MRI unit and scans approximately*
34 *5 000 patients per year, of which 80% are*
35 *billable. The scanner operates 65 hours*
36 *per week ...*

37

38 et cetera. "Current wait times", et cetera, et cetera,
39 there's additional data that is needed, is there?

40 A. Yes, correct.

41

42 Q. Which would be what?

43 A. So at that time, I did not get this document because
44 it was a draft, and so it was still being developed between
45 the general manager of Concord, the business unit and the
46 radiology department.

47

1 Q. I'm still not sure I understand why it would take 18
2 months. It's not a criticism of you. Are you able to help
3 us?

4 A. I don't, but I did ask when they were raising the
5 issue of the MRI. I don't go back to every facility,
6 I have to say, and say, "Where are you up to?"
7

8 Q. No, but this is obviously - this is, one, an expensive
9 piece of kit, and obviously an important machine, thought
10 to be needed for providing health care in the district and
11 at the hospital?

12 A. Yes.
13

14 Q. It seems a long time to get the data ready?

15 A. It was, my understanding, very challenging to get the
16 data, but I also think - and I'm surmising at the moment -
17 that part of it was also we were in the middle of
18 discussing the redevelopment of Concord hospital.
19

20 Remember, we were looking to do a very big
21 redevelopment, we only received enough money to do part of
22 that redevelopment, and there were questions being raised
23 about whether or not the second MRI would fit in the
24 existing radiology department if the redevelopment did not
25 occur. So there were discussions. It's a very constrained
26 environment, and it's right next to --
27

28 Q. I think you mean literally fit inside, do you?

29 A. Physical, yes. Unfortunately it isn't the Tardis, and
30 so there's a constrained footprint. Nuclear medicine is
31 right next to it. There were thoughts, when we did have
32 the stage 1 of the redevelopment being planned whether or
33 not some of nuclear medicine could go into part of the
34 stage 1 redevelopment and free up space, but it was
35 determined, in partnership with Health Infrastructure, that
36 that would not be feasible.
37

38 MR MUSTON: Q. It wouldn't appear, based on the
39 grievances and concerns being expressed by radiology, to at
40 least the executive at the hospital, and subsequently to
41 you, that the radiology department was told, "We're not
42 going to action the MRI until we've made a decision about
43 which part of the hospital we want to put it in"?

44 A. My understanding is - I didn't go to all of the user
45 group meetings for the redevelopment. I was on the
46 overarching executive steering committee, but it is my
47 understanding that those discussions were being had at the

1 radiology department level.

2

3 Q. But insofar as those discussions might have touched on
4 the issue of whether the procurement of a second MRI would
5 proceed as had been proposed or would instead be put on ice
6 pending decisions around the redevelopment, you don't know
7 one way or the other what was said, if anything, about
8 that; would that be correct?

9 A. No. My understanding is that people were informed,
10 were part of that decision-making.

11

12 Q. So that in an earlier answer you indicated that you
13 were - or someone within the LHD was awaiting some
14 information about activity data and the like for the
15 purposes of preparing the business case?

16 A. That's right, for the MRI, second MRI, yes.

17

18 Q. And who was that information to be provided by, as you
19 understood it?

20 A. By the - my understanding was by the radiology
21 department, the head of radiology.

22

23 Q. And so you attribute the 18-month delay in preparing
24 the draft business plan to that, in part?

25 A. The - yes, in that process. I think there were more -
26 there's more correspondence in relation to that. I don't
27 have it all, but I understand there is.

28

29 Q. If we look at the email on page 2 of the document that
30 we were looking at a moment ago, you can see it refers to
31 some discussions, and then ultimately do you see it says:

32

33 *Currently we are waiting for the approved*
34 *location plan/drawing for the additional*
35 *MRI. We will finalise the Business Case*
36 *financial information upon receipt of*
37 *plan/drawing and estimated Capital Works*
38 *cost.*

39

40 Would it be fair to infer from that that to the extent
41 activity data and the like was to be provided by the
42 radiologists or the radiology department, that information
43 had been provided and what was being waited for at that
44 point was some approval location plan drawings?

45 A. In that email, yes. There are other email
46 correspondence that indicate that there was data that was
47 being waited for as well.

- 1
2 Q. But looking at the draft business case that has been
3 prepared, which commences at page 5, it doesn't appear as
4 though there's any outstanding data beyond the capital
5 works costs. Flick through it, but it seems the
6 outstanding data which is being sought is that which is
7 underlined and in red within the document?
8 A. Normally - sorry. Normally, a business case would
9 have more activity data than is in this particular business
10 case. Having said that, as I said, this never came to me
11 because it wasn't complete.
12
13 Q. At least based on the email chain that we can see here
14 that you've provided us with, it doesn't appear as though
15 there was, as at 15 February 2018, any further information
16 that was being sought from the radiology department that
17 had not been provided. Would you agree that that's at
18 least a fair reading of these emails?
19 A. If you just look at that email, yes.
20
21 Q. And do you have any explanation as to why a further
22 five years later, the MRI's still not there?
23 A. Two years later, in terms of the 2018.
24
25 Q. Well, but the MRI is not in place yet, is it?
26 A. No.
27
28 THE COMMISSIONER: Q. The business case, if you look at
29 it at page 13 - tell me if I'm missing something - it says
30 under "Issues", "we've got a single MRI at Concord."
31 Second bullet point on that page says, in breakdowns, we've
32 got to send patients to the RPA, during breakdowns, our
33 revenue is compromised and the current wait times with one
34 machine for an outpatient scan is 8 to 10 weeks, with
35 inpatients waiting up to 48 hours. Is there much more that
36 is needed to indicate by way of data that the second
37 machine was needed? That seems like a comprehensive case
38 for a second machine to me, or am I missing something?
39 A. It's a very expensive piece of equipment, around
40 \$4 million.
41
42 Q. I know. I recognise that, yes.
43 A. And many hospitals across New South Wales only have
44 one MRI. So we are required to have certain levels of
45 detail.
46
47 Q. That's a different issue, though - that other

1 hospitals might have had one doesn't mean - there might be
2 sufficient demand in those hospitals as well for a second
3 machine?

4 A. Yes.

5

6 Q. If funds were available?

7 A. Mmm.

8

9 Q. All I'm asking you - and feel free to tell me why I'm
10 wrong - that at least under those bullet points that I've
11 just mentioned, that seems like a strong case, to me --

12 A. Yes, and the --

13

14 Q. -- for a second machine? And leave aside that it
15 costs \$4 million, because I get that and the money has to
16 be found somewhere, I understand that.

17 A. Yes. So it's not within the district's ability to
18 just purchase an MRI. You need to submit to the ministry,
19 and they require a certain standard for the business case
20 with more activity data. You know, I've supported the
21 concept and the principle of having an MRI. The issue is
22 getting the documentation to be able to get the approvals
23 to be able to purchase it.

24

25 Q. Okay. So whatever extra data is needed, the fact that
26 the current machine is used by 5,000 patients a year, if it
27 breaks down, people have got to be sent to the RPA, if it
28 breaks down we lose revenue, and with one machine, people
29 have got to wait 8 to 10 weeks, or if they're inpatients,
30 48 hours, is not enough data for the ministry?

31 A. No.

32

33 THE COMMISSIONER: All right. Okay.

34

35 MR MUSTON: Q. It would seem from the emails that I've
36 just taken you through, though, that the only piece of data
37 that was outstanding as at February 2018 was some plans and
38 some information about the costings of the capital works
39 that would be required to make space for this second piece
40 of equipment?

41 A. As I said, my understanding is - and I don't have the
42 emails in front of me - that there was other data that was
43 being requested. But I don't have that in front of me.

44

45 Q. To the extent that we have to go on what's in front of
46 us, the plans and the costing of the capital works was not
47 information which was to be provided by the radiology

1 department, was it?

2 A. The capital plans required the radiology department to
3 work with capital works to come up with a solution. So
4 engineering can't do that by themselves, they need to talk
5 about the work flows, the way - the processes. So it's
6 unclear from this email about where that process was up to.

7
8 Q. Do you have any reason to think that it was the
9 radiologists and decisions about the location of the
10 machine or the work flows within that department that were
11 the cause of the delay - that is to say, the five or so
12 years that it then took between 2018 and 2023 to finalise
13 the business case?

14 A. I can't say. I don't know.

15

16 Q. If responsibility for that delay didn't rest with the
17 radiology department or any failure on the part of the
18 radiologists to provide information, you can understand why
19 that delay might have contributed to their distress when it
20 came to 2023?

21 A. Yes.

22

23 Q. And the MRI had still not arrived?

24 A. I think it's again important to understand the
25 context. So at the end of 2019 you will recall the
26 bushfires that occurred in New South Wales. Concord was
27 really affected by that, having one of the two burns
28 units --

29

30 Q. I don't doubt that, but that's still almost two years
31 after the draft business case had been prepared?

32 A. And then we had three years of COVID, where I have to
33 say the attention of the district was on a whole range of
34 strategies to assist with the NSW Health response and the
35 priority at that time was keeping patients safe. So the
36 MRI was not front of mind for myself during that period of
37 time.

38

39 THE COMMISSIONER: Q. I shouldn't understand that as
40 meaning that scans aren't important for patient safety, if
41 scans are needed, but you mean keeping people safe in
42 relation to the virus?

43 A. In relation to COVID. The district was very involved
44 in the NSW Health response. That included the setting up
45 of screening at the airports, domestic and international;
46 the setting up of the police-managed quarantine program; as
47 well as the NSW Health special health accommodation for

1 people who had COVID or were at risk of having COVID; and
2 also the establishment of the very large vaccination
3 program.
4

5 MR MUSTON: Q. So is your point that those working
6 within the district and the executive were, during the
7 period of time when this MRI business case was in the
8 process of being prepared, also distracted by a range of
9 other important operational matters?

10 A. Very much so.
11

12 Q. And that distraction on the part of the members of the
13 executive who might have been involved in the development
14 of the business plan and those within the health district
15 head office, as it were, involved in the development of the
16 business plan, might have contributed to a delay by them in
17 bringing it to fruition?

18 A. Yes, I think there were contributions all round.
19

20 Q. So to the extent that in paragraph 83 of your
21 statement you tell us that the business case was to be
22 prepared by the radiology department, with the support of
23 the facility executive, for provision to the Ministry of
24 Health, do we take it from what we have seen in those
25 emails that the process of preparing the business case
26 actually rested with the business case unit --

27 A. The responsibility --
28

29 Q. -- informed by the radiologists?

30 A. My apologies.
31

32 Q. Would that be right? Responsibility for the process
33 of preparing the business case rested with the business
34 case unit, informed by the radiology department providing
35 the information that was required?

36 A. The normal process is that the business case is owned
37 by the department and the business case unit provided
38 support.
39

40 Q. And to the extent that in paragraph 84 you tell us
41 there was an extended delay in the radiology department
42 providing the relevant information for the finalisation of
43 the business case --

44 A. That is one of the contributors.
45

46 Q. One of the contributors, but having regard to what
47 you've just told us about, the various other pressures that

1 were brought to bear upon others within the district,
2 you're not seeking to convey through that paragraph that it
3 was the radiology department and a failure by that
4 department to provide information which is the reason that
5 it took and has taken almost seven years from the initial
6 2016 approval of the process to now, and we still don't
7 have an MRI, a second MRI at Concord?

8 A. That's correct.

9
10 THE COMMISSIONER: Q. Forgive me for not understanding,
11 perhaps, something you've said before, but specifically, in
12 84 when you talk about the extended delay in the radiology
13 department providing the "relevant information", precisely
14 what should I understand to be the relevant information,
15 though?

16 A. It was information in relation to number of scans,
17 types of scans, et cetera.

18
19 Q. So the number of scans that might be performed on the
20 new machine?

21 A. That were being performed on the current machine and
22 then --

23
24 Q. Don't we know that it's 5,000?

25 A. I wasn't involved in the development of it, so that --

26
27 Q. Feel free to say where you've said "relevant
28 information" in that paragraph you're not precisely sure.

29 A. I'm not precisely sure because I was not involved at
30 that point.

31
32 MR MUSTON: Q. Just quickly, at paragraph 86 you tell us
33 about the process whereby procurement of the MRI was
34 approved and then the procurement was cancelled as a result
35 of some discussions that you'd had with Mr McDonald.

36 A. That's correct.

37
38 Q. Can I ask, did you have any discussions with members
39 of the radiology department before you cancelled the
40 procurement of the second MRI, or did you rely on
41 Mr McDonald's judgment about that matter?

42 A. I relied on Mr McDonald's judgment. I discussed it
43 with the ministry and the view was that we should cease
44 that procurement, which was consistent with NSW Procurement
45 policy.

46
47 We'd gone to a panel - I didn't personally, I don't do

1 that myself - and that was approved by the department head
2 with the clinical director. But we determined that we did
3 not want to escalate the issues further, so we ceased that
4 process. I communicated it to our head of procurement. So
5 I didn't have the conversation with the company myself -
6 I don't talk to companies - and we then determined, with
7 the chief procurement officer, myself, for NSW Health, that
8 what we should do is go through a tender process, which
9 different to what we've agreed previously.

10
11 In my previous evidence I talked about that NSW Health
12 has had procurement reform, there are concerns about the
13 amount of time it takes to procure equipment because of the
14 tender process, et cetera, so the panel has a series of
15 equipment from different vendors that have gone through
16 a tender process but at a state level, and then you can
17 select from that panel, which is what was procured, what
18 was being procured, but we went to HealthShare and said
19 could they oversee a tender process, which they did, with
20 the radiology department.

21
22 Q. That last bit was the big and important change as
23 between the first process and the second, wasn't it,
24 though, that the radiology department, a group of people
25 who were feeling a bit disenfranchised because they felt
26 they hadn't been consulted with about important decisions,
27 were consulted with about which particular type of MRI
28 should be bought for them to use in their facility?

29 A. Yes, and it was the same piece of equipment that was
30 ordered in the first place.

31
32 Q. I think there might be some suggestion that it has
33 a different power, but we can - little turns on that.

34 A. It's the same piece of equipment.

35
36 Q. But the fact is the first procurement process which
37 was cancelled did not involve consultation - would you
38 accept did not involve adequate consultation with the
39 members of the radiology department who had been expressing
40 a strong desire to be consulted with in relation to
41 decisions relating to their unit within Concord hospital?

42 A. Yes.

43
44 Q. Including, for example, which type of MRI machine to
45 buy?

46 A. Yes, but they had also expressed concern in previous
47 tender processes about how time consuming that process was,

1 so, you know, in hindsight, we could have gone through the
2 tender process. Having said that, NSW Health procurement
3 reform was aimed at reducing the amount of time clinicians
4 had to spend on what was seen as administrative activities
5 rather than provision of clinical services, so --
6

7 Q. A middle path could have been to sit down with them
8 and say, "We could get this one quickly through these more
9 efficient processes. Alternatively, we can go to a tender
10 process if you're not happy with this particular type of
11 machine, as you've told us before those tender processes
12 can drag on a bit. What would you like to do?"

13 A. In hindsight, could have done that.
14

15 Q. Last point. In paragraph 88 you make an observation
16 about what you understand to be the way in which some
17 concerns Associate Professor Ridley had were reported back
18 to the medical staff council and the impression that that
19 might have created. Do you see that --

20 A. Yes.
21

22 Q. -- the last sentence? Were you present during that
23 meeting?

24 A. 29 February? Oh, yes, 29 February, yes. That was the
25 second workshop.
26

27 Q. Were you present during the medical staff council
28 meeting? We might be at cross-purposes, you see you say in
29 the last sentence that you were present during the
30 workshop, Associate Professor Ridley expressed some
31 discontent, which you've suggested was reported back to the
32 medical staff council in a way which created the impression
33 that the entire department was unhappy. Do you see that?

34 A. I can't recall if I was there or it was reported to
35 me.
36

37 Q. But as you sit there now, you don't know what was said
38 to the medical staff council about Associate Professor
39 Ridley's concerns, do you, really?

40 A. No, I can't remember.
41

42 Q. Why did you include that sentence in your statement?
43 What were you seeking to convey through it?

44 A. So in the ProActive ReSolutions meeting, there were
45 other members of the radiology department present.
46 Dr Ridley - they indicate that they were happy with the
47 process. He indicated that he was not. They indicated

1 that although it wasn't an ideal solution, ie, we're in a
2 physically constrained environment, they wanted to go ahead
3 with the second MRI, and the compromise, in terms of the
4 layout of the second MRI suite, the director or head of
5 department for nuclear medicine had given up additional
6 space to make the MRI fit in better, and although everyone
7 said, you know, "It's still constrained, it's not perfect",
8 they wanted to go ahead.
9

10 My understanding is, at the next medical staff council
11 meeting, that Dr Ridley indicated that the department was
12 unhappy, which is not consistent with the discussion that
13 we'd had in the ProActive ReSolutions workshop.
14

15 Q. But you weren't present at the medical staff council
16 meeting at which Dr Ridley's views were expressed in some
17 way?

18 A. No, but I - I think if we were to go to the minutes,
19 we would see that he expressed his concern.
20

21 MR MUSTON: I've got no further questions for this
22 witness, Commissioner.
23

24 THE COMMISSIONER: Thank you.
25

26 Mr Cheney, do you have any questions?
27

28 MR CHENEY: No, Commissioner.
29

30 THE COMMISSIONER: Thank you very much for your time,
31 Dr Anderson. We're very grateful.
32

33 THE WITNESS: Thank you.
34

35 THE COMMISSIONER: You are excused.
36

37 THE WITNESS: Thank you very much.
38

39 <THE WITNESS WITHDREW
40

41 MR GLOVER: That brings us to Mr Griffiths.
42

43 THE COMMISSIONER: Yes.
44
45
46
47

1 <RICHARD RONALD GRIFFITHS, sworn: [3.22pm]
2
3 <EXAMINATION BY MR GLOVER:
4
5 MR GLOVER: Q. Can you tell us your full name, please?
6 A. Yes, Richard Ronald Griffiths.
7
8 Q. You're the executive director workforce planning and
9 talent development within the ministry?
10 A. I am.
11
12 Q. You've been in that role since about January 2019;
13 correct?
14 A. Correct.
15
16 Q. And to assist the Commission in its work, you've made
17 two statements, the first dated 16 July 2024?
18 A. Yes.
19
20 Q. And that's [MOH.0011.0022.0001]. Do you have a copy
21 with you there?
22 A. I do.
23
24 Q. There are some screens either to your right, opposite
25 you, or feel free to use your hard copy. I understand
26 there's an adjustment you wish to make to the table in
27 paragraph 101 of your statement?
28 A. That's right. There was - for the PMES survey, there
29 was some data that didn't come through, in the printer.
30
31 Q. You've provided the Commission with a full copy of
32 that table, which is, for the benefit of the transcript,
33 [MOH.0010.0457.0001]. Subject to that adjustment, have you
34 had a chance to read through your 16 July statement before
35 giving your evidence again this afternoon?
36 A. I have.
37
38 Q. And are you satisfied that it's true and correct to
39 the best of your knowledge and belief?
40 A. Yes, I am.
41
42 Q. And you've made a second statement dated 2 August
43 2024?
44 A. Mmm-hmm.
45
46 Q. Correct?
47 A. Correct.

- 1
2 Q. That's [MOH.0011.0039.0001]. Have you had a chance to
3 review that statement again before giving your evidence
4 this afternoon?
5 A. I have, yes.
6
7 Q. And are you satisfied that that statement is true and
8 correct to the best of your knowledge and belief?
9 A. Yes, I am.
10
11 Q. I might just start with exploring a little bit about
12 your branch and your role and we might do it by reference
13 to your CV, which is [MOH.0010.0280.0001]. Do you see
14 there in the third paragraph under "Current role", "The
15 Branch is responsible for" - do you see that?
16 A. I do, yes.
17
18 Q. I'm not going to ask you about all of it, but the
19 first area of responsibility you describe is strategic
20 workforce planning.
21 A. (Witness nods).
22
23 Q. What is involved in that function?
24 A. So as it implies, there's obviously layers of
25 workforce planning across the health system. The
26 ministry's role in workforce planning is looking at the
27 system as a whole and coming up with strategies that will
28 benefit the whole system, and that's the responsibility of
29 my branch, is to guide the system in terms of its strategic
30 workforce planning.
31
32 Q. What are the other layers?
33 A. There's local, there's operational workforce planning,
34 there's tactical workforce planning, which - tactical is
35 fairly short-term supply challenges because of an event.
36 Operational is at the local health district level where
37 they need to operationalise the plans for the ministry, for
38 the health system.
39
40 Q. Does tactical sit at the local level or at the
41 ministry level in that --
42 A. It can be both, yes.
43
44 Q. Amongst those layers in your first answer you
45 described the ministry's role as coming up with strategies
46 that benefit the whole system. Does it take into account
47 the work of the other layers in doing that?

1 A. Yes, it does.

2

3 Q. How?

4 A. So it's really looking at - well, if you take it back
5 to the local health district levels, they can't really
6 control pipeline, whereas the ministry is operating at
7 a level that it can influence pipeline. So it's bringing
8 some of that planning from the local level to lift it up,
9 to see how the system can support some of those supply
10 strategies. So it's - yeah, I'll just probably --

11

12 Q. As part of that, does the ministry perspective enable
13 it to identify trends that might be looming on the horizon?

14 A. Correct. So my branch also has responsibility for
15 workforce reporting, workforce analytics and insights, so
16 we monitor the workforce right across the state, including
17 the performance of local health districts in terms of the
18 workforce, so that we can identify some of those trends
19 that are beginning to emerge across the health system and
20 we take that to various forums to see if there's something
21 we need to do to address an emerging trend.

22

23 So it does, it has the - the ministry's branch, or my
24 branch, has that helicopter view of the health system so we
25 can actually assist the organisation with its workforce
26 planning.

27

28 Q. We'll come back to some of those functions and
29 features in a moment. The second one I wanted to ask you
30 about is the next that appears in that same sentence
31 "operational workforce supply strategies". In an earlier
32 answer, you referred to the fact that LHDs may not have the
33 ability to influence pipeline whereas ministry can. Is
34 that the function that I've just drawn your attention to?

35 A. No, not really. Operational workforce supply
36 strategies is - yes, there may be, for whatever reason,
37 difficulties supplying to various areas throughout the
38 state. I have a unit in my branch that has been
39 established to look at deploying workforce to some of those
40 areas where there's ongoing challenges to supply, and so we
41 deploy nurses, allied health for between two and 13 weeks
42 while those organisations can actually continue to recruit
43 to some of those areas.

44

45 Q. Can you give us a practical example of when your team
46 has done that in recent times?

47 A. Well, it's occurring all the time. At the moment

1 we've got about 100 FTE or so out on deployment. So they
2 register with us as an agency, effectively, and we deploy
3 them across the state. But we also move internal workforce
4 around. So at the, for example, bushfire period in 2019,
5 we called on the local health districts to assist with
6 supply and we deployed metro health workers into those
7 bushfire-affected areas, both as fatigue relief but also
8 as supply, because we had some of our own staff affected by
9 the bushfires.

10
11 Q. So it provides assistance in addressing difficult to
12 fill positions but also providing surge capacity in the
13 event of, for example, natural disasters?

14 A. Correct. Yes, with an ultimate aim, really, of trying
15 to bring down the use of agency where we can. So there's
16 some areas that would rely on agency in those scenarios and
17 we're trying to fill that so we don't have to rely on the
18 agencies to the degree that we perhaps have in the past.

19
20 Q. The next function I wanted to ask you about is just
21 beyond halfway down the paragraph, "Workforce governance
22 connection with professional workforce bodies, including
23 registration authorities and medical colleges"?

24 A. Yes.

25
26 Q. Can you just describe that function for us?

27 A. So my branch is the connection between the
28 Commonwealth Department of Health, the workforce areas of
29 the Commonwealth Department of Health, and the New South
30 Wales health system, and also Ahpra and some of the boards.
31 So we liaise - where there's, you know, proposals from
32 a board to change a process, that will come through my
33 branch and we actually - we send information out to our
34 system gather it and respond on behalf of the health
35 system.

36
37 Q. What about the engagement --

38
39 THE COMMISSIONER: You're both going to have to forgive me
40 for interrupting and just going back to a previous topic,
41 but I'm just interested in this.

42
43 Q. The unit in your branch that was established, you told
44 us, to look at deploying workforce to areas where there's
45 ongoing challenges, how long ago was that unit established?

46 A. So we actually established it as part of the pandemic
47 response - well, no, sorry, part of the bushfire response.

1 It carried over to the pandemic.

2

3 Q. So just before the pandemic?

4 A. Yes. It carried across into the pandemic and then
5 it - so it sat within the pandemic response unit at that
6 time, and then it transitioned across into my branch
7 formally and we've just made it permanent.

8

9 Q. And is the hope that it will expand beyond the
10 100 FTE?

11 A. Yes.

12

13 Q. So that it becomes a bigger workforce, if you like, to
14 lower the numbers of agency staff used?

15 A. That's right. We've just had approval to upscale to
16 400 FTE.

17

18 Q. Okay. So that's an ongoing process at the moment?

19 A. Correct. Predominantly nursing and allied health.

20

21 THE COMMISSIONER: Thank you.

22

23 MR GLOVER: Q. Are those 400 FTE envisaged to be
24 employees with NSW Health?

25 A. They will be, yes. And so out of the 100 that we've
26 got at the moment, there's a mix of engagement
27 arrangements, so we've got some that are permanent,
28 full-time workforce, and we've got others on a more
29 casualised arrangement.

30

31 Q. This is the workforce that sits within this cohort of
32 people who can be deployed wherever they may need it by
33 your branch?

34 A. Yes, and there's a bit of a - as I said, there is
35 a mix, and that's because there's particular employees who
36 like that casualised arrangement, and there's others who
37 want more certainty. So we offer both.

38

39 Q. And I think you said primarily it's nursing and allied
40 health staff?

41 A. At this stage, yes.

42

43 Q. Is there scope or ambition to expand it into the
44 medical workforce?

45 A. There is, yes.

46

47 THE COMMISSIONER: Q. I assume the fact that it's been

1 expanded from 100 to 400 FTE is an indication that it's at
2 least been as successful as hoped so far?

3 A. Yes, it has been - it's been very successful.
4

5 Q. Tell me if it has exceeded expectations as well.

6 A. I think it has exceeded expectations and there's been
7 very good response from the local health districts who are
8 the customers of that service. But we are scoping how we
9 might run a similar type of service for medical locums as
10 well.

11
12 MR GLOVER: Q. Is that what you refer to in your
13 statement as work being done to investigate a NSW Health --

14 A. Yes, that is.

15
16 Q. -- for want of a better term, locum agency?
17 A. Correct, yes.

18
19 Q. We might come back to that if time permits. The last
20 part of the role of your unit that I wanted to explore with
21 you this afternoon is collaboration with Commonwealth and
22 state jurisdiction on workforce programs. Can you just
23 describe that function, please? It's the very last one in
24 that third paragraph.

25 A. So the Commonwealth Department of Health has
26 a workforce branch and it will propose nation-wide programs
27 from time to time, where there might be priorities or we
28 need to incentivise people into certain classifications,
29 and we work with that unit to roll it out across the state.
30 That unit also is responsible for the national workforce
31 modelling, and so we work quite closely with that unit and
32 translate its work into our modelling.

33
34 Q. Firstly, how, in a practical way, does your unit work
35 with the Commonwealth unit on the national workforce
36 modelling?

37 A. We use the modelling information - well, going back
38 a step, we work collaboratively with that unit around what
39 should be prioritised for modelling, and then we pick up
40 that data and we bring that into our modelling itself. So
41 it's one of our data sources for our own workforce
42 modelling.

43
44 Q. And does your unit provide inputs to the Commonwealth
45 department for the purpose of its work?

46 A. It has its own methodology and gathers its own data,
47 but we certainly talk about that methodology with the

1 Commonwealth.

2

3 Q. Can I take you to your 16 July statement, please, and
4 we'll start at paragraph 16. In paragraph 16 through to
5 about paragraph 28 you describe a range of data categories
6 that the ministry collects and analyses?

7 A. Mmm.

8

9 Q. I won't take you through each of them in the interests
10 of time, but what I want to explore with you is, having
11 gone through the process of collecting and then analysing
12 it, how, in a practical way, does your team use that in
13 planning and projecting workforce demands, needs, across
14 the spectrum of NSW Health staff?

15 A. So probably in two ways. We report very regularly to
16 the system on its workforce performance, and that can
17 highlight emerging areas of need in the workforce that my
18 team may pick up. If it's a localised issue that we're
19 spotting, we will raise that with the local health district
20 to see if it's something that might be beginning as an
21 issue there but might spread to the state level.

22

23 Q. Just pausing there, are you able to assist us with
24 a practical example of what that might occur?

25 A. Well, we might - just hypothetically, we might spot
26 a spike in agency use in a regional local health district
27 that's over and above what has been a typical trend, which
28 might indicate a supply challenge. And if it's in a
29 particular discipline, we might look, then, to see if
30 that's going to be something that would be replicated
31 across the state, and, if so, we would work - we would
32 bring that to the directors of people and culture meeting,
33 which is a monthly meeting, and we'll look at whether or
34 not we need to tackle that issue as a statewide issue, and
35 then, if so, my branch would then pick that up as a piece
36 of work and engage with the local health districts in
37 coming about the solution.

38

39 Q. Will you also engage with the particular district
40 where that red flag has popped up?

41 A. Oh, yes. Yes, of course. I mean, that would be the
42 first point of inquiry. So another example, I won't name
43 the districts, but we've had cause to look into a trend in
44 a local health district where we were seeing some odd
45 trends against activity, so workforce growth against
46 activity, and so we needed to do a bit of a dive.

47

1 Q. Just pausing there, more staff but not a commensurate
2 expected rise in activity; is that what you mean?

3 A. Not necessarily just more staff, because staff
4 workforce growth in areas where there may not have been
5 activity, but activity growth in other parts of the
6 district. So it just - it caused us to do a little bit of
7 a deep dive into its workforce and what seemed to be
8 developing as a bit of a pattern. So for that you have to
9 work very closely with the local health district to
10 understand the way that they're managing their activity and
11 the way that they're rostering and managing that workforce.
12

13 Q. The example that you've just described, what might
14 that tell you as part of the system management about the
15 function of that particular LHD?

16 A. Well, in that particular example, it showed that there
17 might have been some workforce challenges in those smaller
18 hospitals, and as a result, the activity was transferred to
19 the larger hospital, but hasn't transferred back.
20

21 Q. And is part of the role of your team to work with the
22 local health district to assist them to ameliorate those
23 types of issues?

24 A. Correct. Correct, yes. So that's one way that my
25 workforce picks up that data - my team, sorry, picks up
26 that data. The other is that we look at it. When we go
27 about renewing and refreshing the overall health workforce
28 plan, we do a full analysis of the workforce trend over the
29 preceding period to see if there's areas of specialisation;
30 for example, that might need a particular area of focus.
31

32 There's probably a third, really, which we will both
33 see in data, but we'll also have feedback from different
34 disciplines, that there may be emerging issues, and some of
35 that, of course, can come through industrial associations
36 as approaches to the ministry, that might require us to
37 prepare a particular discipline workforce plan. So, for
38 example, psychiatry was an emerging area of challenge and
39 we've had to develop a psychiatry workforce plan in 2020.
40

41 Q. In that answer you referred to doing a full analysis
42 of the workforce over a particular period. How often is
43 that type of analysis undertaken?

44 A. Well, the health workforce plan is structured over
45 horizons, and so we've developed our last workforce plan
46 from 2022 to 2032 with three time horizons, so we'll be
47 doing that again the next year, the full analysis over the

1 preceding three years.

2

3 Q. Ongoing monitoring and review?

4 A. With ongoing monitoring, yes.

5

6 Q. It's a constant process, I take it.

7 A. It's a bit like painting the Harbour Bridge.

8

9 Q. Can I just ask you about a couple of particular
10 examples that you go to. In paragraph 24 you refer to
11 locum engagement?

12 A. Yes.

13

14 Q. You tell us that a recent trend has been the increase
15 in the use of locums, although you point out that it's
16 still a relatively small component of the overall
17 workforce.

18 A. Mmm.

19

20 Q. Has your team undertaken any analysis to seek to
21 understand why the use of locums has increased over the
22 past four years, I think, in your time frame?

23 A. Yes, we have.

24

25 Q. What has it discovered?

26 A. Well, in terms of causal factors, there's probably a
27 little bit of a national issue that's contributing to it as
28 well. What we found during the pandemic is that the
29 pandemic disrupted our supply in terms of the international
30 workforce, that would fill some of our holes, and so it
31 built an additional reliance on to medical locum agencies.
32 That has resulted in a supply/demand tension and the result
33 is higher prices in terms of prices being demanded by
34 locums and locum agencies. So we know that to tackle that,
35 there needs to be some national approach.

36

37 What we are finding, though, is, because of that being
38 a fairly attractive employment proposition for particularly
39 younger doctors who are prevocational training, that
40 there's a bit of a propensity now for doctors to have what
41 we're sort of seeing as a bit of a gap year to go and locum
42 for a period. There's some advantages in them doing that,
43 by the way, because it does give them exposure to a broader
44 number of hospitals than they would otherwise have exposure
45 to had they stayed with their specialty training in metro
46 Sydney, for example. But it is fuelling the supply/demand
47 challenge at the moment. And so we've got to reverse that

1 as a trend, which is a very difficult thing to do when it's
2 a national market. It's not just a NSW Health market.

3
4 Q. So although the component of the overall workforce
5 that is made up by locum doctors is relatively small, that
6 trend is presenting challenges to the delivery of care in
7 the system, is it?

8 A. Well, it's not so much delivering challenge to care in
9 the system, we're still supplying doctors. It's the way
10 that they're engaged that might vary across the system, and
11 it's the price point. So at the moment it's the price
12 point that's causing us some issue. They're still sitting
13 at about less than 1 per cent of the workforce, so it's not
14 like it's a dominant workforce at the moment. It's our
15 important back-up workforce that we can't do without. It
16 provides us that agility to very rapidly scale up and scale
17 down when we need to. But the price point is the
18 challenge, and if it continues as it is, you know, it's
19 quite a - it's a substantial cost at the moment to rural,
20 predominantly rural local health districts.

21
22 Q. And in paragraph 66 of your statement, you tell us
23 that there's some work being done on a national approach to
24 this issue. Are you familiar with that work and where it's
25 up to?

26 A. I am familiar with that work because that's being
27 coordinated through the national Health Workforce Taskforce
28 that my branch is hosting the secretariat. So I do have
29 a couple of teams in my branch that are working with the
30 states on that national work. At the moment, that's really
31 scoping work. It's to try and get an idea of what the
32 price point is looking like and the engagement methods,
33 what they're looking like in the different states.

34
35 Q. Through that work, I take it from your earlier
36 answers, you've come to the view that this is not a problem
37 confined to New South Wales?

38 A. No, it's absolutely not just New South Wales.

39
40 THE COMMISSIONER: Q. Is it a bigger problem in
41 New South Wales than other states?

42 A. No. No. In fact, some of the other states may not
43 have the drawcard that we do in New South Wales. We've
44 got - we're quite lucky in that we are still considered
45 a desirable employer for medical.

46
47 MR GLOVER: Q. Can I ask you about --

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THE COMMISSIONER: Q. That drawcard, what should I understand you to mean specifically in relation to that? What is the drawcard?

A. Doctors still like to train in New South Wales. I think --

Q. It's the large public teaching hospitals, is it?

A. It's the large public system. You get exposure to more things in New South Wales, particularly than you would in smaller jurisdictions. So there is still something that, thankfully, draws people to our state.

MR GLOVER: Q. Can I take you to paragraph 25, please?

A. Twenty-five?

Q. Twenty-five . This picks up something you mentioned in your last answer.

A. Mmm.

Q. There you tell us that the ministry analyses data on employment mix to determine how the NSW Health workforce is employed and to identify trends such as increasing casualisation of the workforce.

A. Mmm.

Q. Tell us what that issue is.

A. Well, there's a couple of things there. There's growing trends in terms of younger generations preferring casualised arrangements, and that is playing out particularly in medicine, as I said, that gap year concept, before they've put down roots. Young doctors, in particular, are finding that sort of casualised work very attractive. But it is also moving across into other disciplines, other corporate workforces, that we do see casualised arrangements as more attractive, particularly as Millennials and the Gen Z generations come through the workforce.

Q. And in your most recent statement you annex a Deloitte study about that particular feature of the workforce?

A. Correct, yes.

Q. What challenges does that shift in expectation of young workers present?

A. Well, I think it's almost more a problem for perception rather than what it presents in terms of the

1 operations of the health system. There are certainly some
2 advantages in continuity of workforce, but I think the
3 bigger challenge is perception, particularly from both
4 longstanding clinicians but also the public, around
5 stabilised workforces in health. I think we've got time to
6 adjust to it. They're progressively making their way into
7 the workforce. But I don't think it's as big a problem as
8 what people perceive it to be at the moment.

9
10 Q. When you say you think it's more a problem for
11 perception, what is the perception that you have in mind?

12 A. I think people judge success in terms of workforces by
13 the amount of permanent workforce that you've got. Now, we
14 have about 75 per cent - I've got the figures in my
15 statement. I think it's about 78 per cent or something,
16 permanent, then you've got a mix of temporary workforce,
17 and then you've got a casualised workforce that does also
18 include agency, and that's about 5 per cent.

19
20 A lot of people perceive the bigger the permanent
21 number, the better, but it doesn't necessarily mean that
22 that's any safer, but I think there is a perception that if
23 you don't have that permanent workforce, then you might not
24 be doing something right.

25
26 Q. Is that the issue that you refer us to, in
27 paragraph 147(e) of your statement, as one of the
28 challenges faced by the system in addressing training and
29 workforce attraction and retention - that is,
30 a misconception that permanent workforce is the optimal
31 employment condition?

32 A. Yes, and I think - so, yes, I think as a system we
33 need to adjust our indicators of success to account for the
34 changing workforce demographic.

35
36 Q. What change do you consider to be necessary in that
37 respect?

38 A. Well, I think the change in perception. So from my
39 branch perspective, I think we will need to really clearly
40 enunciate what we would see as success in the workforce, in
41 the workforce model and the workforce design, so that both
42 clinicians but also members of the public can understand
43 that that's not a failure if you don't have 75 per cent of
44 your workforce as permanent. I think it's reassuring the
45 public as well that, regardless of the mix, the services
46 can be provided safely.

- 1 Q. Can I take you ahead to paragraph 28?
2 A. Yes.
3
- 4 Q. Here you tell us that the ministry gathers data on
5 attrition and measures retention.
6 A. Mmm.
7
- 8 Q. What does one take from an analysis of rates of
9 attrition and retention within the system as a sign of the
10 health or otherwise of its workforce?
11 A. So in terms of our turnover - now, turnover is people
12 who have moved positions, so it's internal churn. Then
13 you've got attrition, which is people who've left your
14 organisation altogether.
15
- 16 Q. Just pausing there, so turnover, if a doctor was
17 a staff specialist but became a VMO, would that be
18 reflected in a turnover stat but not an attrition stat -
19 those definitions?
20 A. I'd probably need to just take that on notice. I'm
21 not a hundred per cent sure of that one. I can check that
22 one. But it would be, for example, a registered nurse who
23 works at Lismore Base Hospital and moves to Grafton
24 hospital, that would be in the turnover stats. But that
25 would not be reported as attrition, because that person
26 remains in the health system. And the reason that I was
27 unclear about the VMO was that's not through payroll, so -
28 they're paid differently so I might just need to check.
29
- 30 Q. It might have something to do with how the statistics
31 are collected; is that what you mean?
32 A. Beg your pardon?
33
- 34 Q. It might have something to do with how those
35 statistics are collected within the system -- -
36 A. Yes.
37
- 38 Q. -- is that what you're referring to?
39 A. Yes. So in terms of attrition, we're sitting at about
40 6.6 per cent; turnover, about 13. If you look at industry
41 average, most organisations would love to have an attrition
42 rate of 6.6 per cent. That's pretty stable. Turnover, on
43 average, is - well, in the public sector is about
44 18 per cent. So we're sitting below. But as I said,
45 attrition, 6.6 per cent, is significantly below what most
46 organisations would experience.
47

1 THE COMMISSIONER: Q. What do you mean by "industry
2 average"?

3 A. So AHRI - I've annexed to my statement an AHRI report.
4 They actually collect quarterly reports on business and
5 business turnover and they report industry average for
6 public sector as 18 per cent turnover.

7
8 Q. Beyond health, though?

9 A. Yes. Yes, broader public system. So I think in
10 summary - I think we're doing pretty well in health. We've
11 got a fairly stable workforce. We don't lose a lot of
12 workforce. Certainly not at the rate that I think people
13 seem to be under the impression that we do. 6.6 per cent
14 is not a significant number.

15
16 MR GLOVER: Q. Is there, though, a limitation to the
17 utility of attrition and --

18 A. Oh, of course.

19
20 Q. -- turnover stats in measuring the health of
21 a workforce?

22 A. Of course. Because one loss of a workforce in a very
23 small facility is felt, of course. So we don't use that to
24 counter challenges that are being experienced in our
25 hospitals, but we do look at the overall health of the
26 workforce.

27
28 Q. Can I take you to ahead to paragraph 33, please.
29 There you tell us that the ministry relies on the
30 government-wide PMES, that might be described as
31 the "People Matter" survey?

32 A. Correct.

33
34 Q. Then in paragraph 146 - I'm sorry, Mr Griffiths, bear
35 with me just a moment, I've lost my place. So 146(e):

36
37 *Limitations of a one size fits all PMES*
38 *measuring tool.*

39
40 A. Mmm-hmm.

41
42 Q. What's the particular limitation that you are drawing
43 attention to in 146(e)?

44 A. Well, when you're running an organisation the size of
45 the public service, there's only so many questions you can
46 allow each portfolio of the government to ask. It's
47 already a lengthy survey. We do have the opportunity to

1 ask some health-specific questions and we ask about 10 of
2 those. I'd love to ask a lot more, but it's a statewide
3 survey. So we do collect some very localised health
4 information, but it's limited to those questions.

5
6 Q. When you refer to localised health information, is
7 that through the 10 questions that can be added?

8 A. Correct, yes. We also had an arrangement with the
9 vendor that we analyse some additional questions and have
10 a culture index created.

11
12 Q. I might come to that directly. If you go to
13 paragraph 97, please, in this passage of the statement -
14 I'll come to the culture index or score in a moment - you
15 tell us that in 2011, 2013 and 2015, there was a unique
16 survey to NSW Health?

17 A. Yes.

18
19 Q. Is there a particular reason why there is no longer
20 a unique survey to NSW Health?

21 A. Well, it really replicated the PMES to a degree. We
22 did have that additional index in the culture index, but at
23 the time, it was something that was expected to run across
24 health as well, as in the PMES, so we looked to see how we
25 could utilise the PMES in its place.

26
27 Q. And that having now been in the system for some nine
28 years following, does the PMES replicate satisfactorily
29 what was previously a NSW Health specific survey?

30 A. Yes, I think so, yes. I was in the system at the
31 time, and the reports that we get through the PMES, with
32 our health questions, provide us the indices that
33 I've mentioned, the engagement and the culture index, and
34 for us, that was important to trend that information from
35 2011, so I think it does give us some utility.

36
37 Q. If we scroll down, we will see there a table at
38 paragraph 101. This is the table that has been updated.

39
40 MR GLOVER: Commissioner, if your copy of the statement
41 looks like mine, some of these numbers will be cut off, but
42 there's the revised table on the screen.

43
44 THE COMMISSIONER: No, mine looks like that.

45
46 MR GLOVER: You've been favoured with an updated version.

47

1 THE COMMISSIONER: I think mine already looks like that,
2 yes. Thanks.

3

4 MR GLOVER: Q. What is the culture index measuring?

5 A. There's a range of questions that are utilised to
6 develop a reflection on the culture of the organisation.
7 I don't have the questions at hand. They're consolidated
8 to come up with an index that gives a bit of an indication
9 around the general culture in the organisation.

10

11 Q. When you say "an index around the general culture in
12 the organisation", what are we measuring? What is it
13 designed to tell one, if one says, "Well, the culture index
14 in 2023 was 61 per cent"?

15 A. The general sense of satisfaction with the
16 organisation.

17

18 Q. From its workforce?

19 A. From the workforce, yes.

20

21 Q. Can I take you to paragraph 42, please. Here you
22 introduce the concept of workforce modelling. Can you just
23 describe in general terms what is involved in the concept
24 of workforce modelling?

25 A. Sure. Well, at a very high level, we look at the
26 existing workforce stock and we then overlay that with what
27 we see as the input - so what's coming through in terms of
28 academic pipeline - and then factor in anticipated exits,
29 and that gives you a little bit of an indication of what
30 the stock will look like over the forward years.

31

32 Then we also factor in demand and how demand will
33 change over time. We do that in a - we look at a number of
34 different datasets. We work with our colleagues in system,
35 information and analytics to gather that information, as
36 well as we consult quite extensively during the period of
37 analysis to get a sense of models of care change and
38 whether or not there's going to be significant changes to
39 the way that we do business, and then we pull that together
40 as an analysis to see what we might need to do in terms of
41 supply.

42

43 Q. Is this done at a system level or does it become more
44 granular than that?

45 A. No, it's - well, it's done at the system level. If
46 I look at the nursing and midwifery modelling, for example,
47 we've just done the system modelling, and what we're doing

1 now is moving to local health districts to give local - to
2 do some local modelling with them. So in nursing it's sort
3 of done at both levels.
4

5 Q. Do I take it from that that similar modelling for the
6 medical workforce is limited to system-wide approach?

7 A. We model medical both on overall supply but then we
8 focus more on specialties and we do keep that at system
9 level.
10

11 Q. So how, then, does a particular LHD utilise the
12 system-wide modelling in its own planning purposes?

13 A. So when we do the modelling, we look at the supply
14 across the local health districts and we map that out. We
15 then release that modelling to local health districts for
16 incorporation into their own workforce planning. So they
17 have an idea of the supply in their regions and what to
18 expect in terms of statewide changes to supply across those
19 specialties.
20

21 Q. So in mapping future workforce at a system level, it
22 descends, does it, to workforce that would be available in
23 each of the LHDs?

24 A. For medical, not so much to what I think you're
25 suggesting. Nursing, yes. Nursing we will go to quite
26 granular detail with the local health districts. For
27 medical, we keep it at the system level, encouraging local
28 health districts, though, to look at those specialties that
29 are in demand, to incorporate those into their local
30 workforce plans.
31

32 Q. And how, as a practical matter, do they do that, to
33 your understanding?

34 A. Sorry, can you say that again?
35

36 Q. How, as a practical matter, do they do that, to your
37 understanding?

38 A. From my understanding, when I've met with local health
39 district directors of people and culture, they - well, they
40 really look at it quite - if I think of one of the local
41 health districts who has done it quite well, it's probably
42 one of the western districts. They actually translated
43 a lot of that information into their own health workforce
44 plan or their local health district workforce plan.
45

46 The problem with medical specialties though, as you
47 know - or as you would have heard - is a lot of that - it's

1 a difficult market to influence at those local levels, and
2 so we would really need local health districts to be
3 working with us to see how we can assist around some of
4 those specialty training positions.

5
6 Local health districts develop and create training
7 positions, but we need to give them some guidance around
8 some of the areas that are in demand in terms of supply.

9
10 Q. Is there then a difference on the one hand between
11 modelling of future workforce and planning future
12 workforces within the individual LHDs?

13 A. Sorry, I don't understand the question.

14
15 Q. That's probably because it was a bad one. When you
16 are modelling --

17
18 THE COMMISSIONER: I don't understand it either, if that
19 helps.

20
21 MR GLOVER: No, that's fair. I did say it was bad.

22
23 Q. When you are modelling the medical workforce at
24 a system level, and then you tell us that it is then
25 utilised by the local LHDs in their planning, in answering
26 that question you drew a distinction between the medical
27 and the nursing workforces in the sense that it is hard to
28 influence the medical workforce. Is it the case, then,
29 that the modelling looks at the workforce as a whole, but
30 the planning phase is where the LHD will pick up and run
31 with what it needs to do to attract the workforce to that
32 particular area?

33 A. Correct, yes.

34
35 Q. Does the ministry provide support to the LHDs in doing
36 that?

37 A. Guidance. Yes.

38
39 Q. In what form?

40 A. When you say "support", it sort of implies there might
41 be dollars there, which may not necessarily flow, but --

42
43 Q. Or in kind?

44 A. Yeah - well, perhaps, but it's more guidance around
45 what to focus on and how to do it. So we can give them
46 some higher-level guidance around - you know, for example,
47 if they're looking at trying to focus on some disciplines

1 that are in oversupply, we probably guide them away from
2 that, unless there's a genuine demand need in their
3 district for a particular service, and perhaps focus on an
4 area that is more relevant to their service need.

5
6 Q. In paragraph 42, you tell us that analysing,
7 forecasting and managing the workforce supply is complex
8 due to the number of stakeholders involved.

9 A. Mmm.

10
11 Q. As part of this system-wide modelling process, does
12 your team engage with those various stakeholders?

13 A. Yes, they do, yes.

14
15 Q. Who are they?

16 A. Well, there's quite a number. So obviously there's
17 Commonwealth, in terms of the Department of Health,
18 department of ageing. There's various colleges, so medical
19 colleges, other professional colleges, industrial
20 associations, health agencies, insurance companies, private
21 operators. We go quite wide so that we get a pretty good
22 understanding of supply and demand.

23
24 Q. In terms of the colleges and other training
25 institutions, do you agree that as part of a comprehensive
26 workforce plan, looking at the numbers of clinicians to be
27 trained and where they might be trained is an important
28 part?

29 A. Absolutely. And I know I didn't say "education
30 providers", so thank you for prompting. Yes, absolutely.
31 And if I can give you an example --

32
33 Q. Please do.

34 A. -- of that, from time to time when vice-chancellors
35 might be appointed at universities, they do like to come
36 and meet with the health minister, and we will usually
37 accompany them on that visit. In one of those engagements,
38 one of the vice-chancellors suggested he was going to have
39 a look at rallying for some additional Commonwealth
40 supported places in a discipline. It was an allied health
41 discipline. It was one of the ones that wasn't necessarily
42 in supply challenge, it was quite adequately supplied,
43 which was a great opportunity for us to say, "Look, we
44 actually model our workforce and we've got very good allied
45 health modelling on - it's published, and we would really
46 love you to have a look at some of those that we would like
47 to see additional graduates."

1
2 So I think I was talking about, at the time, looking
3 at social work and exercise physiologists, from memory, and
4 moving away from something that was possibly popular with
5 school students but really well supplied.
6

7 Q. Can I take you, on this topic, ahead to paragraph 59
8 of your statement.
9

10 THE COMMISSIONER: Have you got --

11
12 MR GLOVER: I should be finished by 4.30.

13
14 THE COMMISSIONER: Do you want to keep going until 4.30?
15

16 MR GLOVER: Yes. Mr Griffiths is unable to be here
17 tomorrow. I'll try to finish it by then.
18

19 THE COMMISSIONER: Of course. Yes, keep going.
20

21 MR GLOVER: Q. Paragraph 59. Just down to 59, operator?
22 Thank you. This is part your statement where you address
23 workforce maldistribution.

24 A. Mmm.
25

26 Q. In this paragraph, you highlight that which we've
27 heard elsewhere about the metro-focused nature of specialty
28 medical training.

29 A. Mmm.
30

31 Q. In the last sentence you tell us that NSW Health
32 continues to work with stakeholders to encourage training
33 in regional and rural locations. Can you just tell us a
34 little bit more about that work, as you understand it?

35 A. So we've had some really constructive conversations
36 over the last 12 months in particular with medical
37 colleges, for example. We've been engaging very closely
38 with the deans of the various schools. I think there's
39 a growing appetite to support regionalised training and
40 placements. There's obviously a lot of things that we need
41 to consider in increasing training, particularly in those
42 regional areas, and supervision is one that does cause us
43 some difficulties.
44

45 But there have been some really constructive
46 conversations over the last 12 months, as I said, not just
47 with colleges but with universities, with TAFE NSW. It's

1 been quite a good period to sort of ideate with them around
2 how we might address some of the supply challenges in rural
3 New South Wales.
4

5 Q. In addressing some of those supply challenges, do you
6 think that one of the functions that can be performed by
7 the centre is really leading the engagement with the
8 specialist medical colleges about some of those
9 accreditation processes that might limit the opportunities
10 to train outside metro areas?

11 A. Yes, absolutely.
12

13 Q. Rather than perhaps it being dealt with at a facility
14 or LHD basis?

15 A. Yes. It would need to involve both, but yes, that's
16 something that I think we have a good - we're positioned
17 well to facilitate that.
18

19 Q. And if there were more training opportunities in rural
20 and regional locations for medical specialists, I take it
21 you would see that as a benefit to the overall
22 sustainability of the workforce in that region?

23 A. Yes, for sure.
24

25 Q. You tell us in paragraphs 51 and following about
26 workforce planning. I've asked you about some of those.
27 But I want to take you to some of the challenges you
28 highlight in paragraph 146. I've dealt with one of them
29 already. You tell us it's challenging in New South Wales
30 to build a full and accurate picture of workforce need
31 against demand and then to properly develop workforce
32 strategies that address emerging workforce needs. What is
33 the particular challenge that you are highlighting in that
34 sentence, the first sentence of paragraph 146?

35 A. Well, that particular following sentence there is our
36 data picture. There's a lot of data in health. One of the
37 challenges that we have in health is translating that to
38 useful information so it gives us a clear picture of
39 workforce demand.
40

41 The reason that it can be so challenging is
42 workforce - particularly specialised workforces - may not
43 be needed or may not be possible to be moved to areas where
44 there's fractional demand. So it's understanding that
45 fractionated demand in some of those small centres and
46 whether there's adequate demand for a service to justify
47 one FTE of a specialised practitioner there. So getting

1 that picture around what the true demand is in a location
2 is quite difficult, because some of that service is
3 actually provided out of Sydney rather than out of
4 particularly regional New South Wales.

5
6 Q. Aside from that example, what is it about data
7 availability, access and governance that present
8 a particular challenge in workforce planning?

9 A. I think - I think what I was meaning by that
10 paragraph was more along the lines of getting all that data
11 but getting it in a way that's consistent enough to be of
12 use - so our finance data, our activity data, our patient
13 data. It's not necessarily aligned with workforce data,
14 because they are recorded differently.

15
16 Q. Is that the issue that you are talking about in
17 subparagraph (a) --

18 A. It is.

19
20 Q. -- the need for manual correlation of multiple
21 datasets?

22 A. That's right.

23
24 Q. Is there work being done by your team to overcome that
25 challenge as to how data in the system is captured and then
26 reported?

27 A. So we definitely work with our colleague branches to
28 manually correlate, but that is a pretty big exercise and
29 we're one of many data branches that would be impacted.

30
31 Q. If there wasn't a need to manually correlate multiple
32 datasets - that is, it was recorded in a consistent way
33 across the system - that would no doubt be of benefit to
34 the work of you and your team?

35 A. Absolutely, yes.

36
37 Q. Are there steps being taken to arrive at that
38 situation?

39 A. Not that I'm aware of. I'd love that, but I'm not
40 aware of it.

41
42 Q. Whilst we're on paragraph 146, in (b) you identify
43 some limitation of the use of important datasets arising
44 from privacy legislation?

45 A. Mmm.

46
47 Q. Can you give us an example?

1 A. Some of our data is collected for particular purposes,
2 and if we want to use that information in a different way,
3 we're restricted by the privacy legislation.

4
5 Q. What might be an example of an important dataset that
6 you would like to use in your work that currently is not
7 available to you?

8 A. Some of our EEO data, for example, gives us some
9 useful demographic data but it's not necessarily why we
10 would collect it. Similarly, some of the medical
11 information that we collect at the time that we engage our
12 workforce, but we can't necessarily use it in all
13 circumstances.

14
15 Q. Forgive me, you said "EEO data"?

16 A. Yes, the diversity data.

17
18 Q. Thank you. Whilst I've got you on that page, if
19 I take you to paragraph 147(a) --

20 A. Mmm-hmm.

21
22 Q. -- this is part of the challenge you've highlighted in
23 addressing training and workforce attraction and retention.
24 You tell us about the multiple sectors and jurisdictions,
25 and in the last sentence you tell us that it's not possible
26 for NSW Health to control its medical workforce pipeline to
27 address predicted demand, no doubt because of the roles
28 played by those other stakeholders?

29 A. Yes.

30
31 Q. But it's possible, isn't it, for NSW Health, as
32 a system, to influence its pipeline?

33 A. Oh, yes, absolutely.

34
35 Q. And does it seek to do so?

36 A. We do.

37
38 Q. In what ways?

39 A. Well, we work - for example, we work closely with the
40 Commonwealth around what we're seeing as emerging workforce
41 need. We're not obviously able to control that, but we can
42 advocate for additional particularly Commonwealth supported
43 places, which tends to be a pretty attractive pathway for
44 domestic students.

45
46 Q. What about after those students have undertaken their
47 medical degrees? Are there levers that NSW Health can pull

1 to influence its pipeline of workforce?

2 A. Yes. We are working - as I said, we've had some
3 really good constructive conversations with colleges over
4 the recent 12 months around the specialist pipelines, and
5 while we fund those training places, there are some
6 challenges in terms of the requirements that are required
7 to be met from colleges from an accreditation perspective.
8 So mainly supervision is the challenging one for us, and
9 obviously activity. But we are really seeing some shift in
10 the relationship with medical colleges, so I'm pretty
11 confident that, moving forward, I think we'll have a pretty
12 constructive dialogue around workforce need.

13

14 Q. Is that engagement with the colleges - I think I asked
15 you whether it would be better driven by the ministry than
16 the individual LHDs earlier?

17 A. Yes.

18

19 Q. But is it a coordinated effort across the various
20 specialist colleges?

21 A. I think it needs to be. And I do think the ministry
22 is positioned well to be the conduit for that conversation,
23 but it's important that the whole system does engage in the
24 conversation. In recent times where we've had some good
25 dialogue, it's highlighting that I think there's appetite
26 in colleges to consider different ways, for example, of
27 supervision that I think we'll be able to work with. So an
28 example is the intensive care college with virtual
29 supervision. So I think that's exciting. I think it's
30 going to be a much more constructive dialogue moving
31 forward.

32

33 Q. We've spoken a little about the pipeline of medical
34 workforce. Are there particular challenges faced by the
35 system in its pipeline of its nursing and midwifery
36 workforce.

37 A. Sorry, are there --

38

39 Q. Are there any particular challenges associated with
40 the NSW Health pipeline of nursing and midwifery workforce

41 A. So registered nursing, in terms of supply, is looking
42 like supply will meet our demand projections. That's at
43 a state level. That's not accounting for maldistribution.
44 So there will always be some local challenges for supply in
45 different local health districts.

46

47 Midwifery is a different story. There are real

1 challenges with midwifery supply. We would need to
2 significantly increase the pipeline of midwifery to meet
3 demand, and so it is also important, then, that we do look
4 at local demand to understand where some of those - because
5 it doesn't account for the maldistribution, to really get
6 a picture of what's it going to look like at particularly
7 regional local health districts.

8
9 In terms of enrolled nursing, we also need to - we
10 would need to increase the pipeline in enrolled nursing,
11 because the current pipeline is not going to meet projected
12 demand.

13
14 Q. And in the case of midwifery and enrolled nurses, are
15 they challenges that NSW Health has the ability to
16 influence, if not control?

17 A. Yes, and there's some good work occurring in that
18 space. So from midwifery, while we still have a lot of
19 work to do, NAMO, the Nursing and Midwifery Office, offer
20 a mid-start grad - sorry, a grad start, and I'll get them
21 mixed up.

22
23 Mid-start is for registered nurses transitioning
24 across into midwifery, which is helping with the New South
25 Wales position. Other states don't do that, so I think
26 that's a really, really sensible strategy from our nursing
27 counterparts.

28
29 Enrolled nursing, we've had some very good
30 conversations with TAFE NSW and they're very interested and
31 have started work around some additional regional places
32 for enrolled nurses. So we are commencing work on some of
33 the solutions. We're not just reporting it and leaving it.

34
35 Q. What about allied health workforce? Are there
36 challenges in pipeline of allied health workforce?

37 A. There are. The NDIS is causing some challenges in
38 terms of supply across the allied health disciplines. So
39 there are a range of those where work does need to be done
40 to improve the pipeline. So, you know, there are examples
41 where we've identified some critical - small but critical
42 workforces in the allied health area that we've put some
43 funding into to try and increase training of existing
44 allied health practitioners into some of those specialty
45 areas.

46
47 But we're also using our modelling information, as

1 I mentioned before, to really try and influence
2 universities around courses on offer, because we do still
3 have in Australia some courses in allied health that turn
4 out too - you know, graduates and it's - I don't like
5 really using the term "oversupply", but there's adequate
6 graduates. And some of the areas, particularly in the
7 areas where we would like to see some emerging practice, we
8 need to build some of those pipelines. So I'd like the
9 universities to really consider our modelling information
10 so that we know that we're getting some pipeline into some
11 of those areas.

12
13 Q. I take it, for that purpose, the modelling information
14 is shared with those institutions?

15 A. It is. They are. We write to the universities and
16 share our modelling information.

17
18 Q. Is it shared with any other stakeholder in the system?

19 A. Yes, we write quite widely, really. We send that out
20 to universities. We send it to local health districts. In
21 the case of medicine, we send it out to medical colleges.
22 So we share with those stakeholders that we think are going
23 to be able to influence our pipeline.

24
25 Q. Does that extend to industry bodies, unions, for
26 example?

27 A. I'd have to take that on notice. I'm just not sure.

28
29 Q. All right. Is one of the levers that NSW Health can
30 pull to influence its pipeline the establishment of
31 incentives in the system?

32 A. Mmm-hmm. Mmm-hmm.

33
34 Q. And you tell us about a number of them in paragraphs
35 86 and 87 of your statement. Mercifully for everybody, I'm
36 not to going to take you through each of them, but what
37 I would ask you is what work, if any, is done to assess
38 whether these incentives are having their intended effect,
39 either by attracting new employees or retaining existing
40 ones in areas of need?

41 A. Well, I'll speak very specifically about the Rural
42 Health Workforce Incentive Scheme, which - that was
43 a collaborative scheme that came about because of emerging
44 issues, pre-pandemic, in rural New South Wales and was
45 exacerbated by the pandemic.

46
47 In terms of the way we constructed that scheme and we

1 monitor that scheme, we looked at areas of rurality that,
2 using the Modified Monash Model, classified MM3 to MM7,
3 which is fairly remote. So MM3 is sort of fairly
4 large-sized regional towns like Dubbo, through to very,
5 very remote areas, and we've scaled that scheme on the
6 basis of rurality, so the more difficult, the higher the
7 value of the incentive. And we report that - we actually
8 report that on a weekly basis to sort of monitor trends
9 across local health district movements, but that reporting
10 is designed to ensure that we can see whether or not the
11 scheme is having an impact.

12
13 What it's really showing us is that we're seeing a lot
14 more stability in the rural workforce now. So one of the
15 indicators of success for that scheme was retention. So
16 while we obviously wanted to attract people, we were seeing
17 some lowering retention rates, at the back end of the
18 pandemic, which has now - we've arrested that sort of trend
19 and, in fact, it's trending positively upward again. So
20 those sort of - when we develop a scheme, we try and build
21 a success indicator so that we can see whether it's met its
22 intention.

23
24 Q. Although perhaps not as frequently reviewed as that
25 example --

26 A. Yes.

27
28 Q. -- was similar things - similar work done in relation
29 to each of the incentive schemes that you've set out in
30 your statement?

31 A. So yes, but certainly not weekly, as that one is. The
32 tertiary health subsidies, for example, we're reporting
33 those every fortnight, I think, and that's a government
34 commitment, so the government's very interested in how
35 we're tracking with that and that has seen - we've now
36 given out the full set of subsidies for this year.

37
38 Q. When you say that the success of these initiatives are
39 reported, reported to whom?

40 A. For the subsidies, do you mean?

41
42 Q. Yes.

43 A. So reported up through to the ministry executive but
44 also through to the minister's office, in that case.

45
46 Q. Finally, I just want to ask you about something you
47 refer to in your 2 August statement. It's the topic of

1 vacancy data. In paragraph 6 and following you issue
2 a caution about the utility of vacancy data.

3 A. Mmm.

4
5 Q. In paragraph 4 you tell us that the ministry collects
6 that data from time to time. How frequently does the
7 ministry collect the data on medical workforce vacancies?

8 A. For medical workforce vacancies it's really collected
9 fairly infrequently. We've collected it just a few weeks
10 ago. Prior to that, it would have been last year that we
11 last collected that data. It's really as needed. If we
12 think there's some information coming from the system that
13 is suggesting there's an issue with our supply, then we'll
14 go about gathering that data. The reason we don't do it
15 too frequently is it's very manual and it is an impost for
16 the local health districts to have to manually gather that
17 information.

18
19 Q. When it is gathered, though, what are you - you and
20 your team - looking for when you analyse vacancy data
21 across the system?

22 A. Well, which specialties are in supply challenge. If
23 there's a - if it has come about because of some suggestion
24 from the system that there's an area that is of particular
25 concern or worry, then we will obviously look for those
26 areas to see if there's a need to, as a system, address
27 something that might be coming about.

28
29 So an example would be psychiatry. We collected that
30 information recently because there's been focus on some
31 challenges around mental health and in particular the
32 psychiatry workforce.

33
34 Q. So what might vacancy data - let's use, for an
35 example, any particular LHD about the psychiatry
36 workforce - tell the system?

37 A. Well, we really more look at total numbers. I mean,
38 we will look at which local health districts are
39 experiencing particular concern, but we also look at
40 whether or not the workforce has grown or contracted, and
41 if it's grown or contracted in particular areas or across
42 the specialties - sorry, across the staff specialist
43 workforce or is it in the VMO workforce or is it in the
44 junior workforce?

45
46 Q. So it's one of the integers that goes into part of
47 your workforce planning and modelling processes?

1 A. Mmm. There's usually a hypothesis that is considered
2 at the time, so it might be we're seeing we're losing staff
3 specialists to VMOs, you know, and so we'll go to that
4 information to see if there's any validity to that.

5
6 Q. And part of the caution you urge on us in your
7 statement is that, if looked at in a stand-alone way,
8 vacancy data might not represent the effectiveness of the
9 system as a whole; correct?

10 A. That's right, yes.

11
12 Q. And to the extent that then vacancy data would be made
13 public, that would be a concern to you, would it?

14 A. Yes. And for a number of reasons. The first is that
15 I don't think there's a clear understanding around what
16 "vacancy" even means, and we would obviously need to - when
17 we go out in the system asking for vacancy data, we have to
18 put a pretty clear definition around what we're gathering,
19 and I go into some detail in the statement around the
20 variable definitions of "vacancy".

21
22 But the reason that I hold a concern about vacancy
23 data just being publicly available is it is not
24 a reflection of the safety or of the effectiveness of the
25 health service; it's routine churn that occurs in every
26 organisation, and if that information is then
27 misunderstood, I think it unnecessarily erodes public
28 confidence in that service.

29
30 Q. If it were to be made public, though, both of those
31 matters could be taken into account by explanation or
32 qualifiers accompanying the data; correct?

33 A. Could be, but I think there's also risk that that
34 information then is taken up and used for a purpose.

35
36 THE COMMISSIONER: Q. Do I take it that you would have
37 a concern that if that - that the way that vacancy rates
38 are discussed in the public domain may not have the
39 qualifiers or the explanations that are contained in 6(a)
40 to (c) of your supplementary statement?

41 A. That's right, Commissioner. But also --

42
43 Q. In other words, they'll just be published as vacancies
44 without any indication that there might be someone in that
45 role providing the healthcare services that are needed?

46 A. Correct. And in some cases, people that fill that
47 role are highly qualified, highly experienced. So it's

1 really not an issue of safety concern. Yes.

2

3 MR GLOVER: Thank you, Mr Griffiths. I have no further
4 questions for this witness.

5

6 THE COMMISSIONER: Do you have any questions for
7 Mr Griffiths, Mr Cheney?

8

9 MR CHENEY: No, Commissioner. Can I just check that your
10 copy and everybody's copy of the supplementary statement
11 includes the annexure to it that was referred to in the
12 last paragraph, or is that something that is to be
13 provided?

14

15 THE COMMISSIONER: What is the annexure?

16

17 MR CHENEY: It's a table that collects questions that have
18 been deferred to Mr Griffiths by other witnesses and his
19 responses to it. I'm told it is in the hard copy.

20

21 THE COMMISSIONER: Someone's got it. Not me. But I guess
22 it will end up coming to me.

23

24 MR GLOVER: It's H5.21.2.1. It's the annexure referred to
25 in paragraph 20 of Mr Griffiths' second statement, which is
26 [MOH.0010.0450.0001]. In that table, Mr Griffiths has very
27 helpfully collected the questions that I think I mainly
28 asked witnesses, where they deferred to him, and given an
29 answer. So I don't need to take him to it.

30

31 THE COMMISSIONER: Very good. We do have that. All
32 right. Thank you very much for your time. We're very
33 grateful, Mr Griffiths. You are excused.

34

35 THE WITNESS: Thank you.

36

37 <THE WITNESS WITHDREW

38

39 THE COMMISSIONER: We adjourn until 10 o'clock tomorrow?

40

41 MR GLOVER: Thank you.

42

43 THE COMMISSIONER: Thank you. We'll adjourn until then.

44

45 **AT 4.36PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
46 **TO WEDNESDAY, 7 AUGUST 2024 AT 10AM**

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